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Costly Integrated Shield Plans don't bring peace of mind

Keeping healthcare costs in check will require tackling costly private hospitalisation plans.

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Singapore's private health insurance system is in trouble – not from neglect, but from overuse. Integrated Shield Plans (IPs), meant to give Singaporeans peace of mind, are now giving insurance companies headaches.

Payouts for claims are growing faster than the premiums collected. According to the Singapore Actuarial Society, between 2014 and 2023, insurance premiums grew by 8.5 per cent annually, while gross incurred claims rose even faster at 11.9 per cent. Insurers recorded losses in four of those years – 2017 to 2019, and again in 2023.

The Ministry of Health (MOH) has called this a "knotty situation" that must be untangled. There is an old Chinese saying: "To untie the bell, one must find the person who tied it." The question, then, is who will "unbell the cat"?

THE PROBLEM WITH INSURANCE

Behind these numbers are larger and familiar pressures: an ageing population, pricier treatment, and the growing burden of chronic diseases. But there's another culprit: overuse. When patients don't pay a cent at the point of care, they tend to use more – and doctors, paid per procedure, tend to do more.

Data from the Life Insurance Association shows that full-rider policyholders, who pay nothing out of pocket, made 9 to 15 per cent more claims than others between 2015 and 2020. Their average bills were at least 20 per cent higher than those with co-payment. In other words, zero-dollar co-payment has come at a steep collective cost.

In 2016, the Health Insurance Task Force was convened to address these spiralling costs and recommend ways to keep IPs financially sustainable over the long term. It brought together insurers, consumer advocates, doctors and regulators – a show of cooperation in a sector divided by incentives.

The proposals were pragmatic: make costs more transparent, strengthen quality assurance, and design insurance products that promote cost-conscious behaviour among both patients and providers. Insurers, the task force noted, must balance providing comprehensive coverage with maintaining financial sustainability.

Over the years, many of these recommendations have been put into practice. Since 2019, all new IP riders must include a minimum 5 per cent co-payment. Preferred doctor panels were created so fees are agreed upon upfront. Claims-based pricing – where premiums depend on your claims history – were rolled out in 2017 and became more common after 2021. Fee benchmarks, reviews and pre-authorisation became standard, and the Cancer Drug List introduced in 2022 curbed runaway drug costs.

These measures helped. From 2019 to 2023, the growth in insurance premiums slowed to 3.1 per cent annually, closely matched by a 3.3 per cent increase in gross incurred claims. This suggests some stabilisation.

Private insurers have made the effort to reduce their management expenses and distribution costs. Their respective five-year compounded annual growth rates were 2.6 per cent and 1.8 per cent, compared to the 10-year equivalent of 8.4 per cent and 8.6 per cent. At least one private insurer has also been open about comparing charges across different private healthcare providers, and assessing claims reasonableness.

But the system is still under strain. IP insurers collectively lost $47 million in 2023. The bell is still ringing.

UNTANGLING THE KNOT

To truly fix the system, Singapore needs more data and more transparency. Instead of adding yet another round of regulation, insurers, MOH and providers could share insights on cost drivers and claims patterns. Artificial intelligence already analyses claims; its findings and insights should be shared, not siloed.

Doctors too could receive regular "report cards" comparing their billing patterns with those of peers. Such feedback loops – used in the US and UK – have been shown to reduce overtreatment without formal penalties.

In the end, there's no single villain in Singapore's health insurance story. The "cat" isn't just the insurer or the doctor — it's all of us. Each player in the system has a hand on the bell: policymakers setting incentives, doctors ordering tests, insurers pricing risk, and patients making choices.

The deeper challenge lies in the public-private healthcare divide. Many Singaporeans still choose private care despite its significantly higher price tag. This is not always about luxury. It reflects concerns about long waiting times, lack of care continuity, or limited choice of specialists in public hospitals.

MOH has been expanding public hospital capacity and piloting the "principal doctor" model – in which one principal doctor acts as the main point of contact for patients to coordinate their care with other specialists in the hospital – can help close the gap. So can tackling direct cost pressures, such as high commercial rents that drive up private healthcare prices.

Here, MOH could encourage more private specialists to operate from HDB-owned medical centres instead of high-cost private premises. Affordable premises should translate into more affordable care.

PATIENTS MUST CURB UNNECESSARY CONSUMPTION TOO

Consumers too are part of the solution. It may not sound appealing to say that patients must take responsibility for keeping healthcare costs manageable, but awareness and self-agency matter.

Many Singaporeans pay for IP riders that far exceed their needs: roughly half of policyholders use subsidised wards despite having private coverage.

Tools such as the Health Insurance Planner, developed by the CPF Board and MOH, can help Singaporeans select plans that match their needs and financial capacity. Consumers should also expect clear, jargon-free explanations from insurance agents before signing up.

Doing one's homework upfront can prevent costly regret down the road. IPs in Singapore are not portable. Once you choose an insurer, switching later is difficult.

In the end, there's no single villain in Singapore's health insurance story. The "cat" isn't just the insurer or the doctor – it's all of us. Each player in the system has a hand on the bell: policymakers setting incentives, doctors ordering tests, insurers pricing risk, and patients making choices. If all can pull in the same direction – sharing data openly, pricing fairly, and consuming care wisely – the ringing may finally stop. And Singapore's health insurance system can once again do what it was meant to: protect, not overburden.

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