

PRESIDENT'S WELCOME ADDRESS

Text by Dr Daniel Lee Hsien Chieh



Dr Ng Eng Hen, ladies and gentlemen, a very good evening.

Dr Ng is no stranger to us, having worked in Singapore General Hospital and then in the private sector, both successfully; all of us remember his leadership and steady hands as Singapore's Minister for Defence from 2011 to 2025, and prior to that, Minister for Education from 2008 to 2011. Dr Ng's career is a masterclass in leadership. From his clinical mastery in surgery to analytical rigour and finesse in political strategy, he also has stirring oratory skills as well as a formidable vocabulary which I can only aspire to. Dr Ng has been a beacon for our profession. We are honoured to have Dr Ng as our Guest of Honour and Honorary Member tonight. While you have taken a 25-year break from us to pursue a political career, you remain one of us, Dr Ng.

As a public health physician who started out in internal medicine at Changi General Hospital (CGH), I am privileged to have experienced operating a for-profit acute private hospital and then now running the largest group of not-for-profit nursing homes in the long-term care sector. I am humbled to address you this evening as President of the 67th SMA Council, in a time when multiple common challenges face our

profession and the patients whom we serve, one of which has drawn wide concerns – medical inflation.

But before I do that, let me say a few words about myself. I am a graduate of the local medical school and father of three girls. Obviously, I am trichologically challenged because I think and worry too much. I have been in the SMA Council for 14 years and I was an internal medicine trainee who switched to public health. When I decided to make that switch, I was sent by my boss Prof Teo Eng Kiong to see a public health physician in CGH for counselling. He tried his best to dissuade me but obviously he failed, and tonight he is being punished by having to spend the entire dinner at my table. No prizes for guessing as to who that handsome man is.

But let us return to regular programming. The topic of healthcare financing and medical inflation is a complex one. There are many factors driving healthcare costs in Singapore: ageing population, utilisation trends, changes in disease epidemiologies and consumption behaviour, earlier detection of diseases, technological and pharmaceutical advancements, health insurance design, doctors' professional fees, operating expenses driven by real estate prices, healthcare manpower shortages, hospital facility fees – the list goes on. Multiple stakeholders are

involved: payors (consumers, insurers, Government), providers (doctors, hospitals) and patients. In Singapore, the Ministry of Health (MOH) regulates doctors and hospitals whereas the Monetary Authority of Singapore is the regulator for insurance companies. Medical inflation will always be with us. The question is how much.

The Health Insurance Task Force was formed in 2016 and subsequently the Multilateral Healthcare Insurance Committee formed in 2021. A variety of effective measures have since been implemented. In 2018, MOH introduced surgeon fee benchmarks for 200 common surgical procedures on the Table of Surgical Procedures. In 2020, the benchmarks were extended to include anaesthetist fees and doctors' inpatient attendance fees. Since its introduction, close to 90% of doctors have been charging within the recommended surgeon fee benchmarks. The outcomes were effective as intended – the average annual growth in private surgeon fees has slowed dramatically from 3% between 2010 and 2018 to just 0.4% from 2019 to 2023. In addition, MOH has since also introduced hospital fee benchmarks for common surgical procedures and medical conditions. We await outcomes in this regard that will move the needle.

To address rising insurance premiums and private healthcare costs, MOH also introduced new requirements for Integrated Shield Plan (IP) riders. From 1 April 2026, new IP riders sold are no longer permitted to cover the minimum IP deductibles set by MOH. The co-payment cap has also been raised to a minimum of \$6,000. We are heartened that with these measures, it was reported that newly launched IP riders are on average 30% less costly than older ones.

Yet in the same breath alongside the above adjustments, *The Business Times* (BT) reported on 1 April 2026 that five in seven IP insurers had raised the premiums of their base IP plans, and for some, the premium hikes are in the double digits.¹ Based on underwriting results for 2024, four insurers were in the red. BT reported that the most profitable was Prudential, which reported an underwriting profit of around \$25 million. Even the most consistently profitable insurer, Prudential, is raising the base IP premiums for its private hospital and Class A plans. AIA Singapore and Great Eastern were the only two insurers that did not raise premiums.

Past SMA President Dr Ng Chee Kwan wrote to the *Straits Times* Forum on 15 April and informed that between 2019 and 2024, IP insurers kept their overall medical loss ratio (MLR) between 69% and 77%.² This is the percentage of premium income that insurers pay out in medical claims. According to Dr Ng, generally an insurer with a lower MLR has a higher share of income remaining after paying medical claims, to use for administrative costs such as salaries and overheads. In contrast, in the US, MLRs are typically 80% to 85% or higher depending on market segment – small or large group markets. Under the Affordable Care Act in the US, if an insurance company fails to meet these required percentages for a given year, they are legally required to refund the excess premium amount back to the consumer.

Having spent some time in the long-term care sector in Singapore, I have observed a similar transparency

requirement – the Charities Act regulates that the amount of fundraising expenses should not exceed 30% of the total gross funds raised in a financial year. That means to say at least 70% of the total funds raised should directly support the charity's causes and beneficiaries. This is known as the 70/30 fundraising efficiency ratio. This rule applies to all registered charities and Institutions of a Public Character in Singapore. If a charity anticipates exceeding this limit, they must be prepared to justify the high expenses to the Commissioner of Charities.

We must recognise that the context of healthcare in the US or of the not-for-profit fundraising work by charities is different from the for-profit context in which the private health insurance industry in Singapore is placed to function. Having said that, I wonder if there can be any learning points for us to consider. The challenge of medical inflation is multifactorial and cannot be attributed to a single reason alone. All hands must be on deck and work in good faith to manage medical cost inflation and ensure sustainability – that includes regulators, payors, providers and patients.

At the same time, it must be noted that the two groups – the medical profession and the insurance industry – operate on two different paradigms. We owe our patients a duty of care which puts the patient's interests before our own, and while we must provide our patients with viable options, we also advise what we think is the best option for the patient. The patient makes a decision with this knowledge. In contrast, the insurance industry works on the "suitability standard" where agents provide options to their customer which they think are contextually and reasonably suitable. This difference has been highlighted in a joint letter with the Academy of Medicine, Singapore to the *Straits Times* Forum recently.³

In conclusion, ladies and gentlemen, SMA's slogan is "For Doctors, For Patients" – this reflects our recognition that the doctor-patient relationship lies at the heart of any scientific revelation, technological innovation, policy decision

and business practice that affects healthcare, as well as our commitment to protect this relationship and what we always owe our patients – the duty of care.

As doctors who know our patients' medical history, risk factors and family context, we are uniquely placed to advise patients on their likely healthcare needs over time, whether this relates to chronic disease management, hospitalisation risks or preventive care. In an increasingly complex practice environment, I urge all of us in the profession to take on the mantle of physician-leadership, now more than ever, and be beacons of our patients' best interests!

Thank you and have a wonderful evening ahead. ♦

Further readings

1. *New Fee Benchmarks for Private Healthcare Sector*. In: Ministry of Health. Available at: <https://bit.ly/3QxcnqD>. Accessed 10 June 2026.
2. Mohan M. *More benchmarks on private hospital fees help, but may not bring down costs: Doctors, healthcare experts*. CNA [Internet]. 27 October 2025. Available at: <https://bit.ly/4eeFI0T>.

References

1. Cua G. *Some IP insurers hike premiums of base plans for private hospital and A-class wards*. *The Business Times* [Internet]. 1 April 2026. Available at: <https://bit.ly/3PH115Q>.
2. Ng CK. *Forum: Way to ensure that insurance premiums are justified*. *The Straits Times* [Internet]. 15 April 2026. Available at: <https://bit.ly/49v4sjO>.
3. Lee D. *Forum: Doctors and financial advisers may give different advice on healthcare decisions*. *The Straits Times* [Internet]. 11 May 2026. Available at: <https://bit.ly/4ecxwOv>.