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Health Insurance

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From the Publisher

The rapid growth of health facilities all over the country is a phenomenon witnessed in the last 10 to 15 years. We have a large number of super-speciality hospitals and a proliferation of diagnostic centres. What is heartening is the availability of these facilities not merely in metropolitan cities but also in state capitals and major district headquarters. There is also a substantial increase in the medical colleges in the private sector turning out a large number of general medical practitioners and specialists. These hospitals and medical practitioners are making available world class facilities at our doorstep today. How many of us can afford to avail of these facilities?

This issue of the **IRDA Journal** puts together some thought provoking articles on what initiatives are required to be taken to provide a wider access to the medical infrastructure that exists today. The Government, both at the Centre and states, is committed to stepping up resource allocation to healthcare in the current plan. There are, however, serious limitations to the public sector intervention in this sector and the effectiveness of those interventions. If 'health for all' has to become a reality, the insurance Industry will have to take the initiative and launch a frontal attack to remove the hurdles that stand in the way of realising this objective.

The Authority on its part has taken a few measures to identify and address the problems that inhibit the growth of health insurance. A Health Insurance Working Group is deliberating on various issues including the problem of non-availability of data. The Sub-group on data for health insurance has recently submitted its Report. A discussion paper on micro-insurance has also been released by the IRDA which has a health insurance component to meet the requirements of the poorer sections of the society. The Working Group on Health has identified many areas on which work has been initiated. It will be an on-going exercise.

The next issue of the Journal is about opportunities of a different kind. We will take a look at what prospects investment in infrastructure projects and activities in other mandated areas hold for the insurance industry. We also look at some wishlists for these activities to take root and bring forth blossoms for the future.

C.S.Rao

C.S.RAO

Inside

ISSUE FOCUS

To Health (Insurance)!

From healing ourselves to healing others – or at least paying the bills to do so. That is the journey we have made from the previous issue of **IRDA Journal** to this one that you hold in your hands.

And further on the topic of healing, we take a close look at how to heal health insurance and rejuvenate it to match the needs of a country all ready to go out and conquer the world!

We have for you a huge spread of delicious food for thought – we had a record number of contributors for this issue which goes to show the preoccupation with this topic among readers – for you in the pages that follow. The rest, we will bring to you in subsequent issues.

The topic for the issue was meant to coincide with the conference on Health insurance organised by BearingPoint, USAID and IRDA in late October and to serve as a brainstorming session to feed the conference.

We have Mr. Kenneth Cahill, Managing Director of BearingPoint and his colleage Ms. Susan Matthies suggesting lessons from elsewhere in the world for growing the Indian Health insurance business and Mr. B.S.R. Rao and Mr. Apparao Machiraju talking about the economics of Health and Life insurance.

Health insurance for the poor is quite an obsession among our writers – and heartenigly so. Mr. Rajeev Ahuja senior Fellow at Indian Council for Research on International Economic Relations (ICRIER) writes on this topic as does Mr. P. C. James, Manager with National Insurance Company from his hands on experience as an underwriter.

Mr. Aloke Gupta is no stranger to our readers on the topic of Health insurance and here he complements the articles with his positive inputs on what companies can do to take the business to the next level towards sustainability under their own steam.

Mr. Robert Kipps and his colleagues from Milliman, a leading American actuarial firm, share with us their observations of the Indian market for Health insurance and its imperatives from their recent visit here to see the lay of the land. Their suggestions are based on their actuarial experience with the national health insurance programme in the US.

Speaking of matters actuarial is also Mr. Piyush I. Majumdar, one of the senior actuaries in India. He touches upon the lack of actuarial input into Health insurance and urges a return to scientific pricing and underwriting to make it fly.

Mr. Misha Segal of BearingPoint brings up the rear with his prescriptions for the Indian market with regards to the Health insurance business in particular.

Health insurance has pushed out almost all our usual columns this month, but we have for you the business statistics in what is close to the end of the half year.

In the next issue we will be talking about investment portfolios of insurance companies, specifically highlighting the opportunities in infrastructure investments.

Until then, goodbye!

K. Nitya Kalyani

Common Good

K. Nitya Kalyani

It was a match made in heaven. And it still is. But the courtship has been long and rather ambivalent.

Insurance companies require long-term debt instruments to match their liabilities – especially life insurance companies. Infrastructure projects require investors in their projects over a long term – to match the execution and life of the projects and the typical timelines that their returns possess.

When, about five to six years ago, the debate on opening up the insurance sector to private sector participation, including foreign participation, was still going on, one of the obvious synergies that was commented upon frequently was that a competitive insurance sector with more companies would augment the resources going into building the country's infrastructure. That was also the time when infrastructure investment, and its critical importance to the development of India's economy and society, was a hot seminar topic.

Together they formed an explosive synergy. And where we are in realising the benefits of that is the topic of the next issue of **IRDA Journal**. Given that this jigsaw puzzle has not yet started fitting the way it should, we take a look at the opportunities that infrastructure investment presents to the insurance industry and the wish list of the potential investee companies.

Meanwhile, here is an idea of the way investment in infrastructure has been. Information culled from the website of the National Highways Authority of India (NHAI) gives the following pattern of investment in its high profile projects: Golden Quadrilateral and North South East West corridors.

	Rs. in crores
Cess	20,000
World Bank/ Asian Development Bank Loan Assistance	20,000
Market Borrowings	12,000
Private Sector	6,000
Total	**58,000**

> It would be mutually beneficial for the insurance industry and investee companies promoting infrastructure projects to work in consonance.

So, only about 10 per cent of the money has come from the private sector (of which insurance sector would have contributed a portion) and another 20 per cent from market borrowings (in which also the insurance sector would have been a participant). Of this there is no doubt that LIC, which actually finds that it never has enough takers for the kind of money it generates year on year and can deploy in investments, has invested the lion's share among insurers if not all investors.

If anything, the numbers point to the enormous opportunity that the insurance companies can seize in the future and our issue will also gauge what it will take for them to do so.

Just for information, the infrastructure sector investments (including housing but excluding government guaranteed bonds) of all insurance companies put together in 2002-03 was Rs.37,794.91 crores - 13 per cent of the total investment portfolio of the sector of Rs. 2,90,560.12 crores. This falls broadly in line with the investment requirements that IRDA's investment related regulations have of insurance companies.

With growing premium incomes insurance companies will be generating larger investment surpluses. Given the global market scenario of indifferent underwriting surpluses, they will also be looking to maximise the returns from their investment portfolios within the framework of their mandated investment patterns which includes not only sectors in which they can and should invest, but also the quality of these investments relating to their safety as they represent policyholders' funds. Given these, it would be mutually beneficial for the insurance industry and investee companies promoting infrastructure projects to work in consonance to maximise the opportunities that will arise. It is ideas for that that the next issue of **IRDA Journal** will explore.

Paying the Bill!

—The great Indian Health insurance puzzle and its solution

K. Nitya Kalyani

When we were children, we had a livewire family doctor who never forgot the name of a family member or any sniffling childhood illness of ours, or indeed the treatment he had prescribed then. He had a phenomenal memory and empathy for his patients, fleetingly though he would see them. A flash of a pen, a prescription for antibiotics and a pat on the head and we were out!

Much later, when I relocated, I acquired a family doctor who patiently wrote copious and meticulous notes about symptoms, diagnoses and prescriptions in long hand in a series of thick bound school notebooks. A unique identifying number he gave each patient would unfold an entire history of colds, flu, eye irritations from looking at the computer too long and backaches from similar and other causes. He too would remember to ask after somebody's college admissions and somebody else's marriage plans.

Their domain knowledge was not just which pill for which ill, but the medical history of each patient and their proclivities to colds or ice cream or some such.

The huge multi-specialty hospital I visited earlier this year for a health check up was different. They had a plethora of diagnostic tests and computer printouts, and the presiding deity had a clipboard which she consulted through the day to read out my name!

In this age of depersonalisation of medicine, the patient gets cold science more often than a warm smile and an assurance. Both are needed, but what is required more is the ability to pay for the expertise and the treatments. That, Indian customers have smartly caught on to. The burgeoning demand for hospitalisation policies is witness to this surge in demand for a means of paying for healthcare costs, while it is true that insurance companies are not looking to marketing this as a priority.

The reasons are many. The primary reason is that the business makes losses. In theory it need not. Provided the pricing justifies the costs and the costs are known and managed well. But that is precisely the problem with hospitalisation insurance in India. The pricing is not based on proper costing because the inputs for such a costing have not been systematically gathered and analysed. Add another variable to it in the form of a vast, heterogenous and opaque healthcare system in terms of its pricing and quality of service and the complexity of the situation is revealed a little more.

Writing a policy almost against their will still does not mean they have to do it badly or unprofitably – both puzzles that the industry is still cracking. And there is a live example.

The burgeoning demand for hospitalisation policies is witness to this surge in demand for a means of paying for healthcare costs.

In, of all things, Motor insurance. Motor insurance is compulsory and the pricing is controlled by a tariff. The input costs of garages are opaque to the customer and the charges across the country are disparate and, most often, fraudulent. Any one of us who has had a vehicle accident – or even had to repair a vehicle malfunction - knows the helplessness with which we pay a garage bill because we just don't know whether we got the right repair done or whether we needed it in the first place!

But in this scenario, the industry has created for itself a fair amount of knowledge in terms of input costs and a support system in the form of surveyors to contain costs and run a not too unprofitable Own Damage insurance portfolio. It is a loss making portfolio alright but we must remember that tariff revisions do not keep pace with the new structure of repair/replacement costs of new generation vehicles, or the rising cost of living among garages and mechanics!

The messiah of the industry will have to be data and will be data. It is with this clear focus that the IRDA set up a Health Insurance Working Group and, within that, a Data Sub-group.

The Sub-group submitted its report to the IRDA in early September. The main recommendations of the Sub-group are to set up a National Health Data Repository to and to create an Indian Health Care Financing Administration.

The shared database in the form of a depository is imperative to the successful development of Health insurance with scientific pricing and has pondered various models for setting it up including who the primary sponsors should be, who would pay for it, who would manage it (the Tariff Advisory Committee or an independent organisation), who would own the data and who would have access to this data and on what terms. The questions are to be deliberated upon by the Health Insurance Working Group and the recommendations on this score are to be part of the report of the Group.

As for the health care financing administration, the idea is to ensure that the benefits of standardisation reached the customers and that such a body would ensure the delivery of the optimum quality of care at the most reasonable costs by providing leadership to the healthcare sector at large.

It would be an arm of the IRDA and be responsible for the licensing and monitoring of health insurance organisations, the development of the health insurance market and for ensuring the proliferation of access to affordable healthcare. The Sub-group has proposed that the Working Group take up the creation of such an Administration as its next project.

Going back to the workings of the Sub-group it outlined its work broadly as follows:

- To examine the current data available among stakeholders in healthcare transactions and evaluate the possibility of capturing this data
- To evaluate the possibility of standardising common(required) data elements and collection patterns of this data
- To identify standard coding systems for capturing data such as diagnosis, medical procedures, clinical observations which can be applied by these stakeholders
- To analyse the creation of a data warehouse whereby data is stored and accessed by the industry to benefit from actuarial analysis of this data
- To use data to develop and price new health insurance products to suit the various affordability and geographic health needs of the country's populace

The terms of reference of the Sub-group were split into Sharing of currently available data, Enhanced Data Quality and Standardisation and, Alternative insurance approaches and procedure coding. Of these the last was left to deliberate upon at a later date after the data collation and standardisation work was done.

For tackling the issue of sharing the currently available data, the Sub-group engaged DSK Legal, a prominent legal firm to advise it on confidentiality and privacy issues regarding the data and also of the ownership of the data and its commercial and non-commercial use.

Since over 90 per cent of health insurance transactions related to the public sector (PSU) companies, the Sub-group decided to identify data elements that were captured by all these companies to get a common minimum set. This was to form the basis of collection of the currently available data and the Sub-group has recommended to the IRDA that all TPAs be required to submit data – from the time they contracted with the insurance company to provide TPA services - in the format that was finalised on this basis. Where a company did not have a TPA it should be required to send this data directly and all insurance companies were to submit premium details as well.

Regarding its second mandate – that of enhancing data quality and standardisation - the Sub-group decided to approach this task by breaking it up into three parts.

The first was information at the proposal/enrolment stage relating to identifiers, underwriting information, demographic information and medical and insurance history.

The main recommendations of the Sub Group are to set up a National Health Data Repository to and to create an Indian Health Care Financing Administration.

The second was to capture disease/ diagnosis and medical utilisation information through the use of internationally recognised coding schemes. Implementing Diagnosis, Procedure, Service/Revenue, Clinical Observation and Explanation of Benefits Codes is costly and this aspect had an impact on the Sub-groups recommendation. Hence some of these were recommended to be implemented within the framework in which hospitals were now doing them and some were deferred or it was decided that they could be left to the discretion of the insurer/TPA.

The recommendations included that IRDA adopt a standardised data submission format and require TPAs to collect and electronically submit data either annually or half yearly.

The coding systems and standards to be followed as per the recommendations are:

- Diagnosis Codes: ICD 10 (minimum granularity of 3 digits)
- Procedure Codes: ICD 10 PCS (minimum granularity – 2nd level)
- Service/Revenue Codes: The Sub-group has identified various claims data heads individually for this
- Clinical Observation Codes: To be submitted at a later date
- Explanation of Benefits Codes: As per insurer's/TPA's discretion

The following recommendations were made for identifiers:

- Hospitals: PAN number
- Hospital Chains: PAN number with modifier for each hospital
- Small hospitals and nursing homes: Doctor's registration number with modifiers
- Individual physician: Registration number with Medical Council
- Individual beneficiary: Unique number to be allotted by the National Health Data Repository (a centralised, automated unique number allocation system)
- Insurer: Number as allotted by IRDA
- TPA: License number as allotted by IRDA

The Sub-group has also recommended that the data proposed to be collected be reviewed by a minimum of three actuaries to ensure completeness of data from an actuarial and underwriting point of view. The data should be relevant to the current Indian scenario and also be geared to facilitate changes as the market matures.

The Sub-group report also observes that it would be useful to capture data of health riders offered by life insurance companies. These would add the actuarial experience and knowledge developed by the life sector.

Lessons From Across The World

—How India can break barriers to develop health insurance

As several developed and developing nations have already done, India can expand its health insurance market through the right policies and stringent regulations, observe ***Susan Matthies and Kenneth R. Cahill.*** This would bring quality care at reasonable cost to the teeming millions.

Countries across the globe have adopted health insurance in a big way through various means. While some have found the going easy, thanks to congenial circumstances, many have had to battle it out against various barriers. India can learn lessons from these countries in its attempt to expand the health insurance market, though it must be remembered that the nation really does have a number of unique features that make experiences in other countries only partly relevant.

Health insurance, whether publicly or privately financed, covers a small segment of the Indian population. There is considerable support for broader health insurance coverage, including expanding the role of the private sector. This view is part of the Central Government's Health Strategy, which includes among its goals, recognition of the importance of further development of the private sector, specifically private health insurance[1]. Table 1 depicts the current coverage of the Indian population by selected health insurance schemes (Note: Data collection is not systematic and sources have not been verified).

Countries worldwide have sought to broaden health insurance coverage, particularly private health insurance, through numerous ways. One of the more unusual methods taking shape in India is through the work of the IRDA. It is unusual in that IRDA's charter calls on it to be not just a regulator of the insurance sector but a developer of the sector as well[2]. Most insurance watchdogs around the world do not have such a formal charter to develop the market. IRDA was created by the Insurance Regulatory and Development Act of 1999. The Act provides, *inter alia*, that "the Authority shall have the duty to regulate, *promote* and ensure orderly growth of the insurance... business". Article 14, (1).

> Ideally, health insurance, involving a mix of health insurance company management and risk-taking, state government and individual contributions and local NGO administration, would gradually encompass most of the rural poor.

Mr. C. S. Rao, Chairman, IRDA, has emphasised that an important goal for IRDA as a "developer" of the insurance market is to promote the development of health insurance, particularly private health insurance and managed healthcare. IRDA seeks to do this through a number of activities, including clarifying the legislation and regulation of health insurance, helping to create a positive environment for standardisation of data, providing information to consumers on health insurance and generally fostering a positive business environment for health insurance companies and products.

In addition, IRDA has created a Working Group on Health to bring various stakeholders together to discuss challenges and opportunities for the development of private health insurance.

India spends about five per cent of its GDP for healthcare, which is below the average for low-to middle-income countries. The Centre has reported that public spending on health dropped precipitously during the 1990s to under one per cent of GDP by 1999, lower than all but five countries in the world. (The Government has set a goal to increase public financing to two per cent in the next few years, but even that is comparatively low). In addition, there is evidence that the limited amount the Government does spend is spent disproportionately on those with higher incomes (this is due, in part, to the decentralised public financing to state governments, with wealthier states being able to spend more on health than poorer states)[3].

Current financing of healthcare in India is largely from private 'out-of-

Table 1: Selected Health Coverage in India

Source of Coverage	Covered Lives (Thousands)
Central Government Health Scheme[1]	4,276
Mediclaim[2]	10,000
Universal Health Insurance Scheme (rupee-a-day)	Not available
ESI[3]	31,050
Government Non-Life Insurance[4] Companies	56
Non-Government Non-Life Insurance[4] Companies	13
Employer sponsored[5]	30,000

1 Ministry of Health
2 Express Healthcare Management, March 1-15, 2004
3 ESIS Corporation
4 Data submitted to IRDA, October 2003
5 Express Health care Management, March 1-15, 2004

pocket' expenditures. Most estimates indicate that over 80 per cent of healthcare expenditures are out-of-pocket[4]. Good arguments can be made that the share of health expenditure financed by the Government should rise and that, because of its social nature, the public sector should have the dominant role in financing healthcare – particularly for lower- and middle-income citizens. The reality of the situation is that this is not likely to happen. For the foreseeable future, private expenditures are likely to continue to be the financing source for the majority of healthcare services.

The high share of private financing combined with the poverty of much of India's population, the dominance of the rural informal sector and the low rate of insurance coverage means that a large segment of India's population faces very high or potentially catastrophic healthcare expenditures without the benefits of risk pooling. Risk pooling, either through public or private mechanisms, is the primary way that families and individuals can be protected from severe economic hardship brought on by illness or injury. Indeed, the World Bank noted that one of the primary policy challenges facing India is :

"How will India be able to shift from predominantly private out-of-pocket health financing to risk pooling mechanisms when incomes are so low and most people belong to rural, informal sector?"

Risk pooling can be accomplished through government programmes and subsidies where the pooling of financial resources comes through the tax system. However, as noted above, private spending will continue to dominate healthcare financing in India. Therefore, a strong case can be made for the need to develop private risk-pooling mechanisms, most likely through increased availability and affordability of private health insurance.[5] An increased role for private insurance may permit the Government to target its limited resources more effectively on those most in need.

> Experience from the US, where voluntary private insurance covers most of the employed population, demonstrates not only the importance of effective regulation of both insurers and providers, but also the importance of cost containment.

At this juncture, the Government can take valuable lessons from other countries that have developed extensive private health insurance markets.

Lessons Learned: Selected Examples

Countries with comparable income per capita

Countries with per capita incomes similar to the estimated annual per capita income in India, about US$ 500, include Indonesia, Pakistan, Papua New Guinea and Zimbabwe. India's government health expenditure is significantly lower per capita and out-of-pocket spending for healthcare is much higher than in the other countries. Unlike India, most transitioning countries are moving toward government support for the poorest populations achieved through subsidies to private insurance, public schemes or improved access for the poor to publicly provided care.[6]

The commercial insurance sectors in countries with comparably low incomes offer insurance against accidents and hospitalisations through policies that provide per diem or lump sum cash payments with specified limitations and exclusions very like those in the market in India. However, this insurance is not generally available to the populations most at risk of accident and serious illness, the rural poor. Therefore, the lessons for the Indian insurance industry from the rest of the world will be distinctive for each of two major groups: those that can afford commercial health insurance and those that will require public subsidies if the coverage is to be sufficiently comprehensive and financially sustainable. Given the total population of India, both groups are very large when compared to most other developing countries.

Insurance for Rural and Disadvantaged Populations

In countries as different as China (estimated per capita income US$ 900) and Tanzania (per capita income of only US$ 280), hospital and primary care

Table 2: INDIA: REGULATORY STATUS OF SELECTED HEALTHCARE FINANCING SCHEMES

HEALTH FINANCING SCHEMES	LEGAL REGIME	REGULATOR
Private commercial health insurance	Commercial Law, Insurance Act, 1938 and IRDA Act, 1999 and regulations	IRDA
Public sector insurance companies: (a) Commercial competitive; (b) Subsidised non-competitive.	Own Acts; and Insurance Act, 1938 (subsidies)	(a) IRDA (b) Central Government, Ministry of Finance
ESIS (social security schemes that include finance and provision of healthcare).	Own Act	Ministry of Labour
Corporate self health insurance	Commercial Law	Unregulated
Community-based health insurance	Associations Law, Cooperatives Law	Unregulated. Subsidies by the Ministry of Finance entail hidden regulation
Exempted schemes (Calcutta Hospital and Nursing Home Benefit Association)	Own legal status not affected by the Insurance Nationalisation Act	IRDA

benefits have been covered by health insurance provided through village or other types of mutual support groups. Given the increasing costs of healthcare worldwide, sustainability requires pooling arrangements that are further subsidised by a risk-adjusted public contribution to the pool.

As in India, where a number of such experiments are currently underway, their success depends on the ability of the village/mutual fund to administer collections and claims and to "manage" care by avoiding fraud and abuse.[7] Ideally, health insurance, involving a mix of health insurance company management and risk-taking, state government and individual contributions and local NGO administration, would gradually encompass most of the rural poor.

In some respects, Indian NGOs are leading the way in this effort simply because public spending has been so inadequate. The challenge is enormous because some 800 million lives fall into this category. "Rural insurance should be looked upon as an opportunity and not an obligation. Two aspects that need to be developed so as to allow health insurers to penetrate the rural market are:

- A smaller bundle of innovative products in sync with rural needs and perception
- An efficient delivery system."[8]

Insurance for the growing numbers formally employed in the corporate sector

Corporations are estimated to provide coverage for approximately 30 million lives.[9] The continued rapid growth of the Indian economy and the large number of global corporations now creating new jobs in India, make it likely that close to three times this number would qualify for employer-based insurance.

The private insurance industry is developing the knowledge needed to reach this market. As the sector grows, the insurance industry should use its increasing market power to promote more effective healthcare that, in the long run, will improve its profitability. Currently, employer-financed health coverage is largely unregulated.

The experience of more developed countries

With the exception of the US, developed countries rely on social insurance models to provide comprehensive health coverage for the vast majority of their populations. India cannot provide universal social health insurance given the current low levels of per capita income, formal employment, health information system development, and regulation of healthcare professionals.

In most transitional countries, including those of Central and Eastern Europe, the existence of a social insurance system has increased revenues available to the health sector but, because subscribers still have to make large out-of-pocket payments (both formal and informal) at the point of service, it has been very difficult to either raise the contribution rate to improve access for the poor or maintain high levels of compliance with the system. While not as well off as the EU, these countries have per capita incomes ranging from four to 20 times that of India. If comprehensive universal social insurance systems are struggling in many of these former socialist countries, they do not offer a viable solution for present day India.

A level playing field with adequate consumer protection created through the legal-regulatory framework is necessary, but not sufficient, to promote development of the market. Broader stakeholder involvement is needed.

Nonetheless, there is an enormously important lesson for India from the commercial insurance sectors of OECD countries. This lesson will be pertinent whether private insurance ultimately has a major role in providing health coverage, as in the US, or a more limited complementary role as it does in most European countries. That lesson is the critical importance of effective regulation to the development of the industry. The EU has found that premium revenues from private voluntary insurance actually decreased during the 1990s as a result of excessive deregulation. Moreover, competition did not have the desired impact on administrative costs.[10]

Experience from the US, where voluntary private insurance covers most of the employed population, demonstrates not only the importance of effective regulation of both insurers and providers, but also the importance of cost containment. To increase both the demand for insurance and its profitability, the Indian insurance industry in collaboration with third party administrators (TPAs) and health services providers must soon implement and master critical elements of managed care to complement demand side tools such as co-payments and deductibles for controlling costs and limiting abuse.

Obstacles to Overcome in Developing and Regulating Health Insurance In India

The IRDA convened the first meeting of the Working Group on Health in October 2003.[11] The Group comprises a wide range of stakeholders including IRDA, the Central Ministry of Health and Family Welfare, ESI, insurance companies (public and private), consumers, healthcare providers and TPAs. IRDA recognised that as an insurance regulatory agency it has responsibility over only some of the areas and obstacles that need to be addressed if private health insurance is to develop in India. A level playing field with adequate consumer protection created through the legal-regulatory framework is necessary, but not sufficient, to promote development of the

market. Therefore, broader stakeholder involvement is needed.

The first meeting of the Group was devoted to all stakeholder views on obstacles to the development of the insurance market and possible ways to overcome them. The authors helped IRDA facilitate the meeting and the results of that meeting, along with the authors' perspectives, form the basis for the discussion below.

Perspective of Business, Consumers and Providers

From the perspective of those who could provide health insurance products and services (insurance companies, TPAs), the key problem is the perception that health insurance is not a profitable product line. Given that some other insurance products and services are profitable, there is little incentive to invest the time and resources necessary to develop, receive approval for and market health insurance products. The reasons include a lack of data to properly price products and negotiate payment rates; a regulatory framework that does not recognise the unique features of health insurance products; inadequate services provided by TPAs; the lack of quality assurance measures for health providers; and a lack of consumer awareness about the benefits of health insurance (resulting in higher than average marketing costs).

From the consumer perspective, several obstacles were raised. As with commercial stakeholders, others in the Work Group noted a real lack of knowledge about health insurance and the role it can pay in spreading risks and preventing economic hardship. In part, this comes from the perception that healthcare is a public responsibility (though this is at odds with the realities of financing healthcare in India). Second, there is an underlying belief that claims will not be paid by insurers. This reflects historical problems with claims payments in other forms of insurance.[12]

Healthcare providers (primarily hospitals) raised concerns directed more towards the impact a developing health insurance market may have on their institutions, than towards identifying obstacles to the development of the health insurance market. Hospitals raised concerns about the cost of proving required data, the effects of intermediaries (like TPAs) on their payment rates, and the potential effects of selective contracting by insurers with significant market penetration.

Legal and Regulatory Issues

A major issue is the need to make changes to the insurance law and implementing regulations to take into account special features of health insurance that may differ from other forms of insurance. In other countries, this debate tends to centre around legal and regulatory requirements for capital, financial solvency and licensing. It is often argued that health insurance companies should be subjected to different (lower) capital and financial solvency requirements.

Health insurance claims tend to be more frequent, smoother and predictable than some other forms of insurance. Since it is less risky, capital requirements for insurance companies should reflect this.

It can be argued that health insurance companies face a different risk profile than other forms of insurance. For example, they do not generally face the huge liabilities that confront general insurance when a catastrophic natural disaster (e.g., earthquake) occurs. Also, health insurance claims tend to be more frequent, smoother and predictable than some other forms of insurance (though health risks can increase dramatically as a result of epidemics and other occurrences). To the extent that health insurance is less risky than some other forms of insurance, capital requirements should reflect this, since they should be risk based.

Another argument for lower capital and financial solvency requirements is that some insurance schemes are also providers of healthcare and therefore some of their risk is business risk rather than insurance risk. For example, if a company offering health coverage (such as group and staff model HMOs in the US) contracts with members to provide health services using its staff and facilities, the insurance risk is relatively low (only for the payments they must make to others when they cannot provide the service internally). The capital requirement should reflect this lower level of insurance risk.

Additionally, they may have significant capital invested in infrastructure that can be used to deliver services, but that is normally not counted towards meeting capital or solvency requirements because of its lack of liquidity. This could be an argument for lower capital requirements or including some of the companies' infrastructure as counted capital. This can be the case either when healthcare provider organisations form subsidiaries that provide health insurance or under forms of healthcare service delivery and financing commonly called managed care (in the US)[13].

In the US, for example, differences in supervisory requirements between managed care organisations and indemnity insurance can be seen in the National Association of Insurance Commissioner's Model HMO Act.

Another potential obstacle to the development of a health insurance market is the somewhat fragmented regulatory structure for different healthcare financing schemes in India. Table 2 depicts the regulatory status of selected schemes. The current fragmentation may result in a playing field that is perceived as inequitable, particularly by potential private commercial health insurance organisations.

A final regulatory issue that may have more to do with the smooth functioning of the market than with its development is the need to increase the specialised expertise in health and health insurance of the supervisor (IRDA) for this relatively new and untested market. Activities to increase IRDA's knowledge of health insurance and managed care are already underway with technical assistance sponsored by the US Agency for International Development (USAID).[14]

Crosscutting Issue

The absence of a substantial and accurate database addressing morbidity and mortality and beneficiary and claims-related information is especially handicapping for the development of health insurance. Without such data, no basis exists for establishing actuarially sound premiums. Consequently, premiums lack a valid foundation and will likely be set too high or too low.

In 2003, the Federation of Indian Chambers of Commerce and Industry (FICCI) undertook a study of insurance, surveying 147 respondents comprising life and non-life companies, insurance consultants, and intermediaries. Responding to questions on factors hindering the development of India's health insurance market, 79 per cent cited lack of an adequate data base as a key factor, second only to inadequate "supervision of healthcare service providers."[15]

In collaboration with all major health sector stakeholders, the Ministry of Communications and Information Technology recently completed and published a three-volume *Framework for Information Technology Infrastructure for Health in India*. By clearly specifying the agreed-upon standards, the framework can accelerate the development of standardised data, including the recommended use of ICD-10 diagnosis and associated procedure coding for all inpatient admissions. Some TPAs are already coding cases to be consistent with the National Framework but they represent only a small fraction of admissions. There is much work to be done in sharing existing data to permit robust estimates and in extending the database to include more diverse populations.

Without standardisation in classifying medical diagnoses and procedures and the concurrent collection, compilation and analyses of the resulting disaggregated data on utilisation, the pricing of insurance policies will continue to be arbitrary and health insurance purveyors will not be able to design profitable schemes suited to the pocketbooks of India's diverse populations.

Quality of Care

The large base of small physician practices and the increasing number of private healthcare facilities has worsened the already poor record of the healthcare professions in establishing, monitoring and enforcing standards for quality of healthcare services in India. There are three major bodies that must work together to address this critical issue for increasing both demand for and supply of health insurance products.

The absence of a substantial and accurate database addressing morbidity and mortality and beneficiary and claims-related information is especially handicapping for the development of health insurance.

First, the Union Health Ministry must be the leader in promoting quality of care by establishing and enforcing standards in the public sector. Second, the Ministry must work hand in hand with the Medical Council of India to require responsible self-regulation of its members and of the facilities in which they are providing care. Responsible self-regulation includes processes for accrediting healthcare establishments, regular accreditation reviews, and public disclosure of current accreditation status. Accreditation should require that all healthcare providers at work in the facility demonstrate their credentials for providing specific kinds of care. Third, the State Health Ministries must become actively involved not only in granting licences to both providers and facilities, but also in providing mechanisms for updating and monitoring those that are licensed.

These mechanisms include the establishment of Medical Review Boards with the capacity and the will to remove the licences of those that are shown to be unqualified, require annual continuing medical education (CME) to retain a licence and significant remedial medical education to regain a licence. Resources must be made available to enforce these requirements. Lastly, it is again the responsibility of the various medical disciplines to determine the requirements for their members' credentials, the content of CME, and the treatment protocols appropriate to the illnesses and disabilities that fall within their purview. If these principal bodies do not perform their roles effectively, health insurers cannot develop the networks of qualified providers needed to provide services to the vast number of uninsured

Consumer Information and Activism

As noted in a recent World Bank Report, "the courts have held that health is a fundamental right, as described in the Indian Constitution, and have been active in defining the boundaries of medical negligence. The law is much stronger on paper than in practice, however, because of weak enforcement and long delays in judicial proceedings."[16]

In practice, only a small percentage of health facilities offer consumers a systematic process for gaining information and/or registering complaints, most of which are about billings and claims. Only the most educated appear to take advantage of these information resources.[17] But

studies measuring consumer satisfaction are becoming more common and demonstrate a preference for private care by those surveyed. Health insurance is a separate area where information is widely absent. A recent study noted that high marketing costs for health insurance result in part from widespread ignorance of the potential benefits of health insurance and therefore make it more difficult to develop this line of business.[18]

India's one billion citizens pay for over four-fifths of healthcare expenditures out-of-pocket. The lack of risk pooling for the majority of healthcare services can lead to both under-utilisation of necessary care and catastrophic financial consequences to a largely poor population. Since it is unlikely that the government's share of healthcare spending will rise dramatically in the near future, the pooling of risks through health insurance schemes may have a positive effect. A more developed health insurance market could both protect citizens and permit the public sector to focus its limited resources on the most vulnerable.

That the market has not developed is a consequence of a number of factors, many identified in this article. The key obstacles that need to be addressed include:

- Changes in the legal and regulatory structure for health insurance and managed healthcare
- Collection and compilation of standardised data, particularly related to morbidity and mortality and beneficiary and claims-related information
- Establishment and enforcement of standards for quality in the health sector through accreditation, licensing, credentialing and treatment protocols
- Increasing the information available to consumers in a way that will be useful to them and will help them understand and change their behaviour with respect to what is available to them and how to access it.

"Health insurance properly developed and regulated can act as a bridge between patients and providers balancing quality care at reasonable costs with an effective and accountable healthcare."18

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Endnotes:

1 Reported by Principal Secretary Prasada Rao of the Central Ministry of Health and Family Welfare at the January meeting of the Working Group on Health convened by IRDA Chairman C.S. Rao.

2 Most insurance supervisory agencies around the world do not have this format charter to develop the market.

3 Better Health Systems for India's Poor. David Peters et. Al. The World Bank. Washington D.C. 2002

4 See Ministry of Health and Family Welfare Annual Report for 2002 and Ibid (World Bank, 2002)

5 This does not imply that financing for all "private" health insurance must come from private sources. There have been proposals put forward to include some government subsidies to, for example, community health insurance systems to help those most in financial need. Yet the majority of financing will continue to be private.

6 *Health Insurance in India: The Road Less Traveled,* McKinsey & Co., March 2004, p. 17.

7 David H. Peters, et.al , *Better Health Systems for India's Poor: Findings, Analysis and Options,.*, World Bank Report, 2002, p. 294.

8 Abhijit Nagendranath, et al., *Health Insurance in India: The Emerging Paradigms,* September 2002, p.21.

9 Duggal, Ravi. *Financing Healthcare in India – Prospects for Health Insurance.* Express Healthcare Management. March 1-15, 2004.

10 "Market deregulation does not seem to have had the desired effect of bringing down health service costs, nor can high administrative costs be justified on grounds of innovation. In fact, insurers' profit ratios in most EU member states remain healthy and are higher than those of health maintenance organisations in the United States." (Elias Mossialos et. al., "Voluntary Health Insurance in the European Union", Discussion Paper 19, 2001, p. 59.)

11 A second meeting of the group was held in January 2004. That group focused on one of the most important issues raised in the first meeting – the lack of standardised data in the health sector. Future meetings will be held at regular intervals.

12 This problem is beginning to be addressed with the creation of the Insurance Ombudsman, though consumer views will likely take significant time to change.

13 While there are many forms of managed care in the US and elsewhere, a key feature is usually that the managed care organisation is responsible for the healthcare services of its members either through its own staff and facilities or staff and facilities under direct contract with the organisation.

14 USAID is supporting technical assistance and training in a number of areas of insurance regulation under its India Insurance Sector Reform project being carried out by BearingPoint, Inc.

15 FICCI, "Indian Insurance Sector: Achievements and Prospects," presented to the 8th Conference on Insurance, October 15-16, 2003, New Delhi, p. 8.

16 David H. Peters, et al , *Better Health Systems for India's Poor: Findings, Analysis and Options,* World Bank Report, 2002, p. 294.

17 Peters, 2002., p. 295

18 *Health Insurance in India: The Road Less Traveled,* McKinsey & Co., March 2004, p. 12.

19 Srinivasan R.,.*Health and Population Perspectives and Issues. 2001 Apr-Jun; 24 (2): 65-72*

Medical Policies For The Masses

—The surging need for pan-population health insurance

A policy-driven mass movement towards health insurance for all would not only augment the quality of life of the average citizen but also provide economies of scale, which would in turn lower medical costs, says ***B. S. R. Rao.***

'Extremely unsatisfactory.' The term was used in a recent newspaper report quoting an IRDA official, to describe the progress and growth in the health insurance sector over the past few years. No careful observer of the Indian health insurance scene will put forward a note of dissent. The available information on the penetration of health insurance in the country paints a dismal picture. A number of factors might account for this situation. An understanding of some of the aspects might help in making policies to ensure swift progress of health insurance in our country.

The primary function of health insurance is undoubtedly the reduction of uncertainty. *Ceteris paribus* – individuals prefer to reduce their financial risks and are willing to pay for it. From the society's point of view, health insurance is a problem in the allocation of relatively scarce resources.

As Kenneth Arrow points out, the provision of insurance as such has a "positive scarcity." That is, the reduction of risk bearing – or the ability of people not to be troubled by chance events implied in availability of insurance – is an economic good. It is, to an extent, "free goods" in the sense that if all medical costs a nation incurs are pooled, ideally, there would be "very little uncertainty about the aggregate", save catastrophic events like epidemics. Though some people are ill and some healthy, the statistical variability of the risks is very small in a large population. For a society as a whole, there is very little risk in health.

However, individually there exists a very large risk; there is a small probability that a 'statistical' individual is very ill and a very large demander of medical services. It is, therefore, not easy for a nation to provide insurance fully against medical risks.

(1) In a purely competitive market, resource allocation is efficient, as the market price of goods equals the cost of producing those goods. It follows that no person can be made better off without making someone in the economy worse off. Economics, however, recognises that the general rule that an efficient price system leads to maximisation of the welfare of society requires quite a few qualifications. In this context, three qualifications are highly relevant:

(1) The first pertains to incomplete or non-existant market resulting in incorrect pricing of the goods or services – the price to the buyer is not equal to the seller's cost. Examples are pollution and traffic congestion, besides medical care. A brief discussion of this issue is attempted later in this article.

> People are not necessarily aware of their own interests. Public policy must be designed to make people aware of what they should do, or to provide them more of what they ought to get or less of what they should not have.

(2) The second pertains to inequitable or skewed distribution of income. In the case of medical benefits, it is clear that people with lower incomes (or inadequate incomes) are denied the required medical benefits and services.

(3) People are not necessarily aware of their own interests. As such, public policy must be designed to make people aware of what they should do or to provide them more of what they ought to get or give less of what they should not have than what they desire to have. Examples include curbing or denying the supply of narcotics and alcohol. Another example is tobacco, where the manufacturer needs to make a statutory warning on the danger to health posed by its consumption. In the case of medical care, there appears to be an overestimation of its value.

Besides the above three qualifications, in the medical care market, part of the demand is induced by the supply forces (supply induced demand), violating one of the equilibrium conditions, namely that the demand and supply functions must be independent of each other.

We may now revert to the first issue, that is, the failure of the market to correctly price the goods or service. In the case of medical care, the problem of correct pricing arises from uncertainty surrounding medical care. Writers on the subject specifically refer to two dimensions of uncertainty. The first is the random character of the incidence of illness (in the statistical sense) – uncertainty of incidence of illness – as one does not know when one gets sick, one does not know when one needs medical care. As a result, individuals have a problem of risk in connection with illness and the need for medical care.

In a price system, such risk finally assumes the form of financial uncertainty. If the individual has funds to spend on medical care, his finances may be adversely affected. In the extreme case, in countries where healthcare costs are high, the individual may get financially crippled. In the alternative situation, where the individual is unable to fund medical care, he may have to suffer the inevitable health consequences. A health insurance policy is of good service in such cases.

A second kind of uncertainty, which is equally important or even more so, is one that a health insurance policy will not be able to provide for. The individual does not have information as to what kind of treatment is needed and, furthermore, the probability of success of the treatment. This type of uncertainty is peculiar to the medical

care market. The issue is further complicated by the fact that medical care market is characterised by the presence of the problem of asymmetric information. In the face of the existence of the phenomenon of asymmetric information, the price system fails to ensure an efficient allocation of resources.

Moreover, the efficacy of medical care is clouded by the specialisation of information essentially or exclusively on the supply side. If a patient approaches a doctor, he advises him on what is to be done: either refers him to a diagnostic centre or to a specialist, or recommends an operation or prescribes expensive drugs. Demand for medical services is no longer fully controlled by the receiver of the services or the person actually using them, but by someone else, presumably in the interests of the patient. The medical professional may not consider the patient's financial resources while advising the course of treatment, or the patient's willingness to trade off health against other things, or trade off one aspect of health against another.

There is no guarantee that the physician's judgment about the available alternatives in treatment is superior to the patient's judgment. Even if the motives are genuine, the interplay of decisions gets complicated when financial considerations enter.

Turning to the issue of distribution of wealth and income under the traditional economic model, competition is supposed to ensure that resources are being used efficiently. While allocation of resources in a society may be efficient, it may not be just or fair. Modern economics, in general, does not concern itself with what is right or fair. No concern is spent on whether or not the overall distribution of wealth or income is justified. However, a society, while addressing itself to distributional issues, may choose to tax the rich to provide for the poor. If that happens, it is the result of social choice and not necessarily based on social justice. Social justice is derived from a set of principles concerning what a person ought to have as a right; it is not a matter of preferences.

Adopting John Rawls' system of justice, we can say that a society is better off only when it makes its least well-off people better off. In other words, a society should devote its resources to increasing the primary goods possessed by the most disadvantaged people. According to Rawls, primary goods are defined as "rights and liberties, powers and opportunities, income and wealth". Self-respect is considered another primary goods, but Rawls does not, of course, list it as one of the primary goods. Many analysts, however, do not agree with this decision of Rawls. Ronald Greene is of the view that access to healthcare is not only a social primary good, but possibly one of the most important such goods because disease and ill-health interfere with our happiness and undermine our self-confidence and self-respect.

Lester Thurow opines: "Society's interest in the distribution of medical care springs, not from unspecified externalities … but from individual – societal preferences that 'human rights' include equal right to healthcare." Many analysts advocate "equal access for equal need" in regard to healthcare because this principle provides individuals with the opportunity to use needed health services.

The efficacy of medical care is clouded by the specialisation of information essentially or exclusively on the supply side.

It has always been accepted that poverty should not prevent one from having at least a minimum level of medical care. Arrow observes that the acceptance of this principle is compelling when generational implications are taken into account. "Children should not suffer for the poverty of their parents. At least they should grow up and have a fair chance."

Given this background, we should answer a policy question: should health insurance be made compulsory? While there are people who believe that there should be no compulsion in regard to health insurance on grounds such as the general principle of free choice, freedom for a person to take chances if he prefers, and greater knowledge by an individual about his own circumstances, there are many arguments in favour of compulsory health insurance, of which the following two reasons are noteworthy:

1) The first argument is based upon the economies of scale that can be reaped by the society by making health insurance compulsory. Group policies are so much cheaper than individual policies.
2) The second reason is adverse selection. If individuals are allowed to choose the level of health insurance they desire, those who believe they are healthier and believe they will continue to be healthier will opt out of the system. It is an instance of asymmetric information or informational inequality. The result is creation of inefficiency in the operation of the system.

There is, therefore, a strong case for having compulsory health insurance. To avoid intolerable financial costs in such a case, suitable policy measures are warranted. First, imposition of some part of the cost on the patient or co-payment is required. It may be fixed at 20 to 25 per cent. For very costly treatment 100 per cent coverage is desirable. The demand for medical treatment is not insatiable. Some analysts suggest a relatively small deductible to eliminate small claims coupled with a co-payment rate of 20 to 25 per cent, which goes down to zero if annual medical expenditure adds up to a ceiling amount.

Second, we may attempt increasing the supply of medical care for the purpose of controlling cost of care. This expansion must be accompanied by an appropriate distribution of medical care facilities all over the country. This will reduce the travel costs and inconvenience involved for patients if the facilities are concentrated in metros, cities and big towns.

Finally, there must some direct control of costs involved for providing medical care and its use.

The policy measures suggested above are tentative and extensive research needs to be conducted to evaluate their efficacy and usefulness.

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The Poor Need Health Insurance, Too!

—MFIs and NGOs rev up the momentum

Pointing out that there is an urgent need for public action to build health security into the lives of the poor, *Rajeev Ahuja* examines the ways and means of going about it.

For long out of the scope of minimum health services, the poor in India could only dream of health insurance. The climate is changing now, and health insurance for the poor is gaining momentum. On the demand side, this is partly the result of the development of micro-credit organisations keen on introducing health insurance for their clients who take a loan or credit from them. It is also the result of greater experience from the past initiatives of grassroots non-government organisations (NGOs) that introduced health insurance due to the felt needs of the community, and also of trust hospitals who wanted to minimise default payments.

On the supply side, this development is complemented by the regulatory requirement of IRDA that makes it mandatory for all insurance companies (whether public or private and whether in life or non-life segment) to extend their activities to rural and well-identified social sectors in the country.

As a result, micro-finance institutions (MFIs) and NGOs are increasingly negotiating micro-insurance schemes, including health insurance, with the for-profit insurers for the purchase of customised group insurance policies. For MFIs, integrating insurance with their credit and savings activities makes logical sense, as it helps them reap scale economies in financial management, provides them with a captive market, and enables them to use their existing network and distribution channels to sell insurance.

A recent study of micro-insurance schemes in India by the International Labour Organisation (ILO) documents 51 operational micro-insurance schemes in India. Of these, 25 came up during the past four years alone. Most insurance schemes (66 per cent) are linked with micro-finance services provided by specialised institutions (16 schemes) or non-specialised organisations (15 schemes). Healthcare providers implement only 12 per cent of the schemes. Of all micro-insurance schemes, 57 per cent provide for health insurance (it may be noted that many MFIs and NGOs are in the process of introducing health insurance).

In SEWA's (Self Employed Women's Association, Lucknow) experience, health tops the list of risks for which the poor need insurance. Anywhere from two to three million poor individuals are covered for various health risks through such schemes.

> Three conditions are essential – the presence of minimum healthcare services of reasonable quality, resource mobilisation from the people for whom insurance is sought, and the presence of a nodal agency.

Studies have shown that hospitalisation cost is one of the important causes of impoverishment. In the event of illness, people take loans or sell assets to pay for hospitalisation. At present, a majority of the poor make out-of-pocket payments for hospital care, and such spending is sporadic and not necessarily welfare improving. For example, a small illness during harvest season receives higher funds than a serious illness during non-harvest time, when availability of funds is limited. Therefore, there is a need to help the low-income people spend wisely and judiciously. Health insurance is a mechanism that provides health protection when people actually need it.

In order to extend insurance to low-income people, three conditions are absolutely essential. The first is the presence of certain minimum healthcare services of reasonable quality. The second is the scope of resource mobilisation from the people for whom insurance is sought, and third, the presence of a nodal agency. A nodal agency could be any civil society association/organisation, such as community-based bodies, women's groups, informal economy trade unions, NGOs, MFIs, and micro-entrepreneurs associations, that can mobilise the poor and perform some of the activities normally performed by an insurance company. The presence of a nodal agency is deemed crucial for extending insurance to the poor in a cost-effective manner.

Once these conditions are in place , the context defines the appropriateness of health insurance arrangement. Broadly, there are three types of health insurance arrangements: where a nodal agency acts as an intermediary between the target community and an insurer (the intermediary model); where a healthcare provider provides insurance (the provider model); and where the nodal agency itself underwrites risks (the manager model). At present, all three types of health insurance arrangements exist in the country.

The appropriateness of each depends on the context as defined by the size of the target population, its geographical scatter, and the nature of nodal agency. Choice of appropriate insurance arrangement is guided by the criteria of equity, adequacy and efficiency. For example, a standalone healthcare provider is perhaps best to run an insurance programme for a

medium sized group that is also in a geographical continuum. Similarly, smaller groups that are also geographically dispersed can best be covered through an intermediary model.

Health insurance is not a magic bullet that can finance all types of ailments, and it is important to recognise what it can and cannot cover. It is generally appropriate for covering the cost of inpatient care. Outpatient and maternity care can best be covered through other financial arrangements such as setting up a revolving fund facility that can be used to provide soft credit or by instituting a co-payment mechanism for meeting expenses for such types of care.

There are several good reasons for excluding outpatient care from an insurance programme, notable among these being the administrative complexity associated with its inclusion. Generally, excluding diseases requiring hospitalisation and introducing a waiting period only tend to complicate matters and exclude the target community from benefiting from an insurance programme. A cap on the benefit amount provides a check against cost escalation. On the unit of insurance, typically enrolment should be in terms of individuals, with incentives for family enrolment.

Although health insurance only provides for the cost of hospitalisation, the poor also have to incur many indirect costs, such as wage loss, transportation costs, opportunity cost of time of those who accompany the sick and special meal costs. These costs can be prohibitively high, discouraging a sick person from visiting a hospital and seeking treatment even when he or she has health insurance. For this reason, some health insurance schemes (for example, the two UNDP sponsored pilots in Karnataka) have also provided wage loss benefit that is used creatively by a nodal agency. For example, any unpaid instalment of premium is deducted from the wage loss amount that a sick person is entitled to. In some cases, it is also used to pay the renewal premium for the following year.

The flip side of providing wage loss benefit is that it can induce hospitalisation when it is not required. Some social health practitioners believe the other indirect costs are sufficiently high to check against such tendencies.

Health insurance is likely to be successful where it is only one of the components of a health programme whose other components include spreading health awareness and knowledge, strengthening preventive healthcare through early diagnosis and so forth. For this reason, running a successful health insurance programme requires coordination among multiple agencies.

Since health security to the poor is a priority social need, the government is expected to play a proactive role in building it. Public intervention can take the form of pro-poor regulations as well as assume a more direct form, such as a subsidy. Regulations can be both on the healthcare provision as well as on the supply of insurance. At present, public health services are weak and inefficient, save for a few selected pockets; private healthcare is unregulated, and voluntary healthcare is scattered, unstructured, unregulated and limited in reach. Healthcare provision needs to be strengthened and streamlined if health insurance for the poor is to be developed in a big way. Since health is a state subject, involvement of the state governments is essential in achieving this.

Public intervention can take the form of pro-poor regulations as well as assume a more direct form, such as a subsidy.

Currently, insurance regulation seeks to extend insurance to the low-income people through mandatory social and rural obligations. These regulations do not explicitly call for a cross-subsidy. Perhaps, it is a bit early to review its impact. But there is a good case for greater experimentation in this direction since IRDA is entrusted with the task of developing the market. Perhaps, there is a good case for defining rules for promoting trust and charitable healthcare providers to initiate health insurance within certain geographical reach.

On providing direct subsidy, there are several ways though which the government can ensure that the poor are not excluded from healthcare services. One such channel is to strengthen the existing public health facilities such as Primary Health Centres (PHCs) and Community Health Centres (CHCs). These facilities can handle outpatient as well as maternity care and also provide effective antenatal and postnatal care, the lack of which is among the leading causes of maternal and child mortality in India. Strengthening public healthcare facilities can make the development of insurance for inpatient care that much easier.

In the context of insurance, subsidy can be provided for start-up costs depending on the number of people who join health insurance and can perhaps be routed through a nodal agency of some repute. Likewise, measures such as withdrawal of service tax on rural and social insurance products can also help in lowering the price of insurance for the poor.

To sum up, there is an urgent need for public action in building health security into the lives of the poor. Insurance is a critical financing tool that has been tried and tested by various agencies in different forms, and the results from the on-going initiatives are promising. The experience gathered so far can be profitably applied to upscale and broadbase such initiatives in the country. For successfully running health insurance for the poor, coordination among multiple agencies is needed.

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Covering the Poorest

—Affordable health insurance for the poor

We should ensure health insurance for the poor more urgently to increase the overall benefits to the society. ***P. C. James*** suggests ways and means to achieve this end with a shrewd combination of benefits and delivery methods given Indian conditions.

People have basic needs not only for economic goods, but also for social goods such as education and healthcare. Protection against illness or injury is a fundamental need as good health and wellness is essential to normal life. For the poor and the marginalised, good health is a matter of survival as they are dependent on their bodies for day-to-day earnings. Good health when protected, not only adds benefit to an individual but also aids to the well being of the family, the community, the society and the country. Research has shown that health protection plays a distinctive role in poverty reduction everywhere in the world.

As seen earlier, for the poor their bodies are often their only earning assets, and therefore good health is directly related to their income and survival. In sharp contrast to this there is often an inevitable denial of access to healthcare to them, which is one of the reasons why they face a vicious cycle of poverty, illiteracy and malnutrition. The world over, it is seen that ill health disproportionately affects the poor. It sets off a chain of losses such as deprivation of work and consequent wages, lack of other means to earn, expenditure for medical treatment, the need to borrow money from moneylenders as they do not have access to normal banking channels.

A National Sample Survey Organisation (NSSO) study found the following trends in the matter of healthcare for the poor in India:

1) They spend a much higher percentage of their income on healthcare vis-à-vis the rich.
2) More than three quarters of the spending is on minor ailments, infections and communicable diseases.
3) The poor in their inability to finance treatment delay seeking treatment. Nearly 20 per cent of them do not avail treatment for financial reasons.
4) Borrowings and interest bearing loans are important financial sources for healthcare for the poorest; the proportion reduces as the income level rises.
5) A single instance of hospitalistion can wipe out all family assets.

There is often an inevitable denial of access to healthcare to the poor, which is one of the reasons why they face a vicious cycle of poverty, illiteracy and malnutrition.

The same round of NSSO survey shows that medical expenditures, particularly for inpatient treatment, had more than doubled in urban areas, bringing into focus the significance of medical inflation and the effect that this has on the poor in making treatment out of their reach. It also pointed out that the utilisation of public health facilities for hospitalisation had accordingly dipped from 60 per cent to 44 per cent. It was further noted that there was a decline in OP utilisation due to poor access and the lack of quality of services.

The poor face numerous barriers to accessing healthcare facilities, which can be due to lack of information on the availability and location of services, physical barriers due to distances as also lack of transport facilities, inability to marshal financial resources, and insensitive and unreliable treatment. Of these the biggest barriers are the prohibitive costs in the private hospitals and the poor responsiveness to needs in the public health system.

A recent World Bank study further underlines the vulnerability and risks faced by the poor. It says that a hospitalised person in India spends more than half of his total expenditure on healthcare and more than 40 per cent of those hospitalised have to borrow money or sell assets to cover their expenses; and 25 per cent fall below the poverty line owing to this.

It is clear, therefore, that there is a genuine need to reach health risk financing to the poor through the medium of health insurance. The health infrastructure of the country has been moving from a situation of nil or poor availability of healthcare facilities in the earlier days to a vast three tiered health system set up by the state consisting in the rural areas of subcentres for a population of 5000, primary health centres (PHCs) for a population of 30,000 and community health centres (CHCs) for a group of 1,00,000 population. In the urban areas the infrastructure consists of urban health-posts, taluk hospitals, district hospitals and medical colleges having tertiary facilities. In the non-governmental sector there are fairly large numbers of for profit hospitals and nursing homes as also charitable and trust hospitals.

Despite the large potential and the capabilities we have, the reach and availability of affordable healthcare for all remains a distant dream. The burden

of disease is substantial. There is a palpable inability to control communicable diseases, which accounts even now for 50.3 per cent of the disease burden. Other health issues such as the widespread prevalence of diabetes and cardiac related problems are also surfacing which would need enhanced care to prevent them from becoming unbearable social issues.

Why health insurance for the poor

The poor find themselves continually excluded not only owing to their penury but also due to lack of social empowerment, literacy, and feelings of powerlessness. There is also the factor of inaccessibility and non-availability of healthcare in many remote places, as providers do not obtain the necessary return on investment due to the lack of paying capacity of the poor. Thus there is a vicious cycle of perpetuation of poverty and ill-health due to their inability to obtain proper healthcare.

Insurance can be seen as a weapon of social and economic empowerment for the poor. In particular the insurance of health assumes prime importance. In a globalising environment, the cushion that could have been available by way of joint families, social groups or government support is not available as earlier. On the other hand risks and vulnerability is increasing. In this context it is the insurer's duty to organise, transfer and spread risks so that the society consisting of individuals, families and communities is genuinely protected. The role and capacity of insurers in this regard is bound to grow over time and overshadow the role played by the State and other non-insurance risk mitigating institutions.

Protection of health pays a large demographic dividend to a country. Therefore governments, economists, welfare organisations and social workers are concerned about the transfer of health risks as quickly as possible. A proper health infrastructure backed by financing through health coverage, especially among the weaker sections, can not only transform the economy but also act as a catalyst to beneficial social engineering.

Health insurance is an essential component of personal protection. Thus there can be many reasons to reply to the question 'why health insurance?' These reasons include:

1. Health risk is not only pervasive but also a frequency risk among all the segments, classes, and age groups.
2. The costs of illness and diseases are increasing continuously along with the developmental index, as a result of the progress that is taking place, including environmental degradation as a result of urbanisation and industrialisation as also changes in lifestyle, occupation and food habits.
3. Medical costs are rising, and specialised treatments are becoming common, but costs of treatment are also reaching prohibitive levels.
4. Longevity and diminished mortality rates while improving social indices also bring along substantially more costs to recovery from illness, disease or accident, and also to maintain good health.
5. New disease patterns are emerging. In particular lifestyle diseases are increasing health risks considerably.
6. Rising incomes and prosperity, bring on expectations and lead to larger spends on healthcare. A survey conducted by NSSO in1999-2000 found that out of the 12 types of households classified based on their monthly per capita expenditure (MPCE), the top class has an average per capita expenditure of about 12 times than that of the bottom class in general, but in the case of healthcare, the expenditure incurred is 28 times more.

A hospitalised person in India spends more than half his total expenditure on healthcare. More than 40% of those hospitalised have to borrow money or sell assets to cover their expenses; and 25% fall below the poverty line owing to this.

While the imperative of covering all, especially the poor, is a great need, insurers have their own need to understand the complex nature of health protection and bring in models of coverages based on affordability and sustainability.

Health insurance is not an easy subject, particularly when it relates to the poor. The difficulties faced by the insurers include:

a) Health insurance deals with the complex subject of morbidity, which is determined by a variety of factors such as age, income, occupation, sex, genetic factors, environment and so on. The patterns, intensity and frequency of morbidity are not easily understood and statistics are not readily available.

b) Unlike many other insurances, health insurance is claims intensive. This means that claims will be frequent and the underwriting results will be under strain if the risks are not assessed prudently.

c) Moral hazard and adverse selection are especially distinct possibilities in health coverage. Those with known risks try to enter, and persons with the highest risk try to obtain advantageous terms of cover in their favour.

d) Medical costs have historically been showing inflationary tendencies. This coupled with increasing levels of utilisation puts to peril the rating

structure and the beneficial features of the policy. The rising premium from adverse claims could begin a vicious cycle as those with less risk will begin to leave and those with certainty of claims will stay with a rising trend of claims making the health scheme even more unviable.

e) Health insurance is a highly emotional and service intensive business. Health coverage needs highly specialised service providers such as the TPAs to ensure cashless service, emergency assistance, networking with hospitals, call centres, very fast and responsive turnaround times in claims settlement and complaints handling.

f) Finally, and most importantly, the success of the coverage depends on the proactive approach of the many stakeholders involved. The Government needs to bring in necessary regulations regarding standardisation, coding, rating of hospitals and other parameters of healthcare. The providers need to bring in standardisation in billing and transparency in costs and so on. The insurers need to study the markets for the rural and the poor and offer appropriate products and services. The TPAs and other service providers need to spread into the interiors to network hospitals and offer suitable services.

Risk profile of the poor

Are the poor, 'poor' risks? In health insurance they could be considered acceptable risks for the following reasons:

1. The poor, because they engage in physical labour, are more likely to be prey to contagious diseases rather than to the more expensive lifestyle diseases. Even this happens because of their poor surroundings and inability to obtain clean water etc.
2. The poor are generally reluctant to utilise health services, as it often affects their daily earnings. They are also overawed by the formalities, paperwork and other difficulties in getting service. They also lack ready information on the facilities available for the poor.
3. They would be more amenable to cost controls and agree to utilisation of government facilities and other low cost treatments.
4. The poor would be generally reluctant to cover themselves on an individual basis and broadly such insurances would be successful on group or community basis, which give the insurer a balanced cover by insuring all.
5. Finally, the poor constitute the vast base of the consumer pyramid and hence the numbers and magnitude of the segment make them a very attractive consuming class.

> Pegging the premium in line with an everyday expense such bus fare, a daily food item or a rate like Re.1 per day, can help to move the perception of healthcare protection from that of a luxury to a necessity.

Strategies for insuring the poor

1. Making the price affordable:

Price, especially in the form of annual premium to be paid in one go, can make healthcare cover out of the reach of many, especially wage earners. In the case of the poor, it acts as a major barrier owing to their having little or no savings. Several steps to ease the burden could be considered:

a) Keep the sum insured low: For instance a model has been worked out in a taluk of Karnataka where the sum insure is as low as Rs.2,500 and the premium is only Rs.30 and the scheme is found to be viable.

b) However for persons other than the very poor who are in remote places, a very low sum insured would be meaningless, particularly if private healthcare has to be utilised. Experience shows that a sum insured of around Rs. 30,000 would be suitable for majority of the treatments, except the major critical illnesses, if taken in a low cost hospital. The Universal Health Insurance Scheme is based on this insight and the premium concept of Re.1 per day is also an innovation in this regard.

c) Additionally, floating the sum insured over the family helps to cover more persons at low per capita premium.

d) Pegging the price in line with an everyday expense such bus fare, a daily food item etc. or a rate like Re.1 per day can help to move the perception of health care protection from being a luxury or unaffordable to one that is necessary and to be availed of.

e) Even under the existing rules on premium payment it would be possible but not practicable to collect Re.1 per day from the beneficiaries. The difficulties would lie in the following areas:

   i) The prohibitive cost of collection
   ii) Reconciliation and accounting difficulties
   iii) The risk of break in policy if premium not paid in time
   iv) Automatic cancellation would put both parties into difficulty
   v) In case of seasonal workers such payment would not be possible.

f) These difficulties could be obviated, if the following steps could be considered :

   i) Such insurance should be community oriented schemes

ii) SHGs and NGOs could be involved in financing/ guaranteeing the premium payment

iii) These and similar organisations could additionally take responsibility for collection and payment to the insurer periodically.

iv) The organistions financing, collecting and guaranteeing could charge reasonable fees for such services

v) Since daily/monthly savings target are already in place such mechanisms could also work for collecting the premium.

2. Crafting the right product

Customer aspirations towards healthcare services can be very demanding. This would include demand for preventive, curative and maintenance coverages, and over time would be witnessing increased utilisation as well as expectations of higher order treatments. These could put the viability of the scheme in jeopardy over the longer term. If strict controls are not imposed over costs and utilisation rates, the premium will have to be raised steeply, making the cover out of reach for those it is intended for.

Research among the poor indicates that the following benefits are desired:

Hospitalisation service

Outpatient (OP) treatment

Treatment for chronic ailments

Maternity care

Care for infants and children

Cover for specialist treatment

In addition to treatment per se, the poor would need benefits under other heads as well, such as:

Loss of daily wages

Out of pocket expenses

Transportation costs

Death/disability due to hospital negligence

Death/disability due to accident

Given the poor premium paying ability of those in low income groups it would be very hard to offer a cover against all the components desired above. Nevertheless if strict cost controls could be imposed with the willing participation of all those involved, many of the above covers could be considered.

Various strategies have been in vogue for control of costs and utilisation of facilities. These include:

- Usage of Government facilities only
- Treatment from named charitable hospital
- Treatment at named hospital where low cost treatment packages have been agreed upon

Protection of health pays a large demographic dividend to a country. Therefore governments, economists, welfare organisations, social workers are concerned about the transfer of health risks as quickly as possible.

- Admission to general ward only
- Bed charges limited to a fixed amount

As per common practice bed charges often determine the level of charges for other hospital costs as well. Other limitations could include:

- Use of generic drugs only
- Consultation of named doctors only
- Use of local hospital and treatment at other hospital by referral only
- Imposing sub-limits on various common treatments

With regard to out patient care, it could be encouraged on a controlled basis, as various benefits could be derived. Preventive treatment in time can help to avoid expensive curative treatment. The customer also can obtain total health care. Loss of earnings could be avoided if timely OP treatment can be availed. However outpatient care is possible only if will local general practitioners (GPs) can be available to do service on monthly honorariums depending on the number beneficiaries covered. Thus if 2,000 persons in a community are covered the doctor can be paid Rs.5,000 per month and the basic risk premium per person per annum would be Rs.30 only.

The benefit of this arrangement is that all pay a small premium, but the sick can have as many visits as required. This can also motivate the doctor to ensure that cures are made with as few visits as possible. The doctor would also be empowered to act as a referral for hospitalisation.

3. Guaranteeing the benefits of the product

Since health insurance is an essential product, it must be ensured that it delivers on the promise. This can be achieved with the active participation of many players as explained below:

a) The government public health system has to be upgraded for quality and responsiveness

b) To enable them to do so they can charge user charges payable by the insurer. This will enable them to have the necessary cash flow for day-to-day administration, continuous improvement and upgradation.

c) Private and for profit hospitals need to have beds for the poor with low and transparent charges.

d) Where communities do not have affordable health facilities, the same should be started on the assurance future cash flow that could come by way of assured insurance payments.

e) Willing doctors should be appointed for community service with adequate salary.

f) TPAs will have to spread their services to the rural areas.

g) Insurers will have to shape the products to benefit the customer on real-time basis with assured

coverages which will not be plagued with failure clauses.

h) All services and payments to be agreed with various providers, so that the insured can be given hassle free, cashless service.

4. Administering the scheme

a) Willing hospitals, nursing homes and the government infrastructure to be networked for service.

b) Suitable training scheme to be introduced to promote awareness of health insurance, its benefits and formalities. There could be programmes in the radio and TV to educate volunteers in far flung areas.

c) Giving a role to intermediaries. Insurance is not an easy subject to understand and utilise. Hence, since its inception there had to be intermediation in this area. Apart from the traditional agents, what is required is the active intermediation of Panchayats, cooperatives, NGOs, SHGs and other rural institutions. They are needed to initiate market and administer the scheme for the benefit of the community. Their roles, tasks and responsibilities need to be defined and agreed, and made easy to execute.

d) There will be the need to involve opinion leaders, the field staff of NGOS, medico-social workers attached to health facilities, other multipurpose workers, anganwadi workers, village development committees, their volunteers and so on.

e) The processes and transactions involved should be carefully studied and mapped and made error free to ensure the success and continuity of the scheme.

f) Adapting the product and services to local needs: All schemes, however excellent, may be found unworkable in the light of the unique requirements of specific areas especially as this country is vast and diverse in many characteristics. Hence products and benefits may require continuous tailoring to be of use and to attract all intended beneficiaries.

> While the imperative of covering all, especially the poor, is a great need, insurers have their own need to understand the complex nature of health protection and bring in models of coverages based on affordability and sustainability.

g) Creating necessary feed back and learning loops: Continuous monitoring and periodic evaluation, especially feedback from the users of the service is essential to make such schemes a success. The failure of coordination, the ballooning of costs, the exclusion of the real needy etc. need to be studied so as to ensure continued betterment and relevance for the target group. The learning obtained should be applied wherever possible for continuous improvement.

Conclusion

Many insurance schemes for the poor are being experimented with across the country. Along with food security, health security has become a crying need, and the time has come to scale up the pilot schemes to much larger populations with the active support of the governmental and non-governmental infrastructure that is available. At the root of the success will lie the ability to utilise the meagre paying capacity of the poor to ramp up a responsive and quality scheme to remove the frequent health risk being face by the poor and help to prevent further deterioration of health. The challenges are many, but if all institutions can be convinced to converge on this important issue, there could be substantial breakthrough in health security for all.

The author is Manager, National Insurance Company Ltd. The views expressed here are his own.

The Economics of it all

—How familial economic security hinges on correct need evaluations

Emphasising the financial and social significance of the Human Life Value concept, ***Apparao Machiraju*** argues that the capitalised economic value of an earning individual should be appraised on scientific lines, rather than by mere guesswork.

A majority of us depends on a monthly income, and our lifestyle is now closely linked to acquiring wealth. These have rendered us, along with our families, more vulnerable than our ancestors to environmental and societal changes over which we have no control. Sickness, disability, old age and death pose serious threats to the well being of the family, and formalised means are required to mitigate their adverse consequences. The revolutionary idea that defines the boundary between modern times and the past is being able to manage the risks using the facility of insurance.

In family economics, the dependent family members have to be provided for on a risk based assured capital sum which, when invested, will ideally replace the income devoted to family maintenance. Similarly, for retirement income through pension and annuity plans for the aged. Also, it is to be recognised that disability and sickness lead to having to meet the medical expenses as well as the income needs of the households. Thus, discussing insurance needs without evaluating the possible economic consequences in family and business situations in the event of the breadwinner's sickness, disability and death is like discussing medicine without understanding anatomy.

This article attempts to emphasise the financial and social significance of the "Human Life Value" (HLV) concept, that is, the capitalised economic value appraised on the basis of the income potential of the earning individuals along scientific lines as distinguished from mere guesswork.

Health insurance (comprising both accident and sickness insurance) is referred to as the teammate of life insurance for the protection of human life values against all types of economic death. In fact, life insurance and health insurance are on par as the two protectors of HLV. The public sector insurance companies could establish a health insurance corporation for providing healthcare services with a holistic approach instead of as ancillary services.

Discussing insurance needs without evaluating the possible economic consequences in family and business in the event of the breadwinner's sickness or death is like discussing medicine without understanding anatomy.

The article also aims to present the service phases of life and health insurance, concerning which students of economics, the public generally, and the vast field forces who should serve as counselors to the public, should be informed. This would give them a clear understanding of the far-reaching and manifold usefulness of life and health insurance to the family, to business, and to the insured's personal welfare.

Economists since Adam Smith have recognised that people are important elements of a nation's wealth. The essence of human capital is that investments are made in oneself with an expectation of future benefits. Economic research related to investment in human capital has recently gained substantial recognition. Indeed, the 1991 Nobel Prize was awarded to Gary S. Becker for his pioneering research on human capital.

The HLV concept is a part of the general theory of human capital. Although this has been an area of inquiry for more than four centuries, only in the recent times has the interrelationship between human capital and life, health, and property values insurance been acknowledged. It was in 1924 that S.S. Huebener of the Wharton School, University of Pennsylvania, proposed the HLV concept as a philosophical framework for the analysis of the basic economic risks that individuals face.

He argued that the HLV concept involved five important concepts:

1. HLV should be carefully appraised and capitalised. It is the present value of that part of the earnings of the individual devoted to family dependents and others who benefit from that individual's economic earning capacity. Wherever continuance of a life's value in the economic sense is financially valuable to others, an economic basis for life and health insurance exists.
2. HLV should be recognised as the creator of property values. In other words, HLV is the cause and property values are the effect.
3. The family is an economic unit organised around the HLV of its members. The family economics need to be organised and managed, and its economic values finally liquidated, in the same manner that other enterprises are operated and liquidated.
4. HLV and its protection should be regarded as constituting the principal economic link between present and succeeding generations.

5. In view of the significance of HLV relative to property values, the scientific principles of business management utilised in connection with the property values also should be applied to life values.

No substantial difference exists between various types of insurances as regards their underlying economic purposes – they all render the same fundamental services, and it is merely a matter of application to the particular type of economic value under consideration. All insurances are concerned with three fundamental services:

1. Indemnification of the loss of values
2. The scientific treatment of risk bearing, and
3. The equitable distribution of the cost among the insured

The life and health insurance markets benefit economic development in several ways, such as:

1. Life and health insurance can contribute to social stability by permitting individuals to minimise financial stress and worry.
2. Life and health insurance can reduce the financial burden on the State of caring for the aged and for those made financially destitute because of the sudden death of a family breadwinner.
3. Through the accumulation from thousands of policyholders of small amounts of savings, life and heath insurance services lead to capital formation and infrastructure development.
4. HLV and its protection form a principal economic link between the present and succeeding generations.

Important as life and health insurance are today, their real progress is yet to come. A very large number of the insurable population remains to be insured in the country. In 2003, life insurance density, i.e. premium per capita, was only US$12.9, as against the global density of US$267.1. Life insurance penetration, i.e. premium as a percentage of GDP, in India was 2.26 per cent, as against the global penetration level of 4.59. India's share in the global market remained below 1 per cent (0.81 per cent).

An expert group of the Confederation of Indian Industry (CII) has attempted to project the size of the insurance market over the next 10 years. Premium income of Rs. 1,45,000 crore is projected by 2009-2010, translating into average annual growth of over 19.6 per cent. Premium business from the pension schemes is projected to grow over 22.5 per cent. The projected potential market remains latent unless the insurance companies draw up a long-term strategic action plan incorporating commercial and social agenda, taking into account the context of current and emerging marketplace realities.

We are in a transition stage. We need to focus on "on transition facilitation." We need to address the issues truthfully.

We are in a transition stage. We need to focus on "on transition facilitation." We need to address the issues truthfully, basing our study on unfiltered feedback as to what is happening at all levels in order to be able to formulate appropriate strategies. Most of the major problems confronting the life insurance business in today's situation are marketing oriented, especially the intermediary channels, current and emerging.

The insurance industry has neither closed its ranks to practising incompetents, nor established an internal system for measuring or enforcing professional standards. The public, by and large, has no other recourse than to believe that incompetence or unethical practices are a norm with which it must learn to live. Insurance services counseling covering life and health insurance as a vocation and career may advance and acquire stature and dignity in direct proportion to the education /training received by those in business.

It is therefore with education and training that we ought to be mainly concerned. It is the first and most important step in marketing methodology. The insurance industry should ally with academic institutions who are better equipped to impart non-partisan education, rather than depend on industry run institutions. The in-house institutions, however, are important in being able to supplement training in operational inputs.

The IRDA seems to be seized with formidable issues and challenges for which solutions have to be worked out. Hopefully, with the combined cooperative and supportive efforts of insurance companies, academic institutions and researchers, a new era in insurance services aimed at preservation and conservation of economic health of family units and business enterprises with a holistic and integrated approach will make a beginning.

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Wealth through Health Insurance

—The Way to Sustainable Development

Health insurance is not yet profitable in India for various reasons, But there is a lot that insurance companies can do despite external factors says ***Aloke Gupta.***

The Indian insurance industry at present covers around 95 lakh persons under private health insurance, mainly under Mediclaim, a hospital expenses policy. Despite its inadequacies, Mediclaim has experienced dramatic growth over the years mainly for want of substitutes. From 1995-96 to 2002-03, the number of persons covered increased by 29 per cent per annum and premiums went up from Rs. 129 crore to over Rs.1,000 crore. The percentage of total population covered under Mediclaim rose from 0.084 per cent in 1990-91 to 0.359 per cent in 1998-99 and to 0.9 per cent in 2002-03.

Sustained growth of Mediclaim indicates a huge latent demand for health insurance, fueled by escalating episodes of hospitalisations due to rise in lifestyle diseases, accidents, escalating hospitalisation expenses and the absence of a public health security net.

Recent trends

Despite IRDA's non-statutory stipulations, private sector general insurance companies have found health insurance unattractive. The onus of providing health insurance to the populace has fallen on public sector general insurers. Most private players have cloned the Mediclaim policy or introduced new products like Hospital Cash and Critical Illness, which have had little impact due to passive marketing and 'skimming' – the practice in health insurance where insurance companies seek to enroll only the healthiest people as a way of controlling claim costs. Skimming is also called Creaming and contrasts sharply with *adverse selection.*

The prime inhibitor for growth of health insurance in the country is its non-profitability. The following findings are based on an analysis, by the author, of Mediclaim portfolio of a public sector insurer for 2002-03 and 2003-04:

- Policies to individuals contribute nearly 70 per cent of Mediclaim premium and this share is growing. This growth indicates greater persistency and is organic, fueled by increase in health insurance awareness.
- Mediclaim Claims ratios have worsened during 2003-04 over 2002-03, despite the introduction of TPAs.

> Individual Mediclaim promises to be the growth engine of the health insurance segment. However, insurers need to guard against low premiums, adverse selection and moral hazard.

- Individual Mediclaim, though more prone to adverse selection, leads to lesser losses than Group Mediclaim.
- Group Mediclaim premium is shrinking due to premium undercutting.
- Metros, the main markets for health insurance, account for 80 per cent of Group and 65 per cent of Individual premiums – and for over 125 per cent medical loss ratios.
- Healthcare costs differ considerably between different underwriting regions but the gap is closing rapidly.

Within the given market and external constraints, for health insurance to achieve greater penetration, the following measures are required urgently:

1. Costs of healthcare and medical losses vary widely over regions. Uniform premiums are regressive - policyholders of smaller towns subsidise those in metros and major urban centres. This impacts overall profitability of health insurers. Insurers ought to undertake differential premium pricing based on healthcare cost zoning. Auto insurance provides an example of differential premium based on geographic regions.
2. Individual Mediclaim promises to be the growth engine of the health insurance segment. However, insurers need to guard against low premiums, adverse selection and moral hazard (both those of the policyholder and healthcare provider).
3. To tackle adverse selection, insurers need to take policy design initiatives like incorporating pre-existing conditions clauses on a time scale as also co-insurance and co-payments basis into its basic structure. Health screening for certain age groups can also be introduced.
4. Claim costs control features like graded co-insurance for treatment in out-of-network hospitals and restriction of room occupancy type based on sum insured need to be introduced.
5. 'Provider moral hazard' reflected by increased healthcare utilisation (unnecessary investigations, prolonged hospital stay and inflated hospital bills), is a prime reason for high claims. Hence insurers should insist on some form of DRG -

Diagnosis-Related Group - a system of categorising inpatient medical services and assigning specific reimbursement fees to each category - based or package based contracting with healthcare providers in a bid to make them risk sharers.

6. Hospital charges vary directly with type of room/bed occupancy in a hospital. Healthcare providers nudge health insurance patients towards expensive room/ bed category, leading to higher medical expenses. Health insurance policy design should build room/ bed type restrictions in the policy based upon level of sum insured.

7. Despite the presence of Third Party Administrators (TPAs) in the market for over two years, health insurance claim ratios have not improved. There are unconfirmed reports of their collusion with healthcare providers. TPAs need to take corrective action to justify their role as healthcare facilitators, failing which, their very survival is at stake. They urgently need to control claims by use of DRG or package based negotiated rates with healthcare providers and a tighter management of the pre-authorisation process. They need to define service standards for every stage of interface with policyholders and measure their performance through customer satisfaction surveys.

8. TPAs are repositories of valuable healthcare utilisation data, so critical for product development. They should provide this data to insurers to facilitate product development and innovation.

9. Lack of data on health insurance in India has stymied research and informed debate on products, segments, coverage, profitability, utilisation issues, policyholder and provider behaviour and regional coverage and cost disparities, etc. To enable evolution of health insurance sub-models for the country, IRDA should directly, or through the Tariff Advisory Committee (TAC), collect and disseminate information for each type of health insurance policy.

10. IRDA should also standardise claim forms, billing information and other documents required in the claims process. Through TAC it should develop a health insurance IT solution/platform that provides:

    - Customised electronic policy proposal form for more effective profiling of health insurance customers to facilitate effective premium pricing
    - Electronic pre-authorisation system for common use of all care providers to assess policy validity and to obtain automated pre-authorisation for procedures and treatment compatible with provisional diagnosis and commensurate costs
    - Standardised electronic claim management
    - Electronic medical record system and storage
    - Healthcare provider rating mechanism
    - Framework for case mix reporting by hospital accepting insured patients.
    - Recommended care guidelines for standardised and cost effective care.
    - Utilisation review guidelines
    - Analysis capability to review Treatment-Cost-Analysis, Appropriateness of the Treatment, Disease occurrence rates, Demographic Occurrence Rates, Incidence of Policy-Abuse etc.

The existing health scenario in the country is paradoxical. There is potential for exponential growth in health insurance, yet insurers are reluctant to mine it.

Public sector general insurers, by virtue of being the market leaders as also major loss bearers for this segment, have an evangelist role to play in orderly and sustainable development of health insurance in the country. They need to usher in the *risk-coverage-premium* balance by introducing a basic and sustainable health insurance product. Developing a range of products for different population segments and expounding fundamental guidelines for dealing with healthcare provider issues like credentialing, networking, negotiated contracting and standardised billing are essential.

The existing health scenario in the country is paradoxical. There is potential for exponential growth in health insurance, yet insurers are reluctant to mine it. Profitable health insurance portfolios can facilitate rapid expansion of the healthcare delivery sector by increasing number of patients that can afford hospital care, yet healthcare providers do not wish to rationalise healthcare utilisations. Healthcare Regulators (Ministry of Health, Medical Council of India and the State Health Departments) are apathetic to the need of bringing about necessary changes in healthcare delivery, efficiency and accountability by introducing urgent reforms in sectors like Accreditation, Clinical Standards and adoption of Disease Procedure and Clinical Observation Codes. Finally, the Insurance Regulator, in addition to not initiating health insurance reforms, has done little to clear the confusion about which silo health insurance fits in – life or non-life.

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Prescribed: Growth Tonics

—Private Health insurance in dire need of fillip

To meet the burgeoning need for health insurance in the country, private sector participation is a must, says ***Misha Segal***, who also suggests steps to remove the market barriers for the players.

The health insurance coverage of the Indian population is nothing to write home about. While less than 15 per cent has any health insurance at all, just 3.5 to 5.5 per cent receives private health insurance.

The World Bank estimates that in 1999, either Mediclaim or an employer-based scheme covered approximately 3.5 per cent of the population. In 2002, McKinsey found that private insurance covered 5.5 per cent of the population. Given the liberalisation of the private insurance industry, the percentage may be higher today.

However, most of the existing health insurance products are inadequate. For example, the two major private health plans offered by insurance companies — Mediclaim and Jan Arogya Bima — are indemnity products that only cover inpatient hospitalisation. These plans do not meet the healthcare needs of most Indians, nor do they adequately address their financial situation. A health plan without preventive care does little to thwart major illnesses and hospitalisations. In addition, many citizens do not value the product as they face difficulties in making large payments at the time of illness, even if these are likely to be reimbursed later.

Employer-based schemes, which form the overwhelming majority of private insurance plans, often directly or indirectly leverage the Mediclaim policy. Employers may offer Mediclaim to their workers, or they may create a very similar plan on their own (through self-financing). Alternatively, some employers offer health insurance through their own facilities. In addition, we have heard anecdotally that some employers have created pre-arranged deals with certain providers. It is unclear whether these arrangements are similar to managed care schemes.

Private Health Insurance: Market Barriers

The slow growth in the private insurance market may be due to strong regulatory and competitive barriers. Current law places health insurance under the same umbrella as general insurance. As such, any health insurer must maintain a minimum capital limit of Rs. 100 crore (roughly $22 million), even though health insurance losses are typically much less volatile than property and casualty insurance. This requirement leads to participation from only extremely well financed organisations.

The slow growth may be due to strong regulatory and competitive barriers. The law places health insurance under the same umbrella as general insurance, which deters participation by smaller players.

Additional legislation makes financing even more difficult, as foreign equity participation in insurance ventures has been limited to 26 per cent. (On July 8, Mr. P. Chidambaram, Union Finance Minister, proposed relaxing this requirement by allowing 49 per cent foreign equity participation, which would be a major step in the right direction.)

The practices of the four general insurance company subsidiaries also cause major distortions in the market. The four companies — National Insurance Company, New India Assurance Company, Oriental Insurance Company and United India Insurance company — offer Mediclaim, an indemnity product that only covers inpatient hospitalisation. In addition, they offer Jan Arogya Bima, which does not vary widely from Mediclaim.

Early evidence suggests that Mediclaim and Jan Arogya Bima lose a substantial amount of money. At a June conference co-hosted by the IRDA, United States Agency for International Development (USAID) and BearingPoint, insurers and TPAs (Third Party Administrators – Health Services) reported that health insurance plans typically incur a medical loss ratio of 140 per cent. This anecdotal evidence has been supported by independent research. In *Health Insurance in India: the Emerging Paradigms*, Nagendranath found that "for every Rs. 100 premium the insurance company collects, it spends Rs. 141." A 2002 McKinsey Consulting report indicates that Mediclaim policies maintain a claims ratio of 120 to 130 per cent.

While such losses do not seem sustainable, there may be other motives in play. It has been suggested that general insurers cross-subsidise health insurance losses through gains in other products. Although the general insurance companies fix the insurance premiums of many products based on tariffs set by the Tariff Advisory Committee (TAC), health insurance premiums do not need to be set at any specific prices. Thus, a general insurer may discount health insurance (and even incur a loss) as a way to ensure a broader insurance contract. Health insurance becomes a "loss leader."

Clearly, regulatory and competitive distortions make the health insurance market less attractive. Further, the present rules favour large insurers with multiple insurance products. As a result, these companies may not know much about health insurance. In fact, these companies may just use health insurance as a way to win business.

This may lead to the prevalence of poor health insurance products (like Mediclaim).

Six Steps for Increasing Private Health Insurance

For the nation to move forward, the woeful percentage of those with coverage must increase, as health insurance is a vital component of social protection. Much can be done to improve the situation. By taking the following six steps, the Indian government, through regulatory and/or legislative action, can help curb many of the regulatory and competitive distortions in the current market.

1. Lower Threshold Capital Limit

Current law requires that insurers maintain a minimum capital limit of Rs. 100 crore, which leads to participation from only extremely well financed organisations. While the law hinders the actions of smaller private companies with hopes of entering the industry, almost all NGOs clearly will have difficulty reaching this threshold.

There are valid reasons for requiring a minimum capital level. Yet, Rs. 100 crore is more than a multiple greater than most in the US. State governments in the US set the capital limits which often differ by type of health insurance product (indemnity or managed care). They are typically the greater of (1) a fixed amount (2) a percentage of liabilities, or (3) a percentage of the annual premium. The fixed amount varies from less than $One million to $three million, where indemnity products typically must maintain a higher value than managed care plans .

2. Curb Cross-Subsidisation

General insurance companies are bound to rates set by the TAC for most products. Thus, during negotiations with employers for broader insurance contracts, insurers can only offer discounts on "non-tariff" products, such as health insurance. As a result, the price for health insurance often becomes distorted.

Parliament should eliminate tariffs for all insurance products, which would level the playing field. Encouragingly, legislators are already taking steps to rectify the situation. Over the past year, some members of Parliament have proposed detariffing the general insurance industry. One Bill would start with the Motor Own Damage segment — by the end of fiscal 2004-05, its tariffs would be removed.

3. Increase Foreign Equity

Efforts have been made to increase the inflow of foreign capital funds into the insurance industry. Under the Insurance Regulatory and Development Authority Act of 1999, foreign equity participation in insurance ventures was limited to 26 per cent, and repatriation of policyholder funds was not allowed. While Mr. Chidambaram recently proposed allowing 49 per cent foreign equity participation, Parliament should not stop until it increases the limit to 100 per cent.

> A general insurer may discount health insurance (and even incur a loss) as a way to ensure a broader insurance contract. Health insurance becomes a "loss leader."

It may be recalled that India has relaxed its overall foreign investment policy over the past several years in most industries. For example, 100 per cent foreign equity is now permitted in power, roads, ports, harbours, industrial towns or parks, oil and gas exploration, oil refining, pollution control and management, and the exploration, mining, processing and metallurgy of all minerals except diamonds and precious stones. A few industries still have foreign restrictions, such as newspapers and some agricultural products.

4. Exclusive Regulatory Provisions

Supervision of the insurance industry is necessary to help ensure the financial strength of the market and promote public confidence. However, participants at the recent IRDA conference noted that not all insurance products should be treated the same. For example, health insurance losses are typically much less volatile than those for property and casualty insurance. In addition, the number of parties involved in health insurance — from patient to provider to third-party administrator — also makes this product unique.

As noted above, health insurance currently falls under the same umbrella as general insurance rather than life insurance. Some participants felt that health insurance should be covered under life insurance instead. Such a move would reflect the closer similarity in products, as life insurance policies often invoke many of the same underwriting considerations as those for health.

5. Underwriting Issues

A number of insurance plans openly admit that they underwrite at the time of the claim. In other words, rather than perform their underwriting activities at the time of the sale, insurers may look for reasons that they should not pay for certain procedures after the policyholder has become ill.

In most countries, this practice is considered a major violation. Such practices undermine the entire insurance industry, as consumers may develop mistrust.

Underwriting should occur at the time of purchase. Insurers have their chance to screen prospective purchasers before making the sale. Ways to screen the insurance pool include medical examinations, experience gained from reliable data, and pooling together individuals with similar risk profiles.

6. Incentives for Employers

Currently, there are no government incentives for employers to offer health insurance to their employees. To create demand for health insurance, the central and state government should make premiums tax deductible. In the US, employers can write some or all of their employee health insurance premiums off their taxable income.

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Back to the Actuary

—Thoughts on How Health insurance should grow

Piyush I.Majumdar outlines how scientifically devised Health Insurance can grow healthily in India.

In the year 1965, a leading general insurer had set up a comprehensive Health Insurance department. Indeed, it was the first and perhaps the only time in India that an Actuary was in charge of the company's Health Insurance business! The Actuary's responsibility was to design the group cover as per the client's requirements, develop policy draft, premium rating, build up experience statistics and oversee claims processing. Group Health insurance (changed from its earlier description of Hospitalisation insurance) was being granted only under group coverage from the early sixties.

Clients were issued tailor-made group health insurance covers including a Major Medical cover. The claims experience along with the benefits and premium rates were subject of review at each renewal with the help of detailed experience statistics. The Group Health Insurance business was then intended to be operated more or less on no-loss / no-profit basis and the cover was being granted to the company's valued clients on accommodation basis.

In addition to hospitalisation treatment, cover was also being granted for domiciliary and dental treatments and maternity related medical care. No doubt, this required increased claims handling administration. In several cases, the employer used to provide some assistance in the group scheme administration.

Blissfully, underwriting for large groups permitted covering members without any exclusions in respect of 'pre-existing' conditions. However, for smaller groups or where the participation of members, usually employees, was a small proportion of the total, individual underwriting had to be resorted to. There were also some other insurers underwriting group health insurance business but the extent of actuarial support they had is not known.

Non-insurance health schemes

Some hospitals and / or teams of doctors have devised alternative health covers. The schemes are akin to 'insurance schemes' but so far they seem to have escaped the Regulator's attention under insurance legislation.

Health Insurance Actuary

The Actuary has an essential role to play in transacting health insurance business, for example, product design, premium rating – initially and at renewal, underwriting of impaired lives (i.e., with history of pre – existing illnesses / diseases) and the compilation and analysis of experience statistics. The public sector insurance companies will have received actuarial input (presumably from Indian Actuaries) during the formulation of the Mediclaim policy and its premium-rating schedules originally and at subsequent revisions.

> The Actuary has an essential role to play in transacting health insurance business, for example in product design and premium rating.

'Responsible Actuary'

It would appear that in Germany it is compulsory to have a Responsible Actuary overseeing an insurer's health insurance business. It is perhaps the right time now for the Authority to consider placing similar responsibility on the shoulders of the Appointed Actuary (AA) of the insurer. This would only be a proper reversal of the unfortunate circular of 26 February, 2001 withdrawing the essential product pricing responsibility from the AA, which is prescribed in the Appointed Actuary Regulations for General insurers.

Post retirement medical schemes

Indian Actuaries are already involved in a different manner in that they are required to value the employer's future liability towards the medical benefits payable to the retired employees under such schemes.

Mediclaim

Mediclaim was launched in 1987. As a matter of fact, the brand name, Mediclaim, is now too well known, but surprisingly enough it was not followed up by branding like AutoClaim for Motor insurance – maybe, detariffing of Motor business may bring about such innovation. At least one new insurer was to call it "MediShield" insurance following the Singapore usage!

If one were to ask a youngster about his / her insurance coverage (obviously referring to life insurance), the response would be in the affirmative stating that he / she had a Mediclaim policy! Unfortunately, many seem to be unconcerned about or even opposed to having life insurance. In spite of this, several writers contributing to the IRDA Journal seem to have felt that Mediclaim has not built up the mass appeal that such an important insurance product should have.

Mass appeal

In the past, it was generally believed that one who had to be hospitalised would not return home alive and hence hospitalisation was regarded as taboo! Such a feeling may not now be prevalent amongst many in the cities but that feeling probably still persists in the rural areas. Further, the premium rates are found to be rather high and the underwriting procedure including the exclusions, difficult to comprehend or accept.

The health insurance policy contract needs to be carefully examined and made more comprehensive and customer-friendly. As an example, the insistence on minimum stay in a hospital / nursing home for more than a day (taken as minimum of 25 hours) resulting in

exclusion of minor surgeries not necessarily requiring hospital stay is one such instance. The insurer (and now the TPA) and doctors know how the claim amount may be inflated by adding up the 'imaginary' cost of room charges for 25 hours in order to make up a sustainable claim. The insurer pays more, the doctor earns more (less perhaps income tax) and ultimately the policyholder is made to pay more by way of increased premium at the next renewal.

Mediclaim problems

The IRDA needs to have the current Mediclaim problems thoroughly examined by legal and technical experts as to why there are so many complaints against the insurers with the Ombudsman and consumer courts. Unless this is seriously done, also allowing life insurers to write health insurance business or outsourcing claims handling to the TPAs is unlikely to serve any meaningful purpose.

Life insurers

Extension of HI coverage by life insurers is an excellent idea. Life insurers already seem to grant Critical Illness and Hospital Cash extensions on life policies. If however life insurers were to sell health insurance policies (on reimbursement basis) similar to general insurance policies, response may not be really good unless the current problems faced by the general insurers are sorted out. Further, the health insurance policies requiring large staff (or alternatively dependent on the TPAs) may distract their focus from their main life business. However, Permanent Health Insurance and Long Term Care covers are more suitable for life insurers.

Insurance regulations

On the regulatory side, one possible approach would be to divide insurance business into three main branches of:

- Life insurance (including Pensions)
- General Insurance (excluding Health insurance) and
- Health insurance

An insurer may then choose to register itself for:

- Life insurance with or without Health insurance
- General insurance with or without Health insurance or
- Health insurance

Consideration about the differential minimum capital requirements may be necessary for the three alternatives.

Definition

The IRDA {Registration of Indian Insurance Companies} Regulations, 2000, define

'Health Insurance business' or 'health cover' as effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, on an indemnity, reimbursement, service, pre-paid, hospital or other plans basis, including assured benefits and long term care.

Health insurance business would thus seem to include:

- Medical Expense or Mediclaim insurance

The health insurance policy contract needs to be carefully examined and made more comprehensive and customer-friendly.

- Critical Illness or Dread Disease Insurance
- Hospital Cash insurance
- Long Term Care insurance (LTC)
- Disability insurance – due to accident or disease, which may be short term disability or long term disability. Short term disability due to accident is covered under Personal Accident insurance and Long term disability as under Permanent Health insurance (PHI)

Notes:

- PHI is long – term insurance business and as such should go along with life insurance, apparently not being underwritten in India but is quite common in the UK (underwritten by life insurers as long term insurance). So, the question would arise if the general insurers should also be allowed to transact such long-term business.
- Should short-term disability due to accident, currently included under Personal Accident insurance, be included under Health insurance?
- It is not known if any insurer in India is offering Long Term Care cover and Disability insurance at present.

The TPAs

The insurers have now effectively outsourced some of their administrative work including claims settlement process and enrolment work to the Third Party Administrators at an additional cost to the policyholder. Assuming that the TPAs have adequately trained staff to process the numerous claims, the problems mentioned in the preceding paragraphs will confront the TPAs. The TPA experiment is yet to be tested as to whether they would do better than the insurers themselves in honest, prompt and efficient claims service.

Incidentally, there is already a health cover on offer in the market emphasising that it will be 'TPA – free'!

Experience statistics – IRDA initiative

The erstwhile Health Insurance department of a leading insurer, referred to earlier, had detailed statistics to enable meaningful annual discussions with the clients. Dismantling of the said department, sometime in the late seventies, seems to have adversely hurt the process of maintaining crucial health insurance statistics. However, the PSUs will have depended on some statistics and / or learned actuarial judgement in determining the basic Mediclaim premium rates including the premium rate differentials according to the age groups. It is not known if the subsequent claims experience has, *inter alia*, supported the said age group rate differentials.

It is heartening to know that the Government has taken the positive step to form a high level 'Working Group' comprising 'all stakeholders'. A Data subgroup is also formed with representatives from IRDA, insurers, TPAs, insurance consultants and actuaries too, which is a positive indication for the outcome given the background.

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The Foundation is Numbers

—Three requirements for Health Insurance in India

Ronald G. Harris, Richard A. Kipp and Thomas Snook talk about the foudation of a robust Health insurance system.

In order for the health insurance industry in any country around the world to begin to develop, there are a number of basic conditions that must exist. These basic conditions include, among others, a healthcare delivery infrastructure capable of providing basic and advanced health services to the paying public, health insurance institutions large enough and willing to accept the risk for financing an individual's health care costs in return for a premium, and an adequately sized subset of the population that is interested in protecting its financial wellbeing from catastrophic healthcare costs and can afford the cost of a health insurance product.

For the health insurance industry to then actually thrive – with a market environment in which the industry offers consumers an array of products that provide valuable insurance protection at a reasonable price, and which enables health insurance companies to compete fairly and with reasonable expectation of profitably – progress well beyond these basic conditions is required.

In pursuit of a thriving industry, where the economy and industry are still developing, some of the most central needs are actuarial in nature. These actuarial needs are critical in order for the health insurance industry to be stimulated to grow rapidly, in a manner which serves the longterm interests of a variety of stakeholders. This appears to be the situation facing India today [1].

The purpose of this brief article is to highlight the most critical of these core actuarial needs facing the country's health insurance industry[2].

The three-legged stool of actuarial needs in Health insurance

There are three crucial actuarial elements that need to be present in order for a health insurance industry to develop strength and begin to thrive. These are fundamental to financial viability and growth:

- ***Products*** – Soundly designed health insurance coverage products, which meet consumer needs and can be managed by health insurers for financial success (profitability).
- ***Provider reimbursement*** – Structured, fair bases for determining health insurance benefits and provider payments, which reflect the appropriate financial resources to be paid to providers by health insurers, and which are widely accepted by insurers and providers alike.
- ***Premium rates*** – Appropriate, sustainable methods of accepting risk and setting premium rates which can be sold to consumers in return for valuable financial risk protection, and which foster profitable competition among health insurers. This includes appropriate underwriting practices which mitigate adverse selection at policy issue, so as to ensure that a reasonable mix of insured individuals is achieved, thereby leading to stability and sustainability in premium rates.

> Actuarial elements have been at the heart of the evolution we have experienced in the health insurance system in the US over the past 40 years.

Each of these three core actuarial elements is essential to the growth and financial viability of health insurance. They have been at the heart of the evolution we have experienced in the health insurance system in the US over the past 40 years, including the advent of managed care; and they apply to every other system of comprehensive coverage under individual and group health insurance. Further, and equally important, these three actuarial areas must all be part of an integrated approach to the business. Just as a three-legged stool requires all three legs to be present and to be linked together in a consistent and strong fashion in order for the stool to stand, so too must the three core actuarial elements described above be fashioned together in a consistent and strong fashion.

For each of these three core actuarial needs – products, provider reimbursement, and premium rates – it is well known that a number of severe limitations or deficiencies exist today in the Indian health insurance market and industry[3]. The potential solution to any one of them, however, is dependent on the solution to the others. What this means is that any solution set which is to succeed in facilitating the development and growth of a country's health insurance market – India or elsewhere – must be comprehensive in nature. Further,

any solution must anticipate continued change over time, and enable ongoing development and evolution.

Typical uses of actuarial data in Health insurance

Well founded health care delivery systems and health insurance industries are both data driven. Typically, the provision of medical care services by a delivery system begins with a patient's medical complaint and symptoms. A physician gleans information from an examination and the medical his tory of the patient, augments it as warranted with additional data from laboratory or other diagnostic tests, and then develops a diagnosis. As the need for care may become necessary, a treatment plan is formulated, the physician and possibly a hospital provide medical care services, and the physician continues to monitor and alter the actual care provided as the patient progresses.

This general process of using continually incremented and updated information to manage a patient's outcome is not dissimilar to the corresponding process used to manage the business of health insurance. The health insurance underwriter begins with information gleaned from an insurance application, augments it as warranted with additional explanatory data and documentation, then develops a conclusion as to insurability and the appropriate premium rate level for the risk involved. As a claim may arise, an authorisation is made by or on behalf of the health insurance company, claims are processed and paid, and the insurer continues to monitor and adjust its actuarial and business practices as financial and actuarial experience emerges. In both industries, more reliable and comprehensive data enables greater knowledge on the part of the user of this data, which contributes to more accurate conclusions and decisions and a resulting higher likelihood of a positive outcome. Fundamental to effective decision-making processes in both industries is data.

Actuarial data usually includes a variety of variables. The basic variables involve attributes or characteristics of each of the policyholders and any family members insured, the medical conditions of patients with claims, the specific services rendered by providers, and the cost of reimbursing those services. With such data the actuary is able to develop an understanding of the patterns of use and cost of health care services for the insured population. Typically the actuary would start by creating summaries of the data that reveal the average use and cost of the services rendered. In addition to the average use and cost statistics, the actuary would be interested in the probability distribution of aggregate claims for insureds by size of claim. This sort of study enables the actuary to measure the variability in the cost of claims, and to use such measurements in modeling the impact of benefit structure changes.

More reliable and comprehensive data enables greater knowledge on the part of the user of this data, which contributes to more accurate conclusions and decisions and a resulting higher likelihood of a positive outcome.

These basic types of data give the actuary a tool by which current costs can be understood, as well as a device to model the costs of other new benefit structures. Additionally, such data is used for the next level of analysis, which includes calculation of premium rate renewals, conducting historical trend analysis, understanding provider cost variation, benchmarking against industry statistics of performance, and forming a starting point for forecasts of future use and cost levels. The ability to do this sort of analysis and its value cannot be underestimated. Unless the actuary can analyse the current product portfolio's performance, the future is totally unforeseeable. Even when good data is present the future can't be perfectly predicted. Without it, however, the actuary is no better than any uninformed person in knowing how to help manage a given block of insured business. The stakes are too high to allow that to occur, especially in the case of a quickly growing health insurance market.

Role of data in solving these needs

The formulation of meaningful improvements or solutions to these three critical actuarial needs (products, provider reimbursement, and premium rates – the three legs of the stool) requires information and quantification of historical experience – which means that it requires reliable, comprehensive, and complete data[4]. Managing health insurance business in an actuarially sound and prudent manner, even when the industry is mature and stable, requires such data. We have learned this lesson clearly in the US over the past 40 years as our systems have evolved, both with regard to private group and individual health insurance and our public Medicare and Medicaid programmes. The absence of meaningful, reliable data inhibits growth and change, as we have also experienced in the US, and makes the outcome of any growth or change that does occur highly uncertain.

The apparent lack of complete and accurate actuarial data poses a severe problem today in India for health insurance companies, for regulators, and ultimately for consumers and providers[5].

This deficiency applies to health insurers already present in the Indian market, as well as potential new private health insurers. To facilitate growth and development in the health insurance industry, a jump-start in defining, collecting, and analysing data which addresses the three critical actuarial needs (i.e., the three legs of the stool) is needed. Such a jump-start, to be effective in facilitating growth in the health insurance market, needs to provide access to meaningful actuarial data throughout the industry and to regulators. Such data needs to meet several essential criteria:

- ***Appropriate content*** – Meet both industry actuarial needs and regulatory oversight needs.
- ***Forward-looking*** – Consistent with and able to support an informed vision for the future of the industry.
- ***Comprehensive and universal*** – Collect detailed data from and provide database access across the entire industry, protecting the privacy of patients and the proprietary interests of health insurance company contributors.
- ***End-to-end*** – Enable tracking and evaluation through the entire insuring process, taking advantage of today's technology to do so.
- ***Analysis friendly*** – Captured and maintained in consistent forms whereby actuarial and statistical analysis can be conducted readily by companies within (or entering) the industry and by regulators.

As a practical matter, the data solutions which satisfy these criteria will necessarily entail step-by-step improvements and evolution over time. Making progress effectively, therefore, necessitates a vision of the future and its needs, coupled with a commitment to continuing improvement. Certain areas of change within the industry may be accomplished quickly, since today's technology enables rapid paradigm shifts and leapfrog progress. For example, in the essential areas of data capture, storage, and analysis a platform which can support evolving business models and complex processes can actually lay the foundation for new products and thereby accelerate industry growth. In many respects, a virtual "clean slate" exists in India because the health insurance industry is small and relatively young, with significant growth potential and without significant investment in legacy processes and systems. This creates a very conducive environment for India to adopt the latest and best practices in data collection and actuarial applications.

Looking ahead with optimism

Data to support the three actuarial elements described above is a critical need for the next stage of growth and development in the health insurance industry in India. This is, however, only the beginning. As progress occurs, next order needs can then begin to be addressed – such matters as evidence-based medical treatment protocols, quality of care monitoring, patient management, provider performance and efficiency measurement, and more sophisticated financial arrangements (reimbursement to providers and premium payment by individuals and groups).

Such areas of data support offer unlimited potential in the future management of health insurance company operations, medical care delivery, and public health policy. The jump-start of actuarial data access necessary for the three legs of the stool, however, is the critical industry-wide technology and process backbone needed to facilitate the next stage of growth and development in the health insurance industry in India. It is not overly optimistic to expect that the industry and regulators can work jointly to develop a comprehensive strategy to achieve significant progress in meeting the actuarial data needs for health insurance to thrive in India in the near-term future.

Endnotes:

1 Abhijit Nagendranath, Pallavi Chari, *Health Insurance in India*- The emerging paradigms

2 Randall P. Ellis, Moneer Alam, Indrani Gupta, *Health Insurance in India*—Prognosis and Prospectus

3 Ibid

4 Rosanna M. Coffey, Judy K. Ball, Meg Johantgen, Anne Elixhauser, Patrick Purcell, and Roxanne Andews, *The Case for National Health Data Standards*, vol. 16, number 5, *Health Affairs*

5 *Framework for Information Technology Infrastructure for Health in India, prepared by Department of Information Technology (Ministry of Communic ation & Information Technology)*

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Report Card:LIFE

Life industry grows 64 % in August

The life insurance industry underwrote new business premium of Rs.1,58,022.55 lakh during the month of August, 2004, taking the cumulative premium underwritten during the current year 2004-05 to Rs.7,10,143.06 lakh. LIC underwrote new business premium of Rs.5,84,471.09 lakh up to August, 2004 i.e., a market share of 82.30 per cent, followed by ICICI Prudential and Birla Sunlife with premium underwritten (market share) of Rs.39,977.55 lakh (5.63per cent) and Rs.18,150.60 lakh (2.56per cent) respectively. While LIC's market share declined from 89.71per cent for the period ended August, 2003, all new life insurers increased their market share, over the corresponding previous year numbers. Cumulatively, the new players underwrote first year premium of Rs.1,25,671.97 lakh. In terms of policies underwritten, the market share of the new players and LIC was 8.37 per cent and 91.63 per cent as against 5.78 per cent and 94.22 per cent respectively in the corresponding period in the year 2003-04.

The premium underwritten by the industry upto August, 2004, towards individual single and non-single policies

> The life insurance industry underwrote new business premium of Rs.1,58,022.55 lakh during the month of August, 2004,

stood at Rs.1,18,500.60 lakh and Rs.4,38,890.46 lakh respectively accounting for 27,3,386 and 73,85,358 policies. The group single and non-single premium accounted for Rs.1,39,900.90 lakh and Rs.12,851.09 lakh. The total Individual premium and Group premium underwritten was Rs.5,57,391.06 lakhs and Rs.1,52,752 lakhs respectively as against Rs. 3,54,678.91 lakhs and Rs.78,777.19 lakhs underwritten in the corresponding period of the previous year. The number of lives covered by the industry under the various group schemes was 25,85,751 during the period ended August, 2004. LIC covered 17,99,441 lives under the group schemes accounting for 69.59 per cent of the market, followed by SBI Life with 2,64,883 lives (10.24 per cent), Tata AIG with 1,29,927 lives (5.02 per cent) and MetLife with 84,501 lives (3.27 per cent).

The accompanying tabulation does not include the numbers under the Varishtha Pension Bima Yojana, which was discontinued effective August, 2004. Premium underwritten by LIC under this pension scheme during the period ended April - July, 2004 was Rs.10,7,264.83 lakh towards 54,740 policies.

First Year Premium – August 2004

(Rs. in lakhs)

Sl No.	Company	Premium u/w		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		August	Upto August	Upto August	August	Upto August	Upto August	August	Upto August	Upto August
1	**Bajaj Allianz**	**3,957.41**	**14,395.73**	**2.03**	**17,251**	**70,237**	**0.92**	**3,142**	**52,208**	**2.02**
	Individual Single Premium	1,471.94	5035.22		1,624	5,657				
	Individual Non-Single Premium	2,480.37	9259.88		15,621	64,549				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	5.09	100.63		6	31		3,142	52,208	
2	ING Vysya	762.05	2,606.27	0.37	8,125	34,928	0.46	0	5,898	0.23
	Individual Single Premium	0.19	32.51		10	4,781				
	Individual Non-Single Premium	708.33	2,432.79		8,115	30,141				
	Group Single Premium	53.01	121.14		0	1		0	255	
	Group Non-Single Premium	0.51	19.83		0	5		0	5,643	
3	AMP Sanmar	521.22	1,823.25	0.26	2,705	12,321	0.16	3,349	21,305	0.82
	Individual Single Premium	318.20	848.12		632	1,785				
	Individual Non-Single Premium	178.32	851.89		2,069	10,507				
	Group Single Premium	9.69	30.54		0	1		0	190	
	Group Non-Single Premium	15.01	92.70		4	28		3,349	21,115	
4	SBI Life	4,374.27	12,768.21	1.80	7,613	34,128	0.45	94,848	2,64,883	10.24
	Individual Single Premium	655.47	2,641.90		339	1,483				
	Individual Non-Single Premium	421.54	1,994.24		6,882	31,641				
	Group Single Premium	2,585.73	5,843.29		1	3		24,548	64,713	
	Group Non-Single Premium	711.53	2,288.78		391	1,001		70,300	2,00,170	

(Rs. in lakhs)

Sl No.	Company	Premium u/w		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		August	Upto August	Upto August	August	Upto August	Upto August	August	Upto August	Upto August
5	**Tata AIG**	**1,598.33**	**9,150.07**	**1.29**	**15,253**	**79,673**	**1.04**	**16,197**	**1,29,927**	**5.02**
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	1,464.27	7,168.45		15,221	79,565				
	Group Single Premium	52.84	251.46		0	0		8,931	38,025	
	Group Non-Single Premium	81.22	1,730.15		32	108		7,266	91,902	
6	**HDFC Standard**	**2,011.45**	**9,671.52**	**1.36**	**15,459**	**59,213**	**0.77**	**5,318**	**57,363**	**2.22**
	Individual Single Premium	743.86	2,848.85		1,591	6,222				
	Individual Non-Single Premium	1,238.24	6,385.36		13,858	52,924				
	Group Single Premium	25.07	272.09		8	61		5,111	49,327	
	Group Non-Single Premium	4.28	165.22		2	6		207	8,036	
7	**ICICI Prudential**	**8,803.58**	**39,977.55**	**5.63**	**38,821**	**1,81,635**	**2.37**	**25,818**	**31,965**	**1.24**
	Individual Single Premium	673.01	6,536.80		550	4,115				
	Individual Non-Single Premium	7,640.23	29,626.01		38,267	1,77,471				
	Group Single Premium	3.37	14.96		1	6		794	1,101	
	Group Non-Single Premium	486.97	3,799.78		3	43		25,024	30,864	
8	**Birla Sunlife**	**4,561.86**	**18,150.60**	**2.56**	**11,759**	**48,022**	**0.63**	**5,162**	**19,335**	**0.75**
	Individual Single Premium	111.27	541.85		3,163	9,612				
	Individual Non-Single Premium	3,251.07	13,864.37		8,589	38,378				
	Group Single Premium	39.01	177.19		0	0		325	1,446	
	Group Non-Single Premium	1,160.52	3,567.18		7	32		4,837	17,889	
9	**Aviva**	**1,082.91**	**5,623.20**	**0.79**	**5,705**	**29,521**	**0.39**	**11,034**	**49,047**	**1.90**
	Individual Single Premium	0.89	148.79		38	180				
	Individual Non-Single Premium	1,064.38	5,372.65		5,664	29,326				
	Group Single Premium	1.99	6.38		0	1		23	66	
	Group Non-Single Premium	15.65	95.38		3	14		11,011	48,981	
10	**Kotak Mahindra Old Mutual**	**1,089.93**	**3,626.48**	**0.51**	**4,567**	**16,225**	**0.21**	**7,812**	**35,009**	**1.35**
	Individual Single Premium	149.17	707.27		115	470				
	Individual Non-Single Premium	800.24	2,313.86		4,444	15,740				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	140.52	605.35		8	15		7,812	35,009	
11	**Max New York**	**1,459.34**	**6,356.25**	**0.90**	**15,379**	**65,505**	**0.85**	**3,810**	**34,869**	**1.35**
	Individual Single Premium	16.51	108.08		21	105				
	Individual Non-Single Premium	1,433.30	6,185.48		15,349	65,364				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	9.54	62.69		9	36		3,810	34,869	
12	**MetLife**	**348.36**	**1,522.84**	**0.21**	**3,164**	**10,489**	**0.14**	**5,618**	**84,501**	**3.27**
	Individual Single Premium	12.91	51.62		32	123				
	Individual Non-Single Premium	325.54	1,147.84		3,123	10,327				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	9.91	323.38		9	39		5,618	84,501	
13	**LIC**	**1,27,451.85**	**5,84,471.09**	**82.30**	**15,34,241**	**70,23,186**	**91.63**	**6,09,598**	**17,99,441**	**69.59**
	Individual Single Premium	33,101.61	98,999.59		79,683	2,38,853				
	Individual Non-Single Premium	78,547.11	3,52,287.64		14,53,365	67,79,425				
	Group Single Premium	15,803.13	1,33,183.86		1,193	4,908		6,09,598	17,99,441	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Total	**1,58,022.55**	**7,10,143.06**	**100.00**	**16,80,042**	**76,65,083**	**100.00**	**7,91,706**	**25,85,751**	**100.00**

Note: LIC's business numbers exclude Varishtha Pension Bima Yojana.

Report Card:GENERAL

14.5% growth in August

G. V. Rao

Performance in August 2004

The performance of the general insurers in the month of August 2004 has been in keeping with the past trends. They have added a business of Rs. 170 crore in August 2004 to record the premium level of Rs. 1,340 crore (14.5 per cent growth). The four established players have added Rs. 80 crore to record Rs. 1,105 crore (7.7 per cent growth). The new players have added Rs. 90 crore to record a premium level of Rs. 235 crore (63 per cent growth). This is developing as a pattern for the year 2004.

The past trend of recording higher quantum increases by the new players, a regular feature of their monthly performances, has been maintained in August 2004 as well. The established players are losing in their quantum business increases almost every month, making their market share progressively to get pushed down.

National Insurance with a growth rate of 18 per cent in August has consolidated its second rank even while United India has yet again dropped its premium in August 2004, as it did in July. Oriental has shown a spurt of growth of 11 per cent in July perhaps due to acquisition of new accounts. United India dropping its premium for the second successive month should be of some concern to it.

The new players are led this time by Bajaj Allianz that has achieved an accretion of Rs. 40 crore, whereas the market leader among them ICICI Lombard has achieved only Rs. 12 crore, the same as IFFCO-Tokio. With hardly a difference of Rs. 10 crore till August end between ICICI and Bajaj, one can ask if the Bajaj is likely to emerge as the top ranker among the new players soon. Reliance has shown impressive increase of Rs. seven crore.

The top four ranking performers among the new players are ICICI, Bajaj, Tata and IFFCO with a distinct edge over the rest of the new players.

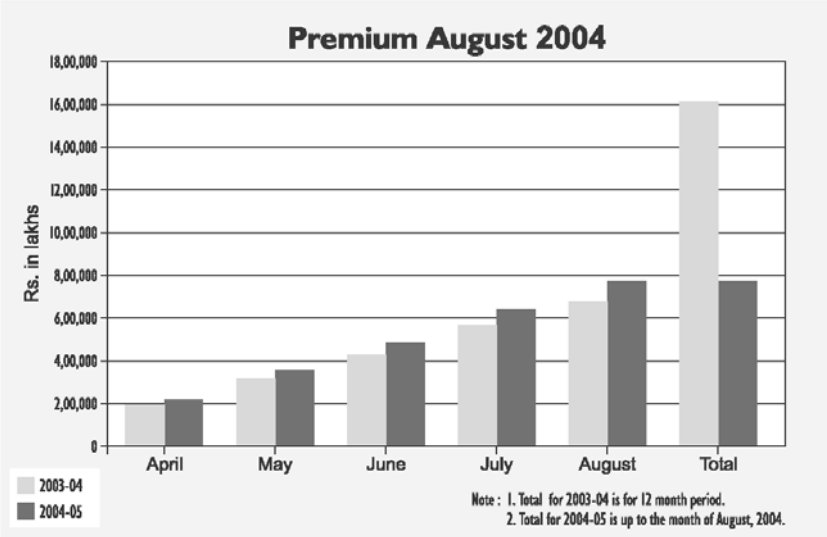
With the portfolios of Motor and Health as the driving forces of the market

GROSS DIRECT PREMIUM (within India) AUGUST, 2004

(Rs.in lakhs)

INSURER	PREMIUM 2004-05		PREMIUM 2003-04		MARKET SHARE UPTO AUGUST, 2004	GROWTH % YEAR ON YEAR
	FOR AUGUST 04	UPTO AUGUST 04	FOR AUGUST 03	UPTO AUGUST 03		
Royal Sundaram	2,406.00	13,130.00	2,173.27	11,021.86	1.70	19.13
Tata AIG	3,412.23	21,132.28	2,624.91	16,446.84	2.74	28.49
Reliance General	1,135.16	7,364.89	457.98	7,291.99	0.96	1.00
IFFCO-Tokio	2,689.41	19,933.39	1,513.91	14,405.19	2.59	38.38
ICICI Lombard	5,004.78	33,735.91	3,789.24	19,547.15	4.38	72.59
Bajaj Allianz	6,141.63	32,740.79	2,215.91	18,304.22	4.25	78.87
HDFC Chubb	1,347.45	6,666.83	900.24	2,839.19	0.86	134.81
Cholamandalam	1,374.60	7,529.33	744.29	3,775.50	0.98	99.43
New India*	30,300.00	1,70,542.00	29,142.00	1,64,846.00	22.12	3.46
National*	29,784.00	1,69,036.00	25,288.00	1,36,722.00	21.93	23.63
United India*	24,087.00	1,35,620.00	24,350.00	1,39,518.00	17.59	-2.79
Oriental*	22,445.57	1,33,485.56	20,232.71	1,26,023.33	17.32	5.92
ECGC	3,672.12	19,980.38	3,412.82	16,804.43	2.59	18.90
TOTAL	**1,33,799.95**	**7,70,897.36**	**1,16,845.28**	**6,77,545.69**	**100.00**	**13.78**

**** Data revised by the respective insurers for the corresponding month of the previous year.***



increases, one can perhaps assume that the established players are losing on their profitable segments of Fire, Marine and Engineering to the new players, while acquiring more of the Motor and Health businesses.

ECGC has recorded a growth of Rs. three crore (nine per cent growth) which similar to the rest of the established players.

Performance up to August 2004

The market at the end of August 2004 grew by a total premium of about Rs. 940 crore to record a gross premium level of Rs. 7,700 crore (13.8 per cent growth). The share of the four established players of it is Rs. 416 crore (7.3 per cent growth) and the new players Rs. 490 crore (52 per cent growth).

National Insurance leads the growth accretion with Rs. 323 crore (the three other established players contributing together only Rs. 93 crore), followed by Bajaj with Rs. 144 crore, ICICI with Rs. 142 crore, Oriental with Rs. 75 crore, New India with Rs. 57 crore, IFFCO by Rs. 56 crore, Tata_AIG by Rs. 47 crore.. The sole exception among all the insurers to have shown a fall in gross business is United India that has recorded a fall of Rs. 40 crore. There is no clue why this has happened except perhaps it is pruning its loss making portfolios to emerge as the player with the lowest incurred loss ratio next year.

The special voluntary retirement scheme of the older companies players has not made any significant impact on their growth rate that is 7.3 per cent, perhaps because they are growing in the segments that are customer driven like the Motor and Health, wherein the customers pursue insurers and there is little competition. The growth rate of the National Insurance of 24 per cent is in stark contrast to the individual performances of the three other established players.

The ECGC with an accretion Rs. 320 crore and a growth rate of 19 per cent has turned in a fine performance.

Market share

The new players have acquired a share of 20 per cent of the market and in the profitable segments like the Fire and Engineering and it is really remarkable that they achieved it with such low capital bases. Diversion of business away from the established players will, however, have to be supplemented with new forms of energy and strategies in other untapped segments. The game of diversion has to be replaced by a broader vision of where the new players want to be at the end of, say, five years from now.

They will also have to deal with the likely scenario of a detariffed market. In a detariffed market the newly won accounts of the new players will be under greater threat in view of their relatively low net worth. Continued reinsurance support will become even more important. Have they a game plan ready in the event the businesses are detariffed? The issue of increased FDI will also bring in the view of the foreign partner to prevail more on the issues of overall objectives, corporate governance and strategy. Interesting times are ahead. With the talk of increased FDI in insurance, the market is back on the high profile list of the nation.

The author is retired CMD, The Oriental Insurance Company.

प्रकाशक का संदेश

पिछले 10-15 वर्षो में, देशभर में स्वास्थ्य संबन्धित सुविधाओं में अभूतपूर्व सुधार देखा है। हमारे पास बड़ी संख्या में सुपर स्पेशलिशट अस्पताल हैं तथा डायगनोस्टीक सैंटर की भरमार भी है। एक सत्य यह हैं कि इन सुविधाओं की पहुँच केवल बडे महानगरों, राज्यों की राजधानी तक ही नहीं बल्कि कई जिलों के मुख्यालय तक भी हैं। निजि क्षेत्र के मैडिकल कालेजो में भी पर्याप्त वृद्वि हुई हैं जिसके कारण बडी संख्या में मैडिकल प्रैक्टीशनर तथा विभिन्न शाखाओं के विशेषज्ञ: उपलब्ध करवाये है। यह अस्पताल तथा मैडिकल प्रैक्टीशनर विश्व स्तर की सुविधाएँ लोगों को आज दरवाजे पर उपलब्ध करवा रहे हैं। हममें से कितने इन सुविधाओं का लाभ उठा सकते हैं ?

जर्नल के इस अंक में कुछ विचार उत्तेजक लेख सामने आये हैं जिनमें उन पहलों का जिक्र किया गया है जिसके अनुसार आज उपलब्ध मैडिकल संरचनात्मक ढाँचे का पुरा उपयोग किया जा सके। राज्य तथा केन्द्र दोनों स्तरो पर चालू योजना में स्वास्थ संबधित स्त्रोत निर्धारण को बहुत महत्व दिया गया है। फिर भी इसमें गंभीर सीमाएँ सार्वजनिक क्षेत्र के हस्तक्षेप में तथा इस मध्यवर्ती हस्तक्षेप के प्रभाव में हैं। यदि "सभी के लिए स्वास्थ" को वास्तविकता बनना है, बीमा उद्योग को पहल करनी होगी तथा एक प्रारंभिक आक्रमण करना होगा उन रूकावटों के विरूध जो इन उद्देश्यों को प्राप्त करने के रास्ते में आते है।

प्राधिकरण ने अपनी भूमिका में कुछ उपायों का अभिज्ञान प्राप्त किया है तथा उन समस्यों को संबोधित किया है जो हैल्थ बीमा की प्रगति में बाधक हैं। एक हैल्थ इंशुरेन्स कार्यदल विभिन्न मुद्दो पर जिसमें सांख्यकि का उपलब्ध न होना भी शामिल है पर कार्य कर रहा है। हैल्थ इंशुरेन्स के एक सह दल ने सांख्यकि के संबन्ध में अपनी एक रिपोर्ट हाल ही में जमा भी की है। माइक्रो इंशुरेंस पर एक चर्चा पत्र आईआरडीए द्वारा जारी भी किया गया है, जिसमें हैल्थ बीमा घटक भी शामिल है जो समाज के गरीब लोगों की जरूरतों की तरफ ध्यान ले जाता है। हैल्थ इंशुरेस कार्यदल ने कई क्षेत्रों को का पता लगाया है जिन पर कार्य को आगे बढाया जा रहा है। यह निरंतर चलने वाला कार्य है।

जर्नल का अगला अंक दूसरे प्रकार के अवसरों पर है। हम उस पर ष्टि डालेगें जो ढाँचागत योजनों मे निवेश की संभावनाओं तथा गतिविधियों को बीमा के लिए आवश्यक करता है। हम यह भी देखेगें की इन शुभकामनाओं कि सूची की जडे जमें तथा भविष्य में यह खिल कर सामनें आये।

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

बोर्डरूम में संस्कृति की जागरुकता के बिना हम सच में अपने दिल पर हाथ रख कर यह नहीं कह सकते कि हम इक्कीसवीं सदी के वातावरण में हैं।

लार्ड पीटर लेविन, अध्यक्ष, लायड्स आफ लंदन

निवेशक जो यह महसूस करते हैं कि उनका संबन्ध दुर्विविक्रय अथवा अन्यथा-कथन से हैं, उन्हे यह मामला पहले वित्तीय सलाहकार के पास अथवा जो संस्था से संबद्ध हो उसके पास ले जाना चाहिये। इसमें असफल होने पर वह वर्तमान उद्योग की तरफ आपनी समस्यों के समाधान की योजनाओं के लिए देख सकते हैं।

श्री थरमैन शर्मुग्राथ्रम, उपाध्यक्ष, सिंगापुर का आर्थिक प्राधिकरण।

हमारे अध्ययन से मालूम हुआ है कि पेशेवर पुर्नबीमा बाजार का अप्रत्याशित विकास हुआ है, जबकि असल पुर्नबीमा किसी अन्य अंश के साथ कमी पर है। वास्तव में वर्ष 1994 तथा 2003 के मध्य नये पुर्नबीमाकर्ताओं की भर्ती 400 प्रतिशत हुई है, जबकि 2 प्रतिशत से अधिक बाजार में हिस्सेदारी रखने वालों का प्रतिशत 16 से कम होकर 10 रह गया है।

श्री स्टीफन क्रिस्टेनसेन, निदेशक, रिसर्च क्लिग रिसर्च एण्ड कंस्लटिग इंकोर्प, जिन्होंने हाल ही में एक अध्ययन सामने लाया है ङ्कलाइफ पुनर्बीमा कैपेसीटी तथा चैलेंजङ्क

वर्ष 2004 तथा 2008 के बीच सतत् प्रीमियम बीमा वृद्धि का पूर्वानुमान लगाया गया है, जिसमें साधारण बीमा तेजी से बढ़ेगा तथा बाजार का बड़ा भाग ले लेगा। इस क्षेत्र के मध्य मुख्य वृद्धि के संचालक कर्मचारी दायित्व, हानि तथा व्यवसायिक संपत्ति क्षति बीमा होगें साथ ही कुछ छोटे क्षेत्र भी वृद्धि दर दिखा सकते हैं।

डबलिन स्थित सलाहकार अनुसंधान तथा व्यवसाय फर्म, (http://www.researchandmarkets.com) अपने बीमा संबन्ध में अपनी मार्किट रिपोर्ट 2004” में जिसमें यू.के. बीमा कंपनियों का विश्लेषण किया गया है।

आप लायड्स के पास सैर करते समय हजारों महिलाओं और पुरूषों को अपने हाथों में फाइलें लिये हुए टहलते हुए देख सकते हैं। क्या यह दिवानापन नहीं है। मैं असहमत हूँ।

श्री डेनिस महोनिन, अमेरिकन बीमा ब्रोकर की यू.के. इकाई के अध्यक्ष तथा मुख्य कार्यपालक, इस तथ्य पर कि बीमा ब्रोकर व्यवसाय अभी भी कैसे पुराने फैशन में किया जाता है।

भारतीय बीमा के बाह्यकरण का राजस्व वर्ष 2003 में 367 मिलियम अमेरिकी डालर (लगभग 1682 रूपये) से बढ़ कर 790 मिलियम डालर (लगभग 3621 रूपये) हो गया। जो वार्षिक चक्रवृद्धि दर 21 प्रतिशत की वृद्धि को बताता है।

ग्लोबल बीमा बाह्यकरण भारतीय परिप्रेक्ष में विहंगमष्टि, झुकाव, अंर्तष्टि, तथा मुख्य बेचने वालों की रूपरेखा ङ्कवैल्यू नोट डाटा बेसङ्क द्वारा प्रकाशित।

अवधारणा बनाम यथार्थ

एच.के. अवस्थी

संचार की विफलता उपभोक्ताओं की असंतुष्टि का प्रमुख कारण है। लेखक का कहना है कि बीमा शर्तों एवं प्रक्रिया के संबंध में पर्याप्त समझ के अभाव और ग़लत अवधारणा के कारण उपभोक्ता शिकायत करते हैं।

युनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड बनाम एमकेजी कार्प (सीटीजे 1997 (5) 69) के मामले में सर्वोच्च न्यायालय ने अपने फ़ैसले में कहा कि "बीमा कानून का यह मूलभूत सिद्धांत है कि संबद्ध पार्टियां पूर्वत: विश्वास का निर्वहण करेंगी। बीमा कंपनी का यह कर्तव्य है कि वह बीमा संबंधी सभी तथ्यों का खुलासा करे, बीमा कराने वाले सभी ग्राहकों को संतुष्ट करे और उन्हें पूरी जानकारी दे, जो कि परस्पर विश्वास को क़ायम करने के लिए सामान्य रूप से ज़रूरी है।"

एक आदमी के बीमा हमेशा उपलब्ध होने वाली अनुग्रह राशि है, इसमें आय किसी आकस्मिक कारणों से नष्ट नहीं होती, बल्कि बनी रहती ऐसी ग़लत धारणाओं को समाप्त करने की तात्कालिक आवश्यकता है। यह बीमा व्यवसाय की स्वस्थ उन्नति के लिए ज़रूरी भी है। पर्याप्त शिक्षा के माध्यम से ही जागरुकता पैदा करने की आवश्यकता है।

बीमा क्षेत्र में भारतीय जीवन बीमा निगम (एलआईसी) का एकाधिकार बीमा क्षेत्र में निजी कंपनियों के लिये खोल देने से खत्म हो गया है। इस क्षेत्र में कई नयी कंपनियां सक्रिय हैं और नई योजनाएं और बेहतर सेवा देने का मौका दिया है, लेकिन दुर्भाग्य से सच कुछ और ही है, क्योंकि बीमा अभिकर्ता अधिक कमीशन की लालच में बीमा की सभी शर्तों और दशाओं का खुलासा बीमा करा रहे व्यक्ति से नहीं करते।

उदाहरण के तौर पर हम देखते हैं कि एजेंट प्रीमियम की राशि लिये बगैर ही उपभोक्ता को भ्रमित करके उनका बीमा करा लेते हैं और इस तरह से स्वास्थ्य बीमा कराते समय उपभोक्ताओं को फंसाते हैं, जबकि पॉलिसी के नियमों के अनुसार ऐसा करना अनुचित है। कुछ दिन बाद बीमा अभिकर्ता बीमा कराने वाले व्यक्ति को सलाह देता है कि वह स्वास्थ्य जांच करा ले और बाकी सब ठीक है। बहरहाल महीने बाद पता चलता है कि वह हृदय रोगी है और एंजियोप्लास्टी कराने जाता है, जिसमें करीब 28,500 रुपये का खर्च आएगा, जिसे बीमा कंपनियां दावे के तौर पर स्वीकार ही नहीं करतीं। उनका तर्क रहता है कि व्यक्ति पहले से ही रोगी था। इस पर बीमा कराने वाला व्यक्ति उपभोक्ता फ़ोरम में अपील करता है। यह कोई एक अकेला मामला नहीं होता। तमाम शिकायतें ऐसी होती हैं कि प्रीमियम देने एवं दस्तावेजों पर हस्ताक्षर करने के बाद उपभोक्ता को चिकित्सा जांच कराने की सलाह दी जाती है। "उपभोक्ता चिकित्सा जांच अपने खर्च पर कराता है। मैं समझता हूँ कि यह भी कमीशन कमाने की एक छिपी चाल है।"

बीमाकर्ता द्वारा जान-बूझकर तथ्यों को छिपाने, धोखा देने या जान-बूझकर दावा लेने के लिये बीमा कराया हो और ऐसी स्थिति में कंपनी दावे को नकार देती है तो निश्चित ही इस पर सवाल नहीं उठाया जा सकता, लेकिन बीमाकर्ता पर दोष मढ़ना यह दर्शाता है कि प्रतिबंधित तथ्यों में दम है। स्वास्थ्य बीमा कराने वाले व्यक्ति का पहले से ही 'रोग गुप्त होना' बीमाकर्ता एवं बीमा कराने वाले व्यक्ति के बीच उसकी व्याख्या एवं अपवर्जन को लेकर विवाद पैदा होता है। बीमा कंपनियों को ऐसा माहौल बनाने की जरूरत है, जिससे कि उपभोक्ताओं को यह न लगे कि उनकी कीमत पर ये कंपनियां मुनाफ़ाखोरी कर रही हैं, या गैर-जिम्मेदार और असहयोगी हैं। बीमा कंपनियों द्वारा यह विश्वास दिलाये जाने की जरूरत है कि उनकी उपेक्षा की कीमत पर बीमा कंपनियां फल-फूल रही हैं। उपभोक्ता महसूस करता है कि वह लगातार ठगा जा रहा है। उसके साथ धोखाधड़ी की जा रही है, उसे गलत रास्ता बताया जा रहा है और वास्तव में एजेंट बताये गये कथन पर विश्वास करने पर उसे भ्रमित किया जा रहा है।

खातों की अनुपलब्धता पर दावा निस्तारण में देरी या रिकार्डों के इधर-उधर होने पर, सर्वेक्षण की रिपोर्ट की पावती आदि किन्हीं कारणों से दावा निस्तारण में देरी होती है। सामान्य तौर पर बीमाकर्ता को दौड़ा-दौड़ा कर उसे हैरान करने पर भी बीमाकर्ता बीमा विनियामक आयोगों व उपभोक्ता फ़ोरम का दरवाजा खटखटाने के लिये मजबूर होता है। कई उपभोक्ता बीमा कंपनी के कार्यालय महीनों तक दौड़ते रहते हैं। अंतत: वह थक जाता है और कानूनी रास्ता पकड़ता है।

हमारे पास दो ऐसे उदाहरण हैं, जिसमें उपभोक्ता के दावे में देरी की गई और भ्रमित किया गया। पहला उदाहरण क्वालिटी काउंसिल ऑफ़ इंडिया के एक अधिकारी का है। उसे सार्वजनिक क्षेत्र की एक बीमा कंपनी से चिकित्सा दावा पॉलिसी अपने परिवार के लिये लेनी थी। उसकी पत्नी का ट्रोजोटाइटिस का इलाज हुआ और उसने जून, 2003 में बीमा कंपनी से 38,628 रुपये का दावा किया। इस दावे को स्वीकृत करने के लिये कंपनी ने थर्ड पार्टी एडमिनिस्ट्रेशन को सौंप दिया। भारी माथापच्ची करने के बाद कंपनी ने 20 फ़रवरी 2004 को मात्र 19,314 रुपये का दावा मंजूर किया। इसमें 50 प्रतिशत राशि दावे के विरुद्ध कम

किये जाने के बारे में कोई कारण भी नहीं बताया गया। अंतत: उस अधिकारी ने न्याय के लिये बीमा विवाद निवारण न्यायालय में अपील की है।

दूसरा मामला एक प्राइवेट कंपनी द्वारा बीमा दावे को निरस्त कर देने का है। वी.आर. जैन ने 16 अक्टूबर, 2003 को एक वर्ष के लिये कैशलेस हॉस्पिटलाइज़ेशन पॉलिसी कराई। पॉलिसी के अनुसार अस्पताल में भर्ती रहने के दौरान प्रतिदिन एक हजार रुपये अनुदान राशि प्रदान ही जाती है। 10 नवंबर, 2003 को उनकी पत्नी एंजियोप्लास्टी के लिये अस्पताल में भर्ती हुईं। अस्पताल में तीन दिन तक भर्ती रहने के एवज में वी.आर. जैन ने बीमा कंपनी से 3,000 रुपये का दावा किया, जिसे कंपनी ने निरस्त कर दिया। निरस्त करने के कारणों में यह स्पष्ट किया गया कि उनकी पत्नी बीमा कराने के पहले से ही हृदय रोग से ग्रस्त थीं। रोचक बात यह है कि पॉलिसी कराते समय ही जैन ने हृदय रोग होने संबंधी आवेदन दिया था, जिसका सीधा मतलब था कि वह (उनकी पत्नी) हृदय रोग से पीड़ित है। कई वर्षों बाद कंपनी ने पॉलिसी स्वीकृत नहीं की। पॉलिसी के समय दी गई राशि से कंपनी ने 17,000 रुपये की बचत की। यह उपभोक्ता को बहकाने का प्रत्यक्ष और स्पष्ट उदाहरण है।

एक अन्य दृष्टांत पॉलिसी नवीकरण का कवर नोट उपलब्ध कराने में देरी करने का है। नई दिल्ली में एक उपभोक्ता ने दस लाख रुपये की देयता बीमा पॉलिसी एक सार्वजनिक क्षेत्र की बीमा कंपनी से ली। पॉलिसी की तिथि 22 अप्रैल, 2004 को समाप्त हो गई। पॉलिसी के नवीकरण के लिये 27 अप्रैल, 2004 को 8,400 रुपये का चेक भेजा गया। दुर्भाग्य से अनेक फ़ोन किये जाने के बाद भी यह लेख लिखे जाने तक (15 जुलाई, 04) पॉलिसी का कवर नोट उपभोक्ता को नहीं उपलब्ध कराया गया था। "इसके पीछे एक कारण पुराने रिकार्डों का खो जाना होगा या फिर चेक कंपनी को न मिल पाना हो सकता है।"

यदि हम वर्ष 1998 एवं 2002 के दौरान के जिला फ़ोरमों के निर्णय किये गये मामलों का विश्लेषण करें तो अधिकांश मामले करीब 83 प्रतिशत बीमा कंपनियों की सेवा को लेकर होंगे। 4.21 प्रतिशत मामले बीमा से संबद्ध हैं। इसी दौरान राज्य आयोगों में 84.91 प्रतिशत निर्णीत मामले सेवा से ही संबद्ध हैं और 8.89 प्रतिशत मामले बीमा सेवाओं से संबंधित हैं।

इसी तरह राष्ट्रीय आयोग द्वारा वर्ष 1998 से 2000 के दौरान निर्णीत मामलों में 79.35 प्रतिशत शिकायतें सेवाओं से संबद्ध हैं, जिसमें बीमा क्षेत्र की सेवाओं की कमी के अधिकांश मामले हैं। इनका हिस्सा 36.99 प्रतिशत है। इससे स्पष्ट होता है कि बीमा कंपनियों का दावे निपटारे का आंतरिक प्रणाली उपभोक्ताओं के लिये मैत्रीपूर्ण नहीं है। इनमें पारदर्शिता एवं तीव्रता का भी अभाव है।

बहरहाल भारतीय विधि आयोग ने वर्तमान बीमा नियमों में बदलाव का प्रस्ताव रखा है। बीमा अधिनियम 1938 एवं आईआरडीए अधिनियम 1999 में भी विस्तृत बदलाव कर नये कानूनों का प्रस्ताव विधि आयोग ने किया है। आयोग ने शिकायत समाधान प्राधिकरण (जीआरए) को पूर्णकालिक बीमा दावा निपटारा तंत्र बनाने का प्रस्ताव रखा है। इस प्रस्ताव में इसका कार्यालय देश के सभी प्रमुख शहरों में खोलने का प्रावधान किया गया है। एक जीआरए में एक न्यायिक एवं दो तकनीकी सदस्यों की नियुक्ति की जाएगी, जो शिकायतों/दावे का निपटारा करेंगे।

मैं कहना चाहता हूँ कि शिकायतों एवं दावों के निस्तारण में समयसीमा भी तय की जाए। यह समय सीमा 90 दिन रखी जा सकती है। 90 दिन के भीतर प्राधिकरण निर्णय हर हाल में दे देगा। इसके लिये इससे अधिक समय दावाकर्ता के वकील को भी नहीं दिया जाएगा। 20 लाख से ऊपर के धनराशि के मामलों में ही प्राधिकरण के निर्णय के विरुद्ध मात्र सर्वोच्च न्यायालय में अपील की जा सकेगी, ऐसा तय किया जाना चाहिये।

उपभोक्ताओं की ओर से हम यही आशा कर सकते हैं कि जीआरए दावाकर्ताओं एवं पॉलिसीधारकों की अपेक्षाओं पर खरा उतरेगा।

लेखक "कंज़्यूमर वायस" के प्रबंधक (विधि) हैं। उनसे cvoice@vsnl.net पर संपर्क किया जा सकता है।

'अंतिम है ढांचागत क्षतिपूर्ति आधारित भुगतान'

इस पर सर्वोच्च न्यायालय की राय

सर्वोच्च न्यायालय ने मोटर वाहन अधिनियम की धारा 163-ए पर अपनी सम्मति दी है। न्यायालय ने स्पष्ट किया है कि अधिनियम की धारा 163-ए एवं 166 दोनों एक-दूसरे से मुक्त हैं, स्वतंत्र हैं और दावाकर्ता एक ही साथ दोनों धाराओं के अंतर्गत क्षतिपूर्ति का दावा नहीं कर सकता। बता रहे हैं लेखक ***डी. वरदराजन.***

मोटर वाहन (संशोधन) अधिनियम 1994 के माध्यम से मोटर वाहन अधिनियम 1988 की धारा 163 ए जोड़ने के बाद सामान्य बीमा धारकों के दावे की बहुलता के कारण अनेक बाधाएं खड़ी हो गयी हैं। धारा 163-ए में वाहन दुर्घटना के भुक्तभोगी या वाहन मालिक को ढांचागत क्षतिपूर्ति नियमन दिये जाने का प्रावधान किया गया है।

बहरहाल इस धारा को लेकर विवाद उठ खड़े हुये हैं। विवाद इस बात पर भी है कि इसका वास्तविक लाभभोगी कौन है और इसका उद्देश्य क्या है। इस धारा से यह भी सवाल उठने लगे हैं कि इसके तहत प्रदान की जाने वाली राहत अंतरिम होगी या अंतिम। दावाकर्ता मोटर वाहन अधिनियम की धारा 163-ए एवं धारा 166 के तहत क्षतिपूर्ति का दावा कर सकता है। हाल ही में दीपालाल गिरी भाई सोनी एवं अन्य बनाम यूनाइटेड इंडिया इंश्यूरेंस कंपनी लिमिटेड (सी.ए.नं. 3126 के 2002 निर्णीत 19 मार्च 2004) के मामले में उच्चतम न्यायालय की एक खंडपीठ ने इस धारा को लेकर उठे विवाद पर स्पष्टीकरण दिया है। निर्णय के अनुसार ढांचागत क्षतिपूर्ति के पूरे मामले में धारा 163-ए के मोटर वाहन अधिनियम की द्वितीय सूची के साथ जोड़कर पढ़ा जाना चाहिये और इस धारा को मुक्त रूप से अधिनियम की धारा 166 से बिना अंतर्युक्त किये संचालित किया जा सकेगा।

कुल मिलाकर क्षतिपूर्ति के लिये नियम का प्रावधान दावाकर्ता का अंतिम रास्ता है। यह स्वाभाविक है। अन्यथा इससे नकारात्मक संकेत जाएगा और बीमा कंपनियों की पूरी व्यवस्था ही अनियमित हो जाएगी। अत: कानूनी तौर पर इनका स्पष्ट होना जरूरी है, जबकि क्षतिपूर्ति मामले की प्रकृति के आधार पर, विवाद का प्रकृति स्वरूप, दुर्घटना के शिकार वाहन या वाहन मालिक, उसकी आयु एवं आय के आधार पर न्यायाधिकार विनिश्चय करता है।

मोटर वाहन अधिनियम की धारा 140 से इतर पार्टियों के बीच विनियमों के अनेक मुद्दों पर अधिनियम की धारा 163-ए के प्रावधानों के कारण विवाद उठ रहे हैं।

इस मामले में संपूर्ण वैधानिक प्रावधानों की जांच करने के बाद सर्वोच्च न्यायालय ने धारा 163-ए से उठे सभी सवालों को समाप्त करते हुये अपने अंतिम निर्णय में यह तय किया है कि क्षतिपूर्ति की अदायगी में दावाकर्ता के अधिकार धारा 163-ए एवं 166 के अंतर्गत अंतिम हैं और यह दोनों अलग-अलग रूप से लागू होते हैं। "दावाकर्ता एक की साथ दोनों धाराओं के तहत क्षतिपूर्ति का दावा नहीं कर सकता। अत: कोई भी क्लाइंट दोनों धाराओं में से किसी एक ही धारा के अंतर्गत क्षतिपूर्ति पाने का हकदार होगा।" यानी वह दोनों धाराओं के अंतर्गत क्षतिपूर्ति का हकदार नहीं होगा। मोटर वाहन अधिनियम की धारा 140 एवं 141 से इतर भारतीय संसद अधिनियम के तहत धारा 163-ए के प्रावधानों के साथ अतिरिक्त क्षतिपूर्ति देने का प्रावधान नहीं करना चाहती। इसके अनुसार सर्वोच्च न्यायालय की तीन सदस्यीय खंडपीठ ने पूर्व की दो सदस्यीय खंडपीठ के ओरिएंटल इंश्युरेंस कंपनी बनाम हंसराज भाई वी. कड़ेल व अन्य (2001) 5 एससीसी 175 (इस मामले में धारा 163-ए के तहत सुनवाई की गयी और उस पर खंडपीठ ने अपनी सम्मति दी) के निर्णय की पुष्टि की। इससे यह और स्पष्ट हो गया कि यदि कोई व्यक्ति धारा 163-ए के तहत आग्रह करता है ता वह 40 हजार रुपये वार्षिक आय के तौर पर प्राप्त करेगा। दीपालाल गिरी भाई सोनी के मामले में (आईबीआईडी) सर्वोच्च न्यायालय की तीन सदस्यीय खंडपीठ ने राय दी कि धारा 163-ए को सामाजिक सुरक्षा प्रावधान के रूप में लेना चाहिये। इस योजना के तहत वे ही लाभान्वित हो सकते हैं, जिनकी वार्षिक आय 40,000 रुपये से अधिक नहीं है। अन्य सभी दावे अधिनियम के अध्याय सातवें के विनियमों के आधार पर निर्धारित किये जाएंगे।

मोटर वाहन अधिनियम की दूसरी सूची में उल्लिखित वार्षिक आय अधिकतम 40,000 रुपये तक ढांचागत क्षतिपूर्ति की प्रति वर्ष गणना के उद्देश्य पर सर्वोच्च न्यायालय ने स्पष्ट किया कि धारा 163-ए वर्ष 1994 में लागू की गयी। केंद्र सरकार के कार्यकारी प्राधिकारी को समय-समय पर दूसरी सूची में संशोधन करने का अधिकार है। मुद्रास्फीति में चढ़ाव-उतार और बैंक ब्याज दर में कमी इन सब को देखते हुये यह आवश्यक हो गया कि केंद्र सरकार इस मामले पर गंभीर विचार करे।

दीपालाल गिरी भाई सोनी के मामले में सर्वोच्च न्यायालय का फैसला सामान्य बीमा धारकों को राहत देने वाला है। यह स्वागत योग्य कदम है। न्यायालय के फ़ैसले से अब इसमें कोई दुविधा नहीं रही कि मोटर वाहन अधिनियम 163-ए एवं 166 के तहत उन्हें दोहरा दावा करने की जरूरत है।

लेखक दिल्ली में अधिवक्ता हैं और आईआरडीए की बीमा सलाहकार समिति के सदस्य हैं।

बीमा विनियामक और विकास प्राधिकरण

सभी के लिए बीमा पर निबंध प्रतियोगिता

विषय

बीमा का प्रसार करने में भाषा की भूमिका
ग्रामीण बीमा के प्रचार-प्रसार में भाषा की भूमिका
बीमा ग्राहक के रूप में अनुभव

प्रथम पुरस्कार
3000 रुपये
द्वितीय पुरस्कार
2000 रुपये
तृतीय पुरस्कार
1000 रुपये

नियम : यह प्रतियोगिता सभी के लिए है। उपरोक्त में से किसी एक विषय पर निबंध लिख कर भेजें। निबंध 1000 शब्दों से ज्यादा का नहीं होना चाहिए। निबंध हिन्दी में स्पष्ट रूप से हस्तलिखित या टाईप किया होना चाहिए। निबंध प्राप्त होने की अंतिम तिथि 23 अक्तूबर 04 है। निबंधों के चयन का अधिकार बीमा विनियामक और विकास प्राधिकरण के पास सुरक्षित है। संतोषप्रद प्रविष्ठियों को आईआरडीए जर्नल में भी प्रकाशित किया जाएगा। प्रतियोगिता के सन्दर्भ में कोई भी पत्र-व्यवहार मान्य नहीं होगा।

केवल हैदराबाद में कार्यरत बीमा कम्पनियों के स्थाई कर्मचारी हेतु निबंध प्रतियोगिता

विषय

बैक ऑफिस तथा फ्रंट आफिस प्रचालन में भाषा की भूमिका
बीमा शिक्षा संस्थानों में शिक्षण की भाषा
बीमा धारक के अधिकार

प्रथम पुरस्कार
2000 रुपये
द्वितीय पुरस्कार
1500 रुपये
तृतीय पुरस्कार
1000 रुपये

नोट : निबंध प्राप्त होने की अंतिम तिथि 14 अक्तूबर 04 है।
उपरोक्त में से किसी एक विषय पर निबंध लिख कर भेजें। अन्य ऊपर लिखे गये नियम लागू।

प्रविष्ठि भेजने का पता : **राजभाषा विभाग, बीमा विनियामक और विकास प्राधिकरण,**
तीसरी मंजिल, परिश्रम भवन, बशीरबाग, हैदराबाद-500 004 दूरभाष : 55820964

'उपभोक्ताओं की अपेक्षा से भी अधिक उपयुक्त'

यज्ञप्रिया भरत

असंतुष्ट, क्रुद्ध व उत्तेजित शिकायतकर्ताओं को संतुष्ट करने का काम कितना कठिन है, यह वही जानता है, जो इनके पाले पड़ता है। फिर भी इस काम में कुछ ऐसे कारक भी हैं, जो आपको बेहतर काम करने का मौक़ा देते हैं। इसे यूँ भी कह सकते हैं कि इसमें सीमा से भी अधिक उपयुक्त करने का मौक़ा मिलता है। इसका फ़ायदा यह है कि शिकायत करने वाले ग्राह का न केवल आप स्वागत करते हैं, बल्कि उसे संतुष्ट भी करते हैं। उसकी शिकायत दूर कर उसे संतुष्ट करने के लिए आप निश्चित समाधान करते हैं।

उपभोक्ता सेवाओं का एक महत्वपूर्ण कार्य है उपभोक्ता की शिकायतों का निवारण करना और शिकायतकर्ता को तात्कालिक रूप से संतुष्ट करना। बेहतर उपभोक्ता सेवाओं में शिकायतकर्ता को विशेष महत्व दिया जाता है। सारी कसरतों के बाद उसे अपनी इच्छित दिशा की ओर झुका लेना बड़ी बात कही जाएगी।

अध्यनों से यह साफ़ दिखाई देता है कि व्यवसायियों को कुल असंतुष्ट ग्राहकों के पाँच प्रतिशत से भी कम ग्राहक शिकायत करते हैं। अधिकांश असंतुष्ट ग्राहक चुप ही रहते हैं। इसमें से अधिकांश तो दोबारा कभी भी नहीं आते और कुछ अपने मित्रों को भी वहाँ जाने से रोकते हैं। जब ग्राहक शिकायत करता है, तो वहाँ कम से कम इतना मौक़ा मिल जाता है कि उसे संतुष्ट किया जाए। इससे संशोधन या सुधार का मौक़ा मिल जाता है।

अच्छी तरह व बेहतर ढंग से बनाया गया उपभोक्ता शिकायत व सुझाव तंत्र मार्केटिंग एवं व्यवसाय प्रगति में सहायक हो सकता है। शिकायत निवारण या सुझाव प्रकोष्ठ कंपनी के विज्ञापन का एक उपयुक्त माध्यम भी हो सकता है। सुझाव व शिकायत निवारण प्रकोष्ठ से ग्राहकों व उपभोक्ताओं के साथ कंपनी सीधे पहुँच में रहती है। यह प्रत्यक्ष संबंध का माध्यम है और इसमें पुष्ट एवं वास्तविक शिकायतें ही कंपनी के ज्ञान में आती हैं।

एक आदर्श समस्या निवारण तंत्र के पास शिकायतों का समाधान करने के लिए एक बेहतर कार्य संहिता भी होनी चाहिए। शिकायत को दूर करने के लिए विशेष प्रक्रिया और समयबद्ध रूप से निपटान इसका एक अभिन्न हिस्सा होना चाहिए। शिकायतें दूर करने की प्रक्रिया की जानकारी सभी को होनी चाहिए। यथार्थ, सही-सही एवं तत्काल शिकायतों को निपटाने के लिए यह आवश्यक है।

शिकायतकर्ता उपभोक्ता (ग्राहक) को समुचित समाधान किया जाना चाहिए, जो उसकी शिकायत के अनुरूप है। शिकायतें प्राप्त करने व दर्ज करने के लिए एक मानक प्रारूप सहायक हो सकता है, ताकि शिकायतकर्ता कम से कम न्यूनतम ज़रूरी सूचना दे सके।

शिकायतकर्ता को समय से जानकारी देना, उसकी समस्याओं का निदान करना और जितनी जल्दी संभव हो सके, उसे निपटाना चाहिए। शिकायत लिखित हो या मौखिक, उन्हें न केवल समय पर और कुशलता से सुलझाया जाना चाहिए, बल्कि पूरे विश्वास के साथ उसे निपटाया जाना चाहिए। उपभोक्ताओं की सभी समस्याएँ समुचित एवं पर्याप्त रूप से निपटाई जानी चाहिए। जब एक शिकायतकर्ता उपभोक्ता शिकायत प्रकोष्ठ में अपनी शिकायतें लेकर आता है तो वह यह आशा करता है कि उसकी शिकायत को गंभीरता से लिया जाएगा। अत: उसे उसी गंभीरता से लिया जाना चाहिए।

जिन शिकायतों का तात्कालिक रूप से समाधान न किया जा सके, उसे संस्थान के उच्च अधिकारी तक ले जाना चाहिए और उनसे उसका समाधान करवाना चाहिए। बहुत से संस्थानों में शिकायत समाधान समिति गठित की गई है और वे अपना काम सफलतापूर्वक कर रहे हैं। इस समिति के सदस्यों के पास निर्णय लेने की शक्ति है और वे उद्देश्यपूर्ण निर्णय लेकर संस्थान की हिस्सेदारी एवं कार्यकलापों की छवि को स्वच्छ बनाए रखते हैं। एक बार समिति जब अपना अंतिम निर्णय दे देती है तो यह समझा जाता है कि शिकायत समाप्त हो गई है। यह भविष्य में आने वाली शिकायतों को निपटाने में भी मददगार होती है।

भारत में आज-कल बीमा कंपनियों के उपभोक्ताओं पर विशेष ध्यान दिया जा रहा है। जब उपभोक्ताओं पर विशेष ध्यान दिया जाता है तो उसके पास चयन करने का पूरा-पूरा मौक़ा होता है। वह इनकी उपयोगिता, सेवाओं एवं पहुँच आदि को जाँच कर स्वेच्छा से निर्णय लेता है। इस प्रक्रिया में वह बीमा कंपनियों के बारे में जानकारी हासिल करता है। इस संबंध में कुछ वर्षों तक जब लोगों के पास विकल्प नहीं था, चयन की स्वच्छता नहीं थी तो वे उस बात को स्वीकार करने के लिए मजबूर थे। उपभोक्ता उनके बारे में बहुत कुछ जानता था।

"आज एक बीमाधारक ज़्यादा जागरूक है और वह अच्छी तरह सोच-समझकर बीमा कराता है। वह अपना उचित अनुचित जानता है" और उसी के अनुसार निर्णय लेता है। जब बीमा कंपनियाँ एवं बीमा अभिकर्ता उपभोक्ताओं के लिए गुणवत्तायुक्त सेवाएँ उपलब्ध कराने के लिए समर्पित नहीं होते हैं, तब ऐसे में किसी कंपनी का अपना अस्तित्व व वैयक्तिक पहचान बनाए रख पाना कठिन कार्य है। इसके लिए कंपनी एवं एजेंट को सदैव प्रतिबद्ध रहना पड़ता है। बीमाकर्ता के अधिकारों व हितों की रक्षा के लिए आईआरडीए यानी बीमा विनियामक और विकास प्राधिकरण कानून, 2002 बनाया गया है। यह कानून सभी बीमाकर्ताओं, बीमा अभिकर्ताओं एवं बीमा कंपनियों पर लागू होता है। यह कानून बीमा बिक्री, बीमा धारक की सेवाओं से संबंधित मामले, जीवन एवं सामान्य बीमा पॉलिसी के बारे में स्पष्ट किए गए मामले, सामान्य एवं जीवन बीमा पॉलिसियों में दावा प्रक्रिया और अन्य संबद्ध सामान्य मामलों को विनियमित करता है।

दूसरे शब्दों में उपभोक्ता सेवा मामले को नियमबद्ध किया गया है। इन नियमों से बीमा कंपनियों एवं मध्यस्थ बँधे हुए हैं। इन्हीं नियमों के अंतर्गत वे अपनी सेवाएँ प्रदान करते हैं। उपभोक्ताओं की शिकायतों को सुलझाने की आवश्यकता को देखते हुए नियमों में भी इसकी व्यवस्था की गई है कि प्रत्येक बीमा कंपनी को एक निश्चित उपयुक्त प्रक्रिया अपनानी होगी। इसके लिए एक प्रभावशाली प्रशासन नियुक्त करना होगा, जो शिकायतकर्ताओं की शिकायतें प्रभावशाली एवं तेज़ी से सुलझाएगा। बीमा लोकपाल की बीमा संबंधी इन सूचनाओं को पॉलिसी प्रमाण-पत्रों के साथ उपलब्ध कराना भी अनिवार्य किया गया है।

बीमा विनियामक और विकास प्राधिकरण (आईआरडीए) ने भी स्वयं एक बीमाकर्ता शिकायत प्रकोष्ठ का गठन किया है और यह जनवरी, 2003 से अपना काम कर रहा है। इस प्रकोष्ठ का मुख्य उद्देश्य पॉलिसी होल्डरों की तकलीफ़ों को जल्द से जल्द दूर करने के लिए सहायता प्रदान करना है। पॉलिसी होल्डरों को हर्जाना या क्षतिपूर्ति तंत्र अपने आप में एक

प्रशासनिक अंग है। यह कंपनी स्तर पर नीति निर्धारण की प्रक्रिया में ध्यानव्य बिंदु है।

प्राधिकरण ने अपनी स्थापना के बाद से ही क़रीब 4,800 से भी अधिक शिकायतें प्राप्त की हैं और जून, 2004 तक 65 शिकायतों को निपटा दिया। क़रीब 27 प्रतिशत शिकायतें जीवन एवं गैर-जीवन बीमा से संबंधित होती हैं।

क़रीब 50 प्रतिशत शिकायतें चिकित्सा दावा बीमा की होती हैं या फिर उससे संबंधित होती हैं। विशेष रूप से वे पॉलिसी के नवीनीकरण को ख़त्म करने से होते हैं। ऐसा प्रीमियम के बढ़ जाने के कारण होता है। बीमाकर्ता के दावों को बीमा कंपनियाँ यह कह कर ख़ारिज करती है कि वह पहले से ही रोगग्रस्त था। इस तरह के विवाद बीमा कराने के पहले से ही बीमा धारक के रोगग्रस्त होने से संबंधित होते हैं। इनके मामले में पहले से ही समीक्षा की आवश्यकता रहती है।

सामान्य तौर पर प्राधिकरण में तमाम शिकायतें दावा भुगतान में की जा रही देरी को लेकर होती हैं। औसतन उपभोक्ता परिश्य दावा प्रबंधन सुस्त होता है। इस प्रक्रिया में गूढ़ता के साथ-साथ पारदर्शिता की भी कमी होती है। तमाम शिकायतें अपर्याप्त लेखन प्रक्रिया, अधिक दर, भ्रामक विज्ञापनों आदि से संबंधित होती हैं। बहुत से उपभोक्ता यह शिकायत लेकर आते हैं कि उन्हें बीमा पॉलिसी के बारे में ग़लत सूचना दी गई। बीमा एजेंट और मार्केटिंग अधिकारी ने भ्रामक सूचनाएँ दीं। कुछ मामले तो ऐसे होते हैं, जिनमें बीमा धारक अपने को तब ठगा महसूस करता है, जब दावे की शर्तें सामने आती हैं और उनमें देरी होती है। शिकायत के लिए एक भी शिकायत काफ़ी होती है।

यह देखा गया है कि तमाम शिकायतें सूचना एवं प्रशासन की विफलता का परिणाम होती हैं। खासतौर से दावों के मामले में यह बात उभरकर सामने आती है कि दावाकर्ता का समय इस खिड़की से उस खिड़की पूछताछ करने में ही बीतता है। इससे बीमाधारक ऊब जाता है। उपभोक्ता कंपनी के पास जब भी अपनी समस्या लेकर जाता है तो वह यह अपेक्षा करता है कि उससे विनम्रतापूर्वक बात की जाएगी, उसकी बात सुनी जाएगी और उस पर उपेक्षात्मक रवैया नहीं अपना जाएगा।

प्राधिकरण को प्रतिदिन अनेक शिकायतें मिलती हैं और उसमें से कुछ तो बिल्कुल बीमा कंपनी के कर्मचारी या मध्यस्थ के क्रूर व्यवहार पर होती हैं। उसमें से कुछ तो कोई खास नहीं होतीं। ऐसे भी उपभोक्ता होते हैं, जो बिना किसी कारण के शिकायत करते हैं, लेकिन इनसे भी यह प्रकट होता है कि किसी एक खास बिंदु पर कुछ है।

उपभोक्ता बीमा मुद्दों पर सीधा और समय से समाधान चाहता है। वह संतोषजनक परिणाम चाहता है। वह प्रीमियम वापसी, दावा भुगतान या पॉलिसी की पुन: शुरूआत महीनों की बजाय कुछ दिनों में चाहता है। अत: तीव्र समाधान बहुत महत्वपूर्ण है। यदि शिकायत साधारण है और बीमा कंपनी तात्कालिक प्रतिक्रिया दे सकती है तो शिकायतों का निवारण 60 दिनों में किया जा सकता है। यदि शिकायत गंभीर और पेचीदा है, जिसमें दस्तावेज़ों, नीतियों, व्याख्याओं, सर्वेक्षण रिपोर्टों आदि के लिए एक बीमा कंपनी को तमाम सीढ़ियों से गुज़रना है तो इसमें अधिकतम 120 दिन लग सकते हैं। शिकायत की पेचीदगी और उस पर बीमा कंपनी की अनुक्रियाशीलता लक्ष्य प्राप्ति में मुख्य परिश्य है।

"शिकायतकर्ता न केवल तीव्र समाधान चाहता है, बल्कि सकारात्मक व संतोषजनक परिणाम भी चाहता है।" यह समाधान चाहे दावे में रुपये की अदायगी भी हो सकती है, प्रीमियम की पुनर्वापसी भी हो सकती है। इसमें बीमा का नवीनीकरण और बीमा कराना भी शामिल हो सकता है। जब शिकायत का निपटारा हो जाता है तो यह ज़रूरी नहीं है कि परिणाम सकारात्मक हो। शिकायतकर्ता के लिए इसका परिणाम नकारात्मक या सकारात्मक भी हो सकता है।

यही स्थिति बीमा कंपनी एवं एजेंट के मामले पर भी लागू होती है। यहाँ इससे यह संकेत मिलता है कि उपभोक्ता को शिक्षित किए जाने की ज़रूरत है। शायद नियमों में भी संशोधन की आवश्यकता है। नकारात्मक परिणामों में ऐसा भी हो सकता है कि शिकायत में तथ्यात्मक कमी हो। ऐसी शिकायतों पर, जिसमें अपर्याप्त तथ्यों के साथ दावा किया गया है, प्राधिकरण कोई निर्णय नहीं दे सकता और इसलिए इसका निपटारा नहीं किया जा सकता। प्राधिकरण के पास तमाम ऐसी भी शिकायतें आती हैं, जहाँ उसका कार्य क्षेत्र नहीं है।

हम महाआकांक्षाओं के युग में जी रहे हैं। यह कहा जाता है कि प्रतिवर्ष उपभोक्ताओं की शिकायतों में 25 प्रतिशत से अधिक की वृद्धि हो रही है। इसका मतलब यह नहीं है कि समस्याएँ उठ खड़ी हुई हैं। ऐसा इसलिए है कि उपभोक्ता ज़्यादा जागरूक हुआ है। यह किसी भी उद्योग के लिए स्वस्थ संकेत है। इससे व्यवसाय में प्रगति हुई है। अच्छी तरह से शिक्षित सूचित उपभोक्ता किसी भी उपभोक्ता संरक्षण कार्यक्रम से महान है।

जीवन बीमा के विनियमों, प्रावधानों, प्रबंधनों एवं अन्य संबंधित मामलों में उपभोक्ता को शिक्षित और सूचित करने का कोई भी कार्यक्रम बीमा कानून के तहत उपभोक्ता का अधिकार है। इससे उपभोक्ता पॉलिसी तय करने में अच्छे-बुरे से परिचित होता है। यह बिंदु उपभोक्ता संरक्षण को बढ़ाने में भी महत्वपूर्ण है। उपभोक्ता को सूचना प्रदान करने के लिए आपस में बेहतर संचार प्रक्रिया भी कंपनी को फ़ीडबैक प्रदान करने का अच्छा साधन है।

प्राधिकरण का मुख्य उद्देश्य उपभोक्ता शिकायतों का निवारण करना है। इसलिए इसका परिणाम जीवन बीमा कंपनियों, उनके अभिकर्ताओं के नियमों एवं कानून के अनुसार काम करने पर निर्भर है। उपभोक्ता शिकायतों के निपटारे में प्राधिकरण बीमा कंपनी एवं उपभोक्ता के बीच काम करती है। यदि व्यवस्था के अंतर्गत निदान संभव है तो भविष्य में फिर वैसी शिकायत नहीं होती। इसका मतलब यह है कि उससे संबंधित शिकायतों में कमी आनी चाहिए। प्राधिकरण की दृष्टि से निरंतर संपर्क एवं उपभोक्ताओं की प्रतिक्रिया उद्योग एवं मध्यस्थों का निर्णायक है।

लेखक आईआरडीए के उपनिदेशक हैं और उपभोक्ता शिकायतों का निपटारा करते हैं। यहाँ व्यक्त विचार उनके अपने हैं।

INSURANCE FUNDS IN HOUSEHOLDS RISE

The share of insurance funds in household savings has shown an increase from 13.5 per cent in 2000-01 to 14.4 per cent in 2001-02 - which was the first year of competition in insurance market after being opened for private players.

Growth and expansion of life insurance market in the post - liberalisation period improved further which can be noted in terms of business of growth of LIC of India, Mr. H Sadhak, Director of LIC Management Development Centre at Borivli has been quoted saying.

During 2001-02, LIC had achieved 137.03 per cent growth in premium income, 54.34 per cent higher when compared with the global growth rate, he said.

During 2003, according to Dr Sadhak, the Indian insurance industry as a whole witnessed nominal growth of 18 per cent as against 11.7 per cent of the global rate.

Premium volume of the Indian life insurance industry had witnessed a growth rate of 18 per cent as against nine per cent globally and premium volume of non-life insurance saw a growth of 17 per cent as against 15.5 per cent world-wide, he noted.

Expanding the life insurance market calls for a macro and micro level strategic design to change penetration and density level by creating an environment for growth through structural and non-structural initiatives. In this scheme of things, marketing becomes the key, Dr Sadak pointed out.

"Since the Indian insurance market is getting integrated with its global counterpart, it is necessary for us to think about the domestic sector in the light of the emerging trend world-wide."

SBI SAYS IT PREFERS TO GO PUBLIC

The State Bank of India (SBI), it is reported, would prefer to offload part of its equity stake in SBI Life Insurance Company to the public rather than offer it to the joint venture's foreign partner Cardif.

India's largest commercial bank plans to take SBI Life public when the company covers 10million lives, SBI chairman Mr. A. K. Purwar has been quoted saying.

SBI Life has, using the bancassurance model, covered 1.8 million lives, and expects to touch the 10 million mark in three years.

SBI Life has to date covered 1.8 million lives with the sale of 2.25 lakh policies, said Krishnamurthy. "We do not have any financial constraint as SBI has the ability to bring in more capital as and when required," he added. The total capital of the insurance venture currently stands at Rs 175 crore.

Since the sector was opened to competition, private insurance joint ventures have increased their share capital from the initial stipulated Rs 100 crore to more than Rs 200-600 crore.

Private insurance joint ventures are waiting for the cap on foreign direct investment (FD) in the insurance sector to be raised to 49 per cent from the current 26 per cent.

UNITED INDIA MULLS LIFE INSURANCE FORAY

United India Insurance Company Limited, the public sector general insurance company, is exploring the possibility of its entry into the life insurance sector, it is reported.

"There is a loud thinking by board members to float a separate subsidiary for life insurance," UII Chairman-cum-Managing Director, Mr. V. Jagannathan has been quoted saying.

UII is also in the process of establishing 400 'micro offices' in rural areas across the country during this fiscal.

The 'unique' micro offices would be located in rural areas, small towns and cluster of villages where the total population was over 50,000, he said, adding, a few such offices opened in Tamil Nadu already had turned out to be a success.

INDIA AMONG TOP 4 ASIAN INVESTMENT DESTINATIONS

The 2004 World Investment Report of the UN Conference on Trade and Development (Unctad), has ranked India among the top four Asian investment destinations and the top 10 developing country recipients of FDI in 2003. The prospects for higher foreign investment flows are brighter in 2004 as the global economy rebounds this year.

The report also brings out the trend that world FDI flows have shifted from manufacturing to services, cornering nearly 70 per cent of FDI. This could help FDI flows into India, which has acquired a strong services sector base.

Over the years, India has also emerged as a source of outward FDI on an average of $1 billion annually. In the recent years, some Indian companies including Tatas and ONGC have acquired companies abroad or created overseas subsidiaries in their bid to become multinational companies.

Mitsui Sumitomo to buy out AXA's stake in Chola AXA Risk

Japanese conglomerate Mitsui Sumitomo, will buy out French financial powerhouse AXA's 50 per cent stake in Murugappa Group company Cholamandalam AXA Risk Services Ltd (CARS), it is reported.

"AXA is inclined to exit from CARS. Mitsui Sumitomo, which has ties with Cholamandalam for general insurance, is willing to buy AXA's stake," a senior official of the group is quoted saying.

The buyout is expected to happen very soon, he said adding Mitsui Sumitomo would buy out the 50 per cent share of AXA Group for about Rs. 1 crore.

Cholamandalam AXA Risk Services is a 50:50 joint venture between France's AXA Group and Cholamandalam Investment and Finance Company Ltd.

The company, which currently has a capital base of Rs. one crore, offers specialised risk services to domestic as well as multinationals in India and Asia.

"Cholamandalam AXA offers risk advisory services to corporates tailored to suit the risk management needs of different businesses," the official said.

After the buy out, Cholamandalam would double the capital base of the company to Rs. two crore.

The move assumes importance in the wake of Mitsui Sumitomo's plans to strengthen its toehold in the country's financial sector.

After forging a 74:26 tie up with Murugappa group in general insurance, the Japanese company wants to partner the Indian company in risk management services as well.

SC asks insurance companies to amend burglary policy

The Supreme Court has advised all insurance companies to amend the definition of "burglary and housebreaking" for the purposes of insurance coverage to give it a meaning closer to realities of life.

The common man by taking a policy against burglary and housebreaking "understands that he has taken a policy against theft" and hardly realises whether the incident of theft should precede violence or force, a Bench comprising Justice S. N. Variava and Justice A. K. Mathur said in a recent judgement.

"Therefore, a policy should be a meaningful policy so that a common man can understand what is the meaning of burglary in common parlance," it said.

"We hope that the insurance companies will amend their policies so as to make them more meaningful to the public at large. It should have a meaning which a common man can easily understand rather than become more technical so as to defeat the cause of the public at large," Justice Mathur, writing for the Bench, said.

Munich Re Launches Indian Service Company

Munich Re has established a new service company, Munich Re India Services Ltd., Mumbai, aimed at strengthening and intensifying "long-standing business relations - some dating back to 1950 - with Indian insurance companies."

Speaking at the official launch of the service company in Mumbai (Bombay), Dr. Detlef Schneidawind, Member of the Board of Management of Munich Re in charge of global life and health reinsurance, was reported saying: "India will profit greatly from further liberalisation and the continual opening of the insurance sector to international insurers and reinsurers, and our clients will benefit from our stronger presence in terms of a more intensive exchange of knowledge in the areas of risk management and product design."

A note from the company observed that the "total premium volume for life insurance in India amounted to the equivalent of 13 billion euros ($16 billion) in 2003. Munich Re anticipates premium volumes in the life insurance market to rise in original currency by around 15-17 per cent per year up to 2010 and envisages good prospects for growth and profitability in reinsurance business."

CHINA WITNESSES BIG BOOM IN PREMIUM GROWTH

Total assets of China's insurance industry had reached 1,111.65 billion yuan (US$132 billion) by the end of August 2004, according to the latest statistics released by the Chinese Insurance Regulatory Commission (CIRC).

The fast-expanding asset scale of the Chinese insurance industry may be attributable mainly to the sustained and rapid growth of the insurance business. In the first eight months of this year, the nation's insurance industry raked in 297.94 billion yuan of premiums, up 12.3 per cent year-on-year. As per available data, China's insurance premiums had jumped from 460 million yuan in 1980 to 388 billion yuan in 2003, with an average annual growth exceeding 29 per cent, far higher than the GDP growth in the corresponding period.

However, the Chinese insurance market is far away from saturation as compared with the mature market in Europe and North American, according to reports quoting a CIRC official. Though the country had scored an increase in the proportion of premiums to GDP from 0.1 per cent in 1980 to 3 per cent in 2003, the proportion is still very low as compared with the average proportion of 8-10 per cent in Europe and North America.

China's effective demand for insurance is obviously insufficient, and there thus is a big space for the development of the insurance industry, the official has been quoting as saying.

INSURANCE ETHICS GROUP CALLS FOR STRINGENT REGULATION

In an increasingly competitive environment, insurance companies must follow high ethical standards to protect and serve consumers and to maintain a strong marketplace, Mr. Brian Atchinson, Executive Director, Insurance Marketplace Standards Association (IMSA), has been quoted as telling a US Senate panel. IMSA, which sets ethical standards for the life insurance, annuities and long-term care insurance industry, requires its members to adhere to strict ethical requirements in their marketing, advertising, sales and customer service.

Testifying before the Senate Committee on Banking, Housing, and Urban Affairs, Mr. Atchinson said: "In an era when the practices of some financial services companies have come under media and public scrutiny, IMSA continues to provide clear ethical leadership."

"Insurance regulation is intended to ensure a healthy, competitive marketplace, to protect consumers, and to create and maintain public trust and confidence in the insurance industry," he said, adding that inconsistent state and federal standards had led to higher costs for companies and consumers without providing more protections.

He was reported to have suggested a uniform, national market analysis system with best practices organisations, such as IMSA, which "would allow regulators to focus on whether an insurer has a sound market conduct and compliance infrastructure in place to better protect consumer interests" rather than technical noncompliance issues.

IMSA is a voluntary, non-profit organisation created to strengthen consumer trust and confidence in the life insurance, long-term care insurance and annuity products industry. Its members represent nearly 60 per cent of the individually sold life, annuities and long-term care insurance policies written in the US.

South Korea to Probe Forcible Sale Of Policies

South Korea's Financial Supervisory Service (FSS) has announced that from October 2004 it will investigate banks to see whether they are forcing borrowers and customers to buy insurance policies in return for loans. According to reports, FSS has also warned that if any irregularities are detected, banks may face fines of up to 10 million won or the suspension of business for a certain period.

The investigation plan was announced after many borrowers had complained about banks asking them to buy insurance policies they did not like in return for lending money.

An FSS regulator has been quoted as saying that while the introduction of bancassurance should lower insurance premiums, the reality is that banks abuse their position as lenders to force borrowers to buy insurance policies. He added that the regulator would make a thorough analysis of the impact of bancassurance before deciding whether to allow banks to sell non-life insurance policies next April.

In a survey, 8.1 per cent of respondents said they had bought insurance policies at banks against their will because of banks' coercion. The Korea Federation of Banks (KFB), the Korea Life Insurance Association (KLIA) and the Korea Non-life Insurance Association (KNIA) jointly surveyed 900 bancassurance buyers to see how much they were satisfied with their decision.

Of the 900 respondents, 131 or 14.6 per cent said they had been recommended insurance policies while applying for bank loans. Of the 131, 73, or 8.1 per cent of the total 900 respondents, replied they had unwillingly signed insurance policies at banks.

"The forcible sale of insurance at banks has been on the rise and banks let workers collect bancassurance applications from family members and friends behind the scenes. They are apparently violating laws which ban banks from selling bancassurance outside their premises," said Mr. Cho Hong-chul, Manager, KLIA.

Meanwhile, the respondents criticised banks for not giving detailed explanations of their insurance premiums. They also said the premiums were not cheaper than those offered by insurance firms.

INDONESIA BANKRUPTCY LAW FOR INSURANCE COMPANIES

Indonesia's parliament has passed a new law that prevents creditors from filing bankruptcy suits against solvent banks and insurance companies. According to reports, the law is aimed at better protecting foreign investors, some of whom have been declared bankrupt by courts despite being clearly solvent after Indonesian creditors filed vindictive petitions against them.

Mr. Yusril Ihza Mahendra, Justice Minister, said the law would satisfy all parties, as it would provide certainties for investors to do business in Indonesia.

The new law specifies that only the finance minister can file a bankruptcy petition against insurance companies and state-owned utility companies in commercial courts. The attorney general and the central bank are the only bodies permitted to file petitions against banks. Currently, any creditor can file a bankruptcy petition in commercial courts.

Earlier this year, Jakarta's Commercial Court declared the local unit of UK Insurer Prudential PLC bankrupt because it refused to pay a disputed fee with a former sales agent.

Prudential's troubles were similar to those faced by the Indonesian unit of Canadian insurer, Manulife Financial Corp., two years ago when its profitable Indonesian unit was declared bankrupt by the same court over a small claim.

You can walk around Lloyd's and still see literally hundreds, thousands of ladies and gentlemen walking around with huge armfuls of files. Why? It is crazy. I despair.

Mr. Dennis Mahoney, Chairman and Chief Executive of the UK arm of American insurance broker Aon on the old-fashioned way in which insurance brokers do business.

Continued steady growth in premium income has been forecast between 2004 and 2008, with general insurance moving ahead more rapidly and thereby gaining share of the market. Within this sector, the main drivers of growth are expected to be employer's liability, pecuniary loss and commercial property damage insurance, although some niche sectors will also show strong growth.

Dublin-based consulting firm Research and Markets in its new 'Insurance Companies Market Report 2004,' which provides an analysis of U.K. insurance companies.

Indian insurance outsourcing revenues are likely to grow from an estimated $367 million (around Rs. 1,682 crore) in 2003 to $790 million (around Rs. 3,621 crore) by 2007, representing a compounded annual growth rate of 21 per cent.

'Global Insurance Outsourcing - The India Perspective: Overview, Trends, Insights and key Vendor Profiles' published by ValueNotes Database.

Investors who feel that they have been subject to mis-selling or misrepresentation should first take up the matter with the financial advisor or the institution involved. Failing which, they can turn to the existing industry dispute resolution schemes.

Mr. Tharman Shanmugaratnam, Vice-Chairman, Monetary Authority of Singapore on its setting up a financial industry-wide, integrated dispute resolution mechanism for all financial products and service providers.

Our study found that the professional reinsurance market has grown dramatically while the number of actual reinsurers with any significant share has shrunk. In fact, between 1994 and 2003, new recurring reinsurance grew by almost 400 per cent, while the number of life reinsurers with share greater than two per cent dropped from 16 to 10.

Mr. Stephan Christiansen, Director of Research at Conning Research and Consulting Inc. which has recently put out the study 'Life Reinsurance: Capacity and other Challenges.'

Without a culture of risk awareness in the boardroom, we cannot truly put our hands on our hearts and say we are ready for the 21st century risk environment.

Lord Peter Levene, Chairman, Lloyd's of London

RNI No: APBIL/2002/9589

Events

11 October 2004
Venue: Mumbai
Seminar on Directors' & Officers' Liability: Trends, Risk and Insurance in a Changing Landscape organised by Institute of Insurance and Risk Management, Hyderabad.

18 - 19 October 2004
Venue: Agra
Third International Symposium on New Technologies for Urban Safety of Mega Cities in Asia organised by Indian Institute of Technology (IIT), Kanpur, and International Center for Urban Safety Engineering, Institute of Industrial Science, University of Tokyo, Japan

27 - 29 October 2004
Venue: Hyderabad
A Billion Lives to Cover: Working together to expand Health Insurance in India organised by USAID, IRDA and Bearing Point.

18 - 23 October 2004
Venue: Pune
Actuarial Practices in Life Insurance by National Insurance Academy (NIA), Pune

25 - 30 October 2004
Venue: Pune
Reinsurance Management (Non-Life) by NIA

28 - 30 October 2004
Venue: Pune
Relational Database Management Systems by NIA
Workshop on Communication & Presentation Skills by NIA

8 - 13 November 2004
Venue: Pune
Market Intelligence (Non-Life) by NIA
Scenario Mapping & Marketing by NIA

8 - 10 November 2004
Venue: Pune
Workshop on Micro Insurance (Combined) by NIA