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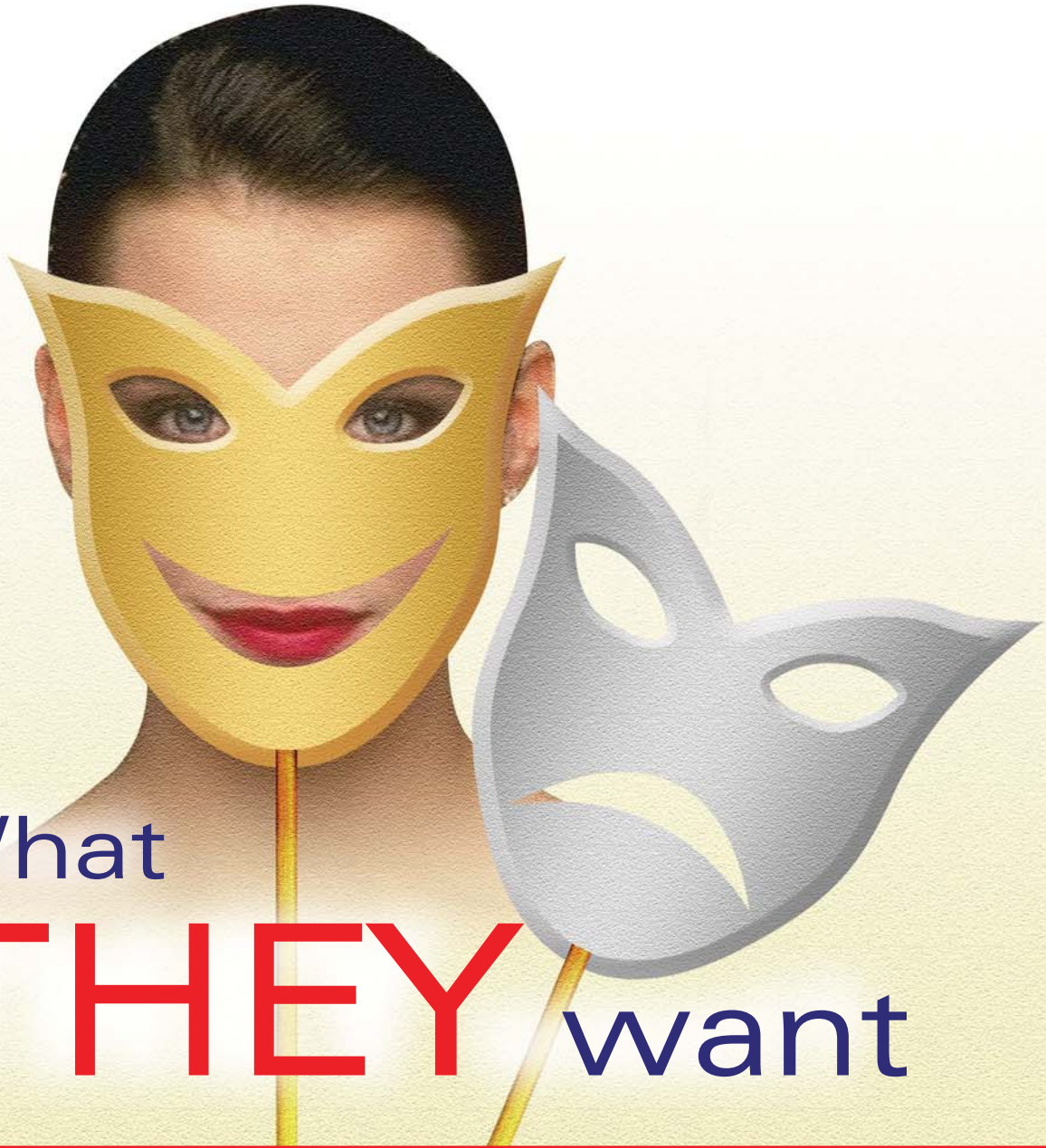

What THEY want

बीमा विनियामक और विकास प्राधिकरण

Journal

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From the Publisher

Information is a great leveller. Whether through television, newspapers or the Internet, what we can learn today is barely a pace behind what is there to know. Products, services, attitudes, values... customers are imbibing the best that the world has to offer and are demanding the same value for their money here as they could get elsewhere.

But knowing and wanting is easier than providing. And that too in a market that has long been working on very different deliverables. Those deliverables were controlled by the the service provider who had virtual monopoly and could determine what he would deliver.

This was one of the things that was expected to change when competition was introduced in the market three years ago. By providing a choice of insurance companies and marketing channels, the insurance customer was presented with the possibility of better service.

Competition was expected to bring in better attention, better systems and services, new products and the technology to support it all in the most contemporary of manners.

Whether that has happened is an assessment that we must constantly make because efforts at customer satisfaction and better customer service levels is a work in progress.

What we look at in this issue of **IRDA Journal** is how well the insurance industry has been tracking customer expectations. Companies and consumer groups have described their experiences and even aspirations and have tried to define where we stand today in front of a customer who is moving faster ahead and who is setting the pace for the kind of products and services he wants. Whether the industry will be able to deliver or it will be a lost opportunity is a question that will always demand analysis and answers.

The next issue continues the same theme but from a different angle. We will explore what new products the enlarged industry has come up with in the last few years and what the implications have been for the market.

C.S.RAO

Inside

Vantage Point - *K. Nitya Kalyani*	4
In the Air	5
Staying Ahead - *Stuart Purdy*	8
Liberalised Customers! - *G.V. Rao*	10
Create the System... - *Shivaji Dam*	12
Quality Interaction - *Antony Jacob*	14
Always Wanting More! - *Abhijeet Chatterjee*	15
Bridging the Gap - *Ajit Narain*	16
Roll up your Sleeves - *Arun Agarwal*	18
Growing with the Customer - *Shikha Sharma*	19
With a Capital 'C' - *Ian J. Watts*	20
Rising to Customer Expectations - *R. Desikan*	25
Listen to the Customer - *Pushpa Girimaji*	27
प्रकाशक का संदेश	28
आत्म-निरीक्षण - *निर्मला अय्यर*	29
कुछ तो लोग कहेंगे	30
उपभोक्ता मामलों में कुछ निर्णय - *एच के अवस्थी*	31
कपट दावे	31
देरी से भुगतान की लागत	32
यह वही है जो वो चाहते हैं... - *के नित्या कल्याणी*	33
भारतीय पुनर्बीमा का यथोस्थान - *जी वी राव*	34
Statistics - Life Insurance	36
Statistics - Non-Life Insurance	38
In Retrospect - *Nirmala Ayyar*	40
News Briefs	42
At What Expense ? - *P.S. Prabhakar*	46
Round Up	48

ISSUE FOCUS

Changing Needs

R. Krishnamurthy 6

Anytime, Anywhere...

Chirag Jain 9

Blessing or Curse

Prof. Manubhai Shah 22

A Time to Network !

The insurance industry saw one of its rare regional meets earlier this month in Delhi. At the XIVth Insurance Congress of Developing Countries (ICDC), organised by the General Insurance Corporation of India (GIC) on behalf of the Association of Insurers and Reinsurers of Developing Countries, the aim was all regional co-operation, developing the reinsurance markets of the Afro-Asian and the Latin American and East European nations.

But past efforts at pooling capacities have not succeeded. That this has not been overcome was apparent from the fact that the Latin American countries did not participate in the congress and the East European countries were barely there. Without them, as Mr. Ezzat Abdel-Bary, Secretary General, Federation Of Afro-Asian Insurer And Reinsurers (FAIR) said, the AIRDC is only another FAIR! Something needs to be done to ensure that the region reaches out to its potential.

Voicing a similar concern was Mr. S. A. Kumar of Asian Re. Asian Re was floated with participation from various Asian government to support the reinsurance market here. But it was struggling from lack of capital and hence capacity to write business, Mr. Kumar pointed out.

Support, of the moral even more than the financial kind, has been slow in coming from the various governments, was the feeling among the participants. If this is taken as the germ of the diagnosis and if we moved purposefully towards it we could establish a strong reinsurance market in this region. And this was one of the aims or aspirations of the liberalisation of the Indian insurance market, among many. The expertise is there and, certainly, the market is there. It is only a matter of vision and a sense of the larger purpose. India, to which most of the developing countries openly look up for guidance and the first move – and this was again openly articulated more than once at the congress, formally and informally – has the opportunity to sow the seeds for a strong reinsurance market in this region.

And the time is now because the GIC Chairman, Mr. P. C. Ghosh, has been made the President of AIRDC for the next two years. And concurrently, the IRDA Chairman, Mr. C. S. Rao, has been made President of the Association of Insurance Supervisory Authorities of Developing Countries (AISADC).

Coming to the theme of this issue, we look at the universal quest of all good businesses. Tracking customer expectations and responding to them. We have for you a feast of thoughts from a cross section of industry members. What emerges is that while methodologies and intentions are clear, it is still early days for the reading of customer expectations to become clear and get crystallised into product offerings.

The case with service quality is more tragic. Read what consumer activists say in this issue. They are the ones who spend time with customers who are in trouble and who have the diagnosis on what went wrong in their interaction with insurance companies. There are lessons to be learnt from here if only people will listen. And the thing is that these are oft repeated lessons.

And we follow up this topic with something related and as important: how well has the industry responded to the need for new products for a new age. That is in the next issue. Please write in to us about this topic. We also, as always, look forward to suggestions of new themes for us to write about.

K. Nitya Kalyani

New Lamps, and Old...

K. Nitya Kalyani

One of the many aspirations that the Malhotra committee report articulated was the need for newer products that reflect the changing security and protection needs of a very fast changing society.

In much less than a generation – in fact in less than even a decade – the attitude and needs of the Indian customer have changed drastically. The earlier apathy and futile resentment of monopoly service providers in different industries have given way to awareness of their rights and higher aspirations wrought through information of what was happening elsewhere in the world.

The need for new products also rose quickly as lifestyles changed dramatically from dignified resignation to an aspirational acquisition spree. If the former was characterised by caution in savings, investment, career choices and working and lifestyles, the latter was more adventurous, choosy and daring in all these and more.

Added to this were the new risks that the new era brought. Greater health consciousness as well as the incidence of more lifestyle diseases has meant that health insurance has seen a strong buyer pull. Higher life expectancy and the breakdown of the joint family system have awoken the need for pensions. Greater need to provide for a young family's uncertain future in the event of death or disablement of the primary breadwinner, specially in the absence of the old close family bonds and sense of financial obligation to the extended family, has brought in a sense of urgency to buying life and property insurances.

It will be said that these changes are really in the urban white collar and professional circles and that is a miniscule part of the population. Perhaps. But another way to look at it is that they are the thin end of the wedge. Their thinking today will transmit itself to other parts of the society. Even today aspirational lifestyles and attitudes are spreading faster than before and rural areas are not immune to its seduction through television. The changes may be to a lesser degree and may even manifest themselves differently, but gone are the complacent and even fatalistic days when the average Indian was content with what he got. And remember, even then he did so not because of a lack of enterprising spirit or dreams but because that was how the environment was.

> But aspirational lifestyles and attitudes are spreading faster than ever and rural areas are not far away from its seduction.

Giving credence to this is the way the automobile and telecom industries have responded to the customer with new offerings. While the models and variants trotted out by the car and motorcycle makers amaze and delight us. Telecom operators, including basic telephone service providers confound us with their tariff packages and schemes which need nothing less than a spreadsheet and whiteboard to be analysed! Bankers and other lenders are flooding the market with newer products and higher service levels every day of the week. And these industries are just some examples of introduction of free market practices including the introduction of competition.

Where are the insurance companies in this regard? New risks need new approaches to protect them. How has the insurance industry responded? Are there new products reflecting the new lifestyles, financial position and expectations of the customers? Are the insurers tracking the changing needs of the society and fashioning new covers to meet the demand? Or are the same old products being tinkered with and repackaged with advertising and marketing filling gaps that products miss? Are some products, hitherto ignored, being demanded more now since their time has come, so to say?

These are the questions we look at in the next issue of IRDA Journal. Don't forget to join us!

What do you THINK?

Has the insurance industry come up with new products to match consumer demand?

Write to us at:
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Towards Regional Cooperation

While regional co-operation and capacity buildup were the main themes of the XIVth Insurance Congress of Developing Countries (ICDC), held in Delhi by the Association of Insurers and Reinsurers of Developing Countries (AIRDC), agricultural insurance, health and old age cover and sharing of data for evolving disaster management initiatives were also equally important.

Dr. (Chief) O.A. Bailey, Commissioner of Insurance, Nigeria and outgoing President of AIRDC and AISADC handing over Presidentship of AIRDC to Mr. P.C. Ghosh, Chairman, GIC, for 2004 to 2006.

The following is the gist of the resolutions adopted by the Executive Board and members of the AIRDC in its General Meeting on March 9 following the XIVth ICDC.

Agriculture insurance critical

Agriculture insurance is very important in developing countries which have economies that are largely dependent on agriculture. The Indian agricultural insurance scheme, particularly, could serve as a model to emulate for any developing economy that is planning to start agricultural insurance.

The two papers on agricultural insurance presented at the ICDC are to be installed as permanent references in the library of the Permanent Secretariat of the ICDC and also placed on the AIRDC website. The Indian report is to be updated regularly, at least during each ICDC.

Health and old age protection – Government-industry partnership needed.

Health protection and retirement income will always be areas of concern in the developing countries. Insurance companies have important roles to play in the schemes adopted by any particular country, whether a national social security system is in place or not. Both social and economic protection mechanisms have long term financial implications for any country; thus plans to adopt any comprehensive system of benefits and coverage in terms of beneficiaries should be studied carefully, and any reform of an existing system be likewise thought out carefully by projecting the long term financial implications. Here is where private insurance companies can perform a complementary role to government-funded systems.

The congress resolved that insurance industry be called upon by governments to take part and offer assistance in the planning, setting up or reforming the national system if any exists in a developing country.

Information flow vital for regional cooperation

Capacity build up and regional cooperation have long been a strategy of the developing countries for decades now. More efficient regional cooperation can be planned if there is a flow of information among the member countries comprising the regions.

One cooperative effort is the compilation of insurance loss statistics that was discussed in the XIIIth ICDC in Nigeria, as a necessary step to achieve regional cooperations.

At the Nigerian congress it had been resolved to take this data sharing activity up with funding from AIRDC and Association of Insurance Supervisory Authorities of Developing Countries (AISADC.) But this effort ran into format compatibility problems and so the XIVth ICDC in Delhi adopted a resolution to standardise the formats and make this a project of all the member countries.

National catastrophe insurance needed

Coping with the disastrous effects of catastrophes is a serious problem of countires all over the world, but more so in develoonig countries which are prone to natural disasters and who can ill-afford to pay for the costs.

The papers on this subject that were read in the XIVth ICDC gave recommendations for modeling catastrophic risks and designing the needed national catastrophic insurance schemes. The recommendations in the World Bank paper fit together with the planned initiatives for capacity build-up and regional cooperation.

The resolution was that the national and regional groups study their particular situations and explore the possibility of adopting the recommendations in the paper.

Harmonising regulations

Globalisation requires harmonised insurance regulatory standards. Since the ultimate aim of all insurance regulation is to protect the interests of the policyholder, the AIRDC and AISADC resolved to work together for this purpose by initiating a joint forum, recognising that they are in a unique position to help harmonise regulatory standards at least for the countries under their umbrella.

Dr. (Chief) O.A. Bailey, Commissioner of Insurance, Nigeria and outgoing President of AIRDC and AISADC handing over Presidentship of AISADC to Mr. C.S. Rao, Chairman, IRDA, for 2004 to 2006.

Changing Needs

- Customer Behaviour in Insurance Buying

R. Krishnamurthy

Challenges for New Age Companies

While explaining risk perceptions, Donald Rumsfeld, US Defense Secretary, made a characteristic statement recently: "There are known knowns; these are things we know we know. We also know there are known unknowns, that is to say we know there are some things we do not know. But there are also unknown unknowns – the ones we don't know we don't know."

In insurance buying, most customers would probably describe their level of understanding of insurance contracts in the above manner. Customers know generally what a policy covers; they also know that there are several fine prints in insurance contracts, which they do not know, or perhaps care to know, at the time of buying. And they also seem to generally conclude that when it comes to making a claim under an insurance policy, there could be several issues of which they are just unaware at the time of buying the policy in the first place.

Changing consumer expectations

A remarkable trend in the insurance industry in the last three years is the rapid change in the knowledge level as well as expectations of the customers. A study conducted last year by *Forte*, a collaborative effort between FICCI and ING Vysya Insurance Co. about the consumer behaviour in the pre- and post-liberalisation days of the industry had revealed stunning changes in consumer expectations.

It looks as though the docile, uninformed, insurance consumer has suddenly been transformed into an aggressive and highly demanding species.

While the fresh air of competition in every sector of the economy brings in major changes in consumer expectations (witness the sea change in the attitude of automobile buyers in India in the last five years), the insurance industry has witnessed a few unique aspects, such as regulation-inspired efforts to educate insurance buyers, and a vast change in the skills and capabilities of the intermediaries involved in distribution.

Key motivating factors for buying insurance

In respect of life insurance, potential buyers are driven to buying a policy for one or more of three major reasons: security of the money invested, saving for one or more specific purposes, and the availability of tax benefit. Customers are increasingly known to place less reliance on the tax benefit factor, and stress more on the security aspect and the end-use objective.

The challenge of the insurance companies is to address the motivating factors imaginatively and come up with genuine solutions. Take for example, the consumer's objective of taking a policy to save money for higher education of a child. This has been a driving force in the sale of new insurance contracts in several other countries too, notably in Asia.

> It is time the Regulator seriously considered the customer expectations of differential premium rates for the same policy bought through different channels, and allowed the practice.

A potential buyer primarily expects that the saving should be a painless process and that the money saved should be absolutely safe. The challenge is to provide not only convenient payment options, but also mechanisms that could offer some measure of protection and relief to the customer if he is forced to disrupt the payment arrangement for unforeseen reasons.

On the issue of the consumers' perception of security of the money invested, there are two important aspects. One is how the features of the insurance contract are put across to the buyer (whether it is a unit-linked policy or endowment oriented). The second is how to address more effectively the question about the dependability of the new generation companies that potential new insurance buyers raise during sales calls especially outside metros and in small towns (referred to in publicity jargon as buyers in the SEC B and C categories).

Both insurance companies and the Regulator need to address this behavioural challenge more actively.

Consumers' experience with the agents and other intermediaries

There has been a vast change in the approach of the insurance agent from the pre-liberalisation days. While the agent in the past established informal contacts with potential buyers and often depended on referrals from friends and family members, the new age companies insist on a professional, and often aggressive stance on the part of the sales staff.

Customer expectations in this regard revolve around two key aspects: first, whether the customer is getting truthful advice from the agent, or if he is pushing a product that yields him the highest commission rate. Invariably, the customers today expect the insurance agent (and other intermediaries such as the bancassurance sales staff) to

provide a ready comparison of competitors' products and how the product the agent is suggesting is superior to the others.

How far is the need-based analysis of insurance requirement, that the new age sales staff are trained to offer, found to be relevant and useful to potential insurance buyers? The answer varies from the metro cities and small towns.

Thanks to the general publicity given by new insurance companies about the protection aspect of insurance, customers in major cities have come to appreciate the need for higher level of insurance cover with reference to their earning stage in working life.

However outside metro cities, customers tend to take a clear view that saving-oriented policies are more needed. There is also marked reluctance to disclose the true personal financial status and the corresponding insurance needs to insurance salespersons.

The second aspect of customers' perception about the new generation of insurance agents is the level of continuing commitment of the agent to arrange post-sale service. Potential insurance buyers are unsure that they would continue to deal with the same agent who sold the policy throughout the term. They would tend to place more reliance on the company's general promises of service and commitment.

This is an important message for the insurance companies. As insurance customers increasingly make arrangements to pay periodical premiums directly through the electronic medium, or though automatic transfers from their bank accounts, thereby bypassing the need for regular post-sale service by the agents, customers would tend to place more reliance on the direct standard of service from the company concerned. Instances of customers requiring agents to arrange for loans against their policies, or change nominations etc. are rare. Therefore companies need to gear themselves to provide high service standards directly.

Premium shopping

Is pricing, or the premium rate for a policy, a deciding factor for buying insurance? It is indeed so in a price-sensitive market such as ours. In several forums, customers have voiced the general feeling that as insurance products become more complex, and they get bundled with several riders, it is becoming impossible to make price comparisons between different companies.

An increasingly larger segment of customers now questions why the premium rate should be the same for a policy if bought direct from the company over Internet, or through a channel considered simpler, such as the bancassurance channel. There is logic in the insurance companies passing on the cost saving to customers in such cases.

It is time the Regulator seriously considered the customer expectations of differential premium rates for the same policy bought through different channels and allowed the practice. For example, it is common for banks abroad to offer a higher interest rate to exclusive Internet clients. It should therefore be conceivable to offer premium rebate to insurance buyers who consciously decide to approach the company directly for buying a policy (after presumably taking the trouble of educating themselves about the product features and other aspects), and choose to deal with the company directly for future servicing needs.

> New age insurance companies should become 'kinetic' enterprises, which can take advantage of unpredictable customer demands and unexpected market events immediately.

Incidentally, a recent study of new age consumer behaviour published by two researchers in the *Harvard Business Review* (July 2002) debunks the customer loyalty factor, long stressed in marketing literature. The authors conclude that long-standing customers do not pay more for the same products, nor do these customers cost less to service.

High expectations on claim servicing

One aspect of customer service from new age insurance companies that remains to be tested widely is the claim payment record. While consumers seem to be satisfied that the survival benefits under a life insurance policy would get paid rather promptly from the tech-savvy new companies, obviating the need for interlocution by the insurance agent, insurance buyers are not yet convinced about hassle-free payment in the event of a claim, whether under a life policy or a general insurance policy. This is especially so in respect of rider benefits such as critical illness or hospitalisation benefits.

The level of consumer skepticism on claim payment is markedly high in respect of non-life insurance products, such as Householders' Package or Mediclaim policies. There is considerable work to be done to boost the level of confidence both by insurance companies and the Regulator.

In their book *Corporate Kinetics*, Michael Fredette and Steve Michaud describe that the speed of change in customer requirements and market dynamics far outpace the ability of most companies to plan ahead. By the time a company completes the development of a strategy and makes investments to pursue the strategy, the opportunity often ceases to exist.

It is therefore important that the new age insurance companies become 'kinetic' enterprises, which can take advantage of unpredictable customer demands and unexpected market events immediately. This is vastly relevant for the Indian market where the insurance consumers are rapidly coming of age.

The author is retired Managing Director and CEO of SBI Life Insurance Company. He can be reached at r.krishna@bom4.vsnl.net.in

Staying Ahead

Stuart Purdy

Four years back when Aviva offered me a position in India, I accepted it without even a second thought. For me it was a challenge to head operations in a country as big and as complex as Western Europe. We launched our operations in June 2002. Over the last two years I have seen the market grow at an exponential pace. I feel that the pace of growth has been partly led by the customer himself who for the first time has been exposed to a wide choice of insurance products and services in the market.

"*Customer Centricity*" is an idiom strongly entrenched in Aviva. This is not merely a mission statement on paper. It is a principle that has percolated across different functional teams and is also a part of the yearly Performance Contract filled up by all the employees.

During my meetings with the customer services team, I particularly like to hear the queries and feedback of our customers both pre as well as post-sales.

A few years back, for customers looking at insuring themselves, there was only one option to consider. Expectations were limited to the financial security of their money, the product range was fixed and customer service revolved around their respective agents.

The situation is very different today. With a wider choice, the customer today is not only demanding but is also more aware and knowledgeable about the product details. Transparency is a key theme in our product innovation.

One day I decided to visit our centralised call centre based on the eighth floor of our building to listen to some of the calls being answered. The queries that I heard opened me up to the psyche of the Indian customer as well as the huge potential of the market.

There was a customer who called from Coimbatore, asking about our latest NAV figures! Here is a customer who is keen to track his returns and is also knowledgeable about the details of his product. There was another one who called to know additional details about our fund value.

This made me feel that earlier the customer had one interface for all his queries and feedback on insurance – the insurance agent. Now, he can not only look at a choice of products from 12 different companies but can also look at another point of contact to air his comments and his queries.

I spoke about this to my customer services team. Though they agreed with me, they still felt that the customer continued to look for a 'personal touch.' Even if the customer received additional details about the product from the customer care service or through brochures and other collaterals, he would still in the end like to verify them with his agent. With the growth of private life insurance, the products introduced in the market are also getting more sophisticated. The customer is trying to keep pace with understanding the intricacies of his policy. However he still has a long way to go and that is where the dependency on the agent is still quite strong.

What stuck me most during my trip to the call centre was the insistence of the customer to solve his query on an immediate basis. This was in sharp contrast to the earlier days when the customer was used to his agent getting back to him after a few weeks. He has now started looking at insurance as any other financial service, expecting high standards of customer care.

I started my career as an insurance agent. The days that I spent interacting with the customer helped me perceive his needs and act accordingly.

My sales team has also been giving me feedback about the way the behaviour of the customer has changed over the last few years. Earlier the customer looked at insurance as a tax saving product. Now the customer has started looking at it as a key investment tool and asks queries related to illustrations and the different benefits accrued from the wide choice of products.

Aviva on its part has introduced some key initiatives for its customers. One of them is the "Financial Health Check", which is a complimentary service administered by our expert Financial Planning Advisers (FPAs). The Financial Health Check is a need based analysis of the customer's long-term savings and insurance needs. Depending on your life stage and earnings, the Financial Health Check assesses and recommends the right insurance product for you. We always advise our customers to go through a Financial Health Check before deciding on their investments. The other is the SMS service which informs the customer about the policy enforcement, premium due date, policy lapse, additional single premium as well as indexation.

We have invested in a sophisticated information technology system to ensure the online availability of customer records. A customer can call from any part of the country and the customer care executive has his records in front of him. This not only makes the customer comfortable with the company but also expedites the solution of the problem.

The insurance industry has one of the best regulators in the country today. The IRDA has been able to regulate the companies appropriately while ensuring the development of the market.

The Regulator's recent initiative of introducing a code of conduct for life insurers on the correct illustration of their products is strongly customer focused.

Some companies were showing illustrations with returns far in excess of what can be achieved in the long run. Further they were also not differentiating between guaranteed and non-guaranteed benefits.

From April 1, this will stop and all companies will have to show illustrations with two scenarios: low return and high return. At the moment the rates fixed are six per cent and 10 per cent but companies can show illustrations with less than six per cent also. Another benefit is that customers can more easily compare policies of different companies on a like to like basis, as the rate of return assumed will be the same.

I started my career as an insurance agent. The days that I spent interacting with the customer helped me perceive his needs and act accordingly. In India the customer has started tasting the fruits of a competitive market. He will now be more demanding and will start educating himself about the intricacies of an insurance product. That's a challenge that the insurers need to rise up to.

The author is Managing Director, Aviva Life Insurance Company.

Anytime, Anywhere...

Chirag Jain

Businesses are being exposed to progressively higher levels of uncertainties. This has driven up the cost of doing business on many fronts. One of the most important elements of this cost is the cost of risk management.

Businesses have always faced a multitude of risks and have been using various tools for minimising it. But in the last couple of decades, a plethora of natural and man-made events have resulted in organisations looking at risk management tools with renewed interest. As insurance is the key technique for mitigating operating risks, it has ceased to be a backroom finance focus and is a matter of strategic management in the boardrooms nowadays.

Obviously the customer today is very demanding and is eager to learn about risk management. Many CEOs are taking direct interest in risk management for their organisations and are participating in formulating risk strategies.

Many corporates and large groups have been making efforts to acquire expertise in risk management and have sought help from insurance companies on a range of activities starting with basic awareness workshops to more detailed risk assessment programmes.

We have been involved in many such programmes and it was very heartening to see a high level of interest coupled with increasing focus. Further, there is a clear expectation of a partnership approach from insurance companies, and corporates expect an insurance company to add value in forging risk solutions by:

◆ *Dimensioning the needs* – Indian corporates are being exposed to many risks due to their efforts to globalise their business. As these risks are very new to them, they have sought the help of insurance companies to understand them. For example, many companies are re-examining the efficacy of traditional liability covers for their risk needs.

◆ *Advising on the possible set of solutions* – Customers are expecting insurers to provide an array of risk transfer mechanisms and not just an insurance policy.

◆ *Evaluation and strategic advice on suitability of solutions* – Corporates want insurers to help them carry out risk analysis to arrive at a tolerable risk scenario. Insurers are supposed to assist in arriving at risk perception through analysis of industry trends.

◆ *Linking risk management to corporate objectives* – Corporates have recognised that efficient risk management can be a competitive advantage and is also critical for business continuity planning in cases of disasters.

As all businesses are fine-tuning their logistics and optimising use of capital, they are expecting insurance companies to deliver solutions which are aligned with their needs on a real time basis.

◆ *Developing a solution tailored to look after their needs* – While interacting with certain customers we realised that we needed to provide a specialised cover to deal with weather risks. We also realised that there are no prior experiences available to guide us for this cover and were amazed as to how a simple customer can have such a complex need.

As all businesses are fine-tuning their logistics and optimising use of capital, they are expecting insurance companies to deliver solutions which are aligned with their needs on a real time basis. Insurance companies are being expected to use technology innovatively to deliver cost effective and flexible insurance solutions. While we have delivered many generic and customised technology driven policy issuance and servicing solutions to our customers and intermediaries, there are some areas of bottlenecks.

The general insurance industry is facing a scenario where distribution of most retail products is economically unviable. Our experiences have revealed that there is a good market for the retail products, which is inaccessible due to distribution constraints. By growing the e-insurance market, regulators can bring about a paradigm shift in the way insurance distribution takes place at present and can help the industry grow at a much faster pace.

The tailoring of optimal solutions is a very key expectation and is being provided in most of the special contingency covers. In addition, there is expectation of detariffing which will enable customisation and risk based pricing for customer.

Customers are clearly expecting insurers to understand their business, their core strengths, their vulnerabilities and new opportunities and to provide solutions that address their needs anytime, anywhere.

We, the insurers, have to look at our customers very differently and go beyond the expected.

The author is the Operations Head at ICICI Lombard General Insurance Company looking after Underwriting Operations, Customer Service and Quality.

Liberalised Customers!

- A Challenge for Insurers

G.V. Rao

Liberalisation and customer dominance

Liberalisation of the insurance sector has facilitated entry of more players of diverse complexion including those from the private sector with a foreign pedigree for selling insurance products. The injection of additional distributor channels has added to the flavour of more competition. Customers now have a wider choice of selection of insurance providers giving them a voice and a unique identity long denied to them.

The customers of today, armed with cell phones, laptops, money in their pockets and a driving ambition to succeed in their respective professions, want quality insurance products of more value at lower cost and guaranteed to perform as understood by them. They care less for and are even contemptuous of insurers having complex, problematic and fatiguing procedures of transactions either in organising covers or in settlement of claims.

Customers want insurers to perform keeping their needs and requirements as the primary purpose of their business rather than the control mechanisms that benefit the insurers' shareholders and managements. Time spent with insurers and their fragmented departments based on functions and products are regarded as the additional costs and inconveniences of doing business with them.

Customer Economy

From a monopolistic provider's economy, the balance has suddenly swung in favour of a customer economy with more competitors pursuing the same set of customers putting the latter in drivers' seats. Insurers have now become supplicants for scarce buyers forcing them to choose between enhancing customer value and shareholder value as a corporate strategy. Anticipating customers' needs and delivering on promises made in contracts and with a human face has become the basis of delivering customer value. Are insurers ready to face the new challenges of the customer economy?

With tariffs making insurance products seem like commodities and with competition ever sharp with no differentiation among the providers, customers have realised that in the power game of insurance transactions they now have the upper hand. The developments in communication and information technology, the use of Internet for information exchange, globalisation and liberalisation of the financial sector have changed customer profiles beyond recognition making the self-serving insurance regimes run for cover to retain their premiums.

Are the insurers, ever slow- footed, so shell-shocked that they are unable to understand and adapt to the new customer demands for services and products made on them? Do they understand how their customers' buying preferences and service attitudes have changed while the insurers have remained either immobile or have become poorer in their business strategies, work practices and management and employee attitudes? Customer economy has changed the rules of how the insurance game is played.

> Ask your customers how your services are perceived by them. They will tell you what is wrong with you. Reform continually to stay ahead.

What do customers want?

Customers of today are better educated, better informed, more discriminating, more sophisticated and are more individualistic. What they value in an insurance transaction has dramatically changed. They have an aggressive competitive outlook and have more choice of providers. They value their time. The speed of response, reliability of insurance products, transparency and fairness of the provider are more valued. They look to their convenience and want insurers to perform for their benefit.

Customers increasingly are resorting to a management-based approach to buying insurance. They attach more significance to the spectrum of insurance coverage they buy and their relative costs. They are eager to learn more of how their insurances are structured and the cost-benefit aspects of insurance purchases. Negotiation and evaluation of insurers' presentations are done on a team-based approach. They understand better the legal principles on which insurance purchases are based and are keen to press for their contractual rights. They are better aware of the avenues available to them to get their complaints resolved and know how to pressurise insurers to perform.

This article seeks to highlight a few areas of transformation of the customer profiles that has put a challenging strain on the service and selling capabilities of insurers and for which they have yet to find solutions that can work for them. Insurers in the public and private sectors must revisit their structure, systems and attitudes if they want to survive at the market place that is full of bargain, challenges and deal cutting.

Customers are better educated

The customers of today know quite a good deal more about insurance, their risk exposures, insurance pricing and claims settlement. They have access to consultants, brokers and other intermediaries to learn from. They are more commercial minded and understand what they have bought more clearly and are aware of their contractual rights. They are fussy and do not hesitate to complain about shoddy service or advice if they feel they have been short charged.

Customers have begun to put more value on convenience and on speedier disposal of problems. Time and saving on it for other personal works has become a primary item of value. What a customer values has changed and that is convenience and time over cost and transparency in transactions over rigidity and surprise in negotiations.

Customers are more discriminating

Given a wide choice of availability of insurance providers, customers are

discriminating in their selection of the insurer. They look at price, coverage and track record of insurers and their reputation and informality in business dealings before they make up their minds. They are less relationship oriented and more commercial minded. They drive hard bargains, are better informed and are skilful negotiators as befits their trained commercial instincts. They want to deal with people whom they know for their business transactions rather than interact with several different departments with differing perceptions that makes doing business with insurers more taxing. They demand a seamless customer experience across all interactions.

Customers have personalities and working styles!

Insurance is required to be sold to the public and private sector corporations, small and medium enterprises and individuals in urban and rural areas and through a variety of distribution channels. Customer characteristics of each of these categories are different. A single marketing customer approach, as is now commonly practiced, would not work.

Marketing and service operations need to be segmented by the characteristics and needs of each of these groups, and their requirements have to be handled in different ways. Such operations have to focus on making customers want to do business with the company by delivering satisfaction. Are insurers now structured for doing business keeping customer in focus?

It must be remembered that it is the individual employees that deliver all customer service needs. What are their present attitudes towards customers? Who needs whom in the present market context?

Customers and work practices – a few experiences

Customers expect that the structures, systems and work procedures of insurers have been designed to serve them. There is consternation, therefore, when they discover that the organisation is inward looking and is more concerned with deriving benefits only to itself. A customer, it would appear, is incidental to the business transaction and is not the primary purpose.

I had the experience of frequently travelling on British Airways (BA), then making losses in the early eighties, when it treated passengers, from third world countries in particular, as unwanted baggage in their aircraft. Yet, I was surprised to find the same BA treating me royally, five years later, in not only providing additional customer services but with a noticeable change in employee attitudes that my patronage did matter to BA.

By then BA had become the world's favorite airline and earning huge revenues. See, what upgrading customer services through an employee attitudinal change can make to the bottom line of a provider!

The ruling class culture had changed to a serving class culture. There was a newfound respect for the passenger.

> Insurance is a mind game and exercising imagination to scale new heights in customer service is a must.

The process was not easy as all BA employees were put through of customer-orientation training telling them how they should behave and empowering the front-line employees to take decisions in 'moments of truth' as customer interactions are called.

It must also be admitted that occasionally customers too treat service providers rather boorishly. Customers could be loud, uncouth and needlessly aggressive in their transactions with service providers, as they sometimes wrongly believe that service providers here are capable of short charging them given an opportunity.

Customers too should know how to handle a service provider to get better service. The responsibility, however, is more

on the service provider to manage the behaviour of a variety of customer personalities. Insurers' staff should be specially trained in handling customer relations.

Insurers and their customers

Insurers unfortunately have an even more difficult task on their hands in matters of earning customer trust and delivering on service. Their regular customers, targeted by competitors, have to be resold on their coverages annually and insurers have to earn their reputations every year by being the best service providers their customers have experienced by ensuring they have delivered on their promises in a fair and equitable manner. Customers are the arbiters. How does one build such good reputation?

Claims' settlement is always a contentious issue, and tact and diplomacy on the part of employees in dealing with customers matter most. Contract language of policies are subject to interpretation and both skill and knowledge are required, particularly when a customer has to be let down.

Communication skills and anticipating how issues could shape up are special skills of insurers' employees. Speed of response and ensuring that promises made are kept up has more value in insurance as large monies are usually involved. Insurers' have a poor image and this does not need any

Create the System...

...and Go Beyond it!

Shivaji Dam

more reinforcement by their slipping up on these basic premises.

What insurers should do

Customer issues are increasingly getting to the fore dictating either growth or survival as the only alternatives for insurers. What are they doing now? What should they be really doing?

Segment customers on profitability as a criterion by building customer profiles. Give those that contribute most specialised services. Get rid of consistent loss making customers that are a drag. Reorganise structures to get closer to customers and build intimacy. Reorient work procedures through automation to improve speed of response to customers' articulated and unarticulated needs. Give them seamless service and do not fragment services for your convenience. Raise work productivity and innovate new ways of doing current work. Train and retrain employees and change their attitudinal mindset towards customers. You are in business only to acquire and retain customers. Ask your customers how your services are perceived by them. They will tell you what is wrong with you. Face the moments of truth and do not shy away. Reform continually to stay ahead.

Insurers must want to improve on the customer value they are currently providing and differentiate, as BA did, on customer perception as the basis of growth and profitability. Insurance is a mind game and exercising imagination to scale new heights in customer service is a must. Remember customers are constantly learning 0and changing in their needs, demands and the outcomes they desire of how their problems should be resolved. Are insurers listening with their minds and hearts open in their own interests?

The author is retired CMD, The Oriental Insurance Company.

After waiting at the bank for almost an hour, you are finally able withdraw cash. This is something that most of you have often experienced during the 90s. However, today things are quite different. With an ATM at every corner, you have the convenience of withdrawing cash or getting a statement of your account within a few minutes.

Getting a draft made was not easy either. You would have to visit the bank, fill in an application for the draft and then come again in the evening to collect the draft. But now a cheque payable at par serves the purpose without the hassle of visiting the bank.

These are just examples of the changes that have been brought about by a revolution in the banking sector. Drawing a parallel from this industry, the insurance sector can also be expected to move on the same lines.

Creating a robust system of procedures and standards is the first step to providing continued customer delight and loyalty.

A trait that is unique to the insurance business is that the customer trusts the company with his hard-earned savings for a period, anywhere between five to 30 years. In such a scenario it is a challenge for the company to live up to this commitment.

It requires all levels of the organisation, especially top management, to be involved and direct efforts towards this end. Though it requires an initial investment in time, resources and technology, creating a robust system of procedures and standards is the first step to providing continued customer delight and loyalty.

The key issues on customer service in the insurance industry are:

- Speedy documentation and processes at the time of issue of policies
- Easy and simple procedures for medical underwriting
- Quick response to any changes related to the customer's policy namely, change of name, contact details, assignment of policy or term reduction
- Prompt redressal of customer grievances
- Offer to upgrade the policy and provide flexibility to the customers
- Provide updates on the company's performance
- Inform the customer on a regular basis on the status of his account

With a view to providing better services, insurance firms have been tactically adopting customer relationship management (CRM) applications. They have started with basic operational systems to integrate customer information from multiple channels and sales force automation. Technologies such as contact centre segmentation and campaign management tools are maturing and finding wider adoption with a number of insurance companies.

The areas of interface between the customer and the company are important from customer service point of view.

Life Advisors

In most cases, the first point of contact for a customer is the life advisor. He is equipped to advise the customer by understanding his requirements and doing a need analysis. He recommends products that suit the customer's profile and his unique needs.

The advisor's role does not end with the selling of a policy but continues over the term of the policy. He is expected to be in touch with the policyholder at regular intervals giving information on the policy status and any other new developments that may have taken place.

The profile of a life advisor is on the still on a learning curve and there are areas in which he can specialise to provide advise in a proper manner. OM Kotak Mahindra is continuously investing to offer such services and training its life advisors.

Purchase of a policy

Customer service is of any relevance and importance only if measured with respect to the speed at which they operate.

Proposals – medical check –up

Customers may have to undergo a medical check-up before the policy is issued to him. Medical centres and doctors may not be fully sensitive to the needs of the customer. Though the medical procedure is not within the jurisdiction of the insurance company, special efforts are made to educate and train the medical centre to address the requirements of the customer.

Generally, the tests require a fasting blood test and post lunch blood test to be done. To avoid inconvenience to the customer, OM Kotak Mahindra has arranged for both the tests to be completed with one visit. Such initiatives have been undertaken to ensure a comfortable and pleasant experience for customer

Issue of policies

It is important for customers to get their policies quickly and insurance companies are laying down service standards for this purpose. At OM Kotak Mahindra, policies not requiring medicals and which have no additional requirements can be issued within 10 days.

We have also undertaken the Total Quality Management programs, which measures the 3 Sigma of the turnaround of proposals and attempts to reduce the time taken, errors and rework on proposals.

At times there are delays in issue of policies due to loading or incomplete details in the proposal form. To plug this, life advisors are trained on a regular basis to ensure that all the details are filled in correctly and all relevant documents are attached.

Post sales services

Redressal of customer grievances and answering of queries require information technology support. Queries could relate to:

- Minor changes in name or contact details,
- Correction or change in nominee name,
- Reduction or change in term of policy or
- Assignment of the policy.

Insurance companies are building up capabilities to address the same. At OM Kotak, a policy servicing request from a customer is generally responded to within a span of five days. All service requests and queries are logged on to the customer service software which escalates the issues to the next level once the service standard time is not adhered to.

As greater complexity of products and transactions emerge, the level of sophistication that the customer will demand will increase.

Claims

At the time of settling a claim, it is important to get all the documents required. The Life Advisor or office staff would approach the family and assist them with the procedure to ensure prompt and a hassle free experience since inadequate documents could lead to a delay in settling the claim.

Other points for customer contact

Any person who wishes to reach the company for any details can leave a message either on the website or can speak with the customer service executive at the toll free number. Any queries/ leads / complaints generated at these contact points are addressed by the next workingday.

Complaints from customers which are received on the website are in turn passed on to the customer care division for quick redressal.

The future

We can expect a further improvement in the customer service levels with :

- Electronic submission of proposal forms
- Electronic transfer of medical data
- Automatic underwriting to reduce time taken
- Direct debits/ electronic payment of premiums
- Easy withdrawal facilities
- Regular updates on the policy status
- Ability of the customer to procure data from the company website
  - Premium calculation
  - Proposal tracking
  - Daily NAV
  - Switch funds
  - Stock market alerts and recommendations

To summarise, I would like to say that customer service is one of the key drivers in this business. As the business volumes increase and greater complexity of products and transactions emerge, the level of sophistication that the customer will demand will increase. We have put in our building blocks and customer service is the path we need to follow to bring about customer delight.

The author is Managing Director, OM Kotak Mahindra Life Insurance Company

Quality Interaction

Antony Jacob

The Indian insurance industry has understood that customer satisfaction is the direct route to enhancing business performance and sustaining growth. Across the industry, a concerted focus on customers has seen service delivery evolve as a core platform for achieving sustainable competitive advantage. Service plays a critical role – if not *the* critical role – in retaining customers, and customer satisfaction is the ultimate differentiator in financial services business.

Research shows that retaining customers is a far more profitable strategy than gaining market share or reducing costs. A *Harvard Business Review* article says that companies can boost profits by almost 100 per cent by retaining just five per cent more customers.

Managing customer relationships has now become a key strategy for businesses in the financial services sector. This trend is now prevalent in the Indian insurance industry, with competition providing the customer better products, services and expectations. These expectations include faster, better, service in the face of rising loss costs and increasing price competition.

Customers expect to be able to reach their insurance company at any time, by whatever means they choose: by phone, online or face-to-face. Customers expect complete, consistent and accurate answers to all of their questions, whether they are enquiring about the status of a claim or the cost of a new policy.

Customers – whether customers are defined as agents, brokers, group benefits managers or individual policyholders – have high expectations that their insurers will help them manage their risks and be there for them whenever needed. They expect quality service in each and, every interaction they have with their insurer.

To build loyalty, customer service must be consistently excellent and exceed customer expectations. Whilst customer retention and loyalty is built upon a complex combination of product delivery, pricing, and the market environment, customer service does play a huge role in deciding whether a customer remains with an insurer or not. Service excellence is increasingly the most important way of creating distinctive competencies in our business model.

Royal Sundaram's prime area of focus is excellent customer service backed by first-class technology. To reiterate the significance of excelling in customer service to remain competitive, Royal Sundaram has designated 2004-05 as the 'Year of the Customer.'

> Globally, many insurers are adopting a customer focus more than a product focus, as superior service quality provides a competitive edge.

We have over 5,00,000 satisfied customers and this is testimony to the success of our providing insurance solutions and services through multiple distribution channels such as brokers, agents, distribution partners and our joint venture partner, Sundaram Finance, to reach the consumer the way he or she chooses and to deal with them fairly – and promptly. We constantly develop and leverage technology and valuable information to improve the service we deliver to our customers and thereby *add value* to their relationship with us.

The Indian insurance industry is beginning to realise the importance of building excellent customer experience. Globally, many insurers are adopting a customer focus more than a product focus, as superior service quality provides a competitive edge.

The competitive environment drives insurers to focus on improved profitability and increased customer retention. Both these factors depend greatly on the experience the customer has with the insurance company.

We believe that achieving increased customer retention requires improved performance by all our employees, and not only those who hold primary responsibility for the customer experience. Lack of product knowledge, limited ability to handle calls and high turnover are some factors that pose a serious threat to the insurer's success at building profitable relationships.

To adequately handle this situation, Royal Sundaram has launched a new Customer Management System to track customer interactions and achieve a steep improvement in customer service.

A front-end system known as CIMS (Customer Interaction Management System) has been developed to assure that service levels to Royal Sundaram's customers are 'best in class.' Excellence in customer service delivery has been identified by the company as an integral component in the achievement of sustainable competitive advantage.

Given that we already operate across 26 cities in India, it is essential for the call centres and regions/ branches to track customer queries through a workflow and process solution. Apart from tracking individual interactions, the system enables the call agent to respond efficiently to the customer and begin a process of cross-selling and up-selling. I believe this is unique and ground breaking within the Indian insurance market.

We at Royal Sundaram have realised that customer loyalty can be best achieved by streamlining the custom interaction processes within the company. It is important that insurers adopt technologically driven initiatives to achieve customer service excellence. Customer retention and development results in improved profitability and provides quality time and energy to devise strategies to acquire even more new customers – this is the ultimate win-win situation.

The author is Managing Director, Royal Sundaram Alliance Insurance Company.

Always Wanting More!

Abhijeet Chatterjee

The essential objective behind the liberalisation of the insurance sector in India was to improve the service and choice that was available to the consumer.

It has been a little over three years now, and the consumer today is definitely on top. The insurance market has transformed from a seller's market to a buyer's market. The multitude of products being offered by the 14 life insurance and 13 non–life players has not only given the consumer greater choice, but has also resulted in a sharp rise in customer expectations over the last three years.

Customers, faced with an array of insurance products now expect faster delivery of their policies, individual attention, customised offerings, ease of access to information about their policies, multiple payment mechanisms, quick responsiveness to their queries and so on. Moreover, the customer is demanding these services at no additional cost.

How are insurance companies coping?

In an environment where client attrition is one of the primary constraints to growth in the financial services sector, and where individual products are easily replicated, it is the standard of service that is the key differentiator amongst the various service providers. Thus, it has become imperative for insurance companies to continuously re-design products and services to meet the growing customer expectations.

The insurance industry in India today is clearly moving away from selling a broad range of products to a large volume of customers in a 'one-size-fits-all' manner. Instead of focusing on different product lines as silos (i.e., Life, Property and Casualty etc.) insurers are looking for ways to offer highly targeted insurance products that are tailormade to the individual customer with the highest propensity to buy them. Insurers are also designing channel specific products catering to focused segments of customers.

Undeniably, in today's context the majority of sales in insurance is driven through the agency force. An agent is largely responsible for the first informed impression that a client forms about an insurance company. There is an old adage – "the first impression is the last impression". While, all of us would not subscribe to this, as I certainly do not, it is well known and accepted that a highly trained and productive agency force is a necessary (although not sufficient) condition for providing the right level of service to the customer. Against the above backdrop, insurers today have put in place rigorous training programmes for their agents, most of them exceeding the 100 hours mandatory training prescribed by the IRDA.

> The increased customer expectation that we are talking about has occurred amongst a miniscule part of the population.

One critical area where consumers have benefited tremendously since the opening up of the insurance sector relates to the time taken for the settlement of claims. Today, the average period within which a claim is settled has come down from between 50 to 60 days to 10 to 15 days. Customers have also benefited from the greater degree of clarity and transparency in the documentation for the insurance policies.

In order to be able to track the changing preferences and tastes of consumers, most insurance companies in India are adopting advanced CRM tools that are helping them to monitor customer behaviour. These CRM tools allow the companies to obtain details about their customers, and design better products, improve service levels and reduce operational costs.

The Role of Regulations

The path that future regulations in the insurance sector takes will have an important bearing on an insurer's ability to fulfill the rising customer expectations. Three key laws/regulations that need to be changed, in the consumer's interest, are highlighted below.

1) The significant role played by the agency force in the Indian insurance market has already been highlighted above. However the present cap on agent commission rates is severely crippling the insurers ability to attract the right talent into the business. Apart from a few professionals in the field, the majority of the agency forces today are constituted of part-timers.

To enable insurers to recruit fulltime professionals, there is a need to revamp the laws and regulations related to agent compensation under section 40A to 44 of the Insurance Act 1938. Companies need to have the freedom to design compensation plans for agents within a given overall set of guidelines. The poor quality of the agency force is ultimately reflected in the poor service that is received by the consumer.

2) The world over, riders have contributed significantly to the sale of insurance policies and the development of the insurance market. Today in India there exists a 30 per cent cap on riders. In order to enhance the ability of an insurance company to provide customised services to clients there is an urgent need to remove the limitation on the number of new products that can be provided to the customers by removing this cap.

As mentioned, globally, riders have proved to be an effective tool of increasing sale of insurance products. Insurers in India need to be able to adopt the same model as well.

3) The issue of pricing of products, particularly in the general insurance business has been debated for a while now. Tariffs in a liberalised insurance market are an anachronism. Insurers will not be

Bridging the Gap

Ajit Narain

able to pass on the true benefits of liberalisation to the consumer unless there is true competition in the pricing of the all non-life insurance products.

Going forward there are three points of caution that the stakeholders in the insurance industry need to keep in mind.

First, in a country of over a billion people, the increased customer expectation that we are talking about has occurred amongst a miniscule part of the population. There is thus an urgent need to increase the penetration of insurance by effectively targeting the semi-urban and rural parts of the country. The alternate distribution channels, particularly bancassurance and brokers, need to be utilised effectively in doing so.

Second, transparency regarding the disclosure of benefits to policyholders has improved over the last three years, but a lot still remains to be done. In many countries lawsuits from customers related to poor sales practices and lack of disclosures have resulted in significant fines for insurance companies. Steps need to be taken now to avoid similar incidents in India.

Third, and most importantly, the 'increase in customer expectations' is not necessary synonymous with 'increase in customer awareness'. Customer expectations based on misleading information and ignorance can be harmful for the sustainable development of the industry. The industry, along with the other stakeholders in the insurance sector, need to work together in raising the level of awareness amongst people in India.

The author is Executive Officer, Economic Affairs Department, Confederation of Indian Industry.

A customer is a person who initiates and determines the value exchange in a need-delivery-satisfaction-loyalty cycle. When he does so, there are expectations from him which need to be catered to. He expects service, product quality and, in short, return for the money spent. In an emerging insurance market in India, the concept is now developing and the logistics of customer care as in product satisfaction is expected in the financial sector as well.

The developed markets have gone through this initial cycle. This sphere of customer satisfaction, for it is he who drives the market expectations, is what needs to be nurtured. The position changes as do the requirements which are closely linked with the economy of the country. The fast expanding services sector has come to stay and therefore deserves a pivotal role for companies to focus their plans and objectives in line with the customer expectation.

Customer expectations are also closely connected with intermediaries. Their performance becomes equally important.

Gone are the days when an insurance policy was only taken to protect a loan for the house or the liabilities relating to using a motor vehicle (compulsory). Customers now expect a competitive pricing (where there are no tariffs) and a high level of after sales service. Moreover, the awareness for other products like health, travel, liability, credit, etc is fast growing. It is becoming a necessity for the individual and for commercial viability.

A relationship system which bridges expectations with deliverables needs to be the order of the day. This necessitates the company to identify their customers and tailor products and services to his satisfaction. Broadly, it will result in having effective technology based solutions and cultivating a growing database. Every customer requires personalised attention and if a long term relationship is the objective, there is no other way of doing it.

The role of the insurer, therefore, becomes paramount as he spreads into the market. It is not only education of the average man, product design, marketing and IT support. It has to be a planned, phased programme and at the end of the day, economically viable. From an insurance perspective, a company would not like to put all its eggs in one basket. Diversification and spread would happen with improved economic advantages.

Aggression with constraint has to be followed by an insurer. This may sound contradictory. The example hereafter would answer the question.

Leopold Godowsky (son of the late pianist-composer) asked his sister to drive his three-year-old twins to their Westport home. 'By the way,' said Leopold, 'please drive carefully as I have two violins worth fifty thousand dollars in the luggage compartment.'

'Which,' inquired his sister, 'should I watch first, the twins or the fiddles?'

'The twins, of course, of course!' said Godowsky. 'The violins are insured.'

Customer expectations are also closely connected with intermediaries. Their performance becomes equally important. There has to be professionalism and delivery of value added services. The concept of a company handing over its insurance requirements to an intermediary can only happen if the trust develops and that as a corollary is only possible if the broker for instance, has a long term commitment to the market not only as a procurer of business, but also as one technically equipped to service that account.

Financially, it makes sense for both, but practically it has to be demonstrated. Insurers encourage such intermediaries as

-Expectations vs. Deliverables

part of the process of creating bonding and credibility with the client, upgrading service standards and thereby providing customer satisfaction. How successful these channels can become would be the outcome of a sustained committed drive.

Knowing customer satisfaction is not enough: an overall understanding of customers' expectations as compared to that of other companies gives the information real meaning.

To win and retain customers we have to be precise in what we market and what we assure. It is not possible to assess our market position without objectively studying and organising the product and service parameters. If we make promises, we should honour them.

In the Indian scenario, the commercial portfolio is growing. It is getting further impetus with the Governments' plan to liberalise and invite foreign capital. Much has happened but more is expected.

In the retail and rural sector, however, we have a long way to go. What does this mean in terms of objectives? We are a predominantly rural area based economy. To cater to the needs of this section of the society, which is widely spread in a country almost as large as Europe, is not easy. Apart from the fulfillment of the social objective, knowledge and efforts are needed by the insurers and the available channels to project gradually into this sector.

Looking ahead, in this area of operations, where the premiums are low, but the volumes promise to be high, an interlink of products and sales has to be cultivated making it viable for operations. It happens in life that safeguards have to be in place to protect the shareholders' funds and the company at large. Meticulous understanding of the subject is warranted. It sounds simple but in reality, it is a combination of experience through expertise – all driven towards customer delight. Shirley Temple lent her name to a non-alcoholic beverage. When her life was insured with Lloyd's of London, Temple's contract stipulated that no benefits be paid if she met with death or injury while intoxicated. Ironically, she was only seven years old at the time.

The perception of insurance needs to improve. Normally, for historic reasons, the trend was to insure when compulsory or when a problem was expected. That a policy could be a protective instrument that gives you peace of mind are thoughts which are improving with the development of the economy.

Till a few years ago, persons traveling overseas did not envisage the necessity of a medical policy. Now, with the costs of treatment abroad being unaffordable, a traveller does appreciate its necessity. Similarly covering offices and homes for fire and burglary is now being better understood. Selling and marketing in the years to come will have to be a sustained effort. Commitment, consumer demand and reward, database building, market sensitivity, intermediary and company performance are essential parameters that will emerge as part of a company's successful growth.

That a policy could be a protective instrument that gives you peace of mind are thoughts which are improving with the development of the economy.

In an era of development, tracking customer expectations is becoming diverse and demanding. Amongst others, you have to respond to customers needs, pricing and attractive appearance. More so, it must be simple, safe, carry clear instructions, offer good value with exclusions spelt out rather than inclusions. Added features like less warranties and more of guarantees are welcome.

In the same breath the insurer has to be confident that its reinsurance costs are competitive. Very often you cannot dictate an international quote on protections since the credibility of the reinsurer as well as the market experience which determines this aspect. The response, in times of a loss, has to be equally, if not more, efficient as at the time of finalising the sale.

The world of general insurance is vast. Policies can be tailored for cricket matches, events, satellites, body parts, directors' and officers' liability, golf and many more. The broad based factors as explained earlier, of product, service style and price have to be regularly put together.

Although, products and services are necessary for customer loyalty, it is not enough. Customers are often won by defining experiences. This makes them appreciate your product, services and the way of doing business. What delights them is when you explain that the benefit of doubt is always with the client. In an interesting claim, the lady had a fall, and had a hip fracture. When asked by the insurance company to explain a little more of the accident she said "How does it matter to you whether I fell off the bed or slipped in the bathroom?" The moral is that it is good to be inquisitive up to a point otherwise you lose a customer and downgrade your company's image.

With a buoyant and competitive market, it is skills which will be the driver to tracking customer expectations. The companies have to constantly aim towards perfection. Everyone faces the problems and difficulties which emerge from market penetration and combatting them before they affect you is the secret of success. Abbott and Costello, the famous comedy duo, once took out a curious insurance policy with Lloyd's of London. The policy stipulated that $100,000 would be paid in the event that anyone in their audience died... of laughter.

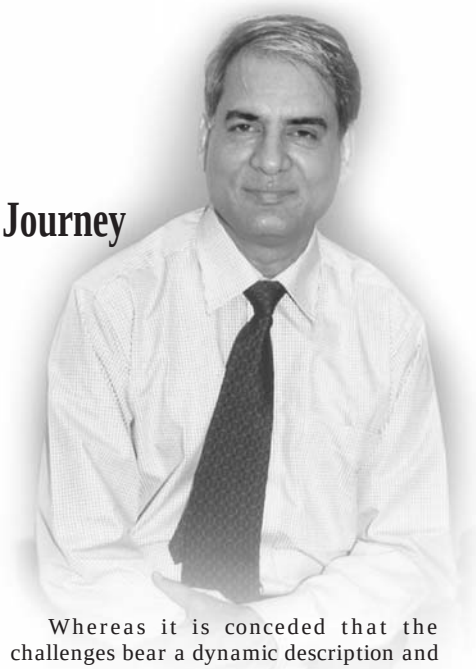
The world marches on and so must you. Work as a team and in the broader interest of the consumer and the company, contribute towards servicing the people. Play the game with zest and challenge and let not anyone say "its not cricket."

The author is CEO and Managing Director, IFFCO-Tokio General Insurance Company.

Roll Up Your Sleeves

- Changing Horizons : A Professional Journey

Arun Agarwal



My professional journey, in insurance, partook of many changes that the global and Indian economy have been subjected to. A realisation that the Customer is the ultimate decision maker has not been a practical concession, but a humbling experience borne out of bewildering changes all around.

Dreaming With BRIC: The Path to 2050

Over the next 50 years, Brazil, Russia, India and China – the BRIC economies – could become a much larger force in the world economy.

If things go right, in less than 40 years, the BRIC economies together could be larger than the G6 in US Dollar terms. By 2025 they could account for over half the size of the G6. Of the current G6, only the US and Japan may be among the six largest economies in US Dollar terms in 2050.

The list of the world's ten largest economies may look quite different in 2050. The largest economies in the world (by GDP) may no longer be the richest (by income per capita), making strategic choices for firms more complex.

The Challenges before the Insurance Industry in India

The insurance industry is a direct descendant of the economic order and its preservation and progression has a direct and proportionate relationship with the levels of growth and sustainability of the economy.

In fact, everything has a life cycle. The universe. The planet. The civilisation. The economies. The companies and the products. The journey of progress is being traversed by the world on the vehicles of various economic orders. But the life of every new economy is becoming shorter and shorter. The agricultural economy's dominance sustained for about ten thousand years: The industrial economy has had a span of only 200 years.

Today what rules the various facets of the environment - social, political and economic – is the Information Economy. Yet, the conclusion of the Information Economy's life span is within viewing distance and a new economy – christened the Bio-economy appears to be emerging and is likely to overshadow the Information Economy during the life time of the new generation.

The economic polity frames have, therefore, necessarily to find linkages with global trends and aim at exploiting the potential thrown up by the new economic order overwhelmed with the information explosion. The underlying thought is that "irrelevance is a greater risk than inefficiency."

The shift in economic policy has been substantial and by and large universal. Currently, the sentiment sweeping across the globe is that of less and less government intervention. Stability and sustainability are perceived to be the fundamental goals of the macro-economic policy. Greater emphasis is being laid on deregulation, competition – internal and external – and more efficacious allocation of resources with a view to enhancing the productive energies. In substance, the focus is on the structure and supply side.

The pragmatic and sagacious managers of the Indian economy, thoughtfully in line with chosen policy prescription, decided to liberalise the industry and open the window to the world to bring choice. The response to

> What's NEW is the buzzword, the rest is imperative and expected.

the initiative of liberalisation of the insurance industry has been spontaneous and universal. Visualising continued high economic growth, low inflation and increasing disposable incomes, greater interest is reflected in the general insurance business with a larger number of companies staking their claim to participating in the process of a unique and universal liberalisation model of India with no limitation on number of operators, geography to operate in, products to market and services to deliver.

The delineated backdrop bespeaks the broad issues connected with deciphering the challenges before the Indian insurance industry. Clearly, the following environmental changes lend flavor to the challenges.

- Liberalisation and globalisation
- Increasing disasters
- Declining interest rates
- Convergence
- Heightened customer expectations

Whereas it is conceded that the challenges bear a dynamic description and emerge as the industry journeys through the phases of evolution, let me venture to list out some of them that appear to be looming large on the horizons of the insurance industry.

A. Risk management

B. Multi-channel distribution network management

C. Customer relationship management

- Product development
- Pricing mechanism
- Technology management
- Fund management
- Knowledge management
- Convergence management
- Stakeholders' conflicts management
- Regulation

D. Corporate governance

The Upshot

Along with the challenges have come expectations: in content, form and delivery: promises are held for accountability, commitments are held for intentions and innovations are held for routineness.

In such a scenario, what we are seeing in our daily lives is a constant phenomenon of 'roll up your sleeves' – 'valuable' customers ask for 'surface contacts' for almost everything – information, advice, changes and improvements where none exist, 'good' customers ask for price advantages all the way, and 'normal' customers ask for attention and solicitation like never before….What's NEW is the buzzword, the rest is imperative and expected.

The author is MD and CEO, Cholamandalam MS General Insurance Company.

Growing With The Customer!

Shikha Sharma

I consider myself fortunate to have participated in the revolution and evolution of the life insurance industry. The last three to four years have been exciting times for us: we have witnessed a sea change in the industry itself, with customers becoming more aware about life insurance, displaying greater willingness to buy it, and thereby demanding much more from a life insurer than ever before. Private players have driven many of these changes, as part of their business strategy in this highly competitive market.

Of course, the biggest beneficiary of the competition amongst life insurers has been the customer. A wide range of products, customer-focused service and professional advice have become the mantras of the industry, with the customer forming the pivot of each company's strategy. It's a task that requires building a 'customer first' mindset across the organisation; at every level, in each person, be it in frontline functions like customer service and sales, or back-office functions like IT, operations or finance.

Today's customer is much more aware about the relevance of life insurance as a protection and financial planning tool, and therefore, more willing to spend some time to understand different products and how they meet his specific needs. Obviously, when he makes this time commitment, he would like advice from someone who understands the issues that impact him and make suitable recommendations.

For a life insurer, this has some clear implications. For instance, they cannot just recruit product-pushing sales people, but must build a team of advisors who go beyond offering only insurance advice to strike a personal relationship with their clients and advise them on their entire portfolio of investments.

Training also becomes of utmost importance, as advisors must understand the role of life insurance in the complete context of financial services, and also possess soft skills such as communication, presentation and time management.

The privatisation of the industry has also introduced new levels of transparency and information sharing, in product as well as in process. This requires the entire company to be aligned with the needs of the customer.

For instance, at ICICI Prudential, our Central Underwriting team often interacts with customers to explain the implications of the findings of their medical tests.

I recall one example when our underwriter was reading the ECG of an applicant and realised that there was a serious problem. Our Chief Medical Officer confirmed that the applicant was suffering from a congenital heart disease, of which he was possibly not aware. The condition was so critical that the applicant required immediate medical attention. The underwriter called up the applicant's doctor and requested him to provide urgent medical assistance to the customer. We subsequently learnt that the applicant had immediately opted for an open-heart surgery, which saved his life.

Once a customer has bought a policy, the next challenge is to provide seamless and efficient service. Here, the challenge for life insurers is even greater, and they've taken a number of steps to make service the differentiating factor, through people and technology. After all, products and processes can be replicated. Multiple service touch points have emerged – call centres, e-mail, facsimile, websites, and of course white mail – which enable customers to get in touch with insurance companies quickly, easily and directly. What's more, the customer controls the process – response time is almost immediate and information is available online.

> It's pivotal to remain in continuous dialogue with the customer. Not just once a year, not just to meet targets.

Each company has taken a different approach to define and respond to changing customer expectations. At ICICI Prudential, we realise that only by building a company that keeps the customer at the centre of all that it does, could we be the frontrunner in this industry.

To this end, we embarked on a Six Sigma journey, and I think it has been one of the most rewarding programmes we have embarked upon. Our approach has been simple – if we wanted to build a customer-centric mindset across the company, we've got to have systems that focus on the customer, and Six Sigma has helped us do just that. Creating multi-functional, multi-location project teams, we have demonstrated to our managers the rewards of focusing on the customer.

Six Sigma has also enabled ICICI Prudential to keep track of and respond to the ever-changing needs and expectations of customers. What kept him happy yesterday might actually upset him next month. That is why it's pivotal to remain in continuous dialogue with the customer. Not just once a year, not just to meet targets, but to ensure that they are actually heard regularly and with the correct intentions – each time, every time.

Once we hear the customer comes the time to embark on the hardest part – actually implementing their feedback. Certainly, there are occasions when we have to reconcile business needs with those of the customer, or completely revamp processes and systems. And others, when the team has to work double-time to resolve seemingly small customer issues. But when I consider all this, it seems completely worthwhile – after all, it is these efforts that have taken ICICI Prudential to its position today.

The author is Managing Director & CEO, ICICI Prudential Life Insurance Company.

With a Capital 'C'

Ian J. Watts

The Consumer is King. Long live the King....

Once upon a time, not so long ago, any offering that was created in 'monopolistic' India was the only option available to the Consumer. He always found himself at the mercy of the seller – be it a manufacturer or a service provider. Thus, the Consumer simply didn't have a say on the quality or the pricing of products and services that were doled out to him.

The insurance sector was no exception to this rule. Take, for example the way insurance was bought and sold till around three years ago. Typically, towards the end of the fiscal year, an advisor would get the Consumer in his 'net' and push across an insurance product by selling him the income-tax tax benefits, sometimes even passing on to him a portion of his commission. The advisor had little concern time or any inclination to see if the policy met the insurance/ savings requirements of the Consumer.

Consequently, more often than not, the insured ended up buying a policy that did not meet his true insurance requirements. The advisor, having met his sales target, also had no concern for rendering post-sales service, thus leaving the Consumer running from pillar to post for issues like premium payments, claims dispute and settlement.

The winds of liberalisation that have been sweeping through every sector in the Indian economy finally arrived in the insurance arena. This has made a significant difference to the Consumer's position in the market. Gone are the days when whatever was doled out to him would be lapped-up for want of choice. Today he has a choice. He has learnt to exercise his choice. He is now both price sensitive and quality conscious. In the present environment, the Consumer clearly is King.

The liberalisation of the Indian insurance industry has put the insurance sector and also the economy on a path of progress. And it couldn't have come at a better time. The increase in contribution of insurance premium from levels of 1.50 to 1.70 per cent in 1998-99 to 2.50 to 2.57 per cent till the end of the financial year 2001-02 as a percentage of the gross domestic product (GDP) confirms that that this sector has been on an impressive growth trajectory.

But it is not just the statistics that have gone-up post liberalisation. The whole approach of buying and selling insurance has undergone a metamorphosis.

The good news is that the level of awareness has increased to such an extent that consumers are looking at the product for the purpose for which it was originally created. For the first time in Indian history, a market that was once unregulated has been reigned in by regulations. The effects of discipline have benefited not just the market players but also consumers with the establishment of best practices.

The whole approach of buying and selling insurance has undergone a metamorphosis.

IRDA is playing a stellar role in regulating and disciplining the market. Offering kickbacks is an offence. Insurance advisors need to undergo a mandatory 100 hours of training, which means that only qualified advisors actually get a license to sell insurance in India. To maintain their license they undergo a further 25 hours every three years.

The insurance players are lending enthusiastic support to the establishment of best practices. Private insurance companies have also taken on the onus of educating the masses. For instance, Tata AIG through its Academy of Excellence and its tie-up with the Association of Financial Planners (AFP) India has created a dedicated programme to train its agents as full-fledged financial advisors. Hence, a Tata AIG financial advisor fully understands the consumers' financial needs, sells him an appropriate product and thereafter services the product to its entire term.

Does this sound a leaf from a textbook? Believe me, these are the changes that we are seeing on the ground, day after day, everyday. Let me give you some examples to elucidate my observations.

Last year, an executive from an MNC company expressed a desire to buy one of our life insurance policies. For this she had to undergo some medical tests. At the eleventh hour, her employers summoned her for an overseas assignment for which she needed to take out an insurance policy. To buy that policy she had to undergo medical tests, the appointment for which was three days hence. Her objective was to get an insurance cover *before* she travelled and also avail the tax rebates for income tax purposes.

The Tata AIG life team went the whole nine yards to bring convenience to her doorstep. We organised the medical tests at her home so that she could buy the policy before she commenced her overseas trip. Further, Tata AIG also delivered a copy of the life insurance premium certificate, on her instructions, to the employer which enabled her to get the entire income tax benefit.

In another example, a management consultant from the 'big-five' MNC management consulting firms wanted to buy our *Mahalife Gold* as a gift for his daughter. His desire was to buy this policy for a sum assured of couple of

lakhs. However, our financial advisor in the course of filling the financial review form, a precursor to the insurance application form, realised that his insurance needs were much higher. The prospect, realising his risk-mitigation requirements, ultimately bought the *Mahalife Gold* policy worth Rs.50 lakhs.

I am not sharing the identities of our customers since we need to respect their privacy. The list of consumer satisfaction letters that we get regularly is a pretty long one. It could well become a case study book in itself!

Another interesting aspect is that in-line with the increase in customer awareness even products are now being tailored to meet their requirements. It has become essential for insurance companies to constantly endeavour to create products and services that meet the specific and changing requirements of the consumer.

Tata AIG is in the vanguard on customer preferences issues. For instance, Tata AIG is offering '*HealthFirst*' – a unique, first-of-its-kind health insurance plan coupled with a life insurance cover and '*Nirvana*', a unique pension plan for individuals. The other innovative product that I have already mentioned in my above example is that of '*MahaLife Gold*' - a unique whole life insurance cover that doubles up as an annuity plan and generates guaranteed annual tax free income.

The story has not ended, but the message is clear. In the present environment, the *Consumer is clearly the King. Long live the King...*

The author is Managing Director, Tata AIG Life Insurance Company.

A New Institute for Surveyors

The IRDA is in the process of helping to promote an institute for surveyors and loss assessors following a Government request. It has appointed Mr. G. V. Rao, retired Chairman and Managing Director (CMD), The Oriental Insurance Company Ltd., as the advisor for this project.

The process is to follow the recommendations of the Bhandari Committee constituted by the Government. The Committee's report recommended mainly that a new institute be initially promoted by the IRDA to be developed by the profession as a self financed, self regulatory body along the lines of the Institute of Chartered Accountants of India (ICAI) or the Institute of Company Secretaries of India (ICSI). It was to set norms and standards and conduct examinations, undertake teaching and research and enforce a code of conduct for its members.

There functioning of the institute will be reviewed after three years and then a decision will be taken regarding conferring on it statutory status through an Act of Parliament.

The Insurance Division of the Department of Economic Affairs of the Ministry of Finance and Company Affairs and the IRDA had been discussing this matter of converting the then existing institute into a statutory body since 2000. The purpose was to make it a self regulatory body for the profession which serves the general insurance industry with its engineering, finance and risk assessment skills. Subsequently however, the association of surveyors split into two bodies and the IRDA expressed its reservations about recognising either body under the circumstances.

It was in this context that a Committee under the Chairmanship of Mr. K. N. Bhandari, former CMD of New India Assurance Company and then Chairman of the General Insurer's (Public Sector) Association (GIPSA) was constituted in December 2002 to look into the matter and make recommendations regarding recognising the institute through an Act of Parliament.

The Committee had as members Mr. R. C. Sharma, then Member (Non-Life), IRDA, Mr. Manu Chaddha, Director of National Insurance Company Ltd. and Mr. G. Bhujbal, Director (Insurance). The Committee's report was submitted in June 2003

There are about 12,000 surveyors in the country. The profession is meant to provide impartial experts to investigate, the cause, facts and circumstances giving rise to general insurance claims and facilitate a just, fair and equitable assessment of the loss.

With the widening of the industry the further professionalisation and consolidation of the profession was required. The Malhotra Committee too called for greater professionalisation and accountability of surveyors to both insurance companies and to consumers.

Blessing or Curse?

Prof. Manubhai Shah

All of us were looking forward to a brighter future when we learnt that we were demonopolising the insurance sector. We hoped that consumers will have a better choice, and that too at lower cost, as it normally happens when competition is ushered in.

Without generalising, I would like to restrict myself to the aforesaid concern in relation to two major areas of general insurance viz. Mediclaim and Third Party Liability (TP) insurance for motor vehicle owners. Individually and collectively they affect millions of consumers in the country.

In the second case, even more so since there is a statutory obligation that no consumer can drive any motorised vehicle on the road unless he has TP insurance.

Let us begin with the Mediclaim insurance cover which is more a necessity, and more so for consumers advancing in age.

What was not happening in earlier days when there was monopoly has started happening now. Insurance companies are using the same argument of choice against the consumer. Let us take a few examples.

This is the case of a consumer who is himself is a consulting physician with specialisation in Neurology. He has had Mediclaim cover for more than 10 years for himself, his wife and other members of the family. Barring the last year or two, there were no insurance claims. Once the insurance claim happened and the policy came for renewal, the insurance company refused the renewal on the following grounds:

1) The first two claims in his 13 year old policy resulted in an Adverse Claims Ratio and therefore it was uneconomical for the company to renew the policy.

2) Since it is an annual insurance cover, the policyholder has a choice to renew or not renew the policy. Since the insurance company cannot compel the insured to renew the policy, the insured cannot likewise compel the company either.

3) Being an annual cover, it is open to the policyholder to go to any other insurance company and for the same reason.

The insurance company does not realise that when the policyholder goes to a new insurance company, his past health record will become a case of pre-existing disease. Is the freedom of the policyholder to go to any other company really freedom?

> Insurance companies are using the same argument of choice against the consumer.

With the intervention of the Consumer Education and Research Centre (CERC), Ahmedabad, the insurance company agreed to renew the policy on the following conditions:

a) Exclusion of the disease from which the policyholder suffered or began to suffer during eight year of policy and in addition also exclude septicemia with hypogamaglobulinemia

b) Premium was doubled

c) There was a further restriction that with every claim there will be a five per cent additional excess

The policyholder had no choice but to accept renewal with aforesaid conditions, or remain totally uninsured.

Let us take another case. The policyholder has been holding the policy for 12 years for a sum of Rs.90,000 which was later on increased to Rs.three lakhs. He had a claim only for last three years. The policy came for renewal on October 4, 2002.

The insurance company refuses to renew the policy. The argument was the same as in the aforesaid case. With great persuasion, the insurance company agreed to renew the policy by increasing the premium three times and by excluding, additionally, heart disease, tuberculosis, renal failure and two other diseases.

With my 25 years of experience in the field of consumer protection, including my four years on the Board of Directors of the General Insurance Corporation of India (GIC) as Ministry of Finance Nominee representing consumer interest, I have never come across any complaint comparable to either of the aforesaid two cases before denationalisation.

The four public sector insurance companies carried an obligation, they being Government of India monopoly companies, that they could not refuse to renew the policy since the consumer has no alternative.

What were the options available to these and similar consumers? The policyholder had no other alternative but to pay such premium, accept conditions and get the policies renewed. These are only illustrative cases. One can think of a number of permutations and combinations including outright rejection of renewal as well.

We as a consumer organisation having received such and similar complaints, had no other alternative but to move the Gujarat High Court at Ahmedabad, besides some individual cases already decided by the Single Judge and appeal pending before the Division Bench.

Gujarat High Court has rejected all the contentions of the insurance companies. Some of them are spelled out above and the Court has said that insurance companies are bound to renew the existing Mediclaim policies on the same terms and conditions without increasing the premium or excluding any one or more of the diseases.

So much so that the insurance companies had advanced an argument that they were running the business of insurance and not any charitable or philanthropic activity.

The High Court sharply reacted to the argument and observed that when a company is not discharging its constitutional or legal obligation, where was the question of expecting charity from it!

The question still remains viz. are the three insurance companies involved in the above cases, all of them Government companies, New India, United India and National Insurance, accepting the decision? Are they going in appeal to the Supreme Court?

What about other insurance companies in the government and non-government Sectors? What are they supposed to do? What is the role of Insurance Regulatory and Development Authority (IRDA)?

All these questions loom large in the minds of millions of policyholders in the country. There is no formal official statement from IRDA as to what the status of the matter's. And what about all the insurance companies which were not parties before the High Court, what are they supposed to do?

If the insurance companies go on appeal to the Supreme Court of India, what is the role that IRDA has to play?

These are not idle questions. Representations have been made to IRDA that it should intervene in the matter and take a holistic view of the Mediclaim insurance cover and what kinds of policy decision it proposes to take and advise or direct or regulate the insurance companies.

We as a consumer organisation are only trying to take up the individual cases and persuade them to follow the judgment of the Gujarat High Court. That is only the tip of the iceberg.

The major national issue of public interest has to be addressed and resolved.

Take another area of crisis. That is regarding compulsory TP liability cover.

As I said earlier, no one can drive any vehicle on the road unless he or she has TP liability cover.

I had the opportunity to learn a great deal more as a member of the Committee popularly known as Justice Rangarajan committee constituted by IRDA on the subject.

> The most disturbing information that came to the surface was the data provided by the Ministry of Surface Transport.

One of the most common complaints which came from the bus and truck operators is that the insurance companies were reluctant to issue third party liability insurance cover more particularly for commercial vehicles like buses, trucks, taxis and auto rickshaws.

Officially and legally they cannot refuse to issue the cover but they try to dodge and delay the matter by giving different queries and/or explanations.

The greater contradiction is that on the one hand the consumer is bound to have such an insurance cover and insurance company refuses, in a direct or indirect fashion, to give the cover.

In the process the most disturbing information that came to the surface was the data provided by the Ministry of Surface Transport about the total number of vehicles registered with the transport authorities throughout the country and the number of vehicles which are covered by the aforesaid third party liability insurance cover.

Extent of premia available

The second issue is that the maximum possible premia is not collected. The risk has to be spread over the owners of all the motor vehicles. If we make a rough estimate of all the vehicles on road and multiply it by even the minimum tariff for third party insurance, the total inflow comes to more than Rs.7,000 crore. Dr. Koteeswaran has kindly estimated the population of vehicles on road in 2001 after removing the vehicles of more than 15 years on the motor transport statistics of the government of India. The total number of vehicles in 2000 so estimated is given in the table below.

Even if we take half that figure, it is more than the GIPSA (General Insurance Public Sector Association) figure of only Rs. 1,108 crore for premium collected by the four

	Buses	Trucks	4 wheelers	2 wheelers	Total
Number of Vehicles	3,75,000	18,68,000	55,76,000	3,66,09,000	
Avg Premium/ Vehicle	Rs. 6,828	Rs. 3,280	Rs. 500	Rs. 135	
Total Premium (Rs. cr.)	256.00	612.70	278.80	494.22	1642.00

nationalised companies in 2001." (Pages 9 and 10 of the main report).

Here comes a painful dimension.

If there are thousands of vehicles on the roads, without compulsory third party liability insurance cover, who is responsible for it? Who should suffer? Who pays the price for it? They are the innocent pedestrians, cyclists, or other passengers travelling in the autorickshaw, bus, taxi and the like.

One recent study has shown that in the case of motor accidents, the victims are mostly pedestrians.

But TP liability cover is a losing business far as insurance companies are concerned. The extent of loss may vary from company to company but the fact remains the same that this is one of losing business for the general insurance companies.

Let us look at the gravity of the matter.

Against the possible premium of Rs. 7,155 crores, insurance companies have been able to receive a premium of only Rs. 1,642 crores.

One aspect of the matter is of course the final implication for the insurance companies.

A very serious aspect of the matter is what about the innocent third parties whether pedestrians, cyclists, or motorists, who sustain accidental injury or death, what happens to them or the members of their family in the unfortunate event of death.

If the vehicle which is not insured causes accidental injury, the law of probability dictates that the driver will run away. It will therefore be treated as a 'hit and run' case.

In the process, the victim or his family will get the fixed compensation, technically called solatium, which is a negligible amount compared to what the family will be entitled to receive on the principles of law already decided by Motor Accident Claims Tribunals (MACTs) which are linked with age of the person who died, number and age of the members of the family, income, his position, years of working and earning, mental harassment, agony and so on and so forth.

Looking from the larger perspective of the innocent people who sustain such accidental injury or die, how are we going to take care of the problem?

A recommendation has been made by the committee that no petrol pump shall provide petrol or diesel to any vehicle which does not carry proof that it is already covered by a TP policy.

Of course there can be other measures as well, like the enforcement of regular random checking on the road by the police and the transport department officials to ensure that the vehicles on the road are insured against TP liability.

> How do insurance companies dare to not provide information and prefer to pay the fine?

The aforesaid report has been signed and submitted during March, 2003.

Whatever little enquiry that I have made with the Ministry of Surface Transport, the recommendation remains unimplemented.

One more disturbing aspect came on the surface during the course of discussion by the Committee. Insurance companies, particularly the four old Government owned general insurance companies which are in existence for more 50 years, are not providing information sought by the Committee.

We were given to understand that they are even paying fine for not providing information. In the absence of information from the insurance companies how would any Committee be able to apply its mind and make meaningful recommendations? How do insurance companies dare to not provide information and prefer to pay the fine?

Is the information really not available or is it that it cannot be made available by looking at the past accounts of the insurance companies or is it deliberately withheld not to provide information so that competing new insurance companies are not able to operate and compete effectively against the older general insurance companies?

Those four companies even today hold more than or around 85 per cent share of the market. On the top of it, they have formed a cartel by the name of GIPSA. The four companies collusively act together as an anti-competitive measure.

We are seriously contemplating filing a public interest litigation before the High Court or the Supreme Court directing the Ministry of Surface Transport, Ministry of Finance, IRDA and the Ministry of Petroleum to ensure that the aforesaid recommendations of the Justice Rangarajan Committee are operationalised both for the benefit of the insurance companies and more particularly of innocent victims on the road who may suffer accidental injury or death by vehicles which are not carrying third party liability insurance cover.

The author is Chairman Emeritus, Consumer Education and Research Centre, Ahmedabad.

Rising to Customer Expectations

R. Desikan

One of the first petitions I filed in the Chennai Consumer Disputes Redressal Forum was challenging the decision of a public sector insurance company to repudiate the claim of a fisherwoman. Because of the delay of the insurance company, the family was reduced to penury. From a comfortable middle class existence, she had been forced to make and sell idlis sitting on the platform of the Chennai railway station. The story, if told in detail, will read like a thriller by a famous author. Let me tell it here briefly.

Rathi Devi borrowed money pledging her jewels and seeking assistance from relatives to buy a motorised boat. From uncertain and abject lower middle class status, she and her husband were able to build themselves up. One day about seven fishing labourers hired by Rathi Devi set off to catch fish.

The boat and all the fishermen disappeared. Rathi Devi had filled the tank with diesel the previous day and the bill was available.

After completing all legal formalities such as FIR, search by the Coastguard etc. when the claim was made, it was rejected. That the insurance company official asked for a percentage could not be proved then or now. When Rathi Devi came to me, we took the case up in the Chennai District Consumer Disputed Redressal Forum and succeeded in proving our point.

The insurance company was asked to pay the compensation with interest. The company preferred appeal after appeal, in the State Commission, from there to National Commission and from there to the Supreme Court. Finally it paid the money.

The attitude of the insurance company was one of defiance of the justification of the claim in the District Forum. This later became merely a routine exercise to go on appeal after appeal. The total amount spent by the insurance company on this litigation (as perhaps it is in most cases) would have exceeded the quantum of compensation claimed, and later paid, with interest.

Thought corruption was the delaying factor in this case, it is a real or imaginary fear of vigilance audit objections that delay the settlement of the most routine of claims.

Establish a simple procedural protocol so that the insured and the insurer are happy in the end.

My questions are:

1) Should the insurance companies, especially the public sector, be paranoid about the remote possibility of the vigilance or the audit official to question the payment?

2) Should not the insurance company executives recognise the standing of an authority of the Consumer Forum and pay the money based on the orders of the district forum. What was the need for going on appeal?

3) Should the insurance company lawyers or standing counsel be the ultimate authority to decide on appeals?

In another case at recent times, a lodge was insured against fire hazard by the lending institution to which the property was mortgaged. A destroyed parts of the building. The owners did not even know that their building was insured by the lending company to protect their loans. When the owner went to pay back the loan after a long time, the finance company asked the reason for delay. They suggested that the owner file an insurance claim.

An arrogant officer of the insurance company whose honesty was in question kept postponing the settlement month after month. At our suggestion the Insurance Ombudsman was approached. It took three years to finally settle the claim. My questions are;

1) Should not be the maximum time for settlement of the claim under the regulation be observed and enforced ?

2) As there are a large number of surveyors available should not the insurance company compel the surveyor to give a report in 72 hours after reference to the surveyor?

3) The claimant must have access or get a copy of the surveyors report within 24 hours of the insurance companies receiving it. Why is this not practiced?

4) Should an insurance company executive resort to bamboozling the staff of a claimant's organisation to persuade them to give false evidence, which happened in this case?

It is a well-known fact that cannot be officially recognised or confirmed as truth that there is huge corruption as a result of a nexus between the insurer, the surveyor and the insurance company executive. In order to break the nexus, I would consider the following actions as essential while settling a claim.

1) Ensure that the insured value is equal to the value of the property or goods or is justifiable.

2) Let the insurance policy in simple understandable plain English summarise the legalistic policy conditions. We have done work in this area but unfortunately the response of insurance companies is cold.

3) Within three days of receiving a claim acknowledge the claim. As the Regulation requires, within 30 days of receiving the documents or and surveyors report if applicable, settle or repudiate it. If the settlement figure is lower than the claim, justify it.

4) If repudiated, give detailed reasons why.

For each of the above establish a simple procedural protocol so that the insured and the insurer are happy in the end. Delays in giving what is due to a citizen-consumer, led to introduction of speed money. Speed money starting at the lowest rung of ladder has resulted into an all pervasive, omnipresent demon eating into the entrails of governance.

Transparency is the best solution. It is also very important that IRDA demands and ensures a user charter that should be handed over along with each policy issued by every insurance company in this country. Today, most of the charters talk about the structure of the company, capital assets etc. which are not relevant to the insurer.

When I pay premium to protect myself from an unexpected event, I must have the confidence and trust that in case of an eventuality my claim will be settled without any fuss, but within laid down norms. The entire basis of insurance is based on mutual trust so that a large number of individuals contribute small amounts to protect themselves from any unpleasant and unexpected situations.

I would also like the IRDA to set up a social audit committee which will study at regular intervals the cutting edge performance of each insurance company and every one of its branches.

The author is Trustee, Consumers Association of India and Centre for Consumer Education, Research, Testing and Training (CONCERT.)

AGAINST THE BREACH

With a view to curb breaches of tariff in the market by general insurance companies, the Tariff Advisory Committee (TAC) has come out with new, stricter norms for dealing with unhealthy practice.

The norms, finalised at a meeting of the board of the TAC on February 16 envisage a timebound disposal of breach of tariff (BOT) complaints by the BOT committee of the TAC.

If the committee decides that there is a breach, the insurer will have to collect the shortfall in premium and rectify the policy. The alternate is to cancel the policy legally and adjust the shortfall against the refund. One of these actions will have to be taken by the insurer within 30 days of the TAC's communication.

If the insurer collects the shortfall within 30 days the TAC will impose a fine of Rs. 1,000 on the erring insurer. If he fails to do so, then the fine will be equivalent to the shortfall and subject to a minimum of Rs. 1,000.

The insurer also has to place the breach of tariff matter in front of its board of directors at its next meeting and confirmation of this action should be sent by the Compliance Officer of the insurer to the TAC within 15 days of the meeting with a certified copy of the minutes of the meeting.

He will further be required to submit a copy of the renewal policy to the TAC for scrutiny. The TAC will also bring to the attention of the IRDA repeated breaches of tariff committed by any insurer.

Listen to the Customer

Pushpa Girimaji

A few years ago, two seniors official of a private insurance company visited me at my workplace. They said they were setting up shop in India and wanted to find out what the consumer expected from an insurer. During our discussion I told them that barring the policy on a vehicle, which is mandatory, I have not taken any policy and have also decided not to take any until I have confidence in the quality of service provided by the insurers. The two gentlemen assured me that their service would be excellent and that they would sell their first policy to me and I would never regret it. They never came back and my opinion of insurers and their quality of service remains unchanged.

In fact a recent personal experience only reinforced my view. I have often had consumers-readers of my column complaining about insurance companies and, when my car was stolen, I thought it was a good opportunity for me to personally see how insurance companies behaved with customers.

What I did see was worse than what I had heard. First of all, I found that even in this age of computerisation, the two branches of the public sector general insurance company which dealt with my case did not interact through e-mail , but through snail mail. Maybe it gave them a chance to delay settlement of claims on the ground that the mail hadn't reached.

My vehicle had been insured in Delhi and the car was stolen in Bangalore. The investigator from the Bangalore office had sent his report, but apparently, had not sent an estimate on the value of the vehicle. "We have written to the Bangalore office, and even sent them reminders, but they have not responded," was the standard reply that I got everytime I enquired about my claim. I must say that the image that this answer gave me was that of a company that had gone back 20 years in a time machine!

I had decided that, during this entire process, I would not get angry whatever the provocation and just let things go the 'normal way.' Carrying out my resolve was indeed tough.

I remember one particularly hot day when I left aside all my work and traveled 30 kms from my home to the insurance office for a signature on a form to be submitted to the Regional Transport Office (RTO). On arrival at the insurance office, I was told that the person concerned had not come and so I should come another day! From the way it was said, this was quite a normal response in that office. I was really taken aback by the insensitivity of the people in that office - they had no inkling of what customer service meant and they were not even apologetic about it.

I refused to budge without the signature and a long argument ensued. I finally got one of them to sign the form, but he took his revenge. When I went to the Regional Transport Office, they told me that the insurance company's PAN number was missing. So I had to travel back and forth twice.

On another occasion I suggested that instead of asking the customer to go and pick up the RTO form and come back again for the insurer's signature, it would be much more convenient if the insurer kept the form at the office. "That's not our job. Why should we help the customer?" asked the person dealing with my case, in righteous indignation. I did not need any more evidence to show the insurance company's attitude to the consumer. What saddened me in the end was that the advisory committee of IRDA had spent considerable time and energy in formulating the Regulation on the protection of policy holders' interest !

> IRDA should also now review the Regulation on Protection of Policyholders' Interest and amend it to tighten loopholes on the basis of consumer feedback.

I would really like to know if insurance companies are collecting data from all their branch offices on the implementation of the Regulation and if so, what the report is. What is the average time taken to settle a claim and in how many cases have the insurers voluntarily paid the interest on the claim amount for delayed settlement? From my own experience and from what I have heard from consumers, the insurers have failed to implement the regulation in its letter and spirit. In fact insurers have found ways of circumventing the regulation and are not paying for any delay.

Here are a few suggestions to ensure implementation of the regulation:

1. First and foremost, IRDA should ask all insurers to prepare a monthly report on their compliance with the Regulation.

2. IRDA should also get done an independent study and take stringent action against those violating the Regulation.

3. The study should also be made public so that consumers can choose only those insurers who respect the rights of consumers.

4. IRDA should also now review the Regulation on Protection of Policyholders' Interest and amend it to tighten loopholes on the basis of consumer feedback.

5. A brief note on the salient points of the Regulation should be given to every policyholder.

6. IRDA should prepare a feedback card and make it mandatory for every insurer to give to the policyholder to be filled up and mailed to IRDA. The purpose of the card should be to get the consumers' feedback on how the policy was sold, whether they were made to understand the various terms and conditions etc.

This would also prevent insurers from resorting to unfair trade practices at the time of selling the policy. In the US, several class action suits have been filed against insurers for UTP and some of them against whom such cases are filed also operate in India.

7.IRDA should also insist on another feedback card from the policyholder at the time of settlement of claim. This will give the IRDA adequate and precise information on the problems faced by the consumer at the time of settlement of claim, the time taken for settlement, etc. Together the two feedback forms would help assess the performance of the insurer vis-à-vis the Regulation.

The author is a consumer rights columnist and a Member of the Insurance Advisory Committee of the IRDA.

प्रकाशक का संदेश

सूचना बराबरी पर लाने वाली है। हम आज टेलीविजन, समाचार पत्र, इंटरनेट से यह जानने के लिये की सूचना के पीछे क्या गतिक्रम है, क्या सीख सकते हैं, उत्पादों, मनोवृत्तियों, मूल्यों ... के संबंध में ग्राहक वह सब कुछ प्राप्त करना चाहता है जो उसे विश्व में बेहतरीन रूप से उपलब्ध है और वह अपने पैसे की वैसी ही वसूली चाहता है जैसी अन्य किसी स्थान पर उसे प्राप्त हो सकती है।

उपलब्ध करवाने की अपेक्षा जानना व इच्छा करना सरल है और वह भी उस बाजार में जो लंबे समय से अलग - अलग सुपर्दगियों के लिये कार्यरत है। वह सुपर्दगीकर्ता नियंत्रित थे सेवा उपलब्ध करवाने वालो से जिनका पूरी तरह से एकाधिकार था कि वह क्या सुपुर्दगी करना चाहते हैं। यह उन चीजों में से एक थी जब तीन वर्ष पहले बाजार में प्रतिस्पर्धा से परिचय करवाया गया। जब बीमा कंपनियों के विकल्प तथा विपण्णन चैनल बीमा ग्राहक को बेहतर सेवा की संभाव्यता के साथ उपलब्ध करवाये गये।

प्रतिस्पर्धा से उम्मीद थी कि वह बेहतर सावधानी लायेगी। बेहतर प्रणालियाँ व सेवा, नये उत्पाद तथा प्रौद्योगिकी जिससे समकालीन आलंबन किया जा सके।

हमें यह अनुमान निरंतर लगाना होगा क्योंकि ग्राहक संतुष्टि तथा बेहतर ग्राहक सेवा - स्तर का कार्य प्रगति पर है।

आईआरडीए जर्नल के इस अंक में हम नजर डाल रहे हैं कि कितनी अच्छी तरह से बीमा कंपनियाँ ग्राहकों की अपेक्षाओं पर कार्यवाही कर रही है। कंपनियों ने तथा उपभोक्ता समुहों ने अपनी अपेक्षाओं व इच्छाओं को वर्णित किया है तथा इसे परिभाषित करने का प्रयास किया है। तीव्रता से आगे बढ़ते ग्राहक के समक्ष हम कहा खड़े हैं जो सेवाओं और उत्पादों के लिये गति निर्धारित कर रहा है। क्या उद्योग इसकी आपूर्ति कर सकेगा अथवा उद्योग यह अवसर खो देगा यह प्रश्न है जो सदैव विश्लेषण तथा उत्तर माँगता है।

अगला मुद्दा उसी अवधारणा से जुड़ा है लेकिन हम इसकी खोज दूसरे दृष्टिकोण से करेंगे कि क्या वह उत्पाद जो पिछले कुछ वर्षों में आ चुके है जो उद्योग को आगे बढ़ाये तथा इसका बाजार पर किस प्रकार का प्रभाव होगा।

सी. एस. राव

आत्म-निरीक्षण

निर्मला अय्यर

दिसम्बर 2003 का आईआरडीए जर्नल पढ़ना एक सुखद अहसास था। कई रूचिकर विषयों पर प्रकाश डाला गया था। जो प्रस्तावों से मूल्य निर्धारण तक था। यह एक रूचिकर यात्रा प्रथम पृष्ठ से अंतिम पृष्ठ तक थी।

हमेशा गणना सकारात्मक तथा नकारात्मक के बीच होती है। दूसरी ओर एक परिकलक वह क्षमता है जो वास्तविकता को झेल सके। यह छाप होती है कि अंतिम परिकलक साधारण बढ़ोतरी इस बात से पीछे रह जाती है कि तथ्यों का सामना करने की कितनी तैयारी है। मल्होत्रा समिति के दृष्टिकोण की पुर्नावृति है जैसा कि उसके बाद कुछ भी उन्नति नही हुई है।

इस बात से भी कोई इंकार नही कर सकता कि इस क्षेत्र के निजी क्षेत्र के लिये खोलने पर जाती हवा राज्य की अभिवृति में आयी है जो उद्योग के अंदर तथा बाहर है। कोई इसे नकार नही सकता कि विदेशी निवेश तथा नये प्रस्ताव उद्योग के स्वास्थ्य के लिये अच्छे ही होंगे। लेकिन बाद में हमारे अंदर इतनी वीरता होनी चाहिये कि हम सिक्के के दोनों पहलुओं पर दृष्टि डाल सकें। यदि हमें कदम जो राष्ट्र ने लिया है उससे लाभ लेना हो। यहाँ कामना यह है कि निकटता से उन गलतफहमियों को देखा जाये जो जीवन बीमा के संबंध में है तथा नये युग के मनोवैज्ञानिक भी इस गलत धारणा में है कि यह अच्छे खाते में बदल सके जिससे उद्योग को मनोवैज्ञानिक रूप से मजबूत बनाया जा सके।

उत्पाद के संबंध में पहली गप्प यह है कि यह पूरी स्थिति का नाजुक परिवेश है। एलआईसी के विरूद्ध आरोप है कि उसके पास उत्पाद नही है जो लोगों की जरूरत को पूरा कर सके। अध्यक्ष के कथन के अनुसार आज तक उनके पास 58 उत्पाद है। टेबल के रूप में यह अनुस्मारक है, उन वापस ली गयी बराबर संख्या के उत्पादों का जो लोगों में जगह नही बना पायी।

वर्तमान में ज्यातादर नयी योजनायें पुरानी है उनको नये नामों में परिवर्तित किया गया है। मूल संरचना में कोई घट-बढ़न होने के कारण। जब आप उस योजना को देखते हैं जो असफल हुई है। ऐसे कई विकल्प तथा समानतायें नही है जिनको एलआईसी ने परंपरागत बीमा में नही था।

जो उन्होंने प्रस्तावित नही किया और वह मूल्य संवर्धन है नये व्यवसायियों द्वारा निवेश लिंक योजना तथा स्वास्थ्य लाभ के रूप में।

एलआईसी पर एक आरोप यह भी है कि उन्होंने ये छोटे परिवर्तन पहले क्यो नही किये? क्योंकि उन्हें भली-भाँति विश्व परिपाटी का ज्ञान था। आज भी सभी बीमाकर्ताओं को यह संज्ञान है कि इस क्षेत्र में इतने आँकड़े नही है कि मृत्यु दर विशेष जीवनों पर उपलब्ध नही है। पुरानी जीआईसी कंपनी मेडिक्लेम के संबंध में कुछ प्रगति नही कर सकी है।

पश्चिम के देशों में भी यह एक नवीन अनुभव है फर्क यह है कि देश जैसे ब्रिटेन तथा अमेरिका को राष्ट्रीय स्वास्थ्य सेवा का लाभ है। एक ऐसी प्रणाली जो उन्हें विश्वसनीय आँकड़े तथा सेवा प्रदान करती है।

भारत में प्रशासन की शर्तों के संदर्भ में स्वास्थ्य का परिदृश्य ऐसा नही है कि नये या पुराने व्यवसायी उसे स्त्रोत के रूप में प्रयोग कर सकें। यह किराये पर लिया हुआ जल है और एक सांत्वना यह है कि इसमें सभी साथ - साथ हैं।

पहले मेडिक्लेम मदद/ राहत व्यापक रूप से उपलब्ध नही थी लेकिन यह कहा थी, यह निर्वाह योजना। स्वास्थ्य सेवाओं में बड़े पैमाने पर लागत यह तुलनात्मक रूप से नयी परिकल्पना है। मेडिसिन के क्षेत्र में उन्नति जिसने इस स्वास्थ्य उत्पादों की नयी माँग प्रारंभ की है।

वर्तमान बाजार में सबसे बड़ा परिवर्धन सावधिक बीमा हुआ है। निश्चित रूप से सावधिक बीमा शुद्ध जोखिम को प्रदर्शित करता है, इसलिये यह सच्चा बीमा है। इसके साथ ही संपूर्ण जीवन बीमा पॉलिसी जो थोड़ी सी मँहगी है एक विजय-विजय पॉलिसी है जो बीमाकर्ता तथा बीमित के लिये लाभ प्रस्तुत करती है।

दूसरी तरफ सावधिक बीमा विशेष रूप से यदि उसे लंबे समय के उच्च वापसी परिलाब्धियों के साथ उच्च बीमित राशि हो तो यह पॉलिसी हानिप्रद होगी। यदि दावा हो तो बीमाकर्ता को हानि होगी और यदि दावा हो या न हो बीमित को हानि होगी। यह बड़ी प्रतिस्पर्धात्मक बाजार सावधिक बीमा के लिये बना रहा है साथ ही बड़ी कटौतियाँ किसी के लिये भी रूचि का विषय नही होगी।

संभवत: जरूरत इस बात की नही है कि दिखावी उत्पादों का गुलदस्ता बनाया जाये जो न एजेंट वर्णित कर सके न उसे समझा जा सके। एक स्वतंत्र लक्षिका ढाँचे का सेट संलग्न किया जाये जिसे मूल योजना के साथ लगाया जाना चाहिये जैसा कि चुनाव किया गया हो मुख्य प्रस्ताव में तथा यह उत्पाद ग्राहक को एक संतुष्टि प्रदान करेंगे। जिससे उनकी विभिन्न आवश्यकताओं की पूर्ति हो।

उत्पादों की संख्या किसी कंपनी की सफलता को मापने की कसौटी नही हो सकती। जीवन निधी बनाने तथा उसकी उपलब्धता की प्रसिद्ध अच्छे प्रमाण प्रस्तुत करेगी। समय की सच्ची आवश्यकता ठीक विक्रय कार्यनीति होगी। इस तरफ ध्यान न देने के कारण यह विभिन्न प्रकार से प्रदर्शित हो है उनमें से एक क्षेत्र ग्रामीण बीमा है।

जब सरकार नियत करती है कि बीमाकर्ता ग्रामीण जनसंख्या में बीमा का विकास करे, अंशदान दे। इसमें दो आज्ञाकारी निर्देश निहित है। पहला बीमा आवरण के लाभ को ग्रामीण जनसंख्या तक पहुँचाया जाये तथा दूसरा महानगरों में नये व्यवसायियों के जमवाड़े को नियंत्रित किया जाये जिससे एलआईसी पर दबाव बनाया जा सके की वह ग्रामीण क्षेत्र का स्तुतिगान करे जो सतत् नही है उस माँग के लिये जो बराबर कार्य करने का क्षेत्र बनाते है। इसलिये हम मिथक के प्रतिफल की ओर बढ़ते है जिसे ग्रामीण व्यवसाय कहते हैं।

“कुछ तो लोग कहेंगे”

ग्रामीण क्षेत्रों ती तरफ एक बाध्यता के रूप में न देखें
वरन् एक संभाव्यता की तरह देखना चाहिये।

श्री सी एस राव, अध्यक्ष,
बीमा विनियामक एवँ विकास प्राधिकरण

आईआरडीए यह सांभव्यता दिखाई पड़ता है कि बीमा
कंपनियों की तरफ से स्वास्थ्य बीमा के प्रति अनिच्छा
है, लेकिन कोई भी अंधेरे में तीर नही चला सकता।

श्री एस वी मोनी, उपाध्यक्ष,
एएमपी सनमार जीवन बीमा कंपनी

कंपनियाँ बढ़ते हुये यह महसूस कर रही है कि
उनकी प्राथमिक संपत्ति आंतरिक उन्मुखता तथा
डिजिटल सम्पत्तियाँ है तथा उसका उन्हें बीमा करवाना है।
यह परिवर्तन ठीक उसी प्रकार का है जिस प्रकार
कृषि अर्थव्यवस्था से औद्योगिक अर्थव्यवस्था में
परिवर्तन पर होता है।

श्री रोब हामसफ,
अर्टोनी एवँ लेखक ई-कॉमर्स पर

विनियमन ढाँचे को बाजार ढाँचे को
अपनाना चाहिये विपरित रूप से नही।
कारण की एफएसए यूके में कोई स्पष्ट विशेष
योग्यता बैंक तथा बीमा के लिये निर्धारित
नही है और आप सह विनियामक के
प्रभावशाली ढंग से विनियमन नही कर सकते।

श्री हार्वड डेविस, निदेशक, लंदन स्कूल ऑफ
इकोनोमिक्स एंड पॉलिटिक्ल साइंस तथा भूतपूर्व
अध्यक्ष वित्तीय सेवा प्राधिकरण, यूके

विनियमन का आधार नियुक्त
बीमांकक के ऊपर पूर्ण निर्भरता, जो
समाज के मामले
में नाजुक दौर में 1991 से 1997 के
मध्य मुख्य कार्यपालक के रूप में था,
इस तथ्य के होते हुये भी कि संभव्यता
में हितों के बीच संघर्ष होगा जो
इस स्थिति में अंतनिर्हित है।

साम्यिक जीवन के नष्ट होने पर
पैनरोज रिपोर्ट

बोर्ड के किसी भी गैर - कार्यपालक सदस्य
को न तो बीमांकन सिद्धांतों तथा प्रणाली का
अनुभव है न कुशलता का... वे स्वंतत्र निर्णय बिना
विशिष्ट मार्गदर्शन के नही ले सकते जो बीमांकक
द्वारा बोर्ड को सलाह के रूप में दिये जाते हैं।

साम्यिक जीवन के नष्ट होने पर पैनरोज रिपोर्ट

उपभोक्ता मामलों में कुछ निर्णय

एच के अवस्थी

चिकित्सा लापरवाही

उपभोक्ता अदालतों में चिकित्सा पेशा करने वालों के विरुद्द बढ़ते हुए मामलों की संख्या के कारण डॉक्टरों ने बीमा आवरण बड़ी राशि का लेना प्रारंभ कर दिया है।

चिकित्सा लापरवाही मामलों में शिकायतकर्ता को यह पात्रता है कि वह बीमा कंपनियों से आवरण की राशि तक धनराशि प्राप्त कर सके। इसी प्रकार का एक मामला राष्ट्रीय कमीशन में एक पुनर्विचार याचिका के समय आया जिसे डॉ. सी. सी. चोबुल ने श्री पंकज श्रीवास्तव के विरुध दाखिल की थी संख्या (2003) सी पी जे 111 (एन सी)।

श्री पंकज श्रीवास्तव ने एक शिकायत जिला फोरम में डॉ. सी. सी. चोबुल के विरुध चिकित्सा लापरवाही के लिए एक शिकायत दर्ज की। डॉ. चोबुल ने एक आवेदन किया जिसमें बीमा कंपनी को सह प्रतिवादी बनाने को कहा गया। इस आवेदन को जिला फोरम ने खारिज कर दिया तथा इसकी अपील पर राज्य फोरम ने भी इसे खारिज कर दिया तथा इसकी अपील पर राज्य फोरम राज्य फोरम ने भी इसे खारिज कर दिया। अत: डॉ.चोबुल ने एक पुनर्विचार याचिका राष्ट्रीय आयोग के समक्ष प्रस्तुत की।

इस याचिका का निपटान करते समय आयोग का दृष्टिकोण था कि बीमा कंपनियाँ एक आवश्यक पक्ष नहीं है लेकिन एक समुचित पक्ष हो सकती है वहाँ तक जहाँ तक की डॉक्टर को आवरण प्रदान किया गया कि यदि चिकित्सा लापरवाही पायी जाए डॉक्टर के विरुध। साथ साथ यदि डॉक्टर के विरुध आदेश दिया जाए तो शिकायतकर्ता को कोई कठिनाई नहीं होनी चाहिए क्षतिपूर्ति की धनराशि प्राप्त करने के लिए उस राशि तक जिसको पॉलिसी में बीमा कंपनी के लिए रखा गया है।

इसलिए राष्ट्रीय आयोग ने श्री पंकज श्रीवास्तव को नोटिस जारी करने के बजाए जो शिकायतकर्ता का। डॉ. चोबुल के आवेदन को स्वीकार किया तथा जिला तथा राज्य आयोग के आदेश को एक तरफ रख दिया। इस प्रकार बीमा कंपनी सह प्रतिवादी के रुप में शामिल की गई तथा शिकायत का निपटान विधि के अनुसार सभी पक्षों को नोटिस देने तथा उनके निवेदन सुनने के बाद होगा।

इसलिए एक शिकायत चिकित्सा लापरवाही के लिए बीमा कंपनी को क्षतिपूर्ति दावेदारी को कार्यान्वित करने के लिए शिकायत में शामिल किया जाएगा। यदि ऐसा उपभोक्ता फोरम द्वारा तय किया जाता है।

कपट दावे

बीमाकर्ता तथा बीमाधारक के बीच यह साझा बात है कि इस पर विश्वास किया जाये कि दूसरी तरफ से दावा जाँच-पड़ताल प्रक्रिया का दुरूपयोग किया जा रहा है। यह वास्तविकता है कि जब दावे को अंतिम रूप दिया जाता है तो परस्पर अविश्वास की स्थिति पैदा हो जाती है।

यह साधारण मान्यता है कि बीमाकर्ता षडयंत्र करते है तथा नाजुक सूचना को छुपाते हैं। बीमा कपट के मामलों में बीमाकर्ता साधरणत: यह धारणा है कि बीमाकर्ता मात्र यह चेष्टा करता है कि ऐसे साक्ष्य एकत्र किये जाये दावा न देने के संबंध में अथवा ऐसे आरोप बनाने की कोशिश करता है अथवा सूचना को दमन करने की कोशिश करता है। जिसका संबंध दावे से होता है। कई समय बीमाकर्ता बीमा लेते हैं लाभ कमाने के लिये अवस्था में वह साक्ष्य बताते है तथा झूठे बिल। वाउचर हानि लागत से अधिक लेते हैं इस कल्पना के साथ कि यदि दावा देय हुआ आधी राशि का भी वह लाभ की स्थिति में होगा।

पिछले वर्ष राष्ट्रीय उपभोक्ता आयोग ने निर्णय श्री आर पी गर्ग द्वारा दायर की गयी पुर्नविचार याचिका पर जो न्यू इंडिया एश्योरेंस कंपनी के विरूद्ध थी।

श्री गर्ग ने अपने वाहन का बीमा, मार्च 13 1999 से मार्च 12 2000 तक करवाया। वाहन 23 अगस्त 1999 को दुर्घटनाग्रस्त हो गया।

श्री गर्ग ने एक प्रथम सूचना रिपोर्ट लिखवाई तथा वाहन को मरम्मत के लिये मैसर्स अरूण सिंह तथा राजा डेंटर के पास भेजा तथा कुल खर्च रूपये 205,905.95 किया। बीमा कंपनी ने सर्वेयर की नियुक्ति की जिसने वास्तविक क्षति 35,379 अंकित की। बीमा कंपनी ने एक जाँचकर्ता की नियुक्ति की। जिसमें पाया कि 38000 रूपये का डेंटिंग बिल काल्पनिक था क्योंकि डेंटर ने स्वंय कहा कि उसने मात्र 8000 रूपये लिये है। बिल में अन्य हेरा-फेरी भी थी।

बिल में हेरा-फेरी तथा श्री गर्ग द्वारा बढ़ा कर बनवाये गये बिलों के आधार पर सर्वेयर व जाँचकर्ता की रिपोर्ट के आधार पर बीमा कंपनी ने हानि की गणना 35,599 रूपये के रूप में की। राज्य फोरम तथा जिला फोरम ने बीमा कंपनी के दृष्टिकोण को ठीक बताया तथा यह स्वीकार किया की दावाकर्ता ने बढ़ा चढ़ा कर बिल बनवाये थे। जिसके द्वारा कपटपूर्ण दावा लेने की चेष्टा की गयी।

अपनी पुर्नविचार याचिका में श्री गर्ग ने कहा कि बीमा कंपनी सर्वेयर की रिपोर्ट पर निर्भर थी तता जाँचकर्ता ने रूपांतरण बीमा फोटोग्राफ को देखे लिया। जिन्हें दुर्घटना के समय लिया गया था। बिना असली मरम्मत की गणना के सभी स्पेयर पार्ट्स के बिल उनके द्वारा प्रस्तुत किये गये मरम्मत की लागत रूपये 157,599.95 थी। राष्ट्रीय आयोग ने जिला तथा राज्य आयोग के रिकार्ड को देखते हुये उनकी सत्यपरकता पर भरोसा नही किया तथा वह साफ हाथों से बाहर नही आ सके। यह स्थापित हुआ कि दावा बहुत बढ़ाया गया तथा बिल झूठे थे।

कमीशन ने याचिकाकर्ता के आचरण की सराहना की जिसने झूठे बिल प्रस्तुत किये तथा कपटपूर्ण दावा प्रस्तुत किया तथा आगे बढ़कर न्याय की माँग की तथा राज्य तथा राष्ट्रीय आयोग में अपील क। अंतत: राष्ट्रीय आयोग ने पुर्नविचार याचिक (घ्र(2003) सी पी जे 107 (एन सी)) को खारिज कर दिया।

चूंकि उपभोक्ता फोरम में कोर्ट फीस देय नही है इसलिये उपभोक्ता फोरम के समक्ष शिकायतकर्ताओं में एक प्रवृति देखी गयी है कि वे उपभोक्ता संरक्षण अधिनियम 1986 का दुरूपयोग करते हैं।

देरी से भुगतान की लागत

न्यू इंडिया एश्योरेंस कंपनी राष्ट्रीय आयोग को यह स्पष्टीकरण देनें में असमर्थ थी कि इसने मैसर्स गैमोन इंडिया लिमिटेड के दावे को अस्वीकार करने में छह वर्ष का समय कैसे लगाया। यह अपने आप में बीमा कंपनी द्वारा सकल कमी थी। इसके अतिरिक्त बीमा कंपनी इसका स्पष्टीकरण देने में असमर्थ थी कि यह आवश्यक क्यों समझा गया कि एक दूसरा सर्वेयर नियुक्त किया जाए तथा क्यों पहले सर्वेयर की रिपोर्ट को स्वीकार नहीं किया गया।

मैसर्स गैमोन इंडिया लि. कि न्यू इंडिया एश्योरेंस के विरुध दाखिल शिकायत (आई 2004) सी पी जे 10 (एन सी) में राष्ट्रीय आयोग ने निष्कर्ष निकाला तथा एक अन्य मामले में नेशनल इंशोरेंस कंपनी बनाम पटियाला ट्रेडिंग कंपनी, पुर्नविचार याचिका संख्या 488/1998 में राश्ट्रीय आयोग ने यह माना की एक दूसरा सर्वेयर नियुक्त नहीं किया जा सकता।

इस मामले में मैसर्स गैमोन इंडिया लि. ने न्यू इंडिया कंपनी से एक पॉलिसी ली थी जिसमें पी3 कुआँ आधारशिला के लिए रोड ब्रिज सियंग नदी के ऊपर रण घाट (पासी घाट, अरुणाचल प्रदेश) पर आवरण प्राप्त करना था। जुलाई 20, 1991 से अप्रैल 19, 1992 के लिए ली गई यह पॉलिसी 32 लाख रुपये की थी। अगस्त 9, 19991 को पी3 कुआँ बाढ़ के कारण झुकाव में आया तथा स्थानांतरित हो गया।

कंपनी ने कहा कुएँ को ठीक करने के लिए कुल 26,21,631 रुपये का खर्च किया गया। इस नुकसान की सूचना 10 अगस्त 1991 को बीमा कंपनी को दी गई। बीमा कंपनी ने श्री डी. के. बोरह को हानि का संज्ञान लेने के लिए नियुक्त किया। दावे का निपटान नहीं किया गया इसलिए शिकायत दर्ज की गई।

नोटिस प्राप्त होने पर बीमा कंपनी ने दावे को लिखित रुप से अस्वीकार किया तथा एक रिपोर्ट दिनांक जुलाई 1, 1994 को फाइल की जिसमें क्षति का अंकन 18,35.938 किया गया था। बीमा कंपनी ने यह रिपोर्ट शिकायत कर्ता को नहीं दी। उसके बाद बीमा कंपनी ने एक और सर्वेयर मैसर्स इंदर चंदा व एसोसिएट्स की नियुक्ति की जिन्होंने अपनी रिपोर्ट फरवरी 14, 1996 को प्रस्तुत की। दूसरे सर्वेयर से रिपोर्ट प्राप्त होने के बाद बीमा कंपनी ने अपने पत्र दिनांक जुलाई 18, 1997 को गैमन इंडिया का दावा निरस्त कर दिया।

बीमा कंपनी ने यह सभी कार्य शिकायत के राष्ट्रीय आयोग में लम्बित होने के समय किया। इसके बाद पक्षों ने हलफनामा दिया. राष्ट्रीय आयोग सो कोई स्पष्टीकरण नहीं मिला कि 6 वर्ष से अधिक का समय बीमा कंपनी का दावा निरस्त करने में क्यों लगा। बीमा कंपनी इस देरी को स्पष्ट करने में विफल रही।

आयोग ने इस देरी को सेवा में सकल कमी बीमा कंपनी की और से बताया। इससे बढ़कर बीमा कंपनी के पास देरी का कोई कारण नहीं था कि दूसरे सर्वेयर को नियुक्त करने की क्या आवश्यकता थी तथा पहले सर्वेयर की रिपोर्ट को स्वीकार नहीं किया गया।

इस कारण बीमा कंपनी पहले सर्वेयर श्री बोहरा की रिपोर्ट पर कार्यवाही करने से मना नहीं कर सकी। शिकायत कर्ता कंपनी इस बात के लिए तैयार थी कि पहले सर्वेयर की रिपोर्ट को स्वीकार किया जाए। इसलिए उन्होंने यह प्रार्थना की कि पहले सर्वेयर की रिपोर्ट के आधार पर 18 प्रतिशत वार्षिक ब्याज के साथ क्षतिपूर्ति की जाए। इन परिस्थितियों में बीमा कंपनी ने 18,35,938 रुपये तथा 17.5 प्रतिशत की दर से ब्याज अप्रैल 1, 1992 को दिया तथा 10,000 रुपये लागत के रुप में शिकायतकर्त्ता कंपनी को दिये।

यह पूरी तरह से बीमा कंपनी द्वारा निष्क्रियता का मामला है कंपनी के दावे के भुगतान के संबंध में अनुक्रिया न देने पर इसके परिणामस्वरुप वित्तिय देयता 18,35,938 तथा 14 वर्ष का वार्षिक ब्याज 17.5 प्रतिशत देय हुआ। तथ्य यह है कि बीमा कंपनियों के पास समक्ष विधि कक्ष है तथा जरुरत है कार्यशीलता तथा सलाह की संबंधित कार्यपालकों के लिए जिससे बिना देरी के दावों का निपटान किया जा सके। आई आर डी ए इस संबंध में उपयुक्त दिशा निर्देश जारी करने पर विचार कर सकता है जिससे सभी कंपनी बीमा दावों का निपटान कर सके।

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C.S. Rao

Date: March 23, 2003 Signature of Publisher

यह वही है जो वो चाहते हैं...

के नित्या कल्याणी

दि प्लेयर: हम ज्यादा प्रेम, रक्त तथा अलंकार शैली से संबंध रखते हैं। हाँ, हम आपके साथ रक्त एवं प्रेम का संबंध रख सकते हैं बिना अलंकार के, हम रक्त एवं अलंकार का संबंध रख सकते हैं बिना प्रेम के तथा हम समवर्ती या तर्कसंगत रुप से तीनों संबंध एक साथ रख सकते हैं, परन्तु हम बिना रक्त के प्रेम या अलंकार का संबंध नहीं रख सकते हैं। रक्त आवश्यक है। सभी संबंध रक्त के बने हैं तुम देखते हो।

गिल्डनस्टर्न: क्या यही वो चाहते हैं?
दि प्लेटर: ये वही है जो हम करते हैं।

-टॉम स्टोपार्ड के नाटक, रोसेनक्रेन्ट्ज एण्डं गिल्डनस्टर्न आर डेड से उधरित

यह वही है जो हम करते हैं...दूरभाष सेवा उपलब्ध करवाने वालों का आसान अभिवृति बैंकर, नुक्कड़ की पंसारी की दुकान, बीमा कंपनी, हम यहाँ हैं आपकी सेवा के लिए...या तो लें या छोड़ दें...यह किस प्रकार का चुनाव विकल्प है? साधारणत: हम इसे लेते हैं।

अब और नहीं, यह एक आँखें खोल देने वाला दशक था। भारतीय उपभोक्ता उस स्थिति में आ गया जिसे वह चाहता था। एक सेवा उपलब्ध करवाने वाले से या दूसरे से और कुल मिलाकर यही कुँजी है।

प्रतिस्पर्धा के बारे में विक्रेता को उत्प्रेरण देने के लिए सोचा गया जिससे ग्राहक के हितों की रक्षा की जा सके। रोचक बात यह है कि अन्य क्षेत्रों में आर्थिक प्रतिस्पर्धा के कारण सेवा क्षेत्र में भी सेवा उपलब्ध करवाने वालों को अपनी योग्यता बताने का अवसर मिला। मजबूत विक्रेता बैंकर्स तथा टेलीकॉम कंपनियाँ के साथ इसलिए बीमाकर्ता भी दबाव में है। श्वेत वस्तु उत्पादकों से वाहन निर्माता तक दबाव में हैं। पिछले सप्ताह सरकारी हैण्डलुम एम्पोरियम में मेरे बैगस् को पार्किंग तथा उठाने का प्रस्ताव भी दिया तो यह सब कहाँ से आता है?

ग्राहक की आवश्यकताओं से कदम से कदम मिलाने के लिए टेक्नोलोजी ने मदद की है। यह भी सही है कि इसने ग्राहक सेवा में तथा नये उत्पाद बनाने में भविष्य का कार्य किया है। पक्के रुप से कुछ प्रसन्न ग्राहक थे। टेक्नोलोजी आने से पहले और आज भी कुछ व्यवसाय हैं जो टेक्नोलोजी पर निर्भर नहीं है और अपने ग्राहकों को प्रसन्न रखे हुए है और अधिक वास्तविकता यह है कि ग्राहक उनके साथ हैं।

यह एक अभिवृति तथा बाध्यता है सेवा उपलब्ध करवाने वालों की जिन्होंने महसूस किया है कि वस्तुओं की योजना में उनका ग्राहक उनका ग्राहक नहीं है, वह स्त्री या पुरुष 'ए' का ग्राहक है जो निकटतम प्रतिस्पर्धा वाले द्वारा गायब कर दिया जाएगा जब तक...नयी अभिवृति उन्हीं पुराने लोगों द्वारा आयी है इकट्ठे रुप में। जब पैसा बहता है तो उस तरफ जहाँ इसकी अधिकतम जरुरत होती है, ग्राहक सेवा या ग्राहक को संतुष्ट करने का प्रयास वही होता है जहाँ इसकी जरुरत होती है।

ग्राहकों के उत्तर के लिए अधिक माँग होगी? यह भी सच है कि वह आज अधिक माँग कर रहे हैं लेकिन माँग बिना इस अधिकार के कि ऐसी परिस्थिति एक प्रभावशाली नीति हो सकती है।

यह उपभोक्ता केन्द्रित विधि बनवा रही है जैसे उपभोक्ता संरक्षण अधिनियम 1986 तथा विनियमक भी अग्रिम पहल करते हैं जैसे आई आर डी ए पॉलिसीधारण हित संरक्षण विनियमन।

यह कागज के कुछ पृष्ठ मात्र हैं यदि लाभांवित ग्राहक इन औजारों को प्रभावशाली रुप से प्रयोग न करें उसके लिए उसे तैयारी करनी होगी शिक्षा द्वारा। इस जागरुकता को देने के लिए कौन जिम्मेदार है? उपभोक्ता समूह? विनियामक? प्रेस या अनेय व्यापक मीडिया? या सेवा प्रदान करने वाला स्वयं?

हमने इन प्रश्नों मे से कुछ के पीछे जाने की कोशिश की हमारे आई आर डी ए के अगले अंक में। एक तरफ हम यह कोशिश करेंगे कि मन पर प्रभाव डालने वाले विचारों को प्रस्तुत करेंगे एक करफ कंपनी का दृष्टिकोण कैसे ग्राहक बदले हैं। हम यह भी कोशिश करेंगे कि उपभोक्ता समुहों के कार्य को उपभोक्ता जागरुकता बताने के लिए जो शिकायतों से संबद्द होना तथा मुकदमेबाजी अपने अनुभव जो उपभोक्ता से संबंधित हो, निष्कर्ष रुप में सामने लाना।

भारतीय पुनर्बीमा का यथोस्थान

जी वी राव

मार्च 2004 के दूसरे महीने में नई दिल्ली मे पुनर्बीमा का विकास तथा व्यापार एशियन क्षेत्र में कैसे किया जाए पर चर्चा करने के लिए विश्व के पुनर्बीमा नेता एकत्र हो रहे हैं। वित्तीय सुरक्षा की व्यापकता तथा वित्तीय सुरक्षा के प्रकार तथा सापेक्षित लागत जिस पर ग्लोबल पुनर्बीमाकर्ता अब तैयार हैं प्राथमिक बीमाकर्ता को पुनर्बीमा उपलब्ध करवाने के लिए अपने इस क्षेत्र में एक बदलते हुए असुरक्षित ग्लोबल वातावरण में परिचर्चा का विषय होंगे।

जोखिम की लागत पुनर्बीमा आवरण की उपलब्धता तथा बाजार सुरक्षा अथवा पुनर्बीमा की दरें गहरी चिंता का विषय प्राथमिक बीमाकर्ता के लिए है। वर्तमान में बड़ी संख्या के बीमाधारकों के दिवालिया हो जाने से तथा अन्य के निम्न श्रेणी पर आ जाने से यह चिंता और बढ़गई है। ऐसा एक सर्वे में निकलकर सामने आया है। प्रबन्धकों का जोखिम प्रबन्ध के प्रति नैरास ने ग्लोबल परिचालन वातावरण को प्रभावित किया है।

दावों के उत्तरदायी के संबंध में न तो यह अपेक्षा है न ऐसा किया गया है कि आतंकवाद को जिसके लिए बहुत कम अतवा बिल्कुल नहीं प्रीमियम एकत्र किया गया था ने कई प्रबन्धकों बीमाकर्ताओं/पुनर्बीमाकर्ताओं के पूल को प्रभावित किया है।

इस लेख का उद्देश्य विश्वं अभिनव परिवर्तन जो पुनर्बीमा बाजार में हो रहे हैं। विशेश संदर्भ को लेते हुए की इन्होंने भारतीयबीमा बाजार को किस प्रकार प्रभावित किया है तथा भविष्य की क्या संभावनाए हैं। यह निरंतर रहने वाले परिवर्तन भारत में तथ बाहर कैसे होंगे।

पुनर्बीमा तथा भूमंडलीकरण

पुनर्बीमा सदैव परस्पर निर्भरता का ग्लोरल व्यवसाय रहा है जबकि अधिकांश बड़े जोखिम तथा महाकाय स्थानीय जोखिमों का पुनर्बीमा बाहरी बीमा बाजार में किया गया जिसका स्थान विशेष रुप से यूरोप तथा यूके है। पुनर्बीमा के लिए पूँजी की पर्याप्ता आधिक्य, बीमा लेखन निपूर्णता जिसको जोखिम मॉडल पर आधारित किया गया, पी एम एल बड़ी मूल्य जोखिम का निर्धारण, देश विशेष से संबंधित जोखिम, दावा अनुभव पर नजर रखना अन्तर्राष्ट्रीय सांख्याकों के अनुसार स्वीकार्यत: भविष्य की प्रोजेक्शन जिसमें संभावित हानि आदमी द्वारा तथा प्रकृति पर निर्भरता पूर्व में हुए अनुभवों तथा भविष्य में प्राकृतिक जोखिम जैसे बाढ़ तथा भूकंप जो जलवायु परिवर्तन के कारण होते हैं, यह सभी मूल्य निर्धारण में महत्वपूर्ण भूमिका निभाते हैं तथा पूनर्बीमा आवरण के लिए नियम व शर्तें प्रसारित करते हैं।

9/11 की हाल की घचनाओं ने यह प्रदर्शित किया है कि सभी निर्पूणता तथा अनुभव जो अब तक एकत्र किया गया है वह अपर्याप्त साबित हुआ है जिससे ग्लोबल पुनर्बीमा व्यापार को सफलता पूर्वक प्रबन्ध नहीं किया जा सका है। 90 के दशक में स्टॉक मार्केट से हुई निवेश आय प्रमुख थी। पुनर्बीमा का मुख्य उद्देश्य उसकी मूल कार्यशैली से बाहर था। पिछले 9/11 की स्थिति बड़ी विचित्र थी जो सभी पुनर्बीमाकर्ताओं को गलत व्यापार कल्पना पर चलाती थी तथा उसने 200 बिलियन डॉलर की पूँजी का सफाया कर दिया जिसका अनुमान 700 बिलियन डॉलर माना गया था। इसको बदलने के लिए आने वाली नई पूँजी का अनुमान 30 बिलियन डॉलर आँका गया है। कठोरता से जो कुछ अपेक्षा थी दरों के सख्त होने के बावजूद।

निवेश समुदाय पुनर्बीमा को पूँजी प्रदान करने में शर्म महसूस कर रहा है क्योंकि वह सोचता है कि पुनर्बीमा का तलपट 'भारित' होगा अप्रत्याशित हानि से अपने व्यापार की प्रकृति के अतिरिक्त। लाभ अर्जन की सत्ता पुनर्बीमा में निवेशक का विश्वासमय मुक्त निवेश के लिए प्राप्त करेगी।

जबकि संबांदत सरकारें विनियमन करती है अपने स्थानीय बाजारों का पुनर्बीमा ग्लोबल स्तर पर काम करता है तथा उसका विनियमन नहीं होता तथा वह मूल्यांकन की विषय वस्तु है।

पिछले दिनों हुई घटनाओं ने पुनर्बीमा क्षमता को दुर्लभ बना दिया जिससे बीमा दरें तथा शर्तें ग्लोबल बाजार में कठोर हो गई लेकिन वित्तीय सुरक्षा में कमी जारी रही। इसके बाद से कई पुनर्बीमाकर्ता नये पुनर्बीमा वातावरण में नई भूमिका निभायेंगे, जो ज्यादा अस्थिरता पुनर्बीमा आवरण में प्रदान करेंगी। इसकी संबंधित लागत वित्तीय सुरक्षा जो कई प्राथमिक बीमा कर्ताओं के लिए होगी कम हो जाएगी। बाजार का विप्लव जो पैदा हुआ है अभी भी निये की तरफ है।

वर्तमान घटनाओं ने पुनर्बीमा को दमदार झटका दिया है जिसका कारण बड़ी हानियाँ तथा निचला स्तर है। इसके कारण जोखिम प्रबन्धन पर पुनर्विचार प्रारंभ हुआ है जिसमें अपनी क्षमता से अधिक स्वीकार्यता है। उसे अधिक सख्ती से छानबीन करनी होगी। अपनी बीमा लेखन सूचनाओं के बारे में तथा अधिक पारदर्शिता को दिखाने के लिए कदम उठाने होंगे, संगणना के अधिक सुधरे हुए तरीके अपनाने होंगे, भविष्य में होने वाली हानियों के लिए सीमा बनानी होगी, दावा कटौती तथा छोटे समय के लिए रद्दीकरण इत्यादि उस प्रस्ताव पर रखना होगा जो पुनर्बीमा के रुप में प्राप्त होता है।

आनुपातिक संधि अधिक प्रचलित है। प्राथमिक बीमाकर्ताओं के मध्य वह कम हुए पुनर्बीमा कमीशन के कारण लुप्त हुई है। गैर आनुपातिक संधि के साथ हानि के अधिक आवरण तथा फैकुलेटिव क स्थापन के लिए अधिकांश मामलों में प्राथमिक बीमाकर्ता बाध्य हुए हैं। यह पहल प्राथमिक बीमाकर्ताओं पर अधिक दबाव बनाने के लिए हुई है जिससे उनके बीमा लेखन योग्यता उन्नत करने और बीमा आवरण दरें बढ़ाई जा सके उनको प्रस्ताव तथा शर्तों पर पूनर्विचार किया जाए की स्वीकृति के लिए।

दायित्व बाजार विशेष रुप से बुरी तरह प्रभावित हुआ है। यह बाजार है सीमित संख्या के भागिदारों का तथा कम संख्या में भावी नेताओं का। इसने बढ़ती हुई दरों को देखा है तथा आवरण में कमी को भी अधिक सारपूर्वक अन्य फोर्ढफोलियो के अतिरिक्त। आतंकवाद के लिए आवरण न्यून हुआ है तथा न्यूक्लियर, बायोलोजिकल तथा कैमिकल जोखिम के लिए यह है ही नहीं।

9/11 के बाद पिछले दो वर्षों में शेयर बाजार में निवेशकों की वापसी हुई है तथा ग्लोबल परिप्रेक्ष्य प्राकृतिक तथा मानव निर्मित विपदा ने कई बड़ी हानियाँ देखी है जिससे पुनर्बीमाकर्ता की वित्तीय निष्पादन क्षमता को उन्नत किया है फिर भी पुनर्बीमा बाजार देयता हानि एसबेस्टो, निर्देशक तथा आधिकारिक देयता जिसका प्रारधान लाभ के लिए अपनी पहले की अवधि के कारण तथा हानि पहले की अवधि स्टॉक के मूल्यांकन पर सतत् रुप से शोधन क्षमता तथा दर की स्वीकार्यत: दर निर्धारित एजेंसी द्वारा।

यूएस बाजार में पुनर्बीमाकर्ताओं की संख्या 1980 में 112 से 2003 में घटकर 30 रह गई। इसी अवधि में पॉलिसी धारकों की अतिरिक्त राशि 3.5 बिलियन डॉलर से बढ़कर 45 बिलियन डॉलर हो गई। निवेशक एसा समझते थे कि यूएस में पुनर्बीमा व्यवसाय लाभप्रद है। हानि संरक्षण विकास का उनके निवेश पर विपरित प्रभाव पड़ा।

अब पुर्नबीमा पर विचार उनके सौदेबाजी के आधार पर होता है। इकठ्ठे रूप में पुर्नबीमा वसूली कुछ पुर्नबीमा वसूली कुछ पुर्नबीमाकर्ताओं से एक समस्या बन गयी। पुर्नबीमा का गैर निष्पादन वह दृष्टि है जो एक प्राथमिक बीमाकर्ता को संघर्ष करना होगा। अपनी वित्तीय मजबूती के साथ। पहले से प्रसादात्मक रूप से बुरी प्रकार के साथ पुर्नबीमा बिलकुल खो गये तथा वह उपलब्ध जोखेनम प्रोफाइल है। पुर्नबीमा की समझौता भाषा शब्दश: अनुवदित होती है। पुर्नबीमा विन्यास तथा पुर्नबीमाकर्ता की इच्छा संबंध बनाये रखने के लिये आसानी से नही ली जानी चाहिये।

इतनी बड़ी ग्लोबल वास्तविकता किस प्रकार भारतीय बाजार को प्रभावित करेगी। एक सुनाये जाने योग्य प्राशुल्क ढाँचे जो व्यापक पुर्नबीमा व्यवसाय को किस प्रकार निभा सकेगा?

भारतीय बाजार - भारतीय बाजार को एक ढाल है क्योंकि यहाँ मजबूत प्राशुल्क ढाँचा है इसने बढ़ती हुयी ग्लोबल दरों से मुक्ति ली है तथा अन्य रोक प्रथाओं तथा शर्तों से जो ग्राहक स्तर पर लेकिन उन शर्तों को कड़ा करती

है जिन पर पुर्नबीमा उपंतिका प्राथमिक बीमाकर्ता के होते है।

इन विकास के अनुक्रिया न करते हुये तथा अधिक बलपूर्वक प्रतिस्पर्धा करने के लिये स्थानीय व्यवसाय के लिये बीमाकर्ताओं ने न केवल अपनी उपंतिका को कम कर दिया है वरन् वह उस लागत से अधिक पर कार्य कर रहे हैं जो उन्हें पुर्नबीमाकर्ता पुर्नस्थापित करते हैं।

यह संक्षिप्त प्रभार का झुकाव मार्जिन की शर्तों के अनुसार केवल प्रीमियम खड़ा करने के लिये खंड बात करते हैं गलत प्राथमिकताओं की भारत भी इन प्रथाओ की।

पुर्नबीमा प्रबंधन प्राथमिक स्तर पर एक उपेक्षित रह जाता है। इस बात का उत्तरदायित्व जीआईसी ने उदारीकरण से पूर्व समय मे अपने ऊपर ले रखा था। पुर्नबीमा प्रंबध जीआईसी स्तर पर अथवा प्राथमिक बीमाकर्ता स्तर पर अधिक आधारित था लाभप्रदता पर। उस बीजक व्यवसाय के बजाय इसके कि वह विनियोजित रूप से पुर्नबीमा कार्यक्रम सांख्यिकी के एकत्रिकरण के आधार पर होता अथवा उसके बराबर होता व्यावसायिक रूप से।

सांख्यिकी का एक्चुरी तथा उसके एकत्र करने में समय की कमी कुछ समुन्नत हुये है लेकिन वह अंतर्राष्ट्रीय व्यवसायिकता की अपेक्षा अभी कम है। भारतीय बीमा बाजार व्यवसायिकता के रूप में तथा उसकी निपुर्णता यह मानने में अभी भी अविकसित है तथा अभी परिपक्व नही हुआ है। न केवल सांख्यिकी एकत्र करने में लेकिन जोखिम का अनुमान लगाने में भी तथा जोखिम प्रोफाइल बनाने में भी उसकी प्रस्तुति वैसी ही है। अभी काफी दूर जाना है अंतरराष्ट्रीय स्तर की ख्याति तथा व्यवसायिकता प्राप्त करने के लिये।

भारतीय बाजार बीमा प्राशुल्क के कारण चिंतित है तथा अब एक संतुष्ट से कम बीमाकर्ता है। वर्तमान प्राशुक में लक्ष्य प्राप्ति नही है पुर्नबीमाकर्ता के दृष्टिकोण से समय पर सांख्यिकी एकत्र न होने के कारण जिसका कारण भारतीय बीमाकर्ता प्रणाली में कंप्यूटरीकरण का न हो ना ने भी स्थिति में कोई मदद नही दी है। भारत यह दावा नही करता है कि उसके पास प्रशिक्षित बीमा व्यवसायियों का समूह है उसके पास पुर्नबीमा के क्षेत्र में भी विशेषज्ञता नही है तथा जोखिम प्रबंध तकनीक का भी बीमालेखन प्राथमिक स्तर पर भी नही है।

भारतीय बीमाकर्ताओं को कठोर मोलभाव करने वाला, दरें कम करने के लिये माना जाता है अपनी सतत् कोशिश में वह यह स्पष्ट नही कर पाते की उन्हें कैसे संतुष्ट किया जाये। न वे मोल भाव शर्तों तथा तर्क अथवा निपुर्णता के आधार पर करते हैं।

भारतीय बाजार ने अब तक प्रयोग किया है ब्रोकर घरेलू तथा अंतरराष्ट्रीय विशेषत: पुर्नबीमा को देने के लिये अपनी प्रतिभा को नियंत्रण प्रदान करने की अपेक्ष अपनी प्रतिभा से मान्य कार्यक्रम स्वीकार करने के लिये। देश में रखे जाने वाली क्षमता का पूर्ण से दोहन नही हुआ है तथा यह प्रगतिशीलता से कम हुई है। नये निजी व्यवसायियों ने अपने पास रखने वाली क्षमता को नही बढ़ा है तथा इस तथ्य के बावजूद की उन्हें व्यवसाय में तीन वर्ष हो चुके हैं वो ऐसी भूमिका निभा रहे हैं कि वह अपने उन्नयकों के प्रारंभ है अपने पास शुद्ध खाते में कम रखते हुये तथा अग्नि तथा अभियांत्रिक पोर्टफोलियो में ।

फैकुलेटिव प्लैसमेंट को भारत के बाहर किया जाता है बिना विस्तृत राष्ट्रीय दोहन क्षमता के जो उपलब्ध है। प्रतिस्पर्धा का खेल एक घातक तत्व को मस्तिष्क में रख कर किया है तथा उपभोक्ता को महत्व नही दिया जाता है। इस बात की बड़ी आवश्यकता है कि सहयोगपूर्ण प्रयास प्राथमिक बीमाकर्ताओं के बीच में तथा जीआईसी राष्ट्रीय पुर्नबीमाकर्ता के बीच किया जाये। उन्हें एक बेहतर पुर्नबीमा बाजार भारत में छोड़ना होगा। नेतृत्व में कमी तथा विपरीत परिचालन व्यवसायियों के मध्य बाजार स्तर पर दृष्टिगोचर होता है।

यहाँ तक की भारत तैयार है पुर्नबीमाकर्ताओं को लाइसेंस देने के लिये की वे यहाँ कारोबार शुरू कर सके। अभी तक किसी बड़े बीमाकर्ता ने इसमें रूचि नही दिखाई है। यह देखा गया है कि म्यूनिक री तथा स्वीस री अपनी शाखायें यहाँ खोलने को तैयार है लेकिन वे कंपनी नही बनाना चाहते। भारत को एशिया तथा अफ्रीका के समीप अपने आप को एक पुर्नबीमाकर्ता के रूप में विक्रय करना होता इसकी विधि तथा व्यवसायियों की प्रतिभा, व्यवसाय तथा कार्यालय संचार अन्य व्यवसायिक अवसर उपलब्ध होंगे।

जीआईसी को राष्ट्रीय पुर्नबीमाकर्ता बनाया गया है वह अभी तक अपनी सार्वजनिक क्षेत्र की कंपनी को प्रवेक्षण के हात से हुये धक्के को संभाल नही पाया है। पुर्नबीमा की विपण्णन के लिये ब्रोकर तथा लेखा कार्यकारी चाहिये न केवल तकनीकी अधिकारी।

पुर्नबीमा क्षमता की उपलब्धता पुर्नबीमा का विकल्प नही है न ही ही यह स्वीकार्य मूल्यांकन है। मूल्यांकन एजेंसी द्वारा एक बाजार प्रमोटर के रूप में। पुर्नबीमा आज भी एक संबंध से चलने वाला व्यवसाय है। जो दो साझदारों के बीच है और यही भावना जीआईसी को अपने ग्राहकों के साथ संबोधित करते हुये करनी चाहिये। जीआईसी को अपनी स्थिति मजबूत करने की जरूर है इससे पहले की कोई अपना कारोबार शुरू करे। इसे अधिक प्रभावशाली ढंग से अफ्रीका तथा एशिया बाजार की उपज लेनी चाहिये।

अनिवार्य अध्यपर्ण-

बीमा अधिनियम 1938 यह प्रावधान करता है कि अनिवार्य अध्यपर्ण जीआईसी जो वर्तमान में 20 प्रतिशत है प्रत्येक उस जोखिम के लिये जिसका लेखन भारत में किया गया है। इसने पुर्नबीमा में अधिक अध्यपर्ण को देश में रखने को संभव बनाया है तथा जीआईसी को एक महत्वपूर्ण शक्ति एशिया क्षेत्र में बनाया है।

बाजार के उदारीकरण तथा प्रतिस्पर्धा उसका मुख्य ध्येय अब उस पर पुन:विचार हो रहा है कि अनिवार्य अध्यपर्ण हो या नही। ब्रोकर के मेहनताना पर बनायी गयी समिति ने यह संस्तुति दी है कि अनिवार्य अध्यपर्ण को प्रगामी रूप से ऐच्छिक व्यवस्था में प्रतिस्थापित किया जाना चाहिये।

यह आने वाले समय में संभव है कि ऐसा हो तथा दोनों प्राथमिक बीमाकर्ता तथा जीआईसी को जरूरत है कि वे अपने व्यवसाय की योजनायें बनायें इस घटक को ध्यान में रखते हुये।

प्राशुल्क उन्मूलन

बीमा बाजार के उदारीकरण के साथ यह जरूरत है कि मूल्य प्रणाली प्राशुल्क ढाँचे से बचा जाये। यह अभी स्पष्ट नही हुआ है कि जीआईसी अपने अनिवार्य अध्यपर्ण को कैसे लगी तथा अंतरराष्ट्रीय बाजार ऐसे परिपेक्ष को कैसे देखेगा। क्या प्रतिस्पर्धात्मक दबाव कारण दरे गिरेंगी? क्या यह प्राथमिक बीमाकर्ता को प्रभावित करेगी। अपनी पुर्नबीमा क्षमता के कारण अपने उपंतिका गिरेगी? यह सट्टा लगाना कठिन है।

निष्कर्ष-

अंतरराष्ट्रीय बाजार में विप्लव के चलते स्थिरता कठिन है। दो वर्ष तक यहाँ तक की यदि कोई बड़ी हानि न हुई हो। भारतीय बाजार की जरूरतों को संबोधित करते हुये अधिक गंभीरता से पुर्नबीमा अभिकल्पना को उसकी इच्छाओं को स्वीकार करते हुये बाजार में संव्य करना तथा राष्ट्रीय अध्यपर्ण क्षमता का विस्तार सहयोग से तथा एक पूल बनाते हुये। निजी व्यवसायी जिनकी पूँजी कम से कम 10 करोड़ तथा को अधिशेष न हो उनको अपने अध्यपर्ण क्षमता को बढ़ाने में वर्षों लगेंगे। बाजार में प्रतिस्पर्धा बिना अध्यपर्ण का आधार हुये एक स्वंय को मात ने वाली साबित होगी क्योंकि वह पुर्नबीमाकर्ता के मीठे अनुभव पर आधारित रहेंगे तथा उनके आयोजकों पर आने वाले वर्षों में।

सार्वजिनक क्षेत्र के बीमाकर्ताओं के लिये जरूरत है इस पुर्नबीमा दस्तावेजों को अच्छी तरह समझने की कि वह उनके लाभ में कितना जोखिम है। जिससे परिचालन लाभ उत्पन्न किया जा सके तथा अध्यपर्ण तो बढ़ाया जा सके। लाभ के व्यवसाय के लिये हानि की अधिकता का आवरण उपलब्ध करवाया जाये। निपुर्णता की जरूरत तथा उन्हें व्यवसायिक सलाह लेने से बचना चाहिये। जो पुर्नबीमाकर्ता या ब्रोकर से मिलती है।

लेखक सेवानिवृत्त सीएमडी ओरिएण्टल इंश्योरेन्स कंपनी लिमिटेड

Report Card:LIFE

New business grows 17 % over January

With the financial year 2003-04 almost drawing to a close, the life industry wrote first year premium of Rs.1,303,756.22 lakh towards 2,06,30,207 policies up to February, 2004. The overall growth over premium underwritten upto January 2004 was 16.98 per cent with private players recording growth of 22.10 per cent and LIC 16.26 per cent during the month.

In terms of policies, the growth was 15.53 per cent. Premium underwritten by the private players in February, 2004 was Rs.1,66,629.31 lakh, viz., 12.78 per cent of total premium underwritten. In comparison, LIC underwrote premium of Rs.11,37,126.91 lakh i.e., a market share of 87.22 per cent.

In terms of policies underwritten, the market share of the private players was 6.25 per cent as against 93.75 per cent of LIC. A comparison of the data for April, 2003 to February 2004 reveals that the insurers have underwritten 77 per cent of the single and first year premiums procured during 2002-03.

The premium written by the private players for individual policies stood at Rs.1,45,912.72 lakh, towards 12,87,588 policies with group premium accounting for Rs.20,716.60 lakh towards 912 schemes. The number of lives covered under group schemes was 14,17,582.

Premium written by LIC under individual schemes was Rs.9,11,093.38 lakh towards 1,93,29,451 policies, and under group schemes was Rs.2,26,033.53 lakh towards 12,256 schemes. The number of lives covered by LIC under group schemes increased to 35,66,606, i.e., 71.56 per cent of the total lives covered.

ICICI Prudential continued to lead amongst the private players with premium at 4.43 per cent and policies at 1.65 per cent. In terms of number of lives covered, SBI life led with 5,71,276 lives viz., 11.46 per cent of the total lives covered.

While private insurers underwrote business under the rural sector at Rs.2,760.18 lakh towards 1,87,605 polices, two insurers have "nil business" under the social sector. The private insurers underwrote premium of Rs.187.16 lakh in the social sector covering 176412 lives. LIC underwrote rural premium of Rs.1,07,725.33 lakh towards 44,14,007 policies and Rs.1,520.23 lakh covering 15,18,958 lives in the social sector.

Premium underwritten by LIC under Varishtha Bima Yojana was Rs.5,24,721.75 lakh towards 2,87,305 policies, i.e., growth of 11.1 per cent and 10.76 per cent, respectively during the month.

(Rs. in lakhs)

First Year Premium – February 2004

		Premium u/w		% of Premium	No. of Policies/Schemes		% of Policies	No. of lives covered under Group Schemes		% of lives under Group Schemes
		February	Upto Feb.	Upto Feb.	February	Upto Feb.	Upto Feb.	February	Upto Feb.	Upto Feb.
1	**Allianz Bajaj**	**2,007.56**	**11,396.91**	**0.87**	**17,168**	**1,42,536**	**0.69**	**1,030**	**55,968**	**1.12**
	Individual Single Premium	2.05	276.43		8	711				
	Individual Non-Single Premium	2,007.23	11,056.49		17,151	1,41,773				
	Group Single Premium	0.00	0.76		0	1		0	781	
	Group Non-Single Premium	-1.72	63.23		9	51		1,030	55,187	
2	**ING Vysya**	**681.79**	**4,517.13**	**0.35**	**8,415**	**59,225**	**0.29**	**128**	**1,212**	**0.02**
	Individual Single Premium	9.40	28.40		1,384	4,180				
	Individual Non-Single Premium	628.12	4,442.41		7,028	55,040				
	Group Single Premium	43.77	43.77		1	1		72	72	
	Group Non-Single Premium	0.50	2.55		2	4		56	1,140	
3	**AMP Sanmar**	**264.13**	**2,100.10**	**0.16**	**3,105**	**36,843**	**0.18**	**5,352**	**58,569**	**1.18**
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	238.76	1,891.83		3,102	36,827				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	25.37	208.27		3	16		5,352	58,569	
4	**SBI Life**	**2,036.63**	**11,617.38**	**0.89**	**10,025**	**60,121**	**0.29**	**40,673**	**5,71,276**	**11.46**
	Individual Single Premium	491.77	2,013.56		463	6,056				
	Individual Non-Single Premium	662.17	2,873.32		9,486	53,682				
	Group Single Premium	770.44	4,588.42		4	22		9,968	48,877	
	Group Non-Single Premium	112.24	2,142.08		72	361		30,705	5,22,399	
5	**Tata AIG**	**2,754.11**	**14,287.10**	**1.10**	**16,368**	**1,36,990**	**0.66**	**25,903**	**1,70,159**	**3.41**
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	987.25	10,373.95		16,360	1,36,928				
	Group Single Premium	45.64	431.24		0	1		8,755	86,358	
	Group Non-Single Premium	1,721.21	3,481.91		8	61		17,148	83,801	

(Rs. in lakhs)

		Premium u/w		% of Premium	No. of Policies/Schemes		% of Policies	No. of lives covered under Group Schemes		% of lives under Group Schemes
		February	Upto Feb.	Upto Feb.	February	Upto Feb.	Upto Feb.	February	Upto Feb.	Upto Feb.
6	**HDFC Standard Life**	**2,218.18**	**15,001.83**	**1.15**	**19,058**	**1,67,769**	**0.81**	**6,501**	**47,834**	**0.96**
	Individual Single Premium	674.71	4,955.47		1,388	35,981				
	Individual Non-Single Premium	1,483.71	9,070.29		17,663	1,31,691				
	Group Single Premium	59.76	976.08		7	97		6,501	47,834	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
7	**ICICI Prudential**	**11,900.37**	**57,714.15**	**4.43**	**79,752**	**3,40,511**	**1.65**	**2,014**	**25,764**	**0.52**
	Individual Single Premium	1,921.00	9,633.00		907	9,003				
	Individual Non-Single Premium	9,969.00	47,743.00		78,839	3,31,461				
	Group Single Premium	3.77	150.95		5	41		1,899	24,800	
	Group Non-Single Premium	6.60	187.20		1	6		115	964	
8	**Birla Sunlife**	**5,247.67**	**24,752.43**	**1.90**	**19,792**	**1,12,254**	**0.54**	**3,665**	**1,44,718**	**2.90**
	Individual Single Premium	258.34	1,255.53		4,485	22,730				
	Individual Non-Single Premium	2,617.66	16,144.20		15,301	89,426				
	Group Single Premium	34.49	357.08		0	0		281	2,793	
	Group Non-Single Premium	2,337.18	6,995.62		6	98		3,384	1,41,925	
9	**Aviva**	**944.16**	**5,935.31**	**0.46**	**7,558**	**56,478**	**0.27**	**11,258**	**51,936**	**1.04**
	Individual Single Premium	50.37	430.33		73	642				
	Individual Non-Single Premium	885.79	5,468.74		7,480	55,818				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	8.00	36.24		5	18		11,258	51,936	
10	**OM Kotak Mahindra**	**973.53**	**6,960.61**	**0.53**	**4,789**	**38,925**	**0.19**	**10,847**	**70,693**	**1.42**
	Individual Single Premium	29.05	289.79		30	248				
	Individual Non-Single Premium	885.00	6,053.66		4,753	38,635				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	59.48	617.16		6	42		10,847	70,693	
11	**Max New York Life**	**1,420.12**	**10,518.15**	**0.81**	**18,137**	**1,17,351**	**0.57**	**3,092**	**2,00,915**	**4.03**
	Individual Single Premium	7.15	153.77		12	172				
	Individual Non-Single Premium	1,405.07	9,959.64		18,121	1,17,094				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	7.89	404.74		4	85		3,092	2,00,915	
12	**MetLife**	**268.62**	**1,828.21**	**0.14**	**2,912**	**19,497**	**0.09**	**2,132**	**18,538**	**0.37**
	Individual Single Premium	7.84	40.52		17	221				
	Individual Non-Single Premium	259.59	1,758.39		2,893	19,269				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	1.19	29.30		2	7		2,132	18,538	
	Private Total	**30,716.85**	**1,66,629.31**	**12.78**	**207,079**	**1,288,500**	**6.25**	**1,12,595**	**14,17,582**	**28.44**
13	**LIC**	**1,59,078.35**	**1,137,126.91**	**87.22**	**2,570,814**	**19,341,707**	**93.75**	**5,18,900**	**35,66,606**	**71.56**
	Individual Single Premium	16,950.36	70,404.38		48,399	151,645				
	Individual Non-Single Premium	1,19,445.01	8,40,689.00		2,520,818	19,177,806				
	Group Single Premium	22,682.98	2,26,033.53		1,597	12,256		5,18,900	3,566,606	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Grand Total	**1,89,795.20**	**1,303,756.22**	**100.00**	**2,777,893**	**20,630,207**	**100.00**	**6,31,495**	**49,84,188**	**100.00**

Note: LIC's business figures do not include Varishtha Pension Bima Yojana.

Report Card: GENERAL

Premium Growth revives to 13%

G.V. Rao

Performance for the month of February 2004

The market premium in February 2004 grew by Rs. 133 crores (13 per cent) to record a monthly premium of about Rs. 1,150 crores in line with the average growth rate of around 12 per cent to 13 per cent. The private players have improved their performance by Rs. 85 crores (88 per cent growth) and the public players including ECGC by Rs. 48 crores (5.2 per cent growth).

The SVRS announced by the four public players has not had any adverse impact on their overall premium increases in February 2004. The four public players have improved their premium levels by Rs. 60 crores (6. 8 per cent) and have maintained their average growth rate of six per cent. ECGC has dropped its premium by Rs. 12 crores (-28 per cent). New India has dropped by Rs. 16 crores (-5.7 per cent). National Insurance has recorded an accretion of Rs. 33 crores (15.3 per cent), Oriental Rs. 24 crores (13.3 per cent), and UIIC Rs. 20 crores (10 per cent).

The psychological disadvantage of SVRS as a morale deflator for the public players has proved to be wrong if the results of February 2004 are any reliable indication of the future trends. New India among them seems to be having the toughest challenge on its hands to reassert itself as the market leader.

The private players have maintained their growth rate of around 85 per cent . They have recorded in February 2004 an accretion of Rs. 85 crores (88 per cent growth) to reach Rs. 182 crores giving continued evidence that they are the market trend setters of growth and accretion. ICICI Lombard with an accretion of Rs. 36 crores (200 per cent growth) looks unstoppable in its march as the top player among the private players.

Bajaj-Allianz, the second ranked player has an accretion of Rs. 17 crores (70 per cent growth). There is almost a race between these two for the top honours. HDFC Chubb has Rs. nine crores accretion followed by Tata AIG with Rs. eight crores. All other players have also shown increases in their premium levels.

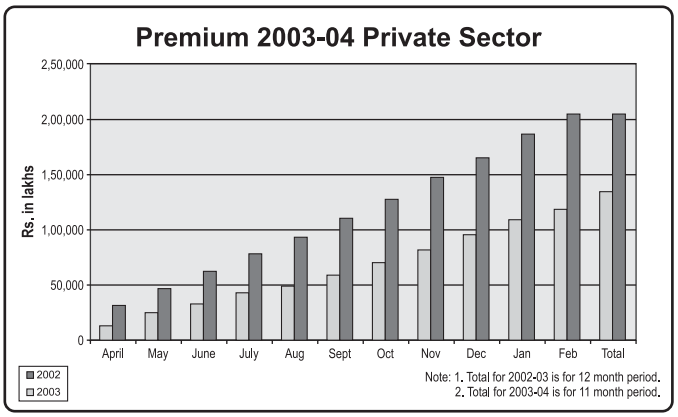
Performance up to February 2004

The premium levels up to February 2004 have gone up to about Rs. 14, 450 crores with an accretion of Rs. 1,600 crores (12.5 per cent growth). Of this Rs. 1,600 crores the eight private

Gross Premium Underwritten – February 2004

(Rs. in lakhs)

Insurer	Premium 2003-04		Premium 2002-03		Market share upto January, 04	Growth % Year on Year
	For the month	Upto the month	For the month	Upto the month		
Royal Sundaram	1,769.47	22,901.82	1,422.86	16,597.74	1.58	37.98
TataAIG	2,401.29	32,450.69	1,550.14	20,031.23	2.25	62.00
Reliance General	882.19	15,404.34	642.33	17,060.86	1.07	-9.71
IFFCO-Tokio	1,934.03	28,466.37	1,574.67	18,906.44	1.97	50.56
ICICI Lombard	5,265.50	45,628.12	1,704.35	19,131.97	3.16	138.49
Bajaj Allianz	4,124.94	42,627.43	2,413.23	25,912.00	2.95	64.51
HDFC Chubb	1,155.14	9,549.06	208.47	602.49	0.66	1,484.93
Cholamandalam	690.60	8,303.44	173.18	809.63	0.57	925.58
New India	26,541.00	3,50,098.00	28,084.00	3,49,888.00	24.22	0.06
National	24,893.00	3,09,132.00	21,603.00	2,59,116.00	21.39	19.30
United India	22,265.00	2,80,149.00	20,315.00	2,69,704.00	19.38	3.87
Oriental	20,371.84	2,62,050.72	17,967.12	2,55,272.73	18.13	2.66
ECGC	2,945.15	38,446.70	4,206.49	31,964.20	2.66	20.28
PRIVATE TOTAL	18,223.17	205,331.28	9,689.23	1,19,052.37	14.21	72.47
PUBLIC TOTAL	97,015.99	1,239,876.42	92,175.61	11,65,944.93	85.79	6.34
GRAND TOTAL	1,15,239.16	1,445,207.70	1,01,864.84	12,84,997.30	100.00	12.47



players have contributed over Rs. 860 crores (73 per cent growth), the four public players Rs. 675 crores (6 per cent growth) and ECGC Rs. 65 crores (20 per cent growth).

National Insurance alone has contributed Rs. 500 crores (19.3 per cent) increase to the overall accretion of Rs. 675 crores of the public players. UIIC has chipped in with Rs. 105 crores (3.8 per cent) and Oriental with Rs. 68 crores (2.7 per cent) with New India recording almost no accretion.

The reasons for the uneven growth rates among the four public players are puzzling.

New India is located in the West that has a premium potential of 40 per cent of the overall premiums; UIIC and Oriental are located in the South and North respectively, having premium potentials of about 25 per cent each; National Insurance in the East with a premium potential of about 10 per cent.

The uneven growth rates could perhaps be explained as due to the competitive pressures generated by the private players who are mostly located in the West. There are more corporate accounts to be targeted in the West than elsewhere.

National Insurance has shown that despite its location in the East with a relatively low potential for business, it is possible to provide tougher competitive pressures to win premium volumes on an all India basis.

The major contributors to the premium accretion of the private players of Rs. 860 crores are ICICI Lombard with Rs. 270 crores (140 per cent), Bajaj with Rs. 170 crores (65 per cent), Tata AIG with Rs. 125 crores (62 per cent) and IFFCO-Tokio with about Rs. 100 crores (50 per cent).

Prospects

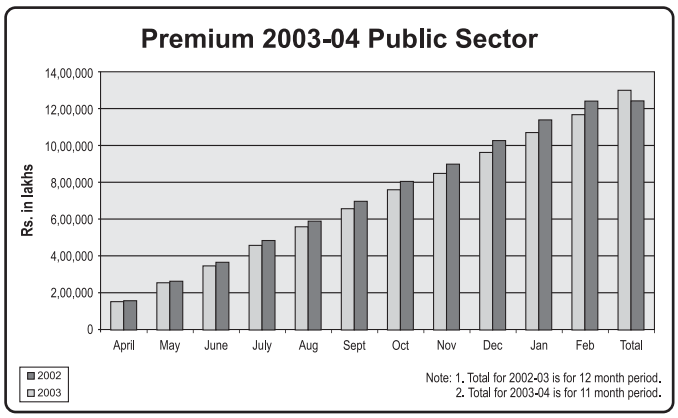
The growth rate of six per cent of the public players is an indication of how tough market conditions have become for them despite the rate increases in Motor business in the first quarter of the current fiscal. Health insurance campaigns like the Universal Health Insurance and bank-tie ups have further boosted their market efforts this year. Despite these special efforts the going for them has been tough. Retention of major corporate accounts has been a major headache for them. Corporate strategies to deal with unhealthy competitive market pressures have yet to be devised and implemented.

With SVRS involving the exit of almost 30 per cent of the Managers and Deputy Managers of each of the public players, the decision-making and servicing capabilities of each will be more sorely tested. How will they cope? That is the immediate biggest challenge before them.

Private players who have had an impressive growth so far have now additional opportunities to mount even more competitive pressures on the available market business of corporates. The current average growth rate of 12 per cent, despite being impressive according to international standards, compares poorly with the growth rate of 20 per cent achieved in the previous fiscal. In the immediate future it is unlikely that there would be any tariff rate increases. Motor Own Damage (OD) business, if it is detariffed, as is likely, may see a fall in rates leading to lower growth rates.

The immediate future and the next fiscal 2004 – 2005 appear as quite daunting with the environment within companies and outside more challenging than ever before. With no precedents and past experience to guide the present leadership of public players it has on its hands the toughest challenge which none of its predecessors have faced.

The author is retired CMD, The Oriental Insurance Company.



In Retrospect

Nirmala Ayyar

Continued from the last issue:

Before we come to rural business, let us first look at the investment-linked plans.

Even today, there are many who feel that the Indian capital market is not a mature market and that it is not ready for investment-linked life insurance plans. If that is the reality in a burgeoning economy, what to say of a decade or two back? There is also the attitude of the people. Notwithstanding the soaring price of gold, there is aggressive selling of gold by the jewellers and the thronging crowds in jewellery shops is indeed an amazing spectacle.

In spite of the rising crime rates, people still consider gold a safer investment than money instruments, possibly because of frequent stock market scams. There has also been the scandal of the failure of the smaller benefit funds recently in the South and of some cooperative banks in the West, to scare people off money deals with unknown or even known entities.

If people are attracted to investment linked plans now, it is rather because the Government's consumerist anti-savings fiscal policies have left no option for the discerning populace. A fear-driven captive market is neither a good nor a lasting market. We can consider that there is a good market for these investment-oriented plans only if people choose them in spite of other equally good investment opportunities available, which is not the case at present.

One should also not forget that though LIC had a monopoly in selling life insurance, it always had to compete with other lucrative savings instruments such as mutual funds, Post Office schemes and National Savings Certificates. It has grown to its giant size largely because people accepted it as a good and safe savings instrument in those days.

Let us also take a look at the health-riders in life policies. Practically all insurers are offering comparable benefits, covering the contingency of the onset of the same set of costly illnesses. There is not much variety here.

But, if we are to believe the announcements regarding recent developments in the field of medicine, such as a vaccine for cancer or injections for cardiac problems, it is quite possible that these leaders in health cost may soon cease to be so, in which case the health riders may lose their novelty.

Would we really be prepared to deal with the rising incidence of major health cost in areas relating to mental illnesses, Alzheimer's or Parkinson's disease, or, cancer and diabetes in children? Because, if the services offered are to be truly need-based, this is where the need will be felt in times to come.

But, quite obviously, it is much easier and more comfortable to cover cardiac and cancer costs. The Western experiment with Long Term Care is not very encouraging from a business perspective. While in India it can be a much less costly proposition, it will, in implementation,

> A fear-driven captive market is neither a good nor a lasting market.

turn out to be a synonym for care of the aged in a scenario of increasing longevity coupled with acute geriatric problems and fragmented family units, and therefore a losing business proposition, or may metamorphose into another way of selling annuity policies. What value does the insurance industry propose to add to this vital sector?

A detailed analysis of these aspects is called for in order to explode the myth that insurance selling is truly need-based, and we could not so far meet the needs of the people.

What, in the final analysis, are specific insurance needs in a person's life? Cover against early death, accidental death, money required to meet expected or unexpected mid-life expenses and provision for old age. A mid-life expense could be a medical expense, an expense for the education or marriage of a child, a housing loan. Anything more than these defined as an insurance need could only be called quibbling.

People are smart. LIC could not sell its Multipurpose policy, the equivalent of the Universal policy of the US. LIC may have 58 products on its table. But what the agents sell and what the people buy with confidence happens to be only the handful of same old Endowment, or whole life type of plans call them by what name you will.

A rose called by any name is as sweet, as the poet said. While it is true we can influence the agent's selling preferences by altering the commission structure, we cannot do this to the buyer of insurance. He counts the cost of the frills. Is it not true that the scenario is the same the world over?

And so we come to Rural Business.

The special annual issue of the **IRDA Journal** makes it very clear that we have not been successful in achieving our objectives in the area of rural business. LIC has a long history of experimentation and also success in rural business. Let us avail ourselves of the benefit of lessons learnt and also use it to get a closer look at the problems in achieving targets in this area.

The real problem with rural business has always been the classification of what can be considered rural. With the fast paced growth of cities, the suburbs merging into surrounding villages, migration of labour from villages to cities, the classification is as stable as quick sands. Our census data becomes outdated by the time it is compiled and published. What is described in it as an agrarian village might no longer be so due to a shift to industry or migration of rural labour. There is also the problem of renaming of places. The names given in the census data may not be the ones in current use. The real villages in the interior may not be identifiable through pin codes.

There is therefore, a need for a differentiated approach to the rural question. What is the objective? Is it to

mop up the savings in rural areas or is it to provide the benefit of insurance to the rural populace? These are actually two different questions because it addresses two different sets of people in the villages of India. Nowhere is the divide between the haves and havenots so wide and deep as in interior villages. Either you are the landlord or you are the labourer. There may be a few other incidental occupations not much more lucrative than that of the labourer.

This situation may not be so evident in the Punjab or Haryana, but it is the root of the problem in Orissa, Maharashtra, Andhra, Kerala, Karnataka and Tamil Nadu. The tales of stark poverty drive terror into the heart. Do these people need insurance? Yes, they do. Can they pay for it? No sir, they cannot afford to pay for it. If we have a quota for rural insurance under such circumstances, what can we expect?

There is one positive aspect to this problem. More and more co-operative efforts for betterment are slowly becoming manifest in rural areas. Such efforts bring prosperity in their wake. Further, there are multiple contributions to the family kitty, since idle hands are not encouraged among the lower income groups. On the other hand alcohol addiction and poor food contribute to a shortening of the life span.

Taking the positive and negative together, it would be wiser to provide only group insurance for the rural poor while individual policies should be reserved for the economically viable.

Determination of the quota allocation does not take into account regional variations and the effect of natural calamities on rural economies. Recent phenomena include the havoc wrought by export policies on rural economies.

Consider Maharashtra. The rich sugar belt could support a substantial influx of insurance business, but those producing food crops in the arid interiors eke out a precarious living. Similarly Karnataka is riven by its famine ridden districts while the cash crops support rich business in coffee and condiments. It will not be practicable to allot area wise quota.

However, the fact that natural calamities wreak far greater havoc on rural economy than on the cities needs careful consideration. Flood or famine, the devastation is in terms of crops and cattle. One incidence of disease can wipe out an entire year's income from the coconut crops in Kerala. The percentage of rural business asked for from the new companies is not very high. But it will require to be modified on an on-going basis, if the elements should prove inclement in any particular area. A reprieve is needed in such cases as otherwise the quality of business can become suspect.

There is need to explore one more myth – that regarding the use of advanced technology. The foreign partners have not only brought in new technologies but new attitudes to technology as well. They are more open to using the latest hardware or software, and not count the cost. This influences also the management style which, true to Indian tradition was feudalistic hitherto, and is now required to switch over to an objective impersonal management style, based only on performance. The pros and cons of this are the subject of management seminars and need not be considered in this context. Has modern technology succeeded in giving better service to people? That is the question. Because, that was one of the important postulates of the Malhotra Committee.

It would be wiser to provide only group insurance for the rural poor and individual policies for the economically viable.

To be able to answer it honestly, we need to be clear as to what we mean by better service. If the indicator is the extent of politeness or finesse and efficiency in dealing with customers, it is a function of human attitude, and not of technology. It is also a function of job knowledge, and ability to use available technology. It might have been available in the past irrespective of technology, and it might be available now irrespective of technology, depending entirely on the person handling the customer. As to whether recorded and mechanical interfaces to customers can be considered better service, there can easily be two views about it. If it is a question of on-line connectivity to the remotest corners of the country, it is heavily dependent on infrastructure facilities provided by the country.

Let us consider for example, the ability to switch funds on-line or pay premiums through the Internet, or browse on product features through the website. What is the target audience and how big is it? Doubtless every village in India will be able to do these things in a matter of fifty years from now, because a beginning has been made now.

LIC started a Technical Services Wing to offer consultancy to other countries, because there was a demand for the competence it had built up in the insurance business. But cost of implementation and training, constitute an important consideration in any technology oriented project. Also technology ought not to be worshipped for its own sake but only for what good it can do for the greatest possible number of people.

This is India Shining and poised to march forward on the path of progress. We are part of the bandwagon. To throw caution to the winds in order to quicken the process, like a child wanting a surfeit of sweets, would tantamount to forgetting lessons from the past. Caution is needed in any new venture, but more so when it is public money that we are spending. To sum up, a lot has been achieved in a short while thanks to all concerned, within and without the country. But as the poet said, 'there are miles to go before we sleep'. Though perspectives have changed, there is still need for an honest search for better solutions.

The author is retired Chief (Data Control and Purification), LIC.

MBA from NIA

The National Insurance Academy (NIA), Pune, will start offering education and consultancy in addition to its existing activities of training and research. With this in view it has introduced a two-year masters programme in business administration (MBA) programme.

Besides setting up two subsidiaries — Emirates Pearl Management Training Institute in Dubai and West African Insurance Institute in Gambia — to act as feeders to NIA, it is setting up three more subsidiaries Mauritius, Sri Lanka and Nepal.

The academy will offer domain-specialised courses in actuarial science and information technology. NIA has entered into a collaboration with the Fair Fax University in the US and is now a member of the Institute of Global Insurance Education (IGIE), a consortium of reputed international academies from the US, UK and Canada. It has tied up with the US-based Life Office Management Association (LOMA).

The NIA plans to start with a batch of 60 students this year – half would be foreign students selected on G-MAT scores while the other half would be Indians admitted through a common admission test (CAT). The academy has secured approval from the All India Council of Technical Education (AICTE) for the MBA programme.

NIA has also tied up with domestic and foreign insurance companies to enable the students get hands on experience

CONSUMER COMMISSION AWARDS CLAIM TO SEAFOOD PLANT

New India Assurance has been ordered by the National Consumer Disputes Redressal Commission to pay Rs. 1.45 crore with 12 per cent interest from May 1, 2000 till date to an export company whose stock of insured seafood was damaged by the Orissa super cyclone in October 1999.

"In our view, the insurance company illegally repudiated the claim," National Consumer Disputes Redressal Commission Presiding Member Justice M.B. Shah and Member Rajyalaksmi Rao said in their order.

The commission also directed the insurance company to pay litigation cost of Rs. 10,000 to the complainant S. K. Exports.

S. K. Exports's seafood processing plant at Bhubaneshwar (Orissa) was insured with New India Assurance since 1995 under the fire policy with extra peril coverage.

Following the cyclone on October 28, 1999, most of prawns in the cold storage was spoilt as there was no power supply, S. K. Exports said. The executive engineer of the electricity company also certified that there was no power supply between October 29, 1999 and November 7, 1999.

S. K. Export's claim was rejected by New India Assurance, saying the nature of loss comes under 'deterioration of stock' policy which the export company had not opted for.

However, S. K. Exports claimed that the special peril premium for the policy, which it paid for six years till the cyclone, also covered the deterioration of stock due to power failure.

The surveyors appointed by New India Assurance, in their report on October 20, 2001 observed that the loss to S. K. Exports due to the cyclone was approximately Rs 1.45 crore.

The insurance company, in its arguments said the freezing plant of the complainant company was not damaged or destroyed by the cyclone.

The consumer court rejected this contention saying, "The cover note specifically provides that the insurance cover is for stock of prawn and other fishes kept at S. K. Export's cold storage. If the cold storage becomes non-functional because of non-supply of electricity, it cannot be said that there is no insurance coverage."

INDIA OFFERS TO SHARE SOCIAL SECURITY SCHEMES WITH PAKISTAN

The thaw in bilateral relations is enabling India to offer Pakistan its expertise in the field of social security for the informal sector.

"We will talk to the Pakistani government if it wants (advice for the social security scheme)," the Daily Times, a Pakistani newspaper, quoted India's Union Labour Minister Sahib Singh Verma as saying in an interaction with a Lahore Chambers of Commerce and Industry delegation.

Highlighting that India's new social security scheme was the first of its kind in the developing world, Verma said that either Pakistan could send its officials or Indian officials could go over there to advise them on the scheme.

The minister further said that the main idea of a social security scheme for the unorganised sector in India was to entitle those 370 million workers in the sector to pension and other benefits including medical insurance and family pension.

The scheme, which would have contributions from employers as well, was part of the 'revolution' to be ushered into the unorganised sector, he added.

Verma further said that the employees between 18 and 35 years would have to contribute Rs.50 and those in the age group of 36 and 50 would pay Rs.100, while there would be contribution from employers, he added. Besides, a monthly pension of Rs.500 would be offered on retirement, permanent or temporary disability or to the widow of a worker.

PROTECTING POLL OFFICIALS

The Election Commission has reportedly decided that every poll official in Jharkhand will get an insurance cover of Rs. 10 lakh.

The insurance will cover officials who die under any circumstances during poll duty, even those who might die due to a heart attack. Besides, the cover will give Rs. 5,00,000 to an official losing any part of his or her body during duty.

The commission has invited tenders from insurance companies for the purpose and has got a response from about half a dozen firms.

The insurance coverage in a state which frequently witnesses extremist related violence, assumes significance in the light of the call by Maoist guerrilla groups to boycott the elections.

In last three general elections, about 20 police officials and 12 polling officials lost their lives. As a punishment for violating the boycott call, six officials have had their hands cut off, it is reported.

Under the insurance scheme, 74,862 polling officials will be covered.

The state has 17,014 polling booths with four officials in each. So, 68,056 polling officials will be deputed and 6,806 will be kept as reserve.

Besides polling officials, police personnel and paratroopers on election duty will also come under the insurance coverage.

Jharkhand goes to the polls on April 20 and 26. In the first phase on April 20, six constituencies considered extremist infested will be covered. Elections to the other eight constituencies will be held on April 26.

ECGC OFFICES GET ISO 9001

The Registered and Head Office of Export Credit Guarantee Corporation of India Limited (ECGC) in Mumbai and its Large Exporters Branch, Mumbai, have been given IS/ISO 9001:2000,quality management systems Certification by Bureau of Indian Standards, India.

According to a press release from ECGC, the scope of the ISO certification for the Head Office is for Issuance of Export Credit Insurance policies, Maturity Factoring Services, Guarantees to Banks, Special Schemes and related products for Exporters/Banks excluding Design and Development.

The scope of the License for its Large Exporter's Branch in Mumbai is for Issue of Export Credit Insurance Policies and related products for Large Exporters excluding activities related to design, development and purchase activities

The ISO certification obtained for the above offices is to ensure continual supply of quality services to its customers as reflected by the Quality Policy adopted by ECGC.

ECGC has also planned to expand the ISO Certification for ten more of its branches during the year 2004 – 2005 in pursuit of its objective of spreading the quality culture throughout the organisation.

ECGC UPS PAK, LIBYAN RISK RATINGS

Export Credit Guarantee Insurance Corporation of India (ECGC) has upgraded Pakistan to second highest country rating category (A2), indicating improved economic and political climate for bilateral trade and lower insurance premium costs.

After new initiatives (for peace and improved relations), the corporation has upgraded Pakistan by two notches to A2 and the premium rates for export insurance for the neighbour would be lower compared to what was charged before, ECGC officials are reported saying.

With this Pakistan has been brought on par with other SAARC nations, making it easy to manage operations.

ECGC has also upgraded Libya to B1 level after conducting a review of economic climate since economic conditions have improved in Libya and India was targetting African states to promote exports.

LIC HAS TOP RECALL

LIC continues to dominate the insurance market in terms of 'recall' and market share, but private insurance companies are increasingly making inroads into the consumer mindspace according to the Taylor Nelson Sofres (TNS) Insurance Tracker.

According to a press release from the company the results of the survey on percentage un-aided company awareness was 99 per cent of LIC while ICICI Prudential came second with 66 per cent. The values for all life insurance companies are given in the table.

Un-aided company awareness (%)

LIC	99
ICICI Prudential	66
SBI Life	29
OM Kotak Mahindra	26
Birla Sunlife	21
HDFC Standard Life	10
Dabur Aviva	12
Max New York Life	13
Tata AIG	18
Allianz Bajaj	17
MetLife	4
ING Vysya	2
AMP Sanmar	7

Dec. 2003 to Jan. 25, 2004

CHINESE INSURANCE FIRMS TO INVEST IN STOCKS

China's stock market is set to receive more investment from insurance firms. The Chinese government has already, in principle, approved insurers to invest directly in equities, according to reports.

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Wu Dingfu, chairman of the China Insurance Regulatory Commission, said China will allow its insurance funds to enter capital markets in gradual steps.

China's 61 insurance firms seek higher investment returns than bonds and banking deposits produce. Premium incomes in the Chinese mainland rose 27.1 per cent from a year earlier to 388.04 billion yuan ($46.75 billion), putting pressure on insurance firms for better yields.

Industry officials expect the insurance regulator to permit insurers to directly invest five percent of their total assets, 912.28 billion yuan by the end of last year, in the A-share markets.

This can allow 45 billion yuan to flow into the stock market.

Fund management firms believe insurance deregulation will not come at the cost of their business. The exposure of insurance firms to mutual funds is low. There were concerns that insurance firm investments would cause a massive flow from mutual funds to equity investment. China's insurance firms use only a tiny proportion of their assets to buy mutual funds.

China's insurance companies placed only 5.10 per cent of their assets in the stock market through the purchase of the securities investment funds last year, falling far short of the 15 per cent investment cap for the mutual funds, according to official statistics.

The outstanding value of investment by insurers reached 873.9 billion yuan at the end of last year, among which 454.97 billion yuan were invested in bank deposits, according to sources with the China Insurance Regulatory Commission.

Swiss Re: Costs Are Rising with Global Temperatures

According to Swiss Re's latest "sigma" report, overall economic losses from natural disasters — aggravated by climate change — in 2003 amounted to an estimated $70 billion. Property insurers across the globe had to contend with losses of some $18.5 billion.

In financial terms total damage attributable to natural and man-made catastrophes in 2003 was $70 billion. At an estimated $14 billion, the drought conditions in central, southern and eastern Europe produced the largest economic loss. Typhoon Maemi in South Korea also contributed a further $5.5 billion.

Of the 2003 total, man-made disasters accounted for $12 billion of economic losses, more than half of which was due to the three-day power outage in the U.S. during August.

Insurers to pay over $18 billion for catastrophes

The property insurance industry bore $18.5 billion, or one quarter, of the total damage from catastrophes in 2003. Last year was notable for the several billion dollar catastrophes.

Six events generated insured property losses in excess of one billion dollars, together accounting for more than half of all insured catastrophe losses reported in 2003.

During April, a storm system swept across the US from the North East to the Midwest, bringing snow and ice, while in May, a record series of more than 400 tornadoes hit the US Mid-West with hailstorms. These two events cost insurers $3.2 billion and $1.6 billion respectively. In September, Hurricane Isabel stormed across the US states along the Eastern seaboard and Ontario, generating an insured property loss of $1.7 billion. Between the end of October and beginning of November, two forest fires raged in California resulting in extensive property damage in the populated forestry zones. In December 2003, flash floods in the South of France caused insured losses of $1 billion.

Natural catastrophes were responsible for significantly more losses than major man-made disasters which caused insured losses of $2.3 billion in 2003, mainly from large industrial fires, explosions and the loss of space satellites.

Burden for property insurers: rising trend

While the insured property loss figure of $18.5 billion is below those of recent record years, 2003 can be added to the list of costly loss years. Catastrophes have caused billions of losses in every year since the late eighties (an inflation-adjusted annual average of $20 billion since 1987). There are strong indications that the billion-dollar loss trend will continue, and the 2003 figures confirm this trend towards high losses, which is being driven by increasingly densely populated areas, higher concentrations of insured values and the development of endangered zones.

2003 was the hottest summer on record for many countries in Europe, and in 2002 there were heavy flash floods in parts of Europe during July and August. As the report outlines there is increasing evidence for a rise in extreme weather events, and hence in insured catastrophe losses. It also shows how the catastrophe bond market is complementing the traditional way of insuring and reinsuring catastrophes.

Munich Re Posts First Loss in 97 Years

Munich Re announced that 2003 resulted in its first net loss since 1906, the year of the San Francisco earthquake. The world's largest reinsurer lost 434 million euros ($533 million) last year, but said that the result "draws a line under three difficult years."

Although the loss wasn't good news, it was largely offset by the company's increase in underwriting profit to 2 billion Euros ($2.46 billion), the reduction of its combined ratios to 96.7 percent in reinsurance and 96.4 percent in primary insurance and solid forecasts of future profits.

The management in a statement said: "With the net loss for 2003, we are drawing a line under three difficult years impacted above all by the bear market on the stock exchanges. As the underwriting result for the year under review showed, we are gearing our operations closely and consistently to profitability in all fields of business.

Munich Re's gross premium income increased slightly to 40.4 billion euros ($49.61 billion). That, combined with the reduced combined ratios, which the company attributed to "the successful outcome of consistent underwriting policy in both business segments," should have produced a profit. But the weak stock market throughout most of 2003, combined with a 1.8 billion Euro ($2.21 billion) tax bill produced the loss instead.

Commenting on the results the rating agency, A.M. Best, said that the company's financial strength rating of A+ (Superior) "remains unaffected following the release of year-end 2003 results in line with expectations." Best also noted the combined ratio improvements, but noted that "earnings from the primary life segment remain under pressure from the volatility of equity markets and relatively high minimum guarantees." The rating agency said it would "closely monitor Munich Re's achievement of its profitability targets during 2004."

Munich Re is also well ahead in implementing the International Accounting Standards (IAS) which are due to become compulsory next January. They are expected to provide a better insight into the earnings performance of the group. The capital market, said the management, will also respect this prompter and more informative reporting. "That's what happened when Munich Re was also among the first companies to switch its consolidated accounting from German Commercial Code to IAS back in 1999."

In discussing the results of its reinsurance operations, Munich Re said premium income fell by 2.6 per cent to 24.8 billion Euros ($30.45 billion), due primarily to "changes in exchange rates; in original currencies it increased by 9.8 per cent. Before amortisation of goodwill, the reinsurance group achieved a pre-tax profit of 2.7 billion Euros ($3.31 billion).

JAPAN'S FIRST WEATHER DERIVATIVE AGAINST HIGH WAVES GOES ON SALE

Sompo Japan Insurance Inc. launched what it claims to be Japan's first weather derivative product against high waves.

The product, developed jointly with Chiba Kogyo Bank, is intended for corporations involved in fishing, tourism and marine entertainment such as pleasure boat operators, the nonlife insurer said.

The derivative product allows clients to get financial compensation if waves above a certain level are observed during a set period on the basis of data collected at some 30 lighthouses nationwide, it said.

The product will be custom-built to meet customer needs, it added.

SHAKEOUT SEEN IN JAPAN HEALTH INSURANCE

A record number of health insurance societies for employees of large companies are expected to dissolve in fiscal 2003, according to a survey by the Health, Labour and Welfare Ministry, Japan.

According to the survey, 36 corporate health insurance societies have disbanded since April 1. Since more such associations are expected to dissolve by the end of the month, the total figure is expected to outnumber the record high of 37 set in fiscal 2002.

The dissolution of corporate health insurance associations for employees of large companies began to be noticeable in fiscal 1998. Sixteen such associations dissolved in fiscal 2000, and 26 in fiscal 2001.

The increase is believed to be due in part to cuts in insurance premium revenues amid the prolonged economic downturn.

The number of such societies that are expected to lose money in fiscal 2003 will decrease to 985 from 1,347 in fiscal 2002 thanks to an increase in the ratio of medical fees covered by salaried workers in April.

But many health insurance societies with smaller corporate members are believed to have been forced to dissolve as they are finding it difficult to continue completing the clerical procedures involved, and their financial conditions show no prospects of improvement.

Corporate employees will be covered by the government-run health insurance programme after their corporate health insurance societies disband, and they will be unable to enjoy a medical bill reduction programme operated independently by corporate health insurance societies.

At What Expense?

P. S. Prabhakar

The insurance industry has several unique features and one of them is that it is the only service industry which has a statutory cap on its management expenses. Section 40C of the Insurance Act read with Rule 17E of the Insurance Rules merrily prescribes a complicated formula to arrive at a percentage of the maximum management expenses that a general insurance company can afford to expend. The age, size of the company as well as its composition of portfolio all will matter in determining the percentage.

If we seek to know the idea behind such a statutory limitation, we might perhaps come up with the following analogy. An insurer is in a business that collects money from many to create a fund in a sort of a fiduciary position. Out of this fund the losses of those unfortunate few are compensated for. It will only defeat the purpose of the spirit of communion, if the business is conducted in an extravagant manner and an unreasonably large part of the 'fund' is frittered away as the cost of doing the business.

To come back to the limits, Rule 17E prescribed (some six and a half decades ago) that the expense limits in the Fire and Miscellaneous portfolio will be in graded bands to approximate to something like 23.8 per cent for the first Rs.1 crore and to a fixed 20 per cent of the balance. On the Marine side, it will be, respectively, 16.3 per cent (for the first crore) and 15 per cent for the balance. So, in effect, the law permits in the range of 18 to 22 per cent of the Gross Premium written in India, which in itself is 'generous', at the current levels of premium generation of the industry.

In 1938-39, the nation was being governed by foreigners, we had just about 30 per cent of the population that we have today and in terms of money, the entire nation's budget size was even less than today's revenue expenditure budget of a general insurance company and the law makers may not have comprehended the implications beyond a certain level while benchmarking the expense limits.

If only they had carried the bands in Rule 17E further, they would have graded down the percentages to five to 10 per cent at the premium levels of say Rs. 100 crores and above. And that would have only meant that the average ratios could not have been more than seven or eight per cent at the current levels of premium generation. The principles of scale economics were not applied beyond a point simply because the law makers could not perhaps imagine that the industry would grow to such massive proportions. The 1939 prescribed ratios have simply been left unamended to the delight of the insurers, who are pretty extravagant in managing costs.

> Management Expenses also, for the sake of realism and uniformity, should be calculated only against the Net Earned Premium Income.

No matter how generous the law was in prescribing the management expenses ratio, the companies have always been playing Oliver! Seldom have they contained their costs even within the bloated benchmark. Every company is supposed to make a specific reference on the adherence to the 40 C limits in their Board Reports. Rule 17-H of the Insurance Rules also prescribes certain actions against an 'extravagant general insurer' that can be taken by the Regulator (which may even extend to cancellation of registration).

Except New India, all the three other PSU companies have exceeded their limits and have made a matter-of-fact reference in their reports. In spite of specific legal restrictions, the Regulator has never initiated any action. The statutory auditors of the companies too have not even thought it fit to make a reference to this issue. Neither has the CAG.

The 40C limitation of expenses is on the Gross Direct Premium (GDP) in India. However, when the apportionment of expenses are made among Fire, Marine and Miscellaneous, they are done on the Gross Premium written plus the RI premium accepted and after giving a 100 per cent weightage to Fire and Miscellaneous and a 75 per cent weightage to Marine.

However, neither of them seems to be reflective of the true situation. Earlier it was mentioned by this author that the claims ratios would appear more realistic if they are calculated on the Net Earned Premium Income. Similarly, the Management Expenses also, for the sake of realism and uniformity, should be calculated only against the Net Earned Premium Income. As already mentioned, it is the NEP, which is post-RI and post-URR, which is a more realistic reflection of the revenue generation.

The purpose behind the matching concept in accounting would be served only if the ratios of claims costs as well as management costs are considered against the NEP. The accompanying table, which has the aforesaid calculation, reveals that New India is at the lowest at 27.15 per cent, Oriental at the highest at 35.18 per cent and both United and National are bordering 30 per cent. If we take the combined ratios (of Claims and Expenses together), we can see that UI tops with 120 per cent, Oriental is second with 114 per cent, National closely follows with 113 per cent and New India comes last with 109

per cent. And this is exclusive of commission costs.

The major portion of the cost of the companies is in the form of employee costs. The PSU industry employs nearly a lakh of employees, organised in nearly four dozens of trade unions (by different nomenclatures), who have always compared themselves with Reserve Bank of India (RBI) employees and have demanded benefits on par with them.

The industry top brass have never taken pains to bring home to them the need for looking at the insurance industry's uniqueness and the need to prune costs. Offices were opened left, right and centre and, in showing the number of offices and in procuring 'premium' at whatever cost, without any concern for the profitability aspect, the companies vied with each other vigorously.

Each of the PSUs has about 20 to 25 thousand employees with an average productivity ratio of less than 50 per cent. It can be seen from the chart that the employee costs range from 66 to 82 per cent of the total costs.

> Employee costs range from 66 to 82 per cent of the total costs of PSU general insurers.

Rs. in cr.

Company	Total Expenses	Gross Direct Prem-India	Actual Expns Ratio%	Increase over 40C limit %	Net Earned Premium	Expenses as % of NEP	Staff Cost in Total Expenses	Staff Cost as % of Total Cost
New India	895	3,921	22.83	-1.03	3,297	27.15	590	65.92
National	601	2,864	20.98	1.24	1,966	30.57	425	70.72
Oriental	653	2,803	23.30	3.42	1,856	35.18	534	81.78
United India	622	2,968	20.96	1.60	2,109	29.49	466	74.92

At long last, the industry has realised about the excess staff and announced a VRS scheme but unfortunately, this is producing unexpected and gloomy effect as the majority of the VRS optees are from the cadre of Officers and that too from the middle and top level.

With several senior executives (including GMs, AGMs and Regional Managers) on their way out, how the industry is going to fill and man those important positions is anybody's guess. The 'domain-intensive' industry is suddenly going to find itself in a big knowledge vacuum. And the question that everyone will want an answer to will be: Will the PSU industry survive? If so, at what expense?

The author, who used to work with the nationalised general insurance industry, is a practicing Chartered Accountant. In this series he will discuss the process of analysing the balance sheet of a general insurance company.

REGIONAL COOPERATION

The Association of Insurers and Reinsurers of Developing Countries (AIRDC) held is biannual Insurance Congress of Developing Countries (ICDC) in Delhi this year. The two day event, on March 8 and 9 was attended by over 500 delegates from 26 countries.

L to R: Mr. N.S. Sisodia, Secretary Finance Sector, Dr. Vijay Kelkar, Advisor to Minister of Finance and Mr. C.S.Rao at the inaugural session of the XIVth ICDC.

CHARTING A NEW COURSE!

The National Insurance Academy (NIA), Pune, inaugurated its new auditorium on March 11. It also announced the launch of its two year MBA programme.

L to R: Dr. K.C. Mishra, Director, NIA, Mr. C.S. Rao, Chairman, IRDA, Mr. G.N. Bajpai, Chairman, SEBI and Mr. S.B. Mathur, Chairman, LIC at the inauguration of NIA's new facility.

REFRESHER!

A three week refresher course on Risk Management and Insurance was conducted by UGC Academic Staff College, Osmania University, in association with International Institute of Insurance and Finance (IIIF), Hyderabad, concluding on March 2.

L to R: Mr. Apparao Machiraju, Director, IIIF, Mr. C. S. Rao, Chairman, IRDA and Prof. P.L. Vishweshwer Rao, Director, UGC Academic Staff College, Open University at the concluding session of the refresher course.

Don't look at the entry into rural areas as an obligation, but as a potential.

Mr C.S. Rao, Chairman, IRDA

The IRDA seems to think there is a reluctance on the part of insurance companies to get into health insurance. But nobody can take a blind shot.

Mr. S. V. Mony, Vice-Chairman,
AMP Sanmar Life Insurance Company

Companies increasingly realise that their principal assets are Internet-oriented or digital assets, and they have to insure them. This is akin to the changes faced when moving from an agrarian economy to an industrial economy.

Mr. Rob Hammesfahr, attorney and
author on e-commerce

The regulatory structure should follow market structure, not the other way round. The reason why FSA makes excellent sense in the UK is that... there is no clear distinction between banks and insurance and you cannot regulate effectively without an integrated regulator.
The case in India for a single regulator is not particularly strong.

Mr. Howard Davies, Director, London School of Economics and Political Science and former head of the Financial Services Authority (FSA), UK

Regulation was based on an over-reliance on the appointed actuary, who in the case of the Society was also the chief executive over the critical period from 1991 to 1997, despite a recognition of the potential for conflict of interest inherent in this position.

The Penrose Report on the failure
of Equitable Life

The actuarial profession was influenced by an environment in the life insurance industry in which kudos went to who sold the most policies...actuaries got caught up in the marketing machine. They were encouraged to devise products that had all sorts of options and guarantees.

The Penrose Report on the failure
of Equitable Life

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Events

April 1 - 2, 2004

Venue : Budapest, Hungary
Central and Eastern European Regional Seminar

April 18 - 22, 2004

Venue: San Diego
RIMS Conference

April 20 - 21, 2004

Venue: Taipei
Pan-Asia Conference on Beating the Negative Interest Spread and Managing Investments for Best Returns by Asia Insurance Review in conjunction with ABeam Consulting, and together with the support of the Insurance Commissioner and the Ministry of Finance, Singapore.

April 26

5th Asian Conference on Bancassurance & Alternative Distribution Channels

May 27 -28

Venue: Hong Kong
5th Conference on Alternative Risk Transfers in Asia with Captives Workshop