

# Global protection gaps and recommendations for bridging them

March 2023

**Report extract:  
Health protection gap**



## II. Executive summary

“The pace of change has never been this fast — yet it will never be this slow again.” This statement by Canadian prime minister Justin Trudeau in 2018 describes the pace at which megatrends disrupt the world we live in, implying high levels of change and uncertainty for both individuals and organisations.

Four megatrends are particularly relevant given their global economic relevance and their impact on human lives:

- **Climate change**, which impacts lives and livelihoods around the globe. The World Economic Forum estimates it will create costs equivalent to between 4% and 18% of global GDP by 2050 if no adequate preventive actions are taken.
- **Technological acceleration** and the use of data, which has increased exponentially over recent years, with the amount of data stored globally expected to reach an unprecedented 180 zettabytes<sup>2</sup> by 2025.
- Changing **demographics** leading to ageing populations (in the USA, for example, 21% of the population is expected to be above 65 by 2030, up from 17% in 2020). At the same time, GDP productivity will shift towards emerging countries, which will account for 35% of global GDP in 2040, up from 25% in 2020.
- Disruptive developments in **macroeconomics and politics**, which will increase the level of uncertainty and volatility across the globe as supply-chain disruptions, inflation and other developments hit economies worldwide (eg, inflation in Europe was at almost 10% in July 2022 compared to 2.5% in the previous year).

These megatrends also change today’s risk landscape by reinforcing existing risks and creating new ones, increasing the vulnerability of both individuals and organisations. Among the newly emerging risk areas are cyber risk, supply-chain disruptions and environmental liabilities.

The risk landscape impacts:

- individuals (such as pensions, health, mobility and homes, as well as disability, morbidity and death);
- businesses (such as business continuity); or,
- both individuals and businesses (namely personal and business liability, property, financial markets, natural catastrophes (natcat) and war and terrorism).

The risks vary in terms of economic relevance, speed of growth, direct impact on human lives (whether they cause major hardship or death) and insurability (whether private insurers or public systems can at least partially cover them).

Of these risks, **pensions, cyber, health** and **natcat** stand out due to their growing economic importance, impact on human lives and insurability. Exploring the current protection landscape and analysing the protection gaps related to these risks is particularly relevant due to their substantial economic and human impact.

While the insurance industry can contribute to reducing these protection gaps when the underlying risks are insurable, a single stakeholder group alone cannot narrow the gaps. Close collaboration between private and public stakeholders is necessary, as governments and other public entities can help build the appropriate regulatory environment, create fiscal incentives or conduct public awareness and prevention campaigns, among other actions.

Below we describe these four protection gaps in more detail and summarise the possible levers that private and public stakeholders can use to reduce them. We end this Executive summary with GFIA’s own recommendations to policymakers for reducing the protection gaps in cyber, pensions and natcat.

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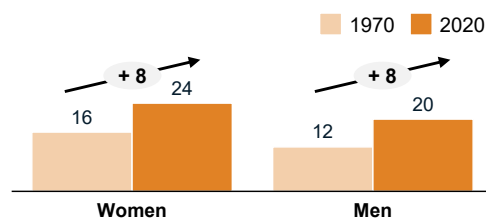
<sup>2</sup> 10<sup>21</sup> bytes or a trillion gigabytes

# Four major protection gaps

Accelerated by current trends

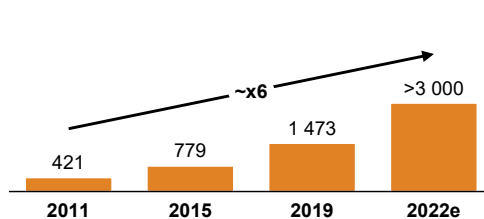
## Pension

Expected life years after labour market exit (OECD countries)



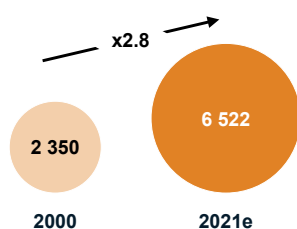
## Cyber

Number of breaches with >50 000 files lost



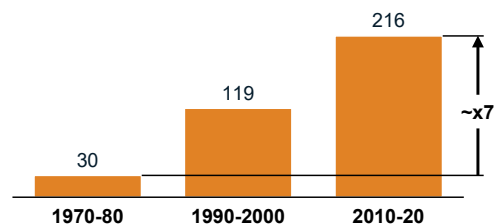
## Health

Health spending<sup>1</sup> in OECD countries (US\$ per capita)

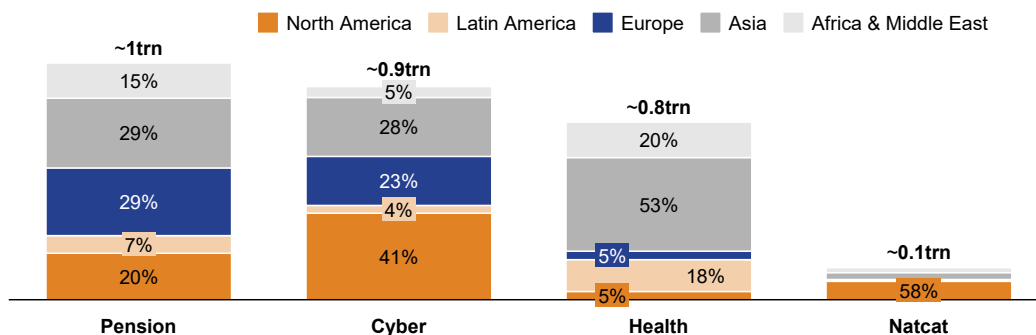


## Natcat

Average annual natcat losses per decade<sup>2</sup> (US\$bn)



## Annual protection gaps (US\$trn) and geographic split



Cumulative gap of US\$51trn after deducting pay-as-you-go, converted into an annuity of US\$1trn p.a. with a 1% interest rate over 40 years

First-order cyber losses (US\$0.95trn) minus paid cyber claims (US\$0.06trn)

Stressful out-of-pocket spending<sup>3</sup> only. Gap could reach up to US\$4.0trn if spending avoided due to financial constraints is included

~60% of natcat losses not insured between 2011 and 2020

e = estimate

- Including personal healthcare (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services and health administration), excluding investments
- Events caused by natural forces triggering insurance policies, eg, floods, storms, earthquakes, droughts, forest fires, frost, hail and tsunamis
- Spending by individuals that puts pressure on their finances

## Health protection gap — particularly prevalent in developing economies

The topic of health protection was on the minds of individuals, organisations and governments long before the COVID-19 pandemic began. Private and public entities invest large amounts of money in advancing medical capabilities (including the automation of medical examinations) each year and substantial progress is being made, including new treatments and medical technology. However, in times of demographic shifts — including an ageing population, increasing morbidity and rising healthcare needs in emerging markets — this topic is gaining importance and is a priority for entire regions, with some societies benefitting more than others from medical advances and enhanced access to healthcare.

The health protection gap can be estimated by looking at stressful out-of-pocket (OOP)<sup>3</sup> health expenditure and estimated avoided costs. It is valued at US\$0.8trn to US\$4trn annually. The lower end of this range only includes stressful OOP health expenditure, which represents a narrower definition of the gap and is particularly relevant in emerging markets. The higher end of the range also includes estimated avoided costs, which represent the largest share of the health protection gap at up to US\$3.4trn (although these costs are difficult to quantify as they are not officially reported). Looking at the geographical distribution of the gap in more detail, we find significant differences: upper-middle-income countries constitute approximately 73% of the gap (US\$2.9trn), while low- and lower-middle-income countries constitute approximately 14% or US\$0.6trn. The rest of the gap is split between the USA, at approximately 7% (US\$0.3trn), and the EU, the UK, Canada and Australia (6%, US\$0.2trn). The growth in the gap shows no sign of slowing, as the decrease in the share of OOP spending in most emerging markets does not seem to be fast enough to address the issue, especially because the populations and the middle classes in those countries continue to grow. A combination of public health infrastructure/security and private health offers (eg, private health insurance) is needed to narrow the protection gap.

There are various potential levers for private and public stakeholders to use to address the protection gap. These include: new distribution channels; awareness campaigns to foster preventive treatments; the promotion of complementary private insurance; and the establishment of add-on healthcare services (eg, prevention services as part of a health ecosystem).

- Using a full set of distribution channels can help deliver coverage to previously underserved groups. In Thailand, for example, multiple insurers started to distribute microinsurance policies through 7-Eleven convenience stores, with four million microinsurance policies being sold through this new distribution channel in 2017.
- Raising awareness, fostering prevention and promoting early detection (eg, via technology and automation) can help avoid or manage illness and severe medical conditions. In Germany, a financial incentive scheme to promote dental prophylaxis helped decrease dental replacements' share of dental treatment costs from 36% in 1997 to 22% in 2020.
- Complementing public health insurance and social security with private insurance can help narrow the protection gap by covering treatment costs otherwise unaddressed by public health systems. Finding the right balance between private and public systems is a key challenge for governments worldwide. In France, 95% of the population has complementary private insurance. As the French public healthcare system covers 70% of the most common treatment costs, complementary insurance reimburses defined percentages of the remaining costs.
- Lastly, offering integrated, add-on healthcare services has the potential to make health management a more central and accessible part of peoples' everyday lives. For example, an African insurer established a service whose users have 25% shorter hospital stays and 14% lower overall claims costs than non-users.

The suitability of these levers for addressing the health protection gap need to be assessed individually for each country, as countries have different starting points (eg, the level of advancement in medical technology).

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<sup>3</sup> Spending by individuals that puts pressure on their finances

# VII. Health protection gap

## Particularly prevalent in developing economies

*For a summary of this chapter, see the Executive Summary, “Health protection gap”, p14.*

The health protection gap was on the minds of governments long before the COVID-19 pandemic began. Policy changes targeting increased health protection in both developed and developing countries, technological advances (including the automation of medical examinations) and an ageing population with increasing healthcare needs are only some of the changes in this area. As the defining global health crisis of our time<sup>360</sup>, COVID-19 made all stakeholders look closely at the health coverage currently provided to individuals and assess whether it is sufficient.

There are substantial differences between countries’ health systems (eg, their level of technological progress) and these need to be taken into account when analysing the health protection gap. The gap consists of two parts. First, it includes the health spending by individuals (eg, when they have insufficient insurance coverage). Second, it includes avoided health costs — the amount that should have been spent by individuals to meet their health needs but was not spent. Building on this definition, we estimate the health gap based on two components:

- Firstly, we start by looking at total out-of-pocket (OOP) expenditure, including the “ordinary” part of health spending — for example, expenditure such as insurance co-payments (in developed countries) and contributions to the cost of dental care and non-urgent medication — as well as “stressful” OOP expenditure that puts pressure on personal or family finances (for example, non-insured treatment of cancer or other critical illnesses).

As total OOP expenditure includes choices made by individuals (in other words, preferring OOP expenditure on health services instead of insurance coverage) it is an imperfect estimate of the real health protection gap, despite often being used as a proxy. We therefore apply a narrower definition and only include expenses that put a large financial strain on individuals paying for health services themselves, ie, we focus on “stressful” OOP health expenditure. This is the part of OOP that leads to cutting down on habitual spending or borrowing money from relatives and financial institutions to cover medical costs. Nevertheless, stressful OOP alone is also still an imperfect estimation of the true need for coverage; several surveys identified that a large proportion of the population of both developing and — in some cases — developed markets avoid necessary health spending.

- Secondly, therefore, we consider the costs that were avoided due to a lack of affordability or a lack of access to healthcare. This can be considered the upper range of estimation of the health protection gap and we will use it as the gap definition. Besides the stressful part of OOP explained above, the avoided healthcare spending can be estimated as a sum of:
  - Avoidable costs that are due to affordability issues.
  - Avoided costs that are due to a lack of access to healthcare infrastructure. These costs mainly arise from low-income countries, with the World Health Organization estimating that 400 million people do not have access to basic health services.

**There are big differences in countries’ health systems, affecting size of health gaps**

**400 million people do not have access to basic health services**

<sup>360</sup> “COVID-19 Pandemic. Humanity needs leadership and solidarity to defeat COVID-19”, United Nations Development Programme, 26 March 2020

## Health protection gap estimated at US\$0.8trn, higher when avoided costs are included

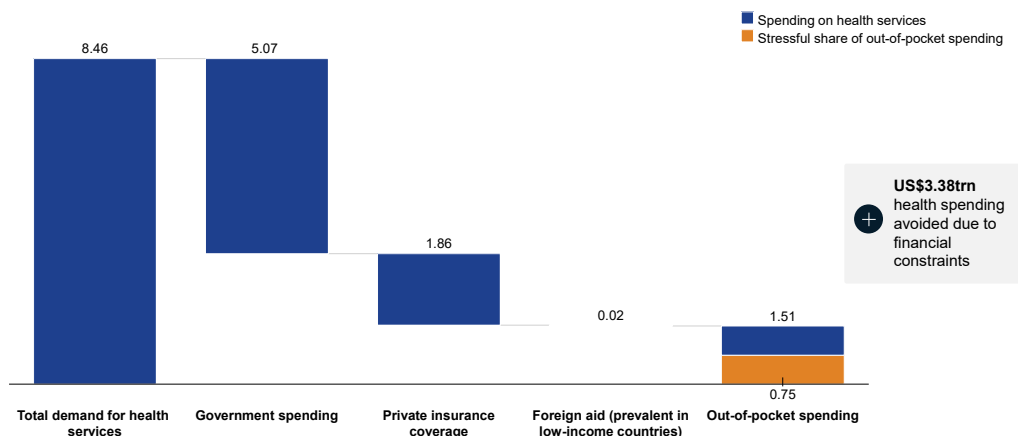
The 2020 health protection gap is estimated at between US\$0.8trn and US\$4.2trn (Figure 29), which is equivalent to 1% to 5% of global GDP. As discussed above, it comprises two parts:

- The 2020 level of stressful OOP expenses worldwide amounted to approximately US\$0.75trn (as estimated by Swiss Re in 2021 based on a multi-country survey). To put this into perspective, total OOP expenditure was US\$1.5trn (ie, including “ordinary” and “stressful” OOP expenditure)<sup>361</sup>.
- Avoided costs were approximately US\$3.4trn in 2020<sup>362</sup>. Around US\$3.2trn stems from emerging markets and roughly US\$0.2trn from the rest of the world. Estimates for emerging markets are based on a survey done by Swiss Re of emerging countries in Asia. These figures were then extrapolated<sup>363</sup> to all low- to medium-income countries globally. The affordability gap in developed (high-income) countries is based on an extrapolation of approximately 56 million people in the USA who claimed they cannot afford the treatment they need<sup>364</sup>.

56 million people in US claim they cannot afford treatment

**Figure 29: Stressful out-of-pocket healthcare spending<sup>1</sup> of US\$0.75trn — including avoided health spending — takes total gap even higher**

Demand for health services — 2020 (\$trn)



1. Spending by individuals that puts pressure on their finances

Sources: WHO; Swiss Re; Geneva Association

## Health protection gap is unevenly spread across the world

The World Health Organization distinguishes four groups of countries when it comes to health expenditure. The first is the USA, which forms its own group because it accounts for 46% of global health spending. The second group consists of other high-income countries, such as those in western Europe, New Zealand, Australia, Japan and Singapore, accounting for 38% of the world's health spending. The third group includes upper-middle-income countries, such as China, Brazil and Mexico, with 14% of global health expenditure.

361 Global Health Expenditures Database, World Health Organization

362 2019 used as a proxy for 2020

363 Based on OOP growth rates and Geneva Association 2018 global gap assessment

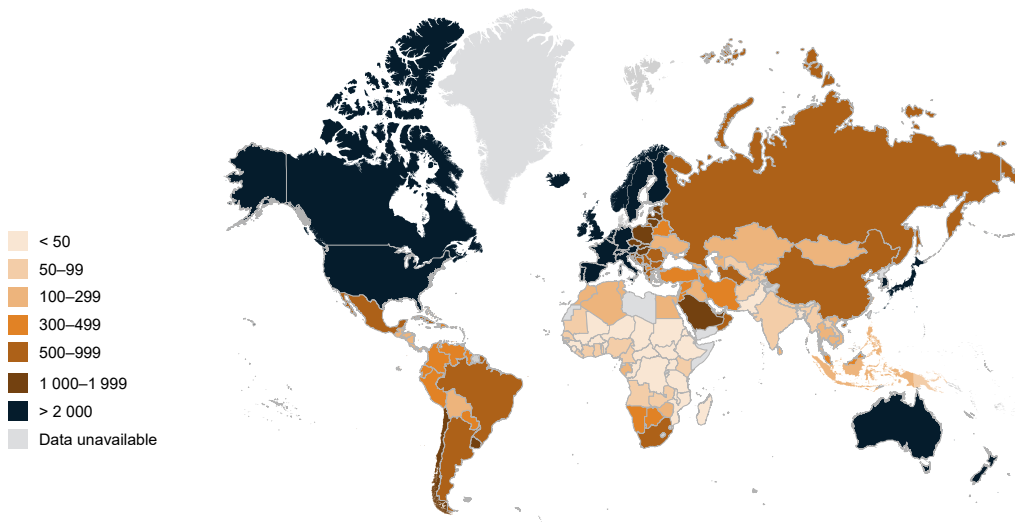
364 Calculation based on the number of people in the USA who avoided some or all healthcare spending in the past year due to affordability and average per capita spending of US\$11 000 for 2020 (NIH)

Finally, the fourth group is low- and lower-middle-income countries, such as India, the Philippines and Vietnam, which account for just 2% of health spending. The distribution of health spending per capita by country is shown in Figure 30. Note that these figures do not consider the effectiveness of the healthcare spending in each country (ie, how the health spending actually contributes to a society's overall level of health).

**Low- and lower-middle-income countries account for just 2% of health spending**

**Figure 30: Uneven geographic spread of health spending**

Health spending per capita — 2019 (US\$)



Source: WHO

Looking at the geographical distribution of the gap, we find significant differences: upper-middle-income countries account for approximately 73% of the gap, or around US\$2.9trn, while low- and lower-middle income countries account for 14%, or US\$0.6trn. The rest of the gap is split between the USA, with approximately 7% (US\$0.3trn), and the other high-income countries (6%, US\$0.2trn)<sup>365</sup>.

These differences can be partially explained by differing dynamics in government and private insurance spending. While overall spending increased by 3.7% per annum over the past 10 years, or by approximately US\$0.24trn per year, high-income countries accounted for approximately US\$0.19trn (80%) of that, with the USA alone accounting for around US\$0.11trn (45%) of the absolute increase.

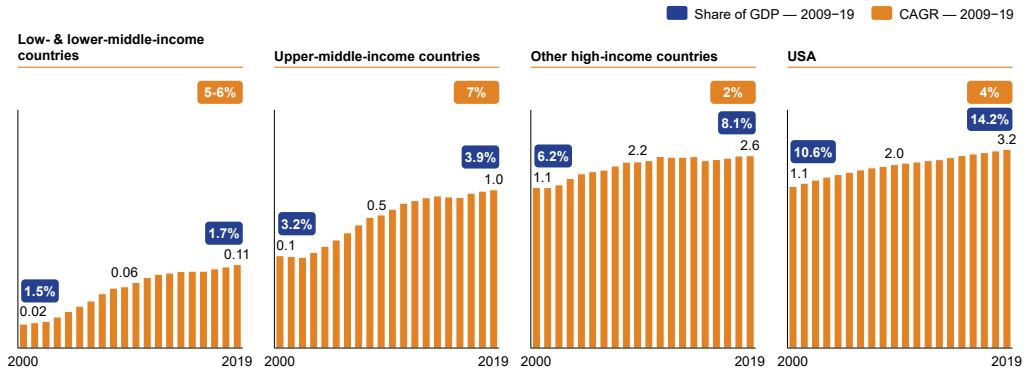
Similarly, government and private insurance spending represents between 2% and 4% of GDP in low- and upper-middle-income countries versus 8% in developed countries and 15% in the USA. These figures have increased over the past few years in all country groupings (Figure 31).

The importance of OOP expenses measured as a share of total spending differs between the groups of countries (Figure 32). The more developed the country, the lower the share of OOP expenses. In low-income countries, they account for around 50% of total spending and in upper-middle-income countries they account for 32%. Although both groups show a decrease in the share of OOP expenditure by around 10 p.p. over the last 20 years, the share remains significant.

<sup>365</sup> Percentages calculated with data from the World Health Organization, the World Bank, Swiss Re and the Institute for Health Metrics and Evaluation

**Figure 31: Government & private insurance spending growing in absolute terms & as share of GDP**

Total health spending by government & private insurance by countries grouped by income level — 2000-19 (US\$trn)



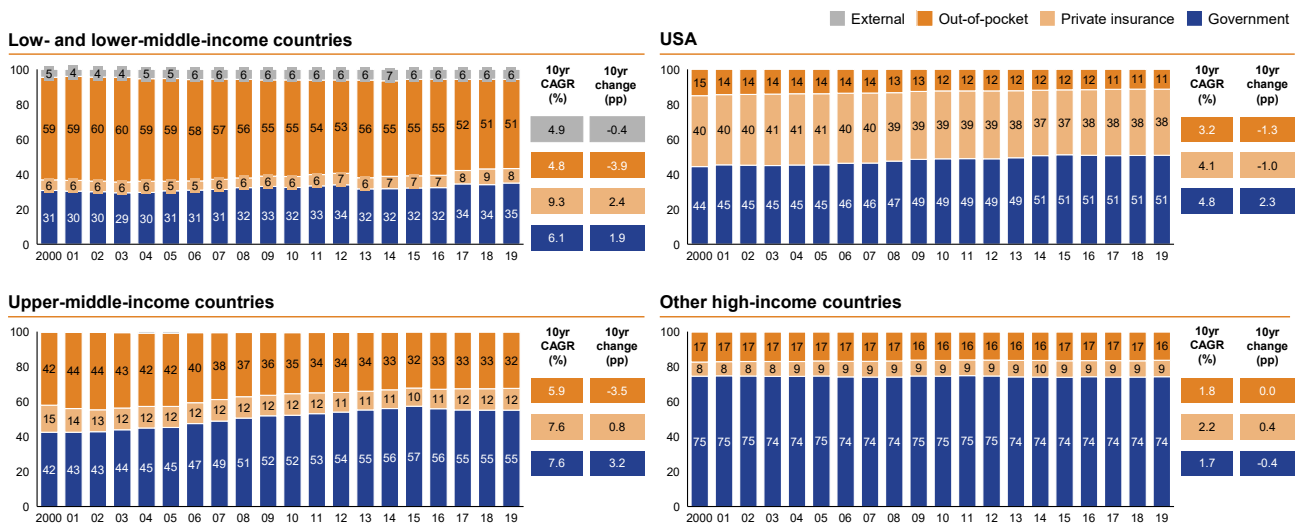
Source: WHO

In contrast, in high-income countries (not including the USA), OOP expenses represent only 16% of total spending and have remained relatively stable since 2000. The USA has the lowest share of OOP expenses of groups at 11%, down 4 p.p. over the last 20 years. OOP expenditure in real terms has grown quickly in low-, lower-middle- and upper-middle-income countries by 5-6% per annum, which is higher than the 2-3% a year in the USA and other high-income countries.

In low-, lower-middle- and upper-middle-income countries, the relatively large OOP share of total healthcare spending is driven by a lower penetration of private insurance and lower public spending. Penetration of private health insurance in these countries, measured as premium as a percentage of GDP, was approximately 0.12%<sup>366</sup> in 2020, and, despite showing a positive trend since 2015, it still remains insignificant, especially when compared to the 1.76% in developed markets<sup>367</sup>.

**Figure 32: Share of out-of-pocket healthcare spending is largest in low-income countries (50%), followed by upper-middle-income countries (32%)**

Split of health spending by countries grouped by income level — 2000-19 (%)



Source: WHO

366 McKinsey Global Insurance Pools; IMF  
367 Ibid



**18% of household income in emerging Asian economies spent on healthcare**

Globally, stressful OOP expenditure grew 5% a year<sup>368</sup> from 2009 to 2019, mainly driven by emerging markets in Asia, which had annual growth of 10% compared with 2-4% in the rest of the world. Emerging Asian markets are also significant in terms of the size of the gap (45-47% of the global gap<sup>369</sup>). Swiss Re explains the stressful OOP gap in emerging Asian economies by the lack of government healthcare coverage. OOP spending on healthcare in those countries accounts for nearly 18% of household income, and the health gap is estimated to be 12% percent of average household income<sup>370</sup>. Healthcare is also quoted as one of the primary reasons for financial stress, with 400 million people unable to afford it. Across emerging Asian markets, Thailand has the lowest gap (approximately 2% of average household income) as a result of the roll-out of a universal healthcare system. The highest gaps are in Malaysia (46% of average household income) and Indonesia (25%). China also stands out due to its high level of OOP expenditure.

### Gap could grow at 4-5% p.a. to reach US\$6-6.5trn by 2030

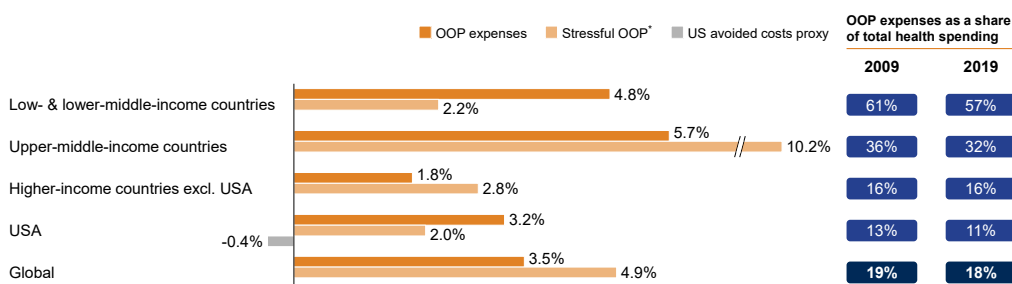
To look at the dynamics in the development of the protection gap, we estimated its past growth rate by examining two sources:

- Trends in total (stressful and non-stressful) OOP spending by country as reported by the World Health Organization. This indicator is measured consistently, and we use it to understand the historical dynamics.
- The Swiss Re Resilience Index, which has been estimated and continuously reported since 2009. It provides an estimate of the stressful part of OOP expenses. Given that stressful OOP spending typically indicates the need for additional funding, we also apply the trend to the avoided costs.

Overall, it can hence be estimated that from 2009 to 2019 the gap increased at approximately 4-5% per annum (Figure 33).

**Figure 33: Growth of out-of-pocket (OOP) & stressful OOP expenses varies between countries**

OOP and stressful OOP growth rates — 2009-19 (%)



Source: WHO, Swiss Re\*

368 Livia Bonato et al., "Resilience index 2021: A cyclical growth recovery, but less resilient world economy", Swiss Re Institute, June 2021

369 "Healthcare in emerging markets: Exploring the protection gaps", The Geneva Association, 2019

370 Rajeev Sharan and Clarence Wong, "The health protection gap in Asia: A modelled exposure of \$1.8 trillion", Swiss Re Institute, 5 October 2018

Health protection has evolved differently among country groups. Upper-middle-income countries showed the fastest growth at 6% for OOP expenses and 10% for stressful OOP expenses. They were followed by low- and lower-middle-income countries, with 5% growth in OOP expenditure and 2% for the stressful segment. Developed countries, including the USA, showed the slowest growth in the gap at 2-3% of total and stressful OOP expenditure. The largest contributors to growth were the upper-middle-income countries, accounting for approximately 60% of the absolute increase.

Given the historical trend of the gap, we estimate that it will continue to develop at 4-5% a year, with a major share originating in emerging markets. At this pace, the gap is expected to reach US\$6-6.5trn a year by 2030 if applied to both OOP spending and avoided health costs (ie, if applied to the maximum of the estimated gap range).

### Public and private stakeholders can make use of a variety of levers












To address the health protection gap, we have identified a toolbox of levers (Figure 34) for private or public stakeholders. It is worth noting that the portfolios of levers chosen by different countries are expected to be highly specific, depending on the position of the insurance industry, past initiatives and policy choices. This toolbox of potential levers should not be thought of as a list of recommendations but as a “menu” of possible actions.

**Figure 34: Health protection gap — toolbox of potential levers**



We have looked at several case studies (Figure 35) that illustrate how some of these levers have been put into practice in some parts of the world by private or public stakeholders.

Figure 35: Overview of case studies

|         | Levers   | Case studies  | Outcomes   |
|---------|--|---|--|
| Private | Establish add-on services to help customers take better care of their health |  Comprehensive health ecosystem  | <p><b>~30%</b> of Chinese population are registered users</p> <p><b>&gt;10</b> Asian countries where service is available</p> <p><b>14%</b> reduction in overall cost of claims by users</p> <p><b>15 hrs</b> Waiting time for appointments, down from 11 days</p> |
|         |  |  Set of health add-on services that can quickly be scaled up across Asian countries                        |  |
|         |  |  Offer of connected health services that specifically rewards users for healthy lifestyles                 |  |
|         |  |  Digital application for patients to manage chronic kidney disease & schedule treatments                   |  |
| Private | Use a full set of distribution channels to increase coverage                 |  Microinsurance policy sales through convenience stores  | <p><b>4m</b> convenience store sales of microinsurance in 2017</p> <p><b>&gt;10 000</b> pharmacies integrated in distribution</p>  |
|         |  |  Pharmacies integrated into health insurance to improve customer experience & expand distribution channels |  |
|         |  |   |  |
| Public  | Raise awareness as well as foster prevention & early detection               |  National board to promote health awareness  | <p><b>80%</b> of citizens attending regular screening for high cholesterol</p> <p><b>14pp</b> reduction in share of dental replacement costs in total dental costs</p> <p>Impact n/a</p>   |
|         |  |  Incentivisation of patients to attend regular preventive screenings                                       |  |
|         |  |  Programme for chronic type 2 diabetes patients to manage their symptoms                                   |  |
| Public  | Complement public health insurance/social security with private insurance    |  Mandatory complementary private insurance   | <p><b>95%</b> of French citizens hold some sort of private health insurance</p> <p><b>42%</b> of Danish citizens hold some sort of private health insurance</p>  |
|         |  |  Incentivisation to take out private complementary insurance   |  |

## Case studies

### Establish add-on services to help customers take better care of their health

This can be done by integrating multiple medical services into one patient experience. Among the commonly integrated services are:

- Services that support and financially incentivise prevention and early detection
- Services for in-person or digital consultation with doctors
- Tele-prescription and tele-pharmacy services

If these add-on services are integrated in one seamless experience for the patient, they are commonly referred to as health ecosystems<sup>371</sup>. These integrated add-on services go beyond simply digitising medical services by facilitating smooth, end-to-end health management, often through one digital app and by leveraging large amounts of data. As a result, they aim to become an established part of users' everyday life and to increase users' engagement with health management topics.

By enabling customers to take better care of their own health, integrated add-on services may also contribute to the positive impact of the other healthcare-related levers in this report. In particular, the levers relating to distribution, prevention, access to healthcare and spending

<sup>371</sup> Julian Kawohl, Niklas Knust, Ulrich Pidun et al., "The untapped potential of ecosystems in health care", Boston Consulting Group, 2021

effectiveness may be reinforced. While multiple insurance products offer add-on services, it is important to note that currently only a few health ecosystems exist in the market. Nevertheless, a few examples of add-on services that are progressing in the direction of health ecosystems are detailed below.

- A large Chinese financial services corporation managed to build what can be considered the closest approximation of a health ecosystem to date. Its services offer a particularly wide integration of both digital and physical health services for its customers. As of December 2021, its offering included 49 100 doctors, 96 000 healthcare providers, 3 600 hospitals (including 50% of Chinese grade A tertiary hospitals<sup>372</sup>), 202 000 pharmacies (34% of all pharmacies in China), and 225 warehouses for drug delivery<sup>373</sup>.

**420 million  
Chinese use  
same healthcare  
app, facilitating  
1.27 billion  
consultations**

All of these healthcare services are integrated into one app where customers may start with a teleconsultation with one of the doctors, then be transferred to attend a physical consultation in one of the affiliated hospitals and, lastly, receive medication delivered from one of the warehouses — all in one seamless process. By offering this service, the provider managed to recruit around 30% of the Chinese population (420 million people) as registered users by the end of 2021. Of these, around 20% (84 million) were using the service on a regular basis<sup>374</sup>. In 2021, the service facilitated 1.27 billion healthcare consultations<sup>375</sup>.

While it is difficult to compare this engagement rate due to the lack of similar services in the region, 20% can be regarded as significant. Achieving a significant engagement rate is key for ecosystems to realise their potential to narrow health protection gaps. Only active users will be encouraged to make their health a more central concern in their lives and participate more in preventive measures. A recent survey among C-level health insurance executives suggests that convenience is the major factor influencing users to stay engaged with a health ecosystem<sup>376</sup>.

In the Chinese example, the comprehensiveness of the services offered can be considered the major driver of convenience for users and represents an aspirational goal for other players. However, this approach may not be realisable in other cases as multiple banking and insurance ecosystems with over 100 million users each already existed in the corporation's portfolio prior to the health ecosystem's establishment<sup>377</sup>. This access to a wide customer base and existing tech infrastructure represented an advantage in establishing the ecosystem. In addition, strict data privacy laws may pose challenges to establishing an equally connected patient offering, especially in certain European countries.

- An international insurance company launched an offering of connected add-on health services in south-east Asia. This service is focused on fewer health offerings — mainly teleconsultations, an AI-based chatbot to check symptoms and other innovative features such as an image-based body mass index calculator<sup>378</sup>. The service is now available in more than 10 Asian locations<sup>379</sup>.

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372 The highest classification of Chinese hospital in terms of size and services

373 "Announcement of unaudited interim results for the six months ended 30 June 2022", Ping An, 2022

374 Ibid

375 Ibid

376 Stefan Biesdorf, Ulrike Deetjen and Basel Kayyali, "Digital health ecosystems: Voices of key healthcare leaders", McKinsey, 12 October 2021

377 "Ping An reports steady YoY growth of 4.3% in operating profit attributable to shareholders of the parent company in 1H2022", Ping An, 2022

378 We Do Pulse – Health and Fitness app, Pulse Ecosystems

379 Ibid

While everyone can use the app's services, customers of the insurer that operates it receive special benefits and features. Today, 90% of the health insurer's policies can be acquired through the app, significantly improving the access to its products for rural populations with limited access to physical points of sale. 1.8 million policies were sold through the app in the first year alone and 70% of its users are new to the insurance company, showing the demand for and wide adoption of such offerings<sup>380</sup>.

- An African health insurance company established a membership system that rewards its members for making healthier lifestyle choices. Users can track and record behaviour such as physical activity, buying healthy food and completing health check-ups and screenings. In return, they receive tangible financial benefits such as cash back on shopping for healthy groceries, buying fitness trackers or signing up for a gym membership<sup>381</sup>. While the programme aims to improve the health of its members, the insurance company benefits too, as the medical costs of its customers decrease. Compared to non-users, users of the app have 10% fewer hospital admissions, 25% shorter hospital stays, and 14% lower overall claims costs<sup>382</sup>. These numbers may also be subject to (at least some) selection effects as younger, healthier customers are more likely to use the app than older ones. Nevertheless, these results still provide an indication of the impact ecosystems can have on decreasing the need for healthcare and hence on reducing the global health protection gap.
- In Canada, the COVID-19 pandemic accelerated the development and adoption of add-on services, especially for teleconsultations, as analyses from the province of Ontario illustrate. Ontario is Canada's largest province, with 38% of the Canadian population<sup>383</sup>. In Ontario, the share of doctor consultations performed online increased from 4% to 60% during the pandemic<sup>384</sup>. Of the patients that had digital consultations, 91% were satisfied with their service. While this level of online consultations was due to the pandemic, 38% of Ontarians surveyed said that they would still use virtual services as their first point of contact with doctors after the pandemic<sup>385</sup>.

This growing adoption of teleconsultation services could contribute to narrowing the health protection gap by decreasing the number of avoided treatments. A survey showed that 7% of Ontarians have no dedicated family doctor and 60% struggle to find available appointments within two days of wishing to consult a doctor<sup>386</sup>. As a result, almost 70% postpone treatments<sup>387</sup>, have not bothered to see a doctor at all<sup>388</sup> or visit emergency rooms with minor conditions that could be treated by a general practitioner<sup>389</sup>.

An initiative by the Toronto General Hospital (TGH) provides an example of how add-on services can be used to decrease waiting times and improve access to medical attention. In 2018, the TGH launched the eKidneyCare app for patients with chronic kidney disease, encompassing digital services such as tracking blood pressure and symptoms, management of medication and direct communications with kidney specialists. In addition, the service includes a feature enabling patients to be referred to primary-care providers and

**African health insurer scheme leads to fewer hospital admissions**

380 "Pulse by Prudential. HSBC investor call", Prudential, 2020

381 "Need a reason to join the world of Discovery today?", Discovery, 2022

382 Dr. Jonathan Broomberg, "Fighting healthcare costs through shared-value", Discovery, 2017

383 "2021 census", Statistics Canada, 2021

384 "Canadians' health care experiences during COVID-19", Canada Health Infoway, 2022

385 "What do Canadians think about virtual healthcare?", Abacus Data, 2020

386 "Primary care performance in Ontario", Health Quality Ontario, 2020

387 Sean Simpson, "Seven in ten Canadians (68%) have skipped seeing a doctor due to long wait times, timeliness or other barriers", Ipsos, 2017

388 Ibid

389 "Virtual healthcare in Canada: The solution at our fingertips", Telus Health, 2019

nephrologists who can then prioritise patients and access their healthcare data virtually. For patients who were referred using the app, median waiting times for specialist appointments decreased from 111 days to 15 hours<sup>390</sup>.

Ensuring that the population has access to high bandwidth internet and is digitally literate is important for optimising the positive impact of digital add-on services. In Ontario, 12% of the population did not have access to internet with a bandwidth above 50 mbit/s in 2020<sup>391, 392</sup>. In the same year, 55% of the Canadian population above 18 years old were not sure where to find digital healthcare services<sup>393</sup>.

Establishing health add-on services could contribute to closing the global health insurance protection gap. At the same time, some overarching drawbacks and limitations should be mentioned. While the Chinese financial services corporation took the role of “ecosystem orchestrator” in the first example, in some markets these may be lacking<sup>394</sup>. Among multiple other factors, including legacy data-security regulations or slow digital adoption by some customer groups, this lack of orchestrators could be the main challenge to the development of add-on services and ecosystems in the future. Orchestrators need to have the abilities and incentives to drive ecosystem development and ensure it reaches a necessary scale quickly. Furthermore, while digital healthcare services are particularly relevant to younger audiences, they may only have a limited potential to improve the health of the elderly, which is the demographic that accounts for most medical expenses today<sup>395</sup>.

**Digital healthcare may only come into its own with younger users**

Therefore, while new technologies may already have a positive impact, their full potential may only be realised when today’s young digital natives grow older and become the healthcare seekers of tomorrow. As an additional consideration, the instant and comprehensive availability of healthcare services may not prompt all customers to contribute to the increased efficiency of their national healthcare systems. If the next telemedicine offering is just one click away, some customers may use these services at a frequency that does not optimise overall efficiency.

To conclude, with increasing comprehensiveness, integration and convenience for its users, the potential of an add-on service or ecosystem to narrow the health protection gap is increasing. Such services have the potential to make personal health a growing focus for customers and hence contribute to improving health-related prevention. In addition, through digital health ecosystems, people with otherwise limited access to physical healthcare could receive better care.

**Use a full set of distribution channels to increase coverage**

In developing countries in particular, access to healthcare, including health insurance and medical treatment facilities, can vary. The largest differences are usually between rural and urban populations. In 2015, 56% of the world’s rural population was without access to health insurance, while only 22% of those in urban regions were not covered<sup>396</sup>. By creating new distribution channels that aim to reduce barriers to health insurance access, private insurance companies could contribute to narrowing the global health protection gap.

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390 Catrina Kronfli, “Realizing the full potential of virtual care in Ontario”, Ontario Chamber of Commerce, 2020

391 “Up to speed: Ontario’s broadband and cellular action plan”, Government of Ontario, 2022

392 S. Gandhi, “From science fiction to science fact: How virtual care can improve health care in rural and northern communities”, Municipal World, 2020

393 “Over half of all Canadians do not know how to find virtual care”, SunLife, 2020

394 Expert interview

395 “Focus on health spending”, OECD, 2016

396 Xenia Scheil-Adlung, “Global evidence on inequities in rural health protection: New data on rural deficits in health coverage for 174 countries”, International Labour Organization, 2015

- In an example from Thailand, many of the country's largest insurance companies started to sell microinsurance through the convenience store chain 7-Eleven when the company received the country's first licence to sell microinsurance in 2013<sup>397</sup>. To acquire health insurance coverage, customers simply need to submit their ID card data and their mobile phone number, and they then receive all additional documents and information via text messages.

The convenience store offers a range of health insurance. For example, one insurer offers a combined life- and hospital-cost insurance at an annual premium of THB500 (US\$14)<sup>398</sup>. Another insurance company offers a selection of health insurance products starting with a US\$4 annual premium (covering up to US\$550) and going up to a US\$16 annual premium (covering up to US\$2 990)<sup>399</sup>. The insurance products are distributed through the 12 400 branches of 7-Eleven Thailand.

As roughly 15% of the Thai population shops at 7-Eleven on a daily basis, (11 million customers per day) and 56% of its outlets are in provincial areas, expanding this new distribution channel improved the access of Thailand's rural population to private microinsurance<sup>400</sup>. In 2017, four years after its launch, the assistant secretary general of the Thai regulatory body for insurance called the microinsurance sale through 7-Eleven a success, with almost four million policies in force — a 10% increase on the previous year. Sales through 7-Eleven were the major channel contributing to this number<sup>401</sup>.

**4 million  
microinsurance  
policies sold  
through Thai  
convenience stores**

While creating additional distribution channels beyond established insurance represents an opportunity to extend coverage to new customers, the quality of the health insurance protection provided is an additional factor to be considered. There are some new distribution channels through which it could be challenging to provide customers with advice on different policy options. If a customer feels that there is a lack of transparency about the health insurance policies available, this could decrease the likelihood that they take out a policy.

- In the USA, multiple private health insurance providers have integrated pharmacies into their distribution networks in a similar way to that in the 7-Eleven case in Thailand. In one US example, a player integrated 10 000 physical pharmacies into its insurance offering<sup>402</sup>. The aim is both to offer a more integrated healthcare experience and to expand distribution to additional physical channels.

This can contribute to narrowing the health protection gaps that exist in the USA. In 2020, 8.6% of US citizens were uninsured, while 34.8% were exclusively covered by public insurance, making them vulnerable to gaps in their personal health insurance protection<sup>403</sup>.

Pharmacies appear to be a suitable channel to expand to, as they take on a more central role in the American healthcare system than in many other countries<sup>404</sup>. In line with that, three of

397 "First time in Thailand with the micro insurance service in 7-Eleven", Ministry of Finance, Government of Thailand, 2013

398 "Personal accident insurance plan for retail 'Micro500' (micro insurance)", AIA

399 "Providing certainty where it matters most: Blue Marble microinsurance", AIG

400 "Convenience store services", CPAll, 2002

401 "7-Eleven to offer travel coverage", Bangkok Post, 10 January 2018

402 "How Aetna and CVS Health are delivering a new model of integrated care", Aetna

403 Lisa N. Bunch and Katherine Keisler-Starkey, "Health insurance coverage in the USA: 2020", USA Census Bureau, 2021

404 Ashley Chiara, "The expanding role of pharmacists: A positive shift for health care", Commonwealth Medicine, 26 March 2019

**70% of vulnerable  
Hispanic groups  
unaware of US  
healthcare reforms**

the five largest US pharmacies (by number of pharmacists employed)<sup>405</sup> — Walgreens, CVS and Rite Aid — serve 4.3% of the population (14 million people) every day<sup>406, 407, 408</sup>.

Due to the high number of customers served, pharmacies could also contribute to further improving the low awareness of health insurance offerings. For example, five years after the initial launch of the Affordable Care Act — one of the most comprehensive healthcare reforms in recent US history — 70% of the vulnerable groups of the Hispanic population were unaware of their improved options for subscribing to healthcare programmes<sup>409</sup>. While measures such as the “Summer Sprint to Coverage”<sup>410</sup> campaign or tax penalty letters<sup>411</sup> have already worked towards improving the awareness of health insurance, distributing private health insurance through physical stores could further contribute to this development.

Other US players broaden distribution channels through different initiatives. For example, one established private insurance company and an insurtech launched a new group health product. The insurance plan is exclusively available to SMEs with one to 50 employees and is distributed through a B2B2C distribution model. The SMEs themselves sign up for the insurance and they can then offer up to three different health insurance plans to their employees. In addition, the employer must cover at least 50% of the employee’s insurance premium<sup>412</sup>. In 2021, the offering was taken up by 16 506 companies across the USA<sup>413</sup>.

Furthermore, multiple US private health insurance players have established fully digital options for customers to acquire their products<sup>414, 415</sup>. However, the effectiveness of linking health insurance offerings and pharmacies could be challenged. The overlap between the people that visit pharmacies and those that have comprehensive health insurance coverage may be substantial, limiting this distribution channel’s potential to narrow health insurance gaps. Extending distribution to convenience stores or shopping malls, for example, may further increase the opportunity created by this lever.

To conclude, expanding the distribution of health insurance products to additional channels may yield potential to extend coverage to people who were previously uninsured. Ensuring that these new channels do in fact create access to new target groups and that they carry products that are relevant to these groups (such as microinsurance products in emerging markets) further enhances the potential offered. In addition, continuing to provide customers with advice on insurance choices can ensure that the quality of insurance coverage does not decrease as distribution increases.

**Raise awareness as well as foster prevention and early detection**

Such actions can improve people’s general health, reduce the need for medical treatment and ultimately contribute to narrowing the health protection gap. The WHO estimates that insufficient

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405 “US national pharmacy market summary 2021”, IQVIA, 2021

406 “Our company at a glance”, CVS Health, 2022

407 “Facts & FAQs”, Walgreens, 2020

408 Jihyun Byun, Suad Ghaddar, Janani Krishnaswami, “Health insurance literacy and awareness of the Affordable Care Act in a vulnerable Hispanic population”, 31 August 2018

409 Ibid

410 “Biden-Harris administration launches ‘Summer Sprint to Coverage’ campaign for final 30 days of special enrollment period”, Centers for Medicare and Medicaid Services news release, 25 July 2021

411 “Letters about tax penalties can increase health insurance coverage”, Office of Evaluation Services, 2018

412 “Cigna + oscar broker sales kit”, Cigna + oscar, 2022

413 “Annual report 2021”, Oscar, 2022

414 “Individuals and family plans”, Aetna, 2022

415 “Shop plans”, Kaiser Permanente, 2022



physical activity alone causes avoidable healthcare costs of US\$54bn annually<sup>416</sup>. In terms of the total cost to society, smoking and obesity are estimated to be among the top three social burdens generated by humans that could potentially be reduced with higher levels of awareness and prevention<sup>417</sup>. Below are examples of how both private and public players can contribute to promoting awareness, prevention and early detection to reduce global healthcare costs.

- In 2001, the Singaporean Health Promotion Board (HPB) was established with the mission to promote healthy ways of living among the country's citizens. The HPB is an official government organisation and to fulfill its mission it collaborates with schools, SMEs, large corporations and "community ambassadors"<sup>418</sup>. Its approach is to execute awareness campaigns, such as its "It's OKAY to Reach Out"<sup>419</sup> campaign to promote mental health, and to provide its partners with specific tools to promote healthier lifestyles within their communities. These tools include assistance in offering healthier food options, providing free exercise sessions, hosting workshops and organising health screenings.

Since its inception, the HPB has been able to improve multiple measures that indicate its success in promoting more healthy lifestyle choices among Singaporeans. For example, screening rates for cholesterol increased to 80% and the rate of healthy food consumption increased from 29% to 49%<sup>420</sup>.

**Singapore health promotion boosted cholesterol screening 80%**

As the latest research indicates that the impact of purely communicative campaigns is unclear, the success of Singapore's HPB may be largely attributable to the actionable support it offers to its communities. For example, while a campaign to increase the awareness of prostate cancer in the UK prompted more health checks the month after it ran, its long-term effect remains unclear<sup>421</sup>. And the USA National Colorectal Cancer Awareness week produced similarly unclear results. While public awareness of this type of cancer increased in that specific week, no increase in US screening rates has been recorded<sup>422</sup>. These findings support the conclusion that simple solutions may only have limited effectiveness and that solutions that are better targeted towards specific groups and incentives will most likely deliver more impact.

- Another example in which a public institution has successfully promoted health awareness, prevention and early detection comes from Germany. Since 2005, citizens can report their attendance at annual dental check-ups and, in return, receive higher reimbursements for the costs of treatment. If check-ups have been attended for five consecutive years, the public insurance reimbursement increases from 60% to 70%. After 10 years it increases to 75%<sup>423</sup>. Private insurance policies can be taken out to cover the remainder of the costs.

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416 "Global action plan on physical activity 2018–2030: more active people for a healthier world", WHO, 2018

417 "Overcoming obesity: An initial economic analysis", McKinsey Global Institute, November 2014

418 "About us", Health Promotion Board Singapore, 2022

419 "National mental well-being campaign, 'It's OKAY to Reach Out', launched to raise awareness on the importance of mental well-being", Health Promotion Board Singapore, 2021

420 "Singapore comes together to celebrate 20 years of healthy lifestyle", Health Promotion Board Singapore news release, 27 October 2012

421 "Checks for prostate cancer hit all-time high on back of NHS and charity awareness campaign", UK National Health Service news release, 19 May 2022

422 David A. Kleiman, Angela H. Kuhnen, Peter W. Marcello, et al., "Has National Colorectal Cancer Awareness Month increased endoscopy screening rates and public interest in colorectal cancer?", "Surgical Endoscopy", 2021, Volume 35, Issue 1

423 "Richtlinie des Gemeinsamen Bundesausschusses zur Bestimmung der Befunde und der Regelversorgungsleistungen für die Festzuschüsse nach §§ 55, 56 SGB V zu gewähren sind (Festzuschuss-Richtlinie) sowie über die Höhe der auf die Regelversorgungsleistungen entfallenden Beträge nach § 56 Absatz 4 SGB V", Gemeinsamer Bundesausschuss, 2021

Since the initiative began, the share of preventive dental treatment in total dental treatment costs has increased, indicating the initiative's success in promoting prevention and early detection in dental care. In 1997, dental replacements accounted for 36.2% of total dental treatment costs and preventive treatment accounted for 49.8%. In 2020, dental replacements only accounted for 22.1% of total costs, whereas preventive treatment accounted for 62.1%<sup>424</sup>.

### Fitness trackers can incentivise healthier lifestyle choices

Various insurers across the globe use fitness trackers to incentivise their customers to make healthier lifestyle choices. For example, a player from the USA uses its app to provide its customers with personalised health and activity goals, and rewards their achievement with bonus points. These points can be used to collect various rewards<sup>425</sup>. Another player from Germany awards bonus points in a similar way and even gives users the option of redeeming them via direct cashback<sup>426</sup>. And a Canadian insurance provider launched a comparable system that also allows users to share activity challenges with their friends or colleagues<sup>427</sup>.

- In an example from Latin America, the insurance company put a similar programme at the core of its business model. That player is currently operating in Chile and Brazil, but planned to expand to seven additional Latin American countries in 2022<sup>428</sup>. Its direct customers are companies that would like to offer life insurance coverage to their employees. As of the beginning of 2022, 2 500 companies were signed up to its service<sup>429</sup>. To improve distribution and decrease costs, life insurance is available to employees exclusively online, starting with a US\$4 monthly policy<sup>430</sup>. After acquiring life insurance, employees can connect their tracking devices to the insurer's app and as they track healthy habits, such as physical activity or meditation, their life insurance coverage increases — at no additional cost to the corporate customer or employee. For example, for every 10 000 steps recorded, an employee's life insurance may increase by \$1. As of the first half of 2022, the company granted US\$30m in increased life insurance plans, incentivising a total of one million users to maintain a healthier lifestyle<sup>431</sup>.
- An insurance company in Japan offers a similar life insurance product. Its customers can pay lower premiums if they participate in regular preventive health checks. If the results of these health checks are favourable, the customer's premium is further reduced. According to the insurer, customers who regularly engage in health checks submit 10% fewer claims than those who do not. In addition, 30% fewer life insurance claims due to deaths have been registered<sup>432</sup>. However, in some countries, the potential offered by such tracking devices may be limited; data privacy concerns may slow down adoption and clear communication might be required to convince customers of the benefits of using the new technologies.
- In the USA, a private insurance company developed a medical programme specifically targeted at preventing patients with chronic diseases from developing more severe symptoms. The programme was created for patients with type 2 diabetes and is based on two key elements.

424 "Jahrbuch 2021: Statistische Basisdaten zur Vertragszahnärztlichen Versorgung", Kassenärztliche Bundesvereinigung, 2021

425 "Attain by Aetna", Aetna

426 "So funktioniert TK-Fit", Techniker Krankenkasse, 2022

427 "Wellness program: enjoy better health and rewards you'll love", RBC Insurance, 2022

428 Carolina Milan, "Chile startup Betterfly hits unicorn status with \$125 million round", Bloomberg, 1 February 2022

429 Randy Nieves-Ruiz, "Latam tiene un nuevo unicornio: Betterfly, valorado en 1,000 mdd; Ilegará a México en alianza con Chubb", Forbes, 1 February 2022

430 "Betterfly raises \$60 million series b in Latin America's largest insurtech round", Business Wire, 2022

431 Ibid

432 "Expanding role of prevention in addition to protection", Dai-ichi Life Holdings, 2018

First, participants are provided with tools that enable them to better monitor their blood glucose levels. These tools include an activity tracker, a mobile continuous glucose monitoring device and an app that sends real-time notifications, based on the recorded blood glucose levels. Second, one-on-one coaching helps participants make lifestyle choices related to nutrition, activity and sleep that will help them control their symptoms<sup>433</sup>.

Eligible customers were able to enroll in the programme at no additional cost. As a result of the programme, certain patients achieved a meaningful reduction in their diabetes symptoms within 90 days, with the customers with the highest pre-therapy glucose levels seeing the sharpest reduction. Other participants were even able to significantly reduce the amount of medication they required or completely discontinue it<sup>434</sup>.

As programmes such as this one become more sophisticated and more frequently adopted, their impact on equality in healthcare coverage could be questioned; as these programmes might not be extended to customers with lower cover, the differences between the health of more and less wealthy individuals could further increase, even in developed markets<sup>435</sup>.

To conclude, the outlined initiatives that aimed at driving awareness, prevention and early detection have been successful. At the same time, not all campaigns are equally likely to deliver results. Based on the examples, initiatives that include multiple stakeholders (eg, schools, workplaces, individuals), implement actionable measures and provide direct financial incentives to customers appear to be particularly successful.

### Complement public health insurance/social security with private insurance

This can serve as an additional pillar for solving healthcare challenges and addressing protection gaps. In OECD countries, private health insurance providers covered approximately 30% of the population in 2020<sup>436</sup> and 10% of total healthcare spending in 2022<sup>437</sup>. In most national healthcare systems, private health insurance plays a complementary role<sup>438</sup>. In addition, taking out private health insurance can be mandatory but is most often voluntary<sup>439</sup>. Research suggests that both an appropriate regulatory framework and an appropriate delivery of private health insurance options to the public are the factors for the success of a two-pillar healthcare system<sup>440, 441</sup>. Below are examples of how private health insurance is delivered in different healthcare systems and an analysis of its impact on narrowing health protection gaps.

- In France, private healthcare insurance policies take on a mandatory complementary role. While 95% of the country's citizens are part of a public insurance scheme<sup>442</sup>, these schemes only cover 70% of the costs of most medical treatment. Patients are required to pay the remainder themselves<sup>443</sup> and this can become costly; as reported in the French press, some

**Private insurance covers 10% of OECD health spending**

433 "Innovative new Level2™ digital health therapy resulted in better health for people with type 2 diabetes", United Health Group, 2020

434 Ibid

435 "Relationship between income and health", The Health Foundation, April 2021

436 Social protection: private health insurance 2000–20, OECD.Stat, 2020

437 "Private health insurance", OECD, 2021

438 "Private health insurance in OECD countries: The benefits and costs for individuals and health systems", OECD, 1 January 2004

439 "Private health insurance spending", OECD, March 2022

440 "Private health insurance in OECD countries: The benefits and costs for individuals and health systems", OECD, 2004

441 "What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?", WHO, 2004

442 Ibid

443 "French 'top-up' health insurance explained", "Connexion", 5 November 2020

COVID-19 patients who needed intensive care faced hospital fees of many thousands of euro afterwards due to insufficient coverage by public schemes<sup>444</sup>.

To fill this significant protection gap of around 30% of most medical treatment, private insurers have introduced “top-up” insurance policies<sup>445</sup>. These reimburse a defined percentage of the remaining costs that can range from a few percent to covering more than 30% if private practitioners charge higher fees than expected by the government.

The supplementary function of these private insurance policies has been significantly strengthened over the last few years. In 2016, the French government introduced the “Accord National Interprofessionnel” (ANI) that obliges all employers to offer their employees options for top-up insurance. The scope of these policies is set out in an additional regulation. Furthermore, the employers must pay at least 50% of the annual policies they offer<sup>446</sup>. In addition, in 2019, the “100% Santé” law came into force, obliging top-up policies to gradually reimburse more of the cost of medical services that were not previously always fully covered, including costs for hearing aids, spectacles and dental prostheses. In addition, other parties beyond insurance providers were included in the changes to the law. Medical service providers such as practitioners and the producers of prostheses were required to offer a defined set of products and services that is guaranteed by the French healthcare system to be fully covered<sup>447</sup>.

**95% of French have complementary private health cover**

As a result of these regulatory changes, 95% of the French population is now covered by complementary private insurance providers<sup>448</sup>. The impact of private insurance plans on closing protection gaps in France therefore seems clear; they improve the coverage of medical costs for 95% of the population by up to 30%.

- The South Korean healthcare system operates in a similar way, with private insurance taking on a complementary but voluntary role. The population is covered by universal healthcare, as 97.2% is covered by the public National Health Insurance Program (NHI) and the remaining 2.8% is covered by the social security service, Medical Aid. While all citizens are covered by the healthcare system, they usually have to contribute 20% to the costs of inpatient care and 30-60% to outpatient care, depending on the provider. As a result, 34.3% of healthcare expenditure was OOP expenditure in 2017, while the average among OECD countries was 20%. Approximately 8% of the population therefore held some sort of additional private health insurance in 2017<sup>449</sup>.

A question in relation to this system is whether costs could be reduced by establishing a healthcare system that is fully public with no need of, for example, marketing expenses or underwriting costs. However, private health insurance providers could create operational efficiencies, as market theory suggests that private players optimise their business as they seek profit in a competitive environment<sup>450</sup>. In addition, a competitive market for complementary private health insurance may foster product innovation<sup>451</sup>.

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444 Ibid

445 “Loi ani: La loi de sécurisation de l’emploi”, Solimut Mutuelle de France, 13 January 2014

446 Ibid

447 “Understanding the French ‘100% Santé’ healthcare reform”, April International, 9 January 2020

448 Isabelle Durand-Zaleski, “International health care system profiles: France”, Commonwealth Fund, 5 June 2020

449 “OECD reviews of public health: Korea. A healthier tomorrow”, OECD, 31 March 2019

450 “What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?”, WHO, 2004

451 Ibid

- In the Danish healthcare system, private health insurers take on a voluntary complementary role. All citizens are automatically enrolled into a publicly financed, universal healthcare system. While the system dates back to the 1800s, today's system was founded in 1973<sup>452</sup>. All Danes have access to a comprehensive public healthcare system, but gaps in its coverage still exist. As a result, 42% of the population has acquired some sort of complementary private health insurance<sup>453</sup>. Although 84% of healthcare costs are covered by public institutions, the adoption of voluntary private insurance plans is increasing. Between 2005 and 2019, private insurers' share of total healthcare expenditure coverage doubled — from 1.5%<sup>454</sup> to almost 3%<sup>455</sup>.

**Danish insurers doubled share of healthcare expenditure to 3%**

There are multiple Danish for-profit private health insurance companies and there is also a nonprofit insurance provider, Sygeforsikringen “danmark”, which is an association owned by its customers<sup>456</sup>. The cover it provides includes dental treatment, drugs, physiotherapy and spectacles and contact lenses<sup>457</sup>. It allows its members to actively participate in the association through regular member meetings and bodies such as representative boards and dedicated local member offices<sup>458</sup>. And it aims to cap its administrative costs at 10% of total premiums collected<sup>459</sup>. Denmark's approach of complementing public insurance/social security with private health insurance significantly reduces the protection gaps for 42% of the population within otherwise comprehensive coverage.

To conclude, the positive impact of a two-pillared health insurance system may be enhanced by making a robust decision on how to balance and design the underlying healthcare system. While private health insurance providers may introduce efficiencies, their higher administrative costs may reduce efficiencies in other areas. Nevertheless, the participation of private health insurance plans appears to be successful in different markets and can therefore be considered a potential lever to narrow health protection gaps.

## Additional levers

### **Widen the base of customers eligible for public and private insurance**

Customers who are ineligible include those excluded due to factors such as preexisting conditions or old age. Related differences in policies could also be harmonised. Current regulations on these two points differ substantially between countries and a large number of customers are not covered due to categorical exclusions or premiums that they cannot afford. For example, while in Hong Kong, Italy and Mexico insurers have greater freedom to define preexisting conditions they regard as exclusion criteria, in countries such as Malaysia, the UK, Australia and the USA, possible exclusions are either entirely prohibited or more tightly defined by governmental regulations<sup>460</sup>. Adjusting such criteria may increase the number of people protected under health insurance policies but may also require insurers to reassess their risk portfolio, potentially increasing prices for some customer groups.

452 Karsten Vrangbæk, “International health care system profiles: Denmark”, Commonwealth Fund, 5 June 2020

453 Ibid

454 Maria Olejaz Tellerup et al., “Denmark: Health system review”, “Health Systems in Transition”, 2012, Volume 14, Number 2

455 “Denmark: Country Health Profile 2019”, OECD, 28 November 2019

456 “Om foreningen: Sygeforsikringen danmark”, Sygeforsikringen “danmark”

457 “Find din Gruppe: Sygeforsikringen danmark”, Sygeforsikringen “danmark”

458 “Om foreningen: Sygeforsikringen danmark”, Sygeforsikringen “danmark”

459 Ibid

460 “International health briefs — preexisting condition exclusions around the world and application language”, RGA Re, 19 January 2016

### **Widen the scope of coverage for public health insurance/social security to reduce untreated conditions**

For example, in some jurisdictions, pharmaceuticals or dental services are not included in universal insurance and are covered by a mix of private and public insurance. This may cause some people to avoid minor treatments that are not covered and ultimately lead to a larger total stress on the health system as conditions that are not addressed early may result in more expensive treatment later.

### **Facilitate access to physical healthcare infrastructure**

This would ensure that all people who have access to health insurance also have access to formal medical attention. Expensive travel may be required for a person to visit the nearest medical facility, especially in rural areas of developing countries, ultimately making it unaffordable to receive any formal healthcare services. If medical services covered by health insurance are not accessible, people may not consider taking out a health insurance policy in the first place.

### **Increase the effectiveness of healthcare spending**

**Smarter health spending could increase effectiveness**

As the productivity growth of the health sector still lags behind productivity growth in the wider economy, government agencies could consider introducing smart regulations that satisfy current healthcare needs<sup>461</sup>. For example, increasing the amount of performance metrics captured or developing a clearinghouse for billing data and insurance-related administrative costs could be ways of improving the productivity of healthcare systems<sup>462</sup>. Mandatory limits on the cost of healthcare could be a move in the same direction, curbing some of the inflation in health services. However, these measures might need to be balanced against potential unintended consequences.

## **Concluding remarks**

At US\$0.8trn to US\$4trn in 2020, or 1-5% of global GDP, the health protection gap is a substantial one. If the current trends continue, it could grow at 4-5% per year, leading to a gap of US\$6-6.5trn in 2030 (if both OOP spending and avoided costs are considered). Health-related protection gaps are especially prevalent in the emerging economies of Asia, Latin America and Africa. The recent COVID-19 pandemic has directed policymakers' attention to this protection gap and has also accelerated efforts to address it. To continue these, public and private players might need to collaborate, create the right frameworks and ensure that health and insurance services can be delivered to more people at higher quality.

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461 Anna Malinovskaya and Louise Sheiner, "Productivity In The Health Care Sector", Hutchins Center on Fiscal and Monetary Policy at Brookings, July 2016

462 Nikhil Sahni, Pooja Kumar, Edward Levine and Shubham Singhal, "The productivity imperative for healthcare delivery in the USA", McKinsey, 27 February 2019

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