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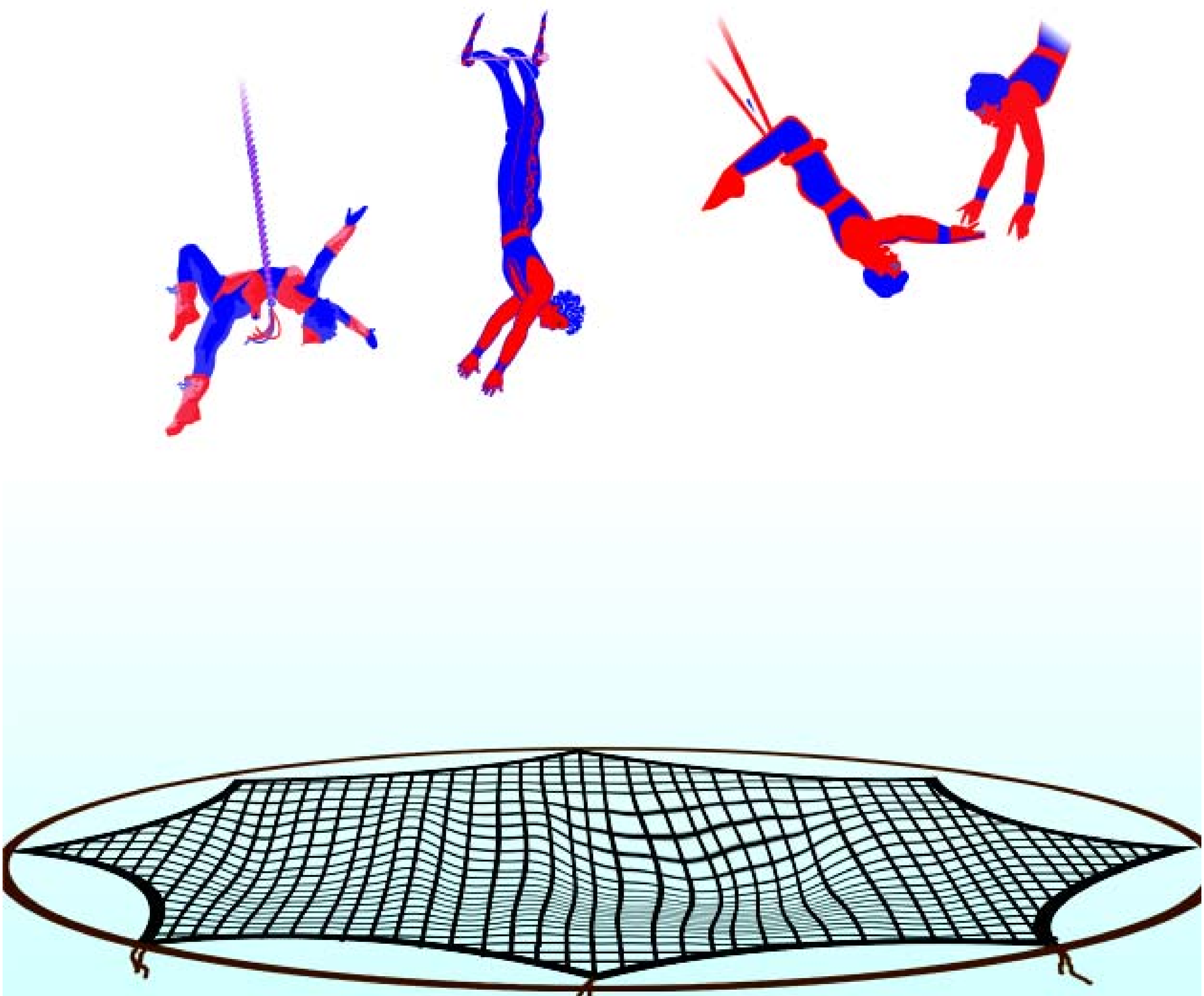
Journal

NOVEMBER 2005



बीमा विनियामक और विकास प्राधिकरण

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Journal
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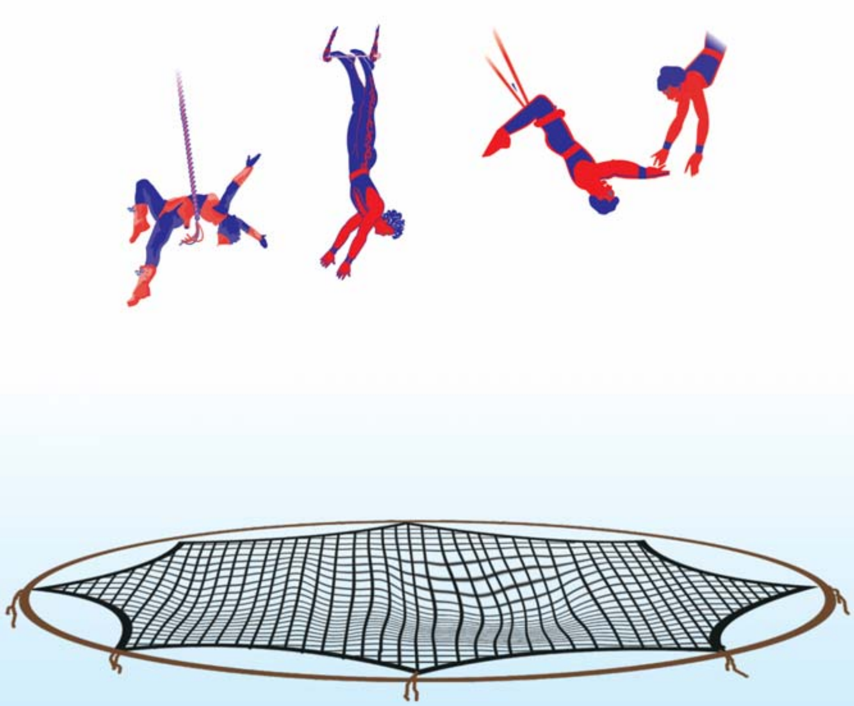


From the Publisher

Political independence, a democratic frame-work and accelerated economic development have been the theme of the Indian independence movement. While we have largely succeeded in achieving the first two goals, rapid economic development had eluded us for a long time. It is only in the last two decades of the last century that we managed to achieve sustained economic development at a reasonable level. We have witnessed a commendable growth in the GDP for more than ten years. This was the result of a series of reforms initiated and successfully competed in the areas of administration, economic policy and fiscal management.

The policymakers are aware that the health of the Nation cannot be judged by the growth in GDP alone. Instances are not wanting where the fruits of development benefitted only some sections of the population. It is not uncommon to see the poor remain poor in spite of rapid economic development at the national level. To take care of this contingency the planners have, in the last thirty years, laid special emphasis on devising schemes whose purpose was to target specific sections of the population and ensure that they are drawn into the mainstream of economic progress. In this edition of the Journal we take a look at some of the social security schemes which form part of the insurance schemes introduced at different points of time.

We also have for you investment statistics of the Life and Non-Life industries as at the end of the last financial year. The figures show the steady accumulation of investment assets by the industry. It is the earnings from this portfolio which pays claims and provides surpluses to be shared by the policyholders and shareholders.

With this issue, the Journal would be completing three years of its existence. During this period we have received valuable inputs from readers from different walks of life. We hope that this support will continue in the future since the publication is meant to serve as a communication channel between the Regulator, the regulated and the policyholders, who are the ultimate beneficiaries.

The next issue of the Journal, our third annual special issue, is about a topic we keep coming back to namely, Consumer Protection. We plan to bring you the legal framework and systems that other financial regulators have created for consumer protection and also look analytically at our own to identify areas where we can enhance the protection to the consumer.

C.S. Rao

C.S.RAO

Inside

ISSUE FOCUS

Follow Through

The Safety Net

Human beings try constantly to establish and protect their financial situation and security. This universal need is reflected in the activities of investment and insurance. It is to provide some level of such protection across the population that countries endeavour so that economic growth may be sustainable – so that more may contribute to it – and its fruits shared more widely.

In this issue we bring you an overview of the social security schemes that have been available in the country and an idea of their scope. We also have Ms. K. G. P. L. Ramadevi proposing her ideal of social health insurance, another layer of social protection that will preserve and enhance the quality of life for the underprivileged.

It is half yearly results time and we have for you the much awaited business figures of Life and Non-Life companies up to the end of September 2005. We also have the investment statistics for the two industries as at March 31, 2005 and look at some trends over the last three years and ponder developments.

With this issue **IRDA Journal** completes three years of existence. It's time to thank all of you who have enthusiastically welcomed the idea of such a communication platform and observed its journey, encouraging us with your enthusiasm and inputs. We have benefited immensely from the various suggestions and criticism you have taken the time to convey to us and earnestly request you to continue to do so. The best way to reach us is to e-mail irdajournal@irdaonline.org. As we continue our journey we would like to hear more from you on what you want to see in this publication to enhance your professional work.

The next issue is our special annual issue – our third one. We propose to profile the customer protection framework and mechanisms that the different financial service industries have put in place, including the insurance industry. We are sure that studying what others do will give us ideas and insights into what we could do better in this vital area.

K. Nitya Kalyani

Consumer Power

As with all things, consumer protection has a lot to do with seeking and applying information says *K. Nitya Kalyani,* adding that the system has the responsibility to disseminate sufficient and appropriate information and to protect the consumers if the service providers fail.

About a decade ago when I was covering the financial services industries for a business daily, a banker told me something that rings true all the time. "The consumer," he said, while discussing non-banking finance company failures and stock market volatility, "cannot be protected. He can only be educated."

As with many things, in being a customer too information is power. It can protect you by warning you off risky investments, or raise your awareness levels so that you are equipped to assess the risks and your ability to bear the potential loss.

If after all this you face fraud or poor service, information and knowledge can help you to take remedial measures. But then there is a great drawback to using education as a means to customer protection – and that is that it is entirely a voluntary thing!

Most customers, and I include myself, arm ourselves pretty poorly with information before making a purchase. This is marked when we buy financial products. This seems to be because of a perceived inability to understand their complexities, an emotional approach to investments – hope, greed, denial and even fantasy! And last but not the least, seller pressure.

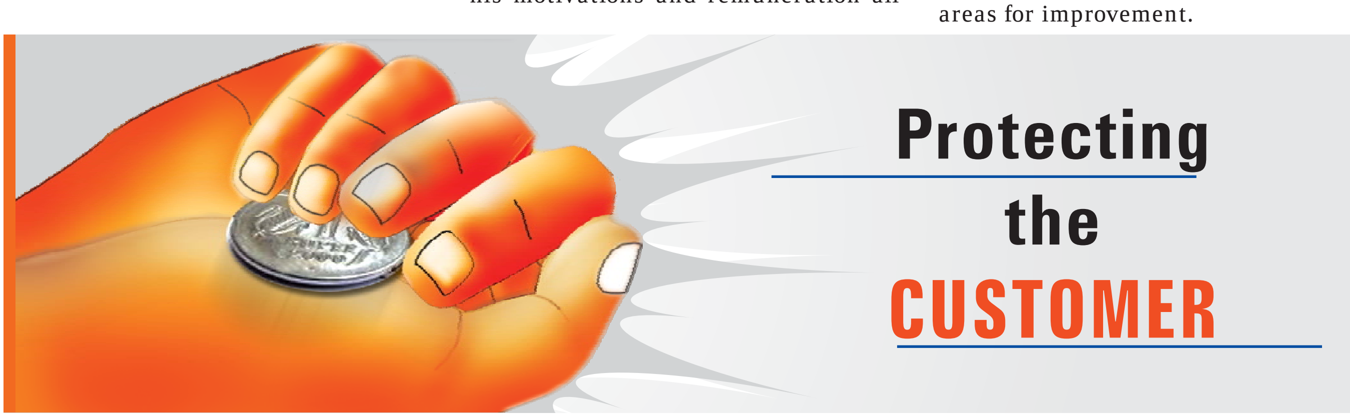
Consumer information is available in plenty before the sale. Not all of it is automatic or sufficiently revealing. Especially when it comes to point of sale information there is misinformation both of and by the agent in equal measures that come into play. It is the buyer who pays for all these shortfalls though.

If information about the nature of insurance schemes and product information is the key to protecting a customer and helping him choose the best product for himself, then a proper selling procedure is critical in avoiding mis-selling. The level of training and knowledge of the selling intermediary, his motivations and remuneration all play a part in choosing the right product at the right time.

It is after these stages – and these protections – that consumer protection comes in. At this stage the product is bought and found to be ineffective or useless. Or the service provider does not perform up to standards and according to norms or as the customer expected him to.

It is at this stage that consumer protection forums come into the picture. If there is fraud, then the Laws and Regulations step in to offer protection to the consumer.

In the next issue of **IRDA Journal** – our third annual issue – the special theme is consumer protection. We will look at all the above aspects of protecting the consumer. The idea is to look also at the legal framework and systems that other financial regulators have created for consumer protection so that we can analyse where we in the insurance industry stand and identify areas for improvement.



General Insurance Council gets New Chairman

IRDA has announced on October 11, 2005 through an Order that its new Member (Non-Life), Mr. K. K. Srinivasan is appointed as Chairman of the General Insurance Council with immediate effect. The Order reads as follows:

In terms of Section 64(2)(a) of the Insurance Act, 1938, the Authority appoints Mr. K. K. Srinivasan, Member (Non-Life), IRDA as the Chairman in place of Mr. Mathew Verghese, who superannuated from the services of IRDA and Mr. P. C. James, Executive Director of IRDA as a Member on the Executive Committee of the General Insurance Council.

This Order will come into force with immediate effect.

Sd/-

(C.S. Rao)
Chairman

IRDA's Designations under Right to Information Act, 2005

IRDA has designated a Central Public Information Officer and an Appellate Authority under the Right to Information Act, 2005. The Order dated October 27, 2005 reads as follows:

Re : Designating "Central Public Information Officer" and "Appellate Authority" under Right to Information Act, 2005

The Right to Information Act, 2005 has since been notified and has come into force with effect from 13.10.2005.

In terms of Section 5 (1) of the Right to Information Act, 2005 Mrs. V. Vedakumari, Executive Director (Admn) is hereby designated as "Central Public Information Officer" for the Authority and in terms of Section 19 (1) of the said Act, Mr. C. R. Muralidharan, Member (Inv) is hereby designated as the "Appellate Authority" to discharge the functions assigned under the Act.

This will be in addition to their normal duties.

Sd/-
(C.S. Rao)
Chairman

IRDA Shifts Surveyors Department to Hyderabad

IRDA has announced the shifting of its surveyors department from New Delhi to Hyderabad with effect from October 24, 2005. The circular reads as follows:

It is hereby informed that the surveyors department of the Insurance Regulatory and development Authority (IRDA), hitherto functioning from its office at New Delhi – 1st Floor, Gate No: 3, 'Jeevan Tara' building, 5, Parliament Street, New Delhi- 110 001 (Phone: 011- 23747648; Fax- 011- 23747650) is being shifted to Hyderabad at Parishram Bhavan, 5th Floor, Basheerbagh, Hyderabad: 500 004 (Phones: 91-040-55820964/91-040-55789768; Fax:91-040-55823334 E-mail: irauth@vsnl.com; Web: www.irdaindia.org) w.e.f 24th October, 2005.

All applications/correspondence to the surveyors department of IRDA are, henceforth, to be sent to the aforementioned address at Hyderabad. Wherever Demand Drafts are to be drawn in favour of the Insurance Regulatory and Development Authority, they shall be made payable at Hyderabad.

Sd/-
(C.S. Rao)
Chairman

IRDA Warning Regarding Brokers' Code of Conduct

IRDA has issued a circular dated 11th October, 2005 to the Principal Officers of licensed Insurance Brokers regarding certain violations of the code of conduct noticed in the market. The circular reads as follows:

Sub: Code of Conduct

It has come to the notice of this office that certain foreign brokers not licensed in India, are entering into arrangements with brokers licensed in India, to service accounts influenced to the Indian broker by the foreign broker in consideration for a share of the brokerage earned on such account.

Such an arrangement is a clear violation of para 3(b) of the Code of Conduct under Regulation 21 of the IRDA (Insurance Brokers) Regulations, 2002. Any broker who has entered into such an arrangement would be committing a breach of Para 3 of the Code of Conduct.

If you have entered into any such arrangements, you are advised to provide full particulars to this office and also to take immediate steps to terminate such arrangement.

Please acknowledge receipt of this circular and confirm compliance with the Regulations.

Sd/-
(C. S. Rao)
Chairman

Report Card:LIFE

Premiums Rise 34.4% at Half Year

First Year Premium Underwritten by Life Insurers for the Period Ended September, 2005

Sl	Insurer	Premium					No. of Policies / Schemes					No. of lives covered under Group Schemes				
		Sept, 05	Upto Sept, 05	Upto Sept, 04	Growth	Market Share	Sept, 05	Upto Sept,05	Upto Sept,04	Growth	Market Share	Sept, 05	Upto Sept,05	Upto Sept, 04	Growth	Market Share
	Bajaj Allianz	**21,442.81**	**64,359.25**	**19,052.20**	**237.80**	**5.68**	**56,123**	**2,02,448**	**88,599**	**128.50**	**1.86**	**33,702**	**1,05,031**	**56,344**	**86.41**	**2.51**
	Individual Single Premium	12,621.34	33,470.54	6,686.41			10,937	28,469	7,210							
	Individual Non-Single Premium	8,584.97	29,691.17	12,195.84			45,175	1,73,862	81,345							
	Group Single Premium															
	Group Non-Single Premium	236.50	1,197.54	169.96			11	117	44			33,702	1,05,031	56,344		
2	**ING Vysya**	**1,848.79**	**6,758.98**	**3,602.23**	**87.63**	**0.60**	**10,626**	**39,793**	**45,517**	**-12.58**	**0.36**	**1,081**	**11,558**	**7,651**	**51.07**	**0.28**
	Individual Single Premium	0.00	2.38	32.51				349	4,781							
	Individual Non-Single Premium	1,727.23	6,117.29	3,338.81			10,622	39,411	40,721							
	Group Single Premium	115.10	490.72	207.18					2			285	1,311	471		
	Group Non-Single Premium	6.46	148.60	23.72			4	33	13			796	10,247	7,180		
3	**AMP Sanmar**	**1,412.22**	**5,541.77**	**2,406.40**	**130.29**	**0.49**	**4,557**	**25,453**	**14,866**	**71.22**	**0.23**	**8,048**	**45,359**	**23,827**	**90.37**	**1.08**
	Individual Single Premium	1,114.40	3,817.45	1,243.11			1,645	6,048	2,483							
	Individual Non-Single Premium	253.35	1,374.86	1029.54			2,898	19,350	12,349							
	Group Single Premium	8.11	68.80	35.66					1					190		
	Group Non-Single Premium	36.36	280.65	98.09			14	55	33			8,048	45,359	23,637		
4	**SBI Life**	**3,665.49**	**16,881.12**	**16,939.21**	**-0.34**	**1.49**	**16,217**	**75,527**	**44,289**	**70.53**	**0.69**	**94,982**	**3,75,653**	**3,85,172**	**-2.47**	**8.97**
	Individual Single Premium	335.46	1,930.87	3,297.93			689	3,104	1,995							
	Individual Non-Single Premium	1,110.53	5,011.77	2,639.50			15,304	71,577	40,788							
	Group Single Premium	1,948.05	8,377.57	8,131.04				2	3			14,207	1,01,629	85,894		
	Group Non-Single Premium	271.45	1,560.91	2,870.74			224	844	1,503			80,775	2,74,024	2,99,278		
5	**Tata AIG**	**3,873.72**	**18,924.79**	**11,237.54**	**68.41**	**1.67**	**21,549**	**1,31,886**	**97,927**	**34.68**	**1.21**	**64,076**	**3,51,293**	**1,54,712**	**127.06**	**8.39**
	Individual Single Premium	34.66	215.51													
	Individual Non-Single Premium	3,271.22	16,574.00	9090.65			21,532	1,31,737	97,806							
	Group Single Premium	235.95	929.00	297.12								13,681	74,163	46,617		
	Group Non-Single Premium	331.89	1,206.28	1,849.77			17	149	121			50,395	2,77,130	1,08,095		
6	**HDFC Standard**	**8,229.91**	**35,214.97**	**12,699.67**	**177.29**	**3.11**	**24,038**	**1,26,664**	**68,010**	**86.24**	**1.16**	**5,516**	**56,739**	**75,481**	**-24.83**	**1.36**
	Individual Single Premium	877.33	4,948.50	3,358.45			3,388	26,283	13,190							

	Individual Single Premium	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]							
	Individual Non-Single Premium	6,224.70	26,026.47	8,759.96			20,643	1,00,313	54,732							
	Group Single Premium	753.96	2,522.85	405.34			6	53	81			5,392	48,509	67,161		
	Group Non-Single Premium	373.92	1,717.15	175.92			1	15	7			124	8,230	8,320		
7	**ICICI Prudential**	**19,535.18**	**81,975.07**	**47,829.60**	**71.39**	**7.24**	**64,520**	**2,81,100**	**2,15,173**	**30.64**	**2.58**	**15,219**	**1,38,774**	**34,770**	**299.12**	**3.31**
	Individual Single Premium	659.82	3,003.35	7,271.40			6,392	13,886	4,562							
	Individual Non-Single Premium	17,651.21	70,429.62	36,469.80			58,119	2,67,108	2,10,553							
	Group Single Premium	385.59	556.62	16.30			2	47	8			14,491	1,10,764	1,386		
	Group Non-Single Premium	838.56	7,985.48	4,072.10			7	59	50			728	28,010	33,384		
8	**Birla Sunlife**	**5,248.41**	**20,793.88**	**23,703.19**	**-12.27**	**1.84**	**23,888**	**89,581**	**62,915**	**42.38**	**0.82**	**1,186**	**7,761**	**40,721**	**-80.94**	**0.19**
	Individual Single Premium	317.66	753.13	640.29			8,514	26,119	14,684							
	Individual Non-Single Premium	4,704.79	19,039.61	18,141.25			15,371	63,442	48,188							
	Group Single Premium	79.97	297.00	217.74								533	2,526	1,849		
	Group Non-Single Premium	145.99	704.15	4,703.91			3	20	43			653	5,235	38,872		
9	**Aviva**	**3,070.01**	**12,810.00**	**7,027.49**	**82.28**	**1.13**	**12,829**	**48,908**	**36,394**	**34.38**	**0.45**	**21,214**	**96,122**	**61,819**	**55.49**	**2.30**
	Individual Single Premium	112.90	258.11	174.07			543	1,516	275							
	Individual Non-Single Premium	2,935.24	12,359.19	6,734.12			12,282	47,384	36,102							
	Group Single Premium	8.06	65.64	13.40					1			52	421	131		
	Group Non-Single Premium	13.81	127.06	105.90			4	8	16			21,162	95,701	61,688		
10	**Kotak Mahindra Old Mutual**	**1,829.49**	**8,212.49**	**4,954.91**	**65.74**	**0.73**	**7,324**	**32,404**	**21,852**	**48.29**	**0.30**	**6,957**	**35,289**	**40,863**	**-13.64**	**0.84**
	Individual Single Premium	272.61	860.05	979.07			386	1,280	655							
	Individual Non-Single Premium	1,522.69	7,025.54	3,296.91			6,927	31,090	21,165							
	Group Single Premium	14.98	61.15				1	2				911	3,999			
	Group Non-Single Premium	19.21	265.76	678.93			10	32	32			6,046	31,290	40,863		
11	**Max New York**	**3,543.96**	**15,084.44**	**7,899.59**	**90.95**	**1.33**	**47,203**	**1,70,978**	**83,655**	**104.38**	**1.57**	**123**	**22,804**	**35,369**	**-35.53**	**0.54**
	Individual Single Premium	18.47	82.07	124.04			25	109	131							
	Individual Non-Single Premium	3,523.97	14,942.85	7,708.61			47,175	1,70,837	83,487							
	Group Single Premium															
	Group Non-Single Premium	1.52	59.52	66.95			3	32	37			123	22,804	35,369		
12	**Met Life**	**1,006.46**	**4,332.07**	**1,934.40**	**123.95**	**0.38**	**8,198**	**36,065**	**14,301**	**152.19**	**0.33**	**27,549**	**1,22,856**	**86,646**	**41.79**	**2.93**
	Individual Single Premium	62.16	259.78	69.19			143	522	183							
	Individual Non-Single Premium	911.50	3,811.11	1,533.37			8,044	35,449	14,074							
	Group Single Premium															
	Group Non-Single Premium	32.80	261.18	331.84			11	94	44			27,549	1,22,856	86,646		
13	**Sahara Life**	**251.67**	**514.29**			**0.05**	**2,152**	**12,955**			**0.12**	**289**	**489**			**0.01**
	Individual Single Premium	206.50	225.45				553	609								
	Individual Non-Single Premium	44.88	288.35				1,596	12,340								
	Group Single Premium	0.29	0.49				3	6				289	489			
	Group Non-Single Premium															
14	**LIC**	**1,52,949.92**	**8,40,909.63**	**6,83,219.65**	**23.08**	**74.26**	**17,61,737**	**96,29,493**	**81,81,843**	**17.69**	**88.32**	**5,64,414**	**28,17,062**	**21,00,964**	**34.08**	**67.28**
	Individual Single Premium	72,132.39	3,15,941.60	1,22,709.50			1,96,320	8,94,936	2,93,334							
	Individual Non-Single Premium	70,421.95	4,06,480.44	4,12,206.79			15,64,124	87,27,602	78,82,169							
	Group Single Premium	10,395.58	1,18,487.59	1,48,303.36			1,293	6,955	6,340			5,64,414	28,17,062	21,00,964		
	Group Non-Single Premium															
	Total	**2,27,908.05**	**11,32,312.76**	**8,42,506.09**	**34.40**	**100.00**	**20,60,961**	**1,09,03,255**	**89,75,341**	**21.48**	**100.00**	**8,44,356**	**41,86,790**	**31,04,339**	**34.87**	**100.00**

Note: Cumulative premium up to the month is net of cancellations which may occur during the free look period.

Investment Portfolio: Life

- March, 31, 2005 with comparative figures

G. V. Rao

The life insurance sector has raised the total investments of its funds to a massive Rs. 4,28,452 crore, as at March 31, 2005, from the previously held Rs. 3,52,624 crore, as at March 31, 2004. The annual quantum accretion in the growth of its invested funds of Rs. 75,828 crore (21.5 per cent) is highly impressive. The Life Insurance Corporation of India (LIC) alone has chipped in with an accretion of Rs. 70,330 crore to this huge increase, with the new players adding their bit with an accretion of Rs. 5,498 crore.

But yet this record falls short of the one achieved in the previous year 2003-04 that saw the overall invested funds grow by over Rs. 91,000 crore: from Rs.2,61,000 crore to Rs. 3,52,600 crore. The contribution of LIC to this increase was over Rs. 89,000 crore. Viewed in this context, of comparative quantum of annual accretions, the performance on accretion front, in 2004-05 leaves one with a question of why this sector did not in 2004-05 excel its own record of the previous year?

But judged on its exclusive merit, a growth of Rs. 75,828 crore in invested funds is truly a remarkable achievement. That in a span of two years the life insurance sector has been able to mobilise funds of over Rs. 1,67,000 crore, post-liberalisation, only highlights the market dynamism that has gripped it right now. The significant contribution of LIC to it of over Rs. 1,59,000 crore needs special mention.

LIC and the rest

The share of LIC that was 99 per cent of the total invested in 2002-03 had dipped slightly to 98.6 per cent in 2003-04 that has now further dipped to 97.6 per cent in 2004-05. In terms of per centage contribution, LIC has contributed 93 per cent to the accretion in 2004-05. With its share of invested funds at over Rs. 4,18,000 crore out of the total invested funds of Rs. 4,28,000 crore of the industry as at March 31, 2005, it stands out as the tallest by far among the current players.

Among the new players, ICICI stands foremost with invested funds of over Rs. 3,470 crore, leaving Birla SunLife next at Rs. 1,296 crore and SBI Life coming in at third position with over Rs. 1,000 crore. The rest of the new players have invested funds of less than Rs. 1,000 crore each.

The new players as at March 31, 2004 had invested funds of Rs. 4,665 crore that has now gone up to Rs. 10,163 crore as at March 31, 2005. The contribution from the new players seems to be picking up momentum.

Sectoral distribution of invested funds

The Life funds of the life insurance industry, as at March 31, 2005, stood at over Rs. 3,66,220 crore (Rs. 3,07,309 crore last year), with Group funds at Rs. 42,680 crore (Rs. 34,075 crore), with Pension and general annuity funds at Rs. 12,023 crore (Rs. 9,552 crore) and Unit linked funds at Rs. 7,528 crore (Rs. 1,688 crore). Cumulatively the funds, as at March 31,

SECTORAL INVESTMENT BY NON-LIFE INSURERS AS AT MARCH 31, 2005

INSURER	LIFE FUND (Rs.Crores)												PENSION AND GENERAL ANNUITY			
	CENTRAL GOVT SECURITIES		STATE GOVT SECURITIES AND OTHER APPROVED SECURITIES INCLUDING CENTRAL GOVT SECURITIES		INFRASTRUCTURE / SOCIAL SECTOR		INVESTMENT SUBJECT TO EXPOSURE NORMS (INCL. OTAI)		'OTHER THAN APPROVED INVESTMENTS (OTAI)		TOTAL (LIFE FUND)		CENTRAL GOVT SECURITIES		STATE GOVT SECURITIES AND OTHER APPROVED SECURITIES INCLUDING CENTRAL GOVT SECURITIES	
PUBLIC SECTOR	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05
LIC	1,43,126.27	1,67,718.86	1,72,917.76	2,06,906.87	38,140.94	44,660.40	93,378.18	1,09,861.60	16,693.50	26,111.98	3,04,436.88	3,61,428.87	5,219.68	5,650.77	7,131.86	9,083.36
TOTAL (A)	1,43,126.27	1,67,718.86	1,72,917.76	2,06,906.87	38,140.94	44,660.40	93,378.18	1,09,861.60	16,693.50	26,111.98	3,04,436.88	3,61,428.87	5,219.68	5,650.77	7,131.86	9,083.36
PRIVATE SECTOR																
HDFC STD	181.86	286.29	189.69	286.29	57.84	85.80	57.91	108.67	18.06	19.68	305.43	480.77	86.79	117.37	86.79	117.37
MAX	2.17	109.09	168.94	315.67	41.36	89.08	31.55	31.62	12.27	15.06	241.85	436.37	0.42	2.81	1.78	12.90
ICICI PRU	382.25	552.82	382.25	552.82	104.58	159.04	171.61	258.77	55.00	75.82	658.45	970.63	91.10	121.87	91.10	121.87
BIRLA SUN	70.55	84.73	77.03	110.75	28.43	31.74	34.92	27.58	2.18	9.56	140.38	170.06		0.06		0.06
TATA-AIG LIFE	178.78	311.91	178.78	311.91	34.80	64.66	7.07	16.19		1.33	220.65	392.76	24.11	58.25	24.11	58.25
OM KOTAK	66.78	108.11	66.78	113.10	27.69	46.92	38.96	40.64		0.73	133.43	200.67	3.30	8.23	3.30	8.23
SBI LIFE	211.34	587.78	211.34	592.78	62.09	155.26	94.42	212.86	30.50	88.46	367.84	960.89	11.93	55.36	11.93	60.37
ALLIANZ BAJAJ	141.37	235.67	141.37	235.67	46.27	74.02	34.27	72.59		20.89	221.91	382.28	2.43	7.13	2.43	7.13
METLIFE	69.06	101.51	69.06	101.51	25.82	30.05	25.31	25.63	11.79	13.34	120.18	157.18		0.21		0.21
AMP SANMAR	58.23	63.54	58.88	65.30	15.96	22.94	23.85	22.47	12.07	6.58	98.69	110.71	5.27	27.87	5.27	27.87
ING VYSYA	37.68	132.91	37.68	132.91	15.68	46.63	21.92	61.69	6.44	14.30	75.28	241.22				
AVIVA LIFE	78.99	79.70	78.99	79.70	29.65	30.21	36.01	35.04	0.19		144.65	144.95				
SAHARA LIFE	60.19	60.47	115.09	102.90	5.73	24.27	22.47	15.32	3.60	0.01	143.29	142.48		0.06		0.06
TOTAL (B)	1,539.25	2,714.53	1,775.88	3,001.31	495.90	860.61	600.25	929.07	152.13	265.75	2,872.03	4,790.98	225.35	399.22	226.71	414.32
TOTAL (A+B)	1,44,665.52	1,70,433.39	1,74,693.64	2,09,908.18	38,636.84	45,521.01	93,978.43	1,10,790.66	16,845.63	26,377.73	3,07,308.91	3,66,219.85	5,445.03	6,049.99	7,358.57	9,497.68

* Negative figure is the reported Net Current Assets.

2005 are: Rs. 4,28,452 crore (Rs. 3,52,624 crore last year).

To the increase in the Life funds of Rs. 58,911 crore, LIC has contributed Rs. 56,992 crore. To the increase in Group funds of Rs. 8,605 crore, LIC has contributed Rs. 8,571 crore. To the increase in the Pension fund of Rs. 2,472 crore, LIC has contributed Rs. 2,218 crore. But in respect of the increase in the Unit-linked funds of Rs. 5,840 crore, LIC has contributed only Rs2, 549 crore, leaving the new players to chip in Rs. 3,291 crore. ICICI, alone, among the new players, has chipped in Rs. 1,557 crore. Birla ranks next with Rs. 651 crore.

Pattern of investment

Out of the total invested funds at March 31, 2005 of Rs. 4,28,000 crore, government securities have absorbed about Rs. 2,52,000 crore (59 per cent), the market securities about Rs. 1,30,000 crore (30 per cent); the balance of investments of about 11 per cent are held in infrastructure sector. The per centage of invested funds in each sector has remained about the same as in the previous year.

The new players, while generally fulfilling the regulations laid down for investments, have shown a preference for investment in market securities, as their business growth perhaps was in the unit-linked policies. Their unit-linked life funds have risen in 2004-05 by Rs. 3,290 crore, while for LIC the growth was only Rs. 2,560 crore. The total unit linked funds of LIC was Rs. 2,769 crore, while for the new players it was Rs. 4,769 crore.

The accretion of invested funds have come from: Life funds by about Rs. 58,911 crore, Group funds by Rs. 8,605 crore, Unit-linked funds by Rs. 5,840 crore and Pension and Annuity funds by Rs. 2,472 crore totaling Rs. 75,828 crore.

The dominant contribution of LIC to the above accretion is: Rs. 56,992 crore to the Life fund, Rs. 8,571 crore to the Group fund, Rs. 2,549 crore to the Unit linked funds and Rs. 2,218 crore to the Pension and Annuity funds.

Final word

The growth in the invested funds of the life insurance sector from about Rs. 2,60,000 crore in 2002-03 to about Rs. 4,28,000 crore in 2004-05 is a superb achievement of the moves of liberalisation and the market friendly regulation. It has shown the bristling dynamism of the life insurance sector in India. With the national economy in high gear and the new players ever competitive, the future of the life insurance business seems to possess limitless possibilities.

The contribution of LIC to life insurance business in India and to the national economy has been outstanding till now. Their role in the share of invested funds shows it up. To keep its momentum going, in a competitive environment, it has to go back to basics, and once again take up its earlier pioneering role of widening the net with more innovative products and at affordable prices; not to amass premium alone but to ensure that even poor lives can realise the benefits of financial security that a life cover provides. LIC's experienced distribution channel may perhaps hold the key for it.

The author is retired CMD, The Oriental Insurance Company Ltd.

FUND (Rs. Crores)				GROUP EXCLUDING GROUP PENSION AND ANNUITY FUND (Rs. Crores)								UNIT LINKED FUND (Rs. Crores)							
INVESTMENT SUBJECT TO EXPOSURE NORMS		TOTAL (PENSION FUND)		CENTRAL GOVT SECURITIES		STATE GOVT SECURITIES AND OTHER APPROVED SECURITIES INCLUDING CENTRAL GOVT SECURITIES		INVESTMENT SUBJECT TO EXPOSURE NORMS		TOTAL (GROUP FUND)		'OTHER APPROVED INVESTMENTS		OTHER THAN APPROVED INVESTMENTS		TOTAL (UNIT LINKDED FUND)		TOTAL (ALL FUNDS) (Rs. Crores)	
31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05	31/3/04	31/3/05
2,112.20	2,378.66	**9,244.06**	11,462.03	19,097.04	25,039.54	25,750.54	33,297.31	8,317.78	9,342.11	**34,068.32**	42,639.42	209.87	2,547.87		210.80	**209.87**	2,758.67	3,47,959.14	4,18,288.99
2,112.20	**2,378.66**	**9,244.06**	**11,462.03**	**19,097.04**	**25,039.54**	**25,750.54**	**33,297.31**	**8,317.78**	**9,342.11**	**34,068.32**	**42,639.42**	**209.87**	**2,547.87**		**210.80**	**209.87**	**2,758.67**	**3,47,959.14**	**4,18,288.99**
14.90	34.54	**101.68**	**151.91**									55.62	280.17	5.30	10.49	**60.91**	290.67	468.03	923.35
0.33	1.13	**2.11**	**14.03**	0.27	1.45	1.14	6.81	0.21	0.44	**1.35**	7.25		20.11		0.33		20.44	245.31	478.09
36.49	44.77	**127.59**	**166.64**									704.31	1,896.27	75.77	440.89	**780.07**	2,337.16	1,566.11	3,474.43
			0.06									447.29	1,047.34	27.32	78.38	**474.62**	1,125.72	615.00	1,295.85
15.68	18.53	**39.79**	**76.78**		14.70		14.70				14.70	12.75	76.00		4.81	**12.75**	80.81	273.19	565.05
4.24	5.13	**7.54**	**13.36**	0.64	2.05	0.64	2.05	0.26		**0.90**	2.05	53.54	304.75		3.57	**53.54**	308.33	195.41	524.40
3.47	18.60	**15.41**	**78.97**	2.21	4.20	2.21	4.20	0.71	6.57	**2.92**	10.77		3.46		0.08		3.54	386.18	1054.17
1.38	2.15	**3.81**	**9.28**	0.61	1.27	0.61	1.27	0.34		**0.95**	1.27	28.60	336.14	0.01	33.10	**28.61**	369.24	255.28	762.07
			0.21	0.44	2.52	0.44	2.52			**0.44**	2.52		1.62		0.12		1.74	120.63	161.66
4.56	22.58	**9.83**	**50.45**										21.40				21.40	108.52	182.56
												20.81	73.70		4.91	**20.81**	78.61	96.09	319.83
				0.39	0.76	0.39	2.06	0.19	0.80	**0.57**	2.85	44.59	122.95	2.53	8.18	**47.13**	131.13	192.35	278.93
			0.06		0.02		0.02				0.02							143.29	142.56
81.06	**147.43**	**307.77**	**561.75**	**4.56**	**26.97**	**5.43**	**33.63**	**1.72**	**7.81**	**7.15**	**41.43**	**1,367.50**	**4,183.91**	**110.93**	**584.86**	**1,478.43**	**4,768.77**	**4,665.38**	**10,162.94**
2,193.27	**2,526.09**	**9,551.83**	**12,023.78**	**19,101.60**	**25,066.52**	**25,755.97**	**33,330.93**	**8,319.50**	**9,349.92**	**34,075.47**	**42,680.85**	**1,577.38**	**6,731.78**	**110.93**	**795.66**	**1,688.31**	**7,527.45**	**3,52,624.52**	**4,28,451.93**

Investment Portfolio: General

— March 31, 2005, with comparative figures

G. V. Rao

The growth in the asset funds for investment by non-life insurers fell in 2004-05 over that of the previous year. The growth in 2004-05 was about Rs 3,337 crore as against about Rs. 3,740 crore in 2003-04. The accretion of funds for investments fell to 9.8 per cent in 2004-05 against 12.3 per cent in the previous year.

Pattern of funds deployment

The industry has persisted with its strategy of investing a higher share in government securities, the portfolio having now gone up to 40 per cent, compared to the statutory "not less than 30 per cent," as a safer place to park its assets. This is up from the 36.4 per cent two years ago in 2002-03. The recent upward swings in the stock market indices do not seem to have made much of an impact on changing their investment patterns. On the contrary, there is a deliberate pruning of the share of market securities, as described below.

The share of invested funds in market securities subject to exposure norms is down to 41.2 per cent in 2004-05 from the high 47.7 per cent in 2002-03, though Regulations stipulate only that they should not be higher than 55 per cent. Whatever is happening on the investment front, therefore, is the result of a deliberate policy rather than regulation bound.

To reiterate, the Regulations require that invested funds should not be less than 30 per cent in government securities, whereas the industry holds 40 per cent at a time when the stock markets are booming. Though the Regulations permit up to 55 per cent of invested funds to be in market securities, its current share is about 41 per cent overall.

Insurers surely cannot say that they are hampered for lack of investment opportunities to generate investment income from the market, within the present regulatory framework.

Why does the industry prefer its investments to be more in government securities? Is the current trend a considered and well-thought out policy? When the Regulations on the invested funds are liberal enough, why is the industry fighting shy of more market investments? What criteria determine the investment policies of each insurer? Do insurers have enough in-house expertise to craft a more fruitful investment policy?

Established players

The asset growth of the invested funds of the five established non-life insurance players shows a deceleration at the end of fiscal 2004-05. The accretion in the invested assets in 2003-04 was about Rs. 2,634 crore (8.2 per cent growth); whereas in the previous fiscal the accretion in the invested funds was about Rs. 3,395 crore (11.2 per cent growth).

In almost all the key target sectors spelt out in the Regulations for investments, there have been lower investments made than in the previous year except in the loan sector. The investments in government securities have risen from 35.8 per cent in 2002-03 to 38.4 per cent in 2003-04, which has risen further to 39.4 per cent in 2004-05.

SECTORAL INVESTMENT BY LIFE INSURERS AS AT MARCH 31, 2005

NAME OF THE INSURER	CENTRAL GOVT SECURITIES		STATE GOVT SECURITIES AND OTHER APPROVED SECURITIES INCLUDING CENTRAL GOVT SECURITIES		LOANS TO HOUSING & FIRE FIGHTING EQUIPMENTS	
	31-Mar-04	31-Mar-05	31-Mar-04	31-Mar-05	31-Mar-04	31-Mar-05
GIC of India	2,436.75	2,744.1766	3,210.94	3,848.9222	841.48	926.9623
New India	2,397.16	2,398.43	3,207.38	3,657.98	431.00	494.58
National	1,266.98	1,082.98	1,665.59	1,596.37	268.94	384.51
United India	1,683.82	1,584.6303	2,583.20	2,645.0448	356.26	321.336
Oriental	1,195.25	1,394.5171	1,722.47	1,976.8826	289.22	307.5443
Public Sector	**8,979.96**	**9,204.73**	**12,389.58**	**13,725.20**	**2,186.90**	**2,434.93**
Reliance	113.09	96.7006	113.09	96.7006	11.64	13.2209
Royal Sundaram	99.58	88.7903	102.35	98.9069	26.33	35.5899
IFFCO -Tokio	97.60	127.87	97.60	127.87	15.88	20.54
Tata AIG	145.33	206.5367	145.33	206.5367	21.51	26.1691
Bajaj Allianz	148.23	256.9	148.23	256.9	32.85	54.96
ICICI Lombard	102.46	160.112	147.92	227.4173	25.00	30.0054
CHNHB Association	2.79	3.9077	2.96	4.0699	0.80	0.8012
Cholamandalam MS	117.06	140.29	117.06	140.29	15.83	15.73
HDFC Chubb	91.11	80.35	91.11	80.35	10.57	15.43
Private Sector	**917.26**	**1,161.46**	**965.65**	**1,239.04**	**160.42**	**212.45**
Industry Total	**9,897.22**	**10,366.19**	**13,355.23**	**14,964.24**	**2,347.32**	**2,647.38**

There has been simultaneously a decrease of invested funds in the market investments subject to exposure norms from 48.6 per cent in 2002-03 to 42 per cent in 2004-05. This shift in the investment pattern by the established players is noteworthy, as it is expected that they are more market savvy. One would have thought the players would prefer the stock market to utilise their funds more productively in a boom period.

Their investment in the social sector has, however, risen impressively from 8.8 per cent in 2002-03 to about 11.6 per cent in 2004-05 against the norm of not less than 10 per cent. So has their investment in the loan sector that stands at seven per cent against the stipulated minimum of five per cent.

Among the established players, General Insurance Corporation of India (GIC) has added more than Rs. 1,000 crore to its invested funds in 2004-05. In the previous year, its accretion to funds was over Rs. 1,370 crore. Over 31 per cent of accretion to the industry's total funds in 2004-05 has come in from GIC alone.

Next ranks Oriental that adds Rs. 544 crore, followed by National with Rs. 487 crore, New India with Rs. 475 crore and United India with the lowest at Rs. 83 crore.

New Players

The new players have added Rs. 703 crore in 2004-05 as against Rs. 344 crore in the year before. Their contribution to the funds accretion in 2004-05 is 21 per cent.

Their reliance on investments in government securities is at an even higher level at 47.9 per cent. It is even lower than the older companies in market securities at 32 per cent. There is a trend, albeit slow, to move downwards in the former and upwards in the latter. They too have met their stipulated requirements of investments in the loan sector and in the infrastructure sector.

The most notable among the new players is Bajaj Allianz that has added Rs. 264 crore to its invested funds of Rs. 349 crore in the previous year. IFFCO and ICICI rank next with accretions of Rs. 123 crore and Rs. 122 crore respectively.

Final comment

With underwriting balances under pressure on account of higher management and procurement costs that are still escalating due to factors beyond the control of insurers, and with incurred claims ratios worsening due to natural disasters and unacceptable Motor losses, investment incomes have inevitably become a major income stream to wipe out growing operational losses.

Insurers under the tariff environment with limited choice to raise rates, perhaps need to appraise their investment tools and strategies to make more money out of invested funds. The onus to do so, with current regulations favouring the industry, is clearly on insurers. GIC has shown that it can be done by the huge additions to its investment funds; but then it has had decades of expertise and practice in playing the market. In the current market situation, determined and discerning insurers can develop both of them faster, given the will and effort. With a new breed of investment savvy CEOs, the future for generating more investment incomes and adding more accretions to invested funds looks brighter.

The author is retired CMD, The Oriental Insurance Company Ltd.

INFRASTRUCTURE & SOCIAL SECTOR		INVESTMENT SUBJECT TO EXPOSURE NORMS (INCL. OTAI)		OTHER THAN APPROVED INVESTMENTS (OTAI)		TOTAL INVESTMENTS	
31-Mar-04	**31-Mar-05**	**31-Mar-04**	**31-Mar-05**	**31-Mar-04**	**31-Mar-05**	**31-Mar-04**	**31-Mar-05**
1,051.70	1,199.3411	4,732.64	4,905.1873	1,379.79	1,455.8082	9,836.76	10,880.41
772.31	1050.08	3,517.55	3,201.04	833.16	770.58	7,928.24	8,403.68
387.62	600.49	1,497.03	1,724.52	485.69	459.9	3,819.18	4,305.89
704.53	691.248	2,483.88	2,552.9329	825.23	705.9787	6,127.87	6,210.56
393.30	460.0087	2,107.57	2,311.5519	575.51	539.6379	4,512.55	5,055.99
3,309.45	**4,001.17**	**14,338.67**	**14,695.23**	**4,099.38**	**3,931.90**	**32,224.60**	**34,856.53**
31.75	25.5884	25.62	57.3185	10.26	12.2565	182.11	192.83
45.91	66.5079	44.99	70.0232	5.54	16.538	219.58	271.03
27.71	44.67	45.90	116.5			187.09	309.58
35.85	40.6601	26.44	38.2806	1.49	0.8027	229.13	311.65
57.28	78.35	110.26	222.54	24.80	35.19	348.62	612.75
47.51	78.6523	127.23	133.3511	26.91	10.6078	347.67	469.43
1.62	1.3354	6.04	6.8375	1.76	1.3686	11.42	13.04
22.15	26.63	15.77	15.52	10.65	10.4	170.81	198.17
21.12	26.14	31.05	55.04	12.89	5.97	153.86	176.96
290.90	**388.53**	**433.32**	**715.41**	**94.30**	**93.13**	1,850.29	2,555.43
3,600.36	**4,389.70**	**14,771.99**	**15,410.64**	**4,193.67**	**4,025.04**	**34,074.89**	**37,411.97**

Some Settled, Some Not Quite

—Handling post-settlement disputes

Claims settlements once accepted cannot be disputed, says the law.
Gnanasundaram Krishnamurthy
examines the various issues surrounding this clause.

The insured files a claim, the insurer settles it and the issue is closed. However, not always. Very often, the insurer disputes the claim, or at least the size of it. The settlement offered is not acceptable to the insured. This routinely gives rise to disputes, which are either settled by the Insurance Ombudsman or the courts. A less frequent, but certainly not uncommon scenario, is of the insured accepting a claim in full and later disputing that the claim is inadequate. The last instance, which has been witnessed in various cases, is handled with a separate set of guidelines.

Clause 9 of the IRDA (Protection of Policyholders' Interests) Regulations, 2002 lays down the claim procedure in respect of general insurance policies. As per clause 9(5), on receipt of the Survey Report or the additional Survey Report, the insurer shall offer a settlement within 30 days. As per clause 9(6), upon acceptance of the offer of settlement by the insured, payment shall be made within seven days from the date of acceptance.

While offering the settlement, the insurers require the insured to execute a discharge voucher for the proposed amount in full and final settlement of the claim. In many a case, the insured, after executing the discharge vouchers and receiving payments, raises a dispute before the grievance redressal agencies on the grounds that the settlement fell short of the original claim, and pleads for a review. The insurance companies' defence typically is that once the payment offered has been accepted, the settlement cannot be reopened.

The view of law

The law has clearly stated, and the highest judicial forum has emphasised, that the claimant cannot seek to reopen the claim settlement after accepting it, unless there was fraud, undue influence or coercion on the part of the companies forcing the insured into accepting the offer of settlement. The consumer dispute redressal forums, following suit, have in a number of cases reaffirmed the aforesaid principle. A few of them are listed below:

What if the insured does not accept the offer of settlement and executes the discharge voucher 'under protest' or stating 'provisional'? While the IRDA regulations are silent on this, the experience is that the companies do not settle such a claim and inform the insured that unless he/she gives discharge for full and final settlement, the claim will not be settled. This amounts to clear coercion, which is not warranted.

1. O.P. No. 54 of 1995 – The New India Assurance Co. Ltd. Vs Marinda Co-op Sugar Mills Ltd. - The complainant accepted a lower amount than he had demanded, but later conveyed its disagreement and sought the balance. The insurer contended that the payment was accepted in full and final settlement. It was held by the National Commission that there was no merit in the complaint.
2. O.P. No. 38 of 2002 – Pochampally Handloom House Vs United India Insurance Co. Ltd. - After accepting full and final settlement, the insured contended that the execution of discharge voucher was not voluntary. The National Commission held that undue influence and coercion cannot be adjudicated without proper evidence in summary jurisdiction and the complainant was at liberty to move Civil Court.
3. Appeal No. 241 of 2002 – Sahib Singh Bacchal Vs National Insurance Co. Ltd. - In this case of full and final settlement of claim, the CDRC Chandigarh upheld the verdict of the District Forum that fraud, coercion or undue influence for acceptance of amount was not shown.
4. Appeal No. 496 of 2002 – M. F. A. N. Vaska Vs United India Insurance Co. Ltd. - CDRC Ahmedabad held that in this case of full and final settlement of claim, further grievance was tenable only in case of fraud or coercion.
5. Appeal No. 1562 of 1992 – Dr. Anil Agarwal Vs The New India Assurance Co. Ltd. & Another – CDRC Lucknow held that acceptance of amount towards full

and final settlement of claim bars the complainant from claiming any further amount.

In several cases, the insurance ombudsmen also have pronounced awards on the above lines.

1. Case No. I.O.O. BBSR 11.309 – A. N. Singh Vs National Insurance Co. Ltd., Ombudsman - Bhubaneswar.
2. Case No. GIC – 71, NIC – 11-03-CHD – Sqn. Ldr. Abishek Gautam Vs National Insurance Co. Ltd., Ombudsman - Chandigarh.
3. Case No. G-6004 - Amarjeet Singh Vs National Insurance Co. Ltd., Ombudsman – Hyderabad.
4. Case No. GI-11-71-2002-03 – Giridhar Saha Vs National Insurance Co. Ltd., Ombudsman - Guwahati.
5. Case No. GI-284 of 2002-03 –V. K. Sharma Vs National Insurance Co. Ltd., Ombudsman - Mumbai.

So far so good. The companies are on strong footing in respect of discharge vouchers executed in full and final settlement. What if the insured does not accept the offer of settlement and executes the discharge voucher 'under protest' or stating 'provisional'? While the IRDA regulations are silent on this, the experience is that the companies do not settle such a claim and inform the insured that unless he/she gives discharge for full and final settlement, the claim will not be settled.

This amounts to clear coercion, which is not warranted. If the companies are happy to settle on discharge voucher for full and final settlement and can successfully plead their case, they should be equally happy to settle on 'under protest' and 'provisional' discharge vouchers also face the litigation if raised later. In the case of The New India Assurance Co. Ltd. Vs. Ved Prakash Arora (RP No.176 of 2002), the National Commission held that the company was liable to pay the balance, as receipt for discharge in full and final settlement was not given.

The end user's interests will be well served if an amendment is brought in this regard, in the Protection of Policy holders' Interests Regulations 2002 by the IRDA.

The author is retired Chairman, LIC of India and served as Insurance Ombudsman for the Maharashtra and Goa Regions.

Surrendered Broker Licence Withdrawn

IRDA had been approached by M/s Enspire Ensurance Broking Solutions Pvt. Ltd. who wanted to surrender their Insurance Broker's licence. After suitable notice to the public for raising objections IRDA has withdrawn the licence through a Notice dated October 26, 2005. The Notice reads as follows:

Re : Surrender the direct insurance broking license (Inspire Ensurance Broking Solutions Pvt. Ltd.)

WHEREAS M/s. Inspire Ensurance Broking Solutions Pvt. Ltd.(hereinafter referred to as broker) a Direct Insurance Broker having Insurance Broking Licence No. 201, Code No. DB096-03 presently having Regd. Office at Commerce House, 5th Floor, 2 A, Ganesh Chandra Avenue, Kolkata had voluntarily approached this Authority vide their letters dated, 15th October and 13th May, 2005, to surrender the direct insurance broking licence granted to them.

WHEREAS the Authority had put up a Notice No. IRDA/DB/096/03 dated 20th June, 2005 on its web site inviting all concerned to express their objections/claims, if any, with regard to the voluntary surrender of the insurance broking licence by the broker within 30 days from the publication of this notice. The Authority did not receive any objections or claims against the request of surrendering the licence made by the broker.

NOW THEREFORE, The Authority in exercise of powers conferred under section 14(2)(a) of IRDA Act, 1999 hereby withdraws the Licence NO. 201 granted to the broker Code No. DB096-03.

This is issued for the information of all concerned in public interest.

Sd/-
(P. C. James)
Executive Director

Specific Replies to Specific Queries

— It pays to pay attention to the finer details

Data deserves a close look both in its entirety and in its various segments and sub-segments down to the lowest meaningful level above granularity, writes *George E. Thomas.*

When my friend had complained of intermittent chills and high fever, his family doctor told him to have a blood test done. He tested positive for typhoid and doxycycline was found to be the most effective antibiotic in treating that particular strain of the disease. The doctor was lucky that he could depend on a pathologist who tested the blood sample and found conclusive evidence of the presence of the typhoid bacteria. Luckier still, the pathologist had done a "culture" test, whereby some of the bacteria were grown separately and treated with different antibiotics and the drug most effective on the particular strain of the germ could be found out. The doctor, as a decision making professional, was definitely luckier than his counterpart of the previous half century who had to hazard a guess on the type of fever and, worse still, on the drug that might have been effective on the specific strain of bacteria. The informed decision taker had the obvious edge over his predecessors as a professional!

While the medical field has made great strides in technology over the past half century, let us, as insurance professionals, ask ourselves how much the quality of our decision making has changed. Are we still like the apothecaries of the 1950s, making decisions based on our own repertory of past experiences, intelligent guesses, gut feelings and at best on the second opinion of another colleague, almost equally (ill) equipped? Yes, insurers certainly have to move from the general or the vague, to the specific or the precise.

Information and communication technology (ICT) takes insurance professionals precisely there - to precision. Specific replies to specific questions, that is what today's insurance professional needs and that is what the industry does not have. Nothing abstract will do. Just hard cold facts and figures that make one look hard at oneself, one's business and the quality of one's decisions should constitute the main menu at the insurer's table. Personal experiences and gut feelings may also count; but these would at best be seasonings or perhaps ornate dressings that are not to be mistaken for the main dish.

Are we still like the apothecaries of the 1950s, making decisions based on our own repertory of past experiences, intelligent guesses and gut feelings?

Data macro and micro

The Indian insurance sector is accustomed to swearing by the wisdom gathered from balance sheet figures and audited statements. With all respect to the professional skills that go into their making, macro figures can hide a lot of what micro figures can reveal. Actually, the gloss of macro figures can make one oblivious to a multitude of micro mistakes that bleed a company. When one thinks of it, we are in a jungle of macro figures, statements, reports - all giving general replies to our general needs of information.

In the past 20 years, newspapers have reported instances in different countries of certain insurers' windows being dressed up by somebody called 'previous CEO' only to be dressed down by somebody else called 'new CEO'. While a little bit of festooning the porch by a CEO might appear tolerable, the company should not forget that clean tables might be hiding a few overstuffed drawers. Claims experience, reserves for claims, returns on investment, value of assets or portfolio-wise performances might unwittingly mask or reveal specifics by a slight flick of the accounting wizard's wand.

The few who do try to look beyond the gloss of macro figures get baffled at many things. To draw examples from the Indian non-life sector, how do the Motor third party claims ratios of some regions appear normal even though it is everyone's knowledge that claims are heavy in those places? How are portfolios having long tailed claims patterns influencing portfolios with short tailed claims and swaying ratio figures? The above questions do not presuppose that someone is intentionally doctoring the data. Neither are they intended to point fingers at well meaning colleagues or even to cut a 'holier than thou' pose. What is intended is only to point out the usefulness of looking at micro level data.

In the Indian context again, this would need a change in the insurers' mind set, which would motivate them to locate their non-productive assets in the form of data lying unattended to in their systems, segregate the chaff from the grain, glean out vital business information from the data and to give them the courage to traverse the road (though less taken by) illumined with information. Valuable data available in the underwriting offices are at present unnoticed, unheeded and unutilised, gathering dust in the insurers' attics. This reminds one of Thomas Gray's *Elegy Written on a Country Churchyard*:

"Full many a gem of purest ray serene. The dark unfathomed caves of ocean bear; Full many a flower is borne to blush unseen. And lose its fragrance on the desert air."

Data deserves a close look both in its entirety and in its various segments and sub-segments down to the lowest meaningful level above granularity. The quality and credibility of data are of paramount importance and need to be guarded fiercely by the insurer. Analysis of partial data, poor quality data or unscientific samples can generate only incorrect and misleading findings, which can possibly be worse than a situation of no information. Clean and credible data is to be ensured so that decision makers are not caught in a 'garbage in - garbage out' situation.

Specifics churned out of data can appear a little ahead of time, intriguing or even a little wonky to the uninitiated. One always comes across a Mr. Conformist who would genially advise; "I have been doing my insurance business this way all through my life and this is the best possible way of doing it", "All these newfangled ideas are meaningless - the market has its own logic" or "These questions and answers are okay but not for my line of business".

The drilling down process

Specific questions are hard to answer; they are equally hard to ask as well. Specific queries can turn out to be disturbing, they can sometimes reveal a close up view of a deep wrinkle

Model Question (Indicative)	Model Answer (Fictitious)
In my company, which **vehicle type** ranks highest in terms of **number of policies, total premium** & **average earning of premium**?	**Two Wheelers** - total policies **Private Cars** - total premium **Buses** – average premium
Of the **Private Cars** covered, which **vehicle model/ make** ranks highest in terms of **number of policies**, **premium** & **average earning of premium**?	**"Model A"** - total policies **"Model B"** - total premium **"Model C"** - average premium
Of the **Private Cars** covered, which **vehicle model** causes more **OD claims** in terms of **numbers, total claim amount paid & average claim size**?	**"Model B"** - total claims **"Model A"** - total claim amount **"Model D"** - average claim size
Among **Private Cars of "Model A"** covered, which **State** ranks highest in terms of **numbers**, **premium** & **average earning of premium**?	**"State P"** - total policies, **"State R"** - total premium, **"State Q"**- average premium
Of the **Private Cars of "Model A"** covered, which **State** has more **OD claims** in terms of **numbers, claim amount paid & average claim size**?	**"State P"** - total claims, **"State P"** - total claim amount, **"State Q"**- average claim size
Of the **OD claims** on **Private Cars of "Model A"** in **"State P"**, how do the **Total Loss** & **Partial Loss figures compare with National Averages?[*National Averages*** *(Hypothetical)**:-** Total Loss Cost -Rs.1,00,000 & Partial Loss Cost - Rs.6500; actual figures to be drawn **from National Data Repository**]*	**Total Losses Rs. 10,00,000** On 10 Claims - Avg. 1,00,000 **Partial Losses Rs. 2,00,00,000** On 2000 Claims-Avg.Rs.10,000
Of the **Private Cars of "Model A"** covered in **"State P",** how do **Spare Parts & Labour Costs** on **Partial Loss claims compare with National Averages? *[National Averages*** *(Hypothetical):- Spare Parts Cost -Rs. 4500 & Labour Cost-Rs.2000; actual figures to be drawn **from National Data Repository**)*	**Cost of Spares Rs. 1,00,00,000** On 2000 Claims - Avg. Rs.5000 **Labour Costs -Rs. 1,00,00,000** On 2000 Claims - Avg. Rs.5000

Deduction 1: Partial Loss Claims in "State P" on "Model A" are higher than the rest of India due to very high labour costs, nearly two-and-a-half times the national average. This is because repairing the particular model of car requires specialised training/ technique/ tools and the manufacturers have only a few authorised workshops in the state.

Deduction 2: An enquiry with the National Repository confirms that the pattern in "State P" applies uniformly to other insurers as well. In states where more authorised workshops exist, repair costs follow the national averages.

Possible strategies for insurers to address the situation:

1. Impose deductible on labour component of repair costs on "Model A" cars in "State P"
2. Discuss concerns in forums of insurers to create awareness on the common problem.
3. Lobby to make the car manufacturer set up more authorised workshops in "State P".

where one was expecting to see a sensuous dimple! One should understand that specific questions, and answers thereto, will generate the necessity for more specific information with increased levels of accuracy, necessitating the need for better standards in the collection and handling of data. Paradoxically, every new specific query makes the previous one 'general'! It is a continuous process of drilling down into the data. This slicing and dicing of data cubes into meaningful and homogenous units should be backed by statistical methods and sound common sense.

The above case is an example of how a specific problem can be addressed by a company from its own data and drawing macro information from a national data repository. But then, there are numerous data elements that would require churning to gather this information; type of vehicle, make of vehicle, pin code, cause of loss, cost of spares, cost of labour etc., being some of them.

There are quite a few other examples as to how specific information from the black box can provide a company with meaningful insights into one's own business:

- How much time has it taken for most of the Motor liability claims for final settlement? (The picture may differ from state to state)
- How much money did companies pay as interest on such cases?
- How many appeals did insurers make on Motor liability cases?
- How many of such appeals did get unfavourable verdicts?
- Was there any avoidable litigation - in terms of legality and in terms of bad publicity for the company? Were the incremental interest costs and legal costs involved in litigation compensated/ justified vis-à-vis the costs saved through favourable judgements?

Specific still, statistical data can be used to study certain trends from past verdicts of higher courts on motor liability – for instance, if one can draw information like, *'70% of third party physical damage cases are decided in favour of insurers'* or *'90% of employee death cases are decided in favour of claimants'* or *'95% of appeals on injury claims less than 2 lakhs are decided in favour of the claimants'*, insurers may be able to have a re-look at their litigation policies. Further, data could reveal state-wise, court-wise or amount claimed-wise variations in trend lines on claims, litigation costs and court award patterns - information which a CEO would not like to ignore.

The slicing and dicing of data cubes into meaningful and homogenous units should be backed by statistical methods and sound common sense.

Astounding revelations

Revelations can be varied and astounding. In Marine Cargo insurance, if the data reveals that *'60per cent of claims on consignments of metal pipes are due to fraying of the ends'*, an insurer might like to build a 'cutting clause' into his policies covering pipes in transit, restricting liability to the damaged portion only and not to the whole pipe. Again, if analyses of health insurance claims can indicate that *'45 percent of the members of group policies aged 20-25 years make one single claim ranging around Rs. 5,000 on account of "unspecified fevers" during their first year of insurance'*, an insurer or a third party administrator may like to find out whether the youngsters are actually getting a non-payable health check up passed off as a disease claim. In health insurance, a better understanding of the demographic characteristics of the insured vis-à-vis claimants, incidence of diseases and their treatment costs, reasons for rejection/ reduction of claims, segmented costs of claims etc. can help insurers in designing new products as well as in administering existing products better. The world of insurance data has its fascinating corridors of vital information as well as confusing mazes where one can lose one's time chasing a dark demon, which actually may not be in existence. A basic knowledge of insurance principles, a mind open to change, an eye for detail, the candidness to accept and correct one's errors of judgement along with a good measure of commonsense constitute one's armour, sword, buckler and spurs in charging ahead through the labyrinths of data and conquering the real demon of rigidity and ignorance with the power of information.

The author is Deputy Manager, I.T. Department, Tariff Advisory Committee (TAC) and a Member of IRDA's Committee on Health Insurance Data. Views expressed in this article are his own.

Two Sides of a Coin

— Sound data capturing leads to scientific rating

The Indian insurance industry has a goldmine of data lying in its backyard. Proper mining of the data will reap rich dividends, points out *M. S. Jayakumar*.

Insurance is a relatively simple concept – it is a method of meeting the financial losses of a few from a common fund formed by the contributions of many who are equally exposed to similar losses. It is a system of spreading the losses of an individual over a group of individuals.

The premium for a group is based on the probable maximum loss it is exposed to and the rates are worked out based on past loss experience. Past loss experience reflecting the premium paid, claims settled and claims incurred but not paid is a major factor determining the premium for the group. Frequency and severity of the claims, scope for risk improvement measures and voluntary excess provisions are also factors that indicate the extent to which the group is exposed to the insured perils and, hence, merit detailed consideration.

The efficiency and accuracy of analysing these factors, however, depend upon the homogeneity of the group and the extent to which the experience is applicable to each member of the group. Based on variations in degree of exposure involved, groups can be divided. To sink the aberrations caused by small numbers, groups can also be merged at macro levels for broad based studies. Classification of risks into smaller or bigger groups enables the insurer to have a close-up view or a panoramic view of the risk; and more important, enables the insurer to price it appropriately. The classification can be based on various factors like geographical locations, type of cover, level of indemnity and risk exposure. Risk assessment can be made by analysing the data on polices issued, claims settled, claims outstanding, claims frequency, quantum of claim per incident, causes of claims, costs involved in handling claims, etc. over the years in respect of a particular group.

Data macro and micro

While macro data on the entire group is required for fixing the overall rating frame work and planning corporate strategies on the entire portfolio, micro level data on each sub-group is required for fixing appropriate segmented rates. The principle of equity demands that equitable, if not equal, premium should be charged for similarly placed risks.

The reason for classifying risks on the basis of similarity is to make homogenous self-supporting sub-groups. Thus, the losses incurred by a sub-group are absorbed by the same sub-group only and no cross subsidisation takes place. For instance, a person insuring his building should not be subsidising the motor accident losses incurred by another group. Similarly, one insuring his marine cargo should not be

The principle of equity demands that equitable, if not equal, premium should be charged for similarly placed risks.

paying for the losses incurred on cattle insurance. However, views differ as to where the boundaries of a sub-group end and where cross subsidisation begins. One can always ask why an insured covered for motor own-damage should pay for motor third party claims.

All these exercises, or any other scientific study, can be attempted only if accurate, relevant and reliable data is available. Consequences of non-availability of data within an insurance company could be charging arbitrary premium, which may give rise to losing quality business to competitors in the long run. Without micro level underwriting data, premiums may be fixed without considering the merits and demerits of each sub-group. The resultant cross subsidisation of portfolios may result in high hazard risks paying premiums less than or equal to normal hazard risks. This would be doing injustice to the good insured and favouring loss-making insured.

There are no regulations or mandatory standards requiring insurers to collect and maintain quality underwriting data. All regulations as of now stipulate only the submission of financial information. The information required to be published as per the Insurance Act, is the only authentic data available to the insuring public, which comprises financial statements. (Consumers' right to information is another matter.) It is the only data available with most of the insurers and that too in a consolidated form. These statements classify non-life insurance into Fire, Marine and Miscellaneous. Engineering, Motor, Workmen Compensation, Aviation, etc. are clubbed together as 'Miscellaneous'. IRDA, vide its regulation dated March 30, 2002, made it mandatory for insurers to adopt segment reporting as specified under International Accounting Standards (IAS) –17.

Prior to segment reporting, the underwriting information of each portfolio was not available. When the data even at macro level was rare to get, data at micro level was seldom available. A minimum of five years data can give a good indication of the performance of a sub-group. As private players entered the market only in 2000, most of the past data is available with public sector companies alone. Even today, private insurers' share of the market is only 20 percent, as against the 80 percent of public sector insurers. The major portion of even the present data still remains with the public sector insurance companies.

Capturing of data

The sources of data are the proposal and claims forms submitted by the insured. The proposal form is generally filled by marketing department personnel and signed by the insured. No insured takes time to check the details except the sum insured and premium to be paid. Thorough scrutiny of details takes place only when the claim arises. In some cases, even big industrial giants are not aware of most of the warranties and exclusions applicable for different type of policies.

In a fully computerised environment, data is entered at lower levels. While entering, only the fields that affect the premium are entered with care. The other fields, which may not be a rating parameter today, but definitely will have an impact on the future pricing of the product, are not filled in. Data entry errors and skipping of information is a general phenomenon in data capturing of public sector as well as private sector insurers. Generally, “others” or “code 99” is filled in these fields. There is, therefore, a gap between the data intended to be captured and the data actually captured by the system.

Another lacuna of the system is that all the data captured is not reflected in the policy document; so the opportunity of verifying the data captured is not available to the insured.

Three public sector companies are using common software. Till recently the software was a standalone one, installed in operating offices. The main focus was on issuing policies to the customer and consolidation of data at the backend was considered only at the operating office level. There was no provision in the system for consolidation of data at Divisional Offices, Regional Offices and the Head Office. If at all an analysis could be done, it could be done for an operating office only! Even there no connectivity was available between the operating offices and Head office for transmission of data on regular basis.

The question that could come to anyone’s mind would be, without the entire data available at insurers’ head offices, how are the financial statements prepared and annual reports and balance sheets presented to the investors? The answer is here:

1. Operating offices prepare Trial Balance and other financial statements and send them to their next higher-level office, which are finally consolidated at the head office.
2. In case of any specific requirement, the operating offices prepare consolidated statements of underwriting details and forward them to the head office.

This data is not what is needed for working out a detailed analysis or fixing a differential rating for various insurance products. The underwriting information is never available anywhere other than the operating office. The need for a macro level view of underwriting details was not felt since the insurers did not carry out the pricing function for most of the products.

The position now

The time gap between data capturing and analysis can be crucial. Changes in local or reinsurance markets should be reported immediately so that corrective course of action can be taken.

It is heartening to note that the four public sector companies (who control the lion’s share of past data) have realised the need for company level data and are upgrading their software to consolidate all operating offices data up to the level of head office. This is an impressive development in the non-life insurance industry’s data repository scenario. It is expected that all the four major public sector companies will make available their entire company data at their head offices by the end of this financial year.

In the case of private sector insurers, the data captured is transmitted to the data centre at specified intervals. The entire country data of their company can be accessed from one location. The data is transmitted to a single location at their head office, i.e. underwriting as well as financial information is available at one location. It makes the insurer better equipped in deciding the future road map. For example, if a particular operating office is concentrating only on underwriting Engineering business, it may be told to diversify.

The time gap between data capturing and analysis can be crucial, when factors like changes in local market or reinsurance market sentiments etc should be reported to the underwriting offices immediately so that corrective course of action can be taken.

Summing it up

The business of insurance cannot be carried out without reliable and accurate past data. The future road map of an insurer cannot be drawn without this vital information. Micro level underwriting information collated at a single location is required for fixing appropriate rates for various risks based on their merits. The predominant role played by organisations like Insurance Statistics Organisation (ISO) of the US and Association of British Insurers (ABI) in different foreign markets highlights the importance of data collection and its necessity to the insurance market.

Though the Indian market has realised the need and importance of data rather late in the day, it is heartening that it has started moving slowly but steadily in the direction of rate making based on authentic data. Once the national data is warehoused in a centralised data repository and analytical reports are churned out, the Indian insurance industry will realise the potential of the goldmine that had existed all along in its backyard.

The author is Administrative Officer and Systems Administrator, Tariff Advisory Committee, (TAC) Head Office, Mumbai. The views expressed here are his own.

The Safety Net

- Social security schemes as sheet-anchor for ambitious economic growth plans

At the beginning of the last century few workers possessed the security of an old age pension. In the developed countries most either died early or worked until they were in their late sixties, spent a brief retirement living with their children, then died in their early seventies. To be old generally meant to be poor. Being disabled signified that poverty began earlier. To survive the wage earner implied that poverty lasted longer. No support from children meant being thrown back on charity or minimal public support. For developing and middle-income countries matters were a great deal worse: incomes were substantially closer to subsistence levels and the capacity of children to support their parents was less: death came earlier: life was nasty, brutish and short. But by the beginning of the 21st century the situation has dramatically changed.

- Colin Gillion, Director,Social Security Department, in the synopsis of thebook International Labour Organization (ILO) entitled Social Security Pensions: Development and Reform, edited by Colin Gillion, John Turner, Clive Bailey and Denis Latulippe, Social Security Department, ILO.

This chilling description is only truer of developing countries where widespread illiteracy, poor primary healthcare and lack of meaningful empowerment compound the problem.

The improvement referred to above has come in developed countries by way of a reduction in old age poverty to levels comparable to that in the remainder of the population. Social conditions like life expectancy, reasonable income during retirement, disability pensions and women being protected by family pensions as well as their own pensions in many cases have contributed to this. "A large part of this profound improvement in social conditions can be attributed to the creation of social security pensions which must be counted as one of the great social developments of the last hundred years," says the book.

The interesting development is that an increasing number of developing countries are beginning to emulate the experience of the developed countries, in terms of the extension of coverage and in the improvement of benefits it says.

In the developed world, pensions, after growing hesitantly in the first part of the 20th century, underwent an accelerated development in the second half, pension outlays growing at twice the rate of GDP: and more and more developing and middle-income countries joined the number of countries attempting to provide pensions for their people.

The enormity of the task in India alone is borne out by the numbers. The EPF scheme covers just 3.9 crore members in a country with a population of almost 103 crore of whom 40 crore are workers as per the 2001 census.

But, the author goes on to say, the task is only half complete. "Pension schemes throughout the world are in a state of upheaval. "The overwhelming majority of the world's population is still without some form of income security in old age or disability. To extend the security available to workers in the developed countries of the world to workers in all other countries remains a paramount task for the early years of this century. It will require great effort, great imagination and an enlightened adaptation to the different circumstances of developing countries. It means extending the coverage of pension schemes (and all other forms of social security), improving their governance, and ensuring that the design of the schemes is both economically efficient and compatible with internationally accepted human and social values."

The enormity of the task in India alone is borne out by the numbers. The total corpus of the EPF Scheme 1952, EDLI Scheme, 1976 and Employees Pension Scheme 1995 works out to Rs. 1,39,000 crore. This works out to about a third of the invested funds of the life insurance industry which is about Rs. 4,18,000 crore.

The EPF scheme covers just 3.9 crore members in a country with a population of almost 103 crore of whom 40 crore are workers as per the 2001 census. Since there will be overlap only to a certain extent between the EPF members and those with some form of life or annuity covers we can take it that there is an additional percentage of the population that has some kind of social security. But the coverage of both these put together still show how little ground is covered by protection schemes, mandatory or otherwise.

For a country that is moving fast to regain lost ground in economic development, social security is both a critical support and an eagerly sought outcome of prosperity as it is acquired.

Businesses have to be competitive in the domestic market place catering to the growing demands of customers and keeping them happier than their rivals do. On the other side many rivals are not just domestic, they are global players with formidable competitive advantages including significant control over the factors of production. One of these is people and hence their flexibility to acquire or lose workers when and where they choose to maintain their advantage.

For a country that is moving fast to regain lost ground in economic development, social security is both a critical support and an eagerly sought outcome of prosperity as it is acquired.

The implications of this on the job market are significant especially in a country like India where job security, even in the private sector, was widespread and most workers began and ended their working lives with the same employer. Now the situation is fast becoming fluid with job opportunities ebbing and flowing as dictated by various market developments. Finding a job is a lot easier than twenty or thirty years ago, and so is losing it. Employers are quick footed and competitive both in offering jobs and wages depending on the track record of the employee and of course their own requirements as they are in weeding out.

This fluidity in the job market has taken a while to adjust to psychologically and it has helped that it has been working both ways – with new job opportunities coming up. The opening up of enormous opportunities and the change in attitude of youngsters entering their working years to venturing into small enterprises, and not yearning for just secure jobs, is a

Profiles of Some Schemes

Employees' State Insurance

The total corpus of the EPF Scheme 1952, EDLI Scheme, 1976 and Employees Pension Scheme 1995 together amounts to about Rs.1,39,000 crore. It is governed by the Employees' State Insurance Act, (1948).

Employees' State Insurance Scheme of India is an integrated social security scheme tailored to provide social protection to workers and their dependants in the organised sector, in contingencies such as sickness, maternity and death or disablement due to an employment injury or occupational hazard.

Employers 2.54 lakhs, Insured Persons 79.10 lakhs, Number of Insured Person family units 79,12,700, Number of Employees 70,82,300, Total Number of Beneficiaries 3,07,01,300, Number of Insured women 13,47,550, Number of Employers 2,63,65.

Employee's Deposit Linked Insurance

This Rs. 4,000 crore corpus scheme covers all employers to whom the Employee's Provident Fund and Miscellaneous Provision Act, 1952 applies. They have a statutory liability to subscribe to Employee's Deposit Linked Insurance Scheme, 1976 to provide for the benefit of Life insurance to all their employees.

Under the scheme as amended with effect from 24th June, 2000 the insurance benefit is equal to the average balance to the credit of the deceased employee in the Provident Fund during the last 12 months, provided that where such balance exceeds Rs.35,000, insurance cover would be equal to Rs.35,000 plus 25% of the amount in excess of Rs.35,000 subject to a maximum of Rs.60,000. Thus if the length of service is not adequate and/ or the salary is low the average balance may be substantially less and such the benefit to the employee's family is either inadequate or non-existent.

The contribution @ 0.50% of each employee's salary is payable by the Employer to the Provident Fund Authorities.

sign of the times and marks the need for a safety net for those periods in between jobs or at times of adversity in their ventures.

If this one important goal to work towards, the other is a real social security net for those workers who are disabled or who cannot afford to contribute towards a social security scheme themselves. Another sector is the unemployed and the old who have not been part of any such social segment.

There are many state governments who have come out with social security schemes for the old and the poor. While some are self funded others have subscribed to group schemes of life insurers. What is needed is the spread of such schemes while at the same time ensuring that they are sustainable in the long term. Though the self funded schemes come out of state budgets, the fact that many state budgets have been revealed to be fragile to various degrees is cause for worry on this front.

Such schemes could also be vetted for stability and good governance norms if they were to have some common basic parameters and be overseen by a common body. And this brings us to the need for institutional reform even in the existing schemes. The EPF Organisation for example, it has been pointed out, is both a service provider and a regulator, a situation that is contains conflicts of interest.

An important goal is a real social security net for those workers who are disabled or who cannot afford to contribute towards a social security scheme themselves. Another sector is the unemployed and the old who have not been part of any such social segment.

In this area, it is clear that we have barely scratched the surface and have a long way to go in understanding the issues involved and the enormity and nature of the task before us. Parallel to the development of the commercial insurance sector should be the development of social security in the country as they go hand in hand to make the economic growth we are achieving and aiming for meaningful and sustainable.

Profiles of Some Schemes

Employees Provident Fund Scheme	Employees' Pension Scheme 95	Postal Life Insurance
Effective since March 1952, the corpus of the scheme stands at Rs 79,764.5 crore as on March 31 2004, of which 65.3% is in the special deposit scheme, 14.02% in the public sector or FIs, 11.52% in government securities, 8.67% in state government loans and 0.48% in government guaranteed securities. The Constitution of India under "Directive Principles of State Policy" provides that the State shall within the limits of its economic capacity make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old-age, sickness & disablement. The EPF & MP Act, 1952 was enacted by Parliament and came into force with effect from 14th March, 1952.	With a current corpus of Rs. 52,000 crore the Employees' Pension Scheme-95 came into effect from 16.11.95. It has been conceived as a Benefit defined Social Insurance Scheme formulated following actuarial principles for ensuring long term financial sustenance. The new Employees' Pension Scheme-95, repealed and replaced the erstwhile Family Pension Scheme, 1971. The assets and liabilities of the erstwhile Pension Fund were transferred and merged with the new Pension Fund. The benefits and entitlements to the members under the old scheme remain protected and continued under the new Employees' Pension Scheme-95.	Among the oldest schemes in India, Postal Life Insurance (PLI), was introduced in 1884 for postal employees. Over the years it has been extended to the employees of Central and state governments, Central and state public sector undertakings, universities and Government aided institutes, nationalised banks and extra departmental agents of the Postal Department. By March 2000 Postal Life Insurance had procured 25 lakh policies with an aggregate sum assured of Rs. 9,232 crore. Rural postal life insurance (RPLI) was introduced with effect from 24 March 1995 to provide insurance cover at a low premium to the rural masses and to the weaker sections of the society. By March 2000 the sum assured under the RPLI policies were Rs. 2,251 crore.

"विम्याच्या हक्कासाठीची सर्व कागदपत्रं मी पाठवली त्याला आता तीन आठवडे झाले ... ते पैसे लवकर पाठवतील अशी आशा आहे."

"होय, पाठवतीलच. सर्व कागदपत्रं व्यवस्थित असतील तर त्यांना ३० दिवसांच्या आत दाव्याची रक्कम द्यायची असते. तसा नियमच आहे ! "

विमा नियामक आणि विकास प्राधिकरण (आय आर डी ए), ही भारतातील विमा उद्योगाचे पर्यवेक्षण करणारी संस्था विमाधारकांच्या हिताचे रक्षण करते. आयआरडीएने घालून दिलेले काही नियम खालीलप्रमाणे आहे :

- संबंधित सर्व कागदपत्रे मिळाल्यानंतर विमा कंपनीने ३० दिवसांच्या आत हक्काचे पैसे देणे वा काही वाद असल्यास तसे विमाधारकाला योग्य त्या कारणांसहित कळवणे भाग असते.
- प्रस्ताव स्वीकारल्यापासून ३० दिवसांच्या आत विमा कंपनीने संभवता विमाधारकाना प्रस्ताव पत्राची प्रत मोफत देणे आवश्यक असते.
- प्रस्ताव मिळाल्याची पावती दिल्यानंतर १५ दिवसांच्या आंत त्यावर विचार होऊन तसे विमा कंपनीने कळवणे भाग असते.
- आवश्यक ती सर्व कागदपत्रे दिल्यानंतर पैसे चुकते होण्यास विलंब झाला तर विमा कंपनीला तेवढ्या काळासाठीचे व्याज देणे गरजेचे असते.
- जीवन विमा घेणाऱ्या धारकाला (पॉलीसी घेतल्याच्या तारखेपासून) १५ दिवसांचा काळ हा पॉलीसी रद्द करण्यासाठी 'फ्री लुक पिरिअड' (मोफत निरीक्षण काळ) म्हणून मिळतो.
- विमाधारकाने कोणत्याही कारणास्तव संपर्क केल्यास १० दिवसांच्या आंत विमा कंपनीने प्रतिसाद देणे आवश्यक असते.

विमा नियामक आणि विकास प्राधिकरण द्वारा जनहितार्थ प्रकाशित :
इन्श्योरन्स रेग्युलेटरी अॅन्ड डेव्हलपमेन्ट ऑथोरिटी
३ रा मजला, परिश्रम भवनम,
बशीरबाग, हैदराबाद- ५०० ००४.
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For a Healthy Society

- The need for Social Health Insurance in India

To achieve health insurance cover for all, proper funding and efficient administration of the scheme is critical, elucidates *K.G.P.L.Rama Devi.*

As with all forms of insurance, Social Health Insurance (SHI) is prospective financing. This means that funds are collected in advance, mainly in the form of regular contributions (or premiums), without knowing when or for whom they will be needed. These contributions come from the insured households and also often from employers and from the government.

To be characterised as "social" and "insurance", the SHI[1] must have certain characteristics[1]. Countries that implement SHI schemes on a national scale usually adopt broad social security policies and legislation within the social policy stipulated under the National Constitution. In some cases, it is determined by the society's consensus. Some of its major characteristics are:

(1) Compulsory or mandatory membership of individual or groups of individuals, and/or their immediate households and other dependents

(2) Responsibility at the members for payment of the regular income related contributions or flat-rate contributions

(3) Contribution according to the ability to pay (based on economic means) and not related to health risks of individuals, households or employment groups

(4) Establishment of appropriate mechanisms for collecting regular contributions

(5) Choice of healthcare according to the health needs (basic benefit packages are usually pre-set and the schemes allow the members to make co-payment)

(7) Arrangement for social assistance to cover vulnerable populations (young and old, disabled, pregnant women) (Contributions by these groups may be partially or totally subsidised by the government through general revenue.)

(8) Covering a significantly large proportion of population

(9) Funds collected from contributions to be pooled as a single or multiple fund arrangement, administered by a quasi-independent public body.

The SHI should be crafted such that it can meet the demands and aspirations of the targeted group.

The ESI Scheme, India's first and only multi-dimensional social security scheme, offers multiple health insurance benefits covering both the insured and his family at an affordable premium. An important feature of the scheme is that the coverage offered is without any ceiling on the individual worker. From the information available on the ESI web site, the total number of beneficiaries under the scheme is 3,07,01,300. Some of the state governments are also offering health insurance plans.

However, considering the country's vast population, the health coverage is inadequate, limited to only a small proportion of people working in the organised formal sector, covering less than 10 per cent of the total population.

Health insurance has always been more complex on account of the need to tackle the supply side i.e., provision of health services. Despite advances made in finding solutions to the problems and complying with all additional regulations that are involved in health insurance, in such an idealistic situation, only half the country's population will have access to health insurance. The other half, comprising the low-income population (roughly 30 per cent of the BPL population, and add to it another 20 per cent living dangerously close to the poverty line and other neglected sections of the society) will still remain outside its ambit.

Helping the aged

Another vulnerable group not normally welcomed to take health insurance is senior citizens. Ageing is a universal process. Old age is not a disease in itself, but the elderly are vulnerable to long-term diseases such as cardiovascular illness, CVA, cancers, diabetes, musculoskeletal and mental illnesses. They have multiple symptoms due to a decline in the functioning of various body organs. The term 'senior citizen', as defined by IT Act, 1961, means "an individual resident in India who is of age of 65 years or more at any time during the relevant previous year." This is the group that is surely going to make claims because of poor health, as they are more susceptible to sickness.

The well-being of older persons has been mandated in Article 41 of the Constitution, which directs that the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to public assistance in case of old age. The problem assumes great proportions when senior citizens have to lead rest of their life with terminally ill diseases, where the insurers either cancel the health insurance policy or refuse to renew the cover. The insurers are right as per the terms and conditions of the policy and the policyholder has 'no say' in this matter.

As a matter of prudent underwriting policy of Health Insurance, which avoids selection of such adverse risks, insurers do not consider business from these groups as a profitable portfolio and, in most of the cases (including UHIS), the entry age to provide health insurance is restricted to 65 years. Even if the policy is offered beyond that age, it is at the discretion of the insurers, subject to the satisfactory claim experience and medical examination of the policyholder. The government should also effectively plan healthcare services for the elderly and prepare a feasible implementation design relevant to their needs.

In addition to the above two groups, there is one more section of the society which does not have any formal health insurance protection. According to a report on disabled persons in India (Source: TABLE NO. 5A.02, Report-58th Round (No.485), National Sample Survey Organisation), the estimated number (in 00) of disabled persons in India is 21,144,962. There is no scheme or insurance cover specifically made for physically / mentally challenged people (except Jeevan Aadhar of LIC where there is a provision of maintenance of handicapped dependant).

While it is the law which does not allow issuance of an insurance policy to the mentally challenged (it may not be out of place to mention here that since insurance contracts are binding at law, unless the insured is competent to enter into a contract, it is not possible to issue any insurance policy), with regard to offering insurance cover for physically challenged people, being a high risk and sub-standard group, it is the prerogative of the insurance companies whether to underwrite such risks or not. There should be measures to promote the health of the physically and mentally disadvantaged by focusing on the abilities rather than deficiencies.

Hence, these are all the groups who need to be given healthcare protection which is not a profitable proposition to the insurers except under the SHI model, which has to be suitably modified looking into the specific needs of the nation.

Concept of social health insurance

Besides addressing basic issues such as the design of health insurance systems, membership, financing, the type and range of services, questions on statutes, administration, cooperation with healthcare providers and the role of states, the following are the key issues which should be considered while developing the concept:

Another vulnerable group not normally welcomed to take health insurance is senior citizens.

- Need to accurately direct benefits to the target group
- Cost to public funds and to business
- Effects on expenditure of demographic, economic or other national developments
- Effect on families, wider economic, financial or social effects
- Size and distribution of gains or losses experienced by individual beneficiaries
- Vulnerability to fraud and abuse
- Accessibility and quality of service to the public
- Impact on administrative efficiency
- Information needs of target groups and media presentation

The design of the cover

Most of the existing healthcare policies are inadequate, covering only inpatient hospitalisation. This is one of the main reasons for the poor response of the public to health insurance. The SHI should be crafted such that it can meet the demands and aspirations of the targeted group. There is the need for a comprehensive health plan including preventive medicare, which plays a key role in the early detection of major illness. There should be clarity on the scope of cover, the benefits available under the scheme and the price at which they are available.

Ideally, it can be a comprehensive healthcare plan offered at affordable costs (with flexible payment schedules) which can protect the individual against the financial losses due to illness-viz. from birth to death with a combination of OP/IP care, hospitalisation benefits, critical illness cover with long-term healthcare solutions.

"Depending on referral system" before going for expensive secondary and tertiary facilities can be encouraged by making it conditional in the insurance plan. There should be a provision to give a lower reimbursement with higher co-payments when the care is sought at a private hospital without any referral system.

To make it strictly sustainable, a lot of thinking, planning and execution of plans have to be done before the implementation stage. However best the design may be, unless adequate measures are in place at the planning stage itself to control the costs and utilisation levels, the ever escalating healthcare costs and over-utilisation rates can jeopardise any scheme depriving the long-term benefits to the needy.

Eligibility

The targeted groups, viz. the BPL population, lower middle class sections, senior citizens, people with terminal illnesses, physically or mentally challenged or any other socially deprived groups. The scheme should be available to all those who are not covered under any form of health insurance scheme.

Coverage offered

1) Outpatient treatment: (This should also include traditional Ayurvedic systems of alternative medicare which are cost effective and easily accessible to the gen eral public).

2) Maternity & childcare for not more than two children.

3) Hospitalisation & critical illness care:

   Under critical illness care, there are already identified diseases, such as:

   a. Cancer
   b. Heart attack (myocardial infarction)
   c. Stroke
   d. Coronary artery bypass surgery
   e. Kidney/renal failure
   f. Major organ transplants
   g. Multiple sclerosis
   h. Benign brain tumour
   i. Loss of hearing/deafness
   j. Loss of sight/blindness
   k. Paralysis (paraplegia)

   Besides these, the cover should also be extended to:

   a. Multiple burns
   b. Multiple fractures
   c. Any emergency situation that requires hospitalisation with 24 hours.

4) Treatment for chronic ailments and other diseases not covered under any form of health insur - ance

5) Long-term care for terminal ill nesses

The coverage under (4) and (5) should be given to senior citizens who do not get adequate coverage under a standard health insurance policy. However, the premium should be collected on the basis of the economic status and the rich can compensate the poor by higher co-payments, which can be an integral part of the package benefits offered under the scheme. *Ab-initio*, with a view to minimise the risk of anti-selection, there should be a mandatory co-payment of 5 percent on all the benefits of inpatient hospitalisation, besides continuous renewals, a waiting period of six months while making the claims in the first year of the policy should be inserted. It is very important to cover certain medical problems like cancer and ypass surgery from the first year itself.

The more common approach in fully developed national systems is for the central government to retain responsibility for setting policy objectives and budgets, while delegating to agencies the authority to manage their operations.

Administration of the scheme

SHI delivery mechanisms should facilitate benefit delivery that minimises transaction costs while achieving good governance. Governments can deliver as the sole service provider with a centralised system controlling all aspects of a scheme. The more common approach in fully developed national systems is for the central government to retain responsibility for setting policy objectives and budgets, while delegating to agencies the authority to manage their operations. It will always be helpful to have a written list of the objectives that the policy is attempting to meet. These can include the provision of a particular benefit or service at minimal cost, with maximum value for money, ease of administration and reduced vulnerability to fraud and abuse.

i) Usage of government hospitals

Public financing and provision of healthcare services has been the mainstream of health policy for nearly half a century of in post-Independence India. The idea of public provision for all types of healthcare services was reinforced by the fact that the size of private sector was insignificant at the time of Independence. There is a huge system of healthcare delivery already in place, consisting of a diverse network of hospitals, primary health centres, community health centres, dispensaries and specialty facilities financed and managed by the central and state governments.

These facilities are officially available to the entire population either for free or for nominal charges, putting the public healthcare system under the large burden of healthcare spending.

This leads to strain on the funding and, as a consequence, it suffers from quality and access problems, which forces poor consumers also to visit the private facilities for relatively more expensive treatments. It is unfortunate that such a vibrant system has become redundant due to inefficiencies of management. There is a need to revamp the healthcare infrastructure, and strengthen its financial status by making it more autonomous in its administration.

Towards achieving this, there is a need to limit its utilisation levels by the entire population and, except the beneficiaries covered under the SHI Scheme, the hospitals should be allowed to collect user charges based on the services which will generate funds for the maintenance and recharging of the public healthcare systems.

ii) Utilisation of private healthcare providers

The overwhelming focus on a public healthcare delivery system would appear somewhat unrealistic – particularly in view of the fact that health spending in India is mostly private. Many factors have contributed to an interest in the structure and dynamics of private health sector in India. Firstly, the private health sector has grown in many parts of the country, particularly in the areas experiencing agricultural, industrial and service sector developments. The vision for a National Health Service allowed for the existence of small private sector providers to meet the demands of people who would be willing to pay for their services. Taking advantage of this, the facility of inpatient hospitalisation should be extended equally to private / corporate hospitals, too. This will not only increase accessibility to all the existing healthcare service providers, but also helpful in getting quality care in places where no public healthcare facility exists. However, in order to minimise the costs, it is essential to obtain the "Basic Price List" for each and every kind of surgery/ treatment for major ailments from all the participants of healthcare institutes, and based on the averages arrived, prices should be fixed as costs per treatment. Provision may be made for mandatory co-payment of five per cent on all the benefits of inpatient hospitalisation, which will fix the responsibility on the insured to reduce the claims costs.

For instance, under the CGHS scheme, the basic price list has already been made available and it has recognised many private hospitals as well as diagnostic centres across the country to provide healthcare services to its members, as per the price list circulated to them. The procedure followed is a kind of referral from CGHS Local Health Unit, thereby eliminating the risk of over-utilisation of the benefits. There are 68 hospitals and 14 diagnostic centres offering healthcare services under CGHS in the twin cities of Secunderabad and Hyderabad alone. Besides, there are private / corporate hospitals in other places also, including small towns, offering cashless facilities under various health insurance policies of the insurance companies administered through Third Party Administrators. If all these private hospitals can be brought under the ambit of healthcare providers for the SHI Scheme, then accessibility of inpatient hospital care benefits to its members at cost-effective rates will not be a real problem.

If all private hospitals are brought under the ambit of healthcare providers for the SHI Scheme, then accessibility of inpatient hospital care benefits to its members will not be a real problem.

This can be done either by direct participation in the scheme or voluntary participation towards fulfilling the social responsibility.

Financing of the SHI Fund

Insurance is a commercial operation. It is therefore imperative that its products are suitably designed and viably priced in the light of the rural, social and economic conditions and other relevant data. Even where the socio-political objectives of the society require subsidisation, it is essential to determine the commercial price of each product and the element of subsidisation required to make it saleable. SHI systems should be made to closely balance income and spending, with contribution levels and user fees as important elements. The General Insurance companies whose business was essentially commercial should not be saddled with the responsibilities regarding socially oriented insurance business. These purely welfare schemes meant to provide relief to the affected persons should be handled by the concerned government authorities without using insurance agents, which will reduce the costs in administration of such schemes. However, they can indirectly participate in the schemes either as co-insurer or reinsurer, sharing risks using their technical expertise in the successful implementation of the scheme.

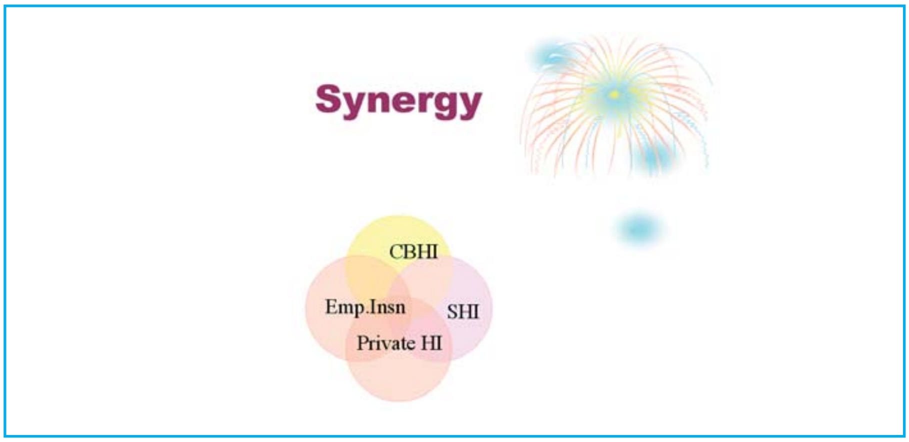
According to the Census, 74.27 percent of Indian population (622,812,376) lives in rural areas. There are 587,226 inhabited villages covered under 466 administrative districts. The success of performance of many informal financial channels can be attributed to the flexibility in payment and levying of penalty for delay in payment. The facility to pay premiums by way of small monthly instalments is envisaged to make health insurance more affordable to a greater population without restricting the scope of cover. Taking a cue from this principle, considering each village as a unit for participation under the scheme, village panchayats can be entrusted with the task of collecting the premium by way of monthly installments, which can be deposited to the SHI Fund through the existing network of nationalised banks. In other places, direct remittances in post offices/nationalised banks/ insurance companies may be considered as per convenience. Irrespective of caste, creed and religion, premiums could be set on a sliding scale that reflects the ability to pay.

With regard to delivering services, if warranted, the services of existing insurers and TPAs can be utilised towards risk management, claims management and reinsurance arrangements. The members can be issued identity cards/ pass books, which should be updated on a monthly basis.

In order to avoid lapse of cover due to non-renewals, there should be extended time limit of payment for two months and flexibility by way of lump sum/ annual payment of premium as well. To begin with, the existing CGHS premium tariff, which is also fixed on sliding scales based on income, should be made applicable to the members for availing of benefits under the Scheme. The cover will get lapsed if there is no deposit of premium continuously for three months. This will help to keep the cover continuous and to minimise the adverse selection risks, making it mandatory to get covered throughout life to avail of the benefits under the Scheme.

The funds can be generated by using the following means:

- Pooling of premium from members based on their income.



- Collecting a percentage of premium from the Commercial Health Insurers or by indirect participation.

The facility to pay premiums via small monthly instalments will make health insurance more affordable to a greater population.

- Certain percentage of the income from private healthcare providers should be collected towards SHIF.
- Voluntary donations towards SHIF.
- Imposing a levy on health degrading products like cigarettes, *gutka*, chewing tobacco, snuff and and *paan masalas*.
- Adoption programmes of villages/ districts by MLAs, MPs, hospitals, corporate offices or other persons/entity as a social welfare measure can be encouraged.
- Initially the premium pool so collected may not be adequate to meet the claims costs. Resources from National Illness funds, World Health Organisation and other similar institutions can be utilised towards building the SHIF corpus.

Ideally, the synergy lies in the co-existence of multiple systems, which needs five 'I's: Improving the operational and administrative machinery, Implementation of standardised healthcare norms, Information dissemination among masses, Integration of various schemes and Insurance coverage for all.

References:
1.WHO's report- Social Health Insurance in South Asia.
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The author is Assistant Director, IRDA. Views expressed here are her own.

प्रकाशक का संदेश

राजनैतिक आज़ादी, लोकतांत्रिक ढांचा और तीव्र आर्थिक विकास ने भारतीय स्वतंत्रता आंदोलन को जन्म दिया था। हालांकि हम पहले दो लक्ष्यों को हासिल करने में काफी हद तक सफल रहे हैं, तीव्र आर्थिक विकास का लक्ष्य काफी समय तक हमें लुभाता रहा है। पिछली सदी के अंतिम दो दशकों के दौरान ही हम एक उचित स्तर पर दीर्घकालिक आर्थिक विकास कर पाए हैं। हमें दस वर्ष से अधिक समय के लिए सकल घरेलू उत्पाद में प्रशंसनीय वश्द्धि देखने को मिली है। यह प्रशासन, आर्थिक नीति और वित्तीय प्रबंधन के क्षेत्रों में शुरू की गई सुधार श्शृंखलाओं तथा उनके सफलतापूर्वक पूरा होने का नतीजा है।

नीति निर्धारक जानते हैं कि किसी राष्ट्र की मजबूती को केवल सकल घरेलू उत्पाद में वश्द्धि से ही आंका नहीं जा सकता है। इस बात के कम उदाहरण नहीं हैं कि विकास से आबादी के केवल कुछ वर्ग लाभान्वित हुए हैं। राष्ट्रीय स्तर पर तीव्र आर्थिक विकास के बावजूद गरीब लोगों का गरीब बना रहना असामान्य बात नहीं है। इस अनिश्चितता को दूर करने के लिए पिछले तीस वर्ष के दौरान योजना बनाने वालों ने ऐसी योजनाएं तैयार करने पर अच्छा-खासा जोर दिया है जो जनसंख्या के विशिष्ट वर्गों को ध्यान में रखते हुए तैयार की गई थीं और यह सुनिश्चित करती थीं कि उन्हें आर्थिक प्रगति की मुख्य धारा में शामिल किया जाए। हम पत्रिका के इस अंक में ऐसी कुछ सामाजिक सुरक्षा योजनाओं पर नजर डालेंगे जो अलग-अलग समय पर शुरू की गई गई बीमा योजनाओं का हिस्सा थीं। मौजूदा समय में उनकी कारगरता और प्रासंगिकता की भी कुछ गहरी छानबीन की गई है।

हम आपके लिए पिछले वित्त वर्ष के अंत में लाइफ और नॉन-लाइफ उद्योगों के निवेश आंकड़े भी लेकर आए हैं। यह आंकड़े उद्योग द्वारा निवेश परिसंपत्तियों के लगातार संचय को दर्शाते हैं। इसी संविभाग की आमदनी से दावों का भुगतान होता है तथा वह अधिशेष उपलब्ध ा होता है जिसमें बीमाधारक और शेयरधारक हिस्सेदारी करते हैं।

इस अंक के साथ इस पत्रिका के तीन वर्ष पूरे हो जाएंगे। इस अवधि के दौरान हमें विभिन्न क्षेत्रों के पाठगगणों से मूल्यवान सुझाव प्राप्त हुए हैं। हम आशा करते हैं कि यह सहयोग भविष्य में भी जारी रहेगा क्योंकि इस प्रकाशन का प्रयोजन विनियामक, और विनियमित पक्षों तथा बीमाधारकों के बीच, जो अंतिम लाभार्थी हैं, एक संवाद चैनल के रूप में सेवा प्रदान करना है।

इस पत्रिका का अगला अंक, हमारा तीसरा वार्षिक विशेष अंक एक ऐसे विषय के बारे में है जिस पर हम बार-बार वापस आते हैं, अर्थात उपभोक्ता संरक्षण। हम उपभोक्ता संरक्षण के लिए दूसरे वित्तीय विनियामकों द्वारा तैयार किए गए कानूनी ढांचे एवं व्यवस्थाओं को आपके सामने पेश करना और साथ ही अपने कानूनी ढांचे एवं व्यवस्था पर विश्लेषणात्मक नजर डालना चाहते हैं, ताकि उन क्षेत्रों की पहचान हो सके जहां हम उपभोक्ताओं की अधिक बेहतर तरीके से रक्षा कर सकते हैं।

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

अनुमान है कि कैटरीना हयूरीकेन आज तक की सबसे महंगी प्राकृतिक आपदा है।

जनरल इंश्युरेंस न्यूज़लेटर, फाइनेंशियल सर्विसेज़ ऑथॉरिटि (एफ.एस.ए.), यू.के.

हम कैटरीना के परिणामस्वरूप सीधे प्रीमियॅम में तुरंत वद्धि होने की आशा नहीं कर रहे हैं, लेकिन जलवायु परिवर्तन के अधिक व्यापक मुद्दे बीमाकर्ताओं को अत्यधिक गंभीर रूप से प्रभावित करले लगे हैं।

श्री मैल्कॉम टार्लिंग, प्रवक्ता, एसोसिएशन ऑफ ब्रिटिश इंश्युरर्स

कैटरीना और रीटा हॅयूरीकेन यह याद दिलाते हैं कि बीमाकर्ताओं के पूरे साल के परिणाम आपदायी नुकसान की सीमा तक प्रभावित हुए हैं, और इस साल के तूफानी मौसम में कैटरीना ने खासतौर पर पूरे साल के लाभ को अत्यधिक प्रभावित किया है।

श्री निक प्रेट्टजॉन, चीफ एक्यूटिव, लॉयड ऑफ लंदन

करार निश्चितता की बहस के नजदीक रहे लोग इस बात पर एकमत हैं कि करार की निश्चितता प्रदान करने के लिए अधिकांश आवश्यक बदलाव व्यवहार और संस्कृति से जुड़े हैं। केवल इस कारण कि कोई कार्य कुछ समय के लिए एक निश्चित तरीके से किया गया है, इसका यह अर्थ ज़रूरी नहीं है किबदलाव की ज़रूरत नहीं है। संसार और पर्यावरण बदलता है और कारोबार जिन कानूनी एवं प्रचालन जोखिमों में अरक्षित रहता है, उनका न बदलना अधिक प्रभावित कर रहा है।

श्री जूलियन आड़म्स, हेड ऑफ होलसेल इंश्युरेंस, एफ.एस.ए.

मेरा मानना है कि किसी भी सुधार कार्यक्रम में हमारे बाज़ार के सामाजिक महत्त्व को अनदेखा नहीं किया जाना चाहिए और अंततः सुधारों के जरिए हमारे बाज़ार के आर्थिक रूप से अधिक सुरक्षित एवं कुशल बनने की ुलना में इन सुधारों की सभी पहलुओं की जांच की जानी चाहिए, ताकि अंतिम उपयोगकर्ता के साथ सही एवं निष्पक्ष बर्ताव संभव हो सके।

श्री जूलियन आडम्स, हेड ऑफ होलसेल इंश्युरेंस, एफ.एस.ए.

यह महत्त्वपूर्ण है कि अब बाज़ार, करार की निश्चितता की उद्योगव्यापी परिभा ा पर राजी हो गया है। ‘शुरुआत से पहले बीमाकृत व्यक्ति और बीमाकर्ताओं के बीच सभी र्तों (हस्ताक्षरित पंक्तियों सहित {अंशदायी बाज़ार के लिए}) की संपूर्ण एवं अंतिम रजामंदी से करार की निश्चितता हासिल होती है।’

जनरल इंश्युरेंस न्यूज़लेटर, एफ.एस.ए.

सुस्वागतम!

यह श्री के.के. श्रीनिवासन के लिए एक सहज कायाकल्प था जिन्होंने सितंबर की शुरूआत में आई.आर.डी.ए. में सदस्य(नॉन-लाइफ) के रूप में कार्यभार ग्रहण किया। चार साल तक टैरिफ सलाहकार समिति (टी.ए.सी.) के सचिव के रूप में अपने कार्यकाल के दौरान टैरिफ के रक्षक रहे श्री श्रीनिवासन अब उसे हटाने में सहायता कर रहे हैं। विनियामक कार्यालय में कार्यभार ग्रहण करने के कुछ ही दिनों के भीतर सामान्य बीमा उद्योग को टैरिफ त्यागने का एक रोडमैप जारी किया जा चुका है।

श्री श्रीनिवासन ने १९६९ में दि न्यू इंडिया इंश्यूरेंस कंपनी में, जब यह निजी क्षेत्र में थी, एक प्रबंधन प्रशिक्षु के रूप में कार्यभार ग्रहण किया था। उनका कहना है, "टैरिफ से मुक्त होना ही स्वयं में इस उद्योग और विनियामक के लिए एक भारी चुनौती साबित होगा।" इस रोडमैप का महत्त्व कंपनियों द्वारा हासिल की जाने वाली सुस्पष्ट एवं सुसाध्य समय-सीमाओं और मील-पत्थरों में निहित है। उनका कहना है, "सभी कंपनियों की अच्छी साख एवं पुख्ता आधार है और वे इसको हासिल करेंगी क्योंकि यह उनकी प्रतिष्ठा का प्रश्न है।"

उनका कहना है कि टैरिफ दरों का स्थान लेने वाली व्यवस्था सुविवेचित होनी चाहिए और कंपनियों को अपनी आंतरिक मार्गदर्शी मैनुअलों को अंतिम रूप देना होगा तथा उन्हें अपनी हामीदारी प्रणालियों में एकीकृत करना होगा।

इसके अलावा, जिस तरह ये विनियम उन न्यूनतम मानकों को निर्धारित करते हैं जिन पर इस उद्योग को खरा उतरना है, उसी तरह यह रोडमैप उल्लघंन की सजा देने के जरिए की बजाय एक सुचारू प्रक्रिया को सुसाध्य बनाने की मार्गदर्शिका है।

उनका कहना है, "लेकिन एहतियात ज़रूरी है : किसी उद्योग को विनियमित करना एक विशाल खुली सीमा में गश्त लगाने की तरह है। आप भले कितनी भी निगरानी क्यों न करें, उल्लघंन अवश्य होंगे। लेकिन इसके कारण आपको निगरानी बंद करना तथा आपदा आमंत्रित नहीं करनी चाहिए। साथ ही, अनावश्यक विनियमन भी नहीं होना चाहिए तथा विकास भी अवरुद्ध नहीं होना चाहिए।

उनकी राय में यह उद्योग एक विनियामक परिप्रेक्ष्य से विकास अवधि के बाद सुदृढ़ीकरण के दौर में पहुंचने के बाद स्वयं ही विकास के नाजुक दौर में पहुंच गया है। उनका कहना है, "इसी दौर में कंपनियाँ विकास के एक खास चरण और गति तक पहुंचने के बाद आक्रामक विकास की मुद्रा में आ जाती हैं। सीमाओं को लांघने की लालच मौजूद होगा और विनियामक को इस प्रकार दखलंदाजी करनी होगी कि अनुचित कार्यपद्धतियों को हतोत्साहित करते समय उचित विकास अवरुद्ध नहीं हो।" साथ ही यह भी कहा है कि बाज़ार आचरण पर नजर रखने के एक उपयुक्त तंत्र मौजूद होना चाहिए।

इस परिप्रेक्ष्य और टैरिफ मुक्त होने के परिप्रेक्ष्य में श्री श्रीनिवासन ने वृद्धि के उस चरण पर बल दिया जिससे बिचौलियों को गुजरना होगा। दलाल एवं कार्पोरेट एजेंट, टी.पी.ए. तथा सर्वेक्षक, सभी को उनके तकनीकी ज्ञान एवं सेवा स्तर के आधार पर परखा जाएगा। हालांकि कुछ विशेषज्ञ सेवा मुहैया कराने के लिए तैयार हो जाएंगे, इस पर खरा नहीं उतरने वाले पीछे रह जाएंगे और बाज़ार में संकट आ सकता है, ऐसा उनका पूर्वानुमान है।

इसलिए यह महत्त्वपूर्ण है कि बिचौलियों के विनियमों की भी आवधिक रूप से ध्यानपूर्वक पुनरीक्षा की जाए और उनके लिए कार्पोरेट गवर्नेन्स मानकों को शामिल करते हुए संभावित बदलाव किए जाएं।

उन्हें आई.आर.डी.ए. के विनियमन के अधिकाधिक क्षेत्र सेल्फ-रेगुलेटरी ऑरगनाइजेशनों (एस.आर.ओ) को हस्तांतरित होते हुए दिखाई दे रहे हैं। इनमें जनरल इंश्युरेंस काउंसिल प्रमुख है जिसे यह महत्त्वपूर्ण कार्य करने के लिए अपना वांछित रूप जल्दी हासिल करना होगा।

उनका कहना है, यह दिलचस्प है कि टी.ए.सी. की शुरुआत बीमाकर्ताओं की एक एसोसिएशन के रूप में हुई थी जिन्होंने टैरिफ को बाध्यता के रूप में स्वेच्छा से अंगीकार किया था, हालांकि उस समय बाज़ार में नॉर-टैरिफ कंपनियाँ भी मौजूद थीं। १९६८-६९ के के दौरान सामाजिक नियंत्रण उपायों के बाद ही टी.ए.सी. एक सांविधिक निकाय बना था और टैरिफ सभी बीमाकर्ताओं के लिए बाध्यकारी बना दिया गया था।

आज यह एक परिक्रमा पूरी करने तथा पुनः एक स्वैच्छिक निकाय बनने के नजदीक है, तथा इस उद्योग एवं आई.आर.डी.ए. के लिए एक डाटा रिपोजेटरी के रूप में सेवा प्रदान करेगा और तकनीकी मार्गदर्शन मुहैया कराएगा।

श्री श्रीनिवासन, जो अपने नए कार्य के लिए मुंबई से हैदराबाद आए हैं, अभी भी इस नए स्थान में अपने को ढाल रहे हैं। उनकी पत्नी एक अध्यापिका हैं और किसी नए स्कूल में अपने कार्य को जारी रखना चाहेंगी। उनकी किशोर बेटी साल के बीच में स्कूल बदलने पर तालमेल बिठा रही है।

पढ़ने और योग के शौकीन के रूप में वह स्वीकार करते हैं कि पिछले कुछ सालों से वह योग नहीं कर पा रहे हैं और अपराध-बोध के साथ कहते हैं कि उन्हें यह दुबारा शुरू करने की आवश्यकता है! फिर भी पढ़ाई ने उनका साथ कभी नहीं छोड़ा है! हाल में उनकी पसंदीदा पुस्तक राष्ट्रपति डॉ. ए.पी.जे. अब्दुल कलाम की जीवनगाथा, *विंग्स ऑफ फायर* रही है जिसने अपनी इस सीख से उन्हें यह प्रेरणा प्रदान की कि अदनी शुरुआत करने वाला एक व्यक्ति किस तरह केवल उत्कृष्टता एवं कठोर परिश्रम की अपनी इच्छा के जरिए बुलंदियों तक पहुंच सकता है। "सभी उम्र के लोगों को यह किताब अवश्य पढ़नी चाहिए क्योंकि इसमें बुद्धिमत्ता का वही ज्ञान सरल शब्दों में बंद है जो प्रबंधन की किताबों में भव्य तरीके से ब्यान किया गया है।"

हालांकि वे प्रबंधन एवं रोमांच की किताबों के प्रशंसक हैं! हर समय के लिए उनकी पसंदीदा किताब? पीटर ड्रकर की सभी किताबें और खासतौर पर, *मैनेजमेंट चैलेन्जिस फॉर दि २१ सेंचुरी,* वह किताब जो उन्होंने नब्बे साल की उम्र में लिखी थी।

वे प्रसन्नतापूर्वक बताते हैं, "इस किताब में भारत द्वारा आने वाले सालों में अदा की जाने वाली भूमिका का विशेष उल्लेख किया गया था और पिछले पांच सालों में वह सही साबित हो रहा है।"

बीमा का बादशाह

पी.सी. जेम्स के शब्दों में हामीदारी का अर्थ संगठन के लिए वे सभी कार्य, विश्लेषणात्मक क्षमताएं और भूमिकाएं हैं जो संगठन के लिए अच्छे निर्णयों का सृजन करते हैं।

हामीदारी एक निश्चेष्ट बीमा निपुणता है, और इसे बीमाकर्ता की मुख्य योग्यता माना जा सकता है। अनिश्चितता और अतिसंवेदनशीलताओं द्वारा उत्तरोत्तर शासित संसार में व्यक्ति और संगठन की हामीदारी क्षमताओं को प्रगतिशील, गतिशील और अभिनव बनना होगा। इसलिए हर कोई सहमत है कि हामीदारी को एक नियम-आधारित कार्य की बजाय एक जोखिम-आधारित कार्य बनना होगा। टैरिफ-आधारित हामीदारी तंत्र में पूर्वकालीन हामीदारी निपुणता क्षीण हो जाएगी और यह अनम्य टैरिफ से लचीले, मूल्य-आधारित हामीदारी की ओर जाने के लिए एक महत्त्वपूर्ण कारण होगा।

हामीदारी की निपुणताएं इस उद्योग की सभी ज्ञात विशेषताओं के साथ अनुरूप हैं। इस प्रकार, आमतौर पर बीमा को बिक्री माना जाता है तथा क्रय नहीं, और इसलिए खासतौर पर नया कारोबार हासिल करने में दबाव कारक का प्रभुत्व रहता है। विशिष्ट रूप से एक बीमाकर्ता उस नए संभावित ग्राहक को सावधानीपूर्वक देखता है जो स्वेच्छा से और उत्साहपूर्वक सीधे बीमाकर्ता से बीमा खरीदने का प्रयास कर रहा हो। यह सुविदित है कि यह खिंचाव कारक उस समय सुस्पष्ट रूप से अभिव्यक्त होता है जिसे बीमाकर्ता 'अशंकित अवधि' की संज्ञा देते हैं।

मध्यस्थता और दबाव कारक के परंपरागत मूल्य एक अच्छे हामीदार के लिए अमूल्य हो सकते हैं जिसमें जोखिम के बारे में मध्यस्थ का निजी ज्ञान, बीमा की बिक्री के कारण नैतिक जोखिम में कमी, एक प्रशिक्षित मध्यस्थ द्वारा प्रस्ताव फॉर्म को अपेक्षाकृत अधिक सही तरीके से भरना, और निराशाजनक क्षेत्र को सुस्पष्ट करने के लिए मध्यस्थ की उपलब्धता, आवश्यकता होने पर जोखिम का निरीक्षण और इसी प्रकार की बातें शामिल हैं। इसलिए हामीदारी और विपणन के बीच की सुस्पष्ट असंगति और विसंगति को एक शक्तिशाली सहक्रिया में बदला जा सकता है, बीमा की व्याप्ति को आज के सामान्य बीमा की तुलना में वृद्धि के उच्चतर स्तरों पर पहुंचाया जा सकता है।

हामीदारी एक विपणन साधन के रूप में मजबूत हामीदारी अच्छा विपणन भी है। विपणन अंततः ग्राहक के लिए सार्थकता का सृजन एवं पेशकश करके ग्राहक को आकर्षित करना है। हामीदारी विशिष्ट रूप से पेश जोखिमों को बेहतर - और इसलिए बीमा योग्य - जोखिम में बदलने और जोखिमों को हस्तांतरित करने का प्रयास करती है, ताकि अप्रत्याशित नुकसान की भरपाई हो सके। यह एक जोखिम में शामिल संभावित खतरों को समझने, आपदाओं को न्यूनतम बनाने और संरक्षा विशेषताओं को बेहतर बनाने में बीमाकृत व्यक्ति की सहायता करती है ताकि निष्क्रियता अवधि और लागतों को कम किया जा सके। इसलिए अच्छा हामीदार वह व्यक्ति होता है जो ग्राहक के नजदीक है और जोखिमों को उजागर करने एवं समझने की क्षमता के जरिए ग्राहक आकर्षित करने तथा एक पारदर्शी एवं विवेकपूर्ण तरीके से बेहतरी सुनिश्चित करने के द्वारा बीमाकर्ताओं के लिए चोटी का मार्किटियर है।

अच्छी हामीदारी, कारोबारी जोखिमों के क्षेत्र में सक्षमताओं पर ध्यान केंद्रित करने और गैर-कारोबारी जोखिम बीमाकर्ताओं को हस्तांतरित करने के लिए उद्यमी अथवा संगठन के दिल-दिमाग को खोल सकती है।

आदर्श हामीदार न केवल जोखिम की बीमा योग्यता को बेहतर बनाने और उसकी जोखिम विशेषताओं को कम करने को प्रवृत्त होते हैं, अपितु बीमाकृत के जोखिम उत्प्रेरक व्यवहार को बदलने तथा उसमें सुधार करने का प्रयास भी करते हैं। इस प्रकार अच्छी हामीदारी कारोबारी जोखिमों के क्षेत्र में सक्षमताओं पर ध्यान केंद्रित करने और गैर-कारोबारी जोखिम बीमाकर्ताओं को हस्तांतरित करने के लिए उद्यमी अथवा संगठन के दिल-दिमाग को खोल सकती है। एक अनुभवी हामीदार धीरे-धीरे केवल हामीदारी की सक्षमताओं के प्रति सत्यनिष्ठ बनकर ग्राहकों का 'स्वामी' बनने लगेगा।

एक ग्राहक हितैषी गतिविधि

अक्सर हामीदारी की तस्वीर एक ऐसी गतिविधि के रूप में पेश की जाती है जो केवल बीमाकर्ताओं की बाटम लाइन को बेहतर बनाती है और इसलिए बीमाकृत के विरुद्ध कार्य करती है। यह सच्चाई के बिल्कुल विपरीत है। अच्छी हामीदारी सारगर्भित रूप में अच्छी सुरक्षा पेश करती है, और जोखिम प्रबंधन के सभी पहलुओं में बीमाकृत की सहायता करती है। यह अपने बीमा के स्तरों, हानि न्यूनीकरण कदमों का क्रियान्वयन, जोखिम हस्तांतरण की राशियों, बीमाकृत राशि के स्तरों, कटौतियों, वारंटियों और शर्तों जो स्वीकार्य हों, और इसी प्रकार की बातों को आंकने में सहायता करती है। इस प्रकार, अच्छी हामीदारी के कारण ग्राहकों की अत्यधिक सदभावना हासिल हो सकती है। इससे बीमाकर्ता के लिए दीर्घकालिकता और प्रतिष्ठा के उच्चतर स्तरों का निर्माण होता है।

अच्छी हामीदारी से ग्राहक जोखिम सुरक्षा को समझने से जुड़े अनेक पहलुओं के बारे में खुलते है एवं शिक्षित होते हैं, और यह जोखिम सुधार के सभी क्षेत्रों में उनकी सहायता करती है। इसके गुणात्मक प्रभाव हैं जिसके बढ़ने की संभावना है, जैसाकि कोई भी ऐसे भविष्य की संकल्पना कर सकता है जहां बढ़ते जोखिम वातावरण का प्रबंधन ही उत्तरजीविता और दीर्घकालिकता की कुँजी होगी। वर्तमान प्रगति तथा विकास व्यक्तियों एवं संगठनों के लिए अधिकाधिक जोखिम पेश करेगा, और अभी तक अनदेखी अतिसंवेदनशीलताएं अधिकाधिक एकदम प्रकट होंगी। इस प्रकार, हामीदारों को उत्तरोत्तर जोखिम पहचानने, जोखिम मूल्यांकन, जोखिम प्रबंधन, जोखिम हस्तांतरण, जोखिम स्वीकार्यता और जोखिम प्रतिधारण का विशेषज्ञ माना जाने लगेगा और वे एक ऐसे समाज के लिए वरदान साबित होंगे जो जोखिम की महारथ के जरिए सुरक्षित होगा।

इस प्रकार, अच्छी हामीदारी सामाजिक कल्याण का साधन बन जाती है। यह अच्छे जोखिमों और खराब जोखिमों के बीच के अंतर की पहचान करती है तथा जोखिम बेहतरी की सलाह देती है, वारंटियों को लागू करवाती है, कानून, विनियमों और विभिन्न सरंक्षा पद्धतियों के पालन की वांछा करती है, और अंततः जोखिम का मूल्य-निधारण इस तरीके से करती है कि जोखिम सुधार दैनिक गतिविधियों के लिए एक आधारीय आवश्यकता बन जाती है। एक हामीदार की स्वीकृति कि बीमा किया जा सकता है, अक्सर बैंकरों, लेखापरीक्षकों, अन्य साझेदारों तथा जनता के लिए एक अच्छा प्रमाणपत्र बन जाती है। इस प्रकार, अच्छी हामीदारी को हर प्रकार से बढ़ावा देने की आवश्यकता है क्योंकि केवल यही जोखिम के प्रति जागरुकता पैदा करेगी और जनता के लिए बीमा खरीदना रुचिकर बनाएगी।

अर्थव्यवस्था के सभी क्षेत्रों में गहराती और फैलती हुई बीमा सुरक्षा को विकास एवं सामाजिक इंजीनियरी के लिए अनिवार्य माना जाता है। इसके परिणामस्वरूप लोगों के जीवन तथा संगठनों के लिए जोखिम कम होता है और प्रगति एवं संपन्नता को मदद मिलती है। अच्छी हामीदारी और इसमें अंतर्निहित बुद्धिमत्ता संरक्षा एवं सुरक्षा को बढ़ाती है तथा समाज में सभी साझेदारों के भरोसे को बढ़ाती है।

एक चुनौतीपूर्ण कार्य

बीमाकर्ता के दृष्टिकोण के अनुवार जोखिम को वश में करने में अंतर्ग्रस्त जटिलताओं के कारण हामीदारी महत्त्वपूर्ण है। जोखिम छोटे या बड़े, स्थैतिक या गतिशील, अक्सर और/या उग्र हो सकते हैं तथा उनके अल्प अथवा दीर्घकालिक प्रभाव हो सकते हैं। इसके पूरे आयामों की थाह लेना कठिन है और ये ज्ञान एवं विकास की प्रगति के साथ-साथ बदलते रहते हैं। ग्राहकों की विविध आवश्यकताएं होती हैं और वे विभिन्न प्रकार की सुरक्षाओं की मांग कर सकते हैं।

अच्छी हामीदारी सामाजिक कल्याण का साधन भी है। यह अच्छे जोखिमों और खराब जोखिमों के बीच अंतर की पहचान करती है तथा जोखिम सुधार को बढ़ावा देने के लिए जोखिम का मूल्य-निर्धारण करती है।

उत्पाद तथा बीमा दायरे की विशेषताओं के क्षेत्र में नवविचार की निरंतर आवश्यकता है। हामीदारों से जोखिमों को सीमित रखने, बीमा योग्य जोखिमों के बीच पहचान करने में अर्थात वे जोखिम जो सुधार के साथ बीमा योग्य हैं, बीमा के लिए अयोग्य जोखिम और गैर-बीमा योग्य जोखिम हैं, अत्यधिक विशेषज्ञता प्रदर्शित करने की अपेक्षा रखी जाती है। बीमा योग्य हरित से बीमा अयोग्य लाल से अलग करने तथा इनको बीमाकृत की आवश्यकताओं एवं इच्छाओं को पूरा करने के लिए उनके साथ जोड़ना और साथ ही, बीमाकर्ता की बाटम लाइन की रक्षा करते हुए जोखिम को सीमित रखने के जरिए बीमाकृत के कारोबारी अवसरों के लिए आवश्यक अपसाइड की रचना करना हामीदार के कार्य को चुनौतीपूर्ण और कठिन बनाता है।

इस परिदृश्य में बीमाकर्ताओं को इस सच्चाई का अनिवार्यतः सामना करना होगा कि बीमा हामीदारी एक कठिन कार्य हो सकता है। बहरहाल, लाभ उल्लेखनीय है और यह न केवल दोनों पार्टियों के लिए बेहतर बाटम लाइन में रूपांतरित होता है, बल्कि लंबी दौड़ में उत्कृष्ट कारोबारी एवं सामाजिक लाभांश का सृजन भी करता है। इसको हासिल करने के लिए बीमाकर्ताओं को, बीमा क्षमतओं को मौजूदा आर्थिक परिप्रेक्ष्यों, स्थानीय प्रादेशिक परिप्रेक्ष्यों, संगत सामाजिक वातावरण और इसी प्रकार के परिप्रेक्ष्यों में एकीकृत करने की आवश्यकता है।

हामीदारी अपने स्वरूप के कारण ही अग्रसक्रिय और प्रगतिशील होनी चाहिए। यदि किसी देश को उच्चतर विकास के पथ पर अग्रसर होना है तो वह केवल जोखिम का महारथ हासिल ऐसा कर सकता है। कारोबारी जोखिम को छोड़कर दूसरे जोखिम ऐसे क्षेत्र हैं जिसके प्रशमन, हस्तांतरण और राहत के लिए कारोबार एवं व्यक्ति, बीमाकर्ताओं व सादृश्य संगठनों की ओर देखते हैं। बीमाकृत की रक्षा करने के लिए हामीदार को न केवल पिछले अनुभव और डाटा पर नजर डालने की, बल्कि सदैव परिवर्तनशील ऐसे वातावरणों पर भी नजर डालने की आवश्यकता है जिनमें नए जोखिम एवं आपदाएं पनपती हैं। जोखिम संबंधी परिप्रेक्ष्य अब न केवल संख्या के खेल और डाटा विश्लेषण पर, अपितु व्यवहारात्मक तथा अन्य मानवीय आयामों के धुंधले क्षेत्र की जांच पर भी जोर देते हैं।

हामीदारी का आसान रास्ता सांख्यिकीय हो सकता है, लेकिन इसमें अंतःप्रज्ञात्मक, गुणवत्तापरक और भविष्यवादी तत्त्वों का परिवर्धन करना अत्यधिक सार्थक साबित हो सकता है। दुर्घटनाओं के केवल पिछले इतिहास पर नजर डालना दिग्भ्रमक हो

सकता है, प्रणालीगत खामियों के कारण लगभग चूक होने के मामले और भी अधिक महत्त्वपूर्ण हैं। जोखिम क्षेत्रों की सूची की केवल सुनिश्चित प्रत्यक्ष जोखिमों के लिए ही नहीं, बल्कि संविदाओं, देयताओं, करारों और वचनबद्धताओं जैसी अनिश्चितओं के लिए भी जांच करना और भी अधिक महत्त्वपूर्ण है।

कला का सार

हामीदारी का सार जोखिम की पहचान करना, उसका मूल्यांकन करना, उसे आकार देना, उसे सीमित करना तथा उसका मूल्य-निध ारण करना है। इसमें संभावित हानि अरक्षितता के आयामों को मापने तथा जोखिम हस्तांतरण के लिए पर्याप्त प्रतिफल तय एवं प्राप्त करने की योग्यता शामिल है। इस प्रकार हामीदारी प्रक्रिया के अनेक पहलू हैं :

1. सूचना इकट्ठा करना और प्रबंधन डाटा, सूचना, ज्ञान और अनुभव अच्छी हामीदारी पद्धतियों की जीवनरेखाएं हैं। हामीदारी उपाख्यानात्मक और अप्रमाणित प्रयोगात्मक निष्कर्षों से समय के दौरान एवं अलग-अलग स्थानों से एकत्रित किए गए सुस्पष्ट डाटा, तथा ऐसे मॉडलों एवं ढांचों की ओर बढ़ रही है जिनकी रचना दीर्घकालिक सुस्पष्ट हामीदारी नीतियों के लिए की जा सकती है।

2. आपदा पहचान और मूल्यांकन बीमाकर्ता जोखिम एवं आपदाओं के नए स्वरूपों का मुकाबला कर रहे हैं जबकि प्रीमियम की दरें कम हो रही हैं। पूरे विश्व में बढ़ती हुई गर्माहट और पर्यावरणीय क्षय अधिक भयंकर एवं अधिक आवृत्ति वाली आपदाओं की धमकी दे रहे हैं, आतंकवाद और सामाजिक तनाव मानवीय जोखिम को बढ़ाने को प्रवृत्त हैं, तकनीक और विज्ञान में प्रगति अज्ञात हानियों के क्षेत्र में उत्तेतनाओं को जन्म देती हैं। सांसारिक तौर पर साधारण हामीदार को भी अपने सामने पेश होने वाले जोखिमों के परिणामों का मुकाबला करना पड़ रहा है और ग्राहक व बीमाकर्ता, दोनों के लिए सार्थकता पैदा करने हेतु उन जोखिमों के विभिन्न आयामों तथा मूल्य-निर्धारण पर विचार करना पड़ रहा है। यहां स्थल, प्रौद्योगिकीय, सामाजिक एवं नैतिक कारकों के आधार पर उल्लेखनीय अंतर हो सकता है।

3. चयन जोखिमों का वर्गीकरण ऐसी भूमिका निभाता है जो ग्राहक के लिए साम्यता और बीमाकर्ता की उत्तरजीविता के मायनों में महत्त्वपूर्ण है। विभिन्न पैरामीटरों जैसे आवृत्ति/उग्रता, वांछनीय/अवांछनीय, दीर्घकालिक/ अल्पकालिक, सघन/विसर्जित आदि के आधार पर वर्गीकरण हो सकता है। जोखिम पर विचार करते समय जोखिम बेहतरी, मूल्य निर्धारण, वारंटियाँ और शर्तें, पेश किए गए बीमे पर सीमाएं आदि बीमाकर्ताओं के सामने मौजूद विकल्पों को दर्शाते हैं। यह संभव है कि कोई जोखिम बीमा योग्य नहीं हो और उसका कारण बताया जाना आवश्यक है। इस प्रकार प्रत्येक जोखिम का वर्गीकरण होगा और उस पर उत्कृष्ट से बीमा-अयोग्य के पैमाने से विचार होगा ताकि हामीदार को मूल्य-निर्धारण के अगले चरण में जाने में मदद मिल सके।

बीमाकर्ताओं की बाटम लाइन की रक्षा करते हुए बीमा योग्य हरित से बीमा अयोग्य लाल का पृथक्कीकरण और बीमाकृत से इसको जोड़ना ही हामीदार के कार्य को चुनौतीपूर्ण और कठिन बनाता है।

4. मूल्य-निर्धारण मूल्य-निर्धारण हामीदारी का सर्वाधिक महत्त्वपूर्ण घटक है क्योंकि बाज़ार गतिशील है और ग्राहक जोखिमों को हस्तांरित करने की लागतों से निर्देशित होते हैं। हामीदारों को अक्सर इस विरोधाभास का सामना करना पड़ता है कि उन्हें कम हो रही दरों एवं शर्तों पर अधिकाधिक लाभ पेश करने पड़ते हैं। साथ ही, मूल्य-निर्धारण में खामी उग्र परिणामों से त्रस्त है। बहरहाल, हामीदारों के शास्त्रागार में अनेक हथियार मौजूद हैं जिनमें सुविदित तकनीकें शामिल हो सकती हैं, जैसे कटौतियों को लागू करना, वारंटियों को लागू करना, बीमा को सीमित करना, खतरों का विलोपन और दावों पर अधिकतम सीमा शामिल है, ताकि यह सुनिश्चित हो सके कि स्वीकार किए गए मूल्य एवं जोखिम इस प्रकार सुमेलित हों कि बीमाकर्ताओं को प्रयुक्त पूंजी पर प्रतिफल प्राप्त हो सके।

   मूल्य-निर्धारण का असली मुद्दा यह सुनिश्चित करना है कि पूरा मूल्य-निध ारण हो, जिसमें ज्वलंत लागत अथवा आधारीय शुद्ध मूल्य पर विभिन्न लागतें यथा कमीशन, प्रबंधन लागतें, आपदायी लागतों के लिए प्रावधान और एक प्रत्याशित लाभ मात्रा शामिल हों। अच्छे हामीदार अच्छे व्यवसायी भी होते हैं जो इकरारनामे की सुस्पष्ट एवं पारदर्शी शर्तों के माध्यम से दावों एवं विवाद लागतों में कटौती सुनिश्चित करते हैं।

5. बीमा दायरा लागू करना बीमा दायरे का मापदंड देखी गई प्रत्यक्ष एवं नैतिक आपदाओं के मिश्रण पर निर्भर होता है। अच्छी हामीदारी बीमाकृत को प्रभावित करने जोखिमों को पेश किए जा रहे बीमा से सुमेलित करने में भी मदद करती है, ताकि बीमाकृत के लिए सुस्पष्ट सार्थकता मौजूद रहे। बीमा दायरा बीमा की सीमाओं, लागू की गई कटौतियाँ, निबंधन, शर्तें और निष्कासन तथा इसकी जांच करता है कि क्या ये बीमाकृत के वांछित बीमा तथा वसूले गए प्रीमियम के अनुरूप हैं।

6. फीडबैक और नियंत्रण सुदृढ़ हामीदारी प्रबंधन ने हमेशा परिणामों को समझना तथा उनका मूल्यांकन, और फीडबैक के आधार पर बेहतरी का प्रयास करना चाहा है। यह सुनिश्चित करने के लिए कि अपेक्षित रूढ़िवादिता कायम रहे, नियंत्रण तंत्र एवं पद्धतियाँ संगठन में अंतःस्थापित होंगी। फीडबैक लूप को

जीवंत रखा जाएगा और सतत सुधार व नवविचार के चैनल के रूप में इसे बढ़ावा दिया जाएगा। अच्छी हामीदारी शिक्षा और नवविचार को अपनाएगी।

अच्छी हामीदारी के लिए अनेक चुनौतियाँ मौजूद हैं। बीमाकर्ता के लिए इसमें क्षमता की तंगियाँ, विनियामक का अनुपालन, पुनर्बीमा व्यवस्थाएं और सर्वोपरि कार्मिक की गुणवत्ता, खासतौर पर हामीदारी पेशेवरता के प्रति उनकी मनोवृत्ति, उनका अनुभव व ज्ञान और उनके नैतिक मूल्य शामिल हैं। संगठन को हामीदारी के अर्थशास्त्र के साथ सुस्पष्ट रूप से जुड़ना होगा, ताकि निवेशित पूंजी पर प्रतिफल को हासिल करने में निहित प्रचालनिक चुनौतियों का सामना करने में हामीदारों को समर्थ बनाया जा सके।

एक परिपक्व बाज़ार में हामीदारों के लिए हामीदारी कार्य का खाका संभवतः विकसित बाज़ार से अलग है। भारतीय परिप्रेक्ष्य में जोखिम आधारित हामीदारी की ओर जाने के लिए बीमाकर्ताओं तथा कर्मचारियों की तैयारी की जांच किए जाने तथा टैरिफ मुक्त व्यवस्था की शुरुआत और एक विशाल बाजार जो सुव्यवस्थित हामीदारी और बिक्री के आधार पर विकास की प्रतीक्षा कर रहा है, के कारण निपुणताओं को प्रखर बनाए जाने की आवश्यकता है।

नया हामीदार

नया हामीदार जोखिम की गतिशीलता पर केंद्रित होगा और पुरानी पद्धतियों एवं नियमों की अनम्यता से बंधा नहीं होगा। ऐसा हामीदार विश्व की सर्वश्रेष्ठ पद्धतियों को अपनाएगा, तथ्यों एवं विश्लेषणों की अद्यतन जानकारी रखेगा, उत्सुकतापूर्वक अनुभव इकट्ठा करेगा और सबंधित ज्ञान क्षेत्रों का विस्तार करेगा।

उत्कृष्टता की नए पथ पर अग्रसर होने के लिए हामीदार कानूनी मुद्दों से असमंजस में नहीं पड़ेगा बल्कि नई समझ के साथ जोखिमों को देखेगा। उदाहरणार्थ, परंपरागत 'अग्नि' बीमा, परिसंपत्तियों का विविध प्रकार भारी क्षति बीमा करते समय उसे केवल अग्नि से जुड़े जोखिमों के अलावा, परंपरागत रूप से जिसका हर कोई आदी है, सभी संगत स्थानिक, भौतिक एवं सामाजिक कारकों सहित इस बीमे को प्रभावित करने वाले सभी कारकों को देखने की आवश्यकता होगी।

इसी प्रकार, विदेश मेडीक्लेम बीमा कोई स्वास्थ्य बीमा नहीं अपितु एक यात्रा बीमा है जहां जोखिम अलग हैं। एक अच्छे हामीदार को यह चिंतन करने की भी आवश्यकता है कि किस समय एक यात्रा बीमा विदेश आवास बीमा में बदल जाता है, और विदेश में लंबे ठहराव से कौन से जोखिम अंतर उत्पन्न होते हैं। इसी प्रकार, स्वास्थ्य बीमा के मामले में यह जांच करना उपयुक्त होगा कि आमतौर पर एक वार्षिक बीमा किस उम्र में प्रभावी तौर पर एक दीर्घकालिक देखरेख बीमा बन सकता है।

नए हामीदारों का ध्यान जोखिम के आयामों पर केंद्रित होगा, वे पुरानी पद्धतियों एवं नियमों की अनम्यता नहीं बंधे होंगे, वे विश्व की सर्वश्रेष्ठ पद्धतियों को अपनाएंगे, उत्सुकतापूर्वक अनुभव इकट्ठा करेंगे तथा संबंधित ज्ञान क्षेत्रों का विस्तार करते रहेंगे।

कुल मिलाकर हामीदारों को जटिल एवं विकसित हो रहे मुद्दों का उत्तर तलाशने की आवश्यकता है, जैसे प्रौद्योगिकी का समावेशन, आउटसोर्सिंग की घटना, नकारा होने का प्रश्न, बीमाकृत स्वीकार्य राशि का आकलन करने की अनेक चुनौतियाँ, सही बीमाकृत राशि की किस्म का प्रश्न, मुद्रास्फीति का कारक किस तरह शामिल किया जाए, मुद्रा का उतार-चढ़ाव आदि। संविदात्मक, पेशेवर और कानूनी जोखिम जैसे क्षेत्र भी उभर रहे हैं जो जोखिम को तैयार करते एवं सेवा प्रदान करते हैं जहां ग्राहक अपनी सुरक्षा अपेक्षाओं का उत्तर तलाशता है।

एक नरम बाज़ार में मूल्य निर्धारण की चुनौतियाँ आदमी को लड़कों से अलग करेंगी। हामीदारी की रूढ़िवादिता की दुबारा जांच करने में मूल्य निर्धारण विभाग को विभिन्न संभावनाओं की सीमाओं की जांच करने में उत्कृष्टता की आवश्यकता है, ताकि एक ओर बाज़ार परिस्थितियों द्वारा निर्देशित ग्राहक अपेक्षाओं को पूरा किया जा सके और दूसरी ओर, इक्विटी पर वांछित प्रतिफल करने वाली शर्तों पर पहुंचा जा सके। इसका यह अर्थ भी है कि मूल्य निर्धारण की परिस्थितियों के सामान्य होने तक निराशाजनक अवमूल्यांकित क्षेत्रों से बाहर निकलने की हिम्मत रखना।

हामीदारी-केंद्रित बीमाकर्ता

अच्छी हामीदारी परिपक्व कार्पोरेट क्षमताओं का प्रदर्शन करती है, क्षमता निर्माण में सहायता करती है और ग्राहक सार्थकता का सृजन करती है। यह शेयरधारकों और उद्योग की सार्थकता को भी बढ़ाती है। हामीदारी में कड़ा अनुशासन आवश्यक है और सुव्यवस्थित तरीके से निर्णय लेना, कार्यविधि में एकरुपता एवं प्रासंगिकता अपेक्षित है। इसे अलग-अलग अनुभव एवं निपुणताओं का कार्पोरेट अंतर्दृष्टि एवं शिक्षा में कायाकल्प करने की आवश्यकता है। इससे भी अधिक महत्त्वपूर्ण है कि हामीदारी लाभ के लिए होती है और यह पूंजी पर प्रतिफल पर केंद्रित होगी। सुदृढ़ हामीदारी पद्धतियों के कड़े अनुपालन से मूल्य निर्धारण चक्र के जरिए बाज़ार में बने रहने की शक्ति तथा एक लंबी कार्पोरेट आयु सुनिश्चित होती है।

हामीदारी को मुख्य क्षमता में परिवर्तित करना संगठन के लिए अनेक प्रकार से सार्थक होगा, जैसेः

1. यह कारोबार के लाभप्रद क्षेत्रों पर आश्रित होने तथा पूंजी पर वास्तविक लाभ एवं प्रतिफल का सृजन करने में सहज ही मदद करती है।
2. यह जोखिम क्षेत्रों में सार्थकता को प्रकट करके ग्राहक को सेवा प्रदान करती है, और ग्राहक की ऊर्जा को दूसरे उत्पादक क्षेत्रों की ओर मोड़ने

में मदद करना चाहती है।

3. यह आफ्टर सेल्स सर्विस में बीमाकर्ताओं की लागत को कम करती है और दावा अनुपात एवं व्याख्या संबंधी जटिलताओं को कम करने में मदद करती है।

4. यह ग्राहक को समझने तथा उसके साथ वार्ता करने के लिए एक शानदार मंच है, जिससे शिकायतों एवं विवादों की संभावना को कम करने में मदद मिलती है।

5. यह दीर्घकालिक बाज़ार सदभावना और इक्विटी का सृजन करती है।

संगठन के लिए चुनौती है एक हामीदारी और अनुसंधान एवं विकास संस्कृति का निर्माण एवं उसका सतत संपोषण करना, सुस्पष्ट सिद्धांतों की स्थापना और उनका अनुपालन, और प्रतिकूल बाज़ार पद्धतियों के सामने उनके निरंतर निष्पादन पर ध्यान केंद्रित करना। संगठन की हामीदारी नींवों को कम करके आंकने की कीमत पर अल्पकालिक विकासोन्मुखी नीति अथवा जो रोकड़-प्रवाह हामीदारी कहलाती है, को अपनाने के प्रलोभन के परिणामस्वरूप प्रतिष्ठा और लाभ, दोनों में अटल गिरावट आ सकती है।

ग्राहक के लाभों को बढ़ाने के लिए हामीदारी उत्कृष्टता को निरंतर प्रगति की आवश्यकता है। बीमाकृत व्यक्ति को पेशकश की खामियों तथा उस पर लादी गई अनावश्यक लागतों का बोध होता है। इसलिए, अच्छी हामीदारी को निम्नलिखित पर विचार करने की आवश्यकता है :

1. ग्राहक के संज्ञान के अनुसार जोखिम वर्गों का पेश किए गए वास्तविक बीमा दायरे के साथ सुमेल।

2. पी.एम.एल., आपदायी हानि की संभावना और अन्य संगत कारकों के अनुरूप पर्याप्तता पर नजर डालकर बीमा सीमाओं की पुनरीक्षा करने में बीमाकृत की सहायता करना।

2. शर्तों, निबंधनों एवं निष्कासनों को उस बीमे के अनुरूप रखना जिसका फैसला हुआ हो और जो बीमाकृत को सूचित किए गया हो।

3. उपलब्ध एवं पेश किए गए बीमों के बीच अंतराल को दूर करना।

4. बीमों के बीच दिखाई देने वाले अंतराल को दूर करने का प्रयास करना।

नई हामीदारी को अपनी कवरेज़ बढ़ाने पर नजर डालने और नए जोखिमों की कवरेज़ आवश्यकताओं की पहचान एवं मौजूदा कवरेज़ में फेदबदल करके अच्छी तरह जांची-परखी विधियों द्वारा अपनी कवरेज़ का दायरा बढ़ाने की आवश्यकता होगी। बीमाकर्ता पैसों, समय की लागत, ऊर्जा की लागत, मानसिक लागत तथा इसी प्रकार के मायनों में विभिन्न ग्राहक लागतों के हिसाब से कवरेज़ की लागत फलकारिता की निगरानी करना जारी रखेंगे।

संगठन के लिए चुनौती है एक हामीदारी और अनुसंधान एवं विकास संस्कृति का निर्माण एवं उसका सतत संपोषण करना, सुस्पष्ट सिद्धांतों की स्थापना और उनका पालन, और प्रतिकूल बाज़ार पद्धतियों के सामने उनके निरंतर निष्पादन पर ध्यान केंद्रित करना।

बीमाकृत जनता उत्तरोत्तर इस बात से क्षुब्ध ा है कि बीमा के जरिए भरपाई होने वाली हानि तथा वास्तविक हानि के बीच का अनुपात अक्सर १रू४ होता है, जो अंशतः व्यवधानों एवं प्रतिष्ठा संबंधी क्षतियों के कारण तथा अंशतः, और जो खेदजनक है, कवरेज़ में अंतराल या कवरेज़ के लिए पेश की गई सीमाओं की अपर्याप्तता के कारण भी होता है।

बीमाकर्ताओं को उच्चतर दर्जे कवरेज़ की ओर संगठनों को आकर्षित करने के उद्देश्य से अपनी परंपरागत बीमा पेशकशों को पुनर्व्यवस्थित करने की आवश्यकता है जो उन्हें केवल विनियामक, या बैंकर/ऑडिटर द्वारा प्रेरित बीमा खरीदारी से वास्तविक जोखिम एवं सुरक्षा प्रबंधन में ले जाएगा। उच्चतर दर्जे की यह सुरक्षा अपेक्षा एक कार्पोरेट आवश्यकता बन जाएगी क्योंकि संगठन प्रचालनात्मक हानि/लागत न्यूनीकरण के क्षेत्रों में जाना चाहेंगे, स्वतंत्र रेटिंग एजेंसियों से रेटिंग बढ़वाना चाहेंगे और अंततः बाज़ार अग्रणी बनना चाहेंगे, जैसाकि वे चाहते हैं।

एक बीमाकर्ता की उत्तरजीविता और दीर्घकालिकता की जड़ें जोखिमों को सीमित रखने तथा स्वीकार किए गए जोखिमों का पर्याप्त मूल्य निर्धारण करने में समाई हुई हैं। हामीदारी का अर्थ वे सभी कार्य, विश्लेषणात्मक क्षमताएं और भूमिकाएं जो संगठन के लिए अच्छे निर्णयों का सृजन करते हैं। इसलिए एक हामीदारी संस्कृति का संगठन में व्याप्त होना आवश्यक है ताकि अन्य तात्कालिकताओं की तुलना विभिन्न कार्यों में हामीदारी प्राथमिकताओं को पर्याप्त तरजीह दी जाए। आशावादी चिंतन, अटकलबाजी और गुंजाइश रखने पर निर्भर रहने वाली तकनीकों एवं समाधानों की लंबी अवधि की निष्फलता और अकारगरता के कारण अच्छी हामीदारी अंततः अग्रणी के रूप में उभरेगी। इस प्रकार हामीदार भी एक अधिकारप्राप्त निर्णय निर्धारक बन जाएंगे क्योंकि वे संगठन के लिए जोखिम स्वीकार करने और राजस्व सृजन का प्राथमिक कार्य करेंगे जो उसकी सफलता एवं विफलता के बीच अंतर पैदा करता है। इसलिए अच्छी हामीदारी के दर्शन का पालन-पोषण, नवविचार एवं भविष्यवादी उन्मुखता के साथ अनुसंधान एवं डाटा विश्लेषण की संस्कृति भविष्य में अच्छी कंपनियों को विफल कंपनियों से अलग करेगी।

लेखक आई.आर.डी.ए. में कार्यपालक निदेशक (नॉन-लाइफ) हैं। यहाँ व्यक्त किए गए विचार उनके अपने हैं।

Recap

—A listing of some articles from IRDA Journal Volume 3 (December 2004 to November 2005) for quick reference.

INDEX

Report Card: GENERAL

G. V. Rao

Half Year Growth at 15.40%

Performance in September 2005

The premium performance of the non-life insurance sector in September 2005 is in tune with the growth trends seen in the preceding five months of the fiscal. The market grew in September 2005 by Rs. 213 crore, about 14.92 per cent, more or less at about the same growth rate, as it shows up, at the end of the first half of 2005-06 that is 15.39 per cent. The contribution of the new players as also the established ones is in tune with their respective previous performances.

The new players have added a massive monthly accretion of Rs. 150 crore towards the overall accretion of Rs. 213 crore. They have chipped in their usual contribution of 70 per cent to it. Among the new players, the top ranking three, ICICI Lombard, Bajaj Allianz and IFFCO-Tokio alone have generated a monthly accretion of Rs. 123 crore (58 per cent to the total market monthly accretion), emphasising their continued dominant role in driving up the growth rates.

Among the monthly top premium performers, IFFCO and ICICI, with accretions of Rs. 53 crore and Rs. 48 crore respectively, lead the league; with New India ranking third with Rs. 41 crore and Oriental fourth with Rs. 40 crore. Oriental is showing clear signs of going after market share among the established players in 2005-06. The premium growth in September of Bajaj has been rather uncharacteristically subdued at Rs. 22 crore.

The market share of the new players that was only 17.6 per cent in 2004 has now risen to 24.4 per cent in September 2005; a trend that is almost settling into a pattern for 2005-06, in almost every month that has gone by.

GROSS DIRECT PREMIUM (within India) SEPTEMBER, 2005

(Rs.in lakhs)

INSURER	PREMIUM 2005-06		PREMIUM 2004-05		MARKET SHARE UPTO SEPTEMBER, 2005	GROWTH % YEAR ON YEAR
	FOR SEPT. '05	UPTO SEPT. '05	FOR SEPT. '05	UPTO SEPT. '05		
Royal Sundaram	3,493.57	22,513.57	2,622.26	15,752.20	2.16	42.92
Tata AIG	3,966.31	29,296.67	2,888.15	24,020.44	2.81	21.97
Reliance General	1,000.01	7,609.83	768.11	8,133.01	0.73	-6.43
IFFCO-Tokio	7,768.52	42,806.09	2,509.75	22,211.28	4.11	92.72
ICICI Lombard	11,836.39	82,291.22	7,048.12	40,784.03	7.90	101.77
Bajaj Allianz	8,902.80	62,766.49	6,742.26	39,483.05	6.03	58.97
HDFC Chubb	1,513.59	9,279.27	1,413.37	8,080.20	0.89	14.84
Cholamandalam	1,578.47	12,286.60	1,133.85	8,663.18	1.18	41.83
New India	39,798.00	2,28,193.00	35,744.00	2,06,348.00	21.91	10.59
National	28,060.16	1,78,010.35	32,334.90	1,90,218.45	17.09	-6.42
United India	23,906.00	1,62,870.00	22,724.00	1,58,344.00	15.64	2.86
Oriental	26,815.00	1,76,171.00	22,764.00	1,56,439.00	16.92	12.61
ECGC	5,466.27	27,407.71	4,107.14	24,087.52	2.63	13.78
TOTAL	**1,64,105.09**	**10,41,501.80**	**1,42,799.91**	**9,02,564.37**	**100.00**	**15.39**

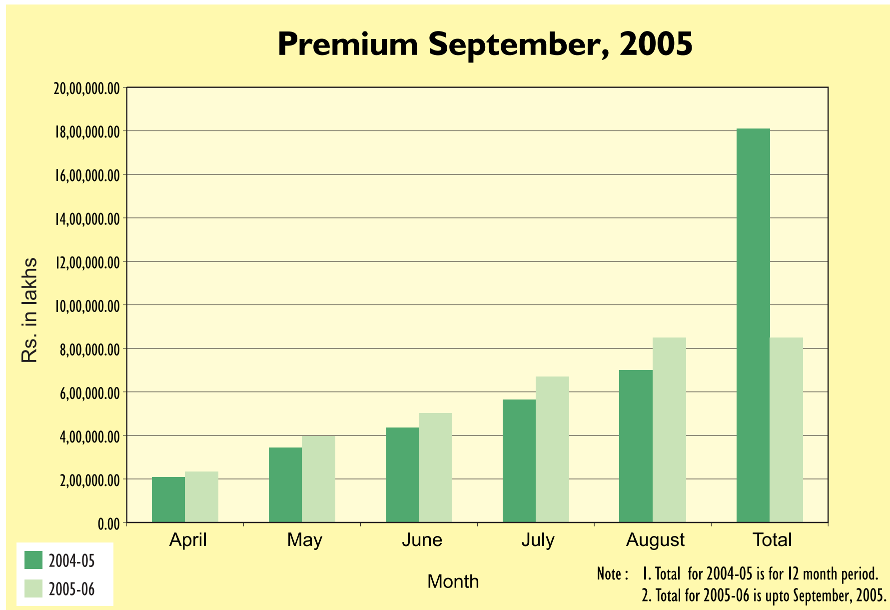
National Insurance continues with its deceleration in premium volumes; in September 2005 it has dropped an additional Rs. 42 crore, bringing the total drop in its premium for the first half of 2005-06 to Rs. 122 crore. The four established players have recorded a growth of Rs. 50 crore in September 2005, recording a growth rate of only 4.4 per cent. The market strategies of each of these dominant established players seem to be at variance with the others.

Performance up to September 2005

The non-life market grew by Rs.1,390 crore (15.39 per cent), with the new players contributing Rs.1,017 crore, the four established players Rs. 340 crore and ECGC Rs. 33 crore to it. The contribution of the new players to the new market growth is 73 per cent, the four established players 24.5 per cent and ECGC 2.5 per cent.

The market share of the new players up to September 2004 was 18.52 per cent. It has now gone up significantly to 25.81 per cent as at end of September 2005. ICICI and Bajaj are poised to cross the Rs. 1,000 crore mark by the end of 2005-06. Here again, the top three new players ICICI, Bajaj and IFFCO have chipped in Rs. 854 crore amounting to 61.4 per cent of the gross accretions of Rs. 1,390 crore. A clear pattern in the monthly accretion performance, as also in the cumulative accretion performance, has begun to emerge.

The market accretions for the first half of the fiscal of Rs. 1,390 crore are led by ICICI with Rs. 415 crore, followed by Bajaj with Rs. 233 crore, New India with Rs. 219 crore and IFFCO with Rs. 206 crore. Oriental has an accretion of Rs. 198 crore. The remaining eight players have accretions each of Rs. 70 crore or less, separating the top five very sharply from the rest.



Reliance and National are the only two players that have dropped their premiums, an uncharacteristic trend in an otherwise climbing market.

Future prospects

The new players seem to have consolidated their efforts to ensure a market share of not less than 25 per cent in the fiscal 2005-06. The top three new players, ICICI, Bajaj and IFFCO seem to be poised to take the market away from the rest of the new players; and perhaps eventually from even the established players. ICICI is clearly the winner so far, having outdistanced all the other new players by a huge premium margin, by over Rs. 180 crore, as of now, not immediately bridgeable by any other new player

The roadmap for detariffing that has been announced would perhaps give a fillip to the efforts of the new players to acquire more new accounts, while the tariffs are still applicable. With the wage revisions imminent for the staff of the established players, they need to ensure their growth rates are reasonable to absorb the inevitable cost increases. That realisation does not seem likely in the immediate, with the sluggish growth rate of less than five per cent unlikely to go up immediately.

The established players have their tasks cut out. Continuing to lose profitable segments of business, with rising management and distribution costs, and with reinsurance costs likely to go up next year, the established players will inevitably come under increasing pressure on all fronts. The expectation that detariffing would create a new level playing field for them to take on competition may be more a hope and perhaps an unsubstantiated assumption at present. But with a new determined team at the helm, one really does hope that things will change dramatically and more quickly too, both for them and for the non-life market as a whole, to grow even faster.

The author is retired CMD, The Oriental Insurance Company.

Climate change concerns bring gloom to UK insurers

Although none of Britain's large general insurers have direct exposure to the Katrina disaster, they almost all insure themselves with the world's largest reinsurers, which will pick up part of the bill for the damage caused by the hurricane. These companies are expected to pass on their higher costs to customers.

An even bigger challenge is posed by climate change. ABI research conducted on the basis of advice from climate experts suggests the global bill for property damage caused by incidents such as Hurricane Katrina could increase by two-thirds over the next 10 years unless immediate environmental action is taken. In Britain, the value of weather-related claims reached £6 billion between 1998 and 2003, twice the total in the previous five years.

Protect your home from quakes

Recent earthquakes in several parts of world have reminded people that they ought to protect their homes – at least to a certain extent – from such tremors. While many of the quakes are small and most are not even felt, people do wonder if another larger earthquake might hit in the future – and if their homes would be protected from damage.

Most homeowner and rental insurance policies do not cover damage caused by an earthquake, but coverage can be added to most policies as an "endorsement" for an additional cost. Earthquake insurance covers the damage to a home and its contents caused by the movement of the earth.

The South Carolina Insurance News Service recommends the following:

- Look around your home for things that could fall or move during an earthquake. If you have a frame house, is it fastened to the foundation? Are your gas connectors flexible to help prevent fire? Learn how to turn off the gas, electricity and water to your house and secure your hot water tank with straps so it cannot tip over.
- Consider retrofitting your home to make it more resistant to earthquake damage.
- Educate your children about earthquakes and what they should do if one occurs.
- Even in earthquake prone areas, fewer than 25 per cent of homeowners have earthquake insurance. Give it good thought. Earthquake insurance can be quite inexpensive. Contact your insurance agent or company to find out what the costs would be for your home.

US insurance sector lagging in online customer care: survey

In a report that examined 47 Healthcare, Life & Health, and Property & Casualty insurer web sites, the insurance industry slipped slightly in its Customer Respect Index (CRI), it has been reported. The survey was carried out by Customer Respect Group, Inc., a US-based research and consulting firm that focuses on how corporations treat their online customers. The findings, from its Fourth Quarter 2005 Online Customer Respect Study of Insurance firms, represent the fifth such study conducted on insurers.

The study measures and analyses corporate performance from an online customer's perspective. It assigns a CRI rating for each company. The CRI is a qualitative and quantitative in-depth analysis and independent measure of a customer's experience when interacting via the Internet. By interviewing a representative sample of the adult Internet population, and by analysing and categorising more than 2,000 corporate Web sites across a spectrum of industries, the Customer Respect Group has identified the attributes that together measure the online customer experience.

Overall, the industry's CRI rating dropped from 6.1 in the second quarter to 5.9. This contrasts with the trend of slow but steady improvements being made in most industries. Property & Casualty had the best sector average with 6.2, followed by Life & Health on 5.9 and Health Care Plans with a disappointing 5.4.

The insurance industry remains the only industry sector evaluated with no web site reaching the standard of 'excellent', noted the report. The industry showed little or no improvement over the previous study and in many key areas fell behind other industry sectors. For example, the industry failed to respond to 26 per cent of e-mail inquiries compared to an "ignore rate" of 16 per cent for financial services. While the quality of the responses improved slightly, the speed of responses decreased, resulting in just 16 per cent of e-mails responded to in a helpful manner and within 24 hours. Especially poor were the healthcare plans, which ignored more than half of the e-mail inquiries.

US database to spot waterlogged vehicles

Ms. Sandy Praeger, Kansas Insurance Commissioner, has reportedly said her professional group has partnered on a US-wide database to track cars and boats from the flooded Gulf region that may be re-sold.

The database is a cooperative effort between the National Insurance Crime Bureau, the National Association of Insurance Commissioners' Anti-fraud Working Group and the Louisiana State Police's insurance fraud unit.

The database – accessible at www.nicb.org — will match the vehicle identification numbers of cars and boats with those that were located in the flood region. Ms. Praeger says many cars and boats will be cleaned up and re-sold, though many of them could have dangerous and unsound electrical systems.

"Making this information available to consumers in an easily accessible format will serve to inform and protect them from vehicle fraud," says Ms. Praeger, who is the NAIC's secretary-treasurer.

CUS disability insurer legally challenged

A lawsuit filed in the Superior Court in California claims that UnumProvident Corp., the US' largest disability insurer, systematically sought ways to avoid paying claims to millions of California customers. The lawsuit, which seeks class-action status, comes less than a month after the company was ordered to pay an $8 million fine to settle similar charges against the company by state insurance regulators.

The lawsuit seeks billions of dollars in premium refunds and damages for denied claims. The suit also names UnumProvident subsidiary Paul Revere Life Insurance Co.

Lloyd's of London updates key system software

Lloyd's of London, the specialist insurance market, has updated the software that forms part of its settlement and trust fund operations, it has been reported. One of the key roles of the system is to settle insurance transactions between syndicates and brokers, with more than £31 billion - in eight different currencies - processed through the system.

The settlement mainframe system receives input including information on premiums, claims, reinsurance, charges, direct feeds, currencies and letter of credit scheme transactions. It ensures payments owed by brokers and underwriters are received, and all payments owed to brokers and underwriters are paid out on time, with statements issued to inform the various parties of what is going on.

Lloyd's had previously been using software from Information Builders called PC Focus but as this package began to age it started looking for an alternative, and decided last year to upgrade to the same software company's WebFocus product. WebFocus downloads files from the mainframe, allowing staff to create payment files and reports in a variety of currencies. It also settles payments to banks and other parties, and processes letters of credit in their preferred formats.

It has reportedly given the insurance market more flexibility to link into other sites. The new software also adds security.

Lloyd's Equitas settles asbestos claims with GM

Equitas, the company set up to assume Lloyd's of London's multi-billion-dollar liability exposures, has reportedly reached a settlement with carmaker General Motors Corp. over asbestos claims. The size of the payment by Equitas to GM was not disclosed but Equitas said the agreement settles all of GM's claims against Lloyd's businesses that are reinsured by Equitas, some of which date back to the 1950s.

GM continues to pursue its lawsuit, filed in January, with UK insurer Royal & Sun Alliance (RSA) over disputed asbestos liabilities that it says RSA should pay. But RSA is set to continue to fight the action, which could take years to resolve.

Asbestos was widely used in manufacturing car brakes at one time because of its ability to withstand high temperatures, but the material later found to cause respiratory illnesses including cancer. Equitas was set up in 1996 to take over and pay off Lloyd's huge exposures, largely to asbestos claims, which threatened to bankrupt the world's oldest insurance market. Equitas effectively assumed all the market's pre-1993 liabilities so that Lloyd's could continue underwriting.

Equitas has been able to reduce its liabilities by making upfront cash settlements with many of its biggest policyholders. Since it was established, Equitas has paid over $7 billion for asbestos claims.

Takaful takes insurance to the Islamic world

For conservative Muslims, insurance is a strict no-no, since it contradicts with some of their religious teachings. In 1903, Arab scholars declared insurance an unacceptable concept.

In 1970 arose an alternate tool in the form of Takaful. It took off in 1985, when the Majma al-Fiqh, the Grand Counsel of Islamic scholars in Makkah, Saudi Arabia, approved of the system. Takaful literally means 'guaranteeing each other'. It meets the norms set by Shariah, or the Arabic term for "path" that prescribes religious codes for Muslims.

Takaful is a concept that provides protection for its community, according to media reports. It is also termed as 'cooperative insurance', wherein the policyholders contribute a certain amount for a common purpose and each of them pay a sum as insurance premium in order to help those who are in need of financial aid. It is a system of mutual help and cooperation. Also, the losses are divided and liabilities spread according to the community pooling system. It does not aim to derive benefits at the cost of others. Instead, it eliminates uncertainty in terms of premium and compensation.

The first Takaful Company - the Islamic Insurance Company of Sudan – was established in 1979. Today, there are about 28 registered Takaful companies worldwide writing Takaful directly and 10 more Islamic marketing agencies placing insurance risk with conventional and Takaful companies. Malaysia is one of the largest markets outside the Arab region for Takaful, writing 72 per cent of the non-Arab Takaful business. This impressive performance has attracted the attention of insurers from many countries.

Back home, LIC has linked up with a Saudi insurance company to form Indo-Saudi Insurance Company, a four-way partnership with LIC, LIC international-Bahrain, the New India Assurance Company and Al Hokair group, it is reported. It will offer 'Takaful' products. This is the first foreign venture where the state owned insurer will retain 50 percent of the investment in a foreign operation. LIC will offer a range of insurance products like endowment, money-back and single premium policies among others. The returns would need to be inbuilt into the pricing, and cannot be called bonus or profits.

RBI allows insurers to adopt screen trading

Insurance companies, who are increasingly turning out to be major buyers of government securities, have reportedly been allowed to trade on screen in the bond market. These institutional players will be able to transact in government securities on the order-matching module of the negotiated dealing system (NDS).

Insurance companies, particularly LIC, General Insurance Corp (GIC) and the four state owned non-life companies, are big players in the bond market. The RBI introduced the screen-based order matching platform on August 1. It is an anonymous platform, similar to the one for equities on the NSE. Transactions take place through the matching of buy and sell quotes. Initially, only the banks and primary dealers had access to this platform. Insurance companies had asked RBI to be allowed to trade using the order matching platform.

The new platform is a departure from the earlier telephone market, where brokers acted as intermediaries. The new system has by and large wiped out brokers from the bond market, as big participants such as state-owned banks have moved out of the telephone market. Mutual funds also want access to the platform, but have yet to be permitted by RBI.

Access to the order matching platform will be a major advantage to insurance companies. Most of the market has moved to the order matching platform and those left out have a significant problem in learning about the market movements and live quotes.

Task force to develop low-cost health insurance

The Ministry of Health and Family Welfare is considering establishing a task force to develop a low-cost health insurance programme as part of the National Rural Health Mission, it is reported. Mr. Anbumani Ramadoss, Health Minister, has already made a presentation on the issue to the Prime Minister.

As per the proposals, over 3,200 community health centres in the country will be strengthened so that they can provide basic healthcare to the masses. The strengthening of the public health delivery system and the availability of a large number of health workers will provide an opportunity to improve risk pooling through the community-based health insurance, it is expected.

It is estimated that household expenditure on healthcare during 2004-05 amounted to more than Rs. 1,00,000 crore.

Life insurers set up new firm study mortality rates

The Life Insurance Council, the representative body for Indian life insurance companies, along with Actuarial Society of India (ASI), has floated a new company called Mortality and Morbidity Investigation Bureau (MMIB), it is reported. To this effect, it has registered MMIB with the Registrar of Companies in Mumbai. The bureau was floated as a 50:50 joint venture between the Council and ASI.

MMIB has been mandated with preparing a new mortality chart on the basis of which life insurers will fix the premium for insurance policies. With the increase in life expectancy, there is a need to upgrade the mortality table to current levels. A new chart will result in a more realistic premium calculation for new policies. At present, new private life insurers base their calculations on the decade-old mortality table prepared by LIC.

The company will also prepare a morbidity table — a set of figures which will indicate incidence and severity of sicknesses and accidents in a defined classes or persons. At present there is no morbidity table. Such a table will enable correct pricing by insurers for all new products. Currently, Indian insurers draw examples from the international experience of reinsurance firms on critical illness.

MMIB will also study recent trends while acquiring data and information on mortality, morbidity and other specific risk-related contingencies in the life insurance domain. Earlier, MMIB was conceived as a trust but fund requirement to run the entity prompted a decision in favour of floating it as a corporate entity. Mr. S. V. Mony, Secretary General of the council, said MMIB is on the lookout for a chief executive responsible for formulating a sustainable revenue model and action plans to reduce MMIB's dependence on external funds.

At present, 14 life insurers have provided Rs. 5 lakh each towards its working capital. Working funds at the initial stages will be provided by life insurers until it attains self-sufficiency. According to an MoU signed by the two promoters, MMIB's board will have four representatives, two each from the promoter organisations.

At a later stage, MMIB will provide consultancy and data service to insurers for a fee. It will initially work in technical collaboration with the Continuous Mortality Investigation Bureau (CMIB) of the UK, where pooled experience is drawn from all member insurers.

Making Health Insurance Universal

The four state-owned general insurance companies have utilised only about Rs 1.5 to two crore for the Universal Health Insurance Scheme in the current fiscal so far, it is reported. Concerned over the small coverage of the scheme, a concrete strategy is reportedly currently being worked out by the finance ministry along with the companies to make the scheme a success.

The government is likely to increase the allocation for the scheme, which is targeted only at the below poverty line population.

Though as per the original proposal, 10 lakh lives were to be covered, the four companies have managed to cover only about 3 lakh lives, it is reported, with the lack of a proper database on the BPL families being a main cause of concern. The scheme has picked up well in the southern states.

The Centre had not made any particular allocation for the current fiscal, though in 2004-05, the Centre had allocated Rs 10 crore for the scheme.

It is learnt the finance ministry is likely to increase the allocation for the next fiscal. The state governments and non-governmental organisations are also likely to be roped in to make the scheme popular.

ECGC May Offer Domestic Credit Cover

Export Credit Guarantee Corporation of India (ECGC), an export promotion organisation of the Union commerce ministry, is reported to be exploring the possibilities of foraying into the domestic credit insurance business.

ECGC is apparently looking at the immense volume of inter-state trade that can be tapped for credit insurance. "The volume of business that domestic trade can generate is huge. Non-payment or default by companies within the country is also quite high that can be insured," ECGC general manager G. M. Ganapathy was quoted saying.

ECGC currently insures close to 15 per cent of the country's exports. ECGC is also talking to French insurance agency Coface for creating a reinsurance back up. "We can start underwriting the risk in domestic business once we have a proper reinsurance backup," the executive said.

“ ”

Hurricane Katrina
has been estimated to be the
costliest natural peril event to date.

General Insurance Newsletter,
Financial Services Authority(FSA),
the UK

We're not expecting
an immediate premium increase
directly as a result of Katrina, but the
wider issue of climate change is beginning to
have a very serious impact on insurers.

Mr. Malcolm Tarling, Spokesman,
Association of British Insurers

Hurricanes Katrina and Rita serve as a
reminder that insurers' full year results are
influenced significantly by the extent of catastrophic
loss, and most notably this year by the severity of the
windstorm season. Katrina, in particular, will have a
significant bearing on full year profits.

Mr. Nick Prettejohn, Chief Executive,
Lloyd's of London

Those close to the contract
certainty debate have been unanimous
on one point: that much of the change needed
to deliver contract certainty is about behaviour and
culture. Just because something has been done in a
certain way for some time doesn't necessarily mean that
change isn't required. The world and the environment
changes and the legal and operational risks which
businesses might be exposing themselves
to by not changing are getting more
considerable.

Mr. Julian Adams, Head of Wholesale
Insurance, FSA

Critically, the market has now agreed an
industrywide definition of contract certainty:
‘Contract certainty is achieved by the complete and
final agreement of all terms (including signed down
lines [for the subscription market]) between the
insured and insurers before inception.’

General Insurance Newsletter, FSA, the UK

I believe that any reform agenda
should not lose sight of the social value
of our market and all aspects of reforms
should ultimately be tested against the diffence
they make in terms of making our market more
financially secure and efficient to enable end
users to receive proper and fair
treatment.

Mr. Julian Adams, Head of Wholesale
Insurance, FSA

RNI No: APBIL/2002/9589

Events

14 –16 November, 2005
Venue: Hyderabad
Annual Seminar on Regulatory Issues for Senior Officers of Insurance Regulatory Agencies by Institute of Insurance and Risk Management, Hyderabad

16–18 November, 2005
Venue: Mumbai
World Conference on Disaster Reduction: Focus on Corporate Sector Role & Responsibility by National Insurance Academy, Pune

18–19 November, 2005
Venue: Pune
2nd Global Symposium on Pensions by Pension Research Insitute, NIA, Pune and Actuarial Society of India.

21–22 November, 2005
Silver Jubilee Seminar on Business Continuity Management by NIA, Pune in collaboration with Information Systems Audit & Control Association, Pune Chapter

24–25 November, 2005
Venue: New Delhi
Samvardhan: Exploring Advancements in Risk and Insurance for Oil and Gas organised by Marsh India in association with National Insurance Academy and Infraline

28 – 29 November, 2005
Venue: Hong Kong
2nd Conference On Pensions & Retirement Planning by Asia Insurance Review (AIR)

28 – 29 November, 2005
Venue: Dubai
2nd Annual Gulf Insurance Forum by AIR