AN EXPLORATIVE STUDY ON HEALTH INSURANCE INDUSTRY IN INDIA

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By

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I here by declare that the thesis entitled "**AN EXPLORATIVE STUDY ON HEALTH INSURANCE INDUSTRY IN INDIA**" submitted by me for the award of Degree of Doctor of Philosophy in **Management** is the result of my original and independent research work carried out under the guidance of **Prof. S.Ganesan**, Director, Jansons School of Business, Coimbatore – 641 659, and it has not been submitted for the award of any degree, diploma, associateship, fellowship of any University or Institution.

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ABBREVIATIONS

AA	Appointed Actuary
ACCORD	Action for Community Organisation Rehabilitation &Development
ACORD	Association for Cooperation Research and Development
AIDS	Acquired Immune Deficiency Syndrome
AOK	Allgemeine Orts Kranten Kasse (German)
ASI	Actuarial Society of India
BPL	Below Poverty Line
BPM	Business Process Management
CGHS	Central Government Health Scheme
CII	Confederation of Indian Industries
CIRE	Centre for Insurance Research and Education
CPAA	Cancer Patients Aiding Association
CRR	Cash Reserve Ratio
EHM	Express Healthcare Management
ENT	Ear, Nose, Throat
EPO	Exclusive Provider Organisation
ESIS	Employee State Insurance Scheme
FICCI	Federation of Indian Chambers of Commerce and Industry
GDP	Gross Domestic Product
GIC	General Insurance Corporation
GIPSA	General Insurance Public Sector Association
GP	General Practitioner
HDFC	Housing Development Finance Corporation
HDR	Human Development Report

HIPAA	The Health Insurance Portability & Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HL7	Health Level Seven
HMO	Health Maintenance Organisation
HSBC	Hong Kong and Shanghai Banking Corporation
ICMR	Indian Council of Medical Research
IIM - B	Indian Institute of Management – Bangalore
ILO	International Labour organisation
INRE	Inward Reinsurance
IRDA	Insurance Regulatory and Development Authority
IT	Information Technology
JV	Joint Venture
KKVS	Kadamalai Kalanjia Vattara Sangam
LOMA	Life Office Management Association
MCH	Maternal and Child Healthcare
MFI	Micro Finance Institutions
MNC	Multi National Company
NCAER	National Council for Applied Economics and Research
NGO	Non-Government Organisation
NHP	National Health Policy
NHS	National Health Service
NIA	New India Assurance
NPA	Non Performing Assets
NSSO	National Sample Survey Organisation
OMP	Overseas Medical Policy
OUTRE	Outward Reinsurance

PHI	Private Health Insurance
PMI	Private Medical Insurance
POS	Point of Service
PPO	Preferred Provider Organisation
PPU	Private Patients Unit
PRI	Panchayat Raj Institutions
PSU	Public Sector Units
RAHA	Raigarh Ambikapur Helath Foundation
RBC	Risk Based Capital
SCUP	Senior Citizens Unit Plan
SDO	Standards Developing Organisation
SEWA	Self-Employed Women's Association
SHG	Self Help Group
SHH	Students Health Home
SSP	Swayam Shikshan Prayog
TAC	Tariff Advisory Committee
TF	Tribhuvandas Foundation
TPA	Third Party Administrators
UK	United Kingdom
UNDP	United Nations Development Program
USA	United States of America
USD	United States Dollars
UTI	United Trust of India
VC	Venture Capitalist
VHS	Voluntary Health Service
WWF	Working Women's Forum

INTRODUCTION

CHAPTER I

INTRODUCTION

India is a country having 16% of the world's population, but its total expenditure of $18 billion on health as on 1990 was only 1 % of the world's total. The per capita health expenditure of India is only $ 21 (1990). Increase in the cost of medicines, hospital services has made the people of the middle income and lower income segments to depend more on Government's plan outlay. But in the last two decades, health has been getting a shrinking share of plan outlay of the Government from 3.3% in 1952, when the population was low, to 0.9% in 1999, when it was high. For a country where 15% of the population has no access to health services and 52% of the population Below Poverty Line (BPL), earning less than $1 per day[1], this does not augur well. In the light of liberalisation of insurance industry, insurance is expected to play vital role in minimising the gap between increasing treatment costs and budget deficiencies.

Insurance plays a vital role in stabilisation and growth of economy of all countries especially the developing countries. Economy of a nation, being dynamic in nature, is subjected to changing political atmosphere, technical environment and consumer preference thus exposing all assets under the sun including the human assets to various risks. The mechanism of insurance assures the safeguard of economy by making the people facing the risk come together and form a common platform. It contributes to social stability by permitting individuals to minimise financial stress and worry. It reduces the financial burden of the state of caring for the aged and for those made financially destitute because of death of a family

[1] Human Development Report (HDR) -1998

breadwinner. It acts instrumental in the form of small savings leading to accumulation of large sums, which can be invested in public / private sector thus helping the economy by creating a source of financing for new businesses, for new homeowners, and for farmers and their equipment.

Insurance can be classified as either private or government insurance. Private insurance, in turn, can be classified into life and health insurance and property and liability insurance. Government insurance can be classified into social insurance programs and all other government insurance plans.

Importance of Health Insurance among other forms of Insurance

As mentioned earlier, risk exists in all walks of life and in all forms. Every risk involves the loss of one or other kind. Of the various losses, loss of health is considered to be the most serious loss. An olden Tamil proverb says "noyatra vazhve kuraivatra selvam" which means, "Healthy life is wealthy life". Needless to mention further, insuring against the risk of health means indirectly covering all other risks. Thus all the countries pay more attention to the health of their citizens and form separate ministry functioning for health. But the focus towards health care status and incidence of diseases varies from one nation to another. Though the focus of the project is over health insurance, health care status and incidence of diseases have direct impact over the health insurance status. Hence, it is important to know about the health care and health care financing status in India.

Distinctive Nature of Health Insurance

Health Insurance is a complex subject and can be said that it is not a pure form of insurance by its nature, unlike life insurance. It is not indemnity insurance, as

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[1] Human Development Report (HDR) -1998

health insurance cannot bring back the lost health and it cannot make good all the losses pertaining to health and related expenses. It is also very difficult to estimate the impact of health. Health Insurance also depends upon the other sectors like hospitals, health care, pharmaceutical etc. for effective functioning. The influence of changes in other sectors impact heavily on health insurance and hence pricing of health insurance products largely depend upon the functions of other sectors.

Health Insurance cannot be considered as wholly a life insurance subject or a general insurance subject. Normally life insurance companies are very particular to see whether insurable interest exists at the time of purchase of the policy but non-life insurers will see the same only at the time of claim of the policy. For example, if a person takes out a policy on her husband's life and later gets a divorce, she is entitled to the policy proceeds upon the death of her former husband if she has kept the insurance in force as the insurance company will see whether the insurable interest exist at the time of inception of the contract. But in general insurance, the insurable interest must exist at the time of loss. For example, if a person say X, has insured his home and sold his home to Y after some time. If fire occurs, X cannot collect the claim, as he no longer has insurable interest in the property. Similarly, Y also cannot claim, as he is not named as an insured under the policy. But in health insurance, the principle of insurable interest is seen both during the inception of the policy and also during claim. Moreover, health insurance covers the features of life insurance and also general insurance. This is the reason why both life and general insurance companies deal with health insurance. In India, life insurance companies have not entered into health insurance segment except offering critical illness riders. There are plans for entering health insurance full-fledged by life insurers in the near future.

Since independence, the health care system in India has been expanded and modernised considerably, with dramatic improvements in life expectancy and the availability of modern health care facilities and better training of medical personnel. At the same time, however, much remains to be done with respect to the accessibility, efficiency and quality of the health delivery system. 'Health for all' has been seen as the central assumption of the health sector debate, thus making the government the central player. Though 'health for all' objectives are laudable, the overwhelming focus on a public health care delivery system appears somewhat unrealistic, particularly in view of the fact that health spending in India is mostly private.

Health Care Financing -Public Health Investments in India

The public health investment in the country over the years has been comparatively low, and as a percentage of Gross Domestic Product (GDP) has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs. 200. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services are from the resources of the States, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding

has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralised pubic health services in the country are to improve significantly, there is a need for the injection of substantial resources into the health sector from the Central Government Budget. This approach is a necessity, despite the formal Constitutional provision in regard to public health, if the State public health services, which are a major component of the initiatives in the social sector, are not to become entirely moribund. The NHP-2002 has been formulated taking into consideration these ground realities in regard to the availability of resources.

Health Care Financing- by Individuals

Unlike in developed countries, Indians lack the sense of preventive health care and health consciousness. As a result, they face financial burden in the form of out-of-pocket expenses to pay for curative health care. These financial burdens are pervasive, and both contribute to many other problems, which face India's health care delivery system and are reinforced by them. Evidence indicates that Indians tend to use health care services more frequently; this is from the demand side.

Supply-side reasons include greater availability of health practitioners both because of the several branches of medicine unique to India and because of the easy and almost unregulated entry of a very large number of private practitioners in each of these branches every year. However, these reasons can at best be a small part of the explanation. Howsoever, easily available health care means, no rational consumer is expected to spend large amounts of his or her income without very good reasons for it. Excessive financial burdens on households arise for a variety of reasons. At one

level, they can be blamed on India's public health care system, which is under funded and suffers from quality and access problems, forcing consumers to visit the private and relatively more expensive treatments. Recent household-level studies on utilisation of health care indicate that even public care is not all that 'free' after all: there are many incidental expenses that consumers have to bear on their own.

Also, consumers are either not insured or are insured inadequately for their health care expenses which require flamboyant insurance marketing for meeting such needs.

Insurance Market in India

The insurance sector in India has come a full circle, from being an open competitive market to nationalisation and back to a liberalised market again. Tracing the developments in the Indian insurance sector reveals the 360-degree turn witnessed over a period of almost two centuries.

The business of life insurance in India in its existing form started in India in the year 1818 with the establishment of the Oriental Life Insurance Company in Calcutta. In 1912, The Indian Life Assurance Companies Act enacted as the first statute to regulate the life insurance business. In 1928, the Indian Insurance Companies Act enacted to enable the government to collect statistical information about both life and non-life insurance businesses. In 1938, the earlier legislation was consolidated and amended to by the Insurance Act with the objective of protecting the interests of the insuring public. In 1946, 245 Indian and foreign insurers and provident societies were taken over by the Central Government and nationalised. LIC formed by an Act of Parliament, viz. LIC Act, 1956, with a capital contribution of Rs. 5 crore from the Government of India. The general insurance business in India, on the other hand, can

trace its roots to the Triton Insurance Company Ltd., the first general insurance company established in the year 1850 in Calcutta by the British. Some important milestones were developed in the twentieth century. In 1907, The Indian Mercantile Insurance Ltd. set up, the first company to transact all classes of general insurance business. In 1957, General Insurance Council, a wing of the Insurance Association of India, framed a code of conduct for ensuring fair conduct and sound business practices. In 1968, The Insurance Act was amended to regulate investments and set minimum solvency margins and the Tariff Advisory Committee (TAC) set up. In 1972, The General Insurance Business (Nationalisation) Act 1972 nationalised the general insurance business in India with effect from 1st January 1973. 107 insurers amalgamated and grouped into four companies viz. the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd., General Insurance Corporation (GIC) incorporated as a company. In 1999, insurance industry was liberalised again allowing new companies to participate.

Insurance Sector Reforms

In 1993, Malhotra Committee, headed by former Finance Secretary and RBI Governor R.N. Malhotra, was formed to evaluate the Indian insurance industry and recommend its future direction. The Malhotra committee was set up with the objective of complementing the reforms initiated in the financial sector. The reforms were aimed at "creating a more efficient and competitive financial system suitable for the requirements of the economy keeping in mind the structural changes currently underway and recognising that insurance is an important part of the overall financial system where it was necessary to address the need for similar reforms..." It strongly recommended that the Insurance Act should be changed allowing private players into

the market and a regulatory body should be set up and made independent statutory body.

Reforms in the insurance sector were initiated with the passage of the Insurance Regulatory and Development Authority (IRDA) Bill in Parliament in December 1999. The IRDA since its incorporation as a statutory body in April 2000 has fastidiously stuck to its schedule of framing regulations and registering the private sector insurance companies. Many private insurers entered into life and general insurance business. But to its disappointment, no specific Health Insurer entered into India. Though it is felt that good market potential exists for health insurance, global health insurer like Cigna who were willing to enter the market withdrew its presence even without registering due to problems faced by health insurance market in the country.

Health Insurance Market in India

Health insurance market in India is a growth sector with considerable future potential. Though the poorest 20% of the population with per capita Real GDP of $527 may not be able to afford much insurance coverage, the richest population of around 180 million with per capita Real GDP of $2641(HDR-1998), gives an indication of the market potential.

There is a marked shift from the days of command and control economy of the past where public expenditure on health was pre-dominant.

What is exciting in the healthcare sector today is the privatisation of the health insurance industry. Privatisation should bring about major changes in the healthcare industry. Insurance will have an impact in terms of standardisation and controlling costs of healthcare. India's famous 300 million middle classes cannot only afford

health insurance but is actively looking for a healthcare solution like health insurance. The voluntary health insurance market, which is around USD 500 million today has the capacity to grow 30 times to around USD 15 billion in less than 5 years. The growth of health insurance market leveraging on the middle-class segment can help the lower-income segment and BPL segment to avail health insurance coverage at subsidised rates in future.

Health insurance schemes in India can be classified as voluntary health insurance schemes (also called as Individual Health Insurance), Corporate (or Group) Health Insurance Schemes, Employees State Insurance Corporation Scheme (ESIS) meant for workers, Central Government Health Scheme meant for central government employees, Community Based Health Insurance Scheme. But there is weakness in the functioning of CGHS and ESIS schemes and hence it is not considered as successful schemes in the current scenario. There is also a plan to privatise ESIS schemes and dissolve CGHS scheme and merge the plan members with insurance companies.

Impact of Privatisation in Health Insurance

After liberalisation, though health insurance market in India is estimated to have larger potential, no specialised health insurers entered into Indian market. Cigna, a renowned health insurer opened its representative office after liberalisation but closed its operations without getting license due to various operational issues. Though Government's intent through legislation to give preference to registration of those insurers has not yielded the desired result as the minimum capital requirement for excusive health insurers is felt to be on the higher side. Many private non-life insurers like Bajaj Allianz, Royal Sundaram, ICICI Lombard, Cholamandalam, Tata AIG,

Reliance, IFFKO-TOKIO entered into the market raising some expectations for health insurance from their side.

But the experience of the public sector non-life companies has not been encouraging with respect to coverage and financial performance. As a result no initiative has been taken to introduce new health insurance products by any of the companies. The private sector non-life companies have introduced slight variations of the existing mediclaim and the private sector life insurers have introduced critical illness riders to their life policies.

To motivate the industry further, the move by IRDA in 2002 to introduce Third Party Administrators (TPA) in health insurance is a revolutionary approach to enforce cashless hospitalisation cover and was expected to pave way for new blood to pass through the weak veins of the Industry.

A TPA is a service organisation under contract from an insurance company to administer its health insurance policies by providing a banquet of services to policyholders. A TPA performs the role of a services integrator- a triangle between the insurer, the insured and the healthcare provider. The range of TPA services include enrolment and benefits management, claims management, provide network management, medical management and customer service management for the health insurance policyholders of an insurance company. But pertinent issues relation to their operations as well as spread of health insurance has been thrown up with respect to insurer, health care providers and TPA's.

While commenting on problems of TPA, Rajeev Ahuja [1] points out that, while junior level functionaries of Public Sector Units (PSU) operating offices, see TPA as a threat to jobs, the managerial cadre have suspicion fearing the nexus between TPAs

and health care providers. Due to these perceptions, claims settlements are delayed, which defeats the very purpose of existence of TPA. The unregulated health care sector poses vital problems like lack of widespread form of accreditation, clinical protocols and guidelines, quality benchmarks and uniformity of hospital charges. Moreover, the softwares used by such hospitals do not follow the internationally acceptable diseases coding system. This creates the problem for TPA to capture health diagnosis and expense related information in a uniform manner and to make related analysis. There have been complaints from public about TPA regarding the delayed issuance of Identity cards, poor functioning of call centers etc. Thus any move in the direction of promoting health insurance sector in India faces lots of pitfalls and hindrances.

Need for the research study

From the problems discussed above, it can be realised that, increase in cost of medicines, healthcare, higher incidence of diseases in India has made people of middle and lower income classes to depend more on Government on one side. But health has been getting a shrinking share in the plan outlay of the government, on the other side thus creating a wide gap.

Health insurance has the scope of filling the gap in the light of liberalisation of insurance industry in India.

The spread of health insurance in the pre-liberalised era was not very prominent. While social insurance schemes like Central Government Health Scheme (CGHS) and Employee State Insurance Scheme (ESIS) suffers from quality of health care delivered, voluntary private health insurance schemes like mediclaim suffer from higher claim ratio.

After liberalisation, though health insurance market in India is estimated to have larger potential, the growth of health insurance market within country is not as expected. Though Insurance companies are showing steady growth in health insurance business (negligible when compared to market potential), exorbitant claims ratio nullify the positive effects of such growth. Hence only way is to improve the customer base aggressively for health insurance and establish more controls over claims ratio.

Though IRDA introduced TPAs for boosting the health insurance in the lines of practices existing in developed markets, the services of TPAs itself attracts many criticisms.

Hence, it is thought as right time to analyse about the existing system and think about the ways of spreading health insurance coverages to all the people including the people in BPL segment in the light of liberalisation.

Hence, the idea behind the research is to find out the hurdles preventing the people to purchase health insurance policies in the country and methods to reduce claims ratio among existing business, which eventually will lead to findings that can promote health insurance in the country.

Hence, there is a need for this research study.

Objectives of the study

The following are the primary objectives of the proposed study:

- To assess the spread of health insurance in India
- To identify the factors that influence health insurance purchases
- To understand the expectations of the people towards health insurance and

- To propose new models & methods to promote health insurance in India.

Methodology

In India, the life style of the people and infrastructural facilities vary widely between the rural and urban segment. Especially when it comes to the out of pocket expenditure and healthcare facilities, wide gap exists between these two. Also health insurance is a complex subject that requires cooperation of various sectors. Hence to understand the nature and problems of allied sectors, review of literature pertaining to health care, hospital industry, pharmaceutical industry, life insurance industry is also undertaken. One more reason for covering such sectors is due to the fact that no comprehensive health insurance research is undertaken so far in India or even if it is done, it is not available to the reach of public.

Literature on various subjects related to health insurance is collected from various sources like IRDA, National Council for Applied Economics and Research (NCAER), Centre for Insurance Research and Education (CIRE), Indian Institute of Management-Bangalore (IIM-B) and various research papers and articles published in various journals and magazines were collected from sources like web-site and libraries of IIM - B, Bangalore University, Jansons School of Business-Coimbatore. Excerpt from various stakeholders of health insurance like senior management people of insurance companies, hospital administrators, pharmaceutical companies, legal experts, TPA, insurance distribution channels were interviewed through an unstructured personal interview method to understand the problems from their perspective that can hurdle the growth of health insurance in India.

Based on the review of various literatures, the spread of health insurance in India was assessed and also based on the expert interviews, the prominent factors

which can be the hurdle for the growth of health insurance was identified. A sample questionnaire was prepared for pilot study. Data for pilot study was collected from Bangalore (urban) the capital city of Karnataka State, Hosur (semi-urban) and Krishnagiri (a rural district) in the state of Tamilnadu and the nearby villages near Krishnagiri and Hosur. At the end of the pilot study, it was found that a single questionnaire might not be suitable across the sections of the society. This is because, when a person was selected for interview, not all questions were applicable to the person. Hence some of the questions were not necessary for response. When the pattern of such questions were analysed, surprisingly it gave an idea to split the population into three segments like people with existing health insurance individual policy holders (voluntary policyholders), people with no health insurance policies (no policyholders) and people covered under group health insurance schemes. The reason for segmenting the population is that expectations of the people from each segment vary. Moreover, some people are already exposed to health insurance. Their experience was differing from the people who are not exposed to health insurance. Recording of their experience will help to identify the pitfalls in the existing health insurance system. But even in this segment, there are differences between the group health insurance policyholders and individual insurance policyholders, the reasons are that group insurance policyholders are not voluntary members of the health insurance system, the coverages are provided by their employers. Hence, they can't be either considered under the category of 'less awareness' like the people with no health insurance or people with 'some awareness' like the people under the category of 'voluntary individual policyholders'.

Hence three sets of questionnaires with different questions specific to each segment viz. no health insurance policies, group health insurance policyholders, individual insurance policyholders was designed for the purpose of data collection.

As the insurance penetration was varying across urban, semi-urban and rural areas, primary data was collected data from in and around an urban, a semi-urban and a rural area. For this purpose, Bangalore (Karnataka State), Hosur (Tamilnadu State) and Krishnagiri (Tamilnadu State) were selected. Bangalore, which is the state capital of Karnataka state, referred as the silicon valley of India experiences enormous growth across all sectors, being it is software or healthcare. Bangalore, also has the advantages of heterogeneous mix of population wherein people from all parts of the country reside, consisting of those who came for the purpose of employment representing a mini-India. Hosur, a semi-urban town in the state of Tamilnadu is selected for the purpose of sampling. Hosur is a growing town adjoining the city of Bangalore. Krishnagiri is a rural town in the state of Tamilnadu. Data was collected in and around these places.

The questionnaire was designed in such a way that to elucidate the demographic characteristics of the segments, reasons for not having health insurance by 'no policyholder' segment, reason for not having additional health insurance coverages by group health insurance and existing policyholder segment (as in India, people can take health insurance coverages up to Rs. 5 lakh and given the fact of increasing incidence of diseases and increasing treatment cost, people should be aware of the options for purchasing additional health insurance coverages, if the existing is not sufficient) , awareness level about entities like TPAs, reach of advertisements etc. Some of the questions in the questionnaire are designed as 'control questions' for the purpose of

qualification of sample. The detailed questionnaire is attached in the Annexure of this report.

Primary data was collected by the researcher and by trained enumerator to avoid any researcher bias during collection of data. This also provided an option to compare the primary data collected by enumerator and the researcher and fine-tune the samples for qualification. The enumerator was provided training on insurance concepts required for the collection of the response. The nature and scope of investigation was explained thoroughly to make the enumerator understand the implications of different questions put in the schedule. The enumerator was also trained to explain the aims and objective of the investigation and also remove the difficulties, which any respondent may feel in understanding the implications of a particular question or the definition or concept of difficult terms.

The process of primary data collection was started in December 2004, the researcher and enumerator did not demarcate any specific segment or place for data collection but based on the convenience of time and place, either researcher or enumerator collected data irrespective of segment and place. During this process, both the researcher and enumerator faced lots of problems across the segments and places. Many of the respondents in urban areas and semi-urban areas initially hesitated to respond under the perception that the researcher and enumerator are agents of insurance company and trying to persuade for purchase of insurance policy, people in rural areas perceived that they are government officials. Hence initially it took a few minutes to explain the respondents about the research purpose and gave assurance that they will not be forced to purchase any policy at the end of the interview for data. Some of the existing policyholders complained about the TPAs and insurance companies seriously under the perception that the survey is a masked survey by some

insurance company. A few doctors were also included in the samples, initially none of the doctors agreed for providing data stating that they are too busy to provide data and hence for collecting data from doctors, the researcher selected a new set of doctors and posed himself as patient for general check-up and after getting prescription and paying fees, requested the doctors to co-operate for data collection which was highly successful. Human Resource department of some of the big companies in the region denied permission to collect data from employees but after constant persuading activity, those companies allowed to collect from employees informally and that too near the gate of their premises. On an average, it took nearly 20-25 minutes to collect a response from 'no policyholder segment' as it involved lot of educational and awareness creating activity about health insurance. From group health insurance segment also, it took nearly 20-25 minutes to collect data as it also involved education and awareness creation activities about the lacunae in group health insurance coverages and need for extra coverages. With respect to existing policyholder segment, it was very difficult to get the address of policyholder from insurance companies and TPAs, even after getting the address, it was too difficult to get appointment from each policyholder as many of them were very busy and often rescheduled their appointments, hence the researcher and enumerator made several attempts to meet them and collect data, on an average, it took nearly 15-20 minutes to collect data from this segment. Due to the above problems, it took nearly four calendar months to collect data. A target of 300 samples was fixed for this research and actually more than 300 samples were collected across the three segments viz. existing, group and no policyholder segment and across places of in and around Bangalore (Urban), Hosur (Semi-Urban) and Krishnagiri (Rural) during the time period of December 2004 till mid of April 2005. Samples were randomly chosen from the population but careful thought was made to ensure that samples are collected

from various stratums of the population with varied income size, family size with different occupation right from street vendors to high-level executives of Multi National Companies (MNC). Of the 300 samples collected, a few samples were rejected, as it did not meet the requirements for qualifying sample. At the end of such qualifying exercise, the sample size across the three segments remained as 73 for existing policyholder segment, 86 for group health insurance segment and 100 for 'no policyholder' segment.

After collection of data, the data was processed through proper classifications and analysis was done with the help of statistical analysis package SPSS.

Limitations of the study

Though the primary data collected is based on random sampling method, it is not possible for the investigator to collect data from all the cities and villages in India. Hence the research report is based on the collection of samples collected from the places in and around Bangalore, Hosur and Krishnagiri. But much careful thought is put before making the selection of the cities and samples.

This study is only about the core health insurance schemes and does not cover study of supplementary schemes like Personal Accident Coverages, Disability Income Coverages etc.

Structure of the Report

The thesis is presented in seven chapters including the present first chapter. First Chapter gives introduction about the health insurance in India and problems associated with it, which motivated the researcher to undertake the research.

The Second Chapter presents a review of literature on the Health Insurance sector in India. In this chapter, review of literature is made, not only pertaining to health insurance but also literature on various sectors viz. health care, pharmaceutical, hospital industry etc. that influences health insurance in India.

The Third Chapter titled 'Genesis and Overview of Health Insurance in India' details right from the genesis when health insurance concept was introduced in India and the status of health insurance in the country at the time of this research.

While the third chapter gives high level details about the genesis and overview of health insurance in India, the Fourth Chapter titled ' Comparative Study of Health Insurance schemes' details about the structure of health insurance schemes existing in India and this chapter also details a brief note about the health insurance systems in various countries.

The Fifth Chapter titled 'Factors and Expectations Influencing Health Insurance' is based on the analysis of the primary data collected and it describes about the various factors, their independence pattern, cluster pattern. The factors were identified based on the practical experience gained by the researcher by way of interviews, review of literature gained during the course of research.

The Sixth Chapter titled 'New Models of Health Insurance' are proposed based on the various findings of the research. Some of the models suggested are based on primary data and some are based on various studies made during the course of review of literature. New Models of Health Insurance are proposed across various issues hurdling the growth of health insurance in India.

The Seventh Chapter titled 'Conclusions' summarises the study and provides conclusion for various factors affecting the growth of health insurance in India.

References

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REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Health insurance in India is dependant upon various stakeholders like health care, pharmaceutical industry, regulators, and hospital industry etc. Hence review of literature was done covering various aspects of health insurance, hospital industry etc.

In a book on 'Risk and Insurance', Mark.R.Greene (1973) [1] points out the major problems in health insurance. He opines that of all the types of insurance, health insurance is more complex, more prone to controversy and criticism. He identifies four major problems in health insurance viz., rising cost of medicines and inflated medical bills, over utilisation - wherein the tendency of the insured to over utilise hospital and medical services, inadequacy - as health insurance cannot serve as perfect indemnity policy, health insurance coverage often prove to be inadequate for the insured to cover hospitalisation expenses, over insurance – people sometimes take insurance policies from more than one company in order to benefit from sickness.

SP Dixit, CS Modi, RV Joshi, (1973) [2] in their book on 'Mathematical Basis of Life Assurance' have stated that rates of premium for the various classes should be consistent with benefits offered. The authors points out that on theoretical ground it is advisable to use different rates of mortality for different classes of assurance depending on their experience. But this is not practicable, as the method would involve preparation of many mortality tables.

Robert et. Al (1975) [3] in their book on 'Health Insurance Plans Promise' and performance provides a new concept on 'doctor care index' based on the United

States of America (US) health insurance sector. They opine that use of medical care is usually reported as doctor visits or hospital days. The authors criticise that such measure hide lot of variation in the amount of work done. Hence based on 'California relative value studies', it is suggested to convert the work done into "dummy dollars" by multiplying the units by the average conversion factors reported by the physicians. It can be inferred that the conversion factors are equivalent from one type of care to another and each is unique by nature and not additive by nature.

Robin E Mastrivic, (1978) [4] in his book 'Determining Health Needs', opines that the planning of health programs and resources must begin with a determination of the extent of need for health services in the population to be served. The types of services needed fall into three categories, basic health maintenance services - the need for which is generated by normal physical development, acute health services - the need for which is generated by incidence of specific episodes of disease or trauma and chronic health services, the need for which is generated by the prevalence of chronic disease and disability.

Kenneth Lee and Anne Mills (1982) [5] in their book on 'Policy and Decision Making in the Health Sector' have surveyed and analysed, individual and collective individual and collective decision-making in the health sector by making use of the market analogy and have opined that there are many players in the sector and conflict of interests among them hurdles the growth.

Aviva Ron, et.al (1990) [6] in their book on 'Health Insurance in Developing Countries', identifies that the health insurance organisation may take one of a number of forms like a separate administration under an existing government ministry, part of a national social security administration, a separate autonomous government or quasi-

government body, a non-government organisation (as for example, when the health insurance scheme is sponsored by a trade union) or a number of non-government organisations, affiliated with different voluntary bodies, and with or without an umbrella organisation to manage all or part of their functions. This helps the reader to understand the various possible forms.

Trevor Hancock, (1993) [7] in an article on the healthy city from concept to application implications for research, states the healthy cities concept is both an old and a new one, old in as much as people have been striving to make cities healthier since the dawn of urban civilisation, new in its manifestation as a major vehicle for health promotion-the new public health – in the pursuit of achieving health for all.

Reider K.Lie in his paper (1993) [8] titled 'Moral basis for the World Bank's investing in Health' has stated that on inequities in health care systems and interest of world bank in investments towards health points out that public money is spent on interventions of low-cost effectiveness for wealthy people in urban areas, at the same time as cost-effective interventions are not available for the rural poor.

These days various insurers discuss Risk Based Capital (RBC) Methodology and this has relevance for health insurance industry also. ND Hooker, et.al (1995) [9] in their paper on 'Risk Based Capital in General Insurance' have stated that the RBC formula comprises of asset risk, credit risk, underwriting loss and loss adjustment expense reserve risk, underwriting premium risk and off balance sheet risk. It should ideally contain the asset risk, premium risk, reserve risk, credit risk, growth risk, catastrophe risk, currency mismatch risk and expense risk. The authors also suggest that RBC should be tested across various extreme conditions.

Charu C. Garg (1998) [10] in the study 'Equity of Health Sector Financing and Delivery in India' has tried to analyse on the financing and delivery of health care in India from viewpoint of equity and concludes that although there is progressivity in public sources of finance, but in terms of government expenditures there is a bias in terms of allocation against the poor, the rural areas, and urban organised sector.

Prof. H. Helen, et.al. (1998) [11] in an attempt to analyse the status of primary health care in the country observe that though general inter-ministerial coordinating body for primary health care has been set up at the national level, unless such bodies have the authority to institute concerted, comprehensive inter-sectoral programmes in support of primary health care, their influence is likely to be quite limited and also observes that their experiences are unrecorded.

Harriett.E.Jones, Dani.L.Long, (1999) [12] in their book on 'Principles of Insurance: Life, Health and Annuities', have defined the differences between life insurance and health insurance that where the amount payable for a life insurance claim is definitely defined by the policy, the amount payable for a health insurance claim is often much less definite. Inflation, changes in the economy and changes in medical practice affect the amount of benefits paid for health insurance claims much more dramatically than such factors affect life insurance claims.

Renbao Chen, Kie Ann Wong, Hong Chew Lee (March 1999) [13] in a note on 'Underwriting Cycles in Asia' based on their analysis paper with respect to select countries viz. Japan, Malaysia, Singapore, South Korea, and Taiwan opine that this study examines the presence and causes of the underwriting cycles in Asia. They observe that underwriting cycle is created by external factors and market characteristics that are outside the control of insurers. These factors include data

collection, regulatory policy renewal and accounting lags, interest rates, stock markets, and the general business cycle.

Randall P Ellis, Moneer Alam, Indrani Gupta (January 2000) [14] in their analysis on the health insurance sector in India, based on reference from many studies have pointed out that the total health spending indicates that in a break-up of this 6%, as much as 4.7% of the expenditure is accounted for by the private sector. Moreover, of the 4.7% around 4.5% comprise out-of-pocket expenditures of the households. Remaining 0.2% includes contributions from the private employers and other non-government organisations.

Vijay Srinivas, (July-2000) [15] in his article on 'How Returns Linked Insurance Products can be Popularised' states the reason for emergence of investment linked products, according to that he states that under normal general insurance policies, only one premium i.e. risk premium is collected. But keeping in view the Indian Psyche, he suggests that return based insurance would be immensely popular.

Anil Gumber and Veena Kulkarni (September 2000) [16] in their pilot study on 'Health insurance for Informal Sector', point out that a survey on 1200 households in Ahmedabad district in Gujarat shows that poor prefer public sector management of health care facilities and 30 percent are uninsured. Over 92 per cent of the non-insured households in both rural and urban areas have no awareness about the existing health insurance schemes, but when they were informed about the various plans, almost all of them showed interest in joining it.

Mahesh Bhatt and Dileep Mavalankar (November 2000) [17] in their paper on 'Health Insurance in India - Opportunities, Challenges and Concerns' have analysed the opportunities for health insurance in India and found that, India has limited

experience of health insurance given that government has liberalised the insurance industry, health insurance is going to develop rapidly in future. They point out that the experience from other places suggests that if health insurance is left to the private market it will only cover those, which have substantial ability to pay leaving out the poor and making them more vulnerable.

Hanson and Berman (2000) [18] made an early attempt to analyse preliminary on the healthcare provisioning across the countries in Middle East, Africa, Latin American countries and Asia to identify the determinants of the size of the private provision sector. Their findings are that while there are existing models of total health expenditure, and, by tautology, the aggregate supply of health services, these models do not explain the differential growth of public and private providers, and thus the structure of the provision sector.

J.Francois Outreville (January, 2001) [19] in his paper, 'The Ageing Population and the Future of Healthcare Plans' has examined the relationship between health care expenditure and age using individual expenditure records rather than cross-sectional data and conclude that as people are living longer, the hope is that they will also live healthier.

Indrani Gupta and Purnima Das Gupta, (February 2001) [20] made a pioneering attempt of an exploratory study to understand the health seeking behaviour in urban Delhi, they concluded that Delhi seems to be segregated along economic status, with the health seeking behaviour of low-income households being quite different from that of middle and high-income households. A greater percentage of high and middle-income households use government facilities, and a greater percentage of lower income households use private facilities.

Soumya Vishwanathan states in her article on 'Banking Industry finds new Market for Medical Professionals' (March 2001) [21], that management consultants have found that providing loans to medical professionals are considered as safe advances in current days.

It seems that there are certain schemes floated by corporate hospital groups, Nadhamuni Sridhar, (March 2001) [22] in his article on 'Health Insurance Scheme by Apollo Group' states that Apollo Group has launched a package christened 'Aashirwad' (or Blessings) for the elderly-aged 45 to 75 years. The scheme involves a Rs 10,000 per annum payment and has an in-built Mediclaim health insurance worth Rs 3 lakhs just in case the elders need hospitalisation.

Nair KS (April to June 2001) [23] in his paper Cost of health care, a study of unorganised labour in Delhi has found that the demand for health care on introduction of health insurance or risk sharing scheme mainly depends on quality of care provided under the scheme. The question of willingness and ability to pay for the health care services also depends on effectiveness of the curatives services provided under the health insurance schemes.

Herbert Meister (August 2001) [24], in his article on Legal Rule of Health Actuaries in Germany states that the quoted premium has to arithmetically grant permanent fulfilment of the insurance policy which means that India has long way to go forward in this direction.

In an article on Police Sanjeevani Nidhi Yojana for police personnel in Maharashtra, Usha Holla (October 2001) [25] has presented that the scheme today covers 90,000 personnel out of the total strength of 1,44,000. The scheme, which is

voluntary, covers 'hospitalisation' expenses of a number of ailments including cardiac operations, dialysis, kidney stone removal, cancer surgery, brain tumor etc. Till last year the coverage was only for the employee and his spouse.

Peter C Smith and Sophie N Witter (November 2001) [26] in their paper on 'Risk Pooling in Health Care' finance suggests three redistributive functions, from the rich to the poor, from the healthy to the sick and from the productive to the unproductive stage of life cycle

Eric and Francis (2001) [27] in their book on 'Insurance from Underwriting to Derivatives' suggest a stochastic simulation approach to analyse various scenarios. Factors suggested by the author for such simulation are capital market assumptions, liability modeling, investment simulations, cash flow simulations, and fair valuation and risk assessment. This has relevance to health insurance, which is very seldom practiced among health insurers.

Rob Kass, et.al (2001) [28] in their book on 'Modern Actuarial Risk Theory' have stated that there is a psychological reason why experience rating is broadly accepted with car insurance and not for instance with health insurance. Bonuses are seen as rewards for careful driving, premium increases as an additional and well-deserved fine for the accident-prone. Many think that traffic offences cannot be punished harshly and often enough. But someone who is ill is generally not to blame, and does not deserve to suffer in his pocket as well.

Ajay Mahal (February 2002) [29] in his attempt to assess the 'Private Health Insurance in India and Potential Impact on Regulatory Issues' has stated that the entry of private health insurance companies in India is likely to have an impact on the costs of healthcare, equity in the financing of care and the quality and cost-effectiveness of

such care. The author points out some practical difficulties of IRDA in implementing health related standards as many of the laws and their implementation are in the hands of individual states as a constitutional requirement.

Ramgopal Agarwala and Zafar Dad Khan (March 2002) [30] in their attempt of classification of labour market in India and insurance state the presence of three segments of the labour market. At the top are the elite white-collar workers consisting of the senior public sector officials and the managerial class in the private sector, for about 1 percent roughly 3 million workers. At the other end are the unorganised sector including the self-employed, informal sector workers, and casual labourers accounting for 92 percent of the labour forces about 300 million workers. In the middle are the regular wage employees in the public sector and in the organised private sector, who account for about 7 percent of the labour forces about 22 million people.

Soumya Vishwanathan (April 2002) [31] in an article on pricing methodology of hospitals has stated that prices are revised on a percentage basis every year, without doing actual profit and loss analysis on each item or procedure.

Prof (Dr) Gopinath N Shenoy (April 2002) [32] in his article on Doctor's fees has pointed out that The National Commission has observed that the charges made by health care service providers need not have any rationale.

EHM News Bureau (May 2002) [33] in its observation on rise in consultation fee based on ORG-MARG survey has stated that the average doctor consultation fee across six metropolitan cities of Delhi, Kolkata, Mumbai, Chennai, Bangalore and Vadodara has gone up by 16-21 per cent. The survey also reveals that there is no uniformity in such increases among cities and doctors'.

Soumya Viswanathan (May 2002) [34] in her analysis on the Insurer-Hospital model of health insurance states that many corporate hospitals like Apollo, KMCH are trying out new plans but it is feared in this article that hospitals coming up with insurance plans may leave enough room for the hospital to manipulate coverage and increase claims.

Soumya Viswanathan, (August 2002) [35] in her article on ISO standards in hospitals observes that when a hospital gets ISO certified, the processes are supposedly under control, which yields 15-20 per cent benefit.

Abhijeet Nagrendranath and Pallavi Chari (September 2002) [36] in their paper on Health Insurance in India, emerging paradigms, have stated that there is great potential for health insurance in India but public and private sector companies should work together to ensure healthy growth and development of the sector.

Devendra B Gupta and Anil Gumber (November 2002) [37] in their paper on external assistance to health sector and its contributions, problems and paradigms, have stated that in the past thirty years India has received considerable external assistance for the health sector, including for family welfare. But various pitfalls have been observed like time lags in the sanction, start-up, and disbursement of donor funds, the implementation is reported to be tardy. This has resulted in both time and cost overruns.

In a mention about McKinsey study on Health Insurance in India (December 2002) [38], it has been stated that universal health care in India is a fond dream but a study report by the CII-McKinsey combine says it is possible by the year 2020. The study has recommended that the Government should stimulate the growth of private, social and community insurance to improve health care affordability in the country.

Anil Gumber (2002) [39] in his paper titled health insurance for the informal sector, problems has stated that it is a well-recognised fact that the contribution of the informal sector to the Indian economy is enormous. He suggests that the Panchayat Raj Institutions (PRI) can play pivotal role in administering, co-coordinating and managing new health insurance schemes and especially community based health insurance schemes.

Ajay Mahal (2002) [40], in his paper on Health Policy challenges for India, private health insurance and lessons from the international experience has tried to draw lessons for Indian health insurance by comparing with the existing system of various countries like UK, USA, Netherlands, Germany, Chile, Singapore and concludes that three important lessons needs to be learnt by India which has poor quality of health care, potentially high costs of care and increased burden of health spending on the poor. The first set of messages has to do with patient satisfaction and quality of care, secondly the choice of providers and third is reconciliation of consumer choice with equity. Private provision and private health insurance are one extreme, with high levels of consumer choice but low levels of equity.

Preker, A. S., Dror, D. M (2002) [41] in their book on 'Social Reinsurance' stresses Reinsurance as a tool for enlarging the risk pool and spreading risks across larger population groups, which no single micro-insurance scheme can do on its own.

Pierre et.al (2002) [42] in their book on Actuarial practice in social security (quantitative methods in social protection series) states that, there is increasing pressure in some countries to cover the services of health professionals involved in alternative medicine or para medical practices, such as chiropractors, acupuncturists, homeopaths, naturopaths and so on. The authors support such views and state that

there is still little empirical evidence to support the actuarial work in such circumstances.

John.A.Nyman (January 2003) [43] in his revolutionising concept presents a health insurance theory, the case of vanishing welfare games, that an important source of value is missing from conventional theory of the demand for health insurance, namely the effect of the transfer of income (from those who purchase insurance and remain healthy to those who purchase insurance and become ill) on purchases of medical care. Because the portion of moral hazard that is attributable to income is welfare increasing and would replace some of moral hazard that is spuriously deemed to be welfare decreasing, the new theory suggests that the value of health insurance has been dramatically undervalued. This theory suggests that once a consumer becomes ill, it makes little sense to impose co-payments to limit consumption. This theory also suggests the current 'managed care backlash' is due to managed care's denying coverage for procedures that the consumer would gladly be willing to pay for with the income transfer from insurance.

IRDA (March 2003) [44] quoting the industry sources on the scope of revenue of TPAs reports that TPAs render services like issuing identity cards, running 24 hour call center services for emergency, cashless hospitalisation and claims processing to health policyholders on behalf of insurance companies. Since all these at the current rates of service charges of between 5.40 per cent and 5.50 per cent of the health policy premiums, and with an estimated Rs. 760 crores of health insurance premium incomes of insurance companies, the TPA industry could earn about Rs.42 crores if all health policyholders opt for their services on their policies.

Arpan.N.Thanawala, an eminent actuary in India, in his article a Long way to go, has stated (April 2003) [45] that not many actuaries in India are trained in the area of general insurance, the regulator should make it mandatory for the appointed actuary to spend stipulated time in various departments of general insurance, till he acquires adequate expertise in order to appreciate the intricacies between various lines of business.

In a paper titled under 'Health Insurance and TPAs, Issues and Challenges', Ramesh Bhatt and Sumesh K Babu (April2003) [46] state that though IRDA has defined the role of TPAs to manage claims and reimbursements. Their role in controlling costs of health care and ensuring appropriate quality of care remains less defined.

Sheenu Jawahar (April 2003) [47] in her article on 'Moral Hazard in Health Insurance in India' based on the sample analysis of claims points out that a study analysing 621 claims and reimbursements pertaining to policy initiation years 1997-1998, and 1998-1999 of the Ahmedabad branch of General Insurance Corporation (GIC) by Prof Ramesh Bhat et al points out that hospitals inflate the hospital charges for patients with insurance coverages.

GP Surekha in her analysis (May 2003) [48] on the increase of Mediclaim premium rates has pointed out that insurance companies used to spend about 18 to 30 per cent of the premium as overhead expenses for providing service to the policyholders in the health sector, premiums on the mediclaim policy have gone up by about 30 per cent since January this year with 6 percent loading towards TPA service charges. The author questions that loading of service charges is a reward for their inefficiency and even then the customer should have option to choose the TPA based on their service standards.

...n (June 2003) [49] in her article on the rationale behind ordering ...estigations by Doctors' states that sometimes, certain investigations are ordered because of the apprehension of being sued in a consumer court. Doctors with good clinical acumen and willingness to spend enough time for physical examination some time have to strike a balance between ordering expensive investigations with limited benefit in assisting him in clinching the diagnosis, especially when patients are poor and without a company paying or having a health insurance to pay for the investigations.

EHM News Bureau (June 2003) [50] in an article on 'Poor response by hospitals force GIPSA to extend deadline for enrollment' cites some practical difficulties in TPA administration a patient suffering from renal colic is denied authorisation by TPAs before clinical diagnosis establishing the illness that is covered is undertaken. At the same time, Doctors' point out that sonography, for instance, is not covered in the first two years and very few patients know about this.

IRDA (July 2003) [51] has notified that it is planning initiatives to rectify the near total lack of data and real time information in two critical areas of insurance and, in fact, in the Indian society, namely health and road accidents. The need for a health insurance data warehouse stems from the fact that no reliable data or information is available in India on this subject. Whether individual health history or morbidity patterns across the populace, very little information is collected, analysed and made public. The plan is to pool data related to incidence of diseases geographically and in terms of socio-economic classes. Also required is a mapping of diagnostic, treatment and drug regimens and their availability and pricing across the country. Using this information, the patterns of morbidity and mortality can be traced, and the market, in

terms of insurance pricing and medical facilities, will then adjust itself to the needs as revealed by the analysed data.

EHM News Bureau, based on the survey done in Mumbai reports (August 2003) [52] that non-availability of a public hospital is forcing about 44 per cent of the households to seek inpatient care services from the private sector, even if they were interested in seeking care from the public sector. Even the outpatient care services that are currently available in the area seemed to be inadequate, as 67 per cent of the households' needs for outpatient care are unmet.

GP Surekha (August 2003) [53] in her article titled Unhealthy competition has observed unhealthy practices in health insurance sector in India with respect to Group health insurance. The author has observed that one of the private insurance companies quoted to a company at one third lower premium for the floater health cover for their 1,000 plus employees against the quote of a public sector insurance company without actuarial calculation and also with increase of benefits, without finding the past claims ratio. If the company referred to the above accepted low premium and has gone for the policy with the private insurer the result after three months, might be refunding of balance premium as per rules leaving period insured at crossroads where no other underwriter could have insured them. This infers the unethical practices prevailing in the industry.

Dr. Noel Coutinho points in his paper titled, National Health Data – Riding on IT Pathway, (September 2003) [54] that IT related to health has primarily supported applications of high performance computing and telemedicine to the delivery of medical care to individuals. Relatively little attention has been paid, by either the private or the public sector, to applications that could improve the capacity of

communities to carry out the non-clinical or population-based functions of health (i.e., services that identify local health problems, prevent epidemics and the spread of disease, protect against environmental hazards, and assure the quality and accessibility of health services).

Bunty Pasricha (September 2003) [55] in his paper about Avoiding being tripped by TRIPS has suggested that the drug companies can take some lessons from the music industry and find out how they convinced Michael Jackson to release his music on the same day in India at one-fourth the price of west because he must have accepted one-fourth the royalty.

Ravi Duggal (October 2003) [56] in his paper on Operationalising rights to health care in India has stated that more than half a century's experience of waiting for the policy route to assure respect, protection and fulfillment for healthcare is now behind us. He suggests that establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law specifically ICESCR, the Alma Ata Declaration among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific. Specific features of this historical baggage are, a very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximising their interests, a complete absence of professional ethics and absolute disinterest in organising around issues of self-regulation improvement of quality and accountability, and need for an organised health care system. A declining public health care system which provides selective care through a multiplicity of schemes and programs and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare.

Jayashree Padmini (November 2003) [57] in her article titled 'Unclear Government Regulations Mar Health Informatics' while pointing out the unhealthy regulations with respect to health informatics states that despite phenomenal growth in health care delivery systems in the government and private sector; health informatics segment in the country has remained non-dynamic and stagnant. The author points out that the non-starter health insurance is the result of such a weak informatics base.

Dr. Arun Bal (November 2003) [58] in his article on medical profession and pharmaceutical companies has made a note on generic drugs that The Hathi Committee in 1974 had suggested promotion of generic drugs, which would have curtailed the unhealthy marketing practices. Though the government accepted the report and decided to have only generic names for few drugs, the decision could not be effectively implemented, probably due to the lobbying by the pharmaceutical sector.

L. P. Mehta (December 2003) [59] in his article on 'Time for Reforms', points out that health insurance with a base of over Rs. 1,000 crores is virtually non-existent today. Only 2.5 per cent of the population is covered by health insurance policies and the premium rates have remained high and customer service and healthcare infrastructure continues to be extremely poor.

Aloke Gupta while analysing the status of health insurance industry in India (December 2003) [60] states that health insurance premium written in 2002-03 was Rs. 1,144 crores as against Rs. 519 crores in 2000-01 representing a growth of over 120 per cent in the three years of a liberalised insurance regime. He points out that premium generated from Overseas Medical Policies (OMP) is also included in the

more generic term of gross health insurance premium that projects an erroneous picture since by no stretch of imagination can this policy be seen to be increasing health insurance penetration in the country.

Referring the history of emergence of TPAs in India and revision of health insurance premium rates in the pre-liberalisation era, Nimish R. Parekh (December 2003) [61] states that in 1996, the first TPA organisation was launched, offering services such as cashless hospitalisation, 24-hour call centre support, enrolment and claims administration. The model was successful and within a short span of three years, over 75 major employers had availed of these services. The average claim value per in-patient claim in metros and semi-metros has risen from Rs. 8,500 in 1995 to over Rs. 30,000 in 2002. But mediclaim premium has been revised only in 1996 and then in 2002. The result of this inherent under pricing is that health insurance portfolios will demonstrate inferior performance in a year just prior to an increase in premium. The impact is further amplified when taking the pure risk premium (which today is just 58 per cent of total premium, the rest being marketing and administrative overheads) into account. Even when a gross premium increase of 30 per cent is factored in between year 2000 and 2001, the loss ratio continues to increase alarmingly.

Craig.F.Churchill, et.al (2003) [62] in their book on 'Making Insurance work for Micro Finance Institutions' (MFI), have proposed a due diligence checklist for micro insurance institutions to identify insurance parameters. The checklist suggests to verify the reputation of the insurance provider, the finance position of the insurer, the claims experience of the insurer and history of claims payouts, the interest of insurer in serving the low-income market, the adjustment of the insurer's products to suit the preferences of the poor, willingness to make a medium or long-term commitment to the MFI, willingness of the insurer to pay the commission to MFI for performing the

agent role, issues related to regulatory compliance by the insurer, insurer's willingness to give responsibility to MFI for verifying claims, insurer's capability of minimising the number of exclusions without jeopardising the sustainability of the plan.

April Harding and Alexander S Preker (2003), [63] in their book on 'Private Participation in Health Services', state that developing countries must include enhanced interaction with private providers. Although recognition of this fact is widespread, most attempts to operationalise such interactions are random. These efforts are often undermined by the lack of information about the private sector, and hence are undertaken in a relative vacuum.

Marcus Radetzki, et.al, (2003) [64] in their book 'Genes and Insurance', mention that freedom of access for insurance companies to genetic information for the purpose of premium differentiation or determining the extent of insurance cover, infringes the insurance clients' autonomy and privacy, and more importantly threatens to leave the groups representing high genetic risks entirely or partially without private insurance cover. Many rich market economics have chosen to avoid this problem by constraining the insurance industry's access to genetic information.

Peters H David and Yazbeck S.Abdo (2003) [65] have attempted to collate various health research in South Asia. In their paper on 'A Framework for health Policy Research in South Asia' points out that only a limited number of local agencies are capable of doing such work, and partly because of the time constraints imposed on the research project by both policymakers and funding agencies. However, they forecase that in the long term, as more institutions become capable of undertaking research and as the type of research methods change to more experimental and longitudinal

approaches, they foresee greater tension between the desirability of competitive means for soliciting research and the need to encourage greater collaboration among researchers. This infers that health related researches have more scope in future but it requires more funding.

Based on House hold survey done by National Sample Survey (NSS) in 1995-96 on 121,000 households wherein 71,300 in rural areas and 49,700 in urban areas on Health Care subsidies, Ajay Mahal (2003) [66] in his paper ' The Distribution of Public Health Subsidies in India' point out that the health care subsidies are not well targeted to the poor, especially rural poor people and poor living in poorly states.

In India, it is well known fact that Government is not having enough infrastructures for meeting the health care needs of the whole population. In this context, VR Muraleedharan, and Sunil Nandraj (2003) [67] in their paper titled 'Private Health Care in India – Policy Challenges and Options for Partnership' points out that government has limited capacity to regulate private health providers and to monitor contracts. Hence they suggest more intervention by the government for collaborative opportunities. The authors suggest the following areas for such collaboration viz. cooperating disease surveillance reporting, contracting for environmental activities in cities, contracting for non clinical services in large hospitals, collaborating on disseminating public health information, sharing resources for managing drug supplies, establlshing patient referral mechanisms etc. They also points out that rise in cost of health care in government hospitals is comparatively lesser than private sector.

Though private health care delivery in India is widely acknowledged, little empirical evidenee exists on how it functions. Chakraborty.S (2003) [68] has made an attempt to study about the same with special reference to Uttar Pradesh State in India.

In his paper on 'Private Health Provision in Uttar Pradesh, India, an attempt has been made by him to understand the functioning of private health sector in Uttar Pradesh with reference to three districts in the state. It has been observed that less than 5 percent of the private hospitals are funded by government and many are financed by financial institutions. Some of the highlights of the findings are the rate of bed occupancy in private sector is only 40 percent, many private hospitals participate only in polio campaigns and family planning programs and do not participate in any other national health programs, there are many infrastructural problems like electricity and telecommunication break downs, poor drainage and inadequate waste disposal and water supplies. It can be inferred from the above that there are more areas for government to enhance its active role for better collaborative opportunities with private sector.

In India, though Consumer Protection Act of 1986 is said to play a vital role in consumer redressal, Bejon, Misra (2003) [69] did a survey of 81 hospitals and interviewed participants of 86 cases brought before consumer courts in Delhi, Lucknow and Hyderabad to find out the effectiveness of the mechanism. The author finds that still the mechanism has lot of room to improve, as dissatisfaction exists among both claimants and defendants because of prolonged litigation involved. It is observed that 90 percent of cases went beyond the stipulated period of 90 days, with most lasting between one and five years. The author has recommended various suggestions to improve the same like increasing communication process between the stakeholders and improving the awareness of consumer redressal mechanisms

Mahapatra, Prasanta (2003) [70] made an attempt to analyse the quality of care in public and private sector in his paper on 'Quality Health Care in Private and Public Health Care Institutions'. In this paper, he points out that India has yet to develop any

national program for development praetiee guidelines, medical review criteria, and on so on. Research capacity for measurement of medical outcomes and risk rating of patients is also lacking. His findings based on the survey conducted in Health Sector in the state of Andhra Pradesh concludes that public sector betters private sector with respect to land and floor space, maintenance of medical protocols and therapeutic guidelines. Private sector bettered in terms of access, availability, convenience, communication, and general comfort. But on a whole, he concludes that the level of patient satisfaction is generally low in both private and public sector.

Joy Roy Choudhury and Rita Dutta in their article on rating standards for hospitals informs that (January 2004) [71] leading private hospitals across the country are planning to set up a national-level body on the lines of National Association of Software and Service Companies (NASSCOM), the apex body of software companies in the country

Ravi Duggal (February 2004) [72] made analysis of 2004-2005 budget with respect to Pharma and medical devises and states that Pharma industry is no longer responsive to the local consumer in terms of adjusting prices lower with the effective duty cuts that have been given to them, he also observes that universal health insurance scheme in the 2003 budget has not really taken off except where NGOs have taken it up as a part of their health programmes.

Satyapal Menon (February 2004) [73] in his article on Health Standards maintenance initiative in India in the lines of HIPAA in USA informs that The Union Government has tied up with the Apollo Hospital Group subsidiary Apollo Health Street Limited to standardise the capture, storage and dissemination of health information as well as to network all healthcare facilities in the country in an

ambitious project called 'Health Unite' inspired by a US legislation. The broad goal of 'Health Unite' is to deliver information to individuals, providers and planners, so that they could use this to make informed healthcare decisions. It also offers a way to connect distributed health data in the framework of a secure network.

Based on a survey, Sapna Dogra (March 2004) [74] in her investigative article on Delhi houses 1600 unregistered nursing homes reveals that when India is promoted as a hub for medical tourism. She also points out that a recent survey carried out by a private company at the behest of the government, found that many unregistered small hospitals and nursing homes were operating in the garb of medical centers and polyclinics.

Dr Gopinath N Shenoy (March2004) [75] in his article on advertising norms of health care institutions points out that Medical Council of India, which prohibits not only registered medical practitioners but also healthcare institutions from advertising. Interestingly, the laws governing such institutions do not forbid them from advertising i.e. the Company Law does not consider advertisement as unethical but on the contrary permits the companies to spend huge amounts on advertisements

SASHD, SASFP (May 2004) [76] in an article on "India-Private Health services for Poor a policy note", have stated that although India has made great strides since independence, fertility, mortality and morbidity remain unacceptably high both compared to countries in the region and those at similar income levels. Almost a third of the Indian population lives in poverty. The impact of poverty on health care and vice-versa is significant. A significant number of private health care providers in India (especially in the rural areas) are untrained practitioners. Although reliable data on their numbers are difficult to compile, it has been estimated that they number well

over 1.25million. The cast majority of these providers are not registered, qualified or regulated. This portrays our poor infrastructure.

Saji Salam (May 2004) [77] in his article titled Healthcare informatics in the next five years explains Health Level Seven (HL7) standards on health informatics pointing that is one of several ANSI-accredited Standards Developing Organisations (SDOs) operating in the healthcare arena. The HL7 Organisation was founded at the University of Pennsylvania in 1987 to design a consensus-based standard for the electronic exchange of healthcare related information. Most SDOs produce standards (sometimes called specifications or protocols) for a particular healthcare domain such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. Health Level Seven's domain is clinical and administrative data. Several years of effort has gone into the making of standards. The advantage for India is that by leveraging these standards, the industry could leap to a higher level.

IRDA in their concept paper on Micro insurance (August 2004) [78] have stated that micro insurance is the most underdeveloped part of micro finance. Yet various schemes exist that are viable, benefiting both the institutions and their clients. Such schemes have generally served two major purposes, they have contributed to loan security; and they have served as instruments of resource mobilisation. The functions that need to be focused must include providing guidance to members, collecting premium installments from members, insurance services to members, communication and exchange of experience, providing linkages with banks, Non-Government Organisations (NGOs) or donors, supporting the proposals of individual members to insurance companies through recommendations.

Rajiv Ahuja (October 2004) [79] in his article on Micro Insurance concepts, NGOs' and health insurance for poor in India points out that a recent study of micro-insurance schemes in India by the International Labour Organisation (ILO) documents 51 operational micro-insurance schemes in India. Of these, 25 came up during the past four years alone. Most are linked with micro-finance services provided by specialised institutions (16 schemes) or non-specialised organisations (15 schemes). Healthcare providers implement only 12 per cent of the schemes. Of all micro-insurance schemes, 57 per cent provide for health insurance (it may be noted that many MFIs and NGOs are in the process of introducing health insurance). The author also points out that although health insurance only provides for the cost of hospitalisation, the poor also have to incur many indirect costs, such as wage loss, transportation costs, and opportunity cost of time of those who accompany the sick and special meal costs. These costs can be prohibitively high, discouraging a sick person from visiting a hospital and seeking treatment even when he or she has health insurance. For this reason, some health insurance schemes (for example, the two UNDP sponsored pilots in Karnataka) have also provided wage loss benefit that is used creatively by a nodal agency. For example, any unpaid instalment of premium is deducted from the wage loss amount that a sick person is entitled to. In some cases, it is also used to pay the renewal premium for the following year. The flip side of providing wage loss benefit is that it can induce hospitalisation when it is not required.

Nareen.N.Joshi (October 2004) [80] in his paper titled Rural Insurance Scenario has attempted to find the rural insurance scenario and has stated that there are a total of 124 million rural households. Nearly 20% of all farmers in rural India own a Kissan Credit Cards. He points out that the 23 million credit cards issued till date

offer a huge data base and opportunity for insurance. The agent plays a major role in creating awareness, motivating purchase and rendering other insurance services.

P.C. James in his article titled 'Covering the Poorest' (October 2004) [81] has referred lots of surveys conducted by World Bank and National Sample Survey Organisation (NSSO). According to a NSSO study, the poor spend a much higher percentage of their income on healthcare vis-à-vis the rich, more than three quarters of the spending is on minor ailments.

Majumdhar (October 2004) [82] in his article on regulations for health insurance criticises the lack of definition of responsibility on actuaries for health insurance. He states that it would appear that in Germany it is compulsory to have a Responsible Actuary overseeing an insurer's health insurance business and it is perhaps the right time now for the authority to consider placing similar responsibility on the shoulders of the Appointed Actuary (AA) of the insurer.

Michael P. Keane, (November 2004) [83] in his paper on modelling health insurance states that new econometric advances have not yet been widely used in the health economics literature. This suggests that more inter-disciplinary studies and research are required.

Express Pharma Pulse Journal in an article on Yashaswini Scheme, (December 2004) [84] has published that Corporate India has joined hands for a worthy cause again this time, Bangalore-based biotech company Biocon Ltd has joined hands with ICICI Lombard General Insurance Company Ltd and the Bangalore's Narayan Hrudayalaya to launch a first of its kind medical insurance scheme for the rural poor. The initiative, christened 'Arogya Raksha Yojana' has been introduced in Anekal Taluk

near Bangalore, which has a population of six lakh people. A scheme 'Yashawini', which offers similar healthcare insurance for farmers for a daily premium of Rs five

David.E.Bell and Arthur Schleifer Jr. (2004) [85] in their book on Risk Management have studied the Claim Patterns and Actuarial rate setting, and points out that the industry suffers from the difficulty of establishing its prices before it knows its costs. With each policy the company undertakes three risks, viz, the likelihood of a claim against policy, the size of the claim, the timing of the claim. The whole idea of an insurance company is that claims will average out over a large number of policyholders. This is true as long as actuarial data continues to predict future claim patterns. Anything that systematically distorts the frequency or size of claims is a threat to the profitability of an insurance line.

Alan C Monheit and Joel C Cantor (2004) [86] have in their book titled State Health Insurance Market reform, opined that while researchers strive to identify causality and obtain a set of plausible and unbiased estimates, policy makers and non-specialists are generally unfamiliar with the estimation methodologies and primarily concerned with whether the research yields a reliable set of empirical estimates that can inform public policy.

In a search about the potential for small employer groups, Thomas C. Buchmuller (2004) [87], in his article, What can we learn from the research on small-group insurance reform, in the book titled State Health Insurance Market reform, states that in early 1990s nearly every state in the United States enacted new regulations governing the sale of insurance to small-employer groups. The author based on US experience points out that universal or near-universal coverage can be achieved only with a combination of public subsidies and some kind of requirement

that people obtain health insurance. It is not reasonable to expect supply-side policies, like that state-level small group reforms, to have had a major effect on coverage.

Suri Seeta Ram (January 2005) [88] in his article Life as a Life Insurance Agent, refers to a survey done in 2001 regarding the awareness and points out that, it was found that 58 per cent of the urban educated did not know about health insurance. As much as 25 per cent of the people who suffered illnesses covered by health insurance did not bother to make a claim, with reasons ranging from "Anyway the insurance company may delay or avoid the payment" to "Who bothers to go over the rigmaroles of making a claim?"

Anil K Maini (January 2005) [89] in his article on Medical Tourism states that the Indian healthcare market is Rs 15 billion and growing at over 30 per cent every year. Indian private hospitals are increasingly finding a mention in the travel itineraries of foreigners, with the trend of medical tourism catching up in the country. If industry estimates are to be believed, the size of the medical tourism industry stands at Rs 1,200 - Rs 1,500 crore (Rs 12-15 billion). A recent CII-McKinsey study on healthcare says medical tourism alone can contribute Rs 5,000- Rs 10,000 crore (Rs 50-100 billion) additional revenue for upmarket tertiary hospitals by 2012, and will account for 3-5 per cent of the total healthcare delivery market.

IRDA (February 2005) [90] in a circular has stated that it has prescribed a mortality table LIC (1994-96) Ultimate Table to be used as base table for pricing the Life Assurance Products and LIC (1996-98) Annuitants' Table for pricing the annuity or pension business and for calculating the liabilities under these products. But there was no benchmark table prescribed for pricing or valuing the liabilities of the Health

products as regards the critical illnesses under Regulation 5 sub regulation 3 of IRDA (Assets, Liabilities and Solvency margin of Insurers) Regulations 2000. With no prescribed benchmark morbidity table, the life insurers are using the critical illness rates provided by their Reinsurers based on experience of another country/ region with adjustments as may be necessary. In this process consistency was lacking with attendant issues like rationale for adjustments made and linkage to underwriting standards not being clear. IRDA referred the issue to the professional body- Actuarial Society of India (ASI) to examine and recommend reference table which can serve as a Standard reference table until Indian lives morbidity table based on experience of Insurers becomes a possibility. ASI after the process of examination by a committee of actuaries has suggested CIBT 93 to be used as the Standard reference Critical Illness rates table to be used under sub regulation 3 of regulation 5 of IRDA (Assets, Liabilities and Solvency margin of Insurers) Regulations 2000 for pricing and valuing the liabilities of Critical Illness Standalone products or Critical Illness Riders- Accelerated or Lump Sum.

A Health Insurance Working Group (February 2005) [91] that had been constituted by IRDA a few months ago has representatives from Ministry of Health, Finance, ESIS, CGHS, Corporate Hospitals, Insurers, TPAs, Actuaries, and NGOs to popularise health insurance and to address the roadblocks hindering its growth. The working group consists of three committees. One of the committees is working towards developing a database for health insurance. The second committee will work towards making the environment conducive for entry of stand-alone health insurance companies while the third committee will address issues related to pre-existing disease and innovate health insurance policies. One of the main constraints lie in terms of access to quality data on mortality and morbidity trends on the basis of which

insurers can price health insurance products and innovate by offering tailor made solutions. One of the steps taken is to rationalise the interpretation of the term 'pre-existing' disease so that genuine claims are not repudiated thereby causing undue pecuniary hardship to the policyholders. Another aspect being considered concomitantly is to devise a mechanism to enable portability of insurance so that policyholders have the freedom to switch their policies from one insurer to another. Other issues, which the group will look into, include designing innovative health insurance products and feasibility of having standalone health insurers.

Falaknaaz Syed (April 2005) [92] in his article Innovative Managed Care model to be launched on a pilot scale foresees that by the year 2025, the importance of HMO approach with emphasis on prevention for the entire Indian community will get appreciated. He also points out that a survey of 100,000 middle class families in Mumbai revealed that on an average each family spends Rs. 10,000 per year for medical expenses.

Jessica Feldman (2005) [93] in her article A roaring rural market, kick starting health insurance for the rural poor narrates her experience she had on behalf of an NGO called Swayam Shikshan Prayog (SSP). Most of the people surveyed were farmers or labourers and family incomes were mostly in the range of Rs. 15,000-20,000 a year. The most frequent treatments were for gastroenterological conditions arising from poor sanitation and waterborne diseases, malaria and complications resulting from pregnancy. Families often sought treatment at public health centers or used home grown methods to alleviate the symptoms. The average expenditure for a hospital visit was Rs. 2,000, but the cost of caring for a serious injury or illness often went above Rs. 5,000. The most significant fact was that a data repository tracking the ailments and treatment of such ailments faced by the rural segment did not already

exist. But the researcher was able to collect data and designed schemes in consultation with Insurers based on the data collected.

TK Sundari Ravindran (2005) [94] in a paper on "Health sector reform and public-private partnerships for health in Asia: Implications for sexual and reproductive health services cautions that such partnerships may have the insidious effect of shifting priority setting more in line with the interests of the private partner, with efficiency and cost-effectiveness dominating all else. This is because the private sector has less to lose from not entering into a partnership, or walking out of it.

Aloke Gupta (2005) [95] in his article titled Initiatives to develop health sector has stated that from 0.104 percent in 1992-93, health insurance penetration (percentage of total population covered under private health insurance) in India has grown to 0.948 percent in 2002-03. It is projected to reach the level of 1.65 percent in 2005-06. During the corresponding period, health insurance premium have grown from Rs. 48.91 crores in 1992-93 Rs. 104.5 crore in 2002-03 and projected to touch Rs. 1800 crore in 2005-06. The penetration levels do not convey a very encouraging picture. Health insurance has been single product (Mediclaim) driven and loss making to insurers and hence not aggressively marketed. It has mainly been bought in metros and large cities with tax incentive being one of the important motivator. The present health insurance market differs from high utilisations by health providers and policyholders. There is no incentive for the policyholder to demand efficiency and cost from the health provider.

Kenneth A Cahill, Susan Matthies (2005) [96] in their paper in Health insurance: global lessons and barriers to development in India opine that in practice, only a small percentage of health facilities offer consumers a systematic process for gaining

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GENESIS AND OVERVIEW OF HEALTH INSURANCE IN INDIA

CHAPTER III

GENESIS AND OVERVIEW OF HEALTH INSURANCE IN INDIA

India is estimated to be a market with high potential currently but still only a meagre percentage of population are covered by some form of health insurance. Though health insurance plans are available in the market today, the scenario was not the same during first half of 20th century when health insurance was discussed for introducing it in India. Since then health insurance has passed through various forms to reach the form of today. This chapter details about the development cycle of health insurance since its genesis in India which can help to understand the importance given to health insurance during various phases and also help to realise the value of health insurance in current scenario. This chapter is classified into two parts, the first part details about the Genesis and overview of the developments in Indian health insurance arena and the second part details about the health insurance statutory environment in India

Section I: Genesis and Overview

In general, the insurance sector in India has come a full circle, from being an open competitive market to nationalisation and back to a liberalised market again. But, historically, the growth of health insurance in India can be segmented into four following phases.

Pre Independence Era (till 1947)

Pre Nationalisation Era (1947-1973)

Nationalisation/Pre-liberalisation Era (1973-1999)

Post Liberalisation Era (from 1999)

Pre-Independence Era

In 1923[1], Workers Compensation Act was passed by Central Government covering 3 million workers. But tlll 1930 very few provinces like Bombay and Central Province took some actions on this like passing of bills, providing maternity benefit to women workers. Though efforts were made to secure legislation o an all India basis, they were defeated by the British Government, which tried to put the recommendations of the Whitley commission for welfare legislation on an all India basis in cold storage.

Actually the subject of health insurance for industrial workers was first discussed by the Indian legislature in 1927 when the applicability of the conventions adopted by the International Labour Conference at its tenth session to India was considered by the Government of India. But Government expressed its inability to sponsor a health insurance scheme but recommended the provincial governments to examine the possibility of implementation of such schemes. But many provincial governments too found it difficult.

In, 1928 The Indian Insurance Companies Act was enacted to enable the government to collect statistical information about both life and non-life insurance businesses. The subject of health insurance for industrial workers was first discussed by the Indian Legislature in 1927 when the applicability of the conventions adopted by the International Labour Conference at its tenth session to India was considered by the government

[1] Usha Mehta and A.D. Narde, 1965.Health Insurance in India and Abroad, Allied Publishers, pp 48-62

The Royal Commission Scheme

A Royal commission on labour was appointed in 1929 to find the need for health insurance among workers. It submitted its report in 1931. It observed that the incidence of sickness is substantially higher than in western countries; the medical facilities are much less adequate; wages are low to meet the health care spending without borrowing. Though the Commission realised that the difficulties in the way of a health insurance scheme for the workers were many and formidable, it proposed a tentative scheme. Though these suggestions could have helped in embarking upon scheme of provision against sickness and old age no action was taken on the recommendations of the Royal Commission.

Though these suggestions could have helped, but no action was taken on these recommendations. During the period of Second World War, the social insurance movement accelerated in India.

The Scheme of the Government of Bombay

The Government of Bombay prepared a scheme of sickness insurance. According to this scheme, every industrial worker was given the legal right to 3 or 4 weeks sick leave with pay every year. The unutilised leave could be turned into cash, which was to be handed over to a fund to be maintained by the government. The amount thus accumulated could be drawn buy the worker either on his retirement or on his reaching a particular age or by his relative if he died during the period of service. The scheme, however, was inadequate as it failed to provide for medical benefits.

In 1938, earlier legislation was consolidated and amended to by the Insurance Act with the objective of protecting the interests of the insuring public.

The Bombay Textile Labour Committee scheme

As a result of the general awakening during the Second World War, the pace of social insurance movement was accelerated in India. Accordingly, the second important step in the direction of sickness insurance w as taken in 1940 by the Government of Bombay when the Bombay textile labour enquiry Committee formulated a scheme:

Table 3.1

Monthly contribution rates

Insured Worker	Employer	Government	Total
Male – As.5	As.10	Anna 1	Re.1
Female – As.5	As.10	Anna 1	Re.1

This contribution scale was subject to the condition that the contribution by the insured worker was in no case to exceed 5 percent of his average monthly income during the preceding quarter. This scheme was an important step forward in the direction of comprehensive sickness insurance plans in as much as it suggested non-separation of cash and medical benefits, setting up of a single and unified fund under central management and recommended contributions from the state. Unfortunately, the government could not implement it. The conference of labour ministers held in 1940 discussed the question of health insurance for the industrial workers and decided that the views of the employers' and employees' organisations should be elicited. The workers' organisations also favoured the principle of compulsory contribution but urged that in view of the low wages of the workers, their contribution should be nominal. The matter came up for discussion before the second conference of labour ministers held in 1941, where it was decided that instead of contributing to the health insurance fund, the government should consider the proposal of standing guarantee to ensure the solvency of the fund.

The Labour Department Scheme

The labour department of the government of India prepared a tentative scheme of health insurance and placed it before the conference of labour ministers held in 1942. No action was taken on this scheme. It was suggested at the conference that the details of a comprehensive scheme should be worked out by a small committee of about three experts. Later, however it was decided to entrust the work to a special officer. Accordingly, Professor B.P. Adarkar was appointed for this work in 1943. He submitted his report in 1944.

Adarkar's Scheme

The scope of the scheme was restricted to three major industries textiles, engineering and minerals and metals. All the perennial factories except those falling under scheduled exceptions, like employment in the armed forces, public departments, public utility concerns etc. were covered by the scheme. A further restriction on its scope was that it was to apply only to the workers between 12 and 60 years if age and drawing less than Rs. 200 a month. The Government of India thought it fit to obtain expert opinion on the report submitted buy Professor Adarkar before taking any action on it and requested the international Labour office to send a deputation to examine the scheme. In response to this request, Messrs. M.Stack and R. Rao of the International Labour Office came to India in 1945 and prepared a note on professor Adarkar's report.

Stack and Rao Scheme

The two experts agreed with the fundamental principles enunciated by Professor Adarkar. The chief medications suggested by them were (i) the separation of the

medical and the cash benefit, (ii) the integration of the maternity benefit and workmen's compensation in the health insurance scheme and (iii) the extension of the scheme to all perennial factories covered by the Factories Act and to non-manual workers.

On the basis of Adarkar's Report and the modification sand alterations suggested in the Stack and Rao scheme, the Government of India introduced a bill in the Central Legislative Assembly on November 6, 1946. It was referred to the select committee on 22nd November 1947. The select committee submitted its report on the 11th February 1948 making substantial improvements in the original Bill. It modified the provisions making it applicable to all the employers in the factories and changed the name of the Bill to the 'Employees' State Insurance Bill', which became a law in the form of the Employees' State Insurance Act in 1948. This Act is the first of its kind not only in India but also in the whole of the South East Aslan region.

Pre-Nationalisation Era

Employees State Insurance Corporation Act (ESIC), 1948 enabled the establishment of ESIC dispensaries across various parts of the country. ESIC provides benefits to employees in cases of sickness, maternity and employment injury. Under the Act, the ESIC has been set p to administer the Insurance Scheme. ESIC hospitals have been set up in many industrial areas and workers get treatment and medicines at concessional rates. Both employers and employees are required to contribute towards a fund, which is used to meet the following expenses.

Various benefits provided for under the Act for including disablement and death benefits and medical treatment.

Establishment and maintenance of hospitals, dispensaries etc.

Administration of the scheme.

Central Government Health Scheme

The scheme, introduced in 1954 as a contributory plan, was aimed at providing comprehensive medical care to the central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is nominal but progressive with salary scales (the contribution starts at an amount as low as Rs. 20 per month). Separate dispensaries are maintained for the exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated.

Railways Health Insurance Scheme

The scheme was started to cater to the health care needs of railways personnel.

Nationalisation/Pre-Liberalisation Era

In 1956, 245 Indian and foreign insurers and provident societies taken over by the central government and nationalised. LIC formed by an Act of Parliament, viz. LIC Act, 1956, with a capital contribution of Rs. 5 crore from the Government of India.

In 1972, The General Insurance Business (Nationalisation) Act, 1972 nationalised the general insurance business in India with effect from 1st January 1973. 107 insurers amalgamated and grouped into four companies viz. the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd. GIC

incorporated as a company. But even after such reforms, health insurance or medical expense insurance schemes have been in existence for a number of years prior to nationalisation of insurance business. These policies were granted on a group basis, only to large corporate clients purely on an accommodation basis, as claim experience was unsatisfactory. There was no scheme for individual and families.

In 1981, a limited cover was devised for individuals and families. This was replaced by a mediclaim policy in 1986 under a market agreement. This scheme was modified in 1996 in the light of experience and suggestions from the insuring public and the medical fraternity. This scheme is available both on an individual and group basis.

In 1984, OMP was introduced to provide payment of medical expenses in respect of illness suffered for accident sustained by Indian residents during their overseas trips for official or holiday purpose. In 1998, Videsh Yatra Mitra policy was introduced with enhanced scope of overseas mediclaim coverages.

In 1990, a deferred health insurance policy 'Bhavishya Arogya Policy' was introduced to cater to the medical care of retired persons. The policy reimburses medical, surgical expenses following illness/accidental injury, incurred by the insured person during his retirement age as defined in the policy.

In 1993, another public sector Unit Trust of India introduced Senior Citizens Unit Plan (SCUP) to provide coverage for hospitalisation expenses up to Rs. 500,000 for the investors after attaining the age of 58 years. Anyone in the 18–54 years age group can join the scheme by a one-time investment and his/her spouse can also become eligible for the medical insurance benefits.

Though it is not a health insurance policy primarily, in 1995, The LIC introduced a special policy known as Asha Deep II in 1995 to cover insurance against four major ailments, namely cancer, paralytic stroke, renal failure, and coronary artery diseases.

In 1996, a mini version of the scheme viz. Jan Arogya Bima Policy for the weaker sections of the society was also introduced by GIC.

In organisational front, some schemes like Police Sanjeevani Nidhi Yojana for police personnel in Maharashtra was started in 1998, the scheme today covers 90,000 personnel out of the total strength of 1, 44,000. That is quite a huge membership considering the fact that the scheme is voluntary. The scheme covers 'hospitalisation' expenses of a number of ailments including cardiac operations, dialysis, kidney stone removal, cancer surgery, brain tumour, etc.

Similarly, many NGOs' like SEWA, CINI provided health insurance coverages to its members

Many of the health insurance policies floated by GIC of India were not popular and some of it were restricted to some selected branches Barring Mediclaim other policies were not very popular even among the insured's. The coverage of mediclaim is about 2.5 million, which is very low as compared to India's 300 million middleclass. The industry claims ratio in this era was (ratio of claims amount over the premium income) 65.35% in 1996-97on a gross premium of Rs. 1.67 billion. During liberalisation, it shot up to 98.45% in 1999-00 on a gross premium of Rs. 4 billion.

Liberalisation Era (From 1999)

IRDA Act was passed in 1999 and after its passage, insurance sector was thrown open to private participation. But no specialised health insurance company entered into the market due to various factors like lack of data, past claims history, higher capital norms etc. Cigna which showed interest initially withdrew its application due to the above factors.

However, after liberalisation, new age insurance companies have started offering health insurance policies in the lines of mediclaim policy i.e., the features of those policies are similar to that of mediclaim policies offered during pre-liberalisation era. This is due to the fact that due to lack of proper data, the new age insurance companies follow almost similar rates as that of mediclaim policies. On the other hand, after liberallsation, life insurance companies started offering critical illness rider.

In 2001, IRDA introduced TPA services in the market. TPAs were introduced to promote the concept of cashless benefit schemes. Though the concept of TPAs existed even before the liberalisation, TPA services were limited to only a few corporate clients. But through IRDA (TPA) Regulations, 2001, TPAs can service to both private and public sector insurance companies. During the same period, IRDA allowed life insurance companies to sell policies with critical illness insurance riders. As per the latest available figures of IRDA (Sep 2004), the sale of critical illness insurance policies is around 3.2 million. Critical illness rider is not a pure form of health insurance by itself. Though the concept of 'critical illness rider' cover may be new to India, the concepts originated around 20 years back itself (1985) in South Africa. The basis of critical illness rider is that to offer risk coverage against life transforming diseases which hit many of the people like stroke, cancer, heart attack and has the

capability of ruining the accumulated wealth of a person, spoil his active work etc. The list of such life transforming diseases are very few and unlike the health insurance policies which promises to cover unlisted various diseases, these critical illness riders limits itself to only certain diseases. To say it simply, critical illness rider is concerned only about diseases, which affect most of the people and not all the diseases, which rarely affect any rarest people. The idea works out because, people are aware of the diseases listed in the critical illness rider benefits and able to visualise the coverages. Though these diseases are covered in health insurance policies offered by non-life companies also, the premium paid includes coverage for all the diseases including the rarest diseases.

But whether critical illness rider falls under health insurance or life insurance is a question? When we compare the requirement of actuarial calculation for pricing health insurance policies (non-life companies) with the critical illness rider (life companies), the pricing of health insurance is more complex as several factors like morbidity rate, incidence rate, hospitalisation expenses etc. are involved. But for critical illness rider, only the age-specific incidence rate is enough, no need to worry about the hospitalisation expenses, inflation rates etc. This looks similar to the mortality rate basics of life insurance though the critical illness rider works on the basis of morbidity. Hence there is no wonder that critical illness riders are promoted by life insurance companies where no specialised health insurance actuaries are required.

A thing to remind again is that though critical illness rider offers health risk coverages, it can no way comparable to the benefits of core health insurance policies. For example, though the policyholder if diagnosed with any of these illnesses listed by the life insurer at any time during the policy term, he would get benefits under the

rider, there is a clause that if policyholder is once diagnosed with any one of the illnesses, the rider would terminate. The list of diseases varies from company to company and there are conditions like the policyholder must survive for at least 30 days after the diagnosis. This period of 30 days varies from company to company. Health Insurance policies also have lots of restrictions when compared but the benefits are more. Hence basically, the policyholders should get cleared of all the doubts before taking policy.

In 2004, IRDA published a concept paper on 'micro insurance' in order to introduce the concept micro-insurance to enable insurers to design and distribute and service micro-insurance products (including health insurance products) and discharge their obligations to the rural and social sectors as per provisions of the Insurance Act, 1938.

It is proposed that an insurer transacting life insurance business shall be permitted to provide life micro-insurance products as well as general micro-insurance products provided it ties up with an insurer transacting general insurance business for the general micro-insurance products, and vice versa.

In addition to an insurance agent or corporate agent or insurance broker who are authorised to solicit and procure insurance business, including micro-insurance business with an insurer in accordance with the provisions of the Insurance Act, 1938 and the regulations made there under it is also proposed to introduce the concepts of 'micro-insurance product' and 'micro-insurance agent'

The operational issues of the above regulations are under review by IRDA.

A note about Growth of Individual Health Insurance Policy Segment

The individual health insurance sector is showing steady growth. Especially both private and public insurance companies are slowly penetrating into the market. The following figure depicts the same

Table 3.2

Details of health business across various insurers during 2003-2004

Insurer	Health Premium (In Crores) 2004-2005	Health premium as a percentage of total non life business	Growth of health premium (2003/04 - 2004/05) %	Growth of total premium (2003/04 - 2004/05) %
ICICI Lombard	118.78	13.4	257.0	74.7
Bajaj Allianz	70.39	8.3	242.2	79.0
Royal Sundaram	30.02	9.1	88.8	28.5
IFFCO-Tokio	28.37	5.6	73.3	56.0
TATA AIG	26.64	5.7	35.3	32.7
Cholamandalam	20.12	11.8	-	75.3
Reliance	7.98	4.9	2.4	0.3
HDFC Chubb	1.97	1.1	-	59.2
Private sector	304.27	8.6	148.0	55.3
New India	504.28	11.9	43.9	4.5
National	364.29	9.5	26.3	11.9
United India	294.19	10.0	5.2	-3.8
Oriental	265.14	8.7	13.9	5.9
Public sector	1,427.9	9.8	24.0	5.2
Total	1,732.17	9.6	36.0	12.3

The above table provides details of the growth of the Health and other non-life businesses. The health segment looks quite vibrant among the private players. ICICI Lombard and Bajaj Allianz are the main players in the health business. Cholamandalam – the latest entrant - seems to be focusing more on its health business; 12 per cent of its business comprises health insurance, which is the second highest among the private players, followed by 13 per cent of the top player ICICI Lombard. The rapid growth of total non-life and health during the past two years suggests that the insurance market, including health, has benefited immensely from the opening up and privatisation, and is probably going to see an even higher growth in the near future. In comparison to the private sector, the public sector companies

have witnessed relatively slower growth. The total business has grown by just five per cent while the health segment has increased 24 per cent, both the numbers being much lower than the 55 per cent and 148 per cent, respectively, in the private sector. However, it must be remembered that the private sector companies have the advantage of being latecomers with a lower base, so any increase over these levels would look substantlal. Also, in terms of volume of business, the four public sector companies had about Rs. 1,428 crore of business in 2004-05, whereas the private sector companies together had a modest Rs. 304 crore. Among the public sector insurers, NIA seems to be more focused on the health portfolio, with 44 per cent growth in 2004-05. Overall, even in the public sector, the health business is growing faster than other non-life business. It is interesting to see that the market shares of different companies keep changing over time, which is an indicator of a thriving and competitive market.

In summary, Though Insurance companies are showing steady growth in health insurance business (negligible when compared to market potential), exorbitant claims ratio nullify the positive effects of such growth. Hence only way is to improve the customer base aggressively for health insurance and establish more controls over claims ratio.

Section II: Health Insurance Statutory Environments

In any country, the statutory environments play crucial role for the growth of business. Health Insurance Statutory Environments are detailed in this part.

Constitutional Environment

The Constitution of India is the fountainhead of all our laws, rules and the regulations. Hence it is useful to begin with the provisions of the Constitution relating to health care and insurance to get idea about the structure encompassing health care and insurance in India.

Article 47 of the Directive Principles of State Policy states, 'duty of State to raise the level of nutrition and the standard of living and to improve public health'. Though the Constitution talks separately of 'Fundamental Rights' and 'Directive Principles of State Policy', some constitutional experts believe that 'the Directive Principles are also fundamental'.

Article 246 of the Constitution of India deals with the subject matter of laws made by the Parliament and the Legislature of States. The Seventh Schedule of the Constitution contains 3 lists, List I – Union List, deals with the subject matters within the purview of the Parliament. List II – State List, deals with the subject matters within the purview of the State Legislatures. List III – Concurrent List, deals with the subject matters, which are common, both, to the Parliament and to the State Legislatures. Insurance falls under the Union List (Item No. 47). Public health and sanitation, hospitals and dispensaries fall under the State List (Item No. 6).

Medical professions fall under the Concurrent List (Item No. 26). Protection and Improvement of environment (Art. 48A) and bio-medical environmental issues fall under the Concurrent List (item Nos. 17, 17A). Drugs (pharmaceuticals) fall under the concurrent list. (Item 19). The Supreme Court of India has evolved principles regarding interpretation of the lists:

Predominance of the Union List over the State List and the Concurrent List and that of the Concurrent List over the State List

If the Union List and the State List overlap, it is the Union List, which shall prevail.

If the Union List and the Concurrent List overlap, it is again the Union List, which shall prevail.

In case of conflict between the Concurrent List and the State List, it is a Concurrent List that shall prevail.

Thus, health care is a sector fragmented between the Centre and the States and the overall legal scenario relating to regulation of health care is not simple. This is affecting the reforms in health insurance in India, as unlike Reserve Bank of India, Insurance Regulatory and Development Authority of India (IRDA) has limitations in exercising its duties. Any changes proposed in the health insurance arena by IRDA have to be implemented by hospitals, which fall under Union and State list.

Regulatory Environment

Insurance in India was governed under Insurance Act, 1938 till IRDA Act was passed in 1999. IRDA Act adopted majority of the provisions of Insurance Act, 1938. But now IRDA is thinking to change some provisions with respect to health insurance. For Example, under Insurance Act, 1938, insurance against sickness and medical treatments is not part of life insurance business. It gets covered under miscellaneous insurance business, which is part of general insurance business. This is not the situation in many other countries. They consider health insurance as part of the

life insurance business. But IRDA is planning to allow life insurers also into the segment.

Under the IRDA Act 1999, the IRDA is vested with the powers of licensing and regulating insurers, including health insurers. The Act states its aim as 'to provide for the establishment of an Authority to protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto and further to amend the Insurance Act 1938, the Life Insurance Corporation Act 1956 and the General Insurance Business Nationalisation Act 1972.'

Section 4(2) of IRDA – Registration of Indian Insurance Companies Regulations 2000 states 'the classes of business of insurance for which requisition for registration application may be made are, life insurance business consisting of linked business, non-linked business or both; or, general insurance business including health insurance business (or health cover)'.

Section 2(f) of the IRDA - Registration of Indian Insurance Companies Regulations 2000 defines health insurance business or health cover as 'the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits whether in-patient or out-patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans basis, including assured benefits and long term care'.

Multi-Disciplinary Nature of IRDA Regulations

A simple reading of the IRDA regulations gives the impression that it aims to regulate, not only insurance companies but also hospitals and other organisations that run insurance (like) plans.

Though health insurance has been brought under the purview of general insurance business, it is reasonable to presume that life insurance companies, which market endowment and other products with health riders, will continue to do so. However, hospitals, which run health-plans, may have to register themselves as insurers. So far none of the private hospitals, which run health plans, appear to have registered themselves as insurers. But stakeholders from other sectors that influence health insurance viz. medical, pharmaceutical industries are primarily governed by its own regulations. Hence how IRDA intends to tackle this issue remains to be seen. Some important regulatory aspects of IRDA are detailed below. The following paragraphs give details of the main provisions of the Insurance Act as many have been elaborated or clarified by the IRDA. They deal with:

Registration and licensing

Management of funds, including control on investments

Control on Management

Solvency margins

Powers to investigate and to issue directions

Special provision s protecting policyholders

Registrations and Licensing

Every insurer is required to obtain a certificate of registration from the IRDA, which has to be renewed every year. An insurer can be registered to transact life insurance business or non-life insurance business, but not both. The fee for registration is Rs. 50,000 for each class of insurance business. The fees for renewal will vary according to the gross premium written direct in India in the previous year, but not exceeding one-fourth of one percent of such premium or Rs.5 crores whichever is less, but not less than Rs. 50000, for each class of insurance business.

Only Indian insurance companies with a share capital of not less than Rs.100 crores consisting of ordinary shares are entltled to be registered. Experts opine that the share capital may be too high for a specialised health insurance company as the break-even period is expected to be more than the rest of the insurance company. Reason for higher break-even period is due to the fact that health insurance industry is having lot of demerits like lack of data, lack of centralised regulation covering all stakeholders under single umbrella etc.

Regulations related to shareholding states that if there is a foreign shareholding, it should not be more than 26percent. Some of the insurance companies have given the management control to their foreign partner despite the low share of the foreign partner. This is due to the fact that Indian partner lack required expertise in handling the business. Now Government is planning to increase the stake to 51% but it is opposed by some of the political parties supporting the government.

In India, the reinsurance for health insurance is not present in a significant manner, rather it can be said it is almost nil. But the regulations are also not in favour of any reinsurance company to set up its shop in India, it states that if a company wants to do reinsurance business, the capital requirement would be Rs. 200 crores.

There are limitations on how much of the share capital can a person hold and also on the voting rights of a single shareholder. Every insurer is required to keep with the Reserve Bank of India a deposit of Rs. 10 crores or 1% of gross direct premium, whichever is less in the case of life insurance business, 3 % of gross direct premium or Rs. 10 crores, whichever is less, in the case of general insurance business, Rs. 20 crores in the case of reinsurance business. The IRDA has the authority to cancel the registration of any insurer for reasons of non-compliance with the

provisions of the Act and the Regulations. The above infers that investment atmosphere is not so conducive for Health Insurance Company.

Management of Funds

An insurer is required to keep a separate account of all receipts and payments in respect of each class of insurance business, viz, life, fire, marine and miscellaneous. In the case of miscellaneous business, the IRDA may prescribe that separate accounts be kept in respect of any sub-class of miscellaneous business. In the case of a life insurer, all the receipts in respect of such business shall be carried to and form a separate fund to be called the life insurance fund, the assets of which are kept separate and distinct from all other assets of the insurer. An insurer is required to prepare, at the end of each financial year in the prescribed form a balance sheet; a profit and loss account, except where the insurer is doing only life, fire, marine business and no other business; a revenue account in respect of each class of insurance business. Insurers are also required to prepare the balance sheet, profit and loss accounts, separate account of receipts and payments and revenue accounts, in respect of insurance business transacted by the insurer in respect of the shareholders funds. Insurers are required to maintain separate accounts relating to funds of shareholders and policyholders. The balance sheet, profit and loss accounts etc, are required to be audited by an auditor and be accompanied by a report on the affairs of the business during that period. Copies of these are to submitted to the IRDA within 6 months. Every insurer transacting life insurance business has to get an actuarial investigation made into its financial conditions, including valuations of its liabilities. This has to be done every year. An abstract of the report of the actuary had to be submitted to the IRDA within nine months, in the prescribed form. The IRDA has the right to order a revaluation. Records have to be maintained of cover notes specifying name of party,

type of cover granted the amount of premium, policies issued, stating the policy number, dates of commencement and expiry of risk, names of the insured, premiums showing date of receipt, the amount and name of party from whom received, endorsements mentioning the policy number to which attached, dates of commencement and expiry of the endorsements, the type of endorsement and the additional premium charged or refund due and cross reference to premium register; bank guarantees and deposits giving particulars of the party, amount and conditions of guarantee or deposits and cross-reference to the relevant policy or policies; claims giving reference to policy number, loss or damage, details of settlement, recoveries from salvage, reinsurance ceded and accepted. But IRDA is not strict enough in imposing actuarial investigations with respect to health insurance business. This creates a sense that health insurance is not much regulated in India.

Control on Investments

Every insurer is required to invest his assets in accordance with the provisions of the Act. Not less than 25 percent of the assets have to be in Government securities, not less than 50% in Government or other approved securities and the balance in any of the approved investments. All the securities are to be held free of all encumbrances, charge, hypothecation or lien. The approved securities and investments are specified in the Act, the IRDA has the authority to make exceptions or to specify new investments. The approved investments are mostly shares and debentures of companies, which have a consistent record of making profits and paying dividends. Immovable property and loans and advances on hypothecation of property are approved. There are limits on the amounts that may be invested in banking companies or investment companies or any one company. The insurer is allowed to invest in an unapproved investment up to 15% of its funds. Loans or

temporary advances cannot be given to directors, managers, or officers, except as loans on policies held by them. Returns in the prescribed form are to be submitted to IRDA every quarter, showing changes in investments. At the end of the year a full statement of all investments as at 31st March has to be submitted. Any contravention of the provisions on investments would make every director manager or officer jointly and severally liable to make good losses apart from being subject to other penalties. In the context of health insurance, the insurers do not feel that the investment norms are very strict. This is one of the reasons that prevents a specialised health insurer to enter India. In USA, authorities of Blue Cross and Blue Shield plans are free to invest in equities market to any extent. This gives an advantage for the health insurance companies to modify the investment mix accordingly relevant to the financial scenario. Many times, such investment returns are capable enough to offset the underwriting losses. Similar situation does not exist in India, which needs proper consideration by IRDA.

Control on Management

The Act seeks to regulate the expenses of an insurer. Managers cannot be paid any remuneration by; way of commission of bonus or share in surplus or share in profits. There are limits on the commission that may be aid to licensed agents, employed for the purpose of procuring business. Limits are prescribed for expenses of management. The percentages are prescribed in relation to the total premium income of the insurer. Officers of insurers have to be whole-time employees. Insurers are required to transaet business from the rural areas and also among the unorganised sector and backward classes. The minimum business requirements from these sectors are prescribed by the IRDA. The IRDA has the authority to lay down the solvency margins in respect of the different kinds of businesses. The IRDA can

order an investigation into the affairs of any insurer five directions to an insurer in the public interest or to prevent actions detrimental to the interests of the policyholders, or to secure proper management. The IRDA can also appoint additional directors on the Boards of insurers or order the removal of managerial persons from office. The IRDA can also order the search of any office of the insurer and seize documents or books of accounts. There are of course, safeguards against the arbitrary use of these powers. In health insurance context, no specialised investigations are done by IRDA. Though IRDA is stipulating norms for expenses, expert quotes states that nearly 35% of health insurance premium goes towards expenses. Proper control over expense norms can help the public to avail health insurance premiums at cheaper costs.

Protecting Interests of Policyholders

The Act provides for nomination in the case of life insurance policies, making settlement of claims much simpler. It provides that life insurance policies cannot be called into question after two years on the ground of misstatements, unless the misstatements are on material information and that they were fraudulently made. Provisions exist for disputes being attended to by the IRDA or by the Ombudsmen.

Regulation by Courts of Law

The law courts, particularly consumer courts, have dealt with a variety of medical issues, like, medical negligence, hospital records, wrong diagnosis, Quackery (medical practice by un-qualified persons), medical ethics, hospital facilities, jurisdiction, etc. On health insurance, issues of delay and denial of claims have been dealt with.

Keeping in view the emerging trend of increased consumer activism in the country, it is reasonable to infer that the role courts of law in regulating medical professionals, medical practices and bio-medical environment, will become more pronounced in the coming years.

Ombudsman Scheme

The IRDA has also appointed ombudsmen. Their function is to resolve complaints in respect of disputes between policyholders and insurers in cost effective, efficient and impartial manner. The complaints to the ombudsman may relate to (a) partial or total repudiation of claims (b) any dispute regarding premium paid or payable in terms of the policy (c) any dispute on the legal construction of the policy relating to claims (d) delay in settlement of claims (e) non-issue of any insurance document to customers after receipt of premium.

The ombudsman is not a judicial authority. It will act as counsel and mediator in matters within its terms of reference. IT has no right to summon witnesses. It has to make its decision on the basis of documents submitted to it. The complainant and the insurer are allowed to make personal submissions. But lawyers are not permitted to argue the case.

Complaints to the ombudsman lie only when the insurer has rejected the complaint or no reply was received within one month of the complaint or the reply was not satisfactory. A complaint can be made within one year after the insurer has rejected the representation. The subject matter should not be already before any court or consumers' forum or arbitration.

The ombudsman is expected to make a recommendation within one month from the date of receipt of complaint. If the complainant accepts this recommendation, the insurer has to comply within 15 days and inform the ombudsman accordingly. If the complainant does not accept the ombudsman's recommendation, the ombudsman shall pass an award in writing, stating the amount awarded which shall not be in excess of what is necessary to cover the loss suffered by the complainant as a direct consequence of the insured peril or for an amount not exceeding Rs.20, 00,000, whichever is lower. The award has to be passed within 3 months. The complainant has to intimate his acceptance to the insurer and the insurer has to comply within 15 days and inform the ombudsman. If the complainant does not intimate acceptance, the award cannot be implemented.

Insurance Councils

Sections 64A to 64T of the Insurance Act, provide for the incorporation of the Insurance Association of India, in which all insurers operating in India are members. This Association will have two councils. The Life Insurance council will consist of members who carry on life insurance business in India and the General Insurance Council will consist of members who carry on general insurance business in India. Both these councils will have executive committees, which are required to aid, advise and assist the insurers, set up standards of conduct and sound practice, render advise to the IRDA with regard to controlling expenses and with regard to action against insurers acting in ways prejudicial to the interest of policyholders. The decisions of the council and the Executive Committees will have to be respected by the insurers.

Looking at the statutory factors and given the fact that health insurance is facing many problems, this research suggest that amendments can be made to make the statutory environment more insurer friendly.

References

[1]Usha Mehta and A.D. Narde, 1965, Health Insurance in India and Abroad, Allied Publishers, pp 48-62

COMPARATIVE STUDY OF HEALTH INSURANCE SCHEMES

CHAPTER IV

COMPARATIVE STUDY OF HEALTH INSURANCE SCHEMES

Though the basic purpose of health insurance is cover health related risks, Health Insurance can exist in different forms. Many forms of health insurance are practiced in India and abroad. This chapter focuses on the details of various forms of health insurance schemes in India and select foreign countries to provide insight about various forms of health insurance coverages. Such insight can help to design new plans for health insurance.

This chapter is classified into two parts. The first part focuses on the various forms of health insurance that exist in India and the second part focuses on the health insurance schemes in select countries.

Section I: Overview of Health Insurance Schemes in India

The various health care programmes presently operating in India can be categorised as follows:

State-run schemes for formal sector employees;

Health Insurance Plan offered by Insurance companies

Corporate sector health care programmes;

Community and self-financing schemes, primarily for workers outside the formal sector; and

Micro-credit linked health insurance schemes.

Membership of Various Schemes

The health insurance policyholder figures of various schemes are depicted below

Table 4.1

Health Insurance Coverage in India[1]

Schemes	Beneficiaries (in million)
The Employee State Insurance Scheme (ESIS)	25.3
Central Government Health Scheme (CGHS)	4.3
Railway Health Scheme	8
Defence Employees	6.6
Ex-servicemen	7.5
Mining and plantations (public sector)	4
Health insurance (Public sector non life companies)	10
Health insurance (Private sector non life companies)	0.8
Health segment of life insurance companies (public and private sector)	0.23
State sponsored schemes	<0.5
Employer run facilities/ reimbursement schemes of private sector	6
Employer run facilities/ reimbursement schemes of public sector	<8
Community health schemes	3
Total	~85

State-run schemes for formal sector employees

There are two schemes, the Central Government Health Scheme (CGHS) and the Employees' State Insurance Scheme (ESIS), sponsored by the central and state governments, respectively, which extend free medical care for both inpatient and outpatient services on co-payment basis to the organised workforce. ESIS also extends cash benefits towards loss of wages due to sickness as well as cash compensation towards permanent physical impairments.

Employees' State Insurance Scheme

The Employee State Insurance Corporation (ESIC) runs the ESIS, which provides both cash and medical benefits. The scheme (launched in 1948) is essentially a compulsory social security benefit to workers in the industrial sector. The original legislation required it to cover only factories using power and employing 10 or more employees, and was later extended to cover faetories not using power and employing 20 or more persons. Persons working in mines and plantations are specifically

[1] IRDA

excluded from the ESIS coverage. Any organisation offering benefits as good as or better than the ESIS is obviously excluded from the coverage.

The monthly wage limit for enrolment in the ESIS has been raised from Rs. 3500 to Rs. 6500 and now to Rs.7500. The contribution is paid in the form of a payroll tax of 4 per cent by the employer and 1.4 per cent by the employee. Medical benefits comprise cash payment for sickness, maternity, temporary or permanent disablement, and survivorship and funeral expenses. Expenditure for medical benefits constitutes 70 per cent of the total benefits paid under the ESIS. These medical benefits are provided primarily through hospitals and dispensaries. But there is mismatch between the requirements and infrastructure despite the fact that less than 10 per cent of the country's total workforce is engaged in the organised sector. Hospitals run by ESIC suffer from lots of pitfalls like poor infrastructure, corruption etc. Also there are instances where employers deprive workers through manipulations to avoid coverage of workers under ESIC Act.

Central Government Health Scheme

The scheme, introduced in 1954 as a contributory plan, was aimed at providing comprehensive medical care to the central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is nominal but progressive with salary scales (the contribution starts at an amount as low as Rs. 20 per month). Separate dispensaries are maintained for the exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated. Over the years, the coverage has grown spatially and also in terms of beneficiaries. By covering all systems of medicines, it delivers services through 320 dispensaries in 17 major cities of most of states. In addition, there are

108 polyclinics, laboratories, and dental units. The total number of beneficiaries was 4.2 million in 1997. Besides providing medical services, the CGHS provides reimbursement for out-of-pocket expenditure for availing treatment in government hospitals and approved private facilities. The list of beneficiaries contains all current as well as ex-government employees, including Members of Parliament, Supreme and High Court judges, and Central Government bureaucrats. The CGHS is widely criticised for its quality and accessibility. Though the number of beneficiaries is increasing the actual use of facility is declining due to switching over to private facility. There are plans by the government to hand over CGHS to the hands of private. Though the scope of the CGHS is limited, inefficient functioning of CGHS reveals the lacunae on the part of policymakers and users to plan properly.

If CGHS and ESIS had been good and efficient enough, it could have served as miniature model for spreading health insurance across the country.

Employer Managed Facilities and Reimbursable Schemes

The government also provides direct health services for employees of a large number of state-owned departments like Railways and Defence and Police services. These departments have set up their own system of dispensaries, hospitals, and personnel and the services are provided free of charge. Railways alone provide health care services through 110 hospitals and 665 dispensaries to nearly 8.6 million beneficiaries .An industrial sector that offers similar kinds of services is the mining sector. There are numerous reimbursement plans offered by the employers for private medical expenses. Many private sector companies, in addition to ESIS and other health insurance schemes, reimburse the expenses. There are normally two kinds of reimbursement,

Employers contribute towards a medical grant/fund, which is annually disbursed as medical allowances to their employees.

Employees incurring medical expenses submit their claims to their employer for reimbursement and reimbursements are linked to individual contributions.

Health Insurance Plan offered by Insurance companies

Health Insurance policies, is not a total indemnity policy but covers upto certain extent towards hospital care and domiciliary hospitalisation benefits, which means specified outpatient treatment provided in place of inpatient treatment. Premiums, eligibility, and benefit

Coverage

GIC introduced first health insurance policy during 1980's in the pre-liberalisation era for public. But during 1990's, in the light of the cumbersome procedure to reimburse the hospitalisation expenses, certain changes were made in the *Mediclaim* policy and accordingly, the premia was revised from 1 September 1996. The salient revisions are as follows.

Sum insured was raised from Rs. 83,000 to Rs. 300,000.

Fixation of premium according to the category of hospital/ward was removed, and now it varies according to five age groups, viz. up to 45 years, 46–55 years, 56–65 years, 66–70 years and 71–75 years.

Rate of premium was reduced (and it became almost half of the previous rate in the higher categories of sum insured). The premium varies between a low of Rs. 175 (up to 45 years age group) and Rs. 330 (71–75 years age group) for Rs. 15,000 coverage to a high of between Rs. 2825 and Rs. 5770 for Rs. 300,000 coverage.

Extending coverage to children between the age of 3 months to 5 years provided one of the parents is concurrently enrolled.

Extending reimbursement of cost of health check-up once at the end of a block of every four underwriting years.

This plan also provides family discount and cumulative bonus. The GIC also floats a group medical policy along the same lines as the individual or family *Mediclaim* policy. Due to risk pooling, the premium gets reduced in the Group

Mediclaim policy.

The GIC, in its efforts to expand coverage, introduced a new policy called *Jan* Arogya Bima *Policy* on 15 August 1996 to cater the health care needs of people belonging to middle and lower income groups. The annual premium ranges between Rs. 70 and Rs. 140 by age, and it is just Rs. 50 for dependent children against a coverage limit of Rs. 5000 in a year. It is expected that this plan would certainly be affordable to large section of India's population. In a short span of about six months, about 400,000 individuals (till March 1997) opted for this plan as against 1.6 million under the

Mediclaim.

The GIC also offers medical benefits and compensation under personal accident policies for individuals and groups. If an injury results in total disablement of the insured and thereby prevents him/her from engaging in any activity or occupation, then 100 per cent of the sum insured is paid. In other cases like irrevocable loss of eyesight, hearing, and different parts of limbs, different percentages of the sum insured are being paid. Bhavishya Arogya Policy (old age medical insurance), also

introduced by GIC in 1991, was designed to enable a person to plan for medical needs during old age out of savings during his/her current earning phase, as an old age security. Under this scheme medical expenses to be incurred over the balance life span after a predetermined age of retirement is reimbursed upto the amount of sum insured. The advantage of this plan is that it assures coverage of all types of conditions from the effective date of benefits.

In 2004, GIC launched Universal Health Insurance scheme at the rate of Re.1 premium per day, this scheme was mainly targeting Below Poverty Line segment. But this scheme also did not fly well. The Government is likely to provide a subsidy of about Rs. 30 crore during the October-March period of the current fiscal under the universal health insurance scheme, it is reported. The scheme, launched in 2003-04 has been modified. As per the scheme, there would be three slabs of subsidy for three different policies. The Government will provide Rs. 200 crore for a policy covering an individual, which has a yearly premium of Rs. 365. The premium for a policy covering five members of a family has been fixed at Rs. 548 and for a seven-member family, it is Rs. 730. The Government has decided to provide a subsidy of Rs. 300 and Rs. 400 respectively for the latter two policies.

Other Public Sector Health Insurance Schemes

Unit Trust of India (UTI), a public-sector undertaking launched the Senior Citizens Unit Plan (SCUP) in April 1993 to provide coverage for hospitalisation expenses up to Rs. 500,000 for the investors after attaining the age of 58 years. Anyone in the 18–54 years age group can join the scheme by a one-time investment and his/her spouse can also become eligible for the medical insurance benefits. Now the scheme stands withdrawn.

The Life Insurance Corporation (LIC) introduced a special policy known as Asha Deep II in 1995 to cover insurance against four major ailments, namely cancer, paralytic stroke, renal failure, and coronary artery diseases. Anyone between 18 and 50 years can opt for an insurance coverage between Rs. 50,000 and Rs. 300,000. This is basically an endowment policy with three terms — 15, 20 and 25 years — with maximum age at maturity fixed at 65 years. The benefits can be claimed only once out of four specified diseases. It includes an immediate payment of 50 per cent of the sum assured, waiver of subsequent premiums; subsequently annual payment up to 10 per cent of sum assured till the policy matures or the insured dies, whichever is earlier; the payment of balance 50 per cent of the sum assured and vesting bonuses are on maturity or death, whichever is earlier. The bonus is paid on full sum assured even though half of the sum assured has already been paid. Though it is not primarily a medical insurance policy, it became popular by selling 175,000 polices during 1995–96 with total sum assured of Rs 13,620 million.

Life Insurance companies started floating health insurance riders in the post-liberalisation era, critical illness rider offers health risk coverages, it can no way comparable to the benefits of core health insurance policies. For example, though the policyholder if diagnosed with any of these illnesses listed by the life insurer at any time during the policy term, he would get benefits under the rider, there is a clause that if policyholder is once diagnosed with any one of the illnesses, the rider would terminate. The list of diseases varies from company to company and there are conditions like the policyholder must survive for at least 30 days after the diagnosis. This period of 30 days varies from company to company. Health Insurance policies also have lots of restrictions when compared but the benefits are more. Hence basically, the policyholders should get cleared of all the doubts before taking policy.

Private Sector Health Insurance Schemes

In the lines of Mediclaim policy of GIC, private insurers like Royal Sundaram, Cholamandalam, Reliance General Insurance, IFFCO-TOKIO Marine Insurance, HDFC-Chubb, ICICI-Lombard, TATA AIG has launched policies with similar features and competitive premium rates.

Plans offered through Bancassurance Channels

With the emergence of Bancassurance Channel in India, many insurance companies have started wooing the customers of their banking channel partners by designing a slightly modified health insurance plan. Though exact performance statistics of those schemes are not yet available, these types of plans attract a negligible audience. But it can be promoted in a right manner by proper strategies.

Cancer Insurance Policy

Cancer is a dangerous disease, which requires lot of financial assistance during the time of suffering. Though many life insurance companies have come out with the concept of critical illness insurance riders which also includes cancer, the benefits offered by those riders is different from regular health insurance policies. But it also happens that regular health insurance policy may not be able to cover the cancer disease with specialised attention. Hence Cancer Patients Aids Association (CPAA) came out with policy which mingles the benefits of critical illness insurance rider and regular mediclaim policy even before the liberalisation period.

In 1994, CPAA introduced the Cancer Insurance Policy in collaboration with New India Assurance Company. The policy is available to healthy individuals who have not suffered from cancer in the past. An individual wishing to take this policy

must first undergo a mandatory free check up at one of the CPAA's Cancer Detection Centres. During the check up, a Physician, a General Surgeon, a Gynaecologist and an E.N.T. Surgeon will screen them. Basic blood tests and a Pap smear test (for women) is performed. If the individual is found to be symptom less as per the screening procedure, they are then enrolled under the scheme of their choice from those listed below. The policy takes effect 30 days from the date of the medical check up. If a pre-cancerous condition is detected, the patient is kept as a follow up case, and enrolled in the scheme after treatment and recovery. In some cases additional tests may be necessary, charges for which are reimbursed for the first check-up. If cancer is detected during the check-up, the policy will not be issued and the premium charge is returned after deducting charges for any extra investigations conducted. The policy has many unique benefits. If the person is subsequently found to be suffering from cancer, reimbursement of expenses for treatment, hospitalisation, investigations related to cancer as specified in the policy document up to the insured amount is made each year against bills submitted until the patient is considered cured or succumbs to the disease. All treatment has to be taken in India and must be allopathic in nature. The policy also covers a free annual check-up at CPAA facilities. Literature and information about the disease is available to the policyholder. Certificate for 50% tax exemption is provided. A cumulative bonus payable to the policy holder shall be increased by 5% on the sum assured for every year during which the policy has been in force prior to claim but this increase will not exceed 50% of the sum insured. Whenever a claim is submitted, CPAA interacts with the patient on one hand and New India Assurance Company on the other hand to ensure that it is settled quickly. Since inception, 39 patients have made 147 claims. There is also a corporate policy, which is becoming increasingly popular among companies who make the cover available to their employees. Some 6500 members are participating in the scheme.

including employees from companies such as HDFC, Godrej, TIFR, SICOM, J.B. Boda and Tata Assets. December 2004, we have over 11,750 policyholders and 61 detected cases of whom 39 survive. Almost Rs. 80 lakh has been disbursed against 228 claims so far. There is also similar plan floated by Cancer society of India (CSI).

Corporate Sector Health Care Programmes

Major corporate houses, given the limitation of the state-owned and ESIS health care services, have developed their own systems for the benefit of their employees. There are broadly two approaches: the first one can be called as empanelment and second one is direct provision of services. Empanelment refers to the arrangement where the employer develops a panel of private hospitals/clinics and/or group Mediclaim coverage. In the context of the second approach, there are instances of emergency services and dispensaries. Some major corporates like the Hindujas and the Tatas have even developed hospitals as trusts or societies. These hospitals more often than not possess the latest state-of-the-art technology.

Apart from this, there are big corporate hospitals, like the Apollo Hospitals, which are characterised by high quality exhaustive hospital benefits but very little outpatient coverage. The delivery of health care services by such hospitals is obviously extremely expensive and some hospitals like Apollo Hospital, to make the availability of its services more viable, have tied up with major insurance companies.

Community-based and Self-financing Programmes

Community and self-generated financing programmes are those usually run by non-governmental organisations (NGOs) or non-profit making organisations. These organisations rely on finances from various sources, including government, donor

agencies, and community and self-generated sources. Workers and families outside the formal sector. The sources of revenue for the programmes can be categorised as:

User fees defined as the payment made by the beneficiaries directly to the health care provider, such as fees for services or prices paid for drugs/immunisation. This mode of financing is not common.

Prepayment/insurance schemes, including payment by members for drugs either at subsidised rate or at cost price.

Commercial schemes for-profit actively run by organisations to finance health care.

Fund raising activities by organisations for financing health care services. In some cases the revenue raised in this manner constitutes more than 5 per cent of the total funds of the organisations.

System of making contributions in kind (such as rice, sorghum, community labour, etc.). This method is not very popular due to difficulty in management.

Other sources of community-based and self-financing include instances like Tribhovandas Foundation providing health care through village milk cooperatives and Amul Union (the milk cooperative organisation) contributing significantly towards health services through putting a cess on milk collection.

The most pertinent point about these schemes is their rural orientation and ability to mobilise resources in a village community. However, most of these schemes have catered to a small section of population with limited health coverage restricted to elementary, preventive, and maternal and child health (MCH) care.

Table 4.2

Snap shot of few schemes[2]

Name, Location, year of initiation, nature of scheme and ownership/ management	Target population, type of membership, size of enrolled population	Premium	Benefits	Exclusions
ACCORD: Nilgiris, Tamilnadu Established 1991 NGO-intermediated (with GIC as insurer	Adivasis 6 months-70 years of age. Voluntary individual 4446 out of 13000	Rs. 20 per person per year (scheme subsidises an additional Rs. 2.50)	All hospitalisations to a maximum of Rs. 1500. Covers care at one trust hospital (or others if referral required)	Only two admissions for delivery covered per woman
KKVS: Madurai, Tamilnadu, Established 2000, NGO –owned	Women members of self help groups (SHG) and their families, age 12 months –55years. Excludes those with a history of chronic disease. Voluntary family or individual 5710 out of a general population of 69278	Rs. 150 if the coverage is for a family including the SHG member and at least one other beneficiary and Rs. 100 if coverage is only for the member	Reimbursement of 75% of hospital expenses up to Rs. 10,000 per family per year. Except in an emergency, benefit only for treatment at kadamalaikkundu Hospital.	Must be an inpatient for at least 48 hours. NO coverage of pre-existing disease nor normal delivery
Navsarjan Trust: Patan, Gujarat, Established 1999, discontinued 2000 NGO-Intermediated (with GIC trust)	Dalits (scheduled caste), 5-80 years of age, voluntary individual 574 individuals	Rs. 159 per individual (payment of which was partly subsidised by an external donor)	Hospitalisation to a maximum of Rs. 15000	Normal delivery, pre-existing disease, >1hospitalisation for newly developed chronic disease, HIV/AIDS and its complications, diseases resulting from drug/ alcohol use
Seba : Calcutta, W.Bengal, established 1982, NGO-Intermediated (with GIC as insurer)	Information on characteristics of target population: na Voluntary Family < 3000 families (?1993 data)	Rs. 105 per member per annum	Hospitalisation expenses upto Rs. 8000	NA
SEWA: Ahmedabad, Gujarat established 1992, NGO-intermediated (with GIC as insurer)	Self employed women and their spouses (ages 19-58 years) Voluntary individuals 92000 of 285000 in target population (2001-2002)	Individual coverage Rs. 20 per annum. Also membership can be paid by fixed deposiT	Inpatient costs (private or public hospital) to Rs. 2000. Fixed deposit members receive one-time flat	Normal delivery, pre-existing disease, >1 hospitalisation for newly

[2] M.Kent Ranson, 2003, Community based health insurance schemes in India: A review, The National Medical Journal of India, Vol. 16, No. 2, pp 79-89

			payment for maternity care, dentures and hearing aid.	developed chronic disease, HIV/AIDS and its complications, diseases resulting from drug/alcohol use
TF – old: Anand, Gujarat, established 1993-94, discontinued 1999, NGO-owned	Residents of one rural district Voluntary household 16%-20% if the target population of 800,000	Rs. 10 per household per year	Discounts on inpatient care (inversely proportionate to their wealth) as a single trust hospital in the district	People deemed sufficiently wealthy (as adjudged by doctor or social worker) were not provided with benefit
TF – New: (Sardar Patel Insurance scheme) Anand, Gujarat established 2001, NGO-Owned	Members if a dairy co-operative depositing at least 300L/year Mandatory Household 113883 households (size of target population: na)	Nominal fee of Rs.1 per household per annum in addition to 3 paise per L of milk deposited (i.e., minimum Rs. 9)	Covers 100% of direct costs of hospitalisation at any of 8 trust hospitals but DOES NOT cover medicines	Costs of special (v. standard) hospital rooms. Heart surgery, cancer, HIV/AIDS, major orthopaedic surgeries, kidney transplants
WWP: Chennai, Tamil Nadu established 2001-2002, NGO-intermediated (with Royal Sundaram as insurer)	Women members of WWF and their families, voluntary Individual Data not available on enrolled population	Children Rs. 65 per year Adults: <45years, Rs. 125 per yr. > 45 yrs, Rs.175 per yr	Inpatient expenses up to Rs. 7000 per year (maximum Rs. 5000 per claim) Limits: Maternity care Rs. 3000 cataract Rs. 2000, bed charges Rs. 100 per day	NA
Mallur Milk Co-operative: Karnataka, established 1973, provider owned scheme	7000 in 3 villages	Previously, mandatory enrolment of all members of Mallur Milk Co-operative (? 1997data). Now, premiums paid from endowment fund, for all community members	Preventive and curative care (entirely free of charge?)	NA
RAHA: Jashpur, chattisgarh, established 1974., NGO owned	Information characteristics of target population: na Voluntary individual 75000 enrolees (1993 data)	Can be paid in rice	Free outpatient a care and after aping an initial entrance fee, members receive free hospital care	NA

			up to Rs. 1000	
Sewagram: sorghum health scheme wardha, Maharashtra established 1978, provider – owned scheme	For the residents of 40 villages; for a village to be included, atleast 75% of the households should be enrolled. Voluntary Household 40 villages (data on population :na)	Rs. 48 per landless household up to 5 people (or can be paid by 15kg of jowar) Additional fees for land-owning households	50% coverage of OPD visits and planned hospitalisations (including normal deliveries) 100% coverage for emergencies and unplanned hospitalisations. Hospitalisations must be at a single teaching hospital	None mentioned
SHH: Calcutta, W.Bengal, Established 1955, provider-owned scheme	University students only Voluntary Institutional or individual 1,020,000 students covered in 1993-94	Rs. 4 per annum, collected through the schools (? 1998data)	Free doctor consultations, drugs and hospital stays at nominal rates	NA
VHS Medical Aid plan: Chennai, Tamilnadu, established 1963 Provider-owned scheme	Anyone may join Voluntary individual 124,715 members (March 1995); but 74% enrolled for free due to their low income	Membership fee graded according to monthly income	Free annual check-up; curative and diagnostic services for outpatient and inpatient services at discounted rates	NA

NA: Not available, **ACCORD**: Action for Community Organisation Rehabilitation and Development, **KKVS**: Kadamalai kalanjia Vattara Sangam, **GIC**: General Insurance Corporation, **SEWA:** Self-employed Women's Association, **TF**: Tribhuvandas Foundation, **WWF:** Working Women's Forum, **RAHA:** Raigarh Ambikapur Health Association, **SHH:** Student's Health home, **VHS:** Voluntary health services

Micro Credit Linked Health Insurance Schemes

Several NGOs and governments worldwide have started micro-credit schemes for vulnerable groups to break the vicious circle of poverty, malnutrition, disease, low productivity, and low income. Micro-credit is now considered not only an effective tool for poverty reduction but also used as an instrument for empowerment of the poor, particularly the women. This operation generates income to the poor by extending them small credits for self-employment and other economic activities. However, it was soon realised that loan repayments by these groups were much below the expected level. The experience suggested that ill health and expenditure on treatment and associated consumption needs were the prime reasons for defaulting on repayments. To plug the erosion of income of borrowers on health care needs, many community based heatlh insurance schemes operate in India. IRDA has come out with plans for micro-insurance schemes and regulations, it has recently launched the concept paper for the same and the discussions are happening around it. Hence very soon some changes in the micro-insurance arena are expected.

Despite the presence of various schemes, the enrolment numbers are not large enough to portray India as health insurance interested nation. Since India is a country with majority of informal population, the NGO & Micro Insurance channels can serve as better option for reaching the informal masses in the country. But from the excerpts of the expert interview[3], it was noted that such schemes get impartial treatment from insurance companies. Insurance companies tend to serve more for high-end customers and not low-end customers from informal sector. Moreover, NGOs and Micro Insurance organisation feels that they are the better people to judge the risk of the segment as they are in closer touch with the people, hence they expect the control

[3] Interview with Jim Roth, Co-ordinator for Micro Insurance Schemes, ILO office, Bangalore on 12.12.2004

over the premium collections and cash management. But Insurance companies deny the privilege stating that there are chances for misuse of the funds. Some NGO's like SEWA came out of the insurance net due to the above factors and even it ran successfully making good surplus for 2 years, but following the Gujarat earthquake, SEWA funds drained out very fast and hence after that, it again joined hands with insurance company for managing the risk operations. One important factor noticed is that NGOs and Micro Insurance organisation lacks professional experience to handle risk management in health insurance and hence there requires proper training by IRDA to promote the professional interests of the organisation which in turn can help the health insurance in reaching the masses. As a research note, it was found that many NGOs hesitated even to respond to the researcher when it was tried to reach them to get their opinion about the insurance coverages.

Though various schemes are available in India, none of the schemes are very effective due to the fact that 'had any of the schemes been effective it would have served as ideal model for spread of health insurance'. Hence, new models are required for India for promoting health insurance by overcoming the demerits.

Section II: Health Insurance Schemes Abroad

In the first part of the chapter, various health insurance schemes existing in India was detailed. At this juncture, it may be worthwhile to summarise the experience with health insurance of select foreign countries to understand their health insurance system. The specific experiences of China, Thailand, Sri Lanka, LATAM countries, USA, UK, Australia, Singapore, Germany is discussed below.

China

China stands out as an example where insurance has been successful in covering a large part of the population both in rural and urban areas. The Chinese expenditure is characterised by high total expenditure, low government expenditure and heavy dependence on insurance financing. There are two kinds of coverage, which are in practice in China, labour insurance medical coverage for state-owned enterprise workers and retired persons, and free medical service, which caters to workers, and retired persons of government agencies and parties and non-profit institutions. A noteworthy feature of China's health care system is the coverage of rural population through various kinds of schemes, which have been designed in accordance with the local economic conditions and public opinion. China's system of health care certainly scores better *vis-à-vis* some of its Asian counterparts like India and Indonesia. India, which is similar to china in terms of population growth, has lots of learnings from china.

Thailand

Thailand has four different kinds of health care financing programmes: voluntary health schemes, mandatory schemes, social welfare schemes, and fringe benefit schemes presents the coverage of these programmes with their important features. The target population of each of these schemes varies in terms of their place of residence (rural/urban) and employment status (formal sector/informal sector). The coverage of population in the informal sector, especially in rural areas is, however, far from a desirable level. In fact, 41 per cent of the population, which is not covered by health insurance scheme largely, consists of subsistence farmers, self-employed, rural workers, and urban dwellers engaged in informal sector activity such as street vending

and small-scale commercial undertakings. From this, it can be inferred that India unlike Thailand is having largely similar type of policies for the whole country. Hence India should plan for designing schemes particular for various segments and sectors.

Srilanka

Srilanka's health care expenditure is characterised by high government, low private, and low insurance expenditures. But similar system cannot be expected from large country like India due to various factors like financial subsidies, varying morbidity patterns across regions etc.

Latin American Countries

The pattern of health care expenditure in Latin American countries varies according to the size of the country (both in terms of population and geographical size) and the income level. Taking a larger perspective, there are mainly two types of managed competition, which are emerging in this region, where government is the sponsor and where private employers are playing the role of sponsor. The former type is followed in countries like Chile, Uruguay, and Colombia. In Chile, for instance, 73 per cent of the population is covered by public health care whereas the remaining 27 per cent are enrolled into the ISPRAE, a private insurance plan. Colombia too has a system of mixed public funding and managed competition, which has not only increased the coverage but also made the system more equitable. In fact, Colombia's health care system has been hailed as one of the most successful ones in the region. Brazil has three distinct systems being availed of by three different income classes – public system primarily by informal sector and low-income workers, private supplementary medicine by formal sector and middle-income workers, and direct out-

of-pocket payments by high-income workers. The lessons that can be learnt for India is that "India can try to adopt similar models of public private partnerships"

United States of America

In the United States of America in excess of $350 billion is spent on health care annually. Healthcare is provided by private hospitals, funded either by individuals, by employers, or by insurance. There are two state medical schemes – Medicare, which caters for the elderly and retired and Medicaid, which caters for the unemployed and the low-paid, the costs for these are shared by the State and Federal governments, although the patient will have to bear a certain percentage according to their means. Medical insurance in the United States has developed into two distinct classes, self funded and fully insured.

Self-funded medical insurance emerged from Employee Retirement Income Security Act (ERISA) was passed by the federal government in 1974, which allows employers to take on the risk of their employee benefits and still receive tax credits for payments made to those employee benefit programmes. The employer could protect his fund against single large claims by purchasing per person excess of loss (known as "specific" cover) and also against an unusually large aggregation of small claims by "purchasing aggregate" cover.

Fully insured medical insurance, for example, under conventional group health insurance, the insurance company assumes all the costs and risks of the group health plan in exchange for payment of a fixed monthly amount per employee. Blue cross and Blue Shield plans are medical expense plans that cover hospital expenses, physicians and surgeons, ancillary charges, and other medical expenses. Blue cross plans cover hospital expenses and other related expenses. The plans provide service

benefits rather than cash benefits to the insured. Blue shield plans cover physicians' and surgeon's fees and related medical expenses.

Managed Care is a generic name for medical expense plans that provide covered services to the members in a cost effective manner. There are several types of managed care plans in US. The most important are Health Maintenance Organisations (HMOs), Preferred provider organisation (PPOs), Exclusive provider organisations (EPOs), Point of service (POS) plans

A HMO is an organised system of health care that provides comprehensive services to its members for a fixed, prepaid fee. HMOs have a number of basic characteristics, first, the HMO has the responsibility for organising and delivering comprehensive health services to its members, second, an HMO provides broad, comprehensive health services to the members, third, selection of a physician is usually limited to physicians who are affiliated with the HMO, fourth, HMO members pay a fixed prepaid fee usually paid monthly for the medical services provided. In addition there is a heavy emphasis on controlling costs

A PPO is a plan that contracts with health care providers to provide medical services to the members at reduced fees. PPOs should not be confined with HMOs. There are two important differences, first, PPO providers typically do not provide medical care on a prepaid basis, but are paid on a fee-for-services basis as their services are used. However, as stated earlier, the fees charged are below the provider's regular fee. Second, unlike an HMO, patients are not required to use a preferred provider but have freedom of choice every time they need care. However, the patients have a financial incentive to use a preferred provider because the deductible and co-payment charges are reduced

An EPO is a plan that foes not cover medical care received outside a network of preferred providers.

A POS plan offers a full range of health services through a combination of HMO and PPO features. If patients see providers who are in network they pay little or nothing out-of-pocket, which is similar to an HMO. However, if the patients receive care from providers outside the network, the care is covered, but the patients must pay substantially higher deductibles and co-payments

USA also passed HIPAA (Health Insurance Portability and Accountability Act) which requires the portability of the health insurance information of the patients even if they move across various employment, hospitals etc. USA imposed strict regulations for compliance by hospitals and health care companies towards HIPAA. At this juncture, it has to be noted that India also needs to impose regulations like this in the future. It may not be possible right now due to unregulated scenario of health care sector. India has been working on a 'Health Unite Framework' in similar lines of HIPAA. The main formation of Health Unite framework is due to the recognition of the need for a standard system across the country that meets the needs of the diverse groups that record, use, transfer and disseminate health information, legal policies that govern the healthcare structure, and education system to help reinforce the strengths and values of the changing face of Indian healthcare system. This framework is under discussion and review.

United Kingdom

In the United Kingdom over 40 billion pounds is spent on healthcare annually of which 97% is publicly funded and 3% is privately funded. Health care in the UK is

provided publicly by the National Health Service (NHS). The scheme provides free health care service to all residents in a network of NHS clinics and hospitals countrywide. It provides for primary, secondary and post-operative care. People must contribute towards dental and optical care according to their means. The government sets the annual NHS budget from tax revenues.

Private medical insurance in the UK evolved from dissatisfaction in the state health system due to long waiting lists for operations and over-crowding inwards. About 11percent of the population purchase private medical insurance. The NHS does encourage its hospital trusts to have private patients units (PPU's) within their hospitals to attract private patients, who either fund themselves, or who have private medical insurance. It is the intention of the government that PPU's are encouraged to care for more patients and so generate more revenue for the hospital trusts and reduce the burden on the state budget. As n alternative to the state system, insurance companies sold a product that, after a consultation with a General Practitioner (GP), allowed the patient to by pass the state system and enter a private hospital. Budget Indemnity Healthcare: Due to the increasing cost of full indemnity policies, insurance companies launched "budget" products. These did not offer inferior levels of cover, just that there was a waiting period before they became operative. If an operation was available on the NHS within a certain (typically six weeks) period, then the operation would be carried out within the state system. If however, the operation could not be performed within this period, then the insurance policy would pay for the operation to be carried out at a private hospital. Another alternative to budget healthcare is a daily hospital cash plan, which provides a cash benefit for each day a patient is in hospital to eliminate loss of earnings due to hospitalisation. Another method of reducing cost of private medical insurance is to restrict the hospitals that the insured can use in non-

emergency situations. India has long way to go for creation of such services. But a thing to note is that due to the long wait queue for NHS benefits, India seems to be a favorable destination for medical tourism business from UK. Even recently it was noted that Apollo group is planning to acquire some hospitals in UK and also it has aggressive plans for promoting medical tourism business.

Germany

Germany does not have national health services like the UK. There are a number of health insurance companies who provide health care for their members. Most of these are government controlled, although some are private companies. Employees with a permanent contract of employment are obliged to take out health insurance with a government controlled health insurer of their choice. The government-controlled insurers are not however, compelled to take on these risks. If the employee fails to contract with an insurer prior to the commencement of employment, their employer must register the employee with the Allgemeine Orts Kranten Kasse (AOK) AOK is the largest government controlled health insurer in German, and in effect is the insurer of last resort. AOK, therefore, has the worst negative risk selection of all healthcare providers in Germany. In the state controlled insurance system an insured person pays a premium, which is a percentage of his gross monthly salary. This percentage figure is the same for all insureds regardless of his salary or the type of risk. The employer must also pay the same percentage, so that the contributions are split 50:50between employer and employee. Unemployed persons receive state funded unemployment compensation, which includes contribution to government health insurer. Since the private health premiums tend to be higher than the government premiums, if a private policy – holder is made unemployed then he would be required to drop out of the private system back into the

state system. Another difference between the state system and the private system is that within the state system the insured pays a premium for his entire family and therefore cover is also provided for the spouse and the children. The private sector covers only the person who pays the premium, any cover for further family members requires an additional premium. This gives an idea for creating a health insurance corporation by government, which can mandatorily insure majority of the population for a small coverage. But given the performance of instititutions like ESIC and CGHS, more cautious measures needs to be taken to learn from the mistakes made in the past.

Ireland

The numbers buying private health insurance in Ireland have continued to grow, despite a broadening in entitlement to public care, to the point where more than two-fifths of the population now has private cover due to concern about waiting times for public hospital care. This is similar to UK experience.

Australia

Under the present system, roughly 60 percent of the population rely on the public hospital system for acute care and 40 percent are privately insured for such care- the latter tending to use private hospitals primarily, but relying on major public facilities in complex or catastrophic situations. Everyone is covered for routine medical care, generally with a co-payment or gap to pay for each medical service. The public medicare system thus provides quality healthcare to all. It is funded from general taxes, mainly commonwealth, plus an earmarked levy on income. There is significant taxpayer support also for private health insurance primarily though a recently introduced government rebate on premiums. Private health insurance is

regulated in Australia to be community rated rather than risk-rated, although now on a lifetime basis, that is premium rise with age of entry and insurers may decline to cover pre-existing health conditions, but explicit discrimination is otherwise not allowed. A consequence of these arrangements is that costs of long-term care, an important component of existing future health costs, are spread across both the insured population and (predominantly) taxpayers. This provides idea for India that improving infrastructure for health care can lead to more public utility of services. By forming a larger tax base for health care specific, health insurance spread can be enhanced at this juncture in India.

Singapore

Singapore is just one of a number of countries which has "provident fund" arrangements providing for a range of welfare needs, but Singapore's CPF is among the most comprehensive, funded by 20 percent contributions from each of the employer and the employee (although the employer component is to be reduced). Retirement income provision is actually not, as some outside comments seem to imagine, the major destinations of savings accumulated through the CPF. The largest need met though it by far is housing. Singaporeans in fact have a much higher level of home ownership (around 90 percent) than do we or, say, Canadians or Americans (all around 70 percent). Nevertheless retirement income provision is one of the CPF's major purposes. CPF contains three elements to provide security against health costs:

Medisave: 6% of salary rising to 7% at age 35 and 8% at age 45 is paid into a medisave account until the balance reached S$16,0000, after which the excess can be transferred into the ordinary account providing for housing, retirement, etc. These

funds possibly together with some out-of-pocket contribution, may be used to pay for hospital and attending doctor expenses.

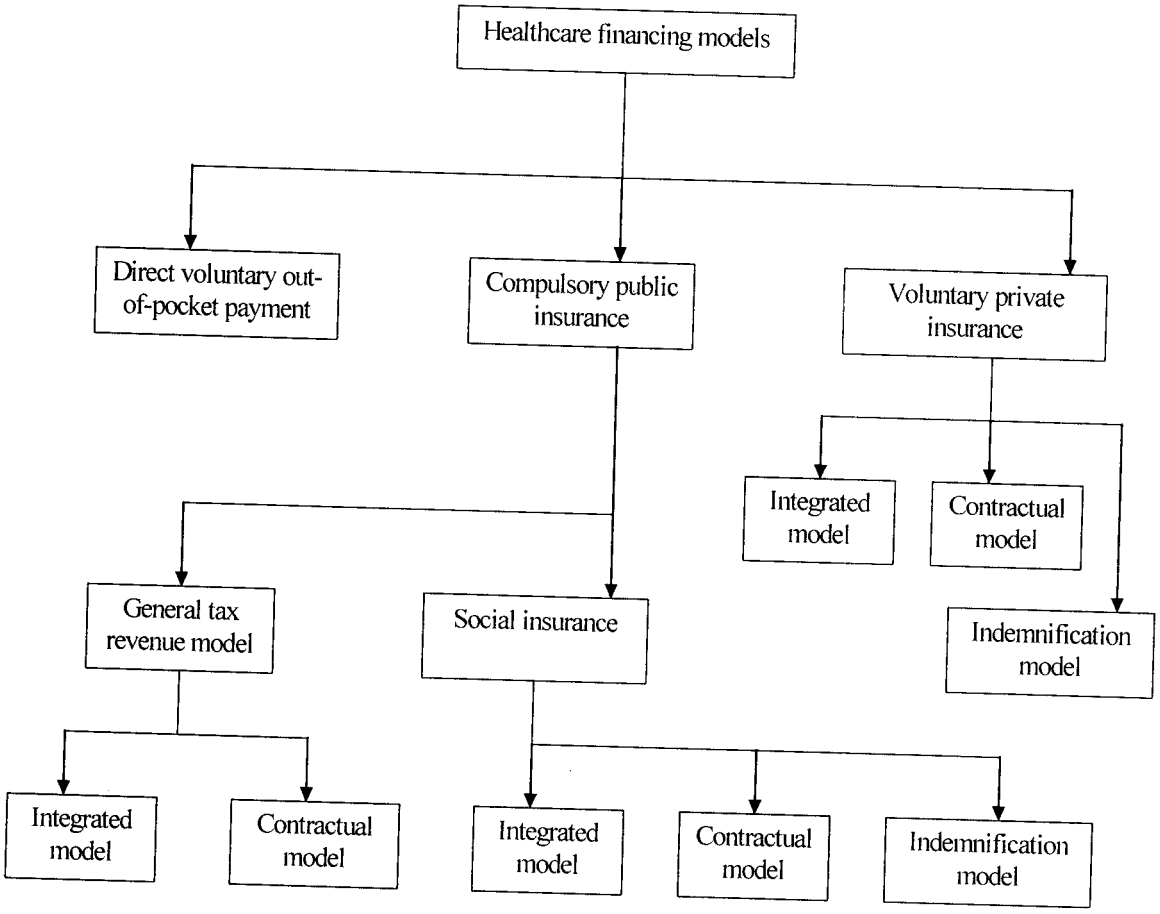
Medishield: This provides the risk pool or insurance element, covering Singaporeans against extraordinary hospital costs. IT is funded by a system of premiums which is essentially age-phased lifetime community rating in its character. There are some exclusion from the scheme (e.g., normal pregnancies) and a lifetime individual coverage limit of S$70,000. In practice, only about 20 to 25% of hospital costs are funded by it, the bulk eoming from Medisave accounts.

Medifund: This is the government safety net to support those without enough resources in their Medisave accounts or in other personal savings to meet their health expenses. IT is particularly important for lower income people and for elderly people whose resources have dwindled. Singapore also allows out of pocket medical expenses in a wider category than the hospital related costs primarily covered by these three elements to be deducted from tax, up to a maximum of 2 percent of salary. The government also subsidises the health system to a substantial degree from its budget. Singapore does not encourage its citizens to take out third party health insurance that could remove too much of their exposure to out of pocket costs. The government does not wish to see healthcare as "Free". In this regard, it might be noted that when they do require hospital care, Singaporeans do have choices- as between private room or large wards and the like-which carry different costs, to be met from their medisave balances or out of pocket.

In India, as already the provident fund schemes are popular. It has to be thought of floating schemes in combination of Provident fund schemes which has feature of health insurance components attached to it.

Comparison Model

In summary, from the study of health insurance systems existing in various countries, it can be inferred that a generic model exists throughout all nations. It can be depicted as below:



Direct out of pocket system is a system wherein the patient pays for his medical expenses on his own. This system is present in all societies, particularly, where the awareness about insurance is not developed sufficiently or where due to paucity of funds the government has not been able to provide much by way of universal health care. However, for expensive medications the poor would be deprived of the medical care under this system.

Compulsory public insurance can be implemented by following either the general tax revenue model or the social insurance model. General tax revenue model is prevalent in nations like Australia, Canada, Russia, Sweden and UK. Here irrespective of one's employment status or any other eligibility criterion, universal coverage is provided by government through providers who may be employees of the state or on contract with the state. General tax revenue is used to finance the expenses. There are two modes of implementing this model i.e., the integrated model and the contractual model. These have been elaborated subsequently.

Social Insurance model is a model wherein the employees and employers are mandated to pay payroll tax to the insurers who negotiate with the physician group to provide the medical care to the insured. The poor, unemployed or the retired are either insured through social insurance funds or there exists hospitals run by state in addition to those privately managed. Nations like Germany, Japan, France, Brazil etc., follow this model. Again this may be d\subdivided into three models i.e., integrated model as in Italy and Spain, contractual model as in Germany and France and the indemnification model.

In Integrated model the hospitals are owned by the state and physicians are employees of the government. Hospitals get funds out of the health care budget and patients do no have to share the expenses. The advantages are, low administrative cost due to unification of administrator and provider, no transaction cost between third party payers (i.e., insurers) and providers relating to verification of payments for service etc. The main disadvantages are that there is little economic incentive to providers to enhance service quality, no incentives for providers to reduce unit costs, and long waiting time for the patients and apathy of providers.

In contractual model, prevalent in Canada, this model is similar to the integrated model except that the state enters into a contract with the service providers either on a fee of service basis or on capitated basis. In a fee of service contract, the physician providing more service gets higher compensation. In order to reduce supplier-induced demand, cost sharing with the patient by way of deductibles may be introduced. Under the capitated payments, fixed payments are made to the providers to care for the patients regardless of the intensity or extent of the service needed by the patients. The advantages of this model is that economic incentive for the physician to deliver only necessary service, reasonable quality of care is assured as poor service may aggravate illness leading to higher cost to provide.

Patient indemnification model reimburses the patient for services they have already paid the provider for. This is prevalent in Belgium and France and suffers from the disadvantage of high processing cost and possibility of higher supplier induced demand.

Voluntary private insurance model wherein the health services are financed through voluntary private insurance either by the employer, employees or individuals. USA and Switzerland are the two nations following this model.

Integrated approach in voluntary private insurance unifies the insurer and provider function within the private sector as in the HMO. HMO's offer comprehensive medical service to members on prepaid basis. It is a type managed care organisation where the financing (insurer) and delivery (provider) of health care are combined in the same entity. The advantages of this model are that administrative costs are saved, economic incentives are provided to providers to deliver minimum

service, quality is enhanced due to competition among HMO's for the customer group.

Contractual model in voluntary private insurance is prevalent in USA and Spain, the HMO acting as the insurer negotiates contracts with private independent physicians to provide care to HMO subscribers. PPOs are another example where groups of providers contract with the employers, insurers and other organisations to provide medical service at a discount.

Indemnification model in voluntary private insurance provides for reimbursement of payment to patients. In order to reduce costs in this model, the patient cost sharing is usually resorted to as in the USA, UK, and Netherlands.

Based on ownership of scheme various models of health insurance can be broadly categorised as state based systems, market based systems, member organisation based systems and private household systems.

FACTORS AND EXPECTATIONS INFLUENCING HEALTH INSURANCE

Krishnagiri (a rural district) in the state of Tamilnadu and in and around these places. At the end of the pilot study, it was found that a single questionnaire might not be suitable across the sections of the society. This is because, when a person was selected for interview, not all questions were applicable to the person. Hence some of the questions were not necessary for response. When the pattern of such questions were analysed, surprisingly it gave an idea to split the population into three segments like people with existing health insurance individual policy holders (voluntary policyholders), people with no health insurance policies (no policyholders) and people covered under group health insurance schemes. The reason for segmenting the population is that expectations of the people from each segment vary. Moreover, some people are already exposed to health insurance. Their experience was differing from the people who are not exposed to health insurance. Recording of their experience will help to identify the pitfalls in the existing health insurance system. But even in this segment, there are differences between the group health insurance policyholders and individual insurance policyholders, the reasons is that group insurance policyholders are not voluntary members of the health insurance system, the coverages are provided by their employers. Hence, they can't be either considered under the category of 'less awareness' like the people with no health insurance or people with 'some awareness' like the people under the category of 'voluntary individual policyholders'.

Hence three sets of questionnaires with different questions specific to each segment viz. no health insurance policies, group health insurance policyholders, individual insurance policyholders was designed for the purpose of data collection.

As the insurance penetration was varying across urban, semi-urban and rural areas, primary data collection was collected data from in and around an urban, a semi-

urban and a rural area. For this purpose, Bangalore (Karnataka State), Hosur & Krishnagiri (Tamilnadu State) were selected. Bangalore, which is the state capital of Karnataka state, referred as the silicon valley of India experiences enormous growth across all sectors, being it is software or healthcare. Bangalore, also has the advantages of heterogeneous mix of population wherein people from all parts of the country reside, consisting of those who came for the purpose of employment representing a mini-India. Hosur, a semi-urban town in the state of Tamilnadu is selected for the purpose of sampling. Hosur is a growing town adjoining the city of Bangalore. Krishnagiri is a rural town in the state of Tamilnadu.

The questionnaire was designed in such a way that to elucidate the demographic characteristics of the segments, reasons for not having health insurance by 'no policyholder' segment, reason for not having additional health insurance coverages by group health insurance and existing policyholder segment (as in India, people can take health insurance coverages up to Rs. 5 lakh and given the fact of increasing incidence of diseases and increasing treatment cost, people should be aware of the options for purchasing additional health insurance coverages, if the existing is not sufficient) , awareness level about entities like TPAs, reach of advertisements etc. Some of the questions in the questionnaire are designed as 'control questions' for the purpose of qualification of sample. The detailed questionnaire is attached in the Annexure of this report.

Primary data was collected by the researcher and by trained enumerator to avoid any researcher bias during collection of data. This also provides an option to compare the primary data collected by enumerator and the researcher and fine-tune the samples for qualification. The enumerator was provided training on insurance concepts required for the collection of the response. The nature and scope of investigation was

explained thoroughly to make the enumerator understand the implications of different questions put in the schedule. The enumerator was also trained to explain the aims and objective of the investigation and also remove the difficulties, which any respondent may feel in understanding the implications of a particular question or the definition or concept of difficult terms.

The process of primary data collection was started in December 2004, the researcher and enumerator did not demarcate any specific segment or place for data collection but based on the convenience of time and place, either researcher or enumerator collected data irrespective of segment and place. During this process, both the researcher and enumerator faced lots of problems across the segments and places. Many of the respondents in urban areas and semi-urban areas initially hesitated to respond under the perception that the researcher and enumerator are agents of insurance company and trying to persuade for purchase of policy, people in rural areas perceived that they are government officials. Hence initially it took a few minutes to explain the respondents about the research purpose and gave assurance that they will not be forced to purchase any policy at the end of the data collection. Some of the existing policyholders complained about the TPAs and insurance companies seriously under the perception that the survey is a masked survey by some insurance company. A few doctors were also included in the samples, initially none of the doctors agreed for providing data stating that they were too busy to provide data and hence for collecting data from doctors, the researcher selected a new set of doctors and posed himself as patient for general check-ups and after getting prescription and paying fees, requested the doctors to co-operate for data collection which was highly successful. HR department of some of the big companies in the region denied permission to collect data from employees but after constant persuading activity, those companies

allowed to collect from employees informally and that too near the gate of their premises. On an average, it took nearly 20-25 minutes to collect a response from 'no policyholder segment' as it involved lot of educational and awareness creating activity about health insurance. From group health insurance segment also, it took nearly 20-25 minutes to collect data as it also involved education and awareness creation activities about the lacunae in group health insurance coverages and need for extra coverages. With respect to existing policyholder segment, it was very difficult to get the address of policyholder from insurance companies and TPAs, even after getting the address, it was too difficult to get appointment from each policyholder as many of them were very busy and often rescheduled their appointments, hence the researcher and enumerator made several attempts to meet them and collect data, on an average, it took nearly 15-20 minutes to collect data from this segment. Due to the above problems, it took nearly 4 calendar months to collect data.

A target of 300 samples was fixed for this research and actually more than 300 samples were collected across the three segments viz. existing, group and no policyholder segment and across places of in and around Bangalore (urban), Hosur (semi-urban) and Krishnagiri (rural) during the time period of December 2004 till mid of April 2005. Samples were randomly chosen from the population but careful thought was made to ensure that samples are collected from various stratums of the population with varied income size, family size with different occupation right from street vendors to high-level executives of MNCs. Of the 300 samples collected, a few samples were rejected, as it did not meet the requirements for qualifying sample. At the end of such qualifying exercise, the sample size across the three segments remained as 73 for existing policyholder segment, 86 for group health insurance segment and 100 for 'no policyholder' segment.

After collection of data, the data was processed through proper classifications and analysis was done with the help of statistical analysis package SPSS. The details of the analysis are described in this chapter.

Limitations of the study:

Though the primary data collected was based on random sampling method, it was not possible for the investigator to collect data from all the cities and villages in India. Hence the research report is based on the collection of samples collected from the places in and around Bangalore, Hosur and Krishnagiri. Hence, after careful thought process the selection of the cities and samples was made.

This study is only about the core health insurance schemes and does not cover study of supplementary schemes like personal accident coverages, disability income coverages etc.

Structure of Analysis

While framing the questionnaire, the researcher framed in such a way that questions related to demographic factors like age, sex, marital status, monthly income, annual medical expenses, life insurance exposure, income tax assessee status etc remains same across all segments. The rationale behind this commonality is to test whether some of the key factors is similar across segments or not and also to identify cluster analysis of factors. Specific analysis of questions pertaining to each segment is done following this. For example, reason for not having health insurance by 'no policyholder segment' and similar questions specific for each segment is analysed. Finally, questions related to awareness of the respondent towards TPAs,

advertisements, new type of schemes is kept common for the same reason. The results of analysis are continued below.

Analysis of Demographic Factors

Demographic Factors play vital role in deciding the insurability of a person and also in the perception, purchasing power of the person towards health insurance. During the collection of primary data, due care has been taken such that respondents are spread uniformly with respect to age, sex, marital status, occupation, work experience etc. with respect to group health insurance segment, data were collected from manufacturing sector (47.67%), service sector (41.86%) and government (6.98%) and others (3.49%). People who are covered by NGOs fell into the others category. It is disheartening to note that some State Governments like do not have health insurance schemes for its employees. Hence only Central Government Employees who are covered by Group Health Insurance were interviewed. At this point, this research suggests the insurance companies and IRDA to strongly persuade the state governments for initiating health insurance group schemes for its employees. It is also a potential segment to explore for aggressive growth of health insurance. Some of the questions also helped the researcher as control question to crosscheck the response related to other questions and qualify the sample. Based on the primary data collected, analysis of data was made subsequently hypothesis was tested to check the relationship of key factors like monthly income, annual medical expenses, exposure to insurance etc. across segments and places. Also a cluster analysis was made over these factors to identify the cluster relationship among these factors and a discriminant analysis was made over these factors to identify the estimation co-efficient of the factors that can help in deciding whether a person is likely to purchase health insurance policy or not.

Monthly Income

Monthly Income is an important factor, which decides the purchasing power of a person. Moreover, monthly income depends upon age, occupation, and work experience factors. A cross-tabulation analysis of monthly income of the respondents collected on the basis of random sampling is made across segment and place. The purpose of this analysis is to know whether income levels and consequently purchasing power are varying across segments or not. Results of the analysis are as below.

Table 5.1

Monthly income across segments

Segment	Monthly income				Total
	Below 3000	3001-5000	5001-10000	Above 10000	
Existing	1	5	26	41	73
No Policy	6	12	32	50	100
Group Insurance	6	7	1	72	86
Total	13	24	59	163	259

A hypothesis was formulated to check whether the income pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o)= Income pattern is independent across segment

Alternative Hypothesis (H_A)= Income pattern is dependent across segments.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.000[1]	Rejected

The associated probability value is 0.00 and it is less than 0.05, hence the null hypothesis (H_o) is rejected. This reveals that the income factor varies across segments. As income factor is associated with the purchasing power, this also infers that the

[1] p value < 0.0005, data generated from SPSS

purchasing power will vary across segments. Hence insurance companies should devise new plans to match the age, sex, occupation and income levels of the people of the segment.

Similarly, Monthly Income is analysed across places. The results are as below

Table 5.2

Monthly income across places

Place	Monthly income				Total
	Below 3000	3001-5000	5001-10000	Above 10000	
Bangalore	5	14	35	115	169
Hosur	5	6	17	38	66
Krishnagiri	2	5	8	9	24
Total	12	25	60	162	259

A hypothesis was formulated to check whether the Income pattern varies across places and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0)= Income Pattern is independent across places

Alternative Hypothesis (H_A)= Income Pattern is dependent.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.071	Accepted

The associated probability value is 0.071 and it is greater than 0.05, hence the null hypothesis is accepted. This reveals that the income factor remains same across places. As income factor is associated with the purchasing power, this also infers that the purchasing power remain same across segments. This is true because, even in rural areas people have got increased purchasing power these days to purchase household appliances like refrigerator, television etc. This also provides hope for insurance sector that if properly planned, people across various places can be persuaded for purchase of health insurance policies.

Annual medical expenses across segments and places

An annual medical expense is a key factor that indicates the health status of the people. It also gives an insight about the insurability of the people. Annual medical expenses are analysed across segments and places and the results are as below.

Table 5.3

Annual medical expenses across segments

Segment	Annual medical expenses				Total
	Below 6000	6001-12000	12001-24000	Above 24000	
Existing	23	10	35	5	73
No Policy	72	14	10	4	100
Group Insurance	70	6	6	4	86
Total	165	30	51	13	259

A hypothesis was formulated to check whether the medical expenses pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0)= Medical expenses pattern is independent across segment

Alternative Hypothesis (H_A)= Medical expenses pattern is dependent across segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.000[2]	Rejected

The associated probability value is 0.000 and less than 0.05, hence the null hypothesis (H_0) is rejected. This reveals that the Medical Expenses factor varies across segments. This may be the reason for varied insurance status across segments. But through proper analysis of morbidity data, specific plans can be floated to target the people of each segment.

[2] p value < 0.0005, data generated from SPSS

Table 5.4

Annual medical expenses across places

Place	Annual medical expenses				Total
	Below 6000	6001-12000	12001-24000	Above 24000	
Bangalore	106	25	32	6	169
Hosur	46	1	14	5	66
Krishnagiri	13	4	5	2	24
Total	165	30	51	13	259

A hypothesis was formulated to check whether the Medical Expenses pattern varies across places and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o)= Medical expenses pattern is independent across places

Alternative Hypothesis (H_A)= Medical expenses pattern is dependent across places.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.094	Accepted

The associated probability value is .094, which is greater than 0.05, which infers that null hypothesis is accepted which means that the annual medical expenses are independent of the region. Hence region wise morbidity rates may be useful, but this research suggests that it is more meaningful to study the morbidity rates across segments and based on the expectations of the segments.

Insurance Exposure

The researcher wanted to check whether the respondents are differing in purchase of health insurance alone but not in case of life insurance. This is strategically very important because, if the people are exposed to life insurance, it becomes easier for insurance companies to leverage on the existing insurance awareness to persuade for health insurance. The analysis of insurance exposure is

done on the basis of premium payment (to understand the premium payment capacity of the people across each segment), penetration analysis across segments (to understand the penetration of public and private companies across these segments) and critical illness rider analysis (to understand the acceptability of critical illness coverages across the segments, as critical illness insurance are the miniature version of health insurance policies, though it is not a complete health insurance coverage by itself. But it can give a fair idea of potential promotional strategies).

Life insurance premium payment analysis

Table 5.5

Life insurance premium payment of existing policyholder segment

Premium paid	None	No idea	Below 5000	5001-10000	10001-15000	15001-20000	20001-25000	25001-30000	30001-35000	35001-40000	40001-45000	45001-50000	50000 & above	Total
No of people	2	4	29	13	6	3	4	2	3	1	2	2	2	73
%	2.74	5.48	39.73	17.81	8.22	4.11	5.48	2.74	4.11	1.37	2.74	2.74	2.74	100

From the above, it can be inferred that majority of the sample pays up to Rs.10000 as life insurance premium per annum. It also shows that there exists potential to woo the segment to purchase more life insurance and health insurance coverages.

Table 5.6

Life insurance premium payment of no policyholder segment

Premium paid	None	No idea	Up to 5000	5001-10000	10001-15000	15001-20000	20001-25000	25001-30000	30001-35000	35001-40000	40001-45000	45001-50000	50000 and above	Total
No of people	52	14	12	8	4	4	2	-	2	-	-	2	-	100
%	52	14	12	8	4	4	2	-	2	-	-	2	-	100

From the above, it can be inferred that around 14 percent of the respondents do not any have idea about the premium paid by them. Also, from the above analysis, it also evident that there are some respondents (14%) who are paying premium ranging

more than 10,000 which shows that by proper marketing program such group of respondents can be easily persuaded to buy health insurance policies.

Table 5.7

Life insurance premium payment of group health insurance segment

Premium paid	None	No idea	0-5000	5001-10000	10001-15000	15001-20000	20001-25000	25001-30000	30001-35000	35001-40000	40001-45000	45001-50000	50000 & above	Total
No of people	38	2	10	6	4	2	8	6	0	6	2	0	2	86
%	44.19	2.33	11.63	6.98	4.65	2.33	9.30	6.98	-	6.98	2.33	-	2.33	100

From the above, it can be inferred that nearly 44.19 percent of the respondents of the group insurance segment do not have life insurance coverages. This identifies that group segment is a potential one for both life and health insurance companies. It also gives an idea of promoting joint exercises by companies to woo the customers of this segment. As the people of the segment are generally more educated, proper marketing plans can bring in enormous results.

Table 5.8

Penetration of type of life insurance companies across segments

Segment		Type of insurance co.				Total
		None	Public Sector Insurer	Private Sector Insurer	Combination of Both	
Existing	% Within Segment	2.7%	68.5%	16.4%	12.3%	100.0%
	% Within name of insurance co.	2.2%	51.0%	30.0%	31.0%	28.2%
	% Of Total	.8%	19.3%	4.6%	3.5%	28.2%
No Policy	% Within Segment	52.0%	28.0%	16.0%	4.0%	100.0%
	% Within name of insurance co.	56.5%	28.6%	40.0%	13.8%	38.6%
	% Of Total	20.1%	10.8%	6.2%	1.5%	38.6%
Group Insurance	% Within Segment	44.2%	23.3%	14.0%	18.6%	100.0%
	% Within name of insurance co.	41.3%	20.4%	30.0%	55.2%	33.2%
	% Of Total	14.7%	7.7%	4.6%	6.2%	33.2%
Total	% Within Segment	35.5%	37.8%	15.4%	11.2%	100.0%
	% Within name of insurance co.	100.0 %	100.0%	100.0%	100.0%	100.0%
	% Of Total	35.5%	37.8%	15.4%	11.2%	100.0%

A hypothesis was formulated to check whether the penetration pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0)= Penetration pattern is independent across segment

Alternative Hypothesis (H_A)= Penetration pattern is dependent across segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.000[3]	Rejected

The associated probability value is less than 0.05 and hence Null Hypothesis is rejected. This infers that the penetration of insurance companies varies across the segments.

Table 5.9

Penetration of type life insurance companies analysis across places

Place	Type of insurance co.				Total
	None	Public sector	Private Sector	Combination of both	
Bangalore	67	57	23	22	169
Hosur	16	29	14	7	66
Krishnagiri	10	11	3	0	24
Total	93	97	40	29	259

A hypothesis was formulated to check whether the penetration pattern varies across places and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0)= Penetration pattern of life insurance companies is independent across places

Alternative Hypothesis (H_A)= Penetration pattern of life insurance companies is dependent across places.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	6	5 percent	0.111	Accepted

[3] p value < 0.0005, data generated from SPSS

The associated probability value is greater than 0.05 and hence in this case, the null hypothesis is accepted which means that the penetration of insurance companies is independent of the places. From the statistics, it can be observed that both private and public insurance companies have started penetrating into various unexplored regions of the past.

Critical Illness rider exposure across Segments and Places

Critical illness rider is a novel concept in India, which is slowly picking up. This also gives leverage for insurance companies to promote health insurance by taking critical illness insurance as base.

Table 5.10

Critical illness rider exposure across segments

Segment	Critical Illness Rider		Total
	Yes	No	
Existing	8	65	73
No Policy	11	89	100
Group Insurance	16	70	86
Total	35	224	259

A hypothesis was formulated to check whether the exposure pattern of Critical Illness Rider varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0)= Critical illness rider exposure is independent across segment

Alternative Hypothesis (H_A)= Critical illness rider exposure is dependent across segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value e	Result
Chi Square	2	5 percent	0.240	Accepted

The associated probability value .240 is greater than 0.05, which indicates that null hypothesis is accepted.

Table 5.11

Critical illness rider exposure across places

Place	Critical Illness Rider		Total
	Yes	No	
Bangalore	24	141	165
Hosur	8	56	64
Krishnagiri	3	27	30
Total	35	224	259

A hypothesis was formulated to check whether the pattern varies across places and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o)= Critical illness insurance exposure pattern is independent across places

Alternative Hypothesis (H_A)= Critical illness insurance exposure pattern is dependent across places.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.770	Accepted

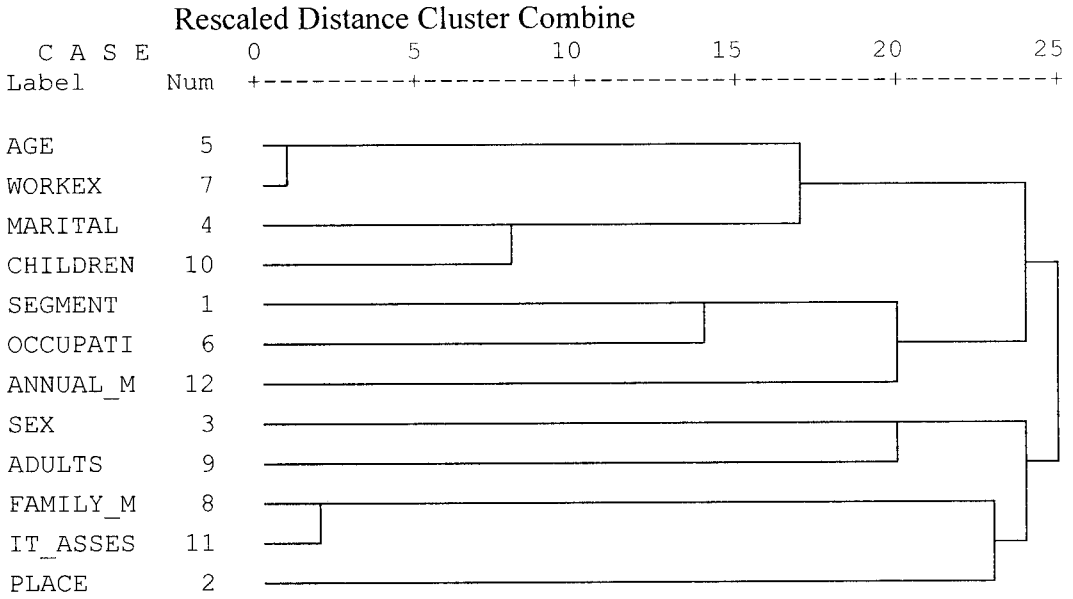
The associated probability value is .770 and greater than 0.05 and hence the null hypothesis is accepted. From the above analysis it reveals that critical illness rider exposure is not varying across segment and places. This gives us an idea that people across segment and places have started realising the need for coverages against illness; they are unaware about the extra benefits of health insurance coverages which can be promoted to help in easier promotion of health insurance coverages, marketing arm of life insurance companies are stronger than health insurance, the packages of these products can be more attractive than health insurance policies etc. Further testing of these inferences is beyond the scope of the current research and also forms scope for any future research.

Cluster Analysis of Demographic Factors

Instead of analysing various demographic factors one by one, a cluster analysis was done to understand the clusters and strength of relationship between the variables. The results of the analysis are as below.

* * * * * * H I E R A R C H I C A L C L U S T E R A N A L Y S I S * * * * * *

Dendrogram using Average Linkage (Between Groups)



Though various factors are accountable for the profile of the population. The cluster analysis of the demographic variables denote that there are five different clusters (at the distance between 20 and 25) viz., cluster one having age, work experience, marital status and dependant children, second cluster segment, occupation and annual medical expenses, sex and adult dependants form the third cluster, monthly income and income tax assessment status forms fourth cluster, place itself forms a cluster.

This gives us an idea of designing new products targeting each cluster. Hence plans can be floated specific to a place, specific to family income and tax assessment

status etc. The agglomeration schedule is provided below that also provides the strength of relationship between various factors

Agglomeration Schedule						
Stage	Cluster Combined		Coefficients	Stage Cluster First Appears		Next Stage
	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	5	7	.800	0	0	5
2	8	11	.769	0	0	8
3	4	10	.578	0	0	5
4	1	6	.426	0	0	6
5	4	5	.333	3	1	9
6	1	12	.266	4	0	9
7	3	9	.241	0	0	10
8	2	8	.155	0	2	10
9	1	4	.147	6	5	11
10	2	3	.144	8	7	11
11	1	2	.099	9	10	0

Factors that decide the purchase of health insurance policy

Based on the data collected, it was tried to understand the weightages of various demographic factors that can help in deciding whether a person is likely to purchase health insurance or not. For this purpose, a discriminant analysis was done taking the Existing policyholder data and 'No Policyholder' data, the results of the analysis is as below. Group Health Insurance Segment is excluded as the coverage is by default and also the samples in the above segment will anyway fall into either of the two categories.

Table 5.12

Classification Function Coefficients

	SEGMENT	
	Existing	No Policy
Place	3.900	4.871
Marital Status	28.974	28.629
Age	.879	.852
Occupation	-.608	-.479
Work experience	-.358	-.354
Monthly income	16.624	17.262
Adults	.977	1.142
Children	7.775	8.211
IT Assessee	26.778	28.051
Annual medical expenses	3.133	1.988
(Constant)	-89.672	-92.335

Fisher's linear discriminant functions

Hence, the equation is as follows:

The estimate of classification function for persons in existing policy segment =

3.9*Place + 28.974*Marital Status + 0.879*Age – 0.608*Occupation – 0.358*work experience + 16.624*Monthly income + 0.977*dependant adults + 7.775*dependant children + 26.778*IT Assessee + 3.133*Annual medical expenses – 89.672

The estimate of classification function for persons in existing policy segment =

4.871*Place + 28.629*Marital Status + 0.852*Age – 0.479*Occupation – 0.354*Work experience + 17.262*Monthly income + 1.142*dependant adults + 8.211*dependant children + 28.051*IT Assessee+1.988*Annual Medical Expenses – 92.335

Rationale behind selection of Factors for the discriminant analysis

Place: Insurance purchasing power varies across the place. Here place refers to urban, semi-urban and rural. Values are urban=1, semi-urban=2, rural=3.

Marital Status: In Indian context, marital status refers to more responsibility towards family and dependants. Values are Married =1, unmarried = 2.

Age: As age increases the health deteriorates.

Occupation: Occupation contains mainly of four categories viz., employed (value=1), self-employed (value = 2), retired (value = 3) and housewife (value = 4). This plays a vital role in the purchasing power as people who are self employed generally hesitate to take the policy, as they prefer to rotate the money in their business, whereas those who are employed prefer to buy more policies.

Work experience: The more the work experience the tendency to accept health insurance, as a necessity is more.

Monthly income: Depending on the capacity of the family, the respondent prefers to purchase the policy and also in contributing towards the premium, after the policy is purchased. Values are below 6000 =1, 6001-12000 =2, 12001-24000 = 3 and above 24000 = 4.

Dependant adults: When there are dependants adults then the purchasing pattern is more.

Dependant Children: Responsibility increases hence the purchasing pattern is affected.

IT Assessee: Income Tax Act, 1961, gives exemption under section 80D for Mediclaim policies, hence this also influences the higher income groups' purchasing pattern.

Inference of the equation

By assigning the values relevant for a selected person and multiplying the values, this research hopes that it is possible to decide whether a person is likely to purchase health insurance policy or not.

Specific Analysis – Segment Wise

No Policyholder Segment

Table 5.13

Analysis of the reason for not having Health Insurance

Respondents' Reasons	Frequency	Percent
Lack of Information	60	60.0
Thought not necessary	4	4.0
Tax benefit	14	14.0
Cannot afford	14	14.0
Wish to buy	2	2.0
No returns	4	4.0
No Savings Component	2	2.0
Total	100	100.0

The above analysis depicts that majority of respondents have stated that lack of information is the main reason for not taking health insurance. Hence proper awareness campaigns should be initiated. People are aware about the tax exemptions provided by the Income Tax Act, 1961, but still do not consider that as a major exemption which will make an impact on their tax payment to the government. Thus, the government should increase the benefits/exemptions for the taxpayers. The other reasons above are self-explanatory. Hence, by proper marketing program, health insurance can be spread.

Analysis of medical emergency management and response regarding thought about insurance during such time

An analysis is made about the steps taken by no policyholder segment during medical emergencies.

Table5.14

Medical emergency management

Medical Emergency Management	Frequency	Percent
Borrow money	28	28
Depending persons	4	4
Savings	64	64
Others	4	4
Total	100	100

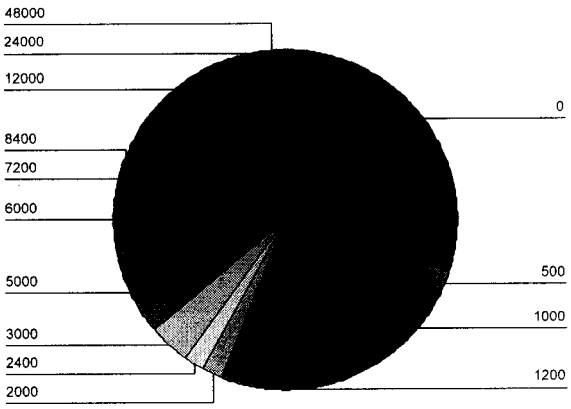
Majority of the people plan to manage their medical expenses through borrowings and savings. Four percent of the respondents were dependants so did not have any idea about health insurance and felt that the persons taking care of them (children, other relatives) would take care of them even during emergencies. A few felt (4%) that they will not fall sick and that such a situation will not occur to them and if at all it occurs, they will pray to god.

Majority (84%) of the respondents had not thought about health insurance at the time of medical emergencies also. Only 16 percent of the people had actually thought about the purchase of health insurance at that time. This is a clear indication that the awareness should be created by health insurance companies as majority of the people (84%) can afford the purchase of health insurance policy.

Interest towards purchase of Health Insurance and preferable channels

Chart 5.1

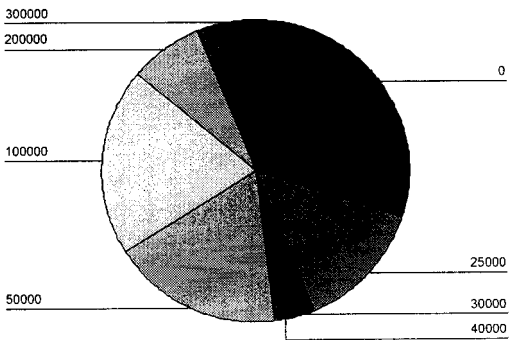
Premium Contribution in case of Purchase of Health Insurance Policy



The respondents were asked regarding their interest to purchase health insurance coverage, given an opportunity to buy the same, the premium and sum assured that they would wish to contribute. The above analysis reveals that majority of the people has shown interest in purchasing policies and pay premium of more than one thousand rupees per annum. Some of the respondents showed interest to purchase policies for all the members of the policies and were ready to pay more than Rs.10, 000 per annum.

Chart 5.2

Coverage sum in case of Purchase of Health Insurance Policy



The above analysis shows that majority of the people have shown interest to purchase a minimum coverage of 25000 and more.

Reason for selecting the coverage and premium amount

Affordability plays important factor (as 35% of the respondents could afford the purchase of health insurance) and many (34%) felt that it is sufficient. Around three percent of the respondents felt that it is a security measure. Twenty eight percent of the respondents were not interested in the purchase of policy at all. Out of those interested, it was surprising to note that many of the respondents were more enthused and showed interest for paying premium more than 10,000 rupees also stated that it is affordable only to that extent. This is interesting because, if a person can purchase a health insurance policy of premium more than 10,000 rupees itself provides a good coverage of risk.

Channel Preference

The respondents were asked about the channel of their preference in case they buy the insurance policies.

Table 5.15

Channels preferred for purchase of health insurance policy

Channels	Frequency	Percent
Agent	40	40.0
Banks	17	17.0
Big hospitals	3	3.0
Direct from company	4	4.0
Not interested	28	28.0
Cannot afford	2	2.0
CGHS	2	2.0
Resident schemes	4	4.0
Total	100	100.0

The above analysis reveals that still agents are the preferred channels, the reasons felt by the respondents are that agents are easy to contact whenever required.

As many of the respondents have experienced the service of agents in life insurance, they expect similar services from agents of health insurance also. These are the reasons for majority of respondents to select agents as preferred channels. Hence insurance companies should plan for promoting the agency channels.

TPA Awareness

The respondents of this segment were asked as to the knowledge about the TPAs and the services that they provide. Majority of the respondents (86%) were not aware of the concept of TPA. Only 14 percent of the respondents were aware about the concept of TPA, in that around 8 percent of people were only aware about the concept but has no clue about their (TPAs) functioning. Rest six persons knew about the concept and also the functioning. The insurance companies should create more awareness about the TPAs and also give details about the cashless hospitalisation facilities.

Group Insurance Segment Analysis

In India, the features of Corporate Health Insurance Schemes vary from employer to employer. In some of the schemes, the employees do not contribute any premium amount but only the employer contributes, in some schemes both employer and employee contribute. Coverages may vary from scheme to scheme like in some cases, coverage is only for the employee, some schemes cover employee and spouse, some other schemes cover employee, spouse and two children, and some schemes, cover employee and all his dependants.

Sum covered also varies, as the policy is a floater policy wherein the sum of coverage is for all the family members of the employee. Some schemes have limit

over each member of the family, and some others have co-payments clause wherein employee should share a portion of treatment expense.

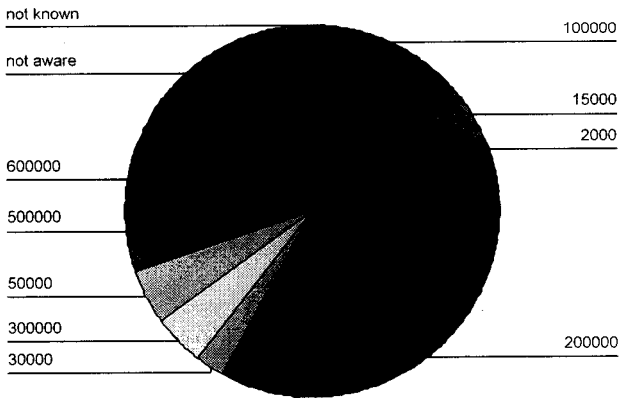
Enrolment into the scheme is another aspect, which varies from one corporate scheme to another. When a person joins the employment, he is included in the medical insurance scheme subject to the terms and conditions of the scheme. If the corporate scheme excludes pre-existing diseases, then the employee run the risk of no coverage for his pre-existing diseases, though it was covered under his previous employment. For example, if a person joins a company at the age of 20 and he was covered under group health insurance scheme. Let us assume that he does not have any disease during the time of his joining but he developed some disease during his tenure with the company. However, the group health insurance scheme provides the coverage. Suppose, if that the person resigns at the age of 35 from the company and joins another company. Let us assume that the new company offers health insurance scheme wherein the pre-existing diseases are not covered, then the employee is treated as a member having pre-existing diseases and will not be getting coverage for those diseases under corporate health insurance scheme. He can't also go for individual health insurance schemes voluntarily as insurers may treat the individual policy excluding the pre-existing disease. Hence, it is advised to have an individual health insurance policy for a minimal amount for two reasons, when the person often switches over the jobs, he runs the risk of loosing the coverage for pre-existing diseases. It may also help him to avoid the waiting period at new employment. Most of the coverages offered by group health insurance schemes are not up to the required value. Hence majority of the employees remain under-insured with respect to health insurance, which denotes the potential for growth for health insurance. The questionnaire is framed for Group Health Insurance policyholders to elucidate the

potential opportunities and also to understand the awareness level and expectations of the people covered under group health insurance schemes.

Group Health Insurance Coverage

Chart 5.3

Analysis of Group Health Insurance Coverage



The above analysis reveals that majority of the people are covered two lakh rupees. Majority of the policies are floater policies, which means that under the coverage, not only the employee but also the dependants are covered. But it is disheartening to note that a sizeable proportion of the segment is not at all aware about the coverages but also gives a picture that those respondents and their family members are either healthy or are not claiming.

Table 5.16

Reason for not having additional health insurance coverages

Respondents' responses	Frequency	Percent
Group Insurance is sufficient	42	48.9
Lack of information	8	9.3
Not necessary for me at present	6	7.0
Cannot afford	4	4.7
Wish to buy	6	7.0
Belief that will not fall sick	14	16.3
No returns	6	7.0
Total	86	100.0

From the above, it can be inferred that almost majority of the people did not think of purchasing additional insurance coverage. Majority of the people felt that the coverage provided by the company was sufficient and that they do not need any extra coverage. 9.3 percent of the respondents were not aware about health insurance at all. 16.3 percent of the respondents felt that they would not fall sick so not coverage is required.

Premium, if health insurance is purchased

The respondents were asked regarding their interest to purchase health insurance coverage, given an opportunity to buy the same, the premium and sum assured that they would wish to contribute. The following pie chart depicts the amount of health insurance premium per annum if at all they take health insurance policy

Chart 5.4

Premium Contribution in case of Purchase of Health Insurance Policy

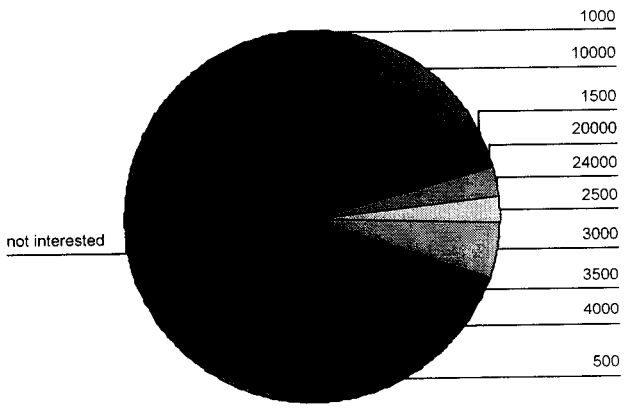


Table 5.17

Coverage if health insurance is purchased

Coverage	None	Up to 50000	50001-100000	100001-200000	200001-300000	300001-500000	500001 and above	Total
No. Of Persons	54	4	8	12	2	6	0	86
%	62.79	4.65	9.30	13.95	2.33	6.98	-	100.00

Majority of the respondents responded that they will not purchase any more, but a few came forward and told that they will purchase additional cover as above. But through marketing strategies and convincing illustrations and case studies, the respondents of the segment can be made to purchase additional coverages.

Table 5.18

Reasons for fixing the amount for coverage and premium

Respondents' Reasons	Frequency	Percent
Not Interested	54	62.8
Sufficient	24	27.9
Tax benefit	2	2.33
Cannot afford	2	2.32
Wish to buy	2	2.33
Savings	2	2.32
Total	86	100.0

The above analysis reveals that only 2.32 percent of the respondents have said that they cannot afford leaving the rest 97.68 percent are affordable. 62.8 percent of the people are not interested in the purchase of policy whereas in case of no policyholders segment the number of people not interested is only 28 percent. This shows that insurance companies can overcome these hurdles by proper marketing strategies. The rest of the reasons are self-explanatory.

Claimant Analysis

Analysis is made on the claimants under the policy. Claims made on dependant parents were 13.3 percent i.e, 11 persons. Claims on children and spouse were 2.3

percent (2 persons) and 4.6 percent (4 persons) respectively. Claims made on self were only 13.9 percent (12 people). No claims were made by 58 persons (67.4%). From the analysis above, it can be inferred that half-of the claims were made by the employee but the rest are made for other family members. It is heartening to note that majority of the people have not claimed at all.

Table 5.19

Rating of Group Health Insurance

Respondents' Rating	Frequency	Percent
Fair	12	14.0
Good	30	34.9
No idea	34	39.5
Poor	4	4.7
Very Good	6	7.0
Total	86	100.0

Rating has got mixed response and out of the responses, majority of the respondents felt that the concepts of group health insurance schemes are good. But researcher found that the respondents need to be educated about the concepts of insurance and services offered under group health insurance schemes

Post-Retirement Conversion Awareness Analysis

Conversion option exists for the members of group health insurance policyholders as and when they retire from the employment. This is very important because many of the employees are left uncovered in the post-retirement period and get their earning drained due to geriatric health problems. Ageing population is major factor to be considered by government and geriatric health insurance is a segment, which needs lot of attention in future. Group health insurance policyholders have the option of converting their group coverage into individual coverage after their retirement from service. But it is sad to notice that 93.02 percent (80 people) of the

people were not aware of the option that can be exercised. This also clearly indicates the failure of Supply Chain Management (SCM) on the part of employers, insurers and TPAs. IRDA should take steps to educate the people on this.

Interest in exercising continuing group insurance after retirement

Analysis reveals that 52 respondents (60.5%) have shown interest in continuing the coverages by exercising the option. The rest (34 respondents) 39.5 percent were not sure about the modus operandi of such system and had doubts of getting benefits, even after explaining the rules. But by proper marketing plans with illustrations, it is possible to make the employees to exercise conversion options.

Existing Policyholders Segment

Source of knowledge about health insurance

The respondents were asked about the way on source of knowledge about health insurance and 67.1 percent (49 people) had taken the policy through agents and came to know about the policy details from agents. 13 people (17.8%) came to know about health insurance though friends, 2 people (2.7%) were continuing from group health insurance after retirement and 2 people came to know about the same from tax consultants. Six persons (8.2%) had directly taken from the companies while only one of the respondents (1.4%) came to know about health insurance through television programme. Therefore it can be inferred that majority of the people prefer agents as the best mode of channel of purchase of health insurance policy as they prefer to get all the formalities completed through an agent and also in case of renewal premiums agents would promptly come and remind and do the needful.

Reason for taking Voluntary Health Insurance:

An analysis is made about the reasons for taking health insurance by respondents, the results are as below.

Table 5.20

Reason for taking voluntary health insurance

Reason for taking voluntary health insurance	Number of persons	Percent
Continuing GI	2	2.7
Security	1	1.4
Tax	21	28.8
To cover medical expenses	49	67.1
Total	73	100.0

Majority of the sample have taken health insurance for medical benefit coverage only. The tax benefit offered by government is not much attractive even among taxpayers; only 31.51% have taken health insurance for tax benefits. 2.74% have viewed health insurance as savings/security in the sense that the amount they invest today is like savings only which provides them security tomorrow (their perception about insurance).

Awareness about Knowledge about pre-existing diseases

This question is asked to understand whether the policyholders have understood the policy conditions while taking policy. 44 persons (60.3%) of the policyholders were not aware of the policy conditions. The rest 29 persons (39.7%) were aware about the same. Hence insurance companies should ensure that proper awareness is created about exclusions through illustrations. This will avoid lapsation of the policies in future also

Decision Factor of purchase while taking HI

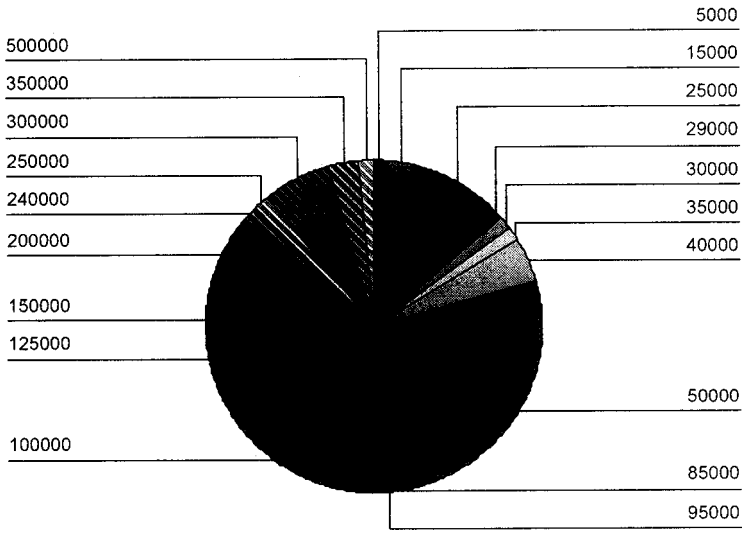
In this analysis, it is planned to find whether premium or sum assured factor influenced the policyholder while purchasing health insurance policy. Majority of sample (82.2%), i.e., 60 persons have considered premium as the deciding factor while purchasing health insurance policy. This infers that despite the awareness of various dreaded diseases in the country, people who know the value of health insurance are not aware of proper health risk management. Further, their risk management plans are limited by premium amount. Rest 13 people (17.8%) were more interested in the coverage amount than the premium.

Analysis of Insurance Company for Health Insurance

Majority of the respondents 59 persons (80.8%) have taken health insurance coverages from public sector insurance companies while 19.percent (14 persons) have taken policies from private insurance companies, which show that private players have started making inroads in this segment. Though a policyholder can take policies from more than one company, no policyholder has taken policies from both private and public companies (unlike in life insurance).

Chart 5.5

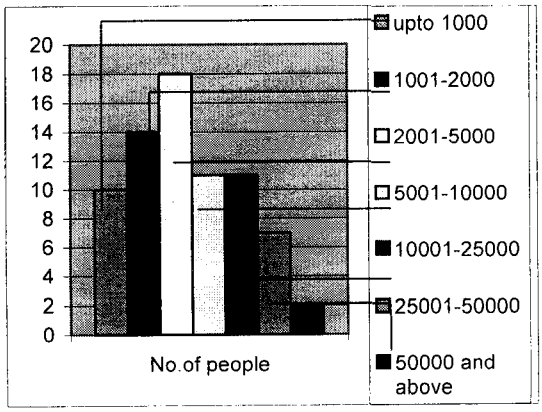
Analysis of health insurance sum assured



The majority of the respondents have taken policies with sum assured of one lakh rupees or below that. Given the scenario of increasing treatment costs and increased private spending, the policyholders should be motivated to buy health insurance coverage of higher amounts. Marketing strategies should be framed in such a way that to educate the public on the conditions of pre-existing disease exclusions, increasing treatment costs etc. to up sell in this segment

Chart 5.6

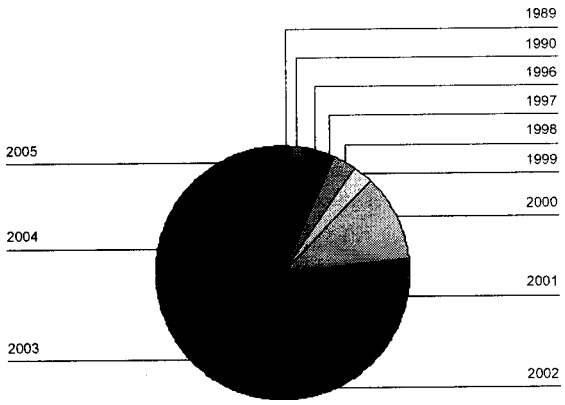
Analysis of Premium paid by Existing Policyholders



From the analysis, it can be inferred that 24 people (32.88%) pay less than Rs2000 per annum and 24.66 percent (18 people) pay Rs. 5000 as premium per annum.. Hence proper marketing strategies can motivate the people to purchase more coverage and pay higher premium.

Chart 5.7

Year of Purchase of the Health Insurance policy by Voluntary Policyholders



The pattern above shows that invariably there is no exponential growth in the sale of health insurance in the past (both in the pre-liberalised and post-liberalised era).

Analysis of Instances where expenses were incurred, but not claimed

22 persons (30.1%) have stated that they have incurred expenses but not claimed for the same. Out of this 12 persons have stated that claiming expenses is a very cumbersome procedure, hence they have not claimed. 10 persons have stated that the amounts of expenses were very small, so they did not want to claim for such small expenses below Rs. 5000. The researcher has found that the reasons are due to the perception of the policyholders they think that it is waste of time and effort to run behind the TPAs'. The rest of the 51 people (69.9%) had no instances where they had

incurred expenses but not claimed. In Group Health Insurance, such feelings didn't exist much as the Human Resources Department often come to help the employees and employees are treated with more care by insurance companies and TPA as the claimant forms part of corporate account.

Acceptance to Long Term Policies

In India, comparatively the response towards life insurance is more. One of the key factors for life insurance is long-term coverage unlike health insurance, which is one-year coverage. Hence an idea was proposed in the research on how the respondents like the idea of similar products in health insurance. 62 persons (72.1%) have stated that they welcome such idea in health insurance, whereas 24 persons (27.9%) have stated that they do not approve of such an idea in health insurance.

A hypothesis was formulated to check whether the response pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Response pattern for long term policies is independent across segment

Alternative Hypothesis (H_A) = the response pattern for long term policies is dependent across segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.042	Rejected

The associated probability value is 0.042 and less than 0.05, hence the null hypothesis is rejected. This reveals that the response varies across segments. As Gender factor is associated with the insurability status, this also infers that the

insurability status will vary across segments and that new type of policies will not be accepted across all segments.

Hence proper marketing strategies needs to be planned and proper plans has to be designed for various sub-segments based on their profiles The reason for failure of similar plans in the past may be due to the fact that the insurance companies floated the plan globally across segments but this research suggests that it should be floated under various versions matching the expectations of sub-segments.

Acceptance to single term policies

In India, people generally are more attached towards fixed deposit products of banking institutions. Hence an idea was proposed in this research to propose similar products in insurance wherein the feature of the product is to pay hefty premium. The benefits will include proportional health insurance coverages and return of premiums with or without additional returns. The idea was proposed to respondents and 32 persons (37.2%) welcomed the idea. The rest 54 persons (62.8%) were not interested. A hypothesis was formulated to check whether the response towards Single Premium policies vary across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Response Pattern is independent across Segment

Alternative Hypothesis (H_A) = Response Pattern is dependent across Segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.024	Rejected

The associated probability value is 0.024 and less than 0.05, hence the null hypothesis is rejected. This reveals that the response pattern varies across segments. Hence the insurance companies should plan for different type of plans for segments.

Advertisements awareness across segments

An analysis is made about the reach of advertisements among segments, the response is as below.

Table 5.21

Segment * Advertisement Cross Tabulation

Segment	Advertisements		Total
	Yes	No	
Existing	26	47	73
No Policy	29	71	100
Group Insurance	48	38	86
Total	103	156	259

A hypothesis was formulated to check whether the reach of advertisements varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o) = Reach of advertisement is independent across Segment

Alternative Hypothesis (H_A) = Reach is dependent across Segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.001	Rejected

The associated probability value is 0.001 and less than 0.05, hence the null hypothesis is rejected. This reveals that the advertisement reach varies across segments. Hence refined advertising strategies are recommended.

Reach of advertisement across places

An Analysis is made whether the reach of advertisement is same across the places viz. Urban, Semi-urban and Rural. The analysis is as below.

Table 5.22

Reach of advertisements across places

Place	Advertisements		Total
	Yes	No	
Bangalore	63	106	169
Hosur	31	35	66
Krishnagiri	9	15	24
Total	103	156	259

A hypothesis was formulated to check whether the reach of advertisement pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (Ho) = Reach of Advertisements is independent across Segment

Alternative Hypothesis (H_A) = Reach is dependent across Segment.

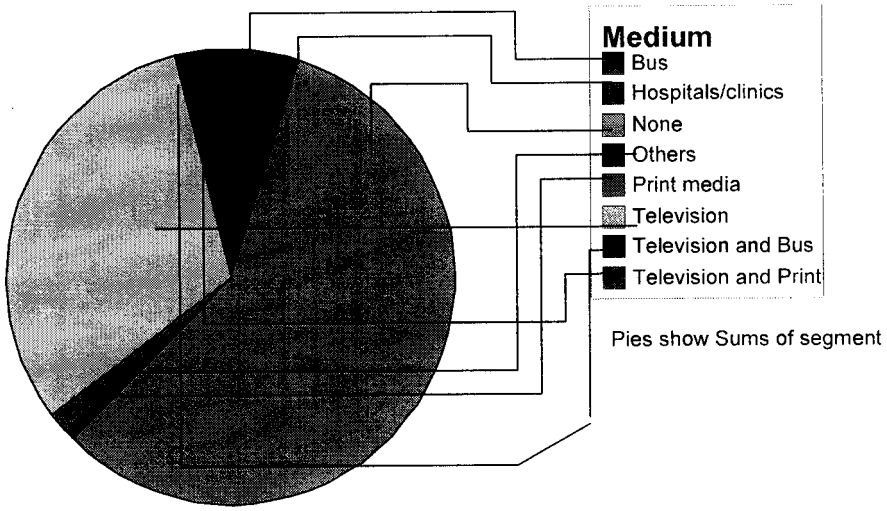
The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.383	Accepted

The associated probability value is 0.383 is greater than 0.05, hence the null hypothesis (H_o) is accepted. This reveals that the advertisements have the capability of reaching uniformly across places. This may be attributed to the fact of the spread of mass media across places.

Chart 5.8

Analysis of Advertisement Medium across Segments



The major medium of reach of advertisements across all segments is depicted above. Television plays an important role in the advertisements across as can be seen from the pie chart, 31.3 percent (81 persons). 149 people (57.5%) were not able to recall any advertisements at all.

Awareness about schemes offered by Big Hospitals

These days, many big hospitals have tied up with insurance companies to offer health insurance schemes exclusively for the public so that they can get benefits whenever they get treatment from these hospitals. But such schemes also not cover the outpatient visits. But in the era where India is growing up as health tourism destination, there is possibility of promoting such schemes within India also. Hence this question was asked to the respondents to know about their view. The responses are as below.

Table 5.23

Awareness about big hospitals across segments

Segment	Awareness about big hospitals		Total
	Yes	No	
Existing	38	35	73
No policy holders	62	38	100
Group insurance	6	80	86
Total	106	153	259

A hypothesis was formulated to check whether the response pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.000[4]	Rejected

The associated probability value is 0.000 and less than 0.05, hence the null hypothesis (H_o) is rejected. This reveals that the response pattern varies across segments. Hence varied marketing strategies needs to be followed by hospitals.

Awareness of health insurance schemes offered by Big Hospitals across Place

The analysis of the awareness across place is as below.

Table 5.24

Awareness about health insurance schemes offered by big hospitals across places

Place	Awareness about big hospitals		Total
	Yes	No	
Bangalore	60	109	169
Hosur	28	38	66
Krishnagiri	18	6	24
Total	106	153	259

A hypothesis was formulated to check whether the awareness pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o) = Awareness Pattern is independent across Segment

Alternative Hypothesis (H_A) = The Pattern is dependent across Segment.

The result of the chi-square test is as below

[4] p value < 0.0005, p value generated from SPSS

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.001	Rejected

The associated probability value is 0.001 and less than 0.05, hence the null hypothesis (H_0) is rejected. This reveals that the awareness pattern varies across places. Big hospitals in urban areas can network with medium sized hospitals in smaller towns to promote internal health tourism.

Interest of respondents in taking Health insurance from Residential schemes if proposed

Housing Sector is witnessing enormous growth in India, many new residential colonies are emerging and many such colonies have formed residential associations. This opens up an opportunity for insurance companies to offer group health insurance schemes for the members of the residential association. The respondents were asked whether they will like such idea if mooted by insurance companies as a special drive and the response is as below across segments and places

Table 5.25

Response towards the idea of health insurance schemes through residential associations across segments

Segment	Interest in health insurance schemes from residential associations		Total
	Yes	No	
Existing	38	35	73
No policy holders	48	52	100
Group insurance	28	58	86
Total	114	145	259

A hypothesis was formulated to check whether the response pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Response Pattern towards the concept of Group Health Insurance through Resident Associations is independent across Segment

Alternative Hypothesis (H_A) = The Pattern is dependent across Segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.028	Rejected

Table 5.26

Response towards the idea of health insurance schemes through residential associations across places

Place	Interest in health insurance schemes from residential associations		Total
	Yes	No	
Bangalore	64	105	169
Hosur	36	30	66
Krishnagiri	14	10	24
Total	114	145	259

A hypothesis was formulated to check whether the response pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Response Pattern towards the concept of Group Health Insurance through Resident Associations is independent across place

Alternative Hypothesis (H_A) = The Pattern is dependent across place

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.021	Rejected

The associated probability value is 0.028 for segment and 0.021 for place, which is less than 0.05; hence the null hypothesis is rejected for both segment and place. This reveals that the response varies across segments and places. Hence proper strategies need to be framed according to segments.

Analysis of the acceptance level of TPA concept across segment

IRDA brought in the concept of TPA for enhanced servicing; response was sought from the policyholders on how they like the concept. Here the people who

responded as 'not aware' were also added to the response of 'No'. The analysis of the same is as below.

Table 5.27

Acceptance of the concept of TPAs across segments

		SEGMENT		Total
		Existing	Group	
TPA Agree	Yes	14	60	74
	No	59	26	85
Total		73	86	159

A hypothesis was formulated to check whether the acceptance pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Acceptance pattern towards TPA concept is independent across segment

Alternative Hypothesis (H_A) = the pattern is dependent across segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.000[5]	Rejected

The associated probability value is 0.00 and less than 0.05, hence the null hypothesis is rejected. This reveals that the pattern varies across segments. It is right time for IRDA to study about the feedback to promote the services.

Analysis of TPA Rating across Segment

The respondents of group and existing policyholder segment were asked to rate the services of TPA and the response is as below.

[5] p value < 0.0005, p value generated from SPSS

Table 5.28

Analysis of the rating of TPAs across the segments

TPA Rating	SEGMENT		Total
	Existing	Group	
No Idea	26	64	90
Excellent	3	1	4
Good	13	11	24
Fair	3	8	11
Poor	28	2	30
Total	73	86	159

The above analysis reveals that TPA has to improve the services.

A hypothesis was formulated to check whether the rating pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o) = Rating Pattern of TPA is independent across Segment

Alternative Hypothesis (H_A) = The Pattern is dependent across Segment.

The result of the chi-square test is as below

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	2	5 percent	0.000[6]	Rejected

The associated probability value is 0.00 and less than 0.05, hence the null hypothesis (H_o) is rejected, inferring that rating of TPA services varies across Group & Individual Insurance segments. This may be obvious as Group Segment is more influential.

Analysis of Claims decision across Existing policyholders and group policyholders

The pattern of claims decision across segments is studied and the analysis is as below.

[6] p value < 0.0005, p value is generated form SPSS

Table 5.29

Analysis of claims decision across existing and group policyholders

Claim status	Segment		Total
	Existing	Group	
Accepted	23	18	41
Rejected	11	1	12
Partly Accepted	8	7	15
Pending	31	60	91
Total	73	86	159

The above analysis shows that there is more number of cases of rejection in existing policyholder segment. A hypothesis was formulated to check whether the claims decision pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_0) = Claims Decision Pattern is independent across Segment

Alternative Hypothesis (H_A) = The Pattern is dependent across Segment

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	3	5 percent	0.001	Rejected

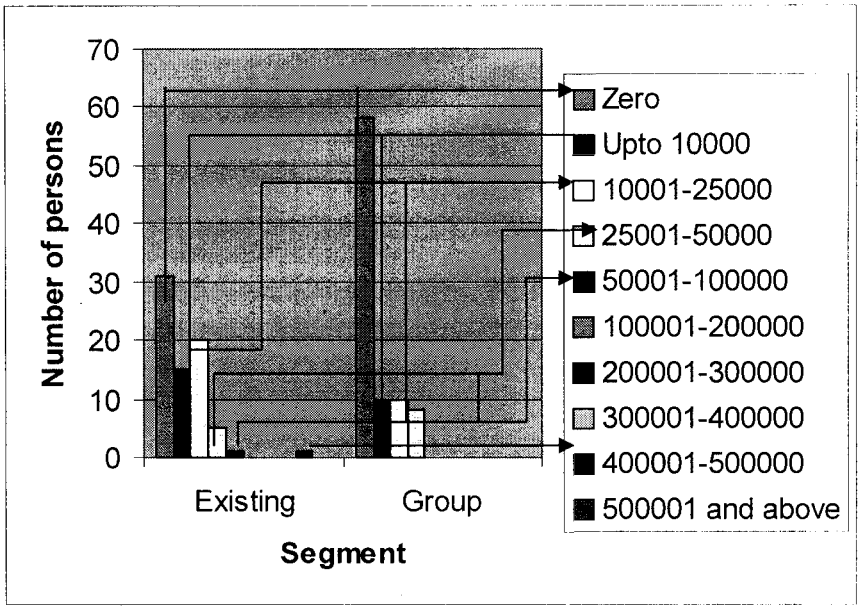
The above infers that the claims decision by TPA varies across Group and Individual segment. Already several studies have also pointed out this fact.

Analysis of Claims Pattern across Segment

Claims pattern is analysed across segments to check whether group health insurance segment is varying with existing health insurance segment or not. Claims are analysed and the result is as below.

Chart 5.9

Claims Patterns across Segments



A hypothesis was formulated to check whether the claims pattern varies across segments and chi-square test of independence was used to test this hypothesis.

Null Hypothesis (H_o) = claims Pattern is independent across Segment

Alternative Hypothesis (H_A) = claims Pattern is dependent across Segment.

Test Used	Degree of Freedom	Level of Significance	Pearson's probability value	Result
Chi Square	45	5 percent	0.091	Accepted

The associated probability value is 0.091 and greater than 0.05; hence the null hypothesis (Ho) is accepted. This reveals that the claims pattern is similar across the segment. This is in sync with the fact that both the segments contribute equally towards claims ratio. This also provides an idea that there is need to map the claims pattern and risk premium rates for these segments. A new model is suggested based on this in the following chapter.

In Summary, it was found that majority of the demographic characteristics remain same across places and segments but the expectations and awareness levels are

varying. Hence a new approach is required to devise new plans to meet the expectations of the people across segments and places.

NEW MODELS OF HEALTH INSURANCE

CHAPTER VI

NEW MODELS OF HEALTH INSURANCE

Based on the review of various literatures, primary data collection and analysis of data, new models are suggested in this research. As the numbers of new models are many, the models are classified under different categories for sake of better readability and integration aspects.

New models can be classified as below

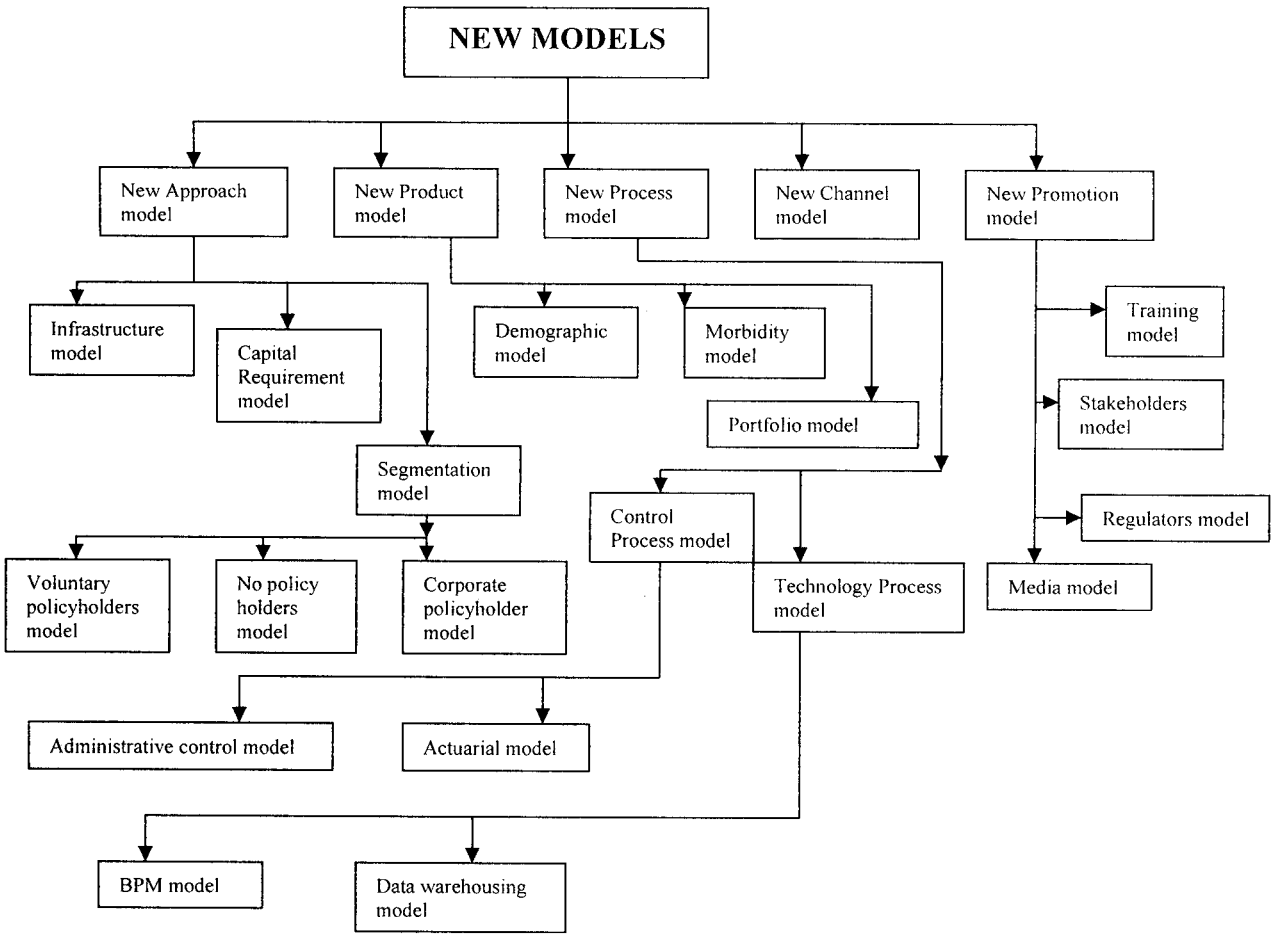
New Approach Models

New Product Models

New Process Models

New Channel Models

New Promotion Models


NEW MODELS
New Approach model
New Product model
New Process model
New Channel model
New Promotion model
Infrastructure model
Capital Requirement model
Demographic model
Morbidity model
Portfolio model
Training model
Stakeholders model
Regulators model
Segmentation model
Control Process model
Technology Process model
Media model
Voluntary policyholders model
No policy holders model
Corporate policyholder model
Administrative control model
Actuarial model
BPM model
Data warehousing model

Section I: New Approach Models

Under this model, this research suggest

New Approach Model for Infrastructure

New Approach Model for Capital requirements

New Approach Model for segmentation

New Approach Model for Infrastructure

For proper functioning of health insurance, proper health care infrastructure should be in place. But it is fact that India is having more health care infrastructure in urban areas than rural areas. The table[1] below gives a snap shot of the same

Table 6.1

Health care infrastructure in rural and urban India

Characteristics	Rural India (per 1000)	Urban India (per 1000)
Hospital beds	0.2	3.0
Doctors	0.6	3.4
Public Expenditure	Rs.80, 000	Rs.560, 000
Out of Pocket Expenditure	Rs.750, 000	Rs.1, 150,000

In such scenario, growth of health insurance cannot be expected in rural areas. Hence, stern actions are required for promoting health care infrastructure in rural areas and semi-urban areas. This can be done by opening up of new hospitals in those areas. But given the fact that the Government spending is only 1% of GDP (which is far lesser comparing other developing countries), development of proper infrastructure cannot be expected in the near future unless some new models are thought of. This research suggests Venture Capital-Health Care Model for India.

[1] Presentation made by Dr.Ravi Duggal on Operationalising right in health care at 10th Canadian Conference on International Health 2003

VC-Health Care Model - Bringing people together and meeting health care needs

Many of the potential resources, though available are scattered around the country. Hence a common platform is required to bring them together. This research proposes Banker-Health Care Model for this, where Banking Institutions can play centric role by contributing Venture Capitals.

The reason for visualising the Banks to play centric role is because the recent spurge in the inflation rates, reduced dependency of the industries over banks, lowering of CRR (Cash Reserve Ratio) by Reserve Bank of India have left bank with more cash than ever before. This has resulted in reduction in interest rates of loans especially Housing Finance Area is expected to witness still lowering of interest rates. It is felt that Housing Finance is one of the lucrative areas where the risk of NPA (Non Performing Assets) is very low. One can witness lot of banks promoting housing subsidiaries with lot of competitive offers for the borrowers.

Like Housing Sector, Banks can also think about investing for Health Care and Health Insurance or form a Joint Venture (JV) with many Health Care providers. This research discusses about the possibilities of banks playing an important role in the health insurance sector and it can be defined as "VC- HealthCare" Model.

Insurance is not new to banking industry at the present era. Many experts found that Bancassurance has lot of potential in India and many banks have obtained license to act as corporate agents for insurers in India. HSBC has floated a separate subsidiary for its insurance services. It has been observed that bancassurance is one

of the best possible ways for the banks to increase the revenue and balance the loss of revenue that is happening due to reduced dependency of industry on banks.

Banks can increase the infrastructure for more accessibility of the people (more hospitals). It can reduce the cost of medicines by funding for more manufacturing. By which it can create more employment for doctors, pharmacists, and insurance professionals. This can be achieved by providing loans to doctors to set primary health care units. A group of doctors to set-up secondary health care units (after verifying their integrity and credibility) can invite big hospitals to set up tertiary health care units in selected areas. It can also involve the local Rotary club, Lions club in setting up of hospitals. Banks can also undertake a study of the Pharma sector to find out the demand for various types of Pharma and issue loans for setting up the pharmacy units, which are in great demand; thereby it can play a vital role in reducing the cost of medicines.

Like wise, banks can identify lot of industrial units manufacturing health care products for granting loans thereby stabilising the industry.

In 1995, a study by Centre for Monitoring Indian Economy indicates that 11 new hospital projects in Indian metropolitan cities alone accounted for a total investment of Rs 5.7 billion. Over and above this, several American and British insurance companies now want to tie up with Indian players to offer and market superior health services, and technology, products and distribution mechanisms.

Scope of Private-Public Participation in Heaith Care

Banks can have agreement with the corporate hospitals (or form a JV) wherein they can finance towards the setup of the branch of those corporate hospitals in rural areas. The surplus doctors existing in the urban areas can be deployed as the

employees of those hospitals in the rural areas. The corporate hospitals can ensure good standard of living for the doctors and other hospital personnel on par with the urban living conditions. The Brand value of the corporate hospitals may attract the doctors to work in the rural branches of those corporate hospitals. Thus, Banks can form a Business Model wherein it can integrate the suppliers of health insurance and provide services to the health insurance policyholders at the subsidised rates.

New Approach Model for Capital Requirements

The Regulator, IRDA stipulates minimum capital requirement of 100 crore rupees (Rs.10 Million) for venturing health insurance in the country. But given the fact of lack of availability of proper data, heterogeneous mix of population in terms of culture, language etc. has prevented specialised health insurers to enter the segment. Only the existing insurance companies offer health insurance products running with claims ratio of more than 100% and offsetting the losses by cross-subsidising the profits earned in other segments like Fire, Marine, Engineering etc. But this cannot be expected from specialised health insurer, as there is no room for such insurers to offset the losses.

Hence IRDA should consider 'Risk Based Capital' (RBC) models for specialised health insurers. Possibility, the regulator cannot allow health insurance companies to operate in specific region or state. Given the fact that regions or states exhibit comparatively homogenous scenario can be a boost for health insurer. Moreover, 'Health' being a state subject, such approach can invite more cooperation from respective state governments towards health insurer of the state. Eventually, this approach can lead to many meritorious decisions like reduction in capital requirements, fulfilment of social objectives by the state etc. Similarly in reinsurance perspective, India is not having proper health reinsurance arrangement; IRDA should

revisit the norms for health reinsurance companies in the lines of approach mentioned above.

New Approach Model for Segmentation

In India, uniformity in approach is adopted for health insurance by insurance companies. They consider that similar demographic factors exist. Health insurance plans features are uniform. So far, Insurance companies view the population as homogeneous and rely more on underwriting practices to avoid unhealthy lives in the health insurance portfolio. For Example, the Mediclaim health insurance premium rates are more or less similar across places but the incidence of diseases is not similar, but insurance companies tries to avoid sub-standard lives by imposing strict underwriting rules in certain places. The researcher found that some insurance companies in Kerala (a state in India) do not underwrite any lives suffering with diabetes[2], even if they underwrite, they specifically exclude diabetes, although no specific instructions exist for the insurance companies. Such practices can lead to failure of social objective in the long run wherein unhealthy lives may be left uncovered. In this case, it is failure of the insurance company to launch specific products for diabetic patients in the region. The reason for such failures is due to lack of proper data and uniformity approach. IRDA is already taking steps to create a national data warehouse for health insurance

This research believes in the fact that 'No Risk is uninsurable, provided proper analysis is made'. Any Effective analysis is dependant upon the basis of analysis. This research suggests that 'Segmentation' as the important base. Insurance companies view that demographic factors of the population, as a whole is more or less similar. But based on the primary data collection, this research has identified that

[2] Based on personal interview with senior official of a TPA

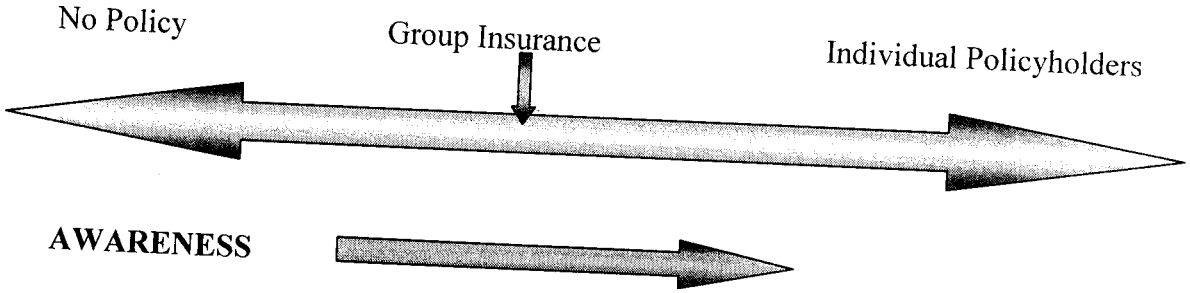
demographic factors are not same and there are different kinds of expectations by the people towards health insurance. This research strongly suggests to analyse the population characteristics on the basis of the following segments[3]. This is the major finding of the research.

People who are exposed to Individual health insurance

People who are exposed to corporate health insurance and

People who are not at all exposed to health insurance.

CONCEPTUAL AWARENESS SCALE



People who are already exposed to individual health insurance are supposed to be the segment that is aware of health insurance. But even among this segment, some have taken policies without understanding the concept of health insurance, prevailing exclusions etc. Majority of the people in this segment are under-insured and one can notice people earning more than 3 lakhs having policy of only 50,000. Agents fail to explain the same due to either poor knowledge or fear of loosing business. Due to this, lot of lapsation occurs in this segment. According the estimates around 10-15% of the health insurance policies get lapsed every year. Agents or Insurance companies fail to explain the consequence of lapses in health insurance.

[3] Excerpts from the research 'Tweaking the Corporate Health Insurance Models in Indian Scenario – An Entry point' published at First World Risk and Insurance Conference, USA, 2005, co-authored by researcher.

With majority of Health Insurance schemes being Yearly renewable policy, Policyholders didn't get reminder notices on time or not at all receive and hence customers forget to renew the policy. Unlike Life Insurance, where if a policy is renewed, the policyholder get benefits without much difference prior to lapsation, in health insurance policyholders loose many important benefits like first year exclusions will come to force and no coverage for pre-existing diseases. Despite all odds a small portion of the segment continues to pay the premiums regularly to enjoy benefits under sec 80D of the income tax act wherein premium payments upto Rs.10, 000 is eligible for deduction from the gross income directly. When we say that individual health insurance policyholders is supposed to have more awareness and stand at one end, at the other end stands the people without health insurance policies. Insurance companies are targeting this segment. But to win over the confidence of this segment is a two-fold activity. First, awareness should be created and second; sale of the insurance policy has to be done. Both the activities are a tough phase in the current scenario. The reasons are: -

Insurance is still viewed only as a tax saving instrument with sizeable investment return. Health Insurance policies do not promise any investment return.

India is still facing the stumbling block of lack of awareness for even life insurance products, which promises good investment return.

Many of the people have more belief in god that they will not incur any medical expenditure. They view the health problems religiously rather medically.

Experts say that, of the 100 per cent health insurance policyholders, approximately 50 per cent are individually insured, while the remaining 50 per cent are employees of corporates.

Under Group Insurance, Insurance is arranged for group of buyers, the benefits are tailored to the needs of the group. Group is based on employment or membership of society or club. In India, most of the group insurance falls under the category of employment only. Benefits of Group insurance are many, like Tax advantages for the employer, better bargaining power, lesser administrative expenses for the insurer, pooling of risk across different levels despite their insurability status etc. Also, as many employers conduct medical test during the appointment, the quality of life is assumed to be good when compared with rest of the population. But mostly the coverages and designs do not match with the characteristics of the group thus ending with more generous coverages, which indicates that there is still potential for up-selling insurance policies in this segment. Marketing programs of insurance companies should focus on this segment for more up-selling opportunities as this segment is neither totally unaware of health insurance benefits nor aware of the importance of having enough health insurance coverage. Given the current scenario of health insurance in India, this segment should be the entry point for the Insurance companies to exploit the maximum potential in this segment.

Paradoxically, this employee population too contributes considerably to the loss ratio of health insurance. Severe competition has brought down the price of corporate policies, eroding the actuarial premium base. Therefore skewed claims ratio is also due to corporate Mediclaim policies. Moreover, Corporates use health insurance as a bargaining tool while deciding to offer the more lucrative and profitable portfolios of Fire and Engineering to the insurance companies. The insurance company makes good profit obtained as premium from these products and is so willing to bear the loss obtained from health insurance product. However, a study by Munich Re in India on the comparison between Group Vs Individual Insurance in terms of Burning cost

across various age groups indicates that Group Insurance Burning costs are relatively lower. From the analysis discussed so far, it is suggested that Marketing Department of Insurance companies should focus more on up-selling opportunities among Corporate Health Insurance Policyholders. But it can be said that the existing framework is not feasible enough to do the same.

Section II: New product models

This research suggests new product models under the following classification

On the basis of Demographic features - Special reference model for informal sector[4]

On the basis of Morbidity features

On the basis of blending Portfolio features

On the basis of Demographic features

On the basis of the analysis of primary data, it is inferred that the demographic characteristics and expectations vary across the segments. Cluster analysis points out different cluster of demographic variables like cluster one having age, work experience, marital status and dependant children, second cluster segment, occupation and annual medical expenses, sex and adult dependants form the third cluster, Family Monthly Income and Income Tax Assessment Status forms fourth cluster, Place itself forms a cluster. The discriminant analysis estimation equation infers that very minute differential factors influencing the respondent to fall in either policyholder or no policyholder category. This gives idea of floating different plans across sub-segments. For example, new plans can be tried out in a sub-segment that exhibits significant variance of occupation and annual medical expenses and so on.

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[4] Excerpts from the researcher's co-authored research 'Health Insurance Models for Informal Sector in India' presented at Asia Pacific Risk and Insurance Association Conference, South Korea in 2004.

This suggestion is in sync with the existing life insurance practices in the country. For example, life insurers float separate plans for 'key man' in the business, females, children, old aged etc. Similar practice should be implemented in health insurance industry also.

This approach can be a starting point with the assumption that morbidity factors will vary across the demographic sub-segments. This will eventually lead to construction of proper data warehouse with enough morbidity statistics.

Special reference to Model for Informal Sector

Morbidity and mortality levels in the country are relatively high which indicates the limited success of the public health system in meeting the preventive and curative requirements of the general population. In this context, informal sector people who form majority of the population, are most deprived people as it may take long time to really benefit the immediate health care requirements due to lacking awareness, infrastructure etc.

The new model proposed is to introduce Reinsurance on Health Insurance for Informal sector in India. Basically, the Government's Universal Health Insurance Scheme or the plans as proposed in this research can be marketed by many NGO's or Association of Informal Sector Group which are functioning all over the country. The workers of the informal sector are identified and aggregated into a homogeneous group. For example, all the weavers in a state are identified to form a group; the association of weavers are the implementing authority of the Universal Health Insurance Scheme. Let this group be called as GROUP-W. Similarly, a group is formed for the farmers in a state and called as GROUP-F. When we make actuarial valuation analysis of each group individually, definitely the premium collected will

not be able to sustain the solvency margin. Hence each group is reinsured with a global reinsurer through IRDA. The reinsurer will evaluate the risk of all the groups collectively and decide the acceptance premium. As many sub-standard groups are pooled together, the risk as a whole is reduced according to Law of Large Numbers. The Insurance Regulatory and Development Authority will act as the co-coordinator of all the groups and collect the premium (which is Ceding premium). The difference between the eeding premium and the acceptance premium, if any is borne by the government or IRDA. The recent announcement of the Government to increase the share in GDP for healthcare ean provide more allocation. Moreover, it can also be thought of including a cess of 0.01% for all the individual insurance policies sold, to fund the difference. Of course, the nodal TPAs in each region will take care of servicing part of these policy holders. The new hospitals which are created on the basis of VC-Health Care Model can also be identified as the nodal centers for treatment. Claims are settled by TPA's and reimbursed by IRDA to TPA's. IRDA in turn will claim the reinsured claim once in a quarter as a consolidated claim from the Reinsurer. Based on the valuation made each year, the premium is revised year after year keeping in mind about the purchasing power of the group policyholders. Modifications in the universal health insurance schemes can also be thought of in later stages based on the data available after implementing this model.

What can be reinsured?

When health care infrastructure is increased, by using the Banking-Health Care Model, the cost of medicines, hospital assistance can be made available at subsidised rates. This can reduce the risk premium to certain extent. But a margin of 10-25% can be kept to avoid abnormal losses. It is not possible to reinsure all the risks covered under health insurance scheme. Hence a limit can be placed above which the risks can

be reinsured. The limit can be in terms of excess of loss ratio for the operating units. Here the operating issues can be assumed to a collective entity of NGO's/Associations at a Town or Taluk or District level.

On the basis of Morbidity features

Any new plan should strategically be placed in such a way that it will not tempt to make fraudulent claim. This can be achieved by doing a perfect research of the existing disease patterns, mortality rates, morbidity rates, consumer behaviour at the hospitals, hospital behaviour towards patients etc. Such sort of research is still a distant dream for us.

For doing such research, it will involve lot of investment cost. Instead we can try with launching of different kinds of plans and do research on the data acquired.

For this, Initially, new health insurance policies can be launched to meet the needs of various sub-groups and there shall be a base health insurance plan, say bH. The base health insurance plan may offer the benefits to cater the treatments of primary ailments. Deductibles can be introduced in these policies like Calendar Year Deductibles where eligible medical expenses are accumulated during the calendar year, and once they exceed the deductible amount, the insurer will pay the benefits.

Apart from the base plan (bH), lot of endorsements may be offered to the policyholders in the form of riders to choose from. The endorsements may be classified based on the secondary and tertiary medical care treatment offers.

The secondary medical care treatment plan (sH) which eventually will include base plan having some higher premiums and cater to the secondary medical care needs of the policy holders. Similarly the tertiary medical care treatment (tH) will

cater to the tertiary medical care needs of the policyholders apart from the base and secondary medical cares.

The above may sound like re-definition of the existing Jan Arogya Bima (for bH) and existing mediclaim for sH and tH. But strategies have to be worked out that the bH plan imbibe some more benefits that exists in mediclaim policies apart from that exists in Jan Arogya Bima.

On the basis of Portfolio blending features

In India, insurers often try blending the features of other forms of insurance and financial products while designing new plans. For example, Unit Linked Insurance plans were floated blending the equity features into insurance, single premium policies with short term were floated by life insurers which was similar to bank's Fixed Deposit product.

In this research, the idea of floating blended products were asked to the respondents especially about the concept of 'Long Term Policies' in the similar lines of life insurance plan features and Single Premium policies in the similar lines of bank's fixed deposit features. It should be noted that prior to liberalisation, similar plans were floated but it ended up in failure. But this time, this type of question is included in the questionnaire to check the response of people across different segments. From the analysis it is found that the response level varies across the different segments.

This indicates that new plans with blended features can be tried but it should be in sync with the demographic characteristics of the segments.

Section III: New process models

This can be sub-classified into two categories

New Control Process Models

New Technology Process Models

New Control Process Models

This can be further classified into

Administrative Control Processes

Actuarial Control Processes

Administrative Control Processes

This model stresses focus on two key areas in health insurance process flow viz. underwriting and claims settlement. Such processes can reduce the fraudulent claims. This research forecasts the increase of frauds in health insurance due to the factors like Presence of new players, Change in purchasing behaviour of consumers wherein customer insuring different risks with different insurers, New distribution channels like Bancassurance, Internet, Appearance of new entities like TPAs, Disappearance of some entities like TAC in the coming year. Increasing controls through technology is a model suggested in this research.

Actuarial Control Processes

Actuarial Control Cycle Model for Health Insurance in India

Importance of the Model:

With many demerits existing in the current health insurance system viz. Lack of Data, Higher Capital norms, Lack of Reinsurance arrangements, Fluctuating investment market scenario, unpredictable lapse rates, inflated claims, management

expenses, it becomes important for any insurance company dealing with health insurance to implement actuarial control cycle to achieve profit.

This model aims at the cross-checking the assumptions and projections across the actual, thus creating room for quicker control actions before something goes wrong.

The Model

The factors considered in this model are

Expected and Actual Morbidity Rates

Expected and Actual Premium contributions

Expected and Actual Investment Returns

Expected and Actual Withdrawal Rates

Expected and Actual Reinsurance Arrangements

Expected and Actual Management Expenses

Expected and Actual Claims.

Expected and Actual Other Incomes

Expected and Actual Other Expenses

Basically, the actuarial control cycle aims at testing the profit, can also be called as 'Profit Testing'.

Equations for the same can be worked as below:

Profit = Income – Expenses

Where

Income = Premium contributions (PC) + Investment Returns (IR)+ Other Income (OI) + Reinsurance Claim Receipts (INRE)

individual and group segments. It is better to analyse the surplus across both segments as below

$$\Delta_{surplus} = \Delta_{Group\ surplus} + \Delta_{Individual\ surplus}$$

Rationale behind the above formula:

Note about the factors in Indian Context

Premium Contributions: Premium contributions is not witnessing steady growth due to various forms of lapses. Again, the lapse rates are different across individual and group schemes.

Morbidity Rates: This varies across region to region. Again various studies suggests that the data is not available with.

Reinsurance: India, as such is not having any reinsurance arrangements for health insurance, but in future the possibilities for reinsurance are bright. If this happens, then group health insurance has good scope of such coverages.

Other Expenses: Group Health insurance coverages often enjoys some form cross-subsidisation as the premium rates are offset with the premium contributions received towards other forms of insurance like Fire, Marine etc. Similarly the Group Schemes enjoys better tax treatments.

Investment Returns: Unlike the Blue Cross & Blue Shield Plans of USA wherein more investments are made in equities market, Indian Insurance Regulations restrict the participation of insurance companies in equity market.

Control Model in Indian Context

This research suggests that actuarial control cycle across group schemes should be mapped with individual schemes to the granular level. This will help in overcoming the deficiencies of data, analysing the impact of various factors over premium and surplus, increases the scope for application of Technology like Data Warehousing and Data mining techniques to perform 'Whatif' analysis and Stochastic analysis seamlessly which can end up in launch of specific plans for select segments as it exist in Life Insurance Market etc.

New Technology Process Models

This research suggest implementation of two important technological processes

BPM Process

Data Warehousing Process

BPM Methodology

Health Insurance Claims processing involves lots of complexities and require frequent changes in the underwriting rules and claims rules. For example, an outbreak of major disease like SARS may have varied impact over the claims processes that require immediate attention in a war foot manner. Similarly, a complicated cardiac ailment may require immediate redefinition of rules not only to cardiac diseases but also to related ailments viz. Hypertension related diseases, neuro related diseases etc.

Certainly, in a legacy environment where most of the rules are hard coded, immediate redefinition of rules and implementation of the same may take long time before which the insurer would have incurred heavy losses. Needless to mention, even if the rules are incorporated, there lies the risk of system overrides by the claim processors due to their habit of overseeing the diseases and approving it unaware about the new rules.

BPM process instigate strict and rigid methodologies which can incorporate all new rules framed out of investigations with immediate effect and also disallow all the system overrides and thus bringing down the claims cost drastically.

In BPM Process, the system administrator can easily define the rules without the requirement for coding. BPM Process creates executable Java Codes for the new rules and implements the same in the system for immediate processing. Thus, it reduces the dependency of the Decision Makers over the IT Department.

Taking into account of the time frame for developing new codes, integrating it with the system, conducting system test in a normal legacy environment. BPM processes comparatively avoid all the above processes and also ensure qualitative system process thus saving cost, manpower etc.

A survey indicates that claims processing cost accounts for 30% of the overall claims expenses. An efficient and effective methodology like BPM may immediately bring down the claims processing cost obviously.

Data Warehousing Methodology: Data warehousing methodology is supplementary to BPM methodology, which eventually is a part of the process after claims are processed.

As mentioned earlier, BPM Process reduces the overall claims processing costs and controls the expenses arising due to system overrides.

Data warehousing using Business Intelligence Techniques helps to analyse the data and plug in claims, which still posses, the risk of overpayment.

It also helps in analysing the data in various dimensions and hence frame new set of underwriting rules and claim rules. For instance, the claims data is analysed across various dimensions viz. Diseases, Treatments, Hospitals, Physicians, Customers, Claims Processors etc. and the same is pitched to identify the hidden patterns.

This will lead the decision makers to identify and set rules on underwriting, claims for a particular diseases, hospital, physician, customer which can be immediately put into effect into the claims system through BPM Process methodology.

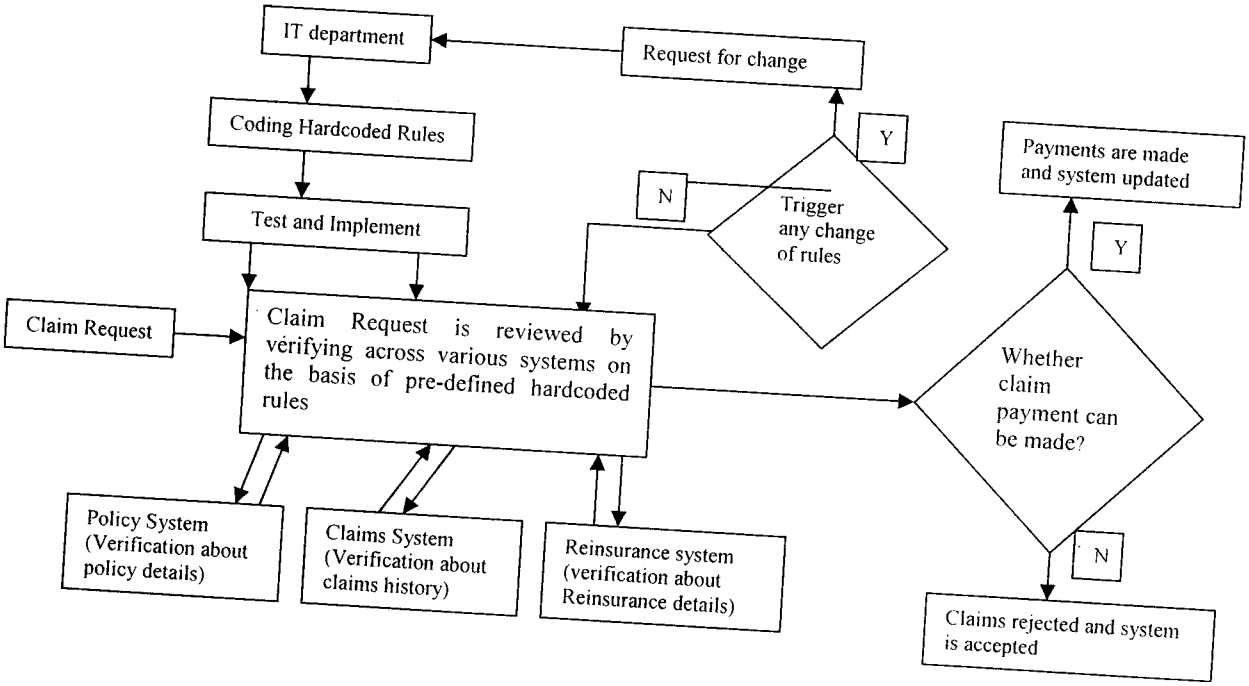
This can also indirectly help the Insurer to better handle knowledge management activities with respect to their claims processors thus adding immense value to the organisation.

All this in turn, can plug in any leakage left out before actual payments are made to the end customer. May be a latency period of 1-2 hour is enough for the Data warehousing system to process a batch of claims records through a incremental batch processing mode to meet the fraudulent challenges and overpayments.

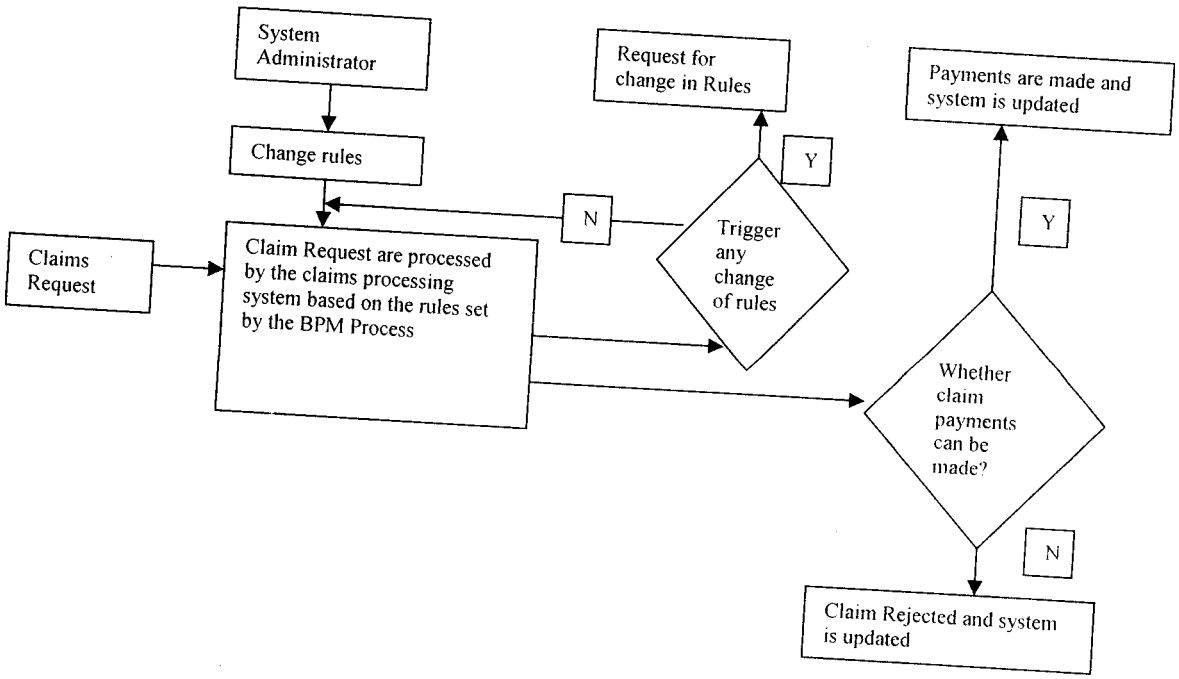
Data Warehousing and Business Analytics without BPM process may also be considered but the same can act only as the Leakage Identifiers and can play only less effective role as Leakage Rectifiers. Needless to mention, for an insurer identification and rectification is an ideal system process to plug in claim leakage perfectly.

Schematic Diagram

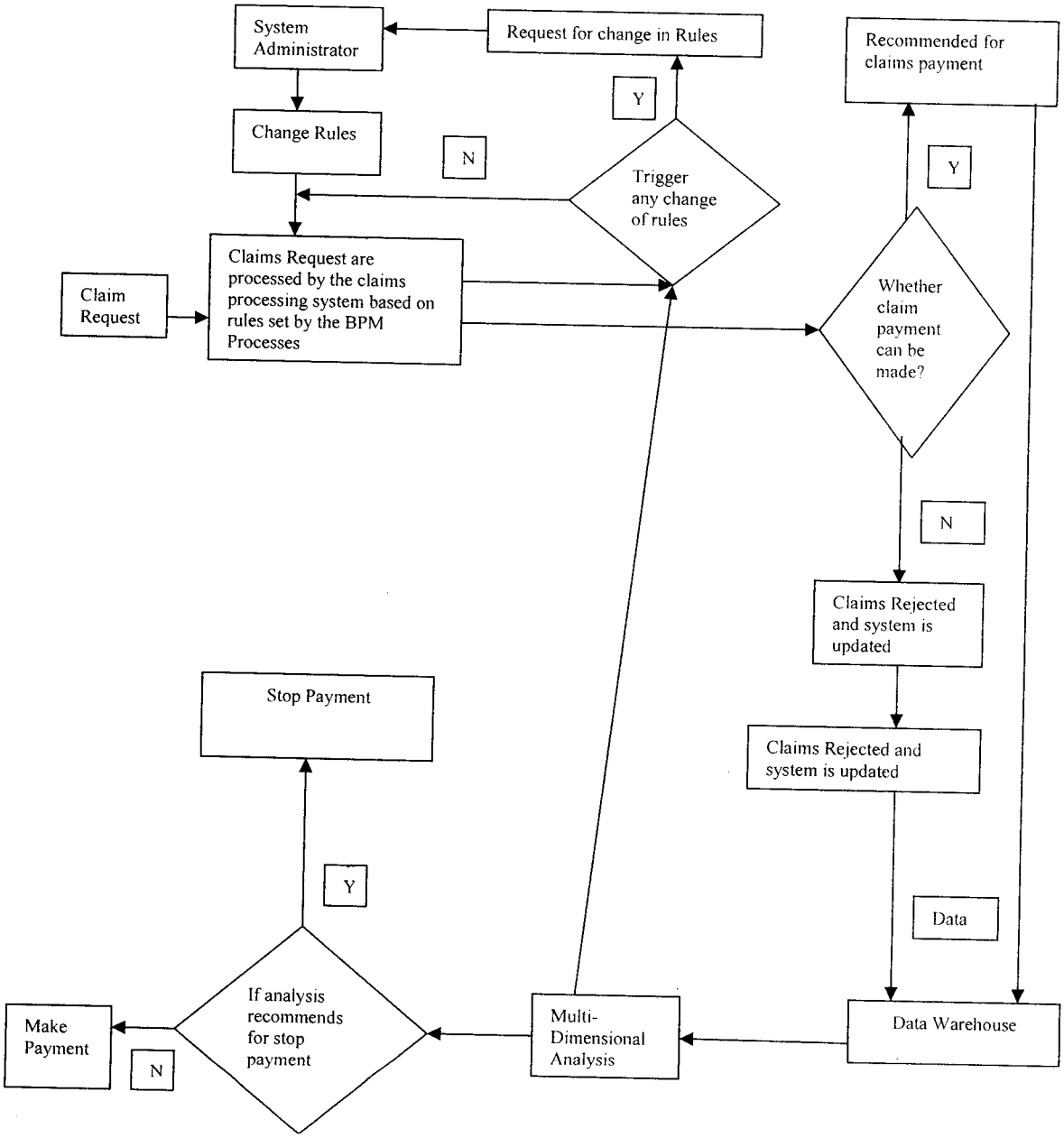
Typical Legacy Application Environment



Claims Process after BPM Implementation



Claims Process after BPM and DWH Implementation



Section IV: New channel models

From the research, it was observed that 'Agents' are the most preferable channels for majority of the respondents. But this research suggests the involvement of Direct Marketing channel in capitalising the Group Insurance segment. One of the findings of this research is that innovative type of Group Insurance Schemes like 'Residential Association Group Health Insurance schemes' is preferred by respondents (Though the response is not same across all segments). This type of channel promotion will have multitude effects. Some of the key aspects of this innovative idea is discussed below:

There is no enough data for scientific calculation of a Model.

Marketing program of insurance companies are more generic.

This has to be focused on a specific segment, which can exhibit the characteristics of general population. This can be taken as a miniature model for analysis and build a scientific database for analysis and building a model.

From the conceptual awareness scale, it can be inferred that group insurance exhibits the characteristics of both aware & unaware segments. Hence, group insurance (corporate) segment can be taken in the first phase as an experimental measure among selected groups. This can be a best method as health insurance involves lots of complex parameters and for collating a good sizeable database from the universe of population (comprising of heterogeneous segments) will take long time. Hence on experimental basis, a method should be followed as a starting point, which can provide quick and effective results. The scope of the same can be extended later. One such method is suggested below:

On an experimental basis, select groups can be chosen across various sectors and the patterns can be studied. For example, (as an illustration) if we identify four

groups (Corporate Insurance) as A, B, C & D. So far insurance companies make analysis of the groups separately and do not collate the data of various groups. But in this method, let us assume that Group A and Group C are exhibiting similar characteristics. Hence the data belonging to Group A & Group D can be pooled and the aggregated data can be studied.

Employers can also share the medical records of the employees, which is performed during the time of appointment. This will enable the insurers to do some sort of medical underwriting of the group.

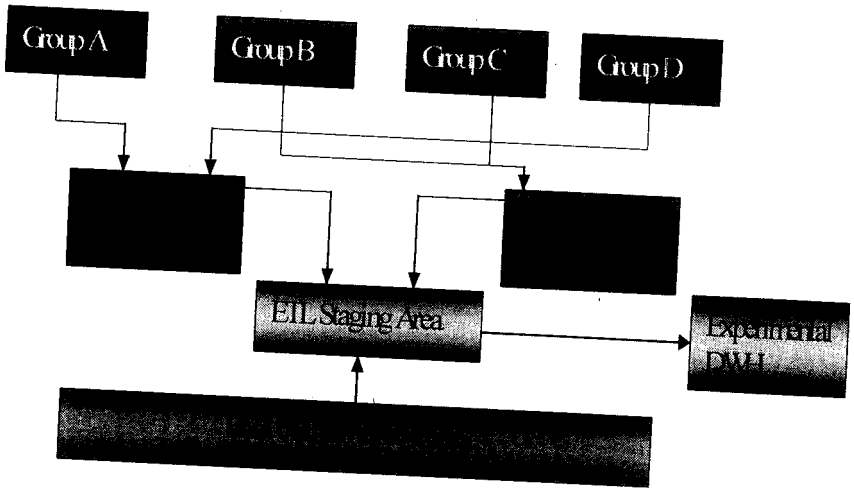
Various parameters forming the base of health insurance premium can be studied in-depth for these groups. For example, the claim pattern of the policyholders under this group for a particular age group – say 30-35 can be analysed in-depth.

The same can be correlated with the available data of individual insurance policyholders.

Mapping & gap analysis using data warehouse between the groups and individual insurance can be done to understand the behaviour of individual insurance.

The same can be then extended to many groups in the next phase

In the final phase, the scope can be enlarged by extrapolation and comparison with the whole set of individual insurance policy data.



Thus, identification of new segments can help not only the growth of health insurance in India but also can help in meeting information needs of the insurance companies for spreading the individual policyholder segment also.

Section V: New promotion models

This research suggests that promotion only through media alone will not work in country like India. In current scenario, promotion can be equated to awareness. Hence this model suggests that promotions should be categorised as below. (Wherein media promotion is one among the factors) Promotion is an integrated component with respect to Health Insurance in India comprising of

Promotion through Media

Promotion through Training

Promotion through Stakeholders

Promotion through Regulations

Promotion through Media

This research identified that the promotion of health insurance through media is not similar across different segments. Hence various kinds of promotional strategies should be followed. At present, insurance companies follow similar promotional

strategies across segments and places. This may be one of the factors slow growth of health insurance despite the knowledge of health related risk among the population. Hence, the promotional materials should be tailored according to the expectations of the people across the segments.

Promotion through Training

Agents are the most effective channels in India, but majority of the agents lack knowledge to explain the features of health insurance in India. Hence insurance companies should consider using agents for promotion of awareness.

Promotion through Stakeholders

Stakeholders can play vital role in promoting health insurance awareness. This study finds out that TPA awareness is not similar across segments. This indicates that the concept of introducing TPA is not serving its real purpose. Hence steps are to be taken to improve the services of TPAs in the context of awareness creation. Similarly involvement of Big Hospitals in Health Insurance should be promoted in awareness perspective also.

Promotion through Regulations

IRDA acts not only as Regulatory but also Development authority. In this sense, still more activities are required from it. IRDA should lobby for more rebates from government like increase of tax rebates etc, allow liberal regulations in the advertisement for hospitals, keep close touch with hospital care industry, may be form joint association with Medical Council of India to devise hospital schemes etc. Such type of activities can promote health insurance.

From the models suggested - New Approach Models, New Product Models, New Process Models, New Channel Models, New Promotion Models, No single

model can work effectively without steps taken to implement a few of other models. For example, Floating of new plans cannot work without involving New Approach Models and so on. The reason is that Health Insurance Sector in India is exhibiting disparate features currently. It may not be possible to clean up and integrate various features of the health insurance system immediately. But Insurance companies and Regulator can try to implement combination of few models suggested in this research. Such combinations are left to the decision of the insurance company and regulator, as it will depend upon the business environment and business trends of the insurance companies.

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CONCLUSIONS

CHAPTER VII

CONCLUSIONS

India is a country having 16% of the world's population, but its total expenditure of $18 billion on health as on 1990 is only 1 % of the world's total. The per capita health expenditure of India is only $ 21 (1990). As per the recent World Bank statistics, the country spends 6% of GDP on Health care of which, nearly 78% is private expenditure and 22% public expenditure. Increase in the cost of medicines, hospital services has made the people of the middle income and lower income segments to depend more on Government's plan outlay. But in the last two decades, health has been getting a shrinking share of plan outlay of the Government. Though Government has promised 2% of the GDP towards health care expenditure, experts opine that still it is below 1%. Hence the gap between the health care costs and government subsidy is widening year after year leaving people under distress and pushing thousands of people to Below Poverty Line (BPL) segment. These factors should have created awareness for health insurance among people and should have pressurised the government to create a public policy towards health insurance.

But India does not have the policy of compulsory health insurance for its people and even the spread of health insurance was very minimal. Moreover, Insurance was in the hands of only public sector companies from 1973-1999 with respect to general insurance and 1956-1999 for life insurance. In 1999, Insurance Regulatory and Development Authority Act (IRDA Act) was passed opening insurance sector for private sector participation. But even after liberalisation, the growth of health insurance was not as expected. Had Health Insurance portfolio been managed professionally, the growth would have been exorbitant. This research was undertaken

to find out whether Health Insurance Sector could help to bridge the gap in the light of liberalisation as Insurance contributes to social stability by permitting individuals to minimise financial stress and worry.

Hence, it was thought that it is the right time to analyse about the existing system and think about the ways of spreading health insurance coverages and managing the portfolio

The objectives for which the present research work was taken up were to assess the spread of health insurance in India, to identify the factors that influence health insurance purchases, to understand the expectations of the people towards health insurance and to propose new models & methods to promote health insurance in India.

Literature on various subjects related to health insurance was collected from various sources like IRDA, National Council for Applied Economics and Research (NCAER), Centre for Insurance Research and Education (CIRE), Indian Institute of Management-Bangalore (IIM-B). Various research papers and articles published in various journals and magazines were collected from sources like web-site and libraries of IIM - B, Bangalore University and Jansons School of Business-Coimbatore. Excerpt from various stakeholders of health insurance like senior management people of insurance companies, hospital administrators, pharmaceutical companies, legal experts, TPA, insurance distribution channels were interviewed through an unstructured personal interview method to understand the problems from their perspective that can hurdle the growth of health insurance in India.

Based on the review of various literatures, the spread of health insurance in India was assessed and also based on the expert interviews; the prominent factors

which can be the hurdle for the growth of health insurance were identified. A sample questionnaire was prepared for pilot study. Data for pilot study was collected from Bangalore (urban) the capital city of Karnataka State, Hosur (semi-urban) and Krishnagiri (a rural district) in the state of Tamilnadu and the nearby villages near Krishnagiri and Hosur. At the end of the pilot study, it was found that a single questionnaire might not be suitable across the sections of the society. This is because, when a person was selected for interview, not all questions were applicable to the person. Hence some of the questions were not necessary for response. When the pattern of such questions were analysed, surprisingly it gave an idea to split the population into three segments like people with existing health insurance individual policy holders (voluntary policyholders), people with no health insurance policies (no policyholders) and people covered under group health insurance schemes, as the expectations and factors influencing health insurance was varying among segments. Primary data was collected data from in and around Bangalore (Karnataka State), Hosur (Tamilnadu State) and Krishnagiri (Tamilnadu State). The scope of the research does not cover study of supplementary schemes like Personal Accident Coverages, Disability Income Coverages etc.

The number of chapters are seven. The first chapter gave an introduction about the health insurance in India and problems associated with it, which motivated the researcher to undertake the research.

The second chapter dealt with review of literature; health insurance in India is dependant upon various stakeholders like health care, pharmaceutical industry, regulators, and hospital industry etc. Hence review of literature was done covering various aspects of health insurance in this chapter.

The third chapter detailed about the Genesis and Overview of health insurance scheme in India. This chapter was classified into two parts, the first part detailed about the Genesis and overview of the developments in Indian health insurance arena and the second part details about the health insurance statutory environment in India. Genesis and Overview details the Genesis of Health Insurance in India during the pre-independence period (prior to 1947) and developments in Health Insurance through different phases viz. Pre Nationalisation Era (1947-1973), Nationalisation/Pre-liberalisation Era (1973-1999), Post Liberalisation Era (from 1999). The statistics of the performance of health insurance during post liberalisation era was also analysed in this section which meets the objective of assessing the spread of health insurance in India. In the second part, health insurance statutory environment was detailed as in any country, the statutory environments play crucial role for the growth of business. The statutory environment covers constitutional environment, regulatory environment covering the aspects of Registration and licensing, Management of funds, including control on investments, Control on Management, Solvency margins, Powers to investigate and to issue directions, Special provision s protecting policyholders and also regulations by courts. In summary, this research suggests that amendments can be made to make the statutory environment more insurers friendly.

Chapter Four details about Comparative Study of Health Insurance Schemes in India, this chapter focused on the details of various forms of health insurance schemes in India and select foreign countries to provide insight about various forms of health insurance coverages. Such insight can help to design new plans for health insurance. This chapter was classified into two parts. The first part focused on the various forms of health insurance that exist in India and the second part focused on the health insurance schemes in select countries.

The various health care programmes presently operating in India can be categorised as State-run schemes for formal sector employees; Health Insurance Plan offered by Insurance companies, corporate sector health care programmes; Community and self-financing schemes, primarily for workers outside the formal sector; and micro-credit linked health insurance schemes. Snap shot statistics of membership of various schemes were presented in this chapter. In summary, it can be said that though various schemes are available in India, none of the schemes are very effective, due to the fact that 'had any of the schemes been effective, it would have served as ideal model for spread of health insurance'. Hence new models are required for India for promoting health insurance by overcoming the demerits of each scheme.

The second part discussed about the health insurance system existing in other countries, this was done to understand about various models of health insurance to draw inference for India. The specific experiences of China, Thailand, Srilanka, Latin American Countries countries, USA, UK, Australia, Singapore, Germany were briefed in this chapter.

The Chinese expenditure is characterised by high total expenditure, low government expenditure and heavy dependence on insurance financing. There are two kinds of coverage, which are in practice in China, labour insurance medical coverage for state-owned enterprise workers and retired persons, and free medical service, which caters to workers, and retired persons of government agencies and parties and non-profit institutions. India, which is similar to china in terms of population growth, has lots of learning from china.

Thailand has four different kinds of health care financing programmes: voluntary health schemes, mandatory schemes, social welfare schemes, and fringe

benefit schemes presents the coverage of these programmes with their important features. India also has different types of schemes, but the point is that efficiency of schemes needs to be enhanced.

Srilanka's health care expenditure is characterised by high government, low private, and low insurance expenditures. But India being a larger country than Srilanka, it is practically impossible in the current scenario to have a model like Srilanka. But many states in India are of size of Srilanka; hence Government can try out test strategies wherein it can try to implement similar models in some of the states. But the feasibility of such models is questionable in current scenario.

The pattern of health care expenditure in Latin American countries varies according to the size of the country (both in terms of population and geographical size) and the income level. Taking a larger perspective, there are mainly two types of managed competition, which are emerging in this region, where government is the sponsor and where private employers are playing the role of sponsor. Like varied models existing across countries in Latin American Countries, India can take learnings from it by varied models across states, but again there are hurdles due to constitutional and regulatory factors. Hence again, the feasibility of such models are questionable.

In USA, Healthcare is provided by private hospitals, funded either by individuals, by employers, or by insurance. But comparatively, USA is having well advanced system. India has already started taking clues from its system like introduction of TPAs which is starting point and can lead to HMO models, Health Unite Framework in the lines of HIPAA etc. In future, India has to learn from USA to prepare itself for handling frauds and improving the information technology.

Health care in the UK is provided publicly by the National Health Service (NHS). The scheme provides free health care service to all residents in a network of NHS clinics and hospitals countrywide. It provides for primary, secondary and post-operative care. People must contribute towards dental and optical care according to their means. The government sets the annual NHS budget from tax revenues.

Private medical insurance in the UK evolved from dissatisfaction in the state health system due to long waiting lists for operations and over-crowding inwards. About 11 percent of the population purchase private medical insurance. The NHS does encourage its hospital trusts to have private patients units (PPU's) within their hospitals to attract private patients, who either fund themselves, or who have private medical insurance. It is the intention of the government that PPU's will be encouraged to care for more patients and so generate more revenue for the hospital trusts and reduce the burden on the state budget. In India, people spend more towards health care from their pocket and have to take learning from UK market in avoiding pitfalls in hospital services especially in the current scenario wherein India has been identified as ideal health care tourist destination. The experience of Ireland is also similar to UK.

Germany does not have national health services like the UK. There are a number of health insurance companies who provide health care for their members. Most of these are government controlled, although some are private companies. Government Insurance Company covers the risk which is not acceptable by private insurance companies. Germany expects its people to be part of private or government schemes. Even if a person drops out from private, he should join government scheme. This gives an idea for formation of health insurance corporation by government,

which can mandatorily insure majority of the population for a small coverage. But given the performance of instititutions like ESIC and CGHS, more cautious measures needs to be taken to learn from the mistakes made in the past.

In Australia, roughly 60 percent of the population rely on the public hospital system for acute care and 40 percent are privately insured for such care- the latter tending to use private hospitals primarily, but relying on major public facilities in complex or catastrophic situations. Private health insurance is regulated in Australia to be community rated rather than risk-rated, this has vital implications for India in terms of requirement of good infrastructure, varied approach towards ratings etc

In Singapore, various schemes like Medisave, Medishield, and Medifund are just one of a number of countries which has "provident fund" arrangements providing for a range of welfare needs. In India, as already the provident fund schemes are popular. It has to be thought of floating schemes in combination of Provident fund schemes which has feature of health insurance components attached to it.

In summary, it can be said that India has lot of opportunities to learn lessons from health insurance systems of various countries. Especially, when India is at cross-roads, this suggestion makes more sense to build a highly efficient health insurance system.

Chapter Five focused on Factors and Expectations influencing Health Insurance in India. This was based on the primary data collected. Primary data was collected from three different segments viz. Existing Policyholder Segment, Group Health Insurance Segment and no policyholder segment.

Based on the primary data collected, analysis of data was made subsequently hypothesis was tested to check the relationship of key factors like Monthly Income, Annual Medical Expenses, Exposure to Insurance etc. across segments and places (urban, semi-urban and rural). Also a cluster analysis was made over these factors to identify the cluster relationship among these factors and a discriminant analysis was made over these factors to identify the estimation co-efficient of the factors that can help in deciding whether a person is likely to purchase health insurance policy or not.

It was found that Monthly Income varied across segments and places. As Income factor is associated with the purchasing power, this also infers that the purchasing power will vary across segments. Hence Insurance companies should devise new plans to match the age, sex, occupation and income levels of the people of the segment.

Monthly Medical Expenses varied across segments but remained same across places, the annual medical expenses was independent of the region. However, region wise morbidity rates is useful; this research suggests that it is more meaningful to study the morbidity rates across segments and places and based on the expectations of the segments.

The analysis of insurance exposure was done on the basis of premium payment (to understand the premium payment capacity of the people across each segment), Penetration Analysis across segments (to understand the penetration of public and private companies across these segments) and Critical Illness Rider Analysis (to understand the acceptability of critical illness coverages across the segments, as critical illness insurance are the miniature version of health insurance policies, though

it is not a complete health insurance coverage by itself. But it can give a fair idea of potential promotional strategies).

It was also noted that 44.19% of the respondents of Group Insurance segment did not have exposure towards life insurance indicating high market potential for life and health insurance. It was noticed that there were respondents who had no idea about the premium payments and there were respondents in 'no policyholder' segment who pay premium more than Rs.10, 000 per annum. Proper marketing strategies can help in wooing the customers for minimum payment of health insurance.

Insurance Penetration Analysis revealed that penetration of insurance companies varied across the segments. Penetration of insurance companies is independent of the places. It revealed that both private and public insurance companies have started penetrating into various unexplored regions of the past.

Analysis on purchase of critical illness rider policies revealed that critical illness rider exposure is not varying across segment and places. This gives us an idea that people across segment and places have started realising the need for coverages against illness; hence this is the right time to target such people for persuading them for health insurance.

Demographic variables play important role in purchase of health insurance. Cluster analysis of demographic variables revealed that that there can be five different clusters (at the distance between 20 and 25) viz., cluster one having age, work experience, marital status and dependant children, second cluster with segment, occupation and annual medical expenses, sex and adult dependants form the third cluster, Family Monthly Income and Income Tax Assessment Status forms fourth

cluster, Place itself forms a cluster. This gives us an idea of designing variety of products targeting each cluster. Hence plans can be floated specific to a place, specific to Monthly Income and Tax Assessment status etc. It was found that the main reason preventing the people from taking health insurance are 'Lack of Information' which means proper marketing programs to create awareness can work for growth of health insurance in India.

Majority of people without health insurance coverage managed to meet the emergency medical expenses through savings or borrowings. This means, the failure of insurance mechanism due to information problems which is preventing the pooling of savings money into insurance pool. Even during medical emergencies, majority of people didn't think about health insurance reveals lack of promotional mechanism even at POS (point of sale/suffering).

Agents are the preferred channels for insurance carriers. New channels like big hospitals, bancassurance are also having some favour among some respondents, which means that channel potential exists for non-conventional channels also. Majority of the people showed interest in purchasing health insurance after explaining the need by the researcher (overcoming information problems). Majority of the respondents (86%) were not aware of the concept of TPA.

Under Group Health Insurance segment, variety of plans exist wherein some are contributory (employees contribute to premium) and some are non-contributory (employees do not contribute) in nature, the group health insurance coverage also varies from one employer to another employer wherein some are floater policies(sum assured is shared by family members) and some are non-floater policies. It is sad to notice that many of the respondents were not having any idea about health insurance

at all. Majority of the respondents from this segment who are aware about health insurance felt that the group health insurance is sufficient for them which show clearly the lack of proper awareness about the need for additional coverages and lack of understanding about the potential for up-selling. But after proper explanation by the researcher, the respondents felt the need for additional coverages and were prepared to purchase policies to a tune of coverage affordable by them.

Ageing population is major factor to be considered by government and Geriatric Health Insurance is a segment, which needs lot of attention in future. Group Health Insurance Policyholders have the option of converting their group coverage into individual coverage after their retirement from service. But it is sad to notice that 90.7% of the people are not aware of the option that can be exercised. This also clearly indicates the failure of Supply Chain Management (SCM) on the part of employers, insurers and TPAs. IRDA should take steps to educate the people on this. 60.5% of the respondents have shown interest in continuing the coverages by exercising the option. The rest were not sure about the modus operandi of such system and had doubts of getting benefits, even after explaining the rules. But by proper marketing plans with illustrations, it is possible to make the employees to exercise conversion options.

Under Existing Policyholder segment, 67.1% of the respondents got health insurance coverages through agents that show the power of the channel. Majority of the respondents have taken policies for the purpose of covering medical expenses only which is the prime purpose unlike life insurance wherein income tax exemptions plays vital role. It is also to be noted that Health Insurance Tax exemptions are not attractive enough due to the reasons that health insurance products do not give investment returns.

Majority of the respondents were not aware of the policy condition (60.3%) ' no coverage for pre-existing disease'. This normally leads to lapsation of policies. While purchasing health insurance, majority of people first consider premium as the deciding factor while purchasing health insurance policy. This infers that despite the awareness of various dreaded diseases in the country, people who know the value of health insurance are not aware of proper health risk management. Further, their risk management plans are limited by premium amount. Though affordability plays vital role, proper product designs with affordable premium rates can help the insurance companies to make inroads quickly.

Majority of the respondents had taken health insurance coverages from Public sector Insurance companies (80.8%) and 19.2% had taken policies from private insurance companies, which show that private players have started making inroads in this segment. Though a policyholder can take policies from more than one company, no policyholder has taken policies from both private and public companies (unlike in life insurance).

The majority of the respondents had taken policies with sum assured of 1 lakh or below that. Given the scenario of increasing treatment costs and increased private spending, the policyholders should be motivated to buy health insurance coverage of higher amounts. Marketing strategies should be framed in such a way that to educate the public on the conditions of pre-existing disease exclusions, increasing treatment costs etc. to up sell in this segment

30.1% of the respondents didn't bother to make claims; the researcher has found that the reasons are due to the perception of the policyholders that claiming for the expenses is cumbersome procedure, avoiding small claims etc. such feelings didn't

exist much in Group Health Insurance Segment as the Human Resources Department often come to help the employees and employees are treated with more care by insurance companies and TPA as the claimant forms part of corporate account.

Based on the expectations, response for some new schemes were sought and analysis of introducing new products like Long Term policies in Health Insurance in the lines of the features of life insurance, Single term products in the lines of Bank's fixed deposit products is liked by some of the respondents. But the favourable response varies across segments, which infers that only varied insurance products can meet the expectation of the people across segments. This will also help in up selling and cross selling of health insurance through other channels also like Bancassurance, Life Insurance Companies as corporate agents etc.

Similarly innovative methods started by large corporate hospitals to offer insurance to its patients by tying up with insurance companies had a mixed response from people across segments and places. Also the idea of promoting Group Health Insurance schemes through Residential Associations in the light of exponential growth of Housing Sector received mixed response across segments and places, but favorable response by some of the respondents denotes the potential for such schemes. Proper marketing and actuarial programs can help in meeting the expectations of people across segments and places towards such schemes.

The reach of advertisements also varied across segments but it is same across places. Same across places is due to the fact of reach of mass media. But difference in the level of awareness across segments is due to lack of proper awareness programs. Though this is a conflicting result (varying between the segment wise result and place

wise result), the same can be attributed to the proportion of people falling under each dimension (places and segment) and reach of mass media.

Analysis of factors like Acceptance to TPA concept, claims decision analysis across the users of health insurance viz. Group Health Insurance and Existing Policyholder segment revealed that, there lies difference in response for the factors taken for analysis. In general, Group Health Insurance Segment showed favourable response to TPA concept, experience better favourable claims decision due to the fact that they are leveraged and backed up by the respective employers. This shows that Existing policyholders lack better negotiating power during claims. Hence the concept of initiating Health Insurance Policyholders Council should be looked at.

But the claims pattern remains same across Group and Existing Policyholder segment. This is in sync with the fact that both the segments contribute equally towards claims ratio. This also provides an idea that there is need to map the claims pattern and risk premium rates for these segments.

In Short, from the factors and expectations influencing health insurance chapter, two main objectives of the research were attained. It was found that lack of information is one of the key factor for slow growth of health insurance in India. The key expectation is the affordability of the people to pay premiums. This in turn requires lot of reworking of strategies by Insurance companies and other stakeholders like launch of variety of plans with varied premium rates, adopting RBC model (Risk Based Capital) to devise new plans, promoting new strategies for promotional activities, promoting new type of distribution channels, formation of association and councils for voluntary policyholders for hearing grievances of policyholders and enable with better negotiating power etc.

The Sixth Chapter focused on suggesting New Models for health insurance in India. The new models are presented under the classification of New Approach Models, New Product Models, New Process Models, New Channel Models, and New Promotion Models.

New Approach Models was classified into New Approach Model for Infrastructure, New Approach Model for Capital requirements, and New Approach Model for segmentation. New Approach Model for Infrastructure detailed about approach for building up health care infrastructure through VC-Health Care Model as growth of health insurance is dependant upon the presence of good infrastructure. VC-Health Care Model suggests the involvement of Venture Capitalists which may be even Banks playing vital role in promoting health care as special drive. New Approach Model for capital requirements suggested that for India, RBC (Risk Based Capital) models can suit well. New Approach Model for segmentation suggests that Insurance companies should segment the people on the basis of their involvement in health insurance viz. No Policyholder segment, Existing Policyholder segment and Group Health Insurance Policy segment. This is because of the awareness level varies and each segment has got enough strengths for selling, cross-selling and up-selling opportunities.

New Product Models is suggested based on the basis of Demographic features - Special reference model for informal sector, On the basis of Morbidity features, On the basis of blending Portfolio features.

Model based on demographic feature is suggested on the basis of the analysis of primary data, it is inferred that the demographic characteristics and expectations vary across the segments. Cluster analysis points out different cluster of demographic

variables like cluster one having age, work experience, marital status and dependant children, second cluster segment, occupation and annual medical expenses, sex and adult dependants form the third cluster, Family Monthly Income and Income Tax Assessment Status forms fourth cluster, Place itself forms a cluster. The discriminant analysis estimation equation infers that very minute differential factors influencing the respondent to fall in either policyholder or no policyholder category. This gives idea of floating different plans across sub-segments. For example, new plans can be tried out in a sub-segment that exhibit significant variance of occupation and annual medical expenses and so on.

This suggestion is in sync with the existing life insurance practices in the country. For example, Life Insurers float separate plans for 'key man' in the business, females, children, old aged etc. Similar practice should be implemented in health insurance industry also. This approach can be a starting point with the assumption that morbidity factors will vary across the demographic sub-segments. This will eventually lead to construction of proper data warehouse with enough morbidity statistics. A special reference model for informal sector in India based on the Grouping and Reinsurance concepts are suggested.

Model based on morbidity features is suggested wherein this model proposes base plan (bH) for primary ailments, secondary plan (sH) for secondary ailments and tertiary plan (tH) for tertiary ailments. Apart from the base plan (bH), lot of endorsements may be offered to the policyholders in the form of riders to choose from. The endorsements may be classified based on the secondary and tertiary medical care treatment offers.

Model based on Portfolio blending features the idea of floating blended products were asked to the respondents especially about the concept of 'Long Term Policies' in the similar lines of life insurance plan features and Single Premium policies in the similar lines of bank's fixed deposit features. It should be noted that prior to liberalisation, similar plans were floated but it ended up in failure. But this time, this type of question is included in the questionnaire to check the response of people across different segments. From the analysis it is found that the response level varies across the different segments. This also gives idea to float return based products wherein extra premium can be invested in equity markets for returns. This will also give more cushions to the insurance companies with more buffer premiums and can also help in reducing claims ratio.

New Process models focused on New Control Process Models and New Technology Process Models

New Control process model focused on Administrative Control Processes and Actuarial Control Processes. Administrative Control model stressed focus on two key areas in health insurance process flow viz. underwriting and claims settlement. Actuarial Control Process Model stresses the need to implement Actuarial control cycle that focus on the difference between the actual and the expected.

New Technology Process Models focused on the usage of Data Warehousing technology and BPM (Business Process Management) process to overcome the workflow related problems and control issues.

New Channel Models suggested the promotion of Group Channels through Direct mode. This model also suggests better actuarial modelling by merging the data of both Individual and Group Insurance business.

New Promotion Models suggested that promotion only through media alone will not work in country like India. This model suggested Promotion through Media, Promotion through Training, Promotion through Stakeholders, and Promotion through Regulations. The crux of this model is that not to depend only upon media but also upon other stakeholders and proper training programs.

But actually, from the models suggested viz. New Approach Models, New Product Models, New Process Models, New Channel Models, New Promotion Models, No single model can work effectively without steps taken to implement a few of other models.

Finally, the researcher suggests the following factors to be taken into consideration on the basis of findings. As Health Insurance depends upon various stakeholders, suggestions are provided with respect to each stakeholder.

Though Government is taking measures to improve health status of the country by devising National Health Plan etc., the allocation towards Health care in the budget is very low. Steps should be taken to devise a separate channel for increasing health care allocation by way of imposing cess etc. Through collection of cess, government should plan for building more infrastructure, as infrastructure as more the infrastructure, more people will start availing health services, which can lead to decrease the cost of health care, when cost of health care becomes less, the premium becomes less which can lead to more attractive opportunity for growth of health insurance.

Steps needs to be taken to avoid conflicts between center and states in health care issues as health falls under concurrent list as per constitution of India. Especially

IRDA should be given free hand to decide on health matters relevant to insurance. If it is not possible, a joint committee involving IRDA, Medical Council etc should be constituted which will have a say in the matters related to health care related insurance.

Government should draw lessons from various countries in creating public policy for health care. The objective should be providing minimum health insurance for all the people. For this, it is suggested to create separate insurance company for health insurance which will cover minimum health insurance needs of the people.

Government should organise more interaction between public and private health care providers. The option of synergetic co-operation between public and private health care institutions in terms of infrastructure, usage of doctors, technology etc. needs to be seriously considered. Such initiative has the potential of increasing the maximum utilisation of available resources thus reducing the cost of health insurance.

The move by IRDA to create national data warehouse is a commendable work. But it should get consultations from many stakeholders in creating efficient data warehouse. The work in progress reports of existing working group for health insurance should be published at frequent intervals to invite suggestions from public. The move by IRDA to introduce TPA is also a welcoming issue. But critics exists that these days, TPA do not engage much in cashless hospitalisation, thus defeating the whole purpose of introduction of TPA. This may be due to operational issues in delay in settlement of payments between TPA and hospitals. IRDA should take aggressive steps to minimise the conflict and it should ensure that maximum number of people should get only claims through cashless hospitalisation. Such activities will enhance the confidence of the people to take health insurance policies especially in rural areas.

confidence among people should be built up such that people should feel free to come to urban to get treatment with a hope of hassle free claims. IRDA should also think about allowing TPA for minimal marketing activities as promotional issue for health insurance. The thought of converting TPA to HMO models also needs to be discussed in the respective forums for more actions.

IRDA should revisit the areas of health insurance capital requirements, investment norms for health insurance. It should create conducive atmosphere for health reinsurance issues. It is disheartening to note that some State Governments like do not have health insurance schemes for its employees. Hence only Central Government Employees who are covered by Group Health Insurance were interviewed. At this point, this research suggests the insurance companies and IRDA to strongly persuade the state governments for initiating health insurance group schemes for its employees. It is also a potential segment to explore for aggressive growth of health insurance.

IRDA should also plan aggressively to launch special plans with micro-insurance focus, many satellite health insurance units should be created in remote areas with the assistance of NGOs. This will create a sense of importance among the informal sector people in remote areas and micro insurance policyholders.

Hospitals fees needs to be standardised. Laws should be enacted to impose strict conditions to use information technology for processing of health data in hospitals (both pubic and private). Hospitals should use ICD codes. Steps should be taken for gradation of hospitals. Fees should be fixed based on gradation. Steps should be taken to make all hospitals get registered. Doctors and other hospital personnel should be trained to do good documentation.

There are greater chances for generating revenue for health insurance through health tourism. Government, hospitals and insurance companies should work together in devising new Health Insurance and Tourism plans (HIT plans) and try to market in abroad so that more premium is generated under this which can help to cross-subsidize premium rates for domestic health insurance plans. This research also suggest to look not only external health tourism but also internal health tourism wherein people from some states can be attracted to visit historic cities in India and also get treatment. This also can help in cross-subsidizing the premium rates.

In case of pharmaceutical industry methods should be devised to get generic drugs at low cost. Proper alert mechanism should be created to check the cost of drugs that can affect the health insurance premium rates.

In insurance companies proper designing of products should be there and premium should be actuarially calculated premium based on morbidity statistics. Variety of plans on regional basis, segment basis should be floated. Many new segments needs to be identified like among Group Insurance Segment, sub-segments like White collar workers, Blue Collar workers can be identified. Similarly products with investment returns like unit linked products should be launched for health insurance. Opportunities for cross-selling health insurance products along with credit card sales, home loans needs to be considered.

This research suggests a new school of thought to view the population into segments as the expectations are certainly varying among various segments. This is in contrary to the existing approach by insurance companies. This research has identified one importance segmentation viz. Existing policyholder segment, Group Insurance

Segment and 'No Policyholder' Segment. This research suggest to look for more up-selling opportunities among existing health insurance policyholder segment and Group Health insurance segment. It also suggest to sub-classify the segments and especially 'No Policyholder' segment into various clusters to analyze the characteristics of clusters and float products according to that.

Many of health insurance policies do not have any limits in claim amount with respect to hospitalisation charges, treatment charges etc. hence it happens that for even loose motion and slight fever, people tend to get admitted in hospital and claim to the tune of Rs.15000, which is totally unjustifiable. Insurance companies should immediately start imposing limits on claims under various heads. Also the option of introducing co-insurance concepts aggressively should be considered.

Insurance companies should often visit the health care centers and hospitals to inspect the services and quality of it. It has been observed by the researcher during one of the expert interviews, that some ayurvedic massage centers have registered themselves as hospitals and the policyholders were wooed to have oil massage and sauna bath but given bills as if they have received some treatment. It is sad to notice that insurance mechanism is becoming pleasure mechanism without proper controls. Such activities should be immediately curbed.

It also happens that private hospitals are provided lot of concessions by government with a view that those private hospitals will serve poorer patients at free of cost. This is done because government is not in a position to start hospitals at many areas. Hence if somebody plans to start hospitals in semi-urban and rural areas and select areas of cities. Government provides concession with a condition to private hospitals to serve poor people. But it is sad to notice that many of the private hospitals

provide treatment at free of cost of relatives of employees and other known friends but show in records that they have provided free treatment to poor. Thus, the purpose of concession by government is defeated. Such instances should be avoided in future by creating a proper control and monitoring mechanism.

The legal redressal mechanism in India with respect to health insurance and health care should be given more publicity and separate assistance cell needs to be created. This can boost the confidence of the people and also help in counterchecking the frauds in the industry.

India should aggressively plan for imposing acts similar to HIPAA in USA, though activity under the name of 'Health Unite Framework' has already started with the collaboration of Apollo Group, more publicity needs to be given with respect to the functions of this working group, this can help in inviting more suggestions from people from various walks of life thus helping to make it feasible. This research suggest that, government should first creating a health data base with minimal fields and should give a identification number. As and when a person comes for treatment to either public or private hospital, his record should be updated with the required fields. As collecting all the information about a person will take long time, it is better to start with minimal information and then updating it. This information should be portable, this can be worked out in the similar lines of how election commission issued voter identity card in India.

Suggestions are provided earlier in this chapter, regarding the idea for new products. Insurance companies should form common data base which can be shared with all insurance companies to check the credibility and insurability of persons applying for health insurance. Insurance companies should also plan their promotional

strategies varying across places and segments meeting the expectations of the people falling under particular segment and place. Training to agents should be enhanced and it should also be treated as promotion oriented activity.

Life Insurance companies should advise the policyholders purchasing critical illness riders to purchase health insurance coverages also. They should clearly indicate the need for taking separate health insurance policy. Such cross-selling network should be enabled.

IRDA and Insurance companies should try to introduce various types of new distribution channels so that almost all the people of the country have maximum probability of meeting at least a distribution channel member. This research has suggested various new types of distribution channels.

India needs to maintain two indices, one on Overall Medical consumer index and the other on Health Insurance Consumer Index (which can also be at the level of each company). This paper suggests having base year as 2000 (a year after liberalisation) for Health Insurance Consumer index. The base of premium can be the risk premium rates of 2000. This should be mapped with the components of health care sector which form part of premium rates viz. Doctor Fees, Cost of Medicines etc. This Index should be compared with Overall Medical Consumer index to find the difference of how much the consumption varies. Detailed analysis is beyond the scope of this research.

More importantly the increase or decrease of index should be publicised often to the public thereby indicating the increase of treatment cost in the country. Analysis of how such treatment cost can affect their lifetime earnings should be published often.

In the interest of keeping the index at favourable level, it can create a set of whistle blowers in the system against malpractices

Usage of technology can be focused on the following areas of health insurance, which can help to fix limits, reduce administrative expenses. The following dimensions are visualised in this research

Enhanced Networking: Enabling proper network connectivity between the stakeholders, especially between Hospitals, TPA's and Insurance Companies for quicker processing of cashless claims.

Implementation of core systems: Hospitals should be upgraded with Hospital Management Systems and all the treatments and documentation should have ICD codes.

Insurance companies should implement core systems with rules engine for underwriting and claims.

Common Portals: Common Database depicting the negative list of customers should be initiated in the first phase. Such negative list should also have data from Employers (referring their blacklisted candidates), Financial institutions like Housing Finance companies, Banks etc. Later this can be expanded in terms of credibility and insurability. Search Access should be enabled for all the insurance and TPAs to search for any customer who is already negative listed.

Data Warehousing and Data Mining techniques: Health Insurance involves complex underwriting rules and based on the claims pattern, the rules has to be changed often and also implemented immediately. Data warehousing and Data Mining techniques can help the insurance companies to reveal the hidden secret in the

data related to need for change in underwriting rules and claims procedures. BPM (Business Process Management) components in the software application can help to implement any relevant changes immediately. Such solutions are being developed these days keeping claims leakage management in mind. Such Data Mining operations can also help the insurance companies to identify the involvement of Moral Hazard.

Important and Crucial suggestions are provided,, many suggestions in detail are provided throughout this research report. Several minor suggestions are not listed in here, due to limitation in pages and time.

In summary, Health insurance in India is still at cross roads and passing through several turns these days though it has started witnessing slow growth atleast. This explorative research has tried its level best to study various problems of the industry and has tried to solve the problem. Several models and suggestions are provided throughout this research report. Though no single suggestion or model can work in alone, a combination of few suggestions or models has the potential for great turnaround even that may be a small beginning of a giant process. But it has the capability of prevent several thousands of people fall below the Poverty line, in bringing smiles among the healthy faces of 100 millions, and of course, the Indian Economy. If some positive change happens somewhere in India based on this research report that will mark the success of this research.

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APPENDICES

"An Explorative Study on Health Insurance Industry in India"

(Data collected is meant only for Research purpose and will not be revealed to others)

Existing policy holders

Personal Details:

1. Name :
2. Address(Name of the place will be enough) :
3. Sex : Male / Female
4. Marital Status : Married / Unmarried
5. Age :
6. Occupation : Employed / Self employed / Retired / Housewife
7. Work experience : _____ Years
8. Monthly Income : Below Rs.3000/Rs.3001-5000/ Rs.5001-Rs.10000/Rs.10001 and above
9. Number of Dependants in your family : _____ Adults. _____ Children
10. Are you an Income Tax Assessee : Yes / No
11. Your approximate annual medical expenses (including for your dependants)

    Less than Rs.6000 / Between Rs.6001-Rs.12000 / Between Rs.12001-Rs.24000 / Rs.24001 and above
12. Your Existing Life Insurance Particulars

    a. How many Insurance Policies do you/your family have? :

    b. How much premium you/your family pay? Rs._____

    c. Have you purchased Critical Illness coverage as a rider so far: Yes/No

    d. Insurance Company: Public Sector companies / Private Sector companies / Both

Health Insurance Policy Details

13a. How did you come to know about this health insurance policy. (Please tick wherever applicable)

Agent / Advertisement / Friends/ Others, if any please, specify:_____

13b. Reason for taking health insurance policy. (Please tick wherever applicable)

Tax Benefit / To cover medical expenses / Savings / Others, if any, please specify_____

13c. While taking health insurance policy, were you aware about its limitations, i.e., coverage about pre-existing diseases? Yes/ No

13d. What did you decide first while taking health insurance policy: Premium / Sum assured

14. Health Insurance Policy Details
    - Insurance Company: Public Sector companies / Private Sector companies / Both
    - Sum Insured :
    - Premium paid :
    - Year taken :

15. Have you made any claims: Yes / No

If yes Please provide the details as below.

Claim year	Claim amount	Claim Status
		Accepted/ Partly Accepted/Rejected/ Pending

16. Are there instances wherein you have incurred medical expenses, but not claimed for the same? Yes / No

    If yes, Reasons for the same_____

17. Are you aware that some Big Hospitals offer health insurance schemes? Yes/No.

18. Will you be interested to join the scheme if your Resident's association/ Recreation clubs comes out with some Group Health Insurance Schemes?

Opinion about Long-Term and Single premium policies if introduced on a Test Basis

19. Will you be interested in a concept of long term policies where you can take health insurance for 5,10,20 years instead of current yearly renewable one year policy: Yes / No

20. Will you be interested in a concept of single premium policies where you will be paying a lump sum amount for some benefits of health insurance: Yes/No

Awareness about Health Insurers

21. Can you recall any advertisements related to health insurance? Yes/No.

    If Yes, Advertising Medium:_____

TPA Related:

22a. Are you aware of TPA's and Cashless hospitalization coverage? Yes/ No

22b. Do you agree with the introduction of TPA's? Yes/No

23. How do you rate the service of TPA?

    a. In Terms of providing information whenever you are in need..

       Excellent / V.Good / Good / Fair / Poor

    b. In Terms of Claims Process

       Excellent / V.Good / Good / Fair / Poor

24. Your suggestions to improve Health Insurance in India._____

"An Explorative Study on Health Insurance Industry in India"

(Data collected is for research purposes and will not be revealed to others)

No policy holders

Personal Details:

1. Name :
2. Address :

   (Name of the place will be enough)
3. Sex : Male / Female
4. Marital Status : Married / Unmarried
5. Age :
6. Occupation : Employed/Self-Employed/Retired/Housewife
7. Experience : _____ Years
8. Monthly Income : Below Rs.3000/Rs. 3001-5000/Rs.5001-Rs.10000/Rs.10000 and above
9. Number of Dependants in your family : _____ Adults. _____ Children
10. Are you an Income Tax Assessee : Yes / No
11. Your approximate Annual medical expenses (including for your dependants)

    Less than Rs.6000 / Rs.6001-Rs.12000 / 12001-24000 / 24000 & above
12. Your Existing Life Insurance Particulars
    a. How many Insurance Policies do you/your family have? :
    b. How much premium you/your family pay ? Rs._____
    c. Have you purchased Critical Illness coverage as a rider so far: Yes/No
    d. How much premium you/your family pay ? Rs._____
    e. Insurance Company: Public Sector companies / Private Sector companies / Both
13. Is there any particular reason for not having Health Insurance Policies
    - Lack of information
    - No return
    - Nobody has approached for this
    - Thought that it is not necessary for me at present
    - Others if any, please specify:_____

14.a. In case of medical emergencies, how do you plan for money/What did you do in the past?
    - From Savings
    - Borrowed money
    - Others if any, please specify:_____

14.b. At that point of time, didn't you think about health insurance? Yes/No

15.a. If you now decide to take health insurance policy, how much premium would you like to pay per annum:

    Rs._____

15.b. Coverage amount you would like to take. Rs.____

15.c. Any specific reasons for fixing the above amount, please specify_____

16. If you are willing to take insurance policy, which mode will you prefer most to buy policies? (√)
    Big Hospitals / Agents / Banks / Directly from the company / Others, if any, please specify:_____
17. Are you aware that some Big Hospitals offer health insurance schemes? Yes/No.
18. Will you be interested to join the scheme if your Resident's association/ Recreation clubs comes out with some Group Health Insurance Schemes?

Opinion about Long-Term and Single premium policies if introduced on a Test Basis

19. Will you be interested in a concept of long term policies where you can take health insurance for 5,10,20 years instead of current yearly renewable one year policy : Yes / No
20. Will you be interested in a concept of single premium policies where you will be paying a lump sum amount for some benefits of health insurance : Yes/No

Awareness about Health Insurers

21. Can you recall any advertisements related to health insurance? Yes/No.
    If Yes, Advertising Medium:_____

TPA Related:

22a. Are you aware of TPA's and Cashless hospitalization coverage? Yes/ No

22b. Do you agree with the introduction of TPA's? Yes/No

23. Your suggestions to improve Health Insurance in India.

Group Insurance Related :

16. Have you made any claims, If yes Please provide the details as below.

Claim year	Claim amount	Claimant	Claim Status
		Self / Spouse /children/ Parents	Accepted/ Partly Accepted/Rejected/ Pending

17. How you rate the services of Group Insurance Schemes? (Provided by the Insurer)

Poor / Fair / Good / Very Good / Excellent

18.a. If you retire/resign from your current job, whether you will continue the policy individually: Yes/No.

18.b. If Yes, Are you aware of the rules? Yes/No

19. Are you aware that some Big Private Hospitals offer health insurance schemes? Yes/No.

20. Will you be interested to join the scheme if your Resident's association/ Recreation clubs comes out with some Group Health Insurance Schemes? Yes/No

Opinion about Long-Term and Single premium policies if introduced on a Test Basis

21.Will you be interested in a concept of long term policies where you can take health insurance for 5,10,20 years instead of current yearly renewable one year policy : Yes / No

22. Will you be interested in a concept of single premium policies where you will be paying a lump sum amount for some benefits of health insurance : Yes/No

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24a. Are you aware of TPA's and Cashless hospitalization coverage? Yes/ No

24b. Do you agree with the introduction of TPA's? Yes/No

25. How do you rate the service of TPA?

a. In Terms of providing information whenever you are in need..

Excellent / V.Good / Good / Fair / Poor

b. In Terms of Claims Process

Excellent / V.Good / Good / Fair / Poor

26. Your suggestions to improve Health Insurance in India. _____