



**Asia-Pacific
Economic Cooperation**

The Role of Private Health Insurance in Expanding Healthcare System Access, Quality, and Affordability in APEC Economies

October 2026

APEC Health Working Group



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Acronyms & Abbreviations

AI	Artificial Intelligence
AMNOG	Act on the Reform of the Market for Medicinal Products (Germany)
ANS	Agência Nacional de Saúde Suplementar (National Supplementary Health Agency, Brazil)
APEC	Asia-Pacific Economic Cooperation
BHYT	Bảo hiểm Y tế (Social Health Insurance, Viet Nam)
BMI	Basic Medical Insurance (People's Republic of China)
CDL	Cancer Drug List (Singapore)
CIIDL	Commercial Health Insurance Innovative Drug List (People's Republic of China)
COB	Coordination of Benefits
EPS	Entidades Prestadoras de Salud (Health-Providing Entities, Peru)
EsSalud	Seguro Social de Salud (Social Health Insurance, Peru)
FONASA	Fondo Nacional de Salud (National Health Fund, Chile)
GES	Garantías Explícitas en Salud (Explicit Health Guarantees, Chile)
HIRA	Health Insurance Review and Assessment Service (Korea)
HTA	Health Technology Assessment
IP	Integrated Shield Plan (Singapore)
ISAPRE(s)	Instituciones de Salud Previsional (Private Health Insurance Institutions, Chile)
ISP	Integrated Shield Plan (Singapore)
JKN	Jaminan Kesehatan Nasional (National Health Insurance, Indonesia)
KPI	Key Performance Indicator
LHC	Lifetime Health Cover (Australia)
MAS	Monetary Authority of Singapore
MHIT	Medical and Health Insurance/Takaful (Malaysia)
MLS	Medicare Levy Surcharge (Australia)
MOH	Ministry of Health (Singapore)
NCD	Non-communicable Disease

NHI	National Health Insurance (Korea)
NHIS	National Health Insurance Service (Korea)
NHSA	National Healthcare Security Administration (People's Republic of China)
NOEMIE	Norme Ouverte d'Échanges entre la Maladie et les Intervenants Extérieurs (France)
NRDL	National Reimbursement Drug List (People's Republic of China)
OJK	Otoritas Jasa Keuangan (Financial Services Authority, Indonesia)
PHI	Private Health Insurance
RESA	Risk Equalization Special Account (Australia)
RMB	Renminbi (Chinese currency)
SGD	Singapore Dollar
SHI	Statutory/Social Health Insurance (used in Japan and People's Republic of China contexts)
SNDS	Système National des Données de Santé (National Health Data System, France)
UCS	Universal Coverage Scheme (Thailand)
UHC	Universal Health Coverage

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Executive Summary

The Asia-Pacific Economic Cooperation (APEC) region encompasses some of the most varied health systems in the world, ranging from high-income economies with well-established universal coverage frameworks to lower-middle-income economies still building the foundations of their public health financing systems. Despite this heterogeneity, member economies share a common challenge: three interrelated forces — the rapidly rising burden of non-communicable diseases, aging populations, and sustained medical cost inflation — are simultaneously increasing demand for health interventions and placing growing fiscal pressure on public health systems that have already made substantial progress toward expanding health coverage to all according to domestic contexts and priorities.

Private health insurance exists in virtually every APEC economy, but its contribution to total health financing has remained modest relative to its potential. In most markets, PHI has developed primarily as an employer-sponsored benefit for formal sector workers, focused on amenity-based interventions rather than on substantive enhancement of public coverage. Out-of-pocket expenditure, not private insurance, remains the primary mechanism through which individuals meet health costs not addressed by public systems.

PHI can do more, and the conditions for it to do so require deliberate government action rather than market development alone. A framework of four archetypes, organized according to the maturity of the public health system and the degree to which the government actively coordinates the public-PHI relationship, reflects the reality that strategies that work in one context need to be adapted, not simply replicated, to another.

Three opportunities emerge where PHI is best placed to make a meaningful contribution to health system goals: strengthening financial protection against the costs of serious illness, giving patients a funded route to innovative technologies the public system cannot yet cover, and improving population coverage by extending access beyond the formal sector populations that most PHI markets currently serve.

Realizing these opportunities requires three enabling conditions. First, governments must define the legal and regulatory framework so that PHI products are designed in deliberate relation to the public benefit package rather than in parallel to it. Second, consumer trust must be actively built and carefully managed, through insurance literacy, clear and comparable product disclosure, and the intentional design of any changes to the public-PHI interface. Third, data and digital infrastructure must connect public and private health financing systems so that government and insurers are working from the same information base, enabling both effective oversight and confident product design.

Intended primarily for APEC ministries of health, finance ministries, and the regulatory agencies responsible for health financing and insurance oversight, the best practice principles and learnings set out here are also relevant to international development organizations, multilateral bodies, and private sector stakeholders engaged in health system strengthening across the region. For government policymakers, these principles are designed to serve as a practical reference: a way of locating their own economy within the broader landscape of PHI development and drawing on what peer economies and global peers have already learned. The challenge of getting PHI to work well alongside public health systems is one that no APEC economy has fully resolved on its own, and the experience of those that have made meaningful progress holds real value for those navigating similar questions. Designed to make that collective learning accessible, this paper supports the ongoing exchange of knowledge and practice that APEC is uniquely positioned to facilitate.

SECTION: 01

Introduction

A Varied Region with a Shared Commitment to Health and Economic Growth

The Asia-Pacific Economic Cooperation (APEC) region encompasses one of the most varied collections of health systems in the world. Spanning high-income economies with decades of consolidated public health infrastructure to lower-middle-income economies still in the process of establishing their foundational coverage frameworks, APEC member economies differ significantly in their health system configurations, financing models, institutional capacity, and health policy priorities. Yet despite this heterogeneity, two common features define the region's health landscape – one source of shared progress and one shared vulnerability.

The first is a steady and reaffirmed commitment to the health and well-being of populations, which has been matched by sustained increases in public health expenditure across virtually all member economies. Most APEC economies have made significant and measurable progress toward Universal Health Coverage (UHC) according to domestic contexts and priorities, several with landmark legislative and programmatic milestones. Indonesia launched the *Jaminan Kesehatan Nasional* (JKN), now the world's largest single-payer economy-wide health insurance program by enrolled population.¹ Viet Nam established the *Bảo hiểm Y tế* (BHYT) social health insurance scheme that nearly encompasses the entire population.² The Philippines enacted a Universal Health Care Law in 2019, which automatically enrolled all Filipinos into the economy-wide health insurance program.³ In 2002, Thailand achieved full population coverage through its Universal Coverage Scheme, making it one of the first and most notable examples of a lower-to middle income economy at the time to do so.⁴ Korea stands as one of the most cited examples globally of rapid UHC achievement, moving from a fragmented, employer-based insurance system to near-universal statutory coverage within a single generation.⁵

Sustained increases in public health expenditure have accompanied this commitment to population health across the APEC region. Between 2000 and 2023, current health expenditure per capita increased substantially across virtually all APEC economies. In most cases, healthcare spending more than doubled and in several cases increasing by five to eight times in real purchasing power parity terms, reflecting both genuine growth in health system investment and the progressive expansion of public financing mechanisms across the region.⁶

Across the region, these commitments reflect a shared recognition, consistent with APEC's broader principles, that population health is inseparable from economic productivity and sustainable growth.

Progress Translating into Population Coverage

Most APEC economies have made formal commitments to expanding health coverage to all, according to domestic contexts and priorities, as a defined policy objective. Coverage for all, a goal that some APEC economies embrace within their domestic health strategies, is commonly understood as ensuring that all people have access to the full range of quality health interventions they need, when and where they need them, without suffering financial hardship.⁷ Domestic progress toward this goal is typically measured across three dimensions: population coverage (who is enrolled), service coverage (which interventions and treatments are included in the benefit package), and financial protection (the degree to which the system shields households from catastrophic and impoverishing health spending).

In recent years, Indonesia; the Philippines; Viet Nam have boasted complete or nearly complete population coverage by UHC. Other economies like Australia; Japan; Korea; Malaysia; Singapore have long provided full population coverage. The United States, while not having adopted UHC as a formal policy goal, maintains a robust health system supported by both public programs and a highly developed private insurance market, with a shared economy-wide aim of providing high-quality healthcare for its citizens.

As a result of these sustained commitments, several APEC Economies have recorded meaningful decreases in out-of-pocket health expenditure - one of the primary indicators of financial vulnerability – over the past two decades. Thailand's out-of-pocket share fell from 27% to 9% of total health expenditure between 2003 and 2022, one of the most significant reductions recorded in the region and a direct reflection of the transformative impact of its domestic Universal Coverage Scheme. Indonesia similarly recorded a sharp decline over the last decade as the JKN program extended its reach, while China's out-of-pocket share dropped by nearly 30 percentage points over the same twenty-year period.⁸

The Triple Threat That Puts Progress at Risk

Despite this progress, health systems across APEC face a series of challenges that threaten to outpace the gains achieved. Three interrelated forces 1) the rising burden of non-communicable diseases (NCDs), 2) rapidly aging populations, 3) and sustained medical cost inflation are simultaneously increasing demand for health interventions while straining the fiscal foundations of public health systems.

The significant and rapidly rising NCD burden worldwide is similarly affecting APEC Economies.⁹ Conditions such as cancer, cardiovascular disease, diabetes, and chronic respiratory illness are now leading causes of premature mortality across member economies, and their treatment is both long-term and increasingly expensive. Critically, coverage for NCD treatment and, in particular, for innovative therapies such as immune-oncology medicines, targeted therapies, and precision treatments remains one of the most significant areas where public health systems have yet to keep pace with the expanding frontier of clinical need across the region.^{10 11}

Demographic aging compounds this challenge. As populations grow older, the ratio of working-age contributors to health systems narrows relative to the number of beneficiaries, placing fiscal pressure on social health insurance schemes that are contribution-financed.

At the same time, medical cost inflation is at a global average of nearly 10%. The pressure on the payers – individuals, private, and public alike - is significant across APEC Economies. In Economies such as Indonesia; Malaysia; and Thailand; soaring with medical inflation is estimated at 17%, 16%, and 15%, respectively.¹²

The result is a set of areas where public health systems aiming for coverage for all face growing pressure: in prevention and treatment of NCDs, in access to new medicines and medical devices, and in financial protection for informal sector workers and other populations who fall outside the formal employment-linked enrollment pathways of many public health schemes.

Private Health Insurance: An existing, but underutilized, health financing mechanism

Against this backdrop, private health insurance (PHI) exists in virtually every APEC economy, spanning a wide range of product types, market structures, and regulatory frameworks. Yet even in economies where private insurance penetration is relatively high, its contribution to total health financing has remained modest to moderate. In most APEC economies, out-of-pocket expenditure continues to be the primary mechanism through which individuals meet health costs not addressed by public systems, while PHI plays a comparatively minor financing role.¹³

The gap between PHI penetration and PHI contribution reflects structural features of how PHI products have evolved in most markets: primarily as employer-sponsored group plans covering working-age formal sector employees; focused on amenity-based benefits such as access to private hospital rooms, shorter waiting times, and choice of provider rather than on substantive enhancement of public benefit packages; and with coverage limits and reimbursement structures that are generally inadequate for the high per-cycle costs of innovative therapies.

This paper explores how PHI can be more effectively leveraged to complement and strengthen health systems in support of affordable and quality access to healthcare, and what conditions are required for this to work.

Pre-Conditions for Effective PHI Integration

The ability of PHI to meaningfully complement or strengthen a public health system depends on the presence of three interrelated pre-conditions.

1. **An existing and maturing private insurance market.** The first pre-condition is the existence of a private insurance market with sufficient penetration and product sophistication to serve as a credible complement to public coverage. A nascent market dominated by rudimentary lump-sum indemnity products offers a fundamentally different policy lever than a mature market with a spectrum of structured benefit designs, risk-pooling mechanisms, and actuarial infrastructure.

The presence of PHI across APEC economies does not, however, imply uniform reach or depth. Private health insurance penetration varies dramatically across the region from under 6% in Viet Nam,¹⁴ where PHI remains concentrated among a small, affluent, urban demographic, to over 80% in Korea,¹⁵ where the majority of the population uses private plans to supplement interventions not covered by the public health insurance scheme. This wide variation reflects fundamental differences in public health system maturity, market development history, government policy orientation, and consumer demand.

2. **Clarity on the government's baseline coverage.** The second pre-condition is that the scope of the public health system's baseline coverage must be sufficiently defined in terms of which populations are covered, which interventions and treatments are included, and what cost-sharing obligations fall on the patient. Where public benefit packages are poorly defined, unstable, or subject to frequent administrative revision, it is structurally difficult for private insurers to design products that complement rather than duplicate or conflict with public financing schemes.

3. **An enabling regulatory environment for integration and supplementation.** The third precondition is the existence of a regulatory and policy environment that actively enables coordination between public and private health financing. This includes frameworks governing coordination of benefits between public and private payers, rules around premium setting and product standardization, and the degree to which government actively directs or incentivizes PHI toward strengthening designated areas of public coverage.

Private Health Insurance's Emerging Role in Strengthening Health Systems

Across APEC, private health insurance is present in some form in all markets, ranging from basic indemnity and hospital cash products to sophisticated integrated supplemental plans. Importantly, a significant trend is emerging across the region: a move toward supplementary insurance products that are explicitly or implicitly designed to enhance and strengthen public coverage rather than simply provide parallel private access.

Supplementary insurance in this report are defined as products that are deliberately structured to offer financial protection and access to healthcare interventions above and beyond what the prevailing public scheme provides.¹ The creation and provision of supplementary insurance can be government-driven, market-driven, or a hybrid of the two.

The trend towards supplementary insurance takes different forms across Economies, as reflected in *Table 1* below:

Economy	Supplementary Insurance Product Form
Australia	The government has taken one of the most explicit policy positions in the region on the role of PHI, including a tax surcharge on higher-income earners who do not hold private hospital cover, a premium loading for those who delay taking up cover after age 31, and a means-tested government rebate on PHI premiums. PHI serves a dual function within this framework: it manages demand on public hospitals by channeling those with means into the private system, and it provides cover for a range of interventions that sit entirely outside the universal public Medicare schedule — including dental, optical, physiotherapy, and other allied health interventions — which Medicare does not fund. PHI thus operates as both a structural complement to Medicare for hospital interventions and a vehicle for extending coverage into areas the public system leaves to the private market. ^{16 17 18}
Chile	Chile operates a formal dual structure, with the <i>Fondo Nacional de Salud</i> (FONASA) as the public scheme and the regulated <i>Instituciones de Salud Previsional</i> (ISAPREs) as the private layer. Sitting across both, the <i>Garantías Explícitas en Salud</i> (GES) plan establishes legally binding guarantees of access, quality, and financial protection for a defined list of high-burden conditions, with private insurers legally required to meet the same standards as the public system. ¹⁹

1 A 2004 OECD report makes a distinction between complementary insurance and supplementary insurance. Complementary insurance is private health insurance that covers costs not included in the public benefit package, while supplementary insurance covers the same services as the public system but offer faster access, greater choice of provider, or enhanced amenities.

Economy	Supplementary Insurance Product Form
People's Republic of China	A rapidly evolving ecosystem of supplemental insurance products, including the Huiminbao government-facilitated city-level plans and, most recently, the 2026 Commercial Health Insurance Innovative Drug List (CIIDL), reflects an accelerating government-led effort to leverage PHI as a mechanism to strengthen the reach and depth of the existing Basic Medical Insurance system, particularly in extending patient access to innovative medicines not yet incorporated into the National Reimbursement Drug List. ^{20 21}
Indonesia	The Coordination of Benefits (CoB) mechanism formally links private insurance to the JKN public scheme, channeling PHI primarily toward amenity upgrades and access to private provider networks. ^{22 23}
Republic of Korea	Complementary insurance products (<i>Silson</i> insurance) have become the dominant form of private coverage, designed to reimburse patient cost-sharing obligations under the National Health Insurance, though successive reform cycles have progressively tightened benefit scope in response to concerns about moral hazard and overconsumption. ^{24 25}
Malaysia	The government has recently moved to develop a standardized Base Medical and Health Insurance/Takaful (MHIT) plan, marking a transition from a purely market-driven PHI environment toward a more structured public-private interface. ^{26 27}
Peru	The most structured point of public-private complementarity is the Entidades Prestadoras de Salud (EPS) system, through which employers and employees can redirect a portion of their EsSalud social insurance contribution to a regulated private health provider, gaining access to private facilities and enhanced interventions. This mechanism is government-regulated but market-delivered and represents a deliberate if partial attempt to integrate PHI as a complement to the public contributory system. Overall PHI uptake, however, remains low, concentrated among higher-income urban households and formal sector employees, with no broader government incentive architecture in place to drive wider adoption. ^{28 29}
Singapore	The Integrated Shield Plans (ISPs) operate as a formal government-designed supplement to the mandatory MediShield Life public scheme, offering enhanced hospital and specialist coverage within a regulated framework that has evolved substantially over the past decade.
Viet Nam	Resolution 72 and the 2024 Law on Health Insurance represent a formal legislative shift, with the government now defining the Social Health Insurance scheme as the essential tier and piloting a regulatory framework for PHI to serve as the supplementary tier.

Table 1: Summary of supplementary insurance products across APEC economies

Yet despite this emerging trend toward supplementary and system-strengthening PHI, a consistent pattern holds across the region: even where private insurance penetration is relatively high, its contribution to total health financing remains modest. Government spending and, critically, out-of-pocket expenditure continue to dominate health financing across most APEC economies suggesting that the design and reach of current PHI markets have not yet translated into significant population-level financial protection.

These examples also reveal something important about the limits of generalization: the conditions under which PHI has begun to play a more meaningful complementary role differ considerably across economies, shaped by the maturity of the public health system, the depth and reach of the existing PHI market, and the degree to which government has actively directed or enabled the integration.

Scope, purpose, and structure of the paper

Across the full spectrum of APEC health system configurations, this paper examines how private health insurance can be more effectively deployed to strengthen healthcare affordability and access, drawing on best practices from both within APEC and beyond APEC for global comparison.

Because starting points differ, so do the most relevant policy and market approaches. To reflect this, the analysis is organized around four broad archetypes, each defined by three dimensions: the maturity of the public health system (in most Economies, defined by the progress on expanding health coverage to all, the depth and penetration of the PHI market, and the extent to which PHI supplements or otherwise strengthen the dominant mode of economy-wide health financing.

These archetypes are not intended as a definitive classification, and economies should not read them as fixed categories. They are an analytical lens to acknowledge that the conditions for effective PHI integration are not the same everywhere, and that strategies in one context need to be adapted, not simply replicated, to another.

The archetypes are organized along two dimensions. The first dimension distinguishes between economies with advanced public health system, where the public system is well-established, broadly covers the population, and provides a clearly defined foundation for PHI to sit alongside, and those with maturing public health system, where coverage is still developing, the boundary between public and private is less precisely drawn, and the framework for PHI integration is still taking shape. The second dimension distinguishes between economies where the government actively coordinates how PHI operates alongside the public system, including setting the benefit package and directing market participants toward policy goals, and those where private insurers drive product design and market development within a framework the government sets but does not actively steer.

Table 2 provides an overview of the APEC and global examples used throughout this paper, organized across the four archetypes, to show how the best practice principles translate across different market context.

Category	Description	APEC Examples	Global Examples
Archetype 1	Advanced public health system with government-led PHI coordination	Singapore	Netherlands; France
Archetype 2	Advanced public health system with market-dominant PHI coordination*	Australia; Japan; Korea	Germany; Ireland
Archetype 3	Maturing public health system with government-led PHI coordination	Chile; China; Indonesia; Malaysia	Brazil
Archetype 4	Maturing public health system with market-dominant PHI coordination	Peru; Viet Nam	None

Table 2: Overview of APEC and global examples organized across the four archetypes

The paper proceeds in two parts. The first examines the three dimensions along which public health systems across the region face the greatest and most sustained pressure: population coverage, service coverage, and financial protection. For each, it sets out the best practice principles and case examples that demonstrate how PHI can contribute to strengthening public systems.

The second shifts from what PHI can contribute to how governments can create the conditions for it to do so, examining the policy, regulatory, and coordination mechanisms under which PHI integration is most likely to succeed. Throughout both parts, examples are drawn from APEC economies and relevant global comparators, with attention to how context shapes what is applicable and what requires adaptation.

SECTION 02

Opportunities for Private Health Insurance to Support Public Health System Goals

This section discusses the three dimensions in which private health insurance has the greatest potential to support public health system goals: population coverage, service coverage, and financial protection. For each, it sets out the best practice principles that apply and draws on case examples that illustrate them in practice.

OPPORTUNITY 1:

Increasing financial protection without undermining health financing sustainability

PHI can extend meaningful financial protection to populations that public systems leave exposed, but the design of that protection must be targeted at the right gap. In advanced markets, the primary challenge is ensuring PHI complements rather than duplicates or undermines measures to ensure system sustainability and avoids over-utilization. In maturing markets, the primary challenge is directing PHI toward the financial exposure for patients not yet covered by the public system, including the range of products and interventions left unreimbursed by the public system. In both cases, the most effective models share a common feature: they are explicitly designed to address what the public system leaves exposed, rather than replicating or eroding what it already provides.

Type 1 and 2 economies tend to see public coverage substantially reimburse most health expenditure, with PHI playing an important role in extending financial protection for the residual costs households would otherwise bear. In these markets, private insurers may compete for policyholders in part by offering reimbursement of cost-sharing obligations (e.g. co-payments and deductibles) that the public system deliberately introduced to encourage appropriate use of healthcare. Where this occurs without adequate safeguards, it can over time reduce the marginal cost of care at the point of use, contributing to higher utilization and placing pressure on both public expenditure and the sustainability of the private insurance market itself.

Type 3 and 4 economies face a very different dynamic. Their public systems provide a baseline of coverage but leave significant financial exposure for households facing serious or prolonged illness. The out-of-pocket burden remains high, particularly for chronic diseases that require long-term care and treatment. The financial protection gap is the space where PHI can provide the most meaningful protection, covering what the public system does not.



Best Practice Principle: To provide the most meaningful financial protection, target the residual gap the public system leaves

The case studies that follow illustrate this principle in action across two distinct contexts. China's experience shows what becomes possible when government stewardship creates the enabling conditions for a new category of financial protection to scale through the private market. Korea's experience shows what ongoing stewardship looks like once that market is established, including the capacity to monitor, evaluate, and recalibrate the framework over time to ensure it continues to serve its intended purpose.

CASE STUDY 1:

APEC – China

China's Basic Medical Insurance system achieved broad population coverage and provided a basic layer of financial protection; however, middle-income households still faced significant out-of-pocket burden when confronting serious illness and high-cost care. Recognizing that the commercial market had not yet developed products capable of addressing that exposure at scale, regulatory authorities took a series of deliberate steps to create the conditions for innovation. By adapting distribution rules to permit internet-based sales and maintaining clear and consistent public coverage parameters, government provided the enabling environment that made a new category of private health insurance commercially viable. The result led to the creation of high-limit medical products in 2015 offering coverage of up to one million RMB at premiums within reach of middle-income households.

From then on, million-RMB medical insurance formally took shape as a product category and gradually became widespread in the market, undergoing continuous iterations and updates. In the same year, the city of Shenzhen also piloted a municipality-led approach to create a new model of insurance that blended public insurance with private commercial underwriting to expand access to individuals with pre-existing conditions and others vulnerable to illness.

The 2015 Shenzhen Critical Illness Supplementary Medical Insurance program became an important early reference point for the later development and scaling of city-level supplementary health insurance programs, commonly known as Huiminbao. By 2023, Huiminbao programs had been launched in over 200 cities across China, collectively enrolling hundreds of millions of participants and demonstrating that affordable supplementary coverage could be delivered at scale through public-private collaboration. The Huiminbao model thus stands as a defining achievement of China's health insurance innovation: a systemic solution that transformed the protection gap from an intractable market failure into a solvable policy challenge.

CONTEXT



- China's Basic Medical Insurance (BMI) system provides near-universal population coverage, offering households a meaningful baseline of financial protection against the costs of illness.
- However, for households facing serious illness, particularly high-cost hospitalization or complex treatment requiring extended care, the financial exposure above the BMI reimbursement ceiling could be substantial.
- Prior to 2016, the commercial health insurance products most widely available to middle-income households were predominantly lump-sum critical illness products that paid a fixed sum on diagnosis, or standard medical reimbursement products with relatively modest coverage ceilings. Neither offered the scale of financial protection that serious illness could demand, and neither was priced accessibly for the mass market.



THE MECHANISM

- **Enabling regulatory framework:** The regulatory framework governing insurance distribution was progressively adapted to permit internet-based sales channels, allowing insurers to reach a mass consumer base that traditional agency-based distribution could not.
- **BMI's stable foundation:** The BMI system's established and consistent coverage parameters provided a stable foundation on which private insurers could build. The clarity of the public system's structure reduced product design uncertainty and made it commercially viable to offer very high coverage limits at premium prices accessible to middle-income households.
- **Government direction enabled two distinct innovations that emerged in parallel and converged to reshape the market:** The first was the million medical product, which offered coverage ceilings of one million RMB at premiums accessible to middle-income households. The second was Shenzhen's city-level Huiminbao supplementary-insurance pilot, which introduced a government-coordinated model with guaranteed enrolment and explicit inclusion of individuals with pre-existing conditions.



THE PROGRESS

1. The two innovations operated in parallel through the late 2010s before converging around 2020. The million medical product demonstrated that high-limit financial protection could be delivered commercially at mass-market price points. The Shenzhen pilot demonstrated that government coordination could extend that protection to populations the commercial market had not reached.
2. As the Shenzhen model scaled into the broader Huiminbao framework, it exerted a pull on the commercial market, influencing how private insurers structured coverage and accelerating a shift toward greater access.
3. It was ultimately the convergence of these two tracks, one market-driven and one government-coordinated, that defined China's progress in expanding financial protection at scale.



KEY TAKEAWAY FOR APEC ECONOMIES

Market-driven and government-coordinated innovation can each unlock financial protection that the other cannot reach alone. Million medical insurance demonstrated that high-limit financial protection could be priced for the mass market, but commercial underwriting alone could not extend that protection to those with pre-existing conditions. Huiminbao demonstrated that government coordination could guarantee enrolment to the populations the commercial market excluded.

CASE STUDY 2:

APEC – Korea

China's example demonstrates what becomes possible when government stewardship creates the conditions for well-targeted PHI to scale. Korea's experience illustrates a different but equally important dimension of stewardship: the capacity to monitor, evaluate, and actively refine a complementary insurance framework as the market matures, ensuring it continues to serve its intended protective function over the long term. The two cases together reflect a continuum of government engagement: from enabling a market to develop around the right gap, to ensuring that a developed market remains well-calibrated over time.

CONTEXT



- Korea's National Health Insurance System provides near-universal public coverage, with cost-sharing obligations built into the design.
- In 2003, the government permitted supplementary PHI to enter the market with the intent of alleviating financial burden on households.
- As the PHI market grew, private insurers competed by offering increasingly comprehensive reimbursement of patient cost-sharing obligations, reducing the marginal cost of care to zero.
- This contributed to moral hazard and adverse selection issues, culminating in very high per capita utilization of outpatient health services.

THE MECHANISM



- **The 4th generation reform:** Introduced in 2021 by the Financial Services Commission, reflected the government's assessment that the complementary insurance framework could be better calibrated to ensure cost-sharing obligations fulfilled their intended function of encouraging appropriate use of healthcare services, while preserving PHI's financial protection role for meaningful medical costs.
- **The 5th generation reform:** Launched in June 2026, represents an evolution of this approach. By differentiating coverage terms between severe and non-severe conditions, it maintains a strong financial protection for serious illness such as cancer while recalibrating cost-sharing for non-severe conditions. The government has introduced a more nuanced framework that concentrates PHI's protective function where the financial burden is the highest.

THE PROGRESS



1. Korea's successive reforms reflect a government actively managing the long-term sustainability of its complementary insurance architecture.

2. Each generation of reform reflects the government's capacity to assess how the PHI market is interacting with the public system and to make deliberate, targeted adjustments that preserve the protective intent of complementary insurance while strengthening the overall health financing architecture.
3. The differentiation between severe and non-severe conditions introduced in the 5th generation is a particularly sophisticated example of this: rather than applying a uniform approach across all types of care, the framework now concentrates PHI's financial protection function where clinical and financial need is greatest.



KEY TAKEAWAY FOR APEC ECONOMIES

Active government monitoring and willingness to refine the regulatory framework over time are as important as the initial design of a complementary insurance system. Korea demonstrates that effective PHI stewardship is an ongoing process, not a one-time policy decision.

China and Korea together illustrate two ends of a stewardship continuum: enabling a market to develop around the right gap and keeping a developed market well-calibrated over time. Chile's experience offers a complementary perspective from a Type 3 economy, showing how a government can establish an explicit financial protection guarantee that applies across both the public and private systems simultaneously, without waiting for the private market to mature first.

APEC Example: Chile

Chile's *Garantías Explícitas en Salud (GES)* plan illustrates how a government in a maturing public health system context can establish explicit financial protection guarantees that apply across both the public and private systems simultaneously. Introduced in 2005, GES established legally binding guarantees of access, quality, financial protection, and timeliness³⁰ for a defined list of high-burden conditions, including cancer, cardiovascular disease, and diabetes³¹, covering both beneficiaries of the *Fondo Nacional de Salud (FONASA)*, the economy-wide public health fund, and those enrolled with a *private Institución de Salud Previsional (ISAPRE)* insurer. Private insurers are legally required to cover all GES-listed conditions and are bound by the same out-of-pocket caps as the public system, meaning a patient's financial exposure for a GES condition is limited regardless of which system they are enrolled in³². The government, rather than leaving the scope of financial protection to market design, defined it legislatively and made it enforceable across the entire system.

OPPORTUNITY 2:

Giving PHI a defined role in covering innovative technologies the public system cannot yet fund

Across APEC, public health systems have made substantial progress in expanding the range of healthcare interventions available to their populations. In many economies, public benefit packages now cover a broad set of treatments that would have been inaccessible to most patients a generation ago. The service coverage challenge that remains is not one of failure but of pace: the rate of innovation in medicines, medical devices, diagnostics, and clinical interventions continues to outrun the capacity of even well-resourced public systems to assess, negotiate, and fund new technologies in a timeframe that meets patient needs. The result, across economies at every stage of development, is a defined gap between what is clinically available and what is publicly funded. This gap differs in character depending on the maturity of the public system, but that exists in some form in virtually every APEC economy. PHI is best placed to address this gap when governments give it a clearly defined role in doing so. PHI also plays a complementary financial protection role that sits alongside its service coverage function: by absorbing high out-of-pocket costs that public systems do not fully cover, it shields households from the catastrophic financial burden that serious illness can impose even within a well-functioning public system. These two functions – extending service access and providing financial protection – are closely linked, and the most effective models address both.

In Type 3 and Type 4 where public budgets are more constrained, the range of technologies that can be publicly funded is narrower, and decisions about what to include in the public benefit package are often driven by fiscal capacity alongside clinical assessment. Where health technology assessment processes exist, they operate within tighter fiscal limits; where they are still being developed, coverage decisions rest more directly on what the public budget can sustain. In both contexts, clinically meaningful technologies that patients need may sit outside public coverage, and the financial burden falls on individuals.

The nature of this service coverage gap differs across economies depending on the maturity of their public health systems and the fiscal capacity of their public budgets. In Type 1 and Type 2 economies with advanced public systems and structured health technology assessment processes, newly approved technologies may be assessed and found clinically valuable but still not publicly funded, either because the cost sits above what the health system can absorb at the negotiated price, or because the assessment concludes that the technology does not meet the cost-effectiveness threshold required for public reimbursement.

PHI extends access to the broadest range of needed healthcare interventions when it has a clearly defined role in covering what the public system does not. In economies with advanced public systems, this means bridging the gap while a public reimbursement decision is pending or stepping in where the public system has assessed a technology and chosen not to fund it. In economies with less mature public systems, it means building coverage around a government-curated reference point that gives private insurers the confidence to offer products beyond the high-income segment. In all three cases, the most effective models share the same feature: PHI is explicitly directed toward the gap the public system leaves, rather than operating in ambiguity about what it is permitted to cover.

Within this approach, we discuss three best practice principles that economies can consider, depending on which archetype they fall under.

For Type 1 & 2 Economies

Type 1 and 2 economies typically have advanced public systems and structured health technology assessment processes. In these economies, two best practice principles arise from how the assessment process works in practice.



Best Practice Principle: Bridging the access gap while reimbursement decisions are pending

In most health systems, a newly approved technology reaches patients only after the public reimbursement process concludes, meaning the assessment period itself creates a window during which patients have no publicly funded route to access a treatment that is regulatory-approved. This is not a flaw in the assessment process; rigorous evaluation of clinical benefit and cost-effectiveness or value assessments is essential to sustainable public coverage decisions. The challenge is the access gap the process creates in the interim.

Some economies have developed design solutions that allow coverage to begin from the point of regulatory approval while assessment continues in parallel, removing the waiting period entirely. Where such an approach is in place, PHI can adopt the same logic, extending coverage during the assessment window rather than waiting for a public reimbursement decision before acting. The key enabler for PHI is regulatory clarity: where governments confirm that PHI may cover a regulatorily-approved technology during a pending reimbursement review, insurers have the certainty they need to design and offer products without ambiguity about what they are permitted to do.

The two case studies that follow illustrate how this principle has been put into practice across two distinct health system contexts. Germany's experience shows what becomes possible when the access decision and the pricing decision are deliberately separated at the point of system design, ensuring that assessment rigor and patient access are not treated as competing priorities. Japan's experience shows how a formally defined evaluation category can give private insurers a clear and stable reference point around which to build a dedicated product, creating a private access route that complements rather than disrupts the public system.

CASE STUDY 3:

Global – Germany

Germany's experience with the Act on the Reform of the Market for Medicinal Products (AMNOG) offers one of the clearest examples of how the coverage decision can be separated from the pricing decision in a way that eliminates the access gap that assessment processes typically create.

Historically, Germany has had one of the fastest access timelines for newly approved medicines of any major health system, with patients able to access treatments almost immediately after regulatory approval for safety and efficacy. When Germany established AMNOG in 2011 to undertake health technology assessments and determine the cost-effectiveness of newly approved interventions, the design challenge was how to run a rigorous assessment process without making patient access contingent on its outcome. The response was to guarantee coverage from day one of regulatory approval and use the assessment to determine the reimbursement price after the fact, ensuring patients are never without a funded route to a clinically approved medicine while the system works out its value.

CONTEXT



- In most health systems, a newly approved technology reaches patients only after the public reimbursement process concludes, meaning the assessment period itself creates a window during which patients have no funded route to access a clinically approved treatment.
- Neither approach serves patients as access is contingent on the reimbursement negotiations.

THE MECHANISM



- **Automatic day-one coverage across both public and private systems:** Prescription drugs in Germany are reimbursed immediately after market launch for all patients, whether they hold statutory or private health insurance, regulatory approval alone triggers coverage and access is not contingent on the outcome of the benefit assessment.
- **A parallel, time-bound assessment process:** The Federal Joint Committee conducts an HTA within six months of market launch, assessing the degree and likelihood of additional clinical benefit of the new medicine compared to the most appropriate existing treatment, the assessment runs alongside patient access, not before it.
- **Assessment determines price, not eligibility:** Once the assessment concludes, reimbursement price negotiations follow between the National Association of Statutory Health Insurance funds and the pharmaceutical company.



THE PROGRESS

1. Because AMNOG is designed so that coverage begins on day one regardless of where the benefit assessment stands, patients are not left waiting on the system to decide whether they can be treated.
2. This differs from markets where coverage depends on the assessment or price negotiation concluding first.
3. Between 2017 and 2020, new medicines including orphan drugs and oncology treatments became available in Germany faster than in almost any other European market, a result of the six-month limit on the benefit assessment paired with the day-one coverage approach.



KEY TAKEAWAY FOR APEC ECONOMIES

Separating access from price negotiation is an important design move. It ensures that patients are not penalized by the time a rigorous assessment process requires, and it gives private insurers a clear and stable basis on which to mirror coverage without ambiguity.

Where Germany's approach resolves the access gap by guaranteeing coverage from day one and using assessment to determine price after the fact, Japan's *Senshin Iryo* program illustrates a different but equally deliberate design response: one in which the government formally defines and publishes a category of treatments under evaluation, giving private insurers the regulatory clarity they need to build a mainstream product around that space.

CASE STUDY 4:

APEC – Japan

Japan's experience with the Senshin Iryo program showcases how PHI can provide patients with access to innovative technologies that are undergoing evaluation for the public system's benefit package. Japan's statutory health insurance system covers a broad range of treatments, but newly emerging technologies seeking statutory coverage may be evaluated under the Senshin Iryo framework, where safety, efficacy, and outcomes data are reviewed before a decision is made on whether to add them to the statutory benefit package. By formally defining and publishing this evaluation category, the government gave private insurers a precise reference point around which to build a dedicated product. The result is that patients have a funded private route to these advanced technologies through a mainstream rider, without the public system needing to change its coverage position.

CONTEXT



- Japan achieved universal health coverage in 1961 under its statutory public health insurance system and provides comprehensive coverage for a defined set of treatments.
- A category of clinically available advanced treatments called Senshin Iryo sit outside the SHI benefit package.
- Senshin Iryo treatments are officially approved by the Ministry of Health, Labour and Welfare as advanced treatments but are not yet covered by public insurance.

THE MECHANISM



- **A clearly defined public-private boundary:** A course of care is either fully covered by SHI or fully privately funded in Japan. Private insurers had a clear and unambiguous space in which to build products targeting the Senshin Iryo category.
- **The Senshin Iryo specialty rider:** An optional rider attached to a standard private medical insurance policy that covers the full cost of approved advanced treatments that sit outside the coverage provided by SHI.

THE PROGRESS



1. The Senshin Iryo rider is now a standard feature offered by major Japanese insurers including Aflac Japan, Sony Life, MetLife Japan, and Nippon Life, giving patients a privately funded route to advanced treatments under evaluation, without requiring any change to the existing SHI framework.



KEY TAKEAWAY FOR APEC ECONOMIES

Where a government formally defines and publishes a category of approved but unfunded treatments, it creates a precise and stable reference. Senshin Iryo scaled because the government drew that boundary clearly, named the evaluation category explicitly, and maintained it consistently over time.



Best Practice Principle: Enabling access through PHI that are regulatory- approved but not publicly reimbursed

Where the public system has assessed a technology and chosen not to reimburse it, usually for cost rather than clinical reasons, PHI can step in. In some markets, ambiguity in billing rules or insurance regulations inadvertently blocks private insurers from covering non-reimbursed technologies even where no policy reason exists to prevent it. Explicitly permitting insurers to offer riders or supplementary products for these technologies gives patients a funded route to access without requiring the public system to change its position. Singapore and Korea illustrate two versions of this approach.

APEC Example: Singapore

MediShield Life³³, the public insurance scheme focuses coverage on cancer drug treatments listed on the Cancer Drug List (CDL)³⁴, the government list of treatments assessed as clinically proven and cost-effective, and thus reimbursable under MediShield Life. Treatments outside this list can include those medicines that are clinically effective, but where, budget impact considerations or reimbursement evaluation criteria have not supported inclusion under the current public framework. Rather than leaving patients without a funded option for these treatments, regulations allow for an explicit private pathway alongside the CDL. Insurers can offer “Integrated Shield Plan (Public-PHI coordinated product) non-CDL riders” which extend coverage beyond the CDL.³⁵ With the non-CDL Classification Framework developed with input from the Chapter of Medical Oncologists, College of Physicians, and the Singapore Society of Oncology, insurers have a standardized, clinically vetted basis for what their riders can cover.³⁶ The result is that a treatment outside the CDL still has a funded private route, alongside the continued evolution of the CDL itself.

Where Singapore's approach is built around a dynamic list that evolves over time, Korea's is built around a durable structural boundary between what the National Health Insurance (NHI) covers and what it does not.

APEC Example: Korea

Korea's National Health Insurance classifies medical interventions into two categories: covered and non-covered. Treatments fall into the non-covered category because NHI does not pay for them due to low economic efficiency or the existence of alternative medical interventions within the covered schedule, rather than because they lack clinical merit.³⁷ This creates a stable, named category of treatments that sit outside NHI's reimbursement schedule. Korea's supplementary private insurance, known as *silbi*, was built explicitly around this boundary, compensating policyholders separately for covered and non-covered items.³⁸

What makes this design commercially viable is not just the existence of the boundary, but the consistency with which government has maintained and applied it over time. Because the non-covered category is clearly defined and does not shift unpredictably, insurers have been able to build a stable, mainstream product around it rather than treating each non-covered treatment as a one-off coverage decision.³⁹ The product works precisely because the boundary it is built around is reliable. This is a direct consequence of deliberate government stewardship: by maintaining clear and consistent definitions for what falls inside and outside NHI coverage, Korea created the conditions under which private insurance could complement the public system in a structured and sustainable way.

The Korea example illustrates a principle that applies across all four approaches: governments are not just initial enablers of PHI complementarity, but ongoing stewards of it. Definitions must be maintained, lists must be updated, and regulatory boundaries must be enforced consistently over time. Where governments allow definitions to drift, permit uncontrolled duplication of public coverage, or fail to update reference frameworks as the clinical and technological landscape changes, the commercial viability of complementary PHI erodes. Sustained government stewardship is as important as the original policy design.

For Type 3 & 4 Economies

Type 3 and 4 economies typically that do not widely assess or fund innovative technologies. In these economies, we put forth one best practice principle.



Best Practice Principle: Establishing a government reference point to guide PHI coverage of innovative technologies

Where public systems have not yet built the capacity to broadly assess and fund innovative technologies, the challenge is different. Private insurers may be willing to cover certain technologies but without a government reference point on clinical value and pricing, they cannot confidently design products that are accessible beyond high-income consumers.

The result has historically been a fragmented private market in which each insurer maintains its own independent drug or technology list, producing inconsistent coverage across the market and uncertainty for patients who cannot reliably predict what their plan will cover. This fragmentation also limits insurer confidence in pricing: without a shared evidence base, the actuarial risk of covering high-cost innovative technologies is difficult to model, which pushes premiums up and keeps these products out of reach for middle-income households.

A government-curated reference list may help address fragmentation in supplementary insurance coverage. By assessing and publishing a defined set of innovative technologies with demonstrated clinical relevance, such a list can provide private insurers with a common reference point for product design and pricing, while helping patients better understand which therapies may be considered for supplementary coverage. The case study below illustrates how China has begun to address this challenge at scale, through the launch of the Commercial Health Insurance Innovative Drug List (CIIDL) — a government-curated reference that gives private insurers the clinical and actuarial foundation they need to build coverage products around high-cost innovative therapies sitting outside public reimbursement.

CASE STUDY 5:

APEC – China

Before the Commercial Health Insurance Innovative Drug List (CIIDL) was introduced, commercial insurers in China developing products to cover innovative therapies had no shared standard to work from. Each insurer maintained its own drug list independently, producing a fragmented market with inconsistent coverage and limited actuarial confidence in pricing high-cost treatments.⁴⁰ The CIIDL, launched in December 2025, changed this by giving the private market something it could not generate on its own: a government-assessed, evidence-based list of high-value innovative therapies sitting outside public reimbursement, against which insurers could confidently design and price supplementary products.⁴¹

Before the CIIDL was introduced, commercial insurers in China generally developed drug lists independently when designing products covering innovative therapies. This contributed to variation in coverage across products and may have limited insurers' ability to price high-cost treatments consistently. The CIIDL, launched in December 2025, sought to address this gap by providing a government-assessed, evidence-based supplementary list of innovative drugs for commercial insurance that sits outside basic medical insurance reimbursement.⁴² The list may serve as a reference for insurers developing supplementary health insurance products.

CONTEXT



- China's National Reimbursement Drug List (NRDL) is a government-managed catalogue of medicines covered by the public health insurance system.
- Certain high-cost breakthrough therapies with strong clinical value sit outside its scope and without a shared government reference point for this category.
- This produced inconsistent coverage across the private market and uncertainty for patients seeking access to these treatments.

THE MECHANISM



- **Launch of the Commercial Insurance Innovative Drug List (CIIDL):** In December 2025, China launched CIIDL to recommend high value, high-cost innovative drugs for commercial coverage. The CIIDL review process adopts a confidential negotiation mechanism with final prices undisclosed to avoid their use as global reference prices abroad.
- **The relationship between public reimbursement list and CIIDL is sequential:** Drugs recommended for inclusion into both NRDL and CIIDL inclusion undergo NRDL negotiations first. If unsuccessful, these drugs move towards CIIDL review.
- **The list is non-binding but functions as a government-endorsed clinical and commercial signal:** While non-binding, the CIIDL serves as a standardized evidence-driven list to help insurers assess the clinical value of high-value drugs and enable better design of specialized insurance products for specialty medicine.

THE PROGRESS



1. The first CIIDL review process listed only 19 of 121 therapies (13.5%) targeting specific, high-need areas such as oncology, Alzheimer's and rare diseases. This implies that CIIDL applies a stringent evidence review process.
2. As of January 2026, the CIIDL drugs have been made available across 965 designated medical institutions and retail pharmacies.
3. A few city-level Huiminbao have adopted all therapies on CIIDL, including Xinjiang and Shenzhen, among others, and many more Huiminbao have adopted part of the therapies on CIIDL.

KEY TAKEAWAY FOR APEC ECONOMIES



- A government-curated reference list of clinically assessed innovative technologies gives private insurers the actuarial and product design confidence to extend coverage beyond the high-income segment, without committing public reimbursement funds to the technologies on the list.
- The sequential design between the NRDL and the CIIDL creates a natural and dynamic link between the public and private systems: as the public floor expands over time, the private coverage layer adjusts around it organically.

OPPORTUNITY 3:

Improving Population Coverage

Across APEC, most economies have made meaningful strides in population coverage, extending financial protection to large shares of their populations through ambitious schemes to expand health coverage to all, according to their domestic contexts and priorities. Landmark programs such as Indonesia's JKN; Thailand's UHC scheme; and Viet Nam's BHYT have dramatically expanded the reach of public health systems, and many APEC economies now report high nominal coverage rates.

Private health insurance, in principle, could help bridge this gap. But the reality across most APEC markets is that PHI has historically developed as a product for higher-income, formally employed, urban populations. Moreover, private insurers operating under commercial principles will gravitate toward lower-risk, higher-income consumers.

This dynamic creates a risk as governments increasingly turn to PHI as a deliberate policy instrument. As PHI gains in popularity and governments seek to use it as a complement to economy-wide and public schemes, its expansion can further exacerbate unequal layers of coverage i.e. protecting those who can afford comprehensive plans while leaving lower-income households, people with pre-existing conditions, and remote or rural populations further behind.



Best Practice Principle: Extend coverage to underserved groups by means of community rating, risk equalization, and income-tested subsidies

PHI can extend coverage to underserved groups, but only if the market is structured to reach them. The policy task is to create conditions, through regulation, incentives, and product standards, that make PHI accessible and meaningful for a broader population.

A fair PHI market depends on charging all consumers the same premium regardless of health status. That principle only holds up when three elements are in place together:

- a. Community ratings set equal premiums;
- b. Risk equalization across insurers removes the incentive to attract only healthier members;
- c. Income-tested subsidies keep the system accessible for lower-income households.

Each element depends on the others. Introducing one without the rest creates imbalances that undermine the original goal.

This interdependence is critical. Community rating alone, without risk equalization, creates strong incentives for insurers to compete for healthier members and avoid sicker ones. Risk equalization, without income support, leaves the system inaccessible for lower-income households who cannot afford community-rated premiums. Income subsidies, without community rating, can simply fund a premium structure that continues to disadvantage those who need coverage most. The three mechanisms are most effective when they are designed and administered together as components of a single integrated system.

Beyond the structural mechanics of the market, there is a further dimension of coverage that PHI oversight must address: the treatment of people with pre-existing conditions. In many APEC markets, exclusions for pre-existing conditions are common features of PHI product design. It is a rational response for individual insurers managing risk, but a serious concern at the system level. Governments that have moved furthest on population coverage have generally addressed this directly, either by prohibiting exclusions altogether or by requiring that any exclusions are time-limited and transparently disclosed.

This paper did not discern archetype-specific patterns in the approach to fair coverage protection. Rather, what appears to matter more than archetype is the degree to which a government has the regulatory capacity to design and enforce the interconnected mechanisms to make PHI fairer.

The two case studies that follow illustrate this interdependence from two different directions. Australia's experience shows what happens when community rating is introduced without the full supporting architecture in place, and what was required to correct it. The Netherlands illustrates what a fully integrated three-part mechanism looks like when all components are designed and enacted simultaneously from the outset.

CASE STUDY 6:

APEC – Australia

Australia's approach to private health insurance was designed primarily around higher-income earners, for whom private cover was either mandated or strongly incentivized through financial penalties. Because the scheme was not a universal requirement, income subsidies were not a central feature of the original design. Those below a given income threshold were not compelled to participate and were therefore not exposed to affordability risk in the same way.

However, the market still faced the problem of commercially-driven risk selection, with insurers gravitating toward younger, healthier enrollees. To address this, Australia introduced community rating, under which individuals pay the same premium for the same product regardless of age or health status. While community rating removed the ability of insurers to price by risk, it created a different challenge: younger and healthier people facing standard adult premiums with limited immediate benefit had a financial incentive to delay or drop coverage, while older and sicker individuals had every reason to enroll.

To sustain community rating while keeping the risk pool viable, Australia relies on a three-pronged strategy:

1. The Medicare Levy Surcharge requires higher-income individuals without private hospital cover to pay an additional 1% to 1.5% levy on top of the standard 2% Medicare Levy, enforced automatically through the annual tax assessment.
2. The Lifetime Health Cover loading, introduced in 2000 imposes a 2% premium surcharge for each year a person delays taking out hospital cover beyond age 30, which is removed after 10 consecutive years of continuous cover.
3. The Risk Equalization Special Account (RESA) operates as a cross-insurer risk pooling mechanism, redistributing high-cost hospital claims across all registered health insurers and removing the financial incentive for insurers to compete by attracting younger and healthier members at the expense of those with greater clinical need.

CONTEXT



- Australia's private hospital insurance market operates on a community-rating principle: every person pays the same premium for the same product regardless of their age or health status. This design ensures that older and sicker members are not priced out.
- However, younger and healthier people, who are unlikely to claim in the near term, face full adult premiums with limited immediate benefit and have a financial incentive to delay joining until they are older or unwell.

- By the late 1990s, younger members were leaving or declining to join, and the remaining pool became older and sicker on average. Claims rose, premiums increased to cover the higher claims.
- Hospital cover participation fell from approximately 50% in 1984 to 30% by 1998. Premium growth was outpacing general inflation, meaning the real cost of cover was rising even before the age-profile effect was fully priced in.



THE MECHANISM

- **A tax surcharge on high-income earners who do not hold PHI:** The Medicare Levy Surcharge (MLS), first introduced in 1997, requires high-income individuals without hospital cover to pay an additional 1–1.5% levy on top of the standard 2% Medicare Levy. The MLS operates through the Australian Taxation Office’s annual income assessment, making enforcement administratively automatic.
- **A premium loading:** The Lifetime Health Cover (LHC) loading imposes a 2% premium surcharge for each year a person delays taking out hospital cover beyond the age of 30. Once an individual has held hospital cover for 10 consecutive years, the loading is removed.
- **A cross-insurer risk pooling mechanism that removes the incentive for insurers to compete by attracting younger and healthier members:** Administered through the Risk Equalisation Special Account (RESA), pools high-cost hospital claims, specifically for older/high-risk insurers, across all registered health insurers.



THE PROGRESS

1. Following the introduction of LHC loading in July 2000, private hospital cover participation recovered sharply from approximately 31% of the population in 1999 to around 45.3% by 2003.
2. Risk equalisation functioned as the structural backstop that allowed community rating to continue. By pooling high-cost claims centrally, it removed the incentive for insurers to design products or marketing strategies oriented toward attracting younger, healthier members.



KEY TAKEAWAY FOR APEC ECONOMIES

Community rating alone will not hold a voluntary market together. Without enrollment incentives (like LHC and MLS) to prevent healthy people from opting out, premiums rise, the pool ages, and the spiral becomes very hard to reverse. The incentives must be introduced alongside community rating, not added later.

CASE STUDY 7:

Global – Netherlands

When the Netherlands made health insurance mandatory in 2006, it also had to create three policy mechanisms to prevent risk selection, unaffordable premiums, and an uneven playing field among insurers. The challenge was that mandatory competitive insurance, without additional safeguards, created an incentive for insurers to attract only healthy enrollees, left lower-income households facing a premium set for the whole population regardless of their ability to pay, and structurally disadvantaged insurers covering disproportionately sick populations, rewarding demographic luck rather than efficiency or quality.

The Dutch response addressed all three problems simultaneously. All insurers were required to accept any person seeking basic health insurance and were prohibited from differentiating premiums by health risk or individual characteristics. Insurers with disproportionately sick populations were compensated from a central health insurance fund through a cross-insurer risk compensation mechanism. Lower- and middle-income households received a statutory means-tested subsidy paid directly to them to offset the cost of compulsory insurance.

CONTEXT



- The Netherlands introduced mandatory competitive health insurance under the Health Insurance Act in 2006, requiring every resident to purchase a standard benefit package.
- Due to this, insurers had an incentive to attract only healthy enrollees.
- Low-income households faced a premium set for the whole population regardless of ability to pay, and without compensation, insurers treating disproportionately sick populations were structurally disadvantaged relative to competitors.
- Without a mechanism to compensate for this, the competitive market advantages insurers for demographic luck rather than for efficiency or quality.

THE MECHANISM



- **Community rating and a guaranteed acceptance obligation:** All health insurers must accept any person who wishes to take out basic health insurance, and the premium charged may not be differentiated by health risk or individual characteristics. The same benefit package is available to all enrollees at a community-rated premium.
- **A cross-insurer risk compensation mechanism:** Because insurers must accept all applicants at the same premium, those who attract a disproportionately sick population are compensated from a central health insurance fund.
- **A government paid income-tested subsidy:** A statutory means-tested allowance paid directly by the government to lower- and middle-income households to offset the cost of compulsory health insurance.



THE PROGRESS

1. The Netherlands has maintained universal enrollment in a mandatory competitive health insurance market since 2006 — a market in which all residents hold coverage, all insurers accept all applicants, and competition operates on quality and premium efficiency rather than on risk selection.
2. Community rating ensures no one is priced out by health status, risk equalization removes the financial incentive for insurers to avoid high-cost enrollees, and the income-tested subsidy ensures the mandatory premium is affordable for lower-income households.



KEY TAKEAWAY FOR APEC ECONOMIES

No single instrument solves the problem; the architecture only works when all three are enacted together and calibrated against each other. The Netherlands illustrates the interdependence of the three core instruments.

SECTION 03

How Governments can Create
The Conditions for PHI to Work
Effectively

The previous section examined the specific enhancements PHI can make to domestic health programs and UHC schemes, across population coverage, service coverage, and financial protection. Meanwhile, this section focuses on **examining the specific approaches and conditions of making the public health system and the PHI market function together in practice.**

Alignment in principle and goals between a public health system and a PHI market does not guarantee that they work well together. Several factors shape how effectively the two systems integrate, including the strength of the regulatory environment, the incentives facing both healthcare providers and insurers, fiscal constraints, and political will. Across APEC economies, three conditions emerge most consistently as the strongest determinants of whether PHI and the public health system truly complement each other or simply coexist:

- **A clearly defined boundary** between the public health system and PHI, which allows insurers to design PHI products and consumers to understand what they are buying or why;
- **Consumer trust**, because even well-designed products fail to achieve meaningful uptake if the population they are meant to serve does not understand or believe in them;
- **Data and digital infrastructure** to improve efficiency and coordination, enabling both the public system and the PHI market to work together and adapt as the health system evolves.

These three conditions for successful public-PHI alignment appear across all four archetypes. Thus, this section sets out three interconnected approaches to meeting these conditions, each grounded in best practice principles.

The case studies draw on APEC economies and comparable markets globally and provide best practice examples for economies at every stage of the journey.

APPROACH 1:

Incentivize the development of PHI products to be complementary to the public health system

In many economies, PHI already operates across a broad spectrum, from supplemental cover that sits directly above what the public system provides, to products that offer faster access, greater choice, or coverage for healthcare interventions outside public provision.

Governments can create conditions to incentivize the development of PHI products to work more deliberately alongside the public layer, filling gaps and reducing out-of-pocket costs. A clearly defined public coverage baseline is what makes this possible. Defining that boundary does not require restructuring the entire PHI market or crowding out the broader range of PHI offerings already in it.

Under Approach 1, we highlight two best practice principles. The first addresses the legal and regulatory conditions that need to be in place for complementary PHI to function. The second addresses how to make this work in practice, covering where PHI sits alongside the public system and how the two interact at the point of care.



Best Practice Principle: Strengthen the legal and regulatory framework for PHI to function as a complement to the public health system

PHI complementarity requires a regulatory environment deliberately structured to enable the public health and PHI systems to work together: one where insurance regulators and health ministries are aligned, insurers understand what a complementary role looks like in practice and what is expected of them, and the right incentives exist for the PHI industry to move in that direction.

Type 1 and Type 2 economies such as Australia; Japan; Korea; and Chinese Taipei offer a reference point for what a well-established regulatory foundation looks like in practice. In each of these economies, sustained dialogue between health and insurance regulators has produced frameworks in which PHI products are explicitly designed in relation to the public benefit package, and where the roles of each system are well understood by industry, government, and consumers. Even so, these economies continue to refine and adapt their frameworks as their markets and public health systems evolve.

For Type 3 and Type 4 economies where PHI markets are still developing, such as Indonesia; Peru; Viet Nam; there is active momentum toward building that same cooperative foundation. These economies are at different stages of building that dialogue, recognizing that insurance regulators and health ministries cannot operate independently if PHI is to play a meaningful role alongside the public system. The priority in these markets is about ensuring that the rules are structured with the public-private relationship in mind.

APEC Example: Viet Nam

The adoption of Resolution 72 in Viet Nam illustrates how policy dialogue between health and regulatory authorities can translate into legislative reform. Resolution 72, adopted in 2023, set out the Communist Party's orientation for healthcare reform, including a commitment to expanding health insurance coverage and improving the sustainability of the public health insurance fund.⁴³ That policy direction has since been carried into amendments to Viet Nam's Law on Health Insurance in 2025, which seeks to broaden the benefit package, tighten the rules around reimbursement, and clarify the boundary between what the public scheme covers and where complementary coverage begins. The reforms reflect a deliberate effort to use legislative change to give PHI a more defined and stable role alongside the public system.

APEC Example: Indonesia

Indonesia illustrates how a regulator can move from supervisor to active shaper of the PHI and public health system relationship through formal rulemaking. Otoritas Jasa Keuangan (OJK), the Financial Services Authority, has progressively refined how PHI relates to Jaminan Kesehatan Nasional (JKN), the domestic public health insurance scheme, since 2014 ⁴⁴. Coordination of benefits (COB) between PHI and JKN was first introduced as a principle in 2016, but uptake remained limited without mandatory enforcement. POJK No. 36/2025 addressed this directly, making COB mandatory across all products, introducing an optional co-payment capped at 5%, and requiring insurers to establish a Medical Advisory Board for service-quality oversight ⁴⁵. As a result, PHI products in Indonesia are increasingly structured to cover what JKN does not, including higher ward classes, interventions outside the JKN benefit package, and patient cost-sharing obligations, rather than duplicating existing public coverage. OJK's ongoing task is to keep these rules workable as the market matures, which depends on continued coordination with the health ministry as JKN itself evolves.

APEC Example: Peru

Peru's *Entidades Prestadoras de Salud* (EPS) system illustrates how a government can create a formal regulatory bridge between the public contributory system and private health providers without restructuring either. Under the EPS framework, employers and employees can redirect a portion of their *Seguro Social de Salud* (EsSalud) social insurance contribution to a regulated private health provider, giving them access to private facilities and enhanced interventions while remaining connected to the public contributory system.⁴⁶ The mechanism is deliberately government-regulated, whereby EPS providers must be licensed, are subject to minimum service standards, and the contribution redirect is capped to ensure the public system retains adequate funding.

Drawing from these examples, the key takeaway is that regulatory work requires sustained engagement between the institutions responsible for public health and those responsible for insurance supervision, a shared understanding of what PHI is meant to do within the health system, and a willingness to revisit standards as the market evolves.

Getting insurance regulators and health ministries to work together is the first step. The second is aligning what the public health system actually covers, because that is what gives PHI a clear and stable role to build from.



Best Practice Principle: Define the public health coverage baseline, position PHI as the supplemental layer, and set the coordination rules so that the system works in practice.

A well-defined public coverage baseline is the foundation on which a supplemental PHI market can develop coherently. Where a government funds a defined benefit package, the terms of that package, namely what is covered, at what level, for whom, and with what cost-sharing obligations, need to be stated with enough precision that insurers designing supplemental products can build around it and consumers can understand where public coverage ends and complementary coverage begins. Without that clarity, PHI products designed to sit alongside the public system tend to develop in ways that are inconsistent, difficult to compare, or poorly understood by the people they are meant to serve. Where that clarity exists, the segment of the PHI market intended to complement public coverage can be designed and regulated as a coherent layer above it, with each part of the system doing a defined job.

APEC Example: Korea

Korea's National Health Insurance (NHI) system illustrates how a clearly defined public benefit package creates the conditions for a well-functioning supplemental PHI market. The NHI benefit package is explicitly structured, with co-payment rates set by service type and care setting, providing a stable and well-understood foundation for both insurers and consumers.⁴⁷ Where the public system leaves space, including co-payments and certain non-covered interventions, the PHI market has developed products that fill those gaps directly.⁴⁸ The most widely held of these, known as *Silsohn* insurance, was standardized by the Financial Services Commission and has since been actively refined by government to ensure it remains aligned with public health system goals.

Clarity on the public health coverage baseline is necessary but not sufficient on its own. Setting claims coordination rules, specifying how costs are shared between the public system and the supplemental PHI layer, and how disputes between the two are resolved, gives insurers actuarial confidence to design and price products that truly work alongside public coverage.

Global Example: France

France illustrates what functional coordination looks like in practice. Under France's two-layer system, the statutory insurer, *L'Assurance Maladie*, processes its share of each claim first, then automatically transmits the residual patient liability to the complementary insurer through NOEMIE, the *Norme Ouverte d'Échanges entre la Maladie et les Intervenants Extérieurs*, a standardized electronic data exchange system. The complementary insurer knows exactly what remains to be covered without the patient having to navigate between the two systems.^{49 50} The *Contrat Responsable* framework reinforces this further by setting minimum and maximum coverage standards for complementary products, ensuring they are designed in direct relation to what *L'Assurance Maladie* covers.⁵¹ That administrative clarity is what allows the two-layer system to work at scale.

For many economies, the challenge is not defining the boundary between public and private coverage but making it work in practice. Claims handling, cost-sharing arrangements, and dispute resolution mechanisms are features that help transform a well-designed framework on paper into a system that consumers, providers, and insurers can rely on.

The experiences of Singapore and China illustrate both elements in practice. Together, they show how a clearly defined public baseline and deliberate coordination rules create the conditions for a supplemental PHI market that is coherent and functional at the point of care.

CASE STUDY 8:

APEC – Singapore

Singapore's experience with Integrated Shield Plans illustrates what becomes possible when the public coverage baseline is defined with enough precision to anchor the private market around it. Before 2005, private health insurance in Singapore duplicated MediShield coverage rather than building on it, and the absence of a defined payer sequence left policyholders navigating claims across two separate systems. The Ministry of Health responded by introducing the Integrated Shield Plan framework, formally combining MediShield Life as the mandatory public base with a private supplemental layer in a single integrated product. MediShield Life pays first; the private insurer covers the residual above the public floor and serves as the single administrator of both layers. The result is a supplemental PHI market that is coherent, well-penetrated, and workable at the point of care, built directly on the clarity of the public coverage baseline beneath it.

CONTEXT



- Before 2005, private health insurance products in Singapore frequently duplicated coverage already provided by the public health insurance scheme, MediShield, rather than building on top of it.
- Without a defined payer sequence, policyholders had to submit claims separately to their private insurer and to the public statutory board.
- There was no formal boundary defining where the public system ended and where private insurance was designed to begin, making product design difficult for insurers and confusing for consumers.

THE MECHANISM



- **Combining the public and private layers into a single integrated product:** In 2005, the government introduced the Integrated Shield Plan (IP) framework, which combined the MediShield Life layer with the private insurer's coverage into a single product that has no duplicate coverage.
- **The public system pays its share first:** MediShield Life pays its portion of the eligible bill first, and the private supplemental layer takes effect on the residual.
- **The private insurer serves as the single administrator of both layers:** The private insurer handles the full claims process on behalf of the policyholder across both the public and private components, removing the administrative burden from the consumer entirely.



THE PROGRESS

1. The framework successfully eliminated the fragmented, duplicative private market, with insurers now designing products explicitly around the public floor.
2. Private health insurance penetration expanded to cover approximately 71% of Singapore residents, one of the highest rates in the Asia-Pacific region.
3. As the market matured, the Ministry of Health introduced mandatory co-payment requirements for Integrated Shield Plan riders in 2018 to address overutilisation, demonstrating the framework's capacity to evolve alongside the market.



KEY TAKEAWAY FOR APEC ECONOMIES

- The Singapore Integrated Shield Plan model is most replicable in economies that already have a public health insurance scheme with a defined benefit package.
- The immediate priority is formalizing the boundary between the public and private layers and building payer sequencing rules into the framework before the private market scales further.

CASE STUDY 9:

APEC – China

China's experience with *Huiminbao* illustrates what becomes possible when government takes an active role in designing a supplemental insurance model that sits directly and deliberately above the public coverage baseline. China's Basic Medical Insurance (BMI) scheme is one of the largest public health coverage programs in the world, providing broad population-level protection. To extend that protection further, particularly for high-cost treatments, advanced medications, and expenses above reimbursement ceilings, the government identified an opportunity to bring supplemental PHI into direct alignment with the public floor.

CONTEXT



- China's Basic Medical Insurance (BMI) scheme is one of the largest public health coverage programs in the world, providing broad population-level protection across urban and rural populations.
- As the scheme matured, the government identified an opportunity to extend that protection further, particularly for high-cost treatments and expenses above BMI reimbursement ceilings.
- Existing commercial health insurance products had developed largely independently of BMI, creating an opportunity to build a supplemental layer explicitly anchored to the public baseline and designed to work alongside it.

THE MECHANISM



- **Anchoring the supplemental layer directly to the public baseline:** Local governments, working alongside the National Healthcare Security Administration (NHSA) and insurance regulators, designed *Huiminbao* products with BMI as the explicit foundation, ensuring the supplemental layer was built in direct relation to what the public system already covered.
- **The public system pays its share first:** BMI reimburses first, and *Huiminbao* covers eligible out-of-pocket expenses above a defined threshold, including high-cost drugs on government-approved lists and catastrophic expenditure above the BMI reimbursement ceiling.
- **Affordability built into the model from the outset:** Products were priced at low premiums, typically in the range of RMB 59 to RMB 100 per year depending on the city, with community-rated pricing and open enrollment periods to support broad participation across income groups.
- **Joint regulatory oversight to maintain alignment:** Insurance regulators and local health authorities worked together to set product parameters, ensuring *Huiminbao* products remained aligned with public health system goals as the model scaled.



THE PROGRESS

1. Huiminbao grew from about 40 million participants in 2020 to over 300 million by late 2023, spreading to more than 158 cities across 21 provinces, making it one of the fastest-scaling supplemental health insurance models in the region.
2. Regulators responded to early strains with a 2024 reform requiring *Huiminbao* to remain voluntary and barring local authorities from bundling it with basic medical insurance, while pushing insurers toward longer-term, adjustable-premium products instead of one-year policies.
3. Since December 2025, *Huiminbao* has also begun covering high-cost “Category C” drugs under the new Commercial Health Insurance Innovative Drug List, with cities like Shenzhen and Shantou already adopting full coverage, extending the model from cost-sharing into financing access to innovative therapies.



KEY TAKEAWAY FOR APEC ECONOMIES

Huiminbao demonstrates that active government involvement in structuring the supplemental layer, rather than leaving it to develop organically, can produce a PHI market that is coherent, affordable, and aligned with public health goals.

When building or strengthening the supplemental layer, there is value in involving health ministries and insurance regulators jointly in product design from the outset.

Where feasible, affordability and simplicity should be built into the supplemental layer deliberately, ensuring that the benefits of private coverage can extend across income groups rather than remaining accessible only to higher-income households.

APPROACH 2:

Build Consumer Trust and Make Private Health Insurance Understandable to the Consumer

The previous approach sets out the regulatory and coverage framework that gives PHI a clearly defined role alongside the public health system. Yet a well-structured framework only delivers if consumers understand what PHI is and trust it enough to act. In many APEC economies, insurance literacy is still developing, awareness of PHI products varies, and consumers may not always see how PHI connects to the public coverage they already have. Even where products are well-structured and reasonably priced, uptake often reflects how well the system has been explained rather than how well it has been designed.

This section sets out four best practice principles to help economies build consumer understanding and trust in PHI: (a) building foundational insurance literacy so consumers understand what they are buying; (b) standardizing products and disclosure requirements so that products can be meaningfully compared; (c) designing PHI products and any changes to the public-private boundary with built-in protections for vulnerable groups; and (d) communicating changes clearly and in advance of implementation.



Best Practice Principle: Build insurance literacy through trusted community and authoritative channels

Insurance literacy is a precondition for effective consumer engagement with PHI across all APEC economies. In Type 3 and 4 economies where PHI is developing, the foundational concept of private insurance (i.e. what it is, how it relates to public coverage, and why it matters) must be established before any product-specific communication can be effective. While insurance uptake may be high in Type 1 and 2 economies with established PHI markets, the population will still benefit from clear language explanations on core concepts such as premiums, deductibles, and coverage limits while communicating any major change that involves their public and private insurance coverage.

In economies where PHI penetration is low, establishing insurance literacy through trusted community and authoritative channels will help guide people toward products suited to their circumstances. Two types of channels work well together. Community-based channels, involving community health workers, and civil society organizations, local public officials, who are embedded in the communities can reach populations that formal or centralized communication often misses. In contrast, authoritative channels draw on regulators, government agencies, and public health bodies whose endorsement gives the message credibility and signals that PHI is part of a broader system people can rely on.

APEC Example: Thailand

In Thailand, the introduction of the Universal Coverage Scheme in 2001 was accompanied by an awareness and education campaign.⁵² Despite near-universal enrollment, many registered members did not know how to access affiliated facilities or understand what benefits they could claim, with the gap widest in rural, low-literacy, and geographically dispersed communities. The Ministry of Public Health responded by deploying “Village Health Volunteers” to facilitate access to primary healthcare and the Universal Coverage Scheme to rural households. Over one million volunteers are now deployed across provinces, each responsible for a cluster of roughly ten households, enabling community-level health communication and enrollment facilitation. Volunteers also provide assisted digital navigation for elderly and low-digital-literacy residents, helping them use the *Thang Rath* health interventions platform to find Universal Coverage Scheme-affiliated facilities.⁵³

The same model can be applied to building awareness and literacy on private health insurance coverage that support health system goals. Where people do not yet understand what insurance is or why it matters, community intermediaries can build that baseline before any PHI-specific communication begins.

Authoritative channels, either from the government or expert groups, provide credibility and consistency of message. The two are most effective in combination where authoritative bodies set the message and community channels disseminate, both reach and trust can be maximized.

APEC Example: Malaysia

Malaysia’s introduction of the voluntary base Medical and Health Insurance and Takaful (MHIT) plan illustrates how official channels can be used to communicate a significant private health insurance development clearly to the public. Bank Negara Malaysia used its regulatory platform, official policy publications, and coordinated industry communication to explain what the base MHIT plan was, who it was designed for, what it covered, and how it sat alongside existing public healthcare provision.⁵⁴ By anchoring the public communication in a clearly defined regulatory product and delivering it through authoritative channels, the message carried a credibility and reach that a market-led announcement would not have achieved.

Building literacy creates the foundation for consumer engagement, but engagement is only meaningful if the products consumers encounter are clear, comparable, and transparent.



Best Practice Principle: Set minimum benefit standards and clear disclosure requirements so consumers can understand, compare, and trust PHI products

To build consumer confidence and trust in PHI products that support health system goals, two conditions need to be in place. The first is establishing a consistent baseline across products through minimum benefit requirements. The second is ensuring that information about those products reaches consumers in standardized terms, clearly presented, and at the right time.

Setting a Consistent Product Baseline and Minimum Standards

Without consistent PHI standards, consumers can face difficulty in choosing the right insurance product for them. Products can vary widely in what they cover and what they exclude. Minimum benefit requirements can build clarity and confidence by establishing a floor that every product must meet, ensuring that when a consumer compares two products, they are comparing like with like rather than trying to decode fundamentally different structures.

APEC Example: Australia

Australia's tiered product classification system, introduced in 2019, offers a useful example of how this can be structured. The reform organized private health insurance products into four standardized tiers: Gold, Silver, Bronze, and Basic.⁵⁵ Each tier defines the minimum clinical categories a product must cover to carry that label. Insurers retain flexibility in how they design within each tier, but the framework gives consumers a clear and consistent basis for comparison across an otherwise fragmented market. The government's role was to set the framework and let the market operate within it, steering product design through standards rather than through case-by-case approval.

Ensuring Clear PHI Product Disclosure at the Point of Purchase

Meeting a minimum standard, however, is not enough on its own. Even well-designed products fail to build consumer confidence if they are not disclosed in a clear and consistent way. When disclosure varies across providers or is difficult to interpret, consumers are left without a reliable basis for comparison.

Global Example: Ireland

Ireland's experience illustrates this point. Despite over 2.55 million people holding private health insurance, only 4% of policyholders switched providers in 2025, even against a backdrop of significant premium increases, pointing to a market where complexity rather than lack of choice is the barrier to informed decision-making.⁵⁶ In response, Ireland's Health Insurance Authority launched a government-operated comparison tool covering all registered plans in the market, helping consumers identify plans suited to their health needs and budget and surfacing upcoming price and benefit changes.⁵⁷ The tool's effectiveness, however, depends entirely on the mandatory standardized disclosure obligation that sits beneath it. Without that foundation, a comparison platform has nothing consistent to compare.

Mandatory standardized definitions, applied uniformly across all licensed insurers and backed by a binding regulatory instrument rather than a voluntary industry code, determine whether disclosure obligations are met systematically or selectively. Where a statutory regulator has explicit authority over insurance product registration and consumer information, it can raise the baseline of transparency across the market and create the conditions for consumers to make genuinely informed choices.

Product standards and disclosure requirements create the conditions for informed choice. But trust built through clarity can quickly be undermined if changes to PHI products or the broader public-private boundary are not designed with consumers in mind from the outset.



Best Practice Principle: Sustain consumer trust through intentional design of public-PHI coordinated products

Whenever coverage boundaries shift, cost-sharing arrangements change, new products replace existing ones, or the relationship between the public system and PHI is recalibrated, designing that change intentionally is essential, regardless of whether the change is framed as a reform, a product update, or a structural adjustment. Compensating benefits and protections for vulnerable groups need to be considered before any public announcement, not added afterward in response to criticism.

Typically, in Type 1 and Type 2 markets, changes often aim to manage medical inflation, improve sustainability, or recalibrate what the public and private layers each cover. The design challenge is about managing change within a public-PHI framework that people already rely on. Where cost-sharing increases, a proportionate compensating benefit should be built into the design from the outset. Visible protections for vulnerable and lower-income groups should not be an afterthought but a precondition for the change holding over time.

In Type 3 and Type 4 economies, the design challenge is often foundational, such as establishing coordination of benefits rules, defining the relationship between PHI and the public scheme, or introducing mandatory product standards for the first time. As consumers may have limited familiarity with PHI, changes that impose new obligations without clear compensating benefits risk undermining trust before it has had a chance to develop.

Across all economies, a phased transition tends to be helpful. Applying changes to new policyholders first, or allowing a defined transition period for existing ones, gives people time to adjust and reduces the sense that something has simply been taken away.

Intentional design ensures that when changes occur, consumers are not left worse off. But even the best-designed change can erode trust if consumers are not given adequate notice and a clear explanation of what is changing and why.



Best Practice Principle: Communicate public-PHI product related changes clearly before they take effect

This principle applies across all APEC economies at every stage of health systems and PHI market maturity, though what it requires in practice differs by context. The common thread is that communication needs to happen before changes take effect and must be clear enough for people to understand not just what is changing but why.

In more established PHI markets, consumers already have a working understanding of what PHI is and how it functions alongside the public system. Even so, well-designed changes can face significant resistance when people do not understand what is happening or why. Clear, plain-language communication before implementation, i.e. what is changing and what people stand to gain, reduces friction and builds public buy-in. The message needs to reach people across different literacy levels and through different channels, including those with limited digital access.

In economies where PHI markets are still developing, the communication task starts earlier and is more extensive. Before people can understand what, a specific change means for them, they need a foundational understanding of what PHI is, why it exists alongside the public system, and what it can do for them that the public system does not. In these markets, building insurance literacy is itself part of the broader agenda, and it is a precondition for any more specific communication about product changes or new requirements to land effectively.

The two case studies that follow illustrate what clear, well-sequenced communication looks like in practice. The Netherlands example shows how coordinated structural disclosure can create an active and engaged consumer market, while the Singapore example shows how reform design and communication can convert a complex and potentially contentious change into one that the public accepts.

CASE STUDY 10:

Global – Netherlands

The Netherlands illustrates what well-timed, coordinated disclosure looks like in practice. As the government sets the annual deductible (*eigen risico*) rather than leaving it to individual insurers, it can disclose the deductible, the projected average market premium, and the household subsidy (*zorgtoeslag*) in a single Budget Day announcement every September. Consumers are able to see the full picture at once rather than a partial one, and the three-to-four-month window before the 1 January implementation date gives them meaningful time to compare products and switch. This results in a highly active consumer market: over one million people switch their health insurers each year following the announcement. The communication framework works because the policy design makes it possible.

CONTEXT



- The Netherlands requires every resident to hold basic health insurance, purchased from a private insurer but regulated to a standard benefit package.
- Three interdependent financial variables determine what a household actually pays each year: the compulsory annual deductible (*eigen risico*), the projected average market premium, and the means-tested household subsidy (*zorgtoeslag*) for lower- and middle-income households.
- Because those three variables are interdependent, consumers cannot assess the real cost of any insurer's product without seeing all three figures at once.
- Without simultaneous disclosure, consumers face a fragmented information environment that makes meaningful comparison and genuine decision-making across the market very difficult.

THE MECHANISM



- **Simultaneous disclosure of all three financial variables on a single fixed annual date:** Every September on Budget Day, the government simultaneously discloses the following year's deductible level, the projected average market premium, and the household subsidy rates. This gives consumers three to four months before the 1 January implementation date to compare insurers and calculate their net position.
- **A defined calendar that gives consumers a structured window to act:** Insurers must publish finalized premiums by 12 November, with exact household subsidy amounts confirmed by 20 November, after which consumers have until 31 December to switch insurer for the following year.



THE PROGRESS

1. The annual Budget Day cycle gives consumers three to four months between the government's policy announcement and the implementation date, long enough to compare insurers, calculate net costs after the household subsidy, and switch if needed.
2. Over one million consumers switch their health insurance plans every year following the Budget Day announcement, demonstrating that a well-structured disclosure framework produces an active and engaged consumer market rather than a passive one.



KEY TAKEAWAY FOR APEC ECONOMIES

Replicating the Netherlands model requires central government control of both the cost-sharing parameter and the compensating subsidy.

Where deductibles or co-payments are set by individual insurers rather than by government, the two instruments cannot be disclosed together in the same way. Before the communication architecture can be designed, the prior policy question of whether government should take greater centralized control of cost-sharing parameters needs to be considered.

CASE STUDY 11:

APEC – Singapore

Singapore's MediShield Life co-insurance reforms illustrate both principles in practice: that reform design must account for distributional impact and build in compensating benefits before going public, and that clear communication before implementation is what converts a well-designed reform into one that the public accepts.

When the Ministry of Health moved to introduce mandatory minimum co-payments in 2021, it simultaneously strengthened MediShield Life through higher claim limits and expanded in-patient coverage, so policyholders could see the public floor rising at the same moment as the private rider was being recalibrated. Tighter rules were applied to new products rather than existing policyholders, providing a workable transition. A further round of reforms in 2026 tightened co-payments further while projecting a 30% reduction in new rider premiums. As the compensating benefits were built into the design before the announcement was made, the government was able to communicate the changes as a systemic recalibration of the two-layer system rather than a withdrawal of benefits, and the reform held.

Singapore's administrative scale and the statutory authority of the Ministry of Health made this sequencing easier to execute. But the underlying logic that cost-sharing restrictions need a visible and simultaneous public benefit improvement to be politically defensible applies regardless of system size.

CONTEXT



- By the mid-2010s, Singapore's Integrated Shield Plan (ISP) market had shifted toward full-rider coverage, absorbing 100% of private hospital costs with no cost-sharing requirement on the policyholder.
- This weakened financial discipline, accelerated private hospital utilisation, and drove sustained medical bill inflation across the private sector.
- With insurers absorbing full claim exposure, premiums rose to unsustainable levels, and the industry itself sought government intervention because the product design had become fiscally non-viable.
- The central political risk was affordability: any reform introducing cost-sharing would fall hardest on lower-middle-income policyholders already struggling with rising premiums, creating the conditions for significant public resistance if not carefully designed and communicated.

THE MECHANISM



- **A mandatory minimum co-payment:** In 2021, the MOH required all ISP products to include a co-payment of at least 5% of covered claims, with a cap on total annual co-insurance liability to protect policyholders against catastrophic cost exposure.
- **In addition, the MediShield Life enhancements to public coverage were rolled out:** This provided higher annual claim limits and expanded coverage for in-patient stay.
- **Reforms applied to new products rather than existing policyholders:** Tighter rules were introduced for new ISP products, providing a transitional pathway that avoided the political difficulty of retrospectively altering existing policyholder entitlements.

- **A further rounds of reforms in 2026 extended co-payments to deductibles:** New riders cannot cover the deductible and doubled the co-payment cap to SGD \$6,000. In return, new rider premiums are expected to decrease by 30%.



THE PROGRESS

1. The 2021 cost-sharing measures introduced meaningful cost signals for Integrated Shield Plan policyholders, helping to moderate overconsumption of private hospital services.
2. Private coverage restrictions were paired with public floor enhancements and communicated as a systemic recalibration of the two-layer system, rather than a straightforward withdrawal of benefits, which was critical to managing public acceptance.
3. The 2026 reforms extended the logic further, with tighter co-payment rules for new products accompanied by a projected reduction in rider premiums, giving government a concrete and credible compensating benefit to communicate to the market.



KEY TAKEAWAY FOR APEC ECONOMIES

Singapore's experience shows public health insurance base must be sufficiently developed to absorb meaningful enhancements at the same time as private restrictions are introduced. The health ministry must have statutory authority to mandate product design changes across all licensed private hospital insurers.

Cost-sharing restrictions and public coverage enhancements must be announced simultaneously so policyholders see the rebalancing clearly.

Applying tighter rules to new products rather than existing policyholders is important to overcome resistance.

APPROACH 3:

Strengthen data systems that connect public and private health financing

A strong digital foundation is what allows public and private systems to coordinate. It gives government clarity on where coverage gaps and opportunities lie and gives insurers the clarity they need to design and price products with confidence.

PHI works best when the government and insurers are working from the same harmonized data. It gives government visibility into where coverage gaps and opportunities exist, and gives insurers the clarity they need for risk underwriting and product design. In most markets, the starting point is not an absence of data, but data that is fragmented across systems, reported in inconsistent formats, or held by institutions without a clear mandate to share it.

Under Approach 3, we highlight two best practice principles. The first addresses how governments can establish the foundational data architecture by setting a common standard and connecting existing systems. The second addresses how that foundation can be put to active use through embedding checks into the claims process to identify issues before they become entrenched, and publishing aggregated data so that trends can be addressed over time.



Best Practice Principle: Set a common data standard and connecting existing systems

The starting point is making sure data exists in a form that can be used. In some markets, this means building a reporting standard from the ground up across many private insurers. In others, it means connecting public systems that already existed but were not designed to be interoperable. Two global examples illustrate what building a common data architecture looks like in practice. Brazil's experience shows what becomes possible when a regulator mandates a single standardized reporting framework across a large and fragmented private insurance market, transforming heterogeneous data submissions into a dataset that supports both oversight and coordination.

CASE STUDY 12:

Global – Brazil

Brazil's National Supplementary Health Agency (ANS) regulated over 668 licensed private health insurers operating across the economy, each serving large volumes of enrolled members and processing significant claims volumes. Before 1998, there was no common reporting standard for insurers to submit operational and financial data. This made it difficult to aggregate data reliably across the market, compare performance between insurers, or identify sector-wide trends. A regulator cannot effectively protect consumers or maintain market integrity without being able to see the market as a whole.

Brazil's response was to build a standardized three-part data architecture. The first component is an insurer registry, which captures information on every licensed private health insurer. The second is a beneficiary registry, which tracks every individual enrolled in a private health insurance plan across the economy. The third is a standardized claims reporting system built on top of them, requiring every insurer to submit claims data in a uniform format using consistent definitions, codes, and timelines.

CONTEXT



- Brazil's private health insurance market (the largest in Latin America) operates under a mandatory licensing regime administered by the National Supplementary Health Agency, the federal government body responsible for regulating all private health insurance operators in Brazil.
- With over 668 licensed private health insurers in the market at any given time, each processing a large volume of transactions between insurers and healthcare providers every month.
- The Agency faces a data completeness and consistency challenge that no regulator can solve through manual collection: without a mandatory common format for how operators record and report their data, each insurer's submissions is structured differently, making market-wide analysis unreliable and comparison across different insurers impossible.

THE MECHANISM



- **An insurer registry and beneficiary registry as the foundational layer that every subsequent data function is built on:** All licensed insurers are required to submit monthly enrollment data to the Agency covering each operator's membership broken down by municipality, sex, age group, and plan type.
- **A common format for electronic claims and data exchange between operators and providers:** The Agency established a mandatory standard governing the format in which all electronic claims data and healthcare expenditure information must be submitted between private health insurance operators and the healthcare providers they pay.

- **A common coding system for health service procedure:** The Agency established a unified procedure coding system which ensures all insurers, providers, and regulators use the same codes when recording, authorizing, and billing for health services.

THE PROGRESS



1. The three-part architecture of registry, claims format standard, and procedure coding system gives the National Supplementary Health Agency a market-wide dataset covering every licensed operator and every enrolled member, structured in a consistent format that enables cross-operator comparison for the first time.
2. This is the achievement: a regulator that previously received heterogeneous data from over 668 operators now receives a consistently formatted dataset from all of them.

KEY TAKEAWAY FOR APEC ECONOMIES



When insurers report data in different formats, regulators cannot see the market clearly and policymakers cannot identify where private coverage could fill public gaps.

Brazil's ANS addressed this by standardizing reporting across all insurers, turning fragmented submissions into a dataset that supports both oversight and coordination.

France's experience shows what becomes possible when two previously disconnected public data systems, one capturing reimbursement claims and the other capturing hospital activity, are formally linked through a government mandate, creating a unified population-level dataset that neither system could generate alone.

Global Example: France

France illustrates what becomes possible when two previously disconnected public data systems are linked through a common standard with a government mandate to use the resulting dataset actively.

France previously operated two entirely separate data systems with no mechanism to link them. One captured reimbursement claims from general practitioners, specialists, and pharmacies; the other captured hospital activity records.⁵⁸ The economy-wide health data system established in 2016 brought both streams together into a single government-operated database, linking reimbursement records, hospital activity data, and mortality records across the full continuum of care.⁵⁹ Standardized clinical coding was made a legal condition of hospital payment, ensuring that data submitted across all settings was consistently structured and reliably linkable at the individual patient level. The system now covers approximately 99% of the French population and is used actively for health expenditure monitoring, care pathway evaluation, provider activity feedback, and population-level health surveillance.⁶⁰ These functions were structurally impossible when the two underlying datasets remained separate.

Establishing a common data standard and connecting existing systems is the prerequisite. But the value of that infrastructure is only realized when the data flowing through it is actively used, to detect problems before they become entrenched, and to surface trends that allow both government and insurers to course-correct before the cost of inaction accumulates.



Best Practice Principle: Leverage data to identify and address issues proactively and retrospectively

A government mandate requiring data to be aggregated, analyzed, and published on a regular cadence turns a passive dataset into something government and insurers can actually act on. Economies have built on this foundation in two complementary ways: (a) by embedding checks directly into the claims process so that issues are identified before payment is made, and (b) by aggregating and publishing data so that trends become visible and can be addressed retrospectively.

Korea's Health Insurance Review and Assessment Service (HIRA) illustrates the first approach of proactive identification of irregularities by building checks directly into the body that processes claims.

CASE STUDY 13:

APEC – Korea

By the early 2000s, HIRA was processing claims from over 90,000 enrolled healthcare providers under a single economy-wide insurance system, reaching 1.3 billion claims annually by 2011. At that scale, manual review was not a viable oversight model. Korea's response was to build active oversight directly into the claims submission process, making automated screening a precondition for payment rather than a separate audit function conducted after the fact. The mandatory digital gateway came first, ensuring every claim entered the same standardized system before any payment decision was made. Automated screening was built on top of that foundation, with human review reserved for complex or high-value cases. The AI-powered integrity monitoring system launched in 2026 is the latest layer added to the same architecture, each capability built on the one that preceded it.

CONTEXT



- Over 90,000 healthcare providers were enrolled in Korea's single National Health Insurance System (NHIS) by early 2000s.
- The Health Insurance Review and Assessment Service (HIRA) was processing high claim volumes. By 2011, HIRA was processing over 1.3 billion insurance claims annually.
- The high volume of claims being processed led to significant exposure to coding errors, over-servicing, and fraudulent filings. This was undermining fiscal sustainability and trust in the system.

THE MECHANISM



- **A mandatory digital claims submission gateway processes all claims before any payment is released:** Approximately 99% of providers submitted claims through this system. Because every claim enters the same digital gateway, automated checks can be applied consistently across all providers and all claim types before any payment decision is made.
- **Automated screening resolves the majority of routine claims without human involvement:** The electronic system executes massive-scale automated audits and filters claims for technical errors, omissions, and clinical guideline non-compliance, resolving most routine claims.
- **HIRA employs a human-in-the-loop AI framework:** Final adjudication, particularly for high-cost or complex therapies, is reserved for HIRA's professional review committees, before results are sent to NHIS for reimbursement.

THE PROGRESS



1. In 2011, the electronic system returned 2.7% of inpatient and 0.1% of outpatient claims as un-reviewable. The automated audit system detected claims with multiple errors at 23.1% (inpatient) and 2.9% (outpatient).
2. HIRA's on-site investigation framework acts as a deterrent and enforcement tool, reporting an average prevention of USD 15 million in annual fiscal leakage from false claims. It serves as a key operational performance indicator (KPI) for system integrity.
3. In 2026, the Ministry of Health and Welfare launched the "AI-Powered Integrity Monitoring System," a fraud detection platform that provides real-time predictive screening of false/fraudulent claims.

KEY TAKEAWAY FOR APEC ECONOMIES



Where a single insurer or a dominant public payer processes the majority of claims, the leverage point for mandating a universal digital gateway is strongest as one institution controls the payment function.

Korea's example also shows that strong analytics is crucial to detecting errors or fraudulent claims.

The case examples below of Singapore and the Netherlands both illustrate the second approach of retrospective identification of issues.

APEC Example: Singapore

In Singapore, claims data across a market of approximately 2.5 million integrated private health insurance policyholders was historically treated as proprietary insurer information.⁶¹ This made it difficult to detect unsustainable trends such as over-servicing and bill inflation early, a limitation that became increasingly consequential as the market grew through the 2000s and into the 2010s.

Singapore's response was to separate the data holding and publication functions between the financial regulatory, the Monetary Authority of Singapore (MAS) and the Ministry of Health (MOH). MAS requires all private insurers to submit standardized regulatory returns covering claim frequency and premium income, while the health ministry publishes aggregated reports covering penetration rates and claim trends.⁶² The impact was direct and measurable: analysis found that policyholders holding add-on coverage that eliminated all consumer cost-sharing claimed 1.4 times more frequently and at 1.4 times higher cost than those without such coverage.⁶³ This provided the statistical basis for the government's decision to mandate minimum consumer cost-sharing in 2021 and to extend those requirements further in 2026.

Global Example: Netherlands

The Netherlands built the same logic into a single statutory instrument. All health insurers are required to submit standardized claims data across 16 distinct care categories, channeled through *Vektis*, an industry-operated data processing body, to the Health Authority. *Vektis* publishes open data files covering all healthcare costs paid by insurers, broken down by care type, sex, age group, and geography.⁶⁴ The result is that the same dataset serves two functions simultaneously: the regulator uses it to monitor market developments, set tariffs, oversee duty of care obligations, and detect fraud, while researchers, policymakers, and local governments use the aggregated open data to monitor healthcare cost developments independently without requiring access to the underlying individual-level data held by the regulator.⁶⁵

CONCLUSION

The challenge of building health systems that are fiscally sustainable and responsive to the needs of aging and growing populations is one that every APEC economy is grappling with, at different speeds, with different tools, and from different starting points. What this paper reflects is that no economy is navigating this challenge in isolation, and that the APEC region as a whole has accumulated a substantial body of practical learning about what works, what does not, and why. The best practice principles set out in this paper are drawn from that collective experience as well as learning from other global examples.

For APEC as a region, the opportunity is significant. The heterogeneity of health systems across member economies is not an obstacle to collective progress but a resource. Economies with more mature health systems and PHI markets (Type 1, Type 2) have already worked through many of the sequencing and design questions that advancing markets (Type 3, Type 4) are now facing. Advancing markets, in turn, bring fresh thinking on how to build the public-PHI interface from the ground up in ways that more established systems cannot easily retrofit.

The exchange of experience across this spectrum, between economies at different stages, across different regulatory traditions, and across the public and private sectors, is where much of the practical value of this paper lies. The best practice principles reflect what economies at different stages of PHI market development have found to be true in practice: that a clearly defined regulatory framework is the foundation everything else depends on; that consumer trust, once lost, is difficult to rebuild and must therefore be designed in from the start; and that the data infrastructure connecting public and private systems is not a technical afterthought but a strategic enabler of the entire public-PHI relationship.

The pressures that APEC health systems face from non-communicable diseases, aging populations, and medical cost inflation are long-term structural forces that will not ease on their own. PHI, on its own, is not a solution to those pressures, but it is a lever that most APEC economies have not yet fully pulled. The best practices and learnings in this paper are intended to make it easier to do so, not by prescribing a single model, but by offering a solutions from which each economy can develop an approach that fits its own context, while contributing to a region-wide effort to make health systems stronger and more sustainable for all.

Case Study References

Case Study 1: APEC – China

1. Ernst & Young & CPIC Allianz Health Insurance. (2018). White paper on China commercial health insurance. Ernst & Young (China) Advisory Limited. <https://www.the-digital-insurer.com/wp-content/uploads/2019/03/1472-ey-white-paper-on-china-commercial-health-insurance.pdf>
2. Commonwealth Fund. (2026, May). International health care system profiles: China. <https://www.commonwealthfund.org/international-health-policy-center/countries/china>
3. Zhang, L. (2021, August). HDHL medical insurance in China: Part 1. *The Actuary Magazine*. <https://www.theactuarymagazine.org/hdhl-medical-insurance-in-china-part-1/>
4. Jing, D., & Wei, H. (2019, April 23). Controversial answer to China's health insurance needs. *Caixin Global*. <https://www.caixinglobal.com/2019-04-23/controversial-answer-to-chinas-health-insurance-needs-101407262.html>
5. Li, Y., Zhang, C., Zhan, P., Fu, H., & Yip, W. (2023). Trends and projections of universal health coverage indicators in China, 1993–2030: An analysis of data from four nationwide household surveys. *The Lancet Regional Health – Western Pacific*, 31, 100646. <https://doi.org/10.1016/j.lanwpc.2022.100646>
6. Choi, W., Shi, H., Bian, Y., & Hu, H. (2018). Development of commercial health insurance in China: A systematic literature review. *BioMed Research International*, 2018, 3163746. <https://doi.org/10.1155/2018/3163746>
7. Khanna, A. (2024, February). Huiminbao: Falling numbers spur reforms. *Asia Insurance Review*. <https://www.asiainsurancereview.com/Magazine/ReadMagazineArticle?aid=47830>
8. Ministry of Finance, Shenzhen Municipality. (2015, November). 深圳市全面实施重特大疾病补充医疗保险 [Shenzhen fully implements supplementary medical insurance for critical and major illnesses] [Chinese language]. http://www.mof.gov.cn/zhengwuxinxi/xinwenlianbo/shenzhencaizhengxinxilianbo/201511/t20151130_1590074.htm

Case Study 2: APEC – Korea

1. Shin, J. (2012). Private health insurance in South Korea: An international comparison. *Health Policy*, 108(1), 76–85. <https://doi.org/10.1016/j.healthpol.2012.08.011>
2. Asia Business Daily. (2026, April 26). Fifth-generation indemnity health insurance launches next month... premiums to drop to 40% of second-generation as therapeutic massage coverage removed. <https://www.asiae.co.kr/en/article/2026042617082958249>
3. Kim, H., & Kang, H. (2020). Moral hazard effects of supplemental private health insurance in Korea. *Social Science & Medicine*, 265, 113054. <https://pubmed.ncbi.nlm.nih.gov/32905966/>
4. Seoul Economic Daily. (2026, January 15). Korea to launch 5th-gen health insurance in April with stronger cancer, heart disease coverage. <https://en.sedaily.com/news/2026/01/15/korea-to-launch-5th-gen-health-insurance-in-april-with>

Case Study 3: Global – Germany

1. Cencora. (2024, Summer). *Benefit-driven pricing: How AMNOG strikes a balance between the financial burden on statutory health insurance and reimbursement of innovative medications in Germany*. <https://www.cencora.com/resources/pharma/htaq-summer-2024-how-amnog-strikes-a-balance>
2. Pharmazie.com. (2025, May 9). *Pharma Pricing Germany: Navigating costs, compliance and transparency*. <https://go.pharmazie.com/en/pharma-pricing-germany-lt/>
3. Gandjour, A. (2023). Impact of the introduction of the AMNOG law on launch delays of new drugs in Germany: A comment. *The European Journal of Health Economics*, 24, 1243–1244. <https://doi.org/10.1007/s10198-023-01607-5>
4. Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen [IQWiG]. (n.d.). *The AMNOG procedure: More than just cost control [In the focus: New drugs — approval, benefit assessment, coverage, Part 3]*. <https://www.iqwig.de/en/presse/in-the-focus/new-drugs-approval-benefit-assessment-coverage/3-the-amnog-procedure-more-than-just-cost-control/>
5. Blankart, K., Naci, H., & Chandra, A. (2022). Availability of new medicines in the US and Germany from 2004 to 2018. *JAMA Network Open*, 5(8), e2229231. <https://doi.org/10.1001/jamanetworkopen.2022.29231>

Case Study 4: APEC – Japan

1. Ikegami, N. (2019). Japan: Achieving UHC by regulating payment. *Globalization and Health*, 15(Suppl 1), Article 72. <https://doi.org/10.1186/s12992-019-0524-4>
2. Ministry of Health, Labour and Welfare. (n.d.). 3. *Growth of economy and accomplishment of universal medical insurance and pension programs: 1955–1964*. https://www.mhlw.go.jp/www1/english/ssp_in_j/services/3rd.html
3. Health and Global Policy Institute. (n.d.). 7.2 *The medical service fee system*. Japan Health Policy NOW. <https://japanhpn.org/en/section-7-2/>
4. Health and Global Policy Institute. (n.d.). *Historical overview*. Japan Health Policy NOW. <https://japanhpn.org/en/historical/>
5. Kawaguchi, H. (n.d.). Unique mixtures of public and private funding in Japan: The ban on billing for mixed medical care service [Working paper]. Policy Research Institute, Ministry of Finance, Japan. http://warp.ndl.go.jp/info:ndljp/pid/10248500/www.mof.go.jp/english/pri/publication/pp_review/ppr016/ppr016b.pdf
6. Ministry of Health, Labour and Welfare. (n.d.). *Advanced medical care services and mixed billing [混合診療・先進医療]*. <https://www.mhlw.go.jp/topics/bukyoku/isei/sensiniryō/heiyōu.html>
7. Ibuka, Y. (2025, July 7). A health economics perspective on the high-cost medical expense benefit system. *Mita Hyoron* [Special feature: Cancer and society]. Keio University. <https://www.keio.ac.jp/en/about/public-relations/mita-hyoron/features/07-6-2/>
8. Kamitani, K. (n.d.). *Advanced medical care system in Japan – Senshin Iryo*. JPRO. <https://www.jpnprou.com/advanced-medical-care-system.html>
9. Uraoka, Y., Inoue, Y., & Nishioka, Y. (2025). *Laws and regulations on healthcare financing and reimbursement: Japan* [Survey chapter]. International Bar Association Healthcare and Life Sciences Law Committee. <https://www.ibanet.org/document?id=Healthcare-Survey-2025-Japan>

Case Study 5: APEC – China

1. Dong, A., & Cui, S. (2025, August 15). *China introduces Commercial Insurance Innovative Drug Catalogue* [Legal update]. CMS. <https://cms.law/en/chn/legal-updates/china-introduces-commercial-insurance-innovative-drug-catalogue>
2. NRD+. (2025, March). *China's commercial insurance catalog accelerates expanding beyond Category C drug list*. <https://www.nrdlplus.com/chinas-commercial-insurance-catalog-accelerates-expanding-beyond-category-c-drug-list/>
3. Wong, F., Fung, R. M., Kao, C., & Lakhanpal, S. (2026). *Early learnings from China's new Commercial Health Insurance Innovative Drug Catalogue*. Avalere Health Advisory. <https://advisory.avalerehealth.com/insights/early-learnings-from-chinas-new-commercial-health-insurance-innovative-drug-catalogue>
4. Patel, B., & Feng, H. (2026, February). *The first China Commercial Insurance Innovative Drug List (CIIDL) for 2026: How will the CIIDL transform pricing and access for innovative care in China?* [White paper]. CRA International. <https://media.crai.com/wp-content/uploads/2026/02/02130556/LS-China-Commercial-Insurance-Innovative-Drug-List-2026.pdf>
5. Yang, Z. (2025, June 16). *China's drug reimbursement transition to support innovation*. *Law and Biosciences Blog*, Stanford Law School. <https://law.stanford.edu/2025/06/16/chinas-drug-reimbursement-transition-to-support-innovation/>
6. Zhu, N. (Ed.). (2026, January 9). *China has renewed the National Reimbursement Drug List and released the first commercial reimbursement list for innovative drugs* [Legal update]. CMS. <https://cms.law/en/chn/legal-updates/china-has-renewed-the-national-reimbursement-drug-list-and-released-the-first-commercial-reimbursement-list-for-innovative-drugs>

Case Study 6: APEC – Australia

1. Australian Government Department of Health and Aged Care. (n.d.). *Lifetime Health Cover*. privatehealth.gov.au. https://www.privatehealth.gov.au/health_insurance/surcharges_incentives/lifetime_health_cover.htm
2. Dwyer, J. (2021, June 1). *Implementation question discussed by the Private Health Insurers (PHI) focus group: Risk equalisation* [Discussion paper]. PHI Focus Group, Australian Accounting Standards Board Transition Resource Group for AASB 17 Insurance Contracts. <https://aasb.gov.au/media/n2jtmub/att2-2riskequal.pdf>
3. Australian Taxation Office. (2026, June 22). *Medicare levy surcharge income thresholds and rates*. <https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge/medicare-levy-surcharge-income-thresholds-and-rates>
4. Nguyen, L., & Worthington, A. C. (2021, July 12). *Adverse selection in Australian private health insurance* [Working paper]. SSRN. <https://doi.org/10.2139/ssrn.3884719>
5. Colombo, F., & Tapay, N. (2003). *Private health insurance in Australia: A case study* (OECD Health Working Papers, No. 8). Organisation for Economic Co-operation and Development. <https://doi.org/10.1787/478608584171>

Case Study 7: Global – Netherlands

1. Commonwealth Fund. (2026, May 1). *International health care system profiles: Netherlands*. <https://www.commonwealthfund.org/international-health-policy-center/countries/Netherlands>
2. Government of the Netherlands. (n.d.). *Standard health insurance*. <https://www.government.nl/themes/family-health-and-care/health-insurance/standard-health-insurance>
3. Bartholomée, Y., & Maarse, H. (2006). The new Dutch health insurance system. *Eurohealth*, 12(2). <https://pnhp.org/news/the-new-dutch-health-insurance-system/>
4. van de Ven, W. P. M. M., & Schut, F. T. (2008). Universal mandatory health insurance in the Netherlands: A model for the United States? *Health Affairs*, 27(3), 771–781. <https://doi.org/10.1377/hlthaff.27.3.771>
5. Wehage, E., Löpmeier-Röh, J. F., Wissinger, E., & Kulp, W. (2024, May). *AMNOG benefit assessment in Germany: Outcomes from 2011 to November 2023* [Conference poster, HTA54]. ISPOR 2024, Atlanta, GA, USA. *Value in Health*, 27(6, Suppl. 1). <https://www.ispor.org/heor-resources/presentations-database/presentation/intl2024-3898/137636>

Case Study 8: APEC – Singapore

1. Fu, A. (2012, June). *Integrated Shield: Past, present and future* [Conference presentation]. Healthcare Insurance Conference, Singapore Actuarial Society. <https://actuaries.org.sg/files/library/forum/presentation/2012/2012%20HIC/S05.%20Integrated%20Shield-Past.%20Present%20&%20Future%20-%20Alvin%20Fu.pdf>
2. Ministry of Health Singapore. (2005, January 26). *Background of MediShield reform 2005* [Press release]. <https://www.moh.gov.sg/newsroom/background-of-medishield-reform-2005/>
3. Ministry of Health Singapore. (2026, April 30). *About Integrated Shield Plan*. <https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/integrated-shield-plans/about-integrated-shield-plans/>
4. Ministry of Health Singapore. (2026, June 1). *How to make a MediShield Life Claim*. <https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/medishield-life/how-to-make-a-medishield-life-claim/>
5. Commonwealth Fund. (2026, May 1). *International health care system profiles: Singapore*. <https://www.commonwealthfund.org/international-health-policy-center/countries/Singapore>
6. Life Insurance Association, Singapore. (2025, November 12). *Life insurance industry records continued strong uptake of annual premium policies for YTD Q3 2025 as overall total weighted new business premiums grew 10.4%* [Media release]. https://www.lia.org.sg/media/4698/20251112_lia-3q2025-results_media-release.pdf
7. Ministry of Health Singapore. (2025, November 26). *New requirements for Integrated Shield Plan riders to strengthen sustainability of private health insurance and address rising healthcare costs* [Press release]. <https://www.moh.gov.sg/newsroom/new-requirements-for-integrated-shield-plan-riders-to-strengthen-sustainability-of-private-health-insurance-and-address-rising-healthcare-costs/>

Case Study 9: APEC – China

1. Meng, Q., Fang, H., Liu, X., Yuan, B., & Xu, J. (2015). Consolidating the social health insurance schemes in China: Towards an equitable and efficient health system. *The Lancet*, 386(10002), 1484–1492. [https://doi.org/10.1016/S0140-6736\(15\)00342-6](https://doi.org/10.1016/S0140-6736(15)00342-6)
2. Yip, W., Fu, H., Chen, A. T., Zhai, T., Jian, W., Xu, R., Pan, J., Hu, M., Zhou, Z., Chen, Q., Xu, J., Fan, W., & Chen, W. (2019). 10 years of health-care reform in China: Progress and gaps in universal health coverage. *The Lancet*, 394(10204), 1192–1204. [https://doi.org/10.1016/S0140-6736\(19\)32136-1](https://doi.org/10.1016/S0140-6736(19)32136-1)
3. Chen, N., Bai, J., Nicholas, S., Maitland, E., Tan, J., & Wang, J. (2022). Preferences for private health insurance in China: A discrete choice experiment. *Frontiers in Public Health*, 10, 985582. <https://doi.org/10.3389/fpubh.2022.985582>
4. NRDL+. (2023, April 12). *Access pathway for innovative medicines in China: Basic social medical insurance*. <https://www.nrdlplus.com/access-pathway-for-innovative-medicines-in-china-basic-social-medical-insurance/>
5. NRDL+. (2023, April 19). *Access pathway for innovative medicines in China: City commercial health insurance (“Huiminbao”)*. <https://www.nrdlplus.com/access-pathway-for-innovative-medicines-in-china-city-commercial-health-insurance/>
6. Ding, H., Wang, X., & Xu, X. (2026, April 28). *Understanding China’s huge expansion of health insurance*. VoxDev. <https://voxdev.org/topic/health/understanding-chinas-huge-expansion-health-insurance>
7. Zhu, N. (2026, January 9). *China has renewed the national reimbursement drug list and released the first commercial reimbursement list for innovative drugs*. CMS Law. <https://cms.law/en/chn/legal-updates/china-has-renewed-the-national-reimbursement-drug-list-and-released-the-first-commercial-reimbursement-list-for-innovative-drugs>
8. Khanna, A. (2024, February). *Huiminbao: Falling numbers spur reforms*. Asia Insurance Review. <https://www.asiainsurancereview.com/Magazine/ReadMagazineArticle?aid=47830>

Case Study 10: Global – Netherlands

1. CZ. (n.d.). *Health insurance deductible explained*. <https://www.cz.nl/en/zorgverzekering/eigen-Risico>
2. CareCostIndex. (2026, March 1). *Mandatory health insurance (Zorgverzekeringswet) in Netherlands 2026: Costs & key stats*. <https://carecostindex.com/country/netherlands/mandatory-insurance>
3. Commonwealth Fund. (2026, May 1). *International health care system profiles: Netherlands*. <https://www.commonwealthfund.org/international-health-policy-center/countries/Netherlands>
4. TikTaal. (2026, March 30). *Dutch health insurance: What you pay, what you get, and when to switch*. <https://tiktaal.nl/blog/dutch-zorgverzekering-explained>
5. Stichting Klachten en Geschillen Zorgverzekeringen. (2025). *Prinsjesdag 2025: De kabinetsplannen voor zorg in 2026* [Prinsjesdag 2025: The government’s plans for healthcare in 2026]. <https://skgz.nl/nieuws/prinsjesdag-2025>
6. Zilveren Kruis. (2025). *Prinsjesdag en je zorgverzekering in 2026* [Prinsjesdag and your health insurance in 2026]. <https://zilverenkruis.nl/en/consumenten/zorgverzekering/veranderingen/prinsjesdag>
7. DutchNews.nl. (2025, November 13). *Price gap between health insurance policies to rise to €511*. <https://www.dutchnews.nl/2025/11/price-gap-between-health-insurance-policies-to-rise-to-e511/>
8. Wehage, E., Löpmeier-Röh, J. F., Wissinger, E., & Kulp, W. (2024, May). *AMNOG benefit assessment in Germany: Outcomes from 2011 to November 2023* [Conference poster, HTA54]. ISPOR 2024, Atlanta, GA, USA. *Value in Health*, 27(6, Suppl. 1). <https://www.ispor.org/heor-resources/presentations-database/presentation/intl2024-3898/137636>

Case Study 11: APEC – Singapore

1. Ng, K. (2018, March 7). Co-payment mandated for new IP insurance riders in bid to curb 'buffet syndrome'. CNA. <https://www.channelnewsasia.com/singapore/co-payment-mandated-new-ip-insurance-riders-in-bid-curb-buffet-syndrome-5737746>
2. Ang, H. M. (2025, November 26). New Integrated Shield Plan riders to have higher co-payment cap from April 2026. CNA. <https://www.channelnewsasia.com/singapore/integrated-shield-plan-rider-co-payment-cap-deductibles-medisave-covered-5489971>
3. MoneySmart. (2020). 3 things to know about MediShield Life premiums & coverage changes in 2021. AsiaOne. <https://www.asiaone.com/money/3-things-know-about-medishield-life-premiums-coverage-changes-2021>
4. Ministry of Health Singapore. (2025, November 26). *New requirements for Integrated Shield Plan riders to strengthen sustainability of private health insurance and address rising healthcare costs* [Press release]. <https://www.moh.gov.sg/newsroom/new-requirements-for-integrated-shield-plan-riders-to-strengthen-sustainability-of-private-health-insurance-and-address-rising-healthcare-costs>
5. Ministry of Health Singapore. (2024, October 15). *Government accepts MediShield Life Council's recommendations to enhance MediShield Life scheme: Government support more than offsets premium increases* [Press release]. <https://www.moh.gov.sg/newsroom/government-accepts-medishield-life-council-s-recommendations-to-enhance-medishield-life-scheme---government-support-more-than-offsets-premium-increases/>

Case Study 12: Global – Brazil

1. International Trade Administration, U.S. Department of Commerce. (2025, August 21). *Brazil: Healthcare* [Economy commercial guide]. <https://www.trade.gov/country-commercial-guides/brazil-healthcare>
2. Agência Nacional de Saúde Suplementar. (2021, April 5; updated 2026, May 28). *TISS — Padrão para troca de informação de saúde suplementar* [TISS — Standard for exchange of supplementary health information]. Government of Brazil. <https://www.gov.br/ans/pt-br/assuntos/prestadores/padrao-para-troca-de-informacao-de-saude-suplementar-2013-tiss>
3. Agência Nacional de Saúde Suplementar. (n.d.). *[ANS supplementary health data dashboard]* [Interactive data visualization]. Government of Brazil. <https://app.powerbi.com/view?r=eyJoiNzFiMGFkMTAtOTNhYS00NzdjLTkzM2ltYzM0ZDdkZGFmYTQ4IiwidCI6ImM0YzliM2VkLWMwZDUtNDdiOC1hYjZhLWM2ZjU5ZWl3YzQ3YSJ9>
4. Montoya Diaz, M. D., Haber, N., Mladovsky, P., Pitchforth, E., Saleh, W. F., & Sarti, F. M. (2020). Private health insurance in Brazil, Egypt and India. In S. Thomson, A. Sagan, & E. Mossialos (Eds.), *Private health insurance: History, politics and performance* (pp. 65–98). Cambridge University Press. <https://doi.org/10.1017/9781139026468.003>
5. Amplimed. (2022, August 1; updated 2025, June 27). *Tabela TUISS: O que é, como consultar e por que usar no seu consultório* [TUISS table: What it is, how to consult it and why to use it in your practice]. <https://www.amplimed.com.br/blog/tabela-tuiss/>
6. Cruz, J. A. W., Cunha, M. A. V. C., Moraes, T. P., Tuon, F. F., Gomide, A. L., & Linhares, G. P. (2022). Brazilian private health system: History, scenarios, and trends. *BMC Health Services Research*, 22, 49. <https://doi.org/10.1186/s12913-021-07376-2>
7. Ocké-Reis, C. O. (2004). *Challenges of the private health plans regulation in Brazil* (Discussion Paper No. 1013). Institute for Applied Economic Research (Ipea). <https://repositorio.ipea.gov.br/bitstreams/78e3e63d-be50-43b1-b0a1-b74c7ad1da89/download>

Case Study 13: APEC – Korea

1. Park, Y.-T., Yoon, J.-S., Speedie, S. M., Yoon, H., & Lee, J. (2012). Health insurance claim review using information technologies. *Healthcare Informatics Research*, 18(3), 215–224. <https://doi.org/10.4258/hir.2012.18.3.215>
2. Digital Convergence Initiative. (2026). *National Health Insurance Service (NHIS) — Machine learning-based fraud detection and prediction system* (Case KOR-001). AI Hub. <https://socialprotectionai.org/use-case/KOR-001>
3. Kim, E.-Y. (2025, September 15). Fraudulent medical claims in Korea hit ₩116.1 bil. over five years. *Korea BioMedical Review*. <https://www.koreabiomed.com/news/articleView.html?idxno=28968>
4. Digital Convergence Initiative. (2026). *National Health Insurance Service (NHIS) — Machine learning-based fraud detection and prediction system* (Case KOR-001). AI Hub. <https://socialprotectionai.org/use-case/KOR-001>
5. The Asia Business Daily. (2026, April 23). “Fake medical bills to be detected by AI”... Crackdown on false and fraudulent health insurance claims strengthened. <https://www.asiae.co.kr/en/article/2026042309140313378>

Report References

- 1 World Bank. (2026, January 5). Lessons from Indonesia's 10-year journey towards universal health coverage [Brief]. Multi-Donor Trust Fund for Integrating Externally Financed Health Programs, World Bank. <https://www.worldbank.org/en/programs/multi-donor-trust-fund-for-integrating-externally-financed-health-programs/brief/lessons-from-indonesia-s-10-year-journey-towards-universal-health-coverage>
- 2 Tuấn Anh. (2026, July 3). [Infographic] Vietnam Social Security: Key achievements in the first 6 months of 2026 [Infographic report]. Vietnam Social Security. <https://vss.gov.vn/english/news/Pages/vietnam-social-security.aspx?ItemID=13022&CatID=198>
- 3 Department of Health, Republic of the Philippines. (2019, October 10). Implementing rules and regulations of Republic Act No. 11223, otherwise known as the Universal Health Care Act. <https://caro.doh.gov.ph/wp-content/uploads/2019/10/UHC-IRR-signed2.pdf>
- 4 Hanvoravongchai, P. (2013, January). Health financing reform in Thailand: Toward universal coverage under fiscal constraints (Universal Health Coverage Studies Series [UNICO], No. 20). World Bank. <https://documents1.worldbank.org/curated/en/476621468132279566/pdf/750000NWP0Box300Reform0in00THAILAND.pdf>
- 5 Kwon, S., Lee, T.-J., & Kim, C.-Y. (2015). Republic of Korea health system review (Health Systems in Transition, Vol. 5, No. 4). Asia Pacific Observatory on Health Systems and Policies; World Health Organization. <https://iris.who.int/handle/10665/208376>
- 6 World Bank Group. (n.d.). World Bank Open Data [Data portal]. <https://data.worldbank.org/>
- 7 World Health Organization. (2023, October 5). Universal health coverage (UHC). <https://www.who.int/health-topics/universal-health-coverage>
- 8 World Bank Group. (n.d.). World Bank Open Data [Data portal]. <https://data.worldbank.org/>
- 9 Asia-Pacific Economic Cooperation (APEC). (2014). APEC framework on community-based intervention to control NCD risk factors. APEC Secretariat. https://www.apec.org/docs/default-source/Publications/2014/8/Framework-on-Community-Based-Intervention-to-Control-NCD-Risk-Factors/FRAMEWORKS_ForPrint_OKE_2.pdf
- 10 Freihart, O., Sipos, D., Aamir, M., & Kovacs, A. (2025). Global burden and future projections of non-communicable diseases (2000–2050): Progress toward SDG 3.4 and disparities across regions and risk factors. PLOS ONE, 20(12), e0336036. <https://doi.org/10.1371/journal.pone.0336036>
- 11 Dent, J., Jorge, M., et. al. (2025). Cancer immunotherapy clinical trials to support urgently needed access in low- and middle-income countries: A report from the SITC global access and impact committee. Journal for Immunotherapy of Cancer, 13(6), <https://doi.org/10.1136/jitc-2024-011258>
- 12 ACCESS Forum. (2026, May 22). The future of healthcare: WHO unveils global strategy for precision medicine [Digital Health & AI]. The ACCESS Forum Learning Hub. <https://theaccessforum.org/learning-hub/the-future-of-healthcare-who-unveils-global-strategy-for-precision-medicine/>
- 13 Aon plc. (2024). 2025 global medical trend rates report: Global overview and data tables. Aon. <https://assets.aon.com/-/media/files/aon/reports/2025/aon-global-medical-trend-rates-report-2025.pdf>
- 14 Bales, S., & Đào, L. H. (2025). Trends and differentials in household out-of-pocket spending for health in Viet Nam, 2010–2022 (Health, Nutrition, and Population Discussion Paper). World Bank. <https://documents1.worldbank.org/curated/en/099558209182518413/pdf/IDU-c994a0dd-c25a-46ee-9dfe-5e95193a46bb.pdf>
- 15 Jung, H. W., Kwon, Y. D., & Noh, J. W. (2022). How public and private health insurance coverage mitigates catastrophic health expenditures in Republic of Korea. BMC Health Services Research, 22, Article 1042. <https://doi.org/10.1186/s12913-022-08405-4>
- 16 Colombo, F., & Tapay, N. (2004). Private health insurance in OECD countries: The benefits and costs for individuals and health systems (OECD Health Working Papers, No. 15). OECD Publishing. <https://doi.org/10.1787/527211067757>

- 17 Australian Government Department of Health, Disability and Ageing. (n.d.). Private health insurance. <https://www.health.gov.au/topics/private-health-insurance>
- 18 Australian Taxation Office. (n.d.). Medicare levy surcharge. <https://www.ato.gov.au/individuals-and-families/medicare-and-private-health-insurance/medicare-levy-surcharge>
- 19 Harvard Kennedy School, Center for Ministerial Leadership. (n.d.). The public-private health financing system in Chile: A teaching case. <https://ministerialleadership.harvard.edu/case-studies/the-public-private-health-financing-system-in-chile-a-teaching-case/>
- 20 Khanna, A. (2024, February). Huiminbao: Falling numbers spur reforms. Asia Insurance Review. <https://www.asiainsurancereview.com/Magazine/ReadMagazineArticle?aid=47830>
- 21 CMS Law. (2025, August 15). China introduces Commercial Insurance Innovative Drug Catalogue [Legal update]. <https://cms.law/en/chn/legal-updates/china-introduces-commercial-insurance-innovative-drug-catalogue>
- 22 Superintendencia de Salud, Gobierno de Chile [Superintendency of Health, Government of Chile]. (n.d.). Cuidamos los derechos de las personas en salud [We protect the rights of people in health]. <https://www.superdesalud.gob.cl/>
- 23 Gobierno de Chile. (2004, August 25). Ley N° 19.966 — Establece un régimen de garantías en salud [Law No. 19,966 — Establishes a regime of health guarantees]. Biblioteca del Congreso Nacional de Chile. <https://www.bcn.cl/leychile/navegar?idNorma=229834>
- 24 Badan Kebijakan Pembangunan Kesehatan, Kementerian Kesehatan Republik Indonesia [Health Development Policy Agency, Ministry of Health of the Republic of Indonesia]. (2023, March 30). The need for coordination for better health services [BKPK News]. <https://www.badankebijakan.kemkes.go.id/en/perlunya-koordinasi-untuk-pelayanan-kesehatan-yang-lebih-baik/>
- 25 Ang, C. W., & Winata, J. (2026, May 4). Health regulations e-Alert: Key updates on Indonesia's health insurance reform. Milliman. https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/5-4-26_Health-Regulations-e-Alert-Key-Updates-Indonesias-Health-Insurance-Reform.pdf
- 26 Kristine Namhee Kwon, Wankyo Chung. (2023). Effects of private health insurance on medical expenditure and health service utilization in South Korea: A quantile regression analysis. BMC Health Services Research, 23. <https://doi.org/10.1186/s12913-023-10251-x>
- 27 Bank Negara Malaysia [Central Bank of Malaysia]. (2024, February 29). Policy document on medical and health insurance/takaful business. <https://www.bnm.gov.my/mhit>
- 28 Poder Judicial del Perú [Judiciary of Peru]. (n.d.). Entidades Prestadoras de Salud [Health-providing entities] [Welfare services page]. https://www.pj.gob.pe/wps/wcm/connect/bienestarsocial/s_bien_social/as_seguros/as_eps
- 29 Contreras-Pulache, H., Pérez Quispe, et. al. (2026). How assured is health in Peru? A cross-sectional analysis of the 2019 National Household Survey. Health Science Reports, 9, e70342. <https://doi.org/10.1002/hsr2.70342>
- 30 Bossert, T., & Leisewitz, T. (2016, January 7). Innovation and change in the Chilean health system. New England Journal of Medicine, 374(1), 1–5. <https://doi.org/10.1056/NEJMp1514202>
- 31 Frenz, P., Delgado, I., Kaufman, J. S., & Harper, S. (2014, September 14). Achieving effective universal health coverage with equity: Evidence from Chile. Health Policy and Planning, 29(6), 717–731. <https://academic.oup.com/heapol/article/29/6/717/638493>
- 32 Giedion, U., Alfonso, E. A., & Díaz, Y. (2013, January). The impact of universal coverage schemes in the developing world: A review of the existing evidence (UNICO Studies Series No. 25). World Bank. <https://documents1.worldbank.org/curated/en/349621468158382497/pdf/753260NWP0Box30ewofExistingEvidence.pdf>
- 33 Ministry of Health, Singapore. (2025, March 19). FAQs on cancer treatment financing. <https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/medishield-life/faqs-on-cancer-treatment-financing/>
- 34 Ministry of Health, Singapore. (2026, May 31). Cancer Drug List. <https://www.moh.gov.sg/managing->

- 35 Life Insurance Association, Singapore. (2022, September 2). Classification of cancer drug treatments which are not on the MOH Cancer Drug List (“Non-CDL Classification Framework”) (LIA Circular MU 84/22). <https://www.lia.org.sg/media/3553/non-cdl-classification-framework.pdf>
- 36 Life Insurance Association, Singapore. (2023, February 1). Frequently asked questions — Non-CDL Classification Framework. https://www.lia.org.sg/media/3716/faqs_non-cdl-classification-framework_draft_1feb23.pdf
- 37 Jung, H. W., Kwon, Y. D., & Noh, J. W. (2022). How public and private health insurance coverage mitigates catastrophic health expenditures in Republic of Korea. BMC Health Services Research, 22, Article 1042. <https://doi.org/10.1186/s12913-022-08405-4>
- 38 Shin, J. (2012). Private health insurance in South Korea: An international comparison. Health Policy, 108(1), 76–85. <https://doi.org/10.1016/j.healthpol.2012.08.011>
- 39 Jung, H. W., Kwon, Y. D., & Noh, J. W. (2022). How public and private health insurance coverage mitigates catastrophic health expenditures in Republic of Korea. BMC Health Services Research, 22, Article 1042. <https://doi.org/10.1186/s12913-022-08405-4>
- 40 NRDL+. (2025). China’s commercial insurance catalog accelerates expanding beyond Category C drug list. <https://www.nrldplus.com/chinas-commercial-insurance-catalog-accelerates-expanding-beyond-category-c-drug-list/>
- 41 Zhou, X., & Guo, X. (2025, September 12). In depth: New innovative drug list could expand access to costly breakthroughs. Caixin Global. <https://www.caixinglobal.com/2025-09-12/in-depth-new-innovative-drug-list-could-expand-access-to-costly-breakthroughs-102361893.html>
- 42 GlobalData / Pharmaceutical Technology. (2025, December). China releases 2025 NRDL and first commercial insurance drug list. <https://www.pharmaceutical-technology.com/analyst-comment/china-2025-nrdl-first-commercial-insurance-drug-list/>
- 43 Vietnam Law Magazine. (2023, September 16). Politburo’s Resolution No. 72 underscores party, state’s strong commitment to public health care. Vietnam Law Magazine.
- 44 Citrawati, C., Suntoro, E. E., & Mahadewi, E. (2023, July). Coordination of benefit (COB) program development analysis: A case study of healthcare insurance in Indonesia. International Journal of Science Technology & Management, 4(4), 742–747. <https://doi.org/10.46729/ijstm.v4i4.845>
- 45 Otoritas Jasa Keuangan [OJK]. (2026, January 14). OJK issues regulation to promote strong and competitive insurance, surety, and pension fund industry. <https://ojk.go.id/en/berita-dan-kegiatan/siaran-pers/Pages/OJK-Issues-Regulation-to-Promote-Strong-and-Competitive-Insurance-Surety-and-Pension-Fund-Industry.aspx>
- 46 OECD. (2025). OECD reviews of health systems: Peru 2025. OECD Publishing. <https://doi.org/10.1787/f3ddb6a4-en>
- 47 Jung, H. W., Kwon, Y. D., & Noh, J. W. (2022). How public and private health insurance coverage mitigates catastrophic health expenditures in Republic of Korea. BMC Health Services Research, 22, 1042. <https://doi.org/10.1186/s12913-022-08405-4>
- 48 Jung, H. W., Kwon, Y. D., & Noh, J. W. (2022). How public and private health insurance coverage mitigates catastrophic health expenditures in Republic of Korea. BMC Health Services Research, 22, 1042. <https://doi.org/10.1186/s12913-022-08405-4>
- 49 Parapluie Mutuelle Prévoyance. (n.d.). Pas de transmission NOEMIE : que faire ? <https://www.parapluie-mutuelle-prevoyance.fr/pas-de-transmission-noemie-que-faire.html>
- 50 A Buckeye in Paris. (2026, March 16). Everything to know about a mutuelle. <https://abuckeyeinparis.com/everything-to-know-about-a-mutuelle/>
- 51 A Buckeye in Paris. (2026, March 16). Everything to know about a mutuelle. <https://abuckeyeinparis.com/everything-to-know-about-a-mutuelle/>
- 52 Hanvoravongchai, P. (2013, January). Health financing reform in Thailand: Toward universal coverage

- under fiscal constraints (UNICO Studies Series No. 20). World Bank. <https://documents1.worldbank.org/curated/en/476621468132279566/pdf/750000NWP0Box300Reform>
- 53 Health Intervention and Technology Assessment Program [HITAP]. (2025). Public participation in the Universal Coverage Scheme (UCS) [Report]. Health Intervention and Technology Assessment Program. <https://www.hitap.net/wp-content/uploads/2025/11/05-UCS-PublicParticipation.pdf>
- 54 Bank Negara Malaysia. (n.d.). Medical and health insurance/takaful reset. <https://www.bnm.gov.my/-/mhitreset>
- 55 Australian Government Department of Health and Aged Care. (n.d.). Hospital cover and product tiers. <https://www.health.gov.au/topics/private-health-insurance/what-private-health-insurance-covers/hospital-cover-and-product-tiers>
- 56 Moran, P. (n.d.). Health Insurance Authority: A review of private health insurance in Ireland. Ipsos B&A <https://www.ipsosbanda.ie/health-insurance-authority-a-review-of-private-health-insurance-in-ireland/>
- 57 Health Insurance Authority. (n.d.). Health insurance comparison. <https://www.hia.ie/health-insurance-comparison>
- 58 Bezin J, Duong M, Lassalle R, et al. "The national healthcare system claims databases in France, SNIIRAM and EGB: Powerful tools for pharmacoepidemiology." *Pharmacoepidemiology and Drug Safety*, 26(8): 954–962, 2017. DOI: 10.1002/pds.4233.
- 59 Atlas of Longitudinal Datasets. National Health Data System (SNDS). <https://atlaslongitudinaldatasets.ac.uk/datasets/snds>
- 60 Bezin, J., Duong, M., Lassalle, R., Droz, C., Pariente, A., Blin, P., & Moore, N. (2017). The national healthcare system claims databases in France, SNIIRAM and EGB: Powerful tools for pharmacoepidemiology. *Pharmacoepidemiology and Drug Safety*, 26(8), 954–962. <https://doi.org/10.1002/pds.4233>
- 61 Ministry of Health, Singapore. (2016, updated 2024). Number of policyholders for MediShield and Integrated Shield Plans, annual [Dataset]. data.gov.sg. <https://data.gov.sg/datasets/a9acac29f36a10e43d4b14a793685c77/view>
- 62 Monetary Authority of Singapore. (n.d.). Insurance statistics [Annual and quarterly data portal]. <https://www.mas.gov.sg/statistics/insurance-statistics>
- 63 Ministry of Health, Singapore. (2025, November 26). New requirements for Integrated Shield Plan riders to strengthen sustainability of private health insurance and address rising healthcare costs [Press release]. <https://www.moh.gov.sg/newsroom/new-requirements-for-integrated-shield-plan-riders-to-strengthen-sustainability-of-private-health-insurance-and-address-rising-healthcare-costs/>
- 64 Nederlandse Zorgautoriteit [Dutch Healthcare Authority]. (2024). Regeling aanlevering declaratiegegevens door ziektekostenverzekeraars [Regulation on the submission of claims data by health insurers] (BWBR0050285). wetten.overheid.nl. <https://wetten.overheid.nl/1.3:c:BWBR0050285&g=2025-03-30&z=2025-03-30>
- 65 Nederlandse Zorgautoriteit [Dutch Healthcare Authority]. (2024). Regeling aanlevering declaratiegegevens door ziektekostenverzekeraars [Regulation on the submission of claims data by health insurers] (BWBR0050285). wetten.overheid.nl. <https://wetten.overheid.nl/1.3:c:BWBR0050285&g=2025-03-30&z=2025-03-30>



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