APEC Health Financing Forum
Enhancing Innovative Healthcare Financing in Pursuit of Sustainable Healthcare

Session 1: Setting the Stage and Introduction to APEC

Ryan MacFarlane Ph.D.
Asia-Pacific Financial Forum Initiative on Health Financing
Director, Crowell & Moring International

September 6, 2022
Studies showing losses in GDP due to aging and projected rise in NCDs

Statements from APEC Leaders, Health and Finance Ministers calling for work to address the fiscal and economic impacts of ill-health

APEC Checklist of Enablers for Alternative Health Financing endorsed

Healthcare financing meeting in Thailand

Thailand study released

Healthcare financing meeting in Japan

Over 500 participants in healthcare financing webinar series

APEC Healthcare Financing Roadmap endorsed
Policy tool endorsed at the 2017 APEC High-Level Meeting on Health and the Economy

Designed to help economies assess the policy and regulatory environment for alternative health financing mechanisms

Organized across six broad pillars:

1. Political will and government coordination
2. Good governance
3. Private sector engagement
4. Legal and regulatory frameworks
5. Health and financial literacy
6. Quality data and evidence
Health Financing Webinar: Role of Private Health Insurance

- Incentives to increase demand and supply of new insurance products
- New / innovative collaborations between insurance companies, healthcare providers, biopharmaceutical companies and governments
- Digital technologies to create cost savings and improve patient outcomes
- Role of private health insurance in addressing out-of-pocket spending
APEC Healthcare Financing Roadmap

Phase 1: - Continuation of healthcare financing information sharing and exchanges

Phase 2: Economy specific engagement and pilot development
- Completion of the APEC Checklist of Enablers for Alternative Health Financing
- Assessment of current policy and regulatory environment in APEC economies and identification of key gaps to address
- Development of economy specific action plans
- Engagement through economy specific workshops

Phase 3: Plan implementation
- Improve overall investment in health and the number of flexible options to invest in and finance access to health innovations across APEC
- Piloting, scale-up and adoption of new health financing programs / initiatives / policy changes at national or regional levels.

Asia-Pacific Financial Forum

Private sector led group that reports to APEC Finance Ministers
Policy tools, reports, webinars, and meeting summaries are catalogued on the APEC website

Including specific sections on:

- Impact Bonds
- Insurance
- Fintech
- Developing partnerships
- Blended finance
- ESG Finance and health
- Economy engagements
- ROI for health

More information at: https://www.apec.org/healthfinancing
Thank you

Terima kasih
Malaysian Health System: Current Scenario and Future Challenges

Professor Dato’ Dr Syed Mohamed Aljunid
MD (UKM) MPH (Singapore) PhD (London); DLSHTM (London); FAMM, FPHMM, FASc.
Professor of Health Economics, Policy and Management
Chair Dept of Health Policy and Management
College of Public Health
Kuwait University
&
President
Malaysian Health Economic Association

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Outline

- Malaysian Health System: The Three Pillars
- What is right about MHS?
- Roles of Private Providers
- What went Wrong with MHS?
- Roles of Ministry of Health
- Health Financing Scenario
- Proposed Solutions To Enhance MHS
- Conclusion
Three Pillars of MHS

PUBLIC
• Ministry of Health
• Ministry of Education
• Ministry of Defense
• Local Authorities

PRIVATE FOR PROFIT
• Private Hospitals
• Private Clinics
• Pharmacies
• Laboratories
• Hospice
• Nursing Homes

PRIVATE NOT-FOR-PROFIT
• Cancer Care NGOs
• Care for HIV/AIDS
• Palliative Care
Health Services

◆ Primary Health Care Services
  ▪ Health Centres for MCH
  ▪ Outpatient Services (GP Clinics); 65% Ambulatory Contact with Private GPs

◆ Secondary and Tertiary Care
  ▪ Public Hospitals (75% of In-patient Beds)
  ▪ Private Hospitals (25% of In-patients Beds)

◆ Hospice and Nursing Homes
  ▪ Private-For-Profit
  ▪ NGOs
Malaysian Health System: “Important Questions”

◆ What have we done right in our Health System?
What have we done right?

◆ Priority on Primary Health Care
  ▪ Health Services
  ▪ Health Infrastructure

◆ Block funding by government
  ▪ Tax-based funding since Independent

◆ Government plays major role
  ▪ Ministry of Health as the main agency given almost all responsibilities

◆ Development of Local Specialists Training
  ▪ Support to local universities
# Health Indicators: 2000-2020

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<tbody>
<tr>
<td>Life Expectancy At Birth (Years)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>70.0</td>
<td>70.6</td>
<td>71.6</td>
<td>71.9</td>
<td>72.8</td>
</tr>
<tr>
<td>Female</td>
<td>75.1</td>
<td>76.4</td>
<td>76.4</td>
<td>77.0</td>
<td>77.8</td>
</tr>
<tr>
<td>Crude Birth Rate (per 1,000 pop)</td>
<td>24.5</td>
<td>21.0</td>
<td>18.4</td>
<td>17.5</td>
<td>14.4</td>
</tr>
<tr>
<td>Crude Death Rate (Per 1,000 pop)</td>
<td>4.4</td>
<td>4.5</td>
<td>4.7</td>
<td>4.8</td>
<td>5.1</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 lv. births)</td>
<td>6.6</td>
<td>5.8</td>
<td>6.2</td>
<td>6.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Toddler Mortality Rate (per 1,000 toddlers pop)</td>
<td>0.6</td>
<td>0.5</td>
<td>0.4</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Maternal Mortality Rate (per 100,000 live births)</td>
<td>30</td>
<td>30</td>
<td>27.3</td>
<td>27.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Perinatal Mortality Rate (per 1,000 total births)</td>
<td>7.5</td>
<td>6.8</td>
<td>7.3</td>
<td>7.8</td>
<td>8.1</td>
</tr>
<tr>
<td>Neonatal Mortality Rate (per 1,000 live births)</td>
<td>3.8</td>
<td>3.8</td>
<td>3.9</td>
<td>4.4</td>
<td>4.0</td>
</tr>
</tbody>
</table>
Roles of Private Health Care

- Most Primary Health Care Facilities are in private Sector
  - Private Clinics – 11,020 (Medical: 8,222; Dental 2,798)
  - Health Centres – 1,138

- Most In-patient Beds are in Public Sector
  - Public sector (2020)
    - Hospitals : 156 (MOH: 146; Non-MOH: 10)
    - Beds : 48,305 (MOH: 44,117: Non-MOH: 4,188)
  - Private Sector (2020)
    - Hospitals: 202
    - Beds: 17,155
Malaysian Health System: “Important Questions”

- What is wrong with our current Health System?
What is wrong with our current Health System?
Ministry of Health Malaysia

- Main provider of health care services
- Responsible for most health policy matters
- Main regulator of healthcare services
- Very dominant role in Malaysian Health Care System
Multiple Roles of MOH

- Policy Maker
- Funder
- Regulator
- Provider
- R&D
- Education & Training

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Governance

◆ Too much power with too much diversified roles

◆ “Jack of all Trade; Master of None”

◆ Work in Silos
  - Poor coordination with other ministries
  - Carry out actions with no adequate expertise

◆ Reactive response and fire fighting rather than proactive
  - COVID-19 Pandemic

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Health Financing Scenario
Source of Funding for Health

◆ Public (52%)
  ▪ Taxation
    • Direct Taxation (60%)
    • Indirect Tax (40%) including GST-Introduce in April 2015)

◆ Private (48%)
  ▪ Out-of-Pocket Payment (39%)
  ▪ Private Insurance (7%)
  ▪ Other Private (2%)
Reforms in Health Financing System of Malaysia

- High OOP Expenditure and Catastrophic Expenditure
- Long Waiting times in public facilities
- Shortage of drugs in public faculties esp for CNCD
- Brain drain of specialists to private sector
- Too much wastages in health spending (eg: Drugs etc)
- Lack of Quality and Efficiency monitoring mechanism
- Seven attempts to Reform since 1985
Why Our Reforms Failed?

◆ Lack of Political Will to pursue the reform
◆ Weakness of Reform Team
  ▪ Technical Capacity of MOH Staff/Silos)
◆ Lack of Information (Cost/PPM etc)
◆ Fighting over control of the proposed Agency: MOH vs EPU
◆ Role of Potential losers: Private Insurers
◆ Lack of Transparency and Public Consultation
◆ Loss of public confidence on government to handle large fund (Cronyism, Corruptions)
Health Human Resource

- Rural-urban Maldistribution of doctors
- Public-private skewness of specialists
- Planning for Human Resource in Health
- Allied health and Support staff
- Role of MOH in Specialist Training
- Pay-For-Performance
Malaysian Health System: “Important Questions”

◆ What should we do now to enhance our Health System?
Proposed Solutions

- Decentralisation
- Higher Priority on Prevention
- Active R&D in Health
- National Health Financing Scheme
- Enhance Efficiency
- Effective Human Resource Planning
Transformed Roles of MOH

GOVERNANCE

Health Policy

MOH

Service Provider

Monitoring and Evaluation

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Conclusion

◆ Malaysian Health System has undergone series of gradual development since pre-independent era
◆ Priority to primary health care and rural development has benefitted most Malaysian
◆ Reform in Health Financing is one of the vital ingredients of overall health system reform
◆ Governance and Decentralization are among important solutions to enhance MHS
◆ MHS need to be transformed to provide effective, efficient, equitable and innovative services to the Malaysian population
Thank You

syed.junid@ku.edu.kw
saljunid@gmail.com

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FROM 1:2 TO 1:3;1:6 AND 1:12

A KALEIDOSCOPIC VIEW OF THE MALAYSIAN HEALTH SYSTEM

DR MURALIYAHARAN M.
MD(UA) M.CommHealth(UKM) Dip.Derm(Thailand) PGDipCR(India)
MSc(London) MMedEd (Malaya) FRSPH (UK) PhD (Public Health)
ASEAN Scholar College of Public Health Sciences Chulalongkorn University
Chevening Scholar London School of Economics and London School of Hygiene & Tropical Medicine
Union for International Cancer Control (UICC) Young Leader 2019-2020
Public Health Physician
Managing Director, National Cancer Society of Malaysia / Co Chair, NCD Malaysia
A story of nasi lemak....
SNAPSHOT OF THE HEALTH SYSTEM:1:2
### Healthcare services

<table>
<thead>
<tr>
<th>Maternal and Child Health Services</th>
<th>Communicable Disease Care Services</th>
<th>Non-Communicable Disease Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>Pregnancy, neonatal care, family health services</td>
<td>Infectious diseases</td>
<td>NCDs including RTDs and other non-infectious origin</td>
</tr>
</tbody>
</table>

### Type of care

<table>
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<tr>
<td>Type of care</td>
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<tr>
<td>Acute</td>
<td>Chronic</td>
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<tr>
<td>Example</td>
<td>Example</td>
<td>Example</td>
</tr>
<tr>
<td>PPH, hyperemesis, PE</td>
<td>Anemia, GDM</td>
<td>Dengue, Covid-19</td>
</tr>
<tr>
<td>Anemia, GDM</td>
<td>Dengue, Covid-19</td>
<td>HIV</td>
</tr>
<tr>
<td>Dengue, Covid-19</td>
<td>HIV</td>
<td>CVA, ACD</td>
</tr>
<tr>
<td>HIV</td>
<td>CVA, ACD</td>
<td>DM, HPT, CVD</td>
</tr>
<tr>
<td>CVA, ACD</td>
<td>DM, HPT</td>
<td>CVD</td>
</tr>
<tr>
<td>Healthcare services</td>
<td>Maternal and Child Health Services</td>
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<tr>
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<td>Public</td>
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<td>Private</td>
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<td>Public</td>
<td>Public</td>
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</tbody>
</table>
The UHC Box

<table>
<thead>
<tr>
<th>Equity in access to health services</th>
<th>Everyone who needs services should be able to get them, not only those who can pay for them</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Quality of health services</th>
<th>Should be good enough to improve the health of those receiving services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection against financial risk</td>
<td>Ensuring that the cost of using services does not put people at risk of financial harm</td>
</tr>
</tbody>
</table>

Three dimensions to consider when moving towards universal coverage:
- Reduce cost sharing and fees
- Include other services
- Extend to non-covered
- Direct costs: proportion of the costs covered
- Services: which services are covered
- Population: who is covered?
### Healthcare services

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<td>Private</td>
</tr>
<tr>
<td>UHC Dimensions</td>
<td>Public</td>
<td>Private</td>
</tr>
</tbody>
</table>

#### 1. Who is covered?
Citizens, non-citizens, government servants, GLC employees, private employees, B40

#### 2. What is covered?
All services, partial services, quality of services being provided, inclusion of innovative care

#### 3. Who is paying for the coverage?
MOF, MOH, MOE, PEKA B40, GLCs, private health insurance, employer health coverage packages, life insurance, SOCSO, EPF, charitable institutions, Out-of-Pocket
Get in touch!

NATIONAL CANCER SOCIETY MALAYSIA

NATIONALCANCERSOCIETYMY

CANCER.ORG.MY
Sustainably financing healthcare

Jomo Kwame Sundaram

Enhancing Innovative Healthcare Financing
in Pursuit of Sustainable Healthcare
6 September 2022
Health care systems typically mixed

By main financing, provisioning sources

<table>
<thead>
<tr>
<th>Financing</th>
<th>Provision</th>
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<tbody>
<tr>
<td>Private financing</td>
<td>Private provision</td>
</tr>
<tr>
<td>Public financing</td>
<td>Public provision</td>
</tr>
</tbody>
</table>

Each country has a dominant mode, but different combinations, with various primary and hospital care configurations. Other variations and different configurations may co-exist, but usually, there will be a dominant mode in each country.
## Healthcare system model choices 1

<table>
<thead>
<tr>
<th><strong>Mixed arrangements (US model)</strong></th>
<th><strong>Social health insurance (German model)</strong></th>
</tr>
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<tbody>
<tr>
<td>• Complex and fragmented</td>
<td>• Social health insurance model</td>
</tr>
<tr>
<td>• Includes out-of-pocket elements, traditional sickness insurance</td>
<td>• Evolved historically from union/workers insurance</td>
</tr>
<tr>
<td>• Medicare, Medicaid: govt schemes for poor, aged</td>
<td>• State subsidies, especially for unemployed, indigent</td>
</tr>
<tr>
<td>• Partial, not universal access</td>
<td>• Needs high degree of labour market formality</td>
</tr>
<tr>
<td></td>
<td>• Not quite universal access</td>
</tr>
</tbody>
</table>
Healthcare system model choices 2

**National Health Service** (UK model)
- Government dominant service payer and provider
- Funded by **taxes**
- Universal access

**National Health Insurance** (Canadian model)
- Government is single payer
- Providers, hospitals are public/private mix
- Funded by **taxes**
- Universal access
Private/voluntary health insurance

• Private health insurance increasing worldwide
• Problems of health care system dominated by private health insurance:
  • Very limited risk pooling only for wealthy
  • Problems include ‘moral hazard’, ‘cherry-picking’ (e.g., excluding pre-existing conditions and ‘loading’)
  • Weak negotiating power vis-à-vis health care providers
  • Premiums face upward cost pressures, not sustainable
Social health insurance (SHI) claims to address 2 problems

• Raising more money for national health spending (via payroll taxes), i.e., an additional, \textit{de facto}, regressive flat tax only on employees, with matching employer contributions

• Integrating (over-burdened) public healthcare sector with (under-utilized) private sector through [unified] provider payments system
But SHI viability doubtful

• Insurance model undermined by demographic transition as premiums continue to rise with shrinking working share relative to non-working population

• Unsurprisingly, European countries have either already reduced payroll financing in favour of general revenue financing, or are doing so
Social health insurance: poorer outcomes despite higher health expenditure:

• per capita health spending increased by 3–4%, without corresponding improvements in health outcomes

• worse mortality and morbidity rates for diseases requiring strong population-based public health programs, e.g., breast cancer
SHI less cost effective

SHI requires costly layer of insurance management and administration (for enrolment, collection, coverage, benefits, claims, payments)

Health insurance administration spending per capita, 2007

Source: McKinsey Global Institute, Nov. 2008)
Risk pooling: Revenue financing > SHI

• Social health insurance
  • Poor: covered by government subsidies
  • Non-poor informal sector: difficult to collect, and to cover/protect
• Formal sector
  • Non-enrolment, evasion problems
  • Collection, insurance admin. costs substantial

• Revenue-based financing
  • Pools risk across entire population
SHI not sustainable in long-term

- Insurance-based healthcare financing, including SHI:
  - Upward pressure on costs
  - Moral hazards
  - Provider-induced demand
  - Cost escalation spirals
- Strong, *costly* administrative controls needed by insurance requirements
Likely adverse economic, social effects

• More informal employment
• Less decent work
• Implications:
  • Less revenue collection
  • More financial crises
    → increased unemployment
    → lower contributions
    → less coverage
Public resistance to SHI

• Successive SHI schemes proposed over years not acceptable to most
• Additional tax further reduces take-home pay, unacceptable to most
• Government has duty to improve public access to healthcare ['universal HC' SDG, 'health for all']
• Greater equity and access to quality HC important for government legitimacy
Why revenue-based financing?

Why enhance revenue-based health care financing:

• Risk pooling for larger populations
• More efficient, cost-effective
• Less expensive
• More sustainable
1. Egalitarian principles
2. Nation-building
3. Global norms:
   - Universal health coverage (UHC)
   - Equitable access to quality healthcare:
     Ability to pay and location no longer barriers to quality health care access
   - Sustainable financing over long term
   - Cross-subsidization & social solidarity
Per capita health spending, 2015

Source: Global Health Expenditure Database (GHED) WHO NHA on 3rd July 2018
Healthcare financing reform lessons

• Avoid SHI: costlier and less cost-effective
• Also avoid path-dependency issues
• Typically regressive
• Avoid and reduce escalation of healthcare costs, typical of health insurance
• Ensure sustainable financing over long term
• Strengthen revenue base; ring-fencing?
Other govt healthcare challenges

• Govt health care often under-resourced, worse due to leakages & inefficiencies
• Loss of experienced staff (specialists, nurses, etc.) to private sector, abroad
• Uneven health progress indicators
• Powerful health insurance lobbies
Healthcare system reforms needed

• Improve preventive HC, primary HC and public hospitals to help ensure universal HC with equitable access for all to quality HC

• Reward HC providers for keeping people well, e.g., via capitation payments to GPs, rather than by paying for curative services.

• Improve incentives to retain HC personnel in public sector
Recent decades have seen different HC system mixes still changing in many countries.

Health care gaps in charges and quality still growing, increasing access inequalities.

Healthcare systems should provide equitable access to quality health care.

Healthcare provisioning should be based on need, a citizen’s entitlement, regardless of means.
Thank you for your interest and attention
Private Health Insurance In Malaysia

Presented by:
Mark O’Dell CLU, ChFC, CFP, RFP
Facts concerning Private Health Insurance in Malaysia

- Over 9m Malaysians have private health insurance (individual and employer group plans).
- Health Insurance claims inflation exceeded 8% from 2013 to 2018. (Actuarial Partners claims study)
- Pre-covid combined ratios exceeded 95% of premiums with many insurers making losses.
- Fragmented market with more than 40 insurers offering health plans.
- Painful and inefficient process of claims authorization and insured hospital admissions.
Challenges and Gaps in Private Health Insurance in Malaysia

- The cost of medical care at private hospitals in Malaysia has been increasing along with the premiums/contributions of private medical insurance/takaful.

- Middle class and seniors at risk of coverage being priced out of private health insurance.

- Medical care cost management largely left to insurers.

- There is a lack of price transparency across private hospitals.

- Policy design encourages over consumption of health care services.

- Underwriting and pre-existing conditions leaves less healthy Malaysians to pay out of pocket for private health care.
Looking Ahead...

- All stakeholders need to be responsible for managing health care costs.
- Policyholder co-payments needed to align interests and reduce over consumption.
- Costs of common procedures across private hospitals need to be published.
- Technology to be deployed to reduce administrative costs and improve policyholder patient experience.
- Explore public/private partnership through integrated national health insurance scheme.
  - **Public**
    - Basic coverage for all.
    - Subsidies for low income and seniors.
  - **Private**
    - Voluntary top up to basic coverage.
THANK YOU
Strengthening Universal Health Coverage in Malaysia: Opportunities for innovation in private health insurance
MALAYSIA has a tax-financed public healthcare system with access to an extensive list of low-cost healthcare services, and subsidized services provided by the public facilities.

The nation also employs the use of additional schemes such as the mySalam scheme and PekaB40 scheme that were rolled out in 2019 to provide additional financial protection.
THE THREE PILLARS TO UNIVERSAL HEALTH COVERAGE

- **POPULATION:** Who is covered?
- **SERVICES:** Which services are covered?
- **FINANCIAL PROTECTION:** What do people have to pay out-of-pocket?

**Coverage Mechanisms:**
- Extend to non-covered
- Reduce cost sharing and fees
- Include other services
FUNDAMENTAL HEALTH POLICY CHALLENGES TO SUSTAIN UHC

01
Achieving UHC requires a balanced approach across the three dimensions.

02
Countries are facing strained UHC budgets with significant deficits.

03
The growing tide of noncommunicable diseases threaten to overwhelm health systems.
APPROACHES TO STRENGTHEN UHC

1. SUSTAIN UHC
   - Supplementary UHC insurance
   - Comprehensive low premium mass insurance

2. ADDRESS NCD BURDEN
   - Specialty drug insurance
   - Disease-specific insurance

3. REINFORCE PREVENTION
   - Prevention & Wellness Benefits
   - Integrated Education & Awareness
   - Biomonitoring to incentivize healthy behavior

ENABLERS
- POLICY ENVIRONMENT
- DIGITAL INNOVATION
MULTISTAKEHOLDER APPROACH ANCHORED AROUND PHI

**DIGITAL**
Digital technologies provide for scale (e.g., digital wallets, telcos), personalization (insurtech aggregators), and value-added services (e.g., telemedicine).

**INSURERS**
Traditional (re) insurers and insurtech companies lead on product design and underwriting the risk.

**NONPROFITS**
Community-based groups can play an important role in raising awareness, educating, and uptake of PHI products.

**PHARMACEUTICAL**
Pharmaceuticals can provide basic clinical data that help in benefit design and underwriting, adding value-added education and awareness services, and assisting vulnerable populations.

**GOVERNMENT**
Government bodies across healthcare and finance can create an enabling policy environment that supports the creation and uptake of insurance.
ECOSYSTEM APPROACH TO ENSURE INSURANCE UPTAKE

**DESIGN CORE MODEL**
Product design (who benefits, what are the benefits, and how much?)
Risk/underwriting (is the model sustainable for the insurer?)

**EDUCATION & AWARENESS**
Can the insurance be bundled with another service that the customer values like telemedicine, education or awareness, data packages?
How will people find out about the policy? Is it simple, easy to understand? Are insurance agents trained or incentivized to sell?

**INCREASE VALUE PROPOSITION**

**SALES & DISTRIBUTION**
How to make the insurance access easy and convenient to purchase?

**POLICY ENABLERS: PILOT TESTING, REGULATORY SANDBOXES**
SNAPSHOT: INSURANCE-DIGITAL PARTNERSHIPS IN MALAYSIA

<table>
<thead>
<tr>
<th>Company</th>
<th>Partnership Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIA</td>
<td>Partnered with Policy Street to offer insurance products by AIA on its platform</td>
</tr>
<tr>
<td></td>
<td>Partnered with Holmusk to digitally deliver a range of coaching tools and solutions to AIA's customers by leveraging the Holmusk's data-driven approach</td>
</tr>
<tr>
<td>Great Eastern</td>
<td>Partnered with Policy Street to offer insurance products by Great Eastern on its platform</td>
</tr>
<tr>
<td></td>
<td>Partnered with DoctorOnCall to offer telemedicine via as an optional benefit in Great Eastern's health insurance packages.</td>
</tr>
<tr>
<td></td>
<td>Partnered with Aspirasi to launch microinsurance underwritten by GE to provide affordable, accessible, on-demand insurance to Malaysians</td>
</tr>
<tr>
<td>Prudential</td>
<td>Partnered with DoctorOnCall to offer telemedicine via as an optional benefit in their health insurance packages.</td>
</tr>
<tr>
<td></td>
<td>Partnered with Ouch! to develop new digital propositions encompassing services such as e-payments, e-claims, and access to Prudential's network.</td>
</tr>
<tr>
<td>AXA</td>
<td>Partnered with Fi to distribute insurance products as well as to develop an e-medical card and other health insurance products</td>
</tr>
<tr>
<td></td>
<td>Partnered with Policy Street to offer insurance products by AXA on its platform</td>
</tr>
<tr>
<td>Allianz</td>
<td>Partnered with DoctorOnCall to provide teleconsultation and other healthcare solutions to its corporate members.</td>
</tr>
<tr>
<td></td>
<td>Partnered with Policy Street to offer insurance products by Allianz on its platform</td>
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Keywords: E-Wallets, Telehealth, E-Commerce, Insurtech
RECOMMENDATIONS TO MAKE PRIVATE HEALTH INSURANCE WORK FOR UHC

RECOMMENDATION 1
Private Health Insurance Innovation Models
Countries should explore, adapt, and adopt innovative models of insurance that provide health financial protection for the masses.

RECOMMENDATION 2
Enabling Policy Environment
National governments can function as steward and enabler for the uptake of effective commercial health insurance.

RECOMMENDATION 3
Partnerships
Private insurance ecosystem actors can develop, test, and iterate existing and new insurance models.
Countries should explore, adapt, and adopt innovative models of insurance that provide health financial protection for the masses.

- In countries with robust UHC insurance schemes, (1) supplemental UHC and (2) comprehensive mass insurance models should be considered to "top up" national UHC schemes to provide more comprehensive service coverage, faster access to healthcare services, and the expedited access to therapeutic innovations when needed.

- The other innovative models that countries can consider to protect individuals from health and financial hardship due to NCDs, support healthy lifestyles and prevent the onset or progression of illness include:
  a) disease-specific insurance
  b) specialty drug insurance
  c) Prevention and wellness programs that are linked to insurance
  d) education and awareness solutions to prevent the onset or worsening of health conditions.
  e) integrating financial rewards and incentives to healthy behaviors.
RECOMMENDATIONS TO MAKE PRIVATE HEALTH INSURANCE WORK FOR UHC

National governments can function as steward and enabler for the uptake of effective private health insurance.

- Whole-of-government approach for collaborative innovation with regulatory oversight, requiring coordination between several government bodies:
  - e.g. the Ministry of Health, Ministry of Finance, Central Banks, and other insurance regulatory authorities, as well as digital authorities

- Promote awareness and acceptance of PHI by:
  - Engaging in dialogue with insurance innovation ecosystem to address barriers to insurance uptake and low willingness to purchase
  - Encouraging or mandating insurers to provide clear and simplified policies
  - Tax deductions or other financial incentives

- Scale successful “proof-of-concepts” developed in the private sector
  - Work with private counterparts in insurance, digital, and healthcare ecosystem to pilot test innovative models, or support ecosystem partners who are testing these models
Private insurance ecosystem actors can develop, test, and iterate existing and new insurance models.

- An anchor partner – typically insurance or insurtech – can seek out potential partners to increase the value proposition, sales, and distribution of the product to ensure that the new models provide value to the consumer.
- Digital players have broken new ground in “user experience” that designs and tests products rapidly to solve consumer “pain points.”
  - This strategy serves the healthcare sector well where ecosystem actors have been shifting towards person-centric or patient-centric value-based care.
- Develop solutions that have a greater probability of success upon full launch.
  - This ecosystem approach lays the groundwork for pilot testing and providing the “proof of concept” for further industry innovation and scale, and potential government policy shaping to support UHC goals.
Thank You

You can read the full white paper here: