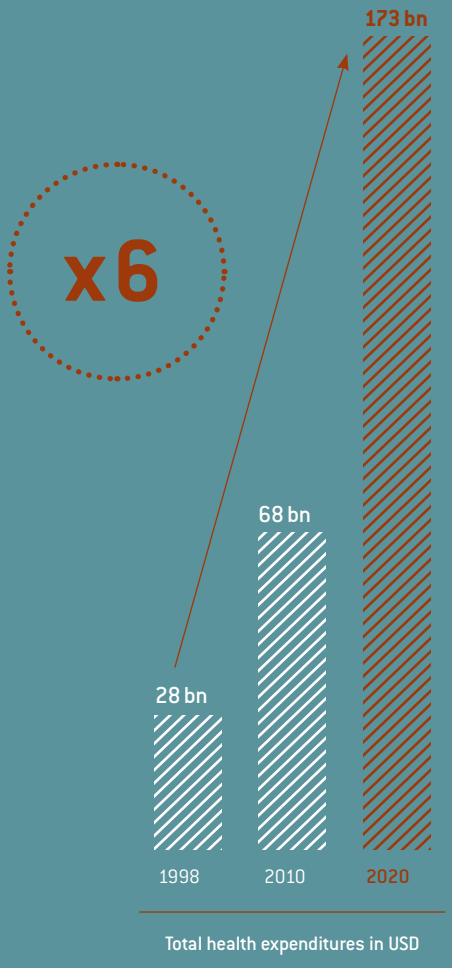
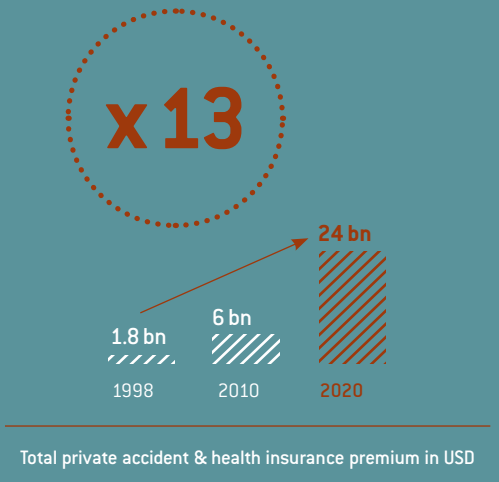
think:act STUDY

In-depth knowledge for decision makers

Health expenditures are booming in Southeast Asia – and the private health insurance market is taking off





SOUTHEAST ASIA – THE NEW FRONTIER FOR HEALTH INSURERS

SOUTHEAST ASIA – THE NEW FRONTIER FOR HEALTH INSURERS

CONTENTS

INTRODUCTION

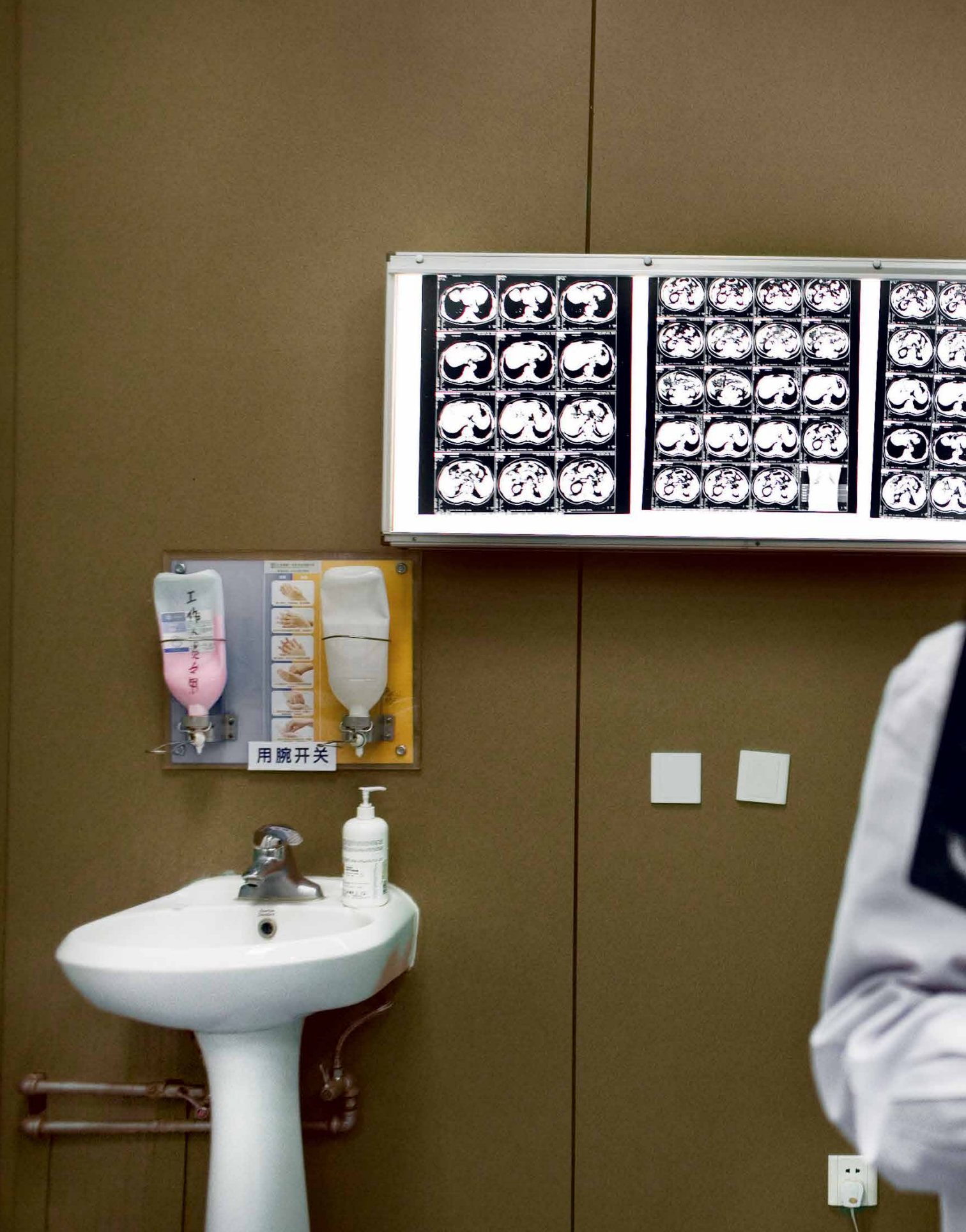
Demand for healthcare is growing rapidly in Southeast Asia (SEA). Overall health expenditures increased two and a half times between 1998 and 2010, reaching nearly USD 68 billion. Private insurance accounts for 4% of this total. Three major factors are driving this development: steady population growth, steep increases in medical costs, and – most importantly – increases in per capita consumption of healthcare services.

The maturity of the healthcare market varies widely across Southeast Asia. Cambodia, Laos and Myanmar are still at an early stage of development, while Indonesia, Vietnam and the Philippines provide basic healthcare services to their populations. Malaysia and Thailand are at a more advanced stage of development and now focus on providing high-quality care. The most advanced market is Singapore, which promotes private contributions to the financing of healthcare.

We anticipate that health expenditures will maintain their growth trajectory, with overall health expenditures in the region reaching USD 173 billion by 2020 – two and a half times its 2010 level. Private health insurance stands to benefit greatly from this growth, increasing its share of expenditures from 4% to 6%. Overall, private health insurance will be driven by the fast-growing mass affluent segment looking for better access to higher-end private healthcare while trying to minimize out-of-pocket expenditures. However, differences will exist between markets. In Indonesia, Vietnam and to a lesser extent Thailand, we anticipate that private health insurance will gain in popularity with less affluent consumers too, as a substitute for the inadequate public insurance schemes in those countries. Overall, the region will see a fourfold increase in the total personal accident and health premium, reaching USD 24 billion in 2020 (2010: USD 6 billion). Malaysia, Singapore, Thailand and Indonesia will remain the four largest markets by far.

Health insurance has historically been driven by the more profitable individual segment in most Southeast Asian countries. This segment of the market is characterized by low-price policies, limited coverage and riders on personal accident or life policies. The next decade will see the group segment making an increasing contribution to the total market, with insurers taking greater advantage of the potential represented by the large numbers of medium-sized enterprises across Southeast Asia.

The health insurance sector in Southeast Asia offers significant opportunities. But it is not immune to challenges, such as boosting customer acquisition, balancing product affordability and coverage, and coping with fast-rising medical costs. Ultimately, insurance companies must build customer trust in their brand and service offering by providing adequate coverage, guaranteed payouts and a smooth, hassle-free claims process. Players who rise to these challenges by implementing best practices on a local level will benefit richly from the growth in the market and, in turn, contribute to the growth and maturity of Southeast Asian healthcare.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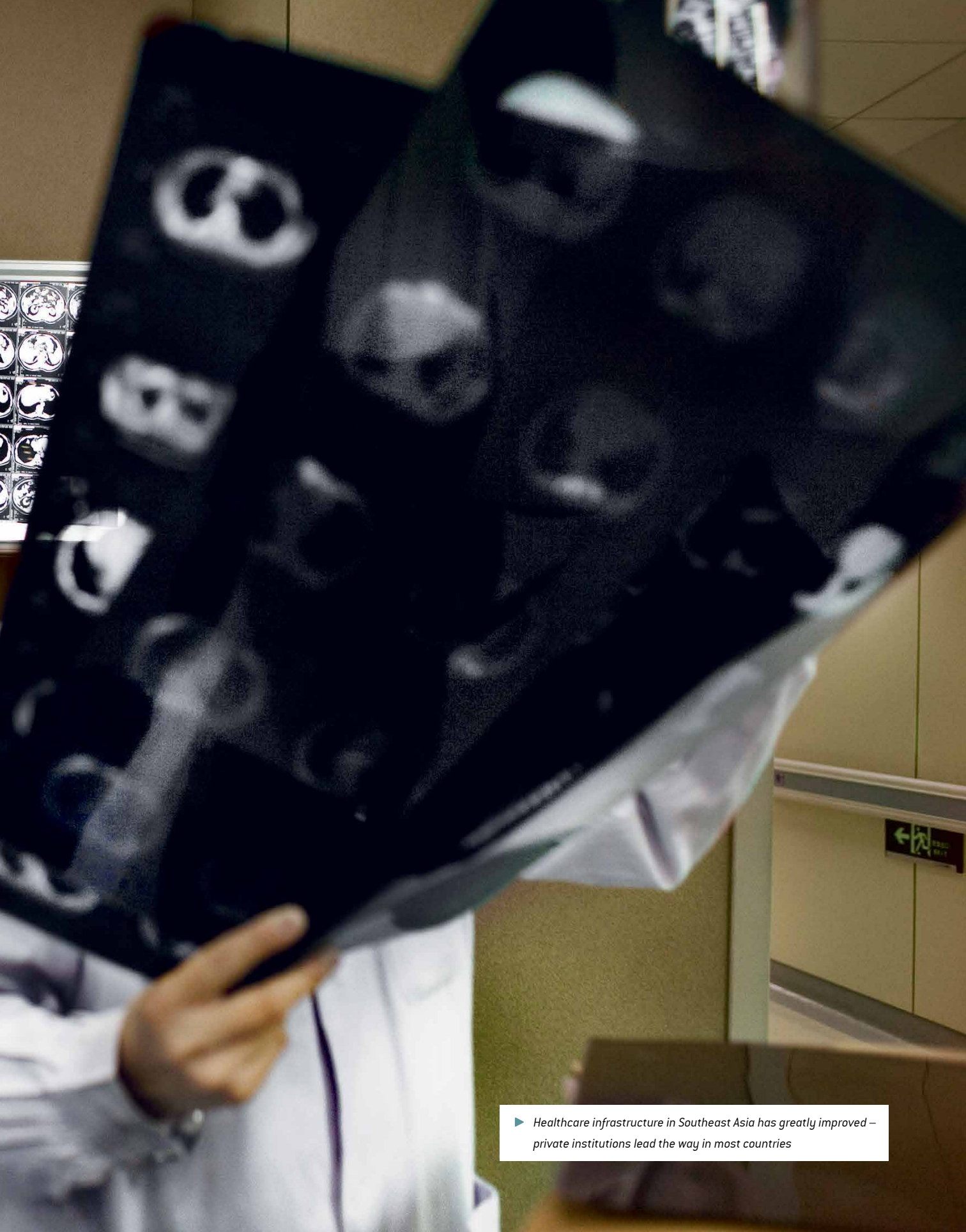


Healthcare infrastructure in Southeast Asia has greatly improved – private institutions lead the way in most countries

HEALTHCARE IN SOUTHEAST ASIA – A GROWING PRIORITY

HEALTH EXPENDITURES HAVE MORE THAN DOUBLED

The healthcare sector has been growing strongly in Southeast Asia over the last decade, outstripping growth in GDP. Total health expenditures in the nine key countries in the region – Cambodia, F2 Indonesia, Malaysia, Myanmar, Laos, Singapore, the Philippines, Thailand and Vietnam – more than doubled in the period from 1998 to 2010, up from USD 28 billion to USD 68 billion. This represents an annual growth rate of 8% per year. Thailand, Malaysia and Indonesia are the three largest markets, together accounting for over two-thirds of total health expenditures across the region.

What lies behind this rapid growth? In a nutshell: volume and F1 price. The key factors powering the market are population growth in the region, rising medical costs and increases in average per capita expenditure on healthcare services:

The volume effect

The volume effect is driven by population growth. Southeast Asia had a population approaching 600 million in 2010, up a massive 30% on its 1998 level of 462 million. This growth contributes to the increase in health expenditures: More people means more demand for healthcare. Indeed, the increase in population alone explains 19% of the growth in health expenditures between 1998 and 2010.

The price effect

The price effect has two main drivers: increases in medical costs and growing per capita consumption of healthcare services.

- Real medical inflation – the increase in medical costs over and above the general inflation rate – was as high as 9% in Indonesia and 8% in Malaysia in 2011. It contributed to 27% of the increase in health expenditures between 1998 and 2010.

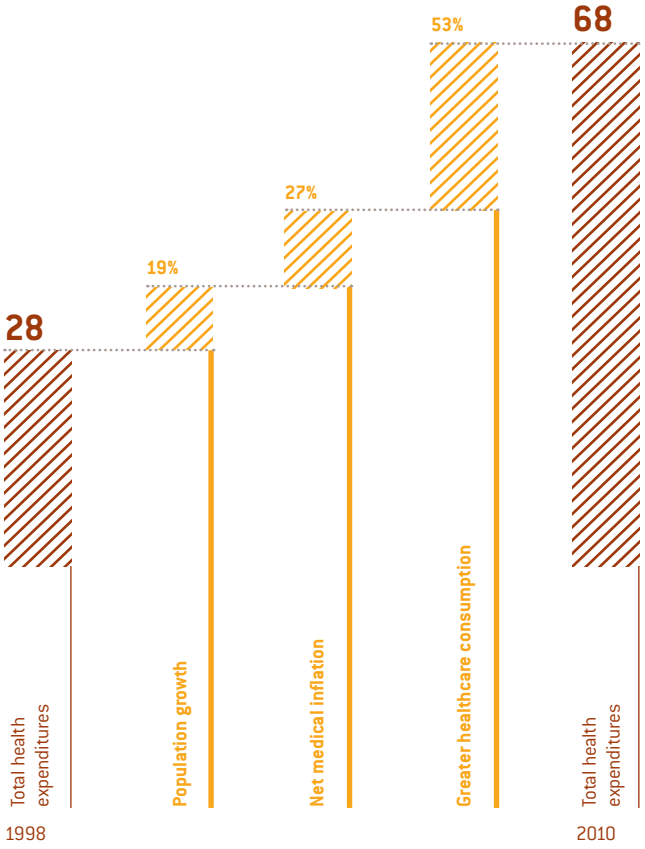
- Per capita consumption of healthcare services has also increased. As populations grow wealthier, people are in a position to spend more on healthcare services. Per capita health expenditures in Southeast Asia rose from an average of USD 60 per year in 1998 to USD 115 in 2010. This trend affects all Southeast Asian countries, where average health expenditures have grown by between 3% and 14% each year since 1998. This is the major driver of growth in health expenditures over the period and accounts for 53% of total growth.

Over the last ten years, both access to healthcare and per capita consumption of healthcare have grown in Southeast Asia. As a consequence, health indicators for the region have improved significantly. Average infant mortality across the region has fallen from 42 per 1,000 in 1998 to 22 per 1,000 in 2010, for example. Driving this improvement are Indonesia and Vietnam, both of which have halved their infant mortality rate. Malaysia and Singapore have maintained their very low levels of infant mortality at fewer than 10 per 1,000, which is in line with OECD countries. Life expectancy has also improved as a result of higher health expenditure – up 4 years in Singapore to 82 and up 2 years in Vietnam to 72.

F1

Drivers of health expenditures in Southeast Asia

1998, 2010 (constant 2010 USD bn)

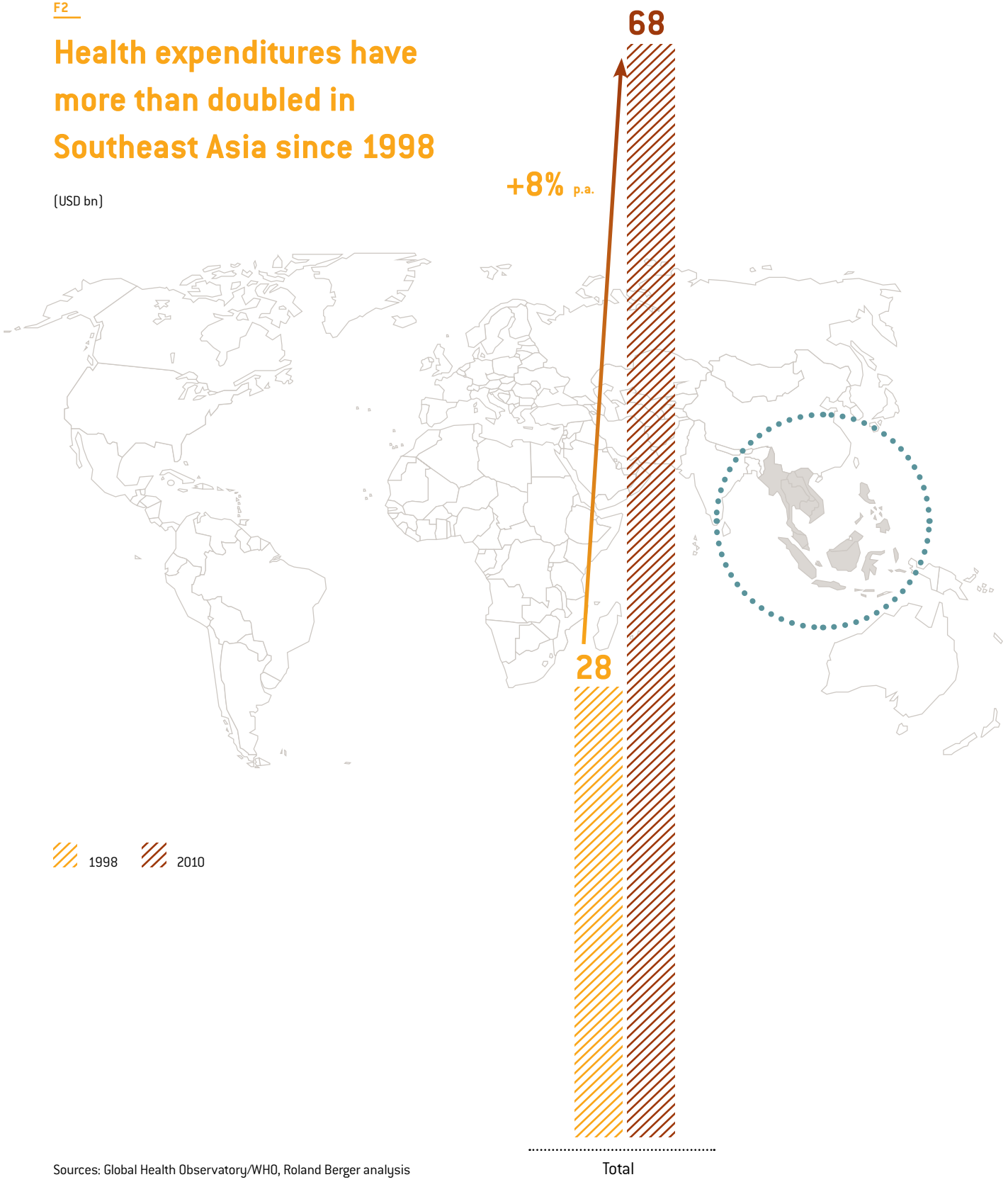


Sources: Global Health Observatory/WHO, Roland Berger analysis

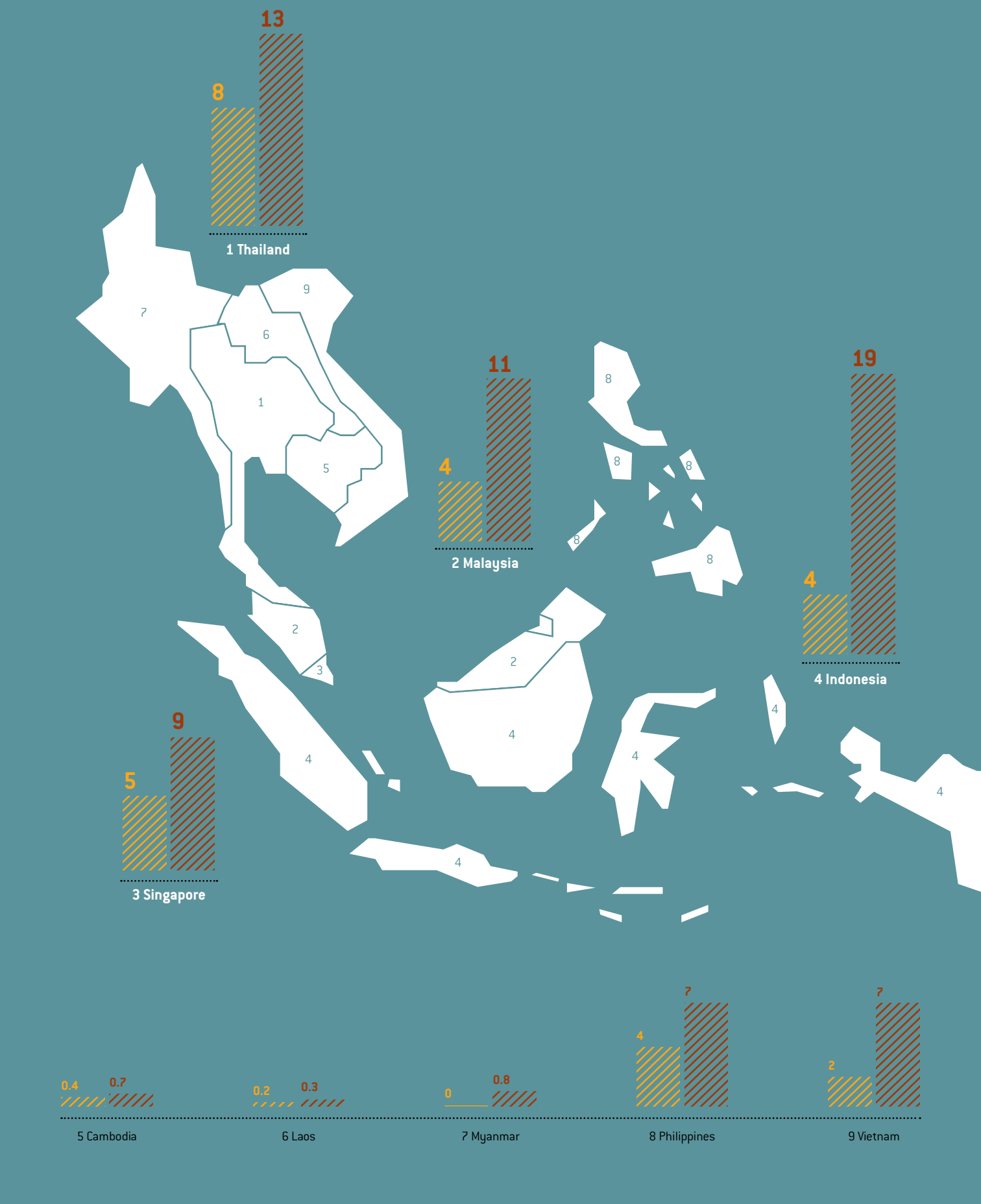
F2

Health expenditures have more than doubled in Southeast Asia since 1998

(USD bn)



Sources: Global Health Observatory/WHO, Roland Berger analysis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6 Laos
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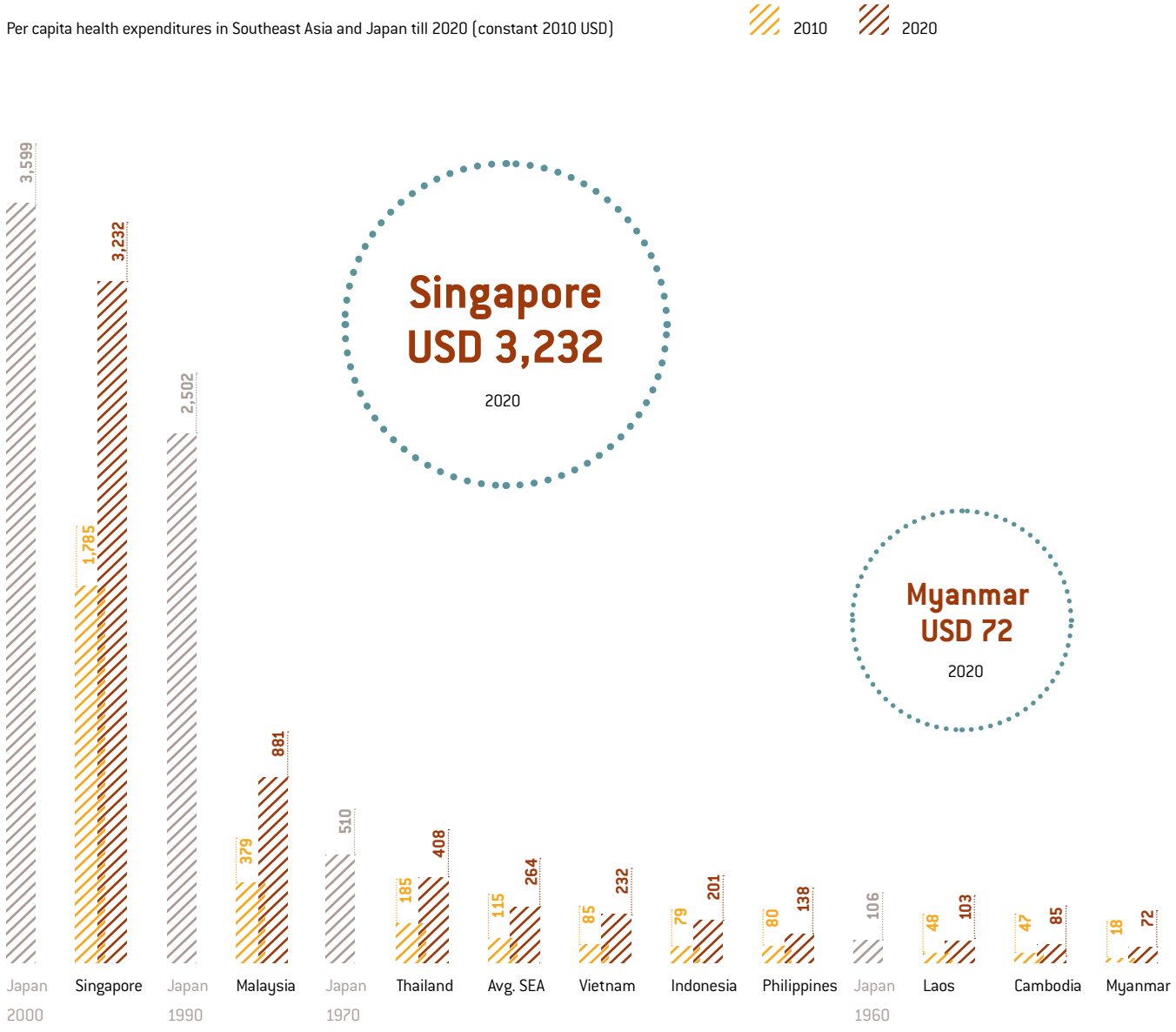
9 Vietnam

F3

Southeast Asian countries show great differences regarding their healthcare expenditures

Per capita health expenditures in Southeast Asia and Japan till 2020 (constant 2010 USD)



Sources: Global Health Observatory/WHO, OECD, Roland Berger analysis

MARKETS DIFFER WIDELY IN TERMS OF STRUCTURE AND MATURITY

Health expenditures have risen in all Southeast Asian countries. However, the Southeast Asian financial crisis affected different countries to a different extent. Thailand, Singapore, Laos and the Philippines were the hardest hit, with per capita GDP stagnating and per capita health expenditures falling in the period from 1998 to 2005. By contrast, other countries in the region experienced a sharp increase in both per capita GDP and per capita health expenditures; in Indonesia, for example, per capita health expenditures doubled to USD 39.

Great disparities remain between different countries in the region, both in terms of average per capita health expenditures and the maturity of the overall healthcare system. Thus, per capita health expenditures in 2010 ranged from just USD 18 in Myanmar to USD 1,785 in Singapore. The average for the nine countries was USD 115, with only three countries – Malaysia, Singapore and Thailand – experiencing spending above this level. The ratio between per capita health expenditures in different countries is 1 to 100, compared to a ratio of 1 to 323 in 1998, when it ranged from USD 4 (Myanmar) to USD 1,295 (Singapore). Access to healthcare services also varies widely across the region, approaching the level of developed countries in Singapore while remaining at subsistence level in countries such as Cambodia, Laos and Myanmar. In the latter three countries, average life expectancy at birth is below 64 years and infant mortality above 34 per 1,000.

F3

The boom in health expenditures has benefited from the increase in public spending seen across Southeast Asia. The level of public participation is still very uneven, but most governments in the region have recognized access to healthcare as a right for all. In most Southeast Asian countries, social security schemes are being set up or are already in existence. Although these systems take various forms, their ultimate aim is to provide access to basic healthcare for the entire population. The schemes usually have different funds for civil servants, employees and the self-employed, plus a special fund targeting the poorest sections of society – those who are not covered under other schemes and who cannot afford even basic healthcare services.

To what extent these systems rely on private or public financing depends on the general stage of development of the healthcare system in the country. We identify four main stages, with the nine countries at different points along the development trajectory. As countries develop, they move through each of the stages in turn.

F4

Stage 0: Healthcare system largely undeveloped

Stage 1: Most basic healthcare needs met

Stage 2: Choice of a wider range of healthcare services

Stage 3: Private contributions to healthcare financing encouraged

STAGE 0

Healthcare system largely undeveloped

The government makes little contribution to financing healthcare except for basic vaccination campaigns and a few public clinics and hospitals. Healthcare is mostly paid for by individuals in the form of out-of-pocket expenditures, or provided directly or subsidized by non-governmental organizations. Myanmar, Cambodia and Laos are still at this stage of development, with public expenditures on health ranging from USD 2 to USD 17 per capita per year. Out-of-pocket expenditures, NGOs and charities represent over 63% of total health expenditures, and in the case of Myanmar up to 88% (2010).

- MYANMAR
- CAMBODIA
- LAOS

STAGE 1

Most basic healthcare needs met

The government provides broader access to healthcare, covering a significant part of its financing ranging from 35% to 50%. However, out-of-pocket expenditures remain the dominant form of financing. Vietnam, the Philippines and Indonesia are at this stage of development: In Vietnam, 38% of health spending is financed by the public sector, in the Philippines 41% and in Indonesia 49%. All three countries are currently implementing universal public healthcare schemes that will be run as mandatory health insurance systems. Public sector contributions to healthcare expenditures range from USD 30 to USD 40 per capita in these three countries (2010). Access to healthcare is growing, pushing up demand. Indonesia and Vietnam showed the fastest growth in total health expenditures between 1998 and 2010, with annual growth rates of 10% or more.

- INDONESIA
- PHILIPPINES
- VIETNAM

STAGE 2

Choice of a wider range of healthcare services

As the healthcare market matures, a private health insurance system emerges to complement the publicly financed system and replace out-of-pocket expenditures. Malaysia and Thailand are currently at this stage of development, with a very high level of public contributions (56% in Malaysia and 75% in Thailand) and a growing share of financing by private insurers (from 5% of total expenditures for both countries in 1998 to 7% in Malaysia and 8% in Thailand in 2010). Both countries have a well developed healthcare infrastructure strongly supported by public financing. In Malaysia, the government makes direct subsidies to the healthcare sector, enabling lower healthcare costs for patients. Thailand has a social security scheme financed by compulsory monthly payments made by employers and employees, which functions as a public health insurance system covering the entire population. In both countries, the development of the market is now being driven by demand for higher-quality healthcare.

- MALAYSIA
- THAILAND

STAGE 3

Private contributions to healthcare financing encouraged

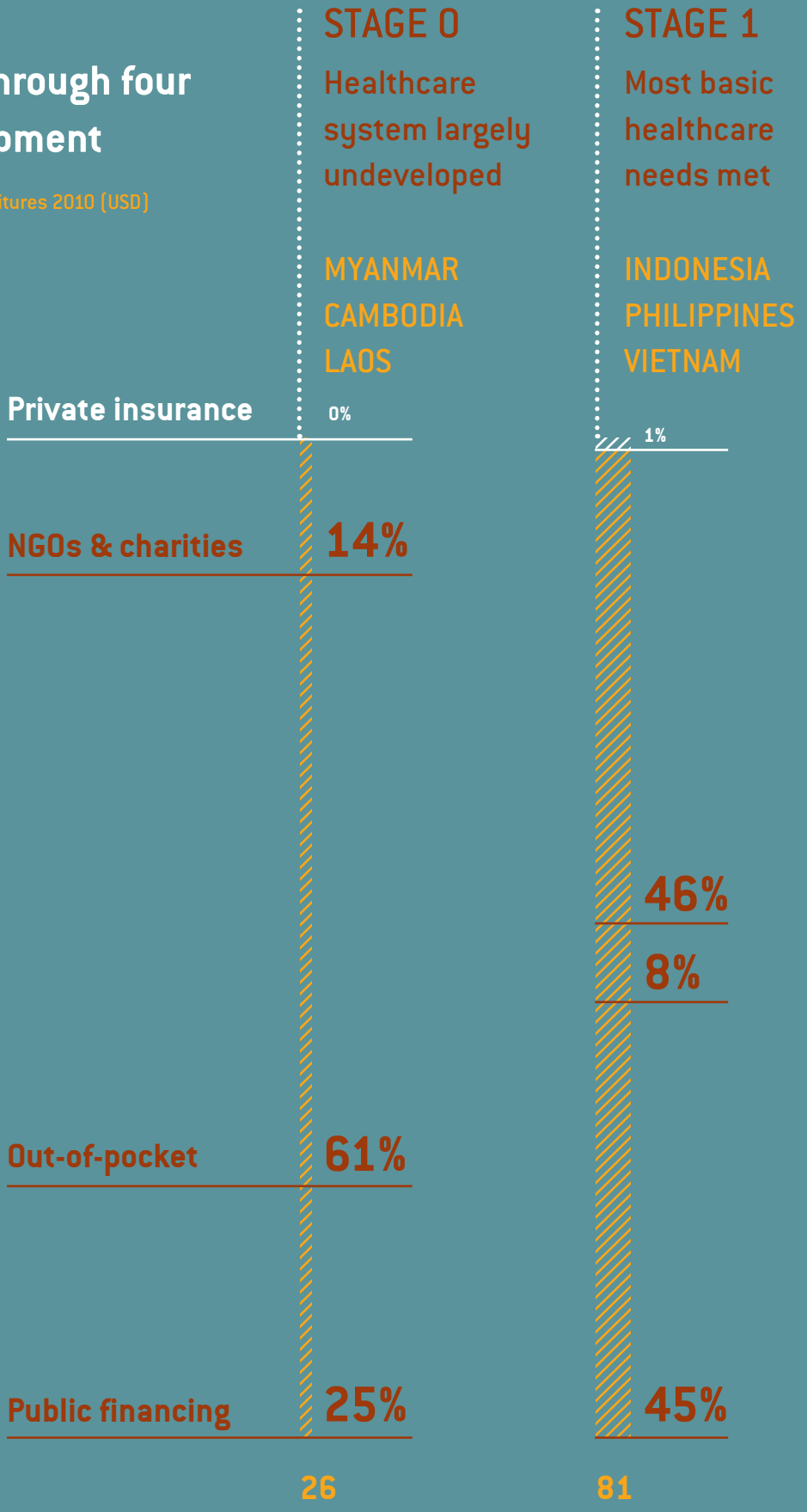
In the final stage of development, the government gradually disengages itself from the funding of healthcare and encourages private contributions. This caters to increasing consumer demand for more sophisticated healthcare services while balancing access to services and increases in costs. Singapore is the only country in the region currently at this stage of development. Since 2005, the country has fostered the development of the private sector by transferring part of the public health insurance scheme to five private insurers.

- SINGAPORE

F4

Countries pass through four stages of development

Source of per capita health expenditures 2010 (USD)



Sources:
Global Health Observatory/WHO,
Roland Berger analysis

STAGE 2

Choice of a wider range of healthcare services

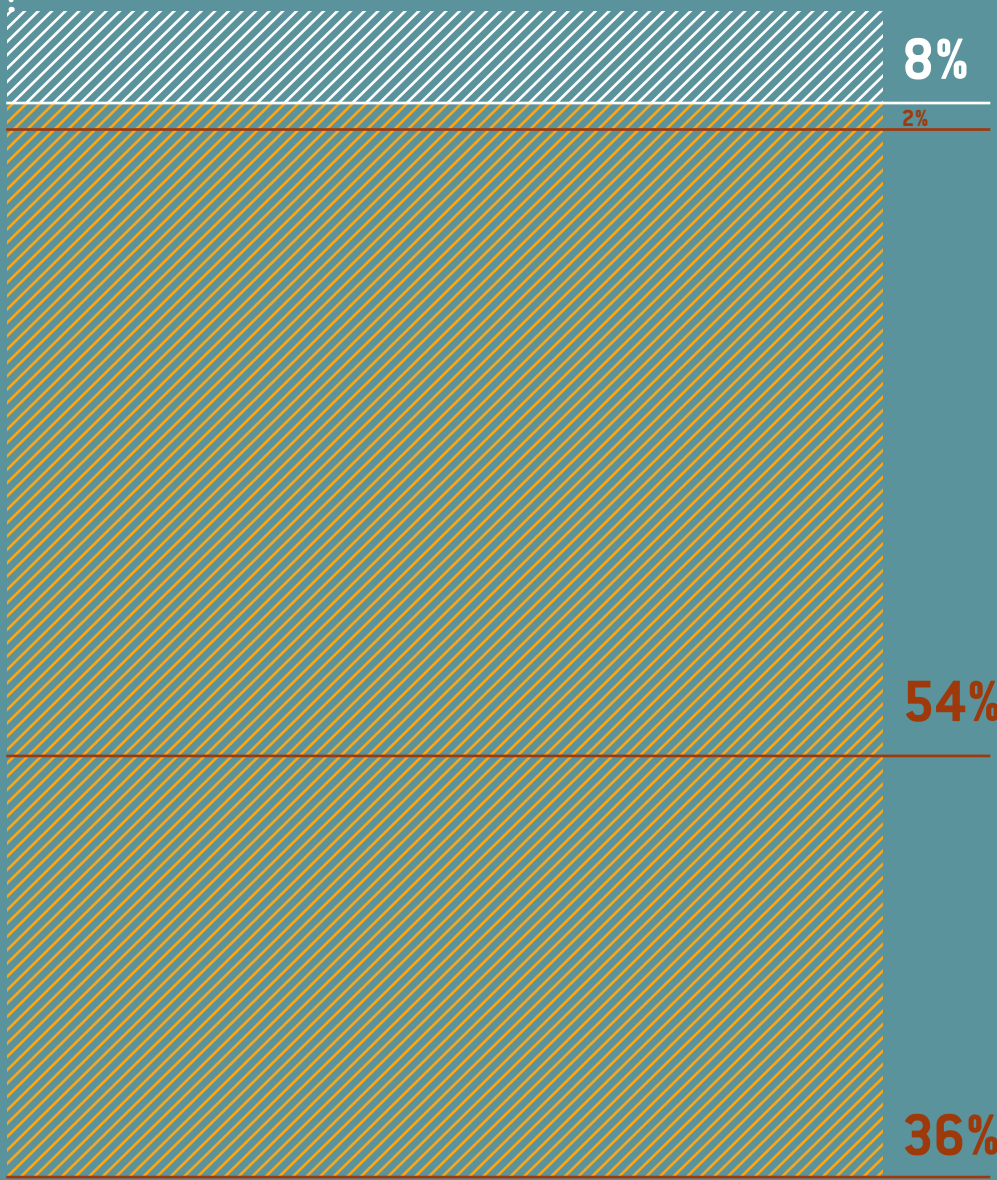
MALAYSIA
THAILAND

241

STAGE 3

Private contributions to healthcare financing encouraged

SINGAPORE



1,785

Public insurance schemes form the basis for a system of healthcare to develop in a country. However, they have certain limitations. People who are covered under a public healthcare scheme, be it social security or subsidized public healthcare, do not necessarily have access to healthcare facilities. In Thailand or Indonesia, for instance, it is difficult for people living in remote areas to access the healthcare infrastructure. People living in densely populated areas may also find that public healthcare facilities are overcrowded. Employment also discriminates with regard to healthcare: Often, the large portion of the population working in the informal sector is not covered by the public scheme, for example.

Another challenge for healthcare systems is the extent of coverage offered by public schemes. Limited coverage means that people still cannot afford medical services. For example, the current scheme in the Philippines does not cover reimbursement of drugs, which many people are unable to pay for. In addition, medical bribery is rife in some countries, raising the cost of medical care and limiting access for the needy.

HEALTH EXPENDITURES WILL CONTINUE TO GROW VIGOROUSLY

Increased spending on healthcare by governments is the main trigger for growth in health expenditures of all types across Southeast Asia. Three key factors will drive the market going forward:

- Access to healthcare for all, regardless of income and location, will continue to improve. The need for universal access to healthcare is recognized throughout the region. Some public healthcare schemes began as early as the 1970s, in Thailand for example, while others have been launched more recently, such as in Vietnam (2005) and Indonesia (2009).

- Healthcare expenditures will also be driven by increasing individual wealth as the economies of Southeast Asia develop. An emerging middle class will demand more healthcare and ultimately higher-end services as people become aware of the importance of healthcare and its accessibility. Demand for better-quality healthcare will push the wealthiest individuals toward private healthcare and more expensive medical technology.

- The third factor driving future healthcare expenditures is the increase in lifestyle diseases such as cancer – which is more often diagnosed as the frequency of screening increases – and the growing healthcare needs of aging populations. In Singapore and Thailand in particular, the number of people over 65 is expected to nearly double by 2020, reaching 10 million in total and representing 15% of the population in Singapore and 12% in Thailand. This is close to the level seen in developed countries such as the United States (13%), Germany (20%) and Japan (23%). In other Southeast Asian countries, this will not yet be a major issue.

Going forward, all Southeast Asian countries are expected to maintain high GDP growth rates of between 4% and 12% a year. F5
According to our model, healthcare expenditures will follow a similar trend, with growth of around 10% annually in the region (compared to 8% annually between 1998 and 2010 and 12% annually between 2005 and 2010). By 2020, healthcare expenditures in the region should reach a total of USD 173 billion, or USD 264 per capita.

In terms of financing, we expect public spending to increase in all nine countries. The least developed countries – Cambodia, Laos and Myanmar – will show the strongest growth as they move into Stage 1 of healthcare development. The health expenditures of these three countries will nearly double, approaching USD 100 per capita, with public financing representing 36% of expenditures in F3
2020 (up from 25% in 2010).

Overall growth in health expenditures will be strongest in the countries transitioning from Stage 1 to Stage 2, namely Indonesia, Vietnam and to a lesser extent the Philippines. In these countries, average health expenditures per capita will reach a level of USD 200 by 2020.

Malaysia and Thailand will maintain their high annual growth rates of above 8% in health expenditures, with per capita spending reaching USD 881 in Malaysia and USD 408 in Thailand by 2020. Both the public and private sectors will drive this growth, their relative contributions remaining largely unchanged.

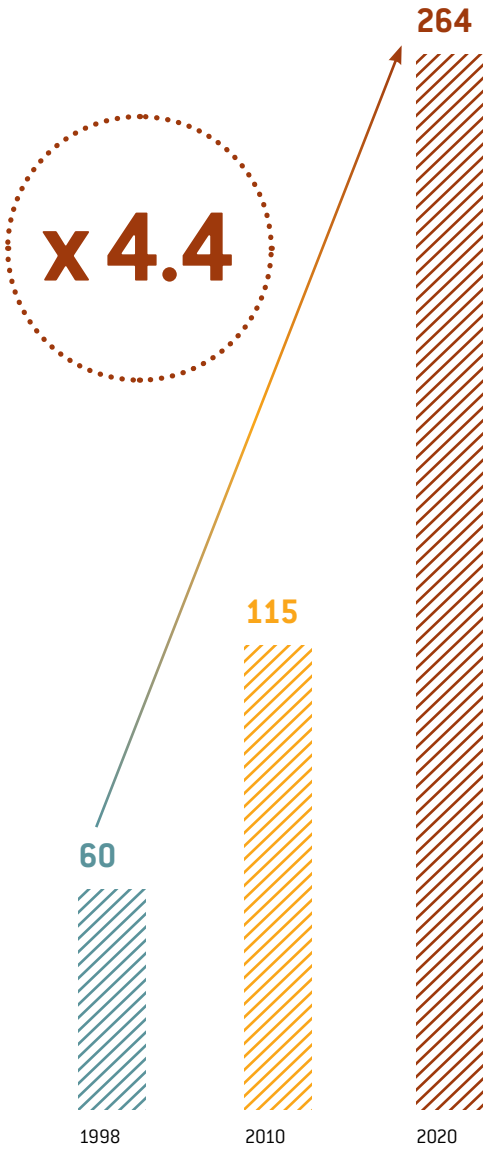
In Singapore, per capita health expenditures are expected to grow to levels slightly below that seen by Japan in 2000, with spending in 2020 reaching USD 3,232 (compared to USD 1,785 in 2010). If Singapore maintains its current policy, the financing of growing healthcare expenses will not be driven by the public sector. Indeed, private funding may well account for 75% of total healthcare expenditures by 2020. Even if Singapore does allocate additional public money to cater to its aging population, we expect the vast majority of healthcare to be privately funded.

The penetration of private health insurance in Southeast Asia will increase, accounting for 6% of health expenditures by 2020 (compared to 4% in 2010). The overall share of out-of-pocket expenditures will fall to 38% in 2020 (compared to 41% in 1998), despite the absolute figure for average per capita health expenditure growing more than fourfold over the same period.

F5

Average per capita health expenditures in Southeast Asia

(USD)



Source: Global Health Observatory/WHO, Roland Berger analysis

Quick access to efficient healthcare facilities is a coveted luxury in most of Southeast Asia

PRIVATE HEALTH INSURANCE – BOOM EXPECTED

Private health insurance is a very new market and still underdeveloped in Southeast Asia. However, a boom in the market is expected in the coming years. It is likely that individual policies will be the main driver of this market growth, but strong development is also foreseen in the group segment. We examine the trends in more detail below.

PRIVATE HEALTH INSURANCE REMAINS LOW IN SOUTHEAST ASIA

Total health expenditures covered by private insurance more than doubled between 1998 and 2010 in Southeast Asia, reaching a level of USD 2.9 billion. Nevertheless, the market for private health insurance is still in its infancy, with average per capita expenditures of just USD 5 covered by private insurance in 2010. The market is concentrated in three countries – Malaysia, Singapore and Thailand – which together accounted for over 80% of health expenditures covered by private insurance in 2010. Even here, average per capita health expenditures covered by private insurance are still below the levels seen in OECD countries.

The development of private health insurance in Southeast Asia reflects the stage of development of the healthcare system in the country in question. The least developed countries, where per capita health expenditures are below USD 50 a year, have no private health insurance market at all. Indonesia, Vietnam and the Philippines, the three countries in Stage 1 of healthcare development, have per capita health expenditures of USD 80-100 per capita, of which on average less than USD 1 is covered by private insurance. The penetration rate of health insurance in these countries is below 10% of the population. Malaysia and Thailand are in Stage 2 of healthcare development and their per capita health expenditures are between USD 150 and USD 1,000. The penetration rate of health insurance is also higher here, at between 15% and 20%, although less than USD 30 of per capita health expenditures are covered by private insurance. The absolute level of out-of-pocket expenditures and their growth rate are good indicators of the potential of private health insurance in a country. This is because the primary incentive for buying health insurance is to reduce out-of-pocket expenditures. Another factor is that private insurance can make it possible for policyholders to afford treatment in private healthcare facilities – especially urgent hospital care – without having to sell their house, for instance. Indeed, out-of-pocket expenditures are the traditional adjustment variable for an increase in healthcare costs or consumption of healthcare.

F6

Per capita health expenditures paid for by private health insurance

2010 (USD)

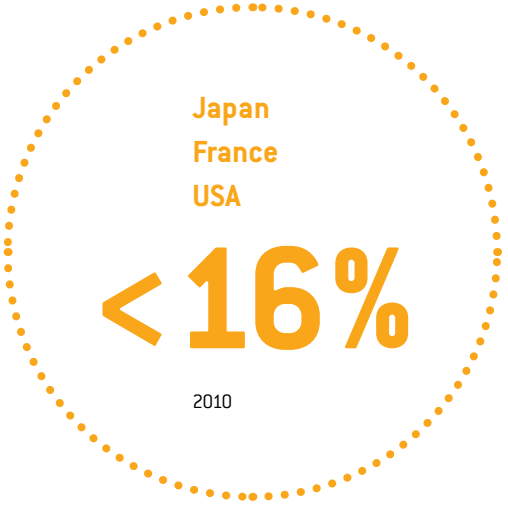
Source: Global Health Observatory/WHO, Roland Berger analysis

Out-of-pocket expenditures have more than doubled since 1998 in Malaysia and Singapore, reaching a level of USD 130 in Malaysia (or 34% of total health expenditures) and USD 964 in Singapore (54% of total health expenditures) in 2010. This compares to out-of-pocket expenditures of less than 16% of total health expenditures in developed countries such as Japan, France or the USA. The situation in Thailand is different. Here, there has been a sharp decrease in out-of-pocket expenditures, from USD 44 in 1998 to USD 26 in 2010, due to the steady increase in both public financing and private insurance.

F7

High out-of-pocket expenditures in Southeast Asia fuel the demand for private health insurance

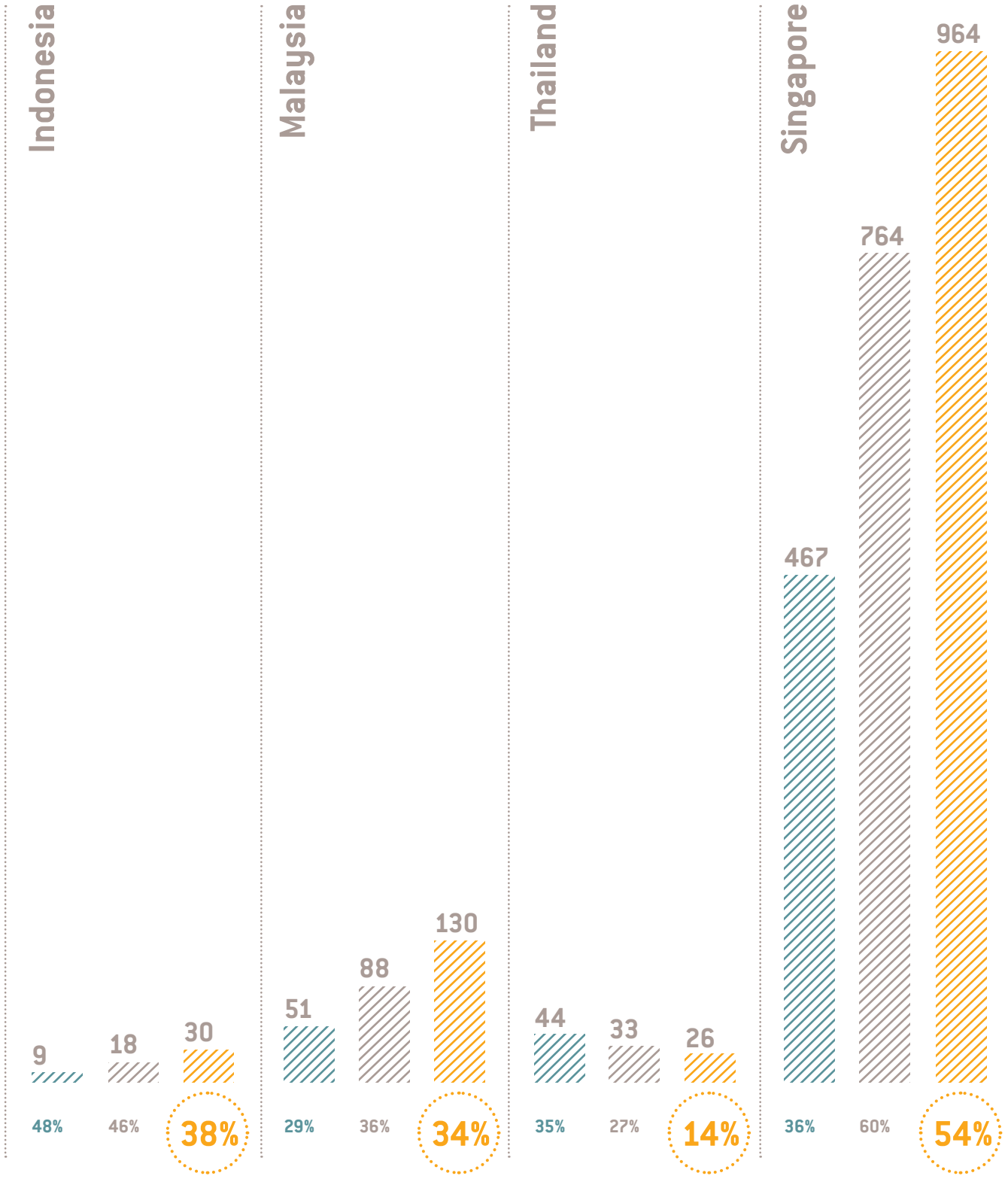
Average per capita out-of-pocket health expenditures and share of total (USD)



In most developed countries, average out-of-pocket expenditures are less than 16% of total health expenditures

Sources: Global Health Observatory/WHO, Roland Berger analysis

1998 2005 2010


Indonesia
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46%
38%
Malaysia
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88
130
29%
36%
34%
Thailand
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33
26
35%
27%
14%
Singapore
467
764
964
36%
60%
54%

INDIVIDUAL POLICIES DRIVE THE MARKET

The maturity level of a market drives consumers' perception of the necessity of health insurance. Consumers that have only had access to public health insurance in the past and who can now afford private health insurance will generally seek to protect themselves against the most costly eventualities – critical illnesses such as cancer or heart disease and personal accidents. Indeed, these are among the first policies to be sold as standalone policies in emerging insurance markets such as Indonesia and Thailand.

As populations grow wealthier and become more aware of the benefits of healthcare, they tend to purchase additional products such as hospital cash, hospital income plans and hospitalization cost coverage. More advanced health insurance markets offer packaged policies that include all of these services yet remain affordable by offering different levels of coverage. This is the case in Malaysia, for example, where most private insurers offer four to five variations on each plan so that they can reach a larger share of the population. Additional coverage for critical illnesses, dental services or maternity expenses are usually sold as riders on the existing personal accident or health policy rather than as a full policy. However, insurers should be aware of the fact that healthcare consumption tends to increase significantly once consumers have purchased health insurance.

Individual insurance

The Southeast Asian insurance market is strongly driven by individual policies. Such policies represent between 70% and 80% of the market in Malaysia, Singapore and Thailand. Affordability is a key factor in the development of private health insurance. In Malaysia, for example, the overall target population for health insurance – people earning over MYR 3,000 or USD 970 a month – represents about 50% of the total population. So far, only 20% to 30% of this target group has a private health insurance policy, with an average premium around USD 500 a year. In Thailand, the most comprehensive packages target the top 15% of the population – people earning over THB 30,000 or USD 1,000 a month – and premiums are around THB 10,000 or USD 330 a year. More affordable products offering basic protection sell at around THB 3,000 or USD 100 a year and target an additional 20% of the population – people earning more than THB 15,000 or USD 500 a month.

Individual policies are also the most profitable for insurers. Loss ratios can be as low as 30% to 40% in this segment for the best performers and up to 70% for others. The ratios for group insurance policies are significantly higher by comparison. There is also limited regulation of the underwriting and claims processes for individual policies: In many cases, insurers can include special conditions in policies, limit claims by setting a high deductible, implement lengthy waiting periods and cancel policies or increase premiums at will when they come up for renewal.

Group insurance

Companies in Southeast Asia are rarely obliged to take out private health insurance for their employees. Only specific segments of the population benefit from a group insurance scheme or are subject to compulsory private insurance, such as foreign workers, students, civil servants or members of the armed forces.

The group insurance segment has grown quickly over the last decade, at a rate of 20% or more a year. This is much faster than the individual segment, which grew at 11%. However, the group insurance segment still only accounts for 26% of the total premium in Thailand and 20% in Singapore. In Indonesia, the situation is different, with group insurance representing 50% of the market: This reflects the overall low penetration of health insurance in population (especially individual plans). It is worth noting, though, that the most affluent segment of the population often takes out private health insurance outside Indonesia via brokers in Singapore. F8

Distribution channels

Agents and brokers are the two major distribution channels for private health insurance in Southeast Asia. The number of licensed agents and brokers is very high in all nine countries. They are subject to regulatory approval from the country's insurance authority and – except in Indonesia – the commissions they receive are usually capped at between 10% and 18%. Depending on the country, agents generate between 40% and 60% of new policies, mostly in the individual segment, while brokers generate 15% to 25%, mostly in the group segment. Only in Singapore do brokers also play a large part in the individual segment.

Bancassurance is gaining importance as a distribution channel, especially in Indonesia. However, bank branches generally sell health riders on life policies or basic protection products. This means that they will not be the preferred channel for more sophisticated or comprehensive packages. In Malaysia, Indonesia

F8

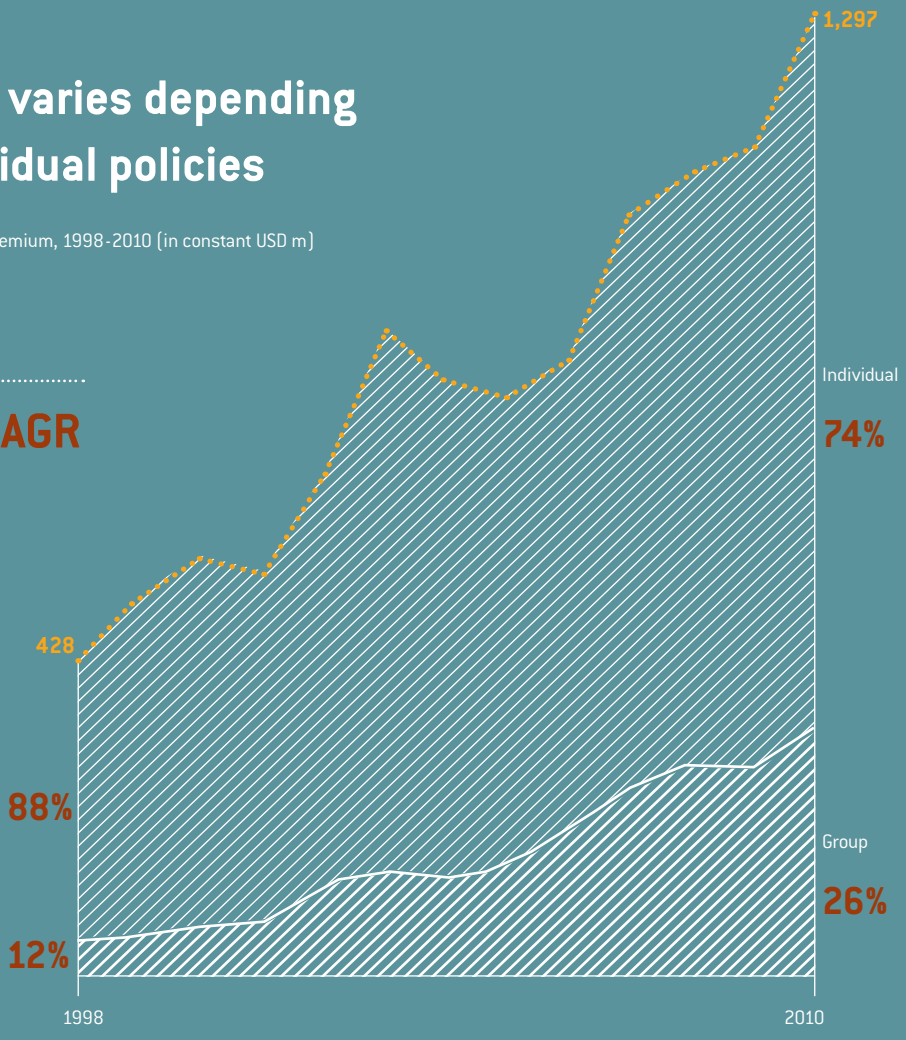
Market structure varies depending on group or individual policies

Total private accident & health insurance premium, 1998-2010 (in constant USD m)

THAILAND

Individual: 11% CAGR

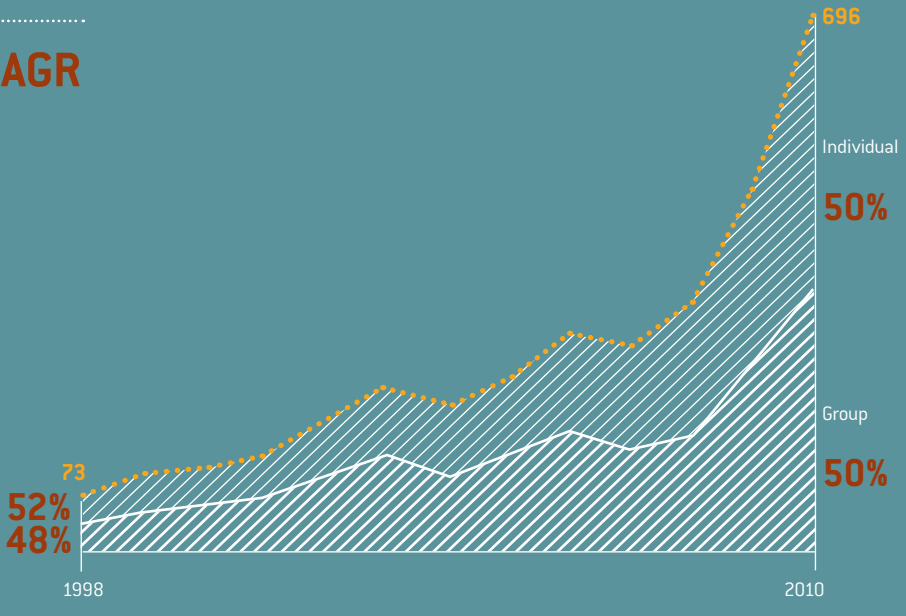
Group: 20% CAGR



INDONESIA

Individual: 23% CAGR

Group: 24% CAGR

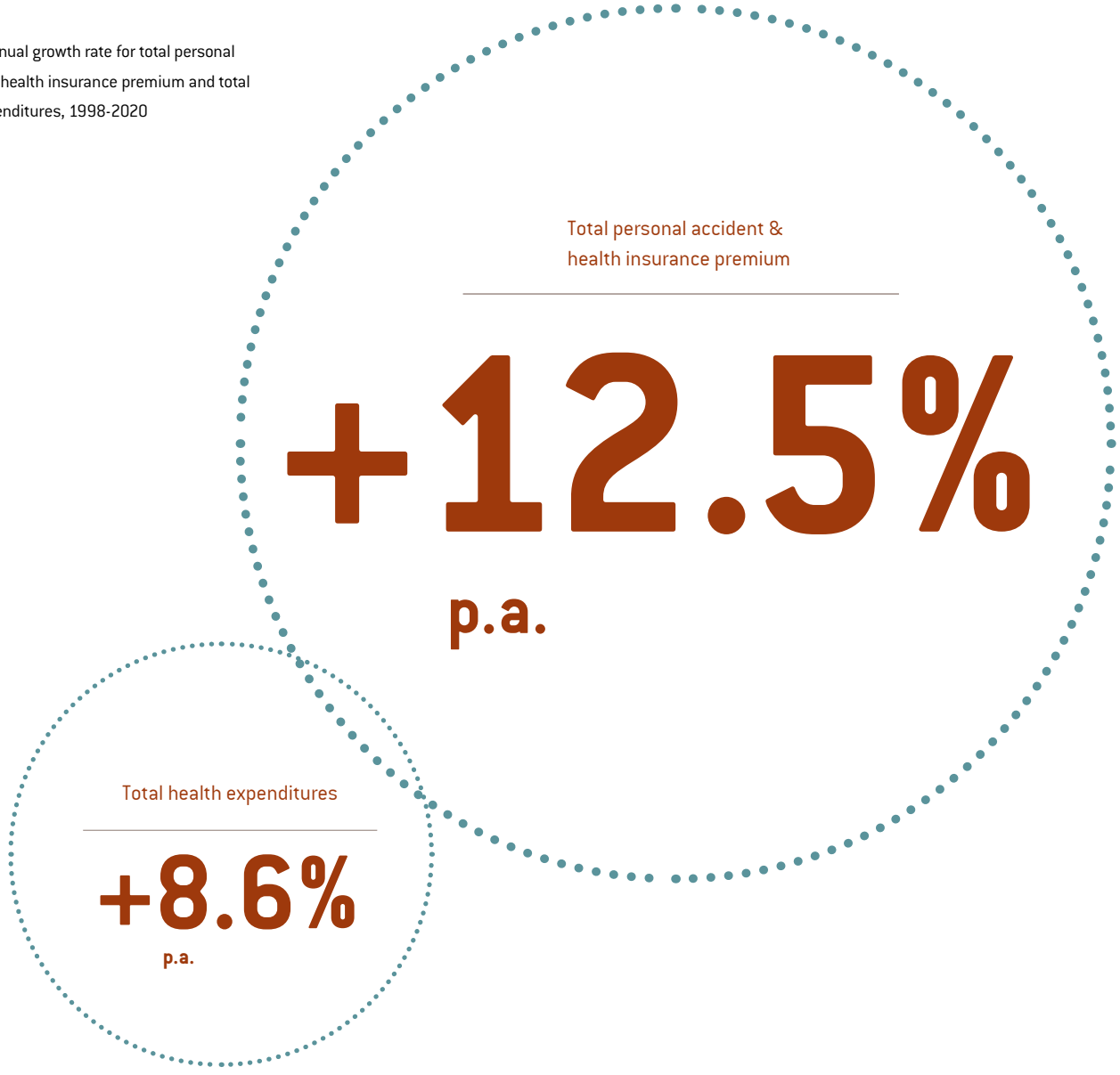


Source: Local insurance regulators

F9

Huge potential for private insurers

Average annual growth rate for total personal accident & health insurance premium and total health expenditures, 1998-2020



Sources: Global Health Observatory/WHO, Roland Berger analysis

and to a lesser extent Thailand, insurers may sell group policies directly to companies. However, direct sales of this type remain a secondary channel, used by only a few innovative players. Alternative distribution channels are also widely used. The most notable of these is telemarketing, used to sell basic personal accident and hospital cash products in Thailand, Indonesia and to a lesser extent Malaysia. International players have expanded their telemarketing capabilities and are actively making use of their bancassurance partners' databases.

More innovative products are also sold in the form of vouchers that customers can activate via their cell phones. In an attempt to increase the penetration of health insurance, regulators have authorized the sale of such vouchers outside traditional channels. In Indonesia, for example, ACA sells its products through supermarket chains, post offices and convenience stores.

Overall, the private health insurance market remains highly fragmented in Southeast Asia. There are 30 licensed health insurers among the life and general insurance companies in Malaysia, 40 in Singapore, 76 in Thailand and over 100 in Indonesia. The more mature markets are more consolidated, with the ten biggest players accounting for close to 80% of the total premium.

International players are usually strongest in the group insurance segment, where they rely upon large corporate clients, especially multinational corporations. Domestic players dominate the individual insurance segment in countries such as Thailand and Indonesia. The small and medium-sized enterprise (SME) market remains relatively untapped in all countries, although several insurers have recently launched initiatives to penetrate this promising segment.

PRIVATE HEALTH INSURANCE IN SOUTHEAST ASIA: A USD 24 BN MARKET BY 2020

Historically, growth of the gross written premium (GWP) for personal accident and health insurance and growth of total health expenditures correlate almost exactly with growth of GDP. This strong correlation is likely to continue in the future. Average per capita GDP is expected to rise at 9% per year through 2020. This translates into an increase in health expenditures covered by private insurance from USD 2.9 billion in 2010 to USD 10.7 billion in 2020, or 14% per year, and an increase in premiums of more than 15% a year.

On this basis, we expect insurance policies in Southeast Asia to generate a total of USD 24 billion by 2020 in GWP for personal accident and health insurance, four times their 2010 level of USD 6 billion. Private health insurance will then account for 6% of the region's total health expenditures, with higher rates in the three most mature markets, namely Thailand (13%), Singapore (11%) and Malaysia (9%). F9

The most mature markets in Southeast Asia will show double-digit annual premium growth between 2010 and 2020: 13% in Malaysia, 15% in Singapore and 15% in Thailand. These three countries together will still account for almost 80% of the health premium in the region in 2020 – some USD 19 billion of the total of USD 24 billion. F10

In Malaysia, Singapore and Thailand, health expenditures covered by private insurance will be driven by the mass affluent and affluent population groups. These individuals expect their insurance policy to give them access to more expensive health-care services in private hospitals and specialized clinics not subsidized by the state. Policyholders want to receive faster treatment, a wider range of treatment options and access to the latest and safest technology. For them, insurance is the only way to limit their out-of-pocket expenditures. The growing appeal of private medical institutions is the biggest driver of the health insurance premium in these countries.

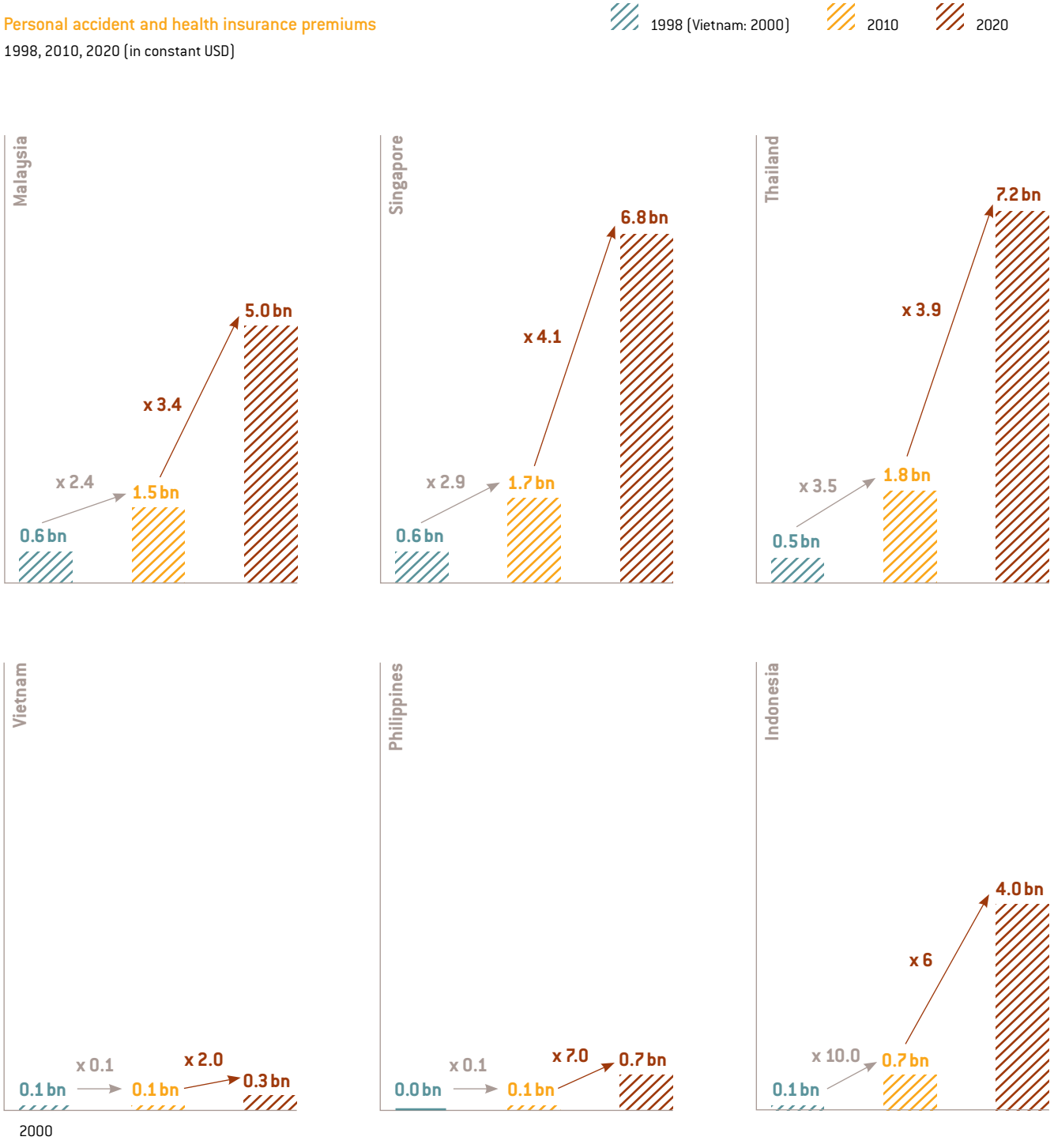
Group insurance will continue to expand over the next decade, increasing its share of total premium from 20-25% in 2010 to 35-45% by 2020. Growth in the corporate segment will mostly be driven by better penetration of the small and medium-sized enterprise market, which accounts for between 60% and 95% of the total workforce in Singapore, Malaysia and Thailand. Insurers in these countries will focus on local medium-sized companies and small corporations with a few dozen to a few hundred employees.

We expect agents to remain the dominant distribution channel in Southeast Asia, despite the development of direct marketing for individual consumers. Specialized riders are also likely to remain the primary policy for entry-level consumers, although in the most developed markets we expect insurers to push comprehensive health packages to mass affluent consumers, the wealthier part of their customer base. Brokers may strengthen their position in the group policy market by focusing their efforts on the growing demand from SMEs.

F10

Personal accident and health insurance premiums

1998, 2010, 2020 (in constant USD)



Sources: Local insurance regulators, Roland Berger

A health insurance market will continue to emerge in Indonesia, Vietnam and the Philippines over the next decade. All three countries will enter Stage 2 of healthcare development, with health expenditures growing fast and health insurance beginning to replace out-of-pocket spending. Public insurance schemes will be strengthened, giving broader access to health services – a precondition for the further development of private health insurance.

F10

Levels of private health insurance in Indonesia, Vietnam and the Philippines are very low at present. Personal accident and health premiums were around USD 130 million in the Philippines and Vietnam and USD 700 million in Indonesia in 2010, equivalent to less than USD 1 per capita in all three countries. By 2020, we expect these premiums to be five times as high.

Indonesia will almost catch up with Malaysia in terms of the total personal accident and health premium, which will hit USD 4 billion by 2020. This will make Indonesia the fourth-largest market in Southeast Asia in terms of both health expenditures covered by private insurers and the total personal accident and health premium. Opportunities in the Indonesian market lie in its high growth potential and its sheer size, as the largest healthcare market in Southeast Asia in terms of value spent.

The Vietnamese health market is dominated by public hospitals, and a private health insurance market has only been in existence since 2000. A number of obstacles remain to the development of private health insurance in Vietnam. In particular, irregular double payments are common practice at hospitals, with patients paying an additional discretionary fee to the physician in order to have access to treatments. This can make the claims process for private insurance even more challenging, discouraging both patients and insurers.

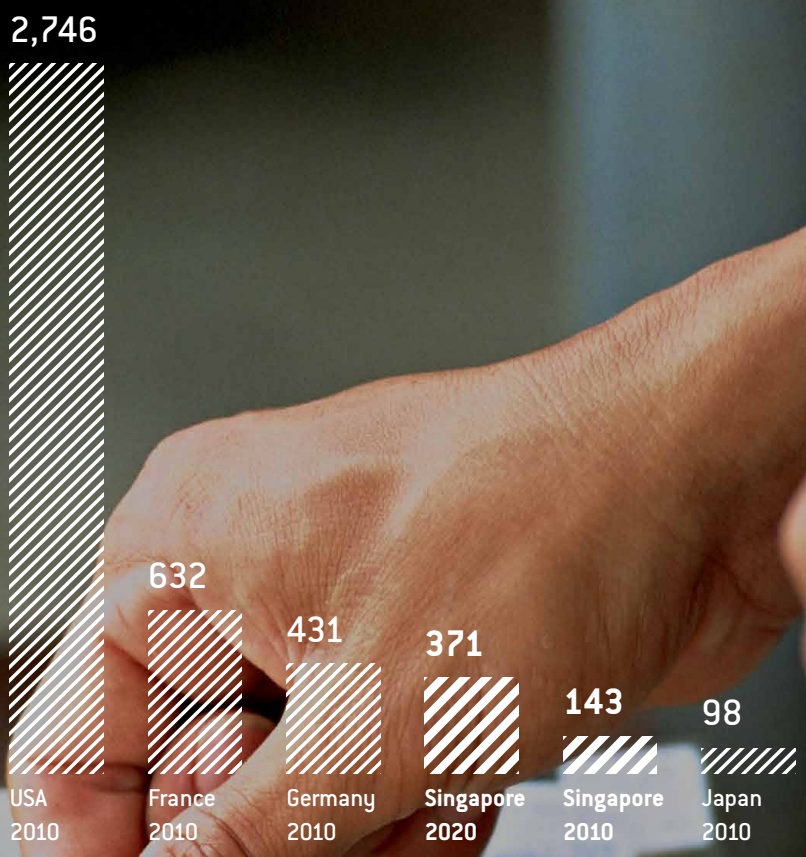
The Philippines has established a public health insurance scheme. Private health insurers have also started to penetrate the market, covering over 1% of health expenditures in 2010.

Cambodia, Laos and Myanmar are still in Stage 0 of healthcare development. They are unlikely to mature enough to present significant growth opportunities for private insurers by 2020. Laos opened up its health insurance market in 2001 but health expenditures covered by private insurance remain under USD 2 million, representing just 0.03% of the total Southeast Asian health insurance market. Private health insurance does not yet exist as such in Cambodia or Myanmar, but these markets are expected to open up sometime around 2015. In all three countries, health expenditures covered by insurance will remain below USD 1 per capita and USD 44 million in total through 2020.

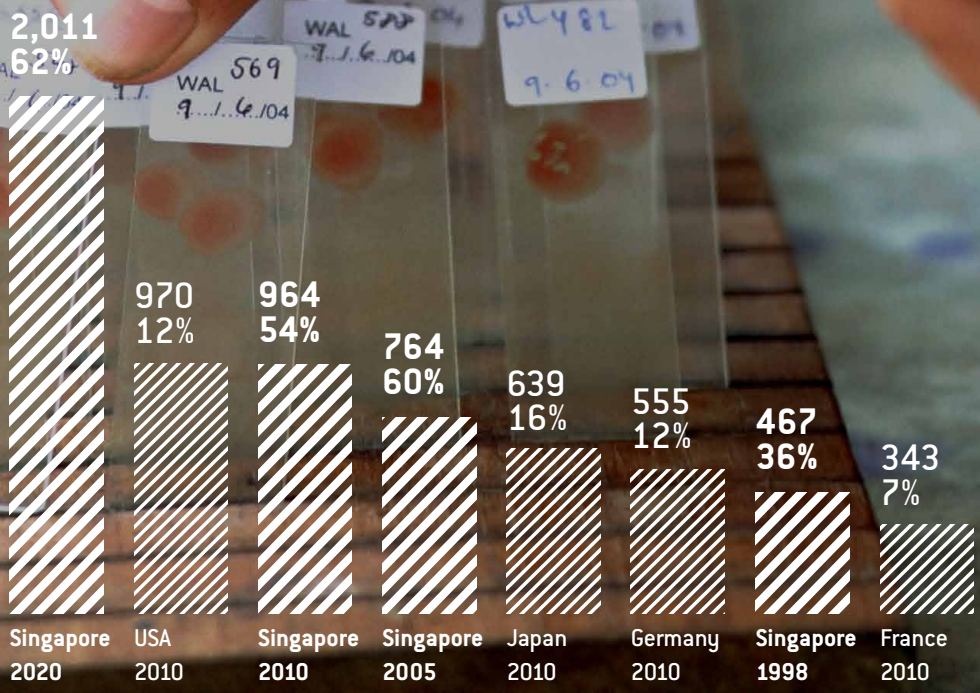
F11

Compared to other developed countries there is still a gap to close

11/1 Per capita health expenditures paid for by private insurers (USD)



11/2 Per capita out-of-pocket expenditures (USD, % of total health expenditures)



SINGAPORE – STILL ROOM FOR GROWTH

Singapore has a well-established private insurance market covering 8% of the country's health expenditures and reaching 70% of its resident population (2010). Private insurance complements the statutory public insurance system Medisave and the voluntary public scheme Medishield. Public coverage of health expenditures is low, however, with Medisave paying maximum daily hospitalization costs of SGD 450 for Singapore citizens. One day in intensive care plus one consultation can easily cost more than double this amount. Moreover, the insurance coverage is subject to numerous exclusion conditions and a high deductible under the Medishield scheme.

Singapore is currently promoting the private funding of healthcare expenditures. Even if the government increases funding to cater more to the aging population, we do not expect to see a significant shift in the proportion of healthcare subsidized by public funding. The complementary insurance plans under the Medishield scheme were transferred in 2005 from Singapore's state social security fund, the Central Provident Fund (CPF), to five private insurers, who act as sole distributors.

On the demand side, we expect to see strong growth continuing in health expenditures. Singapore's growing mass affluent population will drive demand for both more and better quality healthcare services. The ageing population will also drive demand for healthcare services: People aged over 65 are expected to make up 15% of the population by 2020 (compared with just 9% in 2010).

Despite Singapore's effort to push private health insurance, the products offered by health insurers are still limited compared to other developed markets in terms of the amounts covered, total deductible, scope of coverage and the number of underwriting restrictions. Indeed, private health insurance is still mainly driven by low-priced policies – of which there is a wide range – rather than comprehensive packages. F11/1

With low coverage from both public and private health insurance, out-of-pocket expenditures in Singapore are currently the highest in Southeast Asia and they continue to grow. In 2010 they were approaching the absolute levels seen in the USA, albeit accounting for over 50% of financing compared to just 12% in the USA. If current economic trends continue, we expect per capita out-of-pocket expenditures to double by 2020. F11/2

Opportunities lie in private insurers improving or upgrading their product offering to capture the fast-growing demand for healthcare in Singapore. Although Singapore citizens still rely mainly on self-insurance and can be unwilling to pay for private health insurance, the growing burden of out-of-pocket expenditures and ongoing medical inflation will make private health insurance policies increasingly attractive for consumers.

UPDATE

The announcement by the Singapore Government about an enlarged healthcare coverage and increased public contribution was made after this study was printed. The overall projected healthcare expenditures per capita are still expected to reach USD 3,232 by 2020, but the funding by public money is now expected to increase to 40% of the total. Therefore, out-of-pocket expenses should reach USD 1,557 per capita by 2020, and not USD 2,011 as mentioned on page 32, with private insurance covering the remainder (12% of total expenditures by 2020).

▶ *Singapore has a well-established but expensive healthcare system, ranked sixth by the WHO in the year 2000*

HEALTH INSURERS – RISING TO THE CHALLENGES

To develop a profitable business, insurers need to anticipate future developments and potential risks. This is especially critical in the fast-growing Southeast Asia health insurance markets, where the past behavior of consumers is not always a clear predictor of their future behavior and where new health insurance clients often rapidly increase their consumption of healthcare.

Below, we present five key recommendations for insurers in Southeast Asia. By following these recommendations, insurance companies can overcome the challenges and maximize the numerous opportunities offered by this rapidly growing market.

1 ACQUIRE NEW CUSTOMERS BY PROMOTING PRIVATE HEALTH INSURANCE

The emergence of a fast-growing middle class across Southeast Asia provides significant opportunities for insurers to promote private health insurance to new customers. In the 2012 Roland Berger study "Understanding mass affluent consumers in Southeast Asia", we found that health was number 1 out of 18 core values driving individual behavior for Malaysian and Indonesian consumers. Around 15% of the mass affluent population in Malaysia and 25% in Indonesia were considering taking out health insurance in the next 12 months. Singapore also offers opportunities, as even here the penetration rate of private health insurance in the mass affluent segment remains below 70%.

To target the wealthier segments, insurers need to take a close look at these customers' needs and expectations with regard to healthcare. Acquiring new middle-class customers and migrating them from basic, low-price products such as hospital cash to more comprehensive packages will be a significant driver of market growth. At the same time, providers must improve the current product offering.

Wealthier consumers value both faster access to healthcare services (no waiting in line as in cheaper public hospitals) and higher-quality healthcare (leading surgeons, high-end medical equipment). Private clinics offer both. In Indonesia and to a lesser extent Thailand, wealthier clients want health insurance packages that include access to regional or global premium healthcare. Given the sizeable volume of UHNWIs (ultra high net worth individuals) and private banking clients and private banking clients, insurers would do well to explore exclusive top-end products that offer worldwide access to leading hospitals. More than the sum insured or the extent of the coverage, it is the insurer's ability to provide instant access to healthcare services and logistical support that is the key differentiating factor here.

With increased healthcare consumption and customer numbers growing fast, product differentiation is not seen as a strategic issue by many players. Accordingly, few local insurers have

engaged in product innovation, although international players have tried to improve their offering to entice new customers. Customer segmentation is still at an early stage, too, with limited or no targeting of specific customer segments. However, some innovative insurers have started promoting non-financial benefits linked to health insurance, such as advice on a balanced diet and regular exercise or a hotline for health-related issues. In so doing they improve prevention, keep claims down and improve their profitability by drawing attention away from the monetary aspect of their product.

2 TRAIN AGENTS, ADJUST INCENTIVES AND EXPLORE ALTERNATIVE CHANNELS

In many countries, agents are the major distribution channel for individual insurance products. Agents still play a major role in explaining how private health insurance works and what benefits it offers. However, distributing health insurance products via agents can be difficult, especially if the health insurance is provided by a general insurance company. This is because agents working for such companies usually rely on sales of compulsory policies (e.g. motor insurance in all Southeast Asian markets except Indonesia) and may be unwilling or unable to convince customers to take out voluntarily health insurance. Moreover, the commission on a low-price health plan is lower than that on a motor insurance policy. Similarly, life agents may perceive the commission on selling a rider as not worth the effort. Companies therefore need to train their agents appropriately and adjust their incentive systems.

Developing alternative channels for acquiring new clients – especially mass market customers – will be key in the future. This can involve forming partnerships with banks and leveraging data from credit card companies. In some instances, insurers do not need to build up costly infrastructure for telemarketing or employ their own direct marketing experts. Instead, they can leverage the services offered by other insurers or specialized firms in local markets.

3 BALANCE GROUP AND INDIVIDUAL POLICIES

The bulk of the market in most Southeast Asian countries is in the individual segment. Group policies harbor more risks: The underwriting is done at group level and insurers cannot exclude specific individuals from the policy. As a result, group insurance is often less profitable. The inability of the insurer to cancel the policies of employees who exceed claim standards can put the overall profitability of the contract at risk.

Opportunities for insurers lie in balancing risk by complementing group policies with supplementary individual contracts, sold through workplace marketing, for instance. Developing cross-selling between group and individual policies will be key for growth as well as profitability. The corporate segment is subject to strong competition, especially with respect to large corporations, which have great bargaining power over insurers. The most significant opportunities may therefore lie in the SME market, which represents the major part of the workforce – 60-65% in Singapore and Malaysia, 75-80% in Thailand and over 95% in Indonesia. Moreover, providing health benefits is increasingly perceived as an effective way to boost employee retention in such companies.

4 ACTIVELY MANAGE THE COMBINED RATIO

The profitability of health insurance policies can be quickly compromised by uncontrolled costs relating to claims and administration. Combined ratios – the ratio between gross written premium (GWP) and the cost of the claim plus operating expenses – differ greatly among insurance companies and countries. Traditionally, health insurers in Southeast Asia have managed their combined ratios by carrying out an annual review of both the overall ratio and the ratio on each policy, subsequently cancelling any policy that exceeds a certain threshold. Active management of the combined ratio, by contrast, involves working on a continuous basis to optimize the ratio for each policyholder.

Good communication with hospitals is vital to ensure correct estimates of hospital costs and efficient claims processing. Insurers can protect themselves against overbilling by requiring second opinions before major treatments, and home care rather than hospitalization wherever possible. They can work with healthcare providers, especially public institutions, to ensure the best care at the lowest price though the use of better equipment or cheaper drugs. They can also carry out a case-by-case review of the necessity of each treatment or provide economic incentives for physicians to choose less costly forms of care.

In more mature markets, insurers have developed alternative methods of providing high-value non-monetary services to policyholders, thereby controlling the number and the value of claims. These services can take the form of assistance for recovery at home after surgery, including nursing care, cleaning, errand-running, collecting children from school and even helping them with their homework. For injuries that might have long-term repercussions, some insurers provide patients with an extra physiotherapy program to help them recover more quickly and avoid recurrent problems or disability later in life. Other insurers emphasize prevention, offering free health screening or basic care such as teeth scaling for pregnant women to help reduce the premature birth rate. In some cases, insurers encourage good health in their clients by offering rebates on annual premiums for clients who have annual gym memberships, by paying part of the registration fee for recognized weight loss programs such as Weight Watchers, or by covering the cost of periodic appointments with a nutritionist, for example.

Training in claims management can also be key for keeping costs down. Insurers are reporting increased communication difficulties with hospitals, especially private institutions, leading to frequent overbilling and delays in settling claims. Staff working in claims management need to be trained specialists in health insurance: The skills they require are different from those required in life or general insurance.

On the operational side, many insurers struggle to build an efficient, lean organization for handling claims. Even international players with smooth-running processes in their more mature markets may lack critical mass or qualified staff to implement such systems locally. In such cases, making use of a good third-party administrator (TPA) might mean the difference between profit and loss.

5 NAVIGATE THE REGULATORY CONSTRAINTS

Insurance regulators and governmental bodies control many structural aspects of the insurance market in Southeast Asia: licenses for insurers, agents and brokers, pricing grids for public hospitals, caps on commissions, and so on. In the past, regulators have had a stabilizing effect on the market. For example, no new licenses are expected to be issued in Malaysia, Singapore or Thailand. Regulation can even benefit health insurers, such as when private health insurance is made compulsory for certain parts of the population, as in Malaysia.

Regulatory constraints regarding product specifications and policy termination are less strict in Southeast Asia than in some developed countries. It is therefore possible that they will be tightened up in the future, obliging insurers to pay for treatments in private hospitals, restricting conditions on policy cancellations and enforcing continuity of coverage after retirement in the case of group policies, for example.

CONCLUSION

With over 600 million people, a combined GDP of USD 2.2 trillion – only Europe, the USA and China have larger economies – and growth driven by household expenditure, Southeast Asia offers excellent prospects for health insurers. The road ahead is not without pitfalls. But by dealing with the risks and preparing for the opportunities early on, insurers can effectively leverage the coming growth in private health insurance in Southeast Asia. We believe that those who rise to the challenges will reap rich rewards – and in so doing foster further growth in the region's burgeoning healthcare markets.

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METHODOLOGY

The Roland Berger Strategy Consultants Southeast Asian healthcare model focuses on nine key countries in the region: Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam. It mainly uses data for the period 1998 to 2010 published by the Global Health Observatory of the World Health Organization (WHO), the World Bank and the IMF. We examined this data closely and linked the development of health expenditures and health indicators to GDP growth for each country. We then compared the data with figures on health insurance premiums published by the insurance regulators in each country. On this basis, we were able to identify past trends in per capita health expenditures by type of financing and make our projections for future expenditures. These projections are consistent with the IMF estimates for future GDP growth in each country, taking into account the specific multiplier effect observed in each country in previous years. Where data took the form of ranges, we went with the most conservative assumptions in order to mitigate the risk associated with strong past growth and high GDP forecasts.

CREDITS

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