CHAPTER 1

INTRODUCTION

The changing face of insurance sector because of its opening up has been a landmark event in India’s economic history. Gone are the days of the domination of the L.I.C. and G.I.C. when ordinary citizens had to work according to their whims and fancies. Over the past few years the traditional notion of insurance has been turned on its head. Today insurance offers complete solutions to create wealth, protect health and insure life. Added to this, the profile of Indian consumer is changing. Today, while boundaries between various financial products are getting blurred, people are increasingly looking not just at the products but also at integrated financial solutions that can offer them stability of returns along with total protection. The market is already seeing a rise in number of private players bringing with them hopes of wider options and efficient service.

From being encased in a monopoly run from the nationalisation days beginning 1956, the insurance industry has indeed woken up to a deregulated environment with the insurance space now being populated by several players in partnership with multinational giants.

1.1(i) THE CONCEPTUAL FRAMEWORK

There is no single definition of insurance. Insurance can be defined from the viewpoint of several disciplines including law, economics, history, actuarial science, risk theory and sociology. But each possible definition will not be examined at this point. Instead, those common elements that are typically present in any insurance plan will be examined.

American Risk and Insurance Association define Insurance as: “Insurance is the pooling of fortuitous losses by transfer of such risk to insurers, who agree to indemnify insured of such losses, to provide other pecuniary benefits on their occurrence, or to render services connected with the risk.”

Pooling is the spreading of losses incurred by the few over the entire group, so that in the process, average loss is substituted for actual loss. Thus pooling implies sharing of losses by the entire group, and prediction of future losses with some accuracy based on the law of large numbers.
A second characteristic of the insurance is payment of fortuitous losses. A fortuitous loss is one that is unforeseen and unexpected and occurs as a result of chance. Risk transfer is another essential element of insurance. It means that a pure risk is transferred from the insured to the insurer, who typically is in a stronger financial position to pay the loss than the insured. A final characteristic of insurance is indemnification for losses; it means that the insured is restored to his or her approximate financial position prior to the occurrence of loss.

Insurance is the potential financial instrument conferring multiple benefits for the individuals or corporate participating in it, for the financial markets pooling the resultant fund and for the society at large. For the individual it is both a saving device and a device for protecting life against illness, injury and death. Both for individuals and corporate, insurance provides for risks against destruction of assets, due to naturals calamities or thefts. For the financial markets, the insurance sector provides sizable amounts of accumulated insurance funds for primary as well as secondary market transactions. Unlike, other financial institutions, the insurance sector provides almost the entire part of its fund as long-term sources for investment in infrastructure and other products. For the society at large, it provides an endeavouring answer to most delicate question of social security for its populous with the help of the latter’s on savings, thus serving as an instrument of domestic saving as well protection against unforeseen events.

1.1(ii) CATEGORIES OF INSURANCE

The insurance business has been traditionally divided into life insurance and non-life insurance or general insurance.

1) Life insurance: The insurance business that covers life and confers benefits on a person’s death (natural or accidental) is usually called life insurance. There are varieties of life insurance policies like whole life assurance, endowment assurance, term assurance, and life annuity and pension plan. There are now life group insurance plans which insurance companies confer on group of employees belonging to specific companies or institutions. In the U.S., health insurance is classified as life insurance but in India it is classified as non-life insurance.

2) General Insurance: As per the Insurance Act 1938, the general insurance industry in India has been classified into three major insurance categories (1) Fire Insurance (2) Marine
Insurance, and (3) Misc. Insurance like motor insurance, theft, money, health, engineering, personal accident insurance etc.

3) Direct Insurance and Re-insurance: Direct Insurance: An insurance contract in which the insurer agrees to pay the insured for a designated loss. Insurance sold to the public and to known insurance businesses is classified as direct insurance.

Re-insurance: It is the process of insurance companies insuring under-written policies with other institutions in order to offset exposure. Insurance companies, to reduce outright risks associated with under-written risks by spreading risks across alternative institution, use this procedure. It's like buying an insurance policy for an existing insurance policy.

1.1(iii) ANNALS AND EVOLUTION OF INSURANCE IN INDIA

There has always been some form of insurance in India, though of an informal nature. The formal insurance business as we know it today in both life as well as non-life sector, was introduced in India by the British in the 19th century.

LIFE INSURANCE: In 1818, a British firm called the Oriental life Insurance Company was formed in Calcutta. The establishment of the Bombay Life Assurance Company in 1823 in Bombay, the Madras Equitable Life Insurance Society in 1829 and the Oriental Government Security Life Assurance Company in 1874 followed this. The Bombay Mutual Life Assurance Society, formed in 1871, was the first Indian Insurer charging normal rates for Indian lives (which were treated as substandard and attracted extra premium of 15% to 20%).

Even though the first life insurance company was established in as early as 1818, there was no exclusive legislation to govern the activities of insurance companies during the 19th century. The Indian Companies Act 1866 regulated all companies including the Insurance companies. There were no specific regulations for the life insurance business until 1912, when it came to be formally regulated under the provisions of The Indian Life Assurance Companies Act, 1912.

The ten years period 1929-1938 witnessed the establishment of as many as 172 companies and also witnessed liquidation of 61 of them, almost all of them even before a valuation was performed. This spate of liquidation resulted in the introduction of a comprehensive bill in
1937 for controlling life and general insurance business, and soon this bill resulted in Insurance Act, 1938 (1 A 1938). Some important features of the act are:

- Compulsory registration of Insurance Companies
- Control of investment of funds
- Prohibition of rebates, and
- Filing of policy condition and premium rates duly certified by an actuary (in the case of life business).

However, the introduction of this comprehensive legislation did not prevent proliferation of new companies and failures. In April 1945, committee under the chairmanship of Sir Cowasji Jehangir was appointed to enquire into the undesirable development and to suggest the suitable remedial measures. On the basis of the recommendations of this committee, a bill was introduced in 1950 and passed in the same year as the Insurance (Amendment) Act, 1950. The salient features of this act were:

- Minimum capital requirement
- Stricter control on investments and submission of periodical returns on investments
- Ceiling on expenses of management and agency commission, and
- Appointment of administrators for mismanaged companies.

During the 10-year period 1945-1954 around 533-valuation reports were submitted to the Controller of Insurance. Of these, 86 valuations showed a deficit, which was not covered by the free paid up capital; around 25 insurers went into liquidation and an equal number had to transfer their business to other companies. By 1956, 154 Indian Insurer, 16 Non-Indian Insurer and 75 Provident Insurance Societies were carrying on life insurance business in India. The persistent problem of insolvency of life insurers continued and in due course led to the nationalisation of insurance business in India. Life Insurance Corporation of India (L.I.C.) was incorporated, by the act of parliament (L.I.C. Act 1956) with the capital contribution of Rs. 5 Crores by the government.

On 19th January 1956, the management of the entire Life Insurance business of 229 Indian insurers, 16 Foreign Insurance Companies then operating in India and Provident Insurance
societies, was taken over by the central government and then nationalised into L.I.C. of India. The reasons behind nationalisation were:

❖ The geographical spread and the number of lives covered by private insurers were small. Their business was confined mainly to cities and the more affluent segments of society.

❖ A number of malpractices occurred in the industry causing loss to the unsuspecting public. Business houses, which promoted these companies, were diverting large funds for their other concerns. There were instances of mismanagement and misutilisation of funds collected.

❖ The government’s efforts at regulating the industry through various legislative measures were not very effective.

Another justification for nationalisation was to raise the much-needed funds for rapid industrialisation and self-reliance in heavy industries especially since the country had chosen the path of state planning for development. Insurance provided the means to mobilise household savings for the development of the country. Thus, L.I.C. came into being with a stated mission of mobilising saving for the development of the country and also conducting the business in the spirit of trusteeship and providing protection to the people in every part of the country.

GENERAL INSURANCE: General insurance appear to have developed with the industrial revolution in the West and consequent growth of foreign trade and commerce in the seventeenth century. Like life insurance, general insurance also came to India from UK with the establishment of the first general insurance company, Triton Insurance Company Limited, in the year 1850 in Calcutta. Later on in the year 1907, the first insurance company to be set­up by Indians for transacting all classes of general insurance business Indian Mercantile Insurance Company Limited was established.

In 1957, the 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 general insurance industry. Further, in order to increase retention of general insurance business in India, the insurer started a reinsurance company, viz. India Reinsurance Corporation limited in 1965, to which all general insurance companies voluntarily ceded 10% of their gross direct business.
In 1968 the Insurance Act was amended again to regulate investments and set minimum solvency margins, thus providing extension of social control over insurers transacting general insurance business. As also, a Tariff Advisory Committee was set up.

However, before the general insurance companies could be effectively controlled under the new law, the management of non-life insurers was taken over by the central government in 1971 as a prelude to nationalisation. The general Insurance Business (Nationalisation Act, 1972) nationalised the general insurance business in India. General Insurance Corporation (GIC) and its four subsidiaries thus came into being from 1st January 1973. GIC has been acting as the Indian reinsurer since then. The GOI subscribed to the capital of GIC while GIC subscribed to the capital of the four companies.

In 1973 the erstwhile 107 Indian and foreign insurers which were operating in the country prior to the nationalisation, were grouped into the four operating companies, namely,

- National Insurance Company Limited;
- New India Assurance Company Limited;
- Oriental Insurance Company Limited and
- United India Insurance Company Limited.

All the above four subsidiaries of GIC operate all over the country competing with one another and underwriting various classes of general insurance business except for the aviation insurance of national airlines and crop insurance both of which are handled by the GIC. GIC has been acting as the Indian reinsurer since then. 3

1.1(iv) GROWTH AND DEVELOPMENT OF LIC AND GIC, PRIOR TO LIBERALISATION

The main business of LIC is classified into two categories: Individual insurance and Group schemes. Since nationalisation, LIC developed a vast network of branches and expanded its business. Over the period of 32 years from 1956 to 1988, LIC made rapid progress in both the categories. The new business for the year 1987-88 for Individual insurance was around Rs.
12,800 crore compared to Rs. 278 crore in 1957, the first year of nationalisation. The total business in force for individual insurance as on 31st march 1987 stood at Rs. 48,151 crore for 298.6 lakh policies. Under Group schemes also LIC had made good progress. The life fund stood at Rs. 14,502 crore as on 31st march 1987 and the accretion for the year was Rs. 1837 crore. The reversionary bonuses declared were Rs. 72.50 per thousand sum assured per annum for whole life policies and Rs. 58 for endowment policies. The government share of surplus was around Rs. 39.34 crore. The tax paid by the LIC during the year 1986-87 was around Rs. 69.12 crore.

The total new business of the corporation in the form of sum assured during 1998-99 was Rs. 75,316 crore for 148.43 lakh policies. LIC’s Group insurance business up to 31st march 1999 was Rs. 66,085 crore (provisional) providing cover to 219 lakh people. (Source: LIC Annual Reports of respective years)

In 1973, the first year of nationalisation of general insurance, the gross direct premium was around Rs. 184 crore. Over the period of 14 years from 1973 to 1987, GIC and its four subsidiaries made immense progress and the premium income for 1987 was around Rs. 1,535 crore. The investment income of general insurance rose from Rs. 20 crore in 1973 to Rs. 289 crore in 1986, and the profit before tax from Rs. 35 crore to Rs. 318 crore. From 799 offices in 1973, the network grew to around 3000 offices with a workforce close to 60,000 employees. The expansion of offices continued and at the end of March 1998, the network of offices stood at 4,208. (Source: GIC Annual reports)

The insurance industry in India was nationalised in 1956. Before that, there were only rules relating to specification of minimum equity capital requirements for life insurance companies, stricter control over their investments, submission of periodical returns, appointment of administrators for mismanaged companies and ceilings on expenses on management and agency commissions.

Nationalisation brought in more structured form to the industry. The insurance business of the various domestic and foreign companies was first brought under the central government and then nationalised under the Life Insurance Corporation Act 1956. Also there is the Insurance Division that keeps a close watch on the working of Vigilance machinery in LIC, GIC and its subsidiaries. But still there were concerns of:
❖ Relatively low spread of insurance in the country. India is a low income developing economy whose domestic saving potential in long term asset is not as high as that of developed economies. To spread the habit of insurance we need many more companies selling it.

❖ The inefficient functioning of the public sector insurance companies. The general perception about PSUs was that they are inefficient places where nothing is actually got done. With a history like that nobody wants to take a policy from a public sector company.

❖ The untapped potential for mobilising long term contractual savings funds for infrastructure. The Indian population represent a huge untapped potential for insurance companies. Potential for growth is huge in the Indian insurance industry. The middle-income segment of the Indian population, which is a gold mine for prospective insurance seller, is 312 million strong. Against this, LIC serves less than 100 million policies. Only 65 million Indians have been introduced to insurance. All these figures work out to an average of 1.5 policies per person.

1.1(v) OPENING UP OF THE INSURANCE SECTOR

While effecting the reforms in the banking sector and capital markets during the early 1990s, the GOI also recognised the importance of insurance as an important element of the overall financial system where it was necessary to undertake similar reform measures. Almost 300 million people in the country can afford to buy life insurance but of this only 20 % have an insurance cover, which suggests that there is a huge chunk of the population yet to be tapped. The industry has lot of potential and needs to be competitive and market driven. It was perceived that entry of private players would lead to better competition in Indian insurance sector. A truly competitive industry will introduce new products and achieve low premiums and better services. In 1993, R.N. Malhotra Committee was formed to evaluate the Indian insurance industry and recommend its future direction. The 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.
In 1994, the committee submitted the report and some of the key recommendations included:

1. **Structure:**
   - Government stake in the insurance companies to be brought down to 50%.
   - Government should take over the holdings of GIC and its subsidiaries so that these subsidiaries can act as independent corporations.
   - All the insurance companies should be given greater freedom to operate.

2. **Competition:**
   - Private companies with a minimum paid up capital of Rs. 100 crore should be allowed to enter the industry.
   - No company should deal in both life and general insurance through single entity.
   - Foreign companies may be allowed to enter the industry in collaboration with the domestic companies.
   - Postal life insurance should be allowed to operate in the rural market.

3. **Regulatory Body:**
   - The insurance Act should be changed.
   - An insurance regulatory body should be set up.
   - Controller of insurance (Currently a division from the finance ministry) should be made independent.

4. **Investments:**
   - Mandatory investment of LIC Life fund in government securities to be reduced from 75% to 50%.
   - GIC and its subsidiaries are not to hold more that 5% in any company (their current holdings to be brought down to this level over a period of time).

5. **Customer Service:**
   - LIC should pay interest on delays in payments beyond 30 days.
Insurance companies must be encouraged to set up unit linked pension plans.

Computerisation of operations and updating of technology to be carried out in the insurance industry.

The committee emphasized that in order to improve the customer services and increase the coverage of the insurance industry it should be opened up to competition. But at the same time committee felt the need to exercise caution as any failure on the part of new players could ruin the public confidence in the industry. Hence, it was decided to allow competition in a limited way by stipulating the minimum capital requirement of Rs. 100 crore. The committee felt the need to provide greater autonomy to insurance companies in order to improve their performance and enable them to act as independent companies with economic motives. For this purpose it has proposed setting up an independent regulatory body.

1.1(vi) THE INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

The next significant event was the passage of the Insurance Regulatory and Development Authority (IRDA) Act (passed in parliament in December 1999) which opened up the insurance sector to the private players. The Act provides for the establishment of the statutory IRDA to protect the interest of the insurance policy holders and to regulate, promote and ensure orderly growth of the insurance industry.

As per the IRDA Act, to establish a new insurance company for conducting insurance business, it should satisfy the following conditions:

- The aggregate holding of equity shares by foreign company, either by itself or through its subsidiary companies or its nominees, should not exceed 26% paid up equity capital of the Indian insurance company;
- Its sole purpose must be to carry on the life insurance business or general insurance business or reinsurance business;
- It must be formed and registered under the Companies Act, 1956;
- The company has a paid up equity capital of Rs. 100 crore and
- For carrying on the reinsurance business, the company must have the minimum paid up equity capital of Rs. 200 crore.
The Reserve Bank of India (RBI) has also issued guidelines for banks’ entry into the insurance business. For banks, prior approval of the RBI is required to enter into the insurance business. The RBI would give permission to the banks on a case-by-case basis, keeping in view all relevant factors, like banks having minimum net worth of Rs. 500 crore and satisfying other criteria in respect of capital adequacy, profitability and non-performing assets.

The Insurance Regulatory and Development Authority (IRDA) is the apex authority in India for the regulation of Insurance business. Through IRDA Act 1999, the apex institution controls the insurance and reinsurance companies in India. The main duties, powers and functions of IRDA are mentioned in section 14 of IRDA Act, 1999. Some of the main duties are:

- Issuing a certificate of registration, renew, modify, withdraw, suspend or cancel such registration to the applicant;
- Protecting the interests of the policy holders in terms of assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;
- Specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
- Specifying the code of conduct for surveyors and loss assessors;
- Promoting efficiency in the conduct of insurance business;
- Promoting and regulating professional organizations connected with the insurance and re-insurance business;
- Levying fees and other charges for carrying out the purposes of the Act;
- Calling for information from undertakings, inspection or, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermediaries and other organizations connected with the insurance business;
Control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business not so controlled and regulated by the Tariff Advisory Committee under section 64U of the Insurance Act, 1938 (4 of 1938);

Specifying the form and manner in which books of account maintained and statement of accounts rendered by insurers and other insurance intermediaries;

Regulating investment of funds by insurance companies;

Regulating maintenance of margin of solvency;

Adjudication of disputes between insurers and insurance intermediaries;

Supervising the functioning of the Tariff Advisory Committee;

Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations referred to in clause (f) of the IRDA Act

Specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector.

The powers conferred on the IRDA enable it to specify requisite qualifications for intermediaries and agents; to specify the code of conduct for the surveyors and loss assessors; to levy appropriate fees for carrying out this business; to call for information from and conduct inspection or inquiries of organizations connected with insurance business, etc. The IRDA also have powers to control and regulate rates, advantages, etc., in respect of the general insurance business where it is not so controlled or regulated by the TAC; to regulate the investment of funds by the insurance companies; to regulate the maintenance of the solvency margins and to supervise the functioning of the TAC.

The authority also has substantial powers to deal with the cases of non-compliance with the directions issued by the IRDA from time to time, or with the provisions of the Act. It is authorised not only to levy heavy penalties, but can also cancel the registration of the insurers in case of serious offences.

Thus, the rules and regulations formulated by IRDA will help the insurance industry progress further with good infrastructure facilities.
1.1(vii) MARKET STRUCTURE FOLLOWING LIBERALISATION

Following the passage of IRDA Act, private players were allowed into the insurance business in 2000. The Indian insurance sector is experiencing cosmic changes with the entry of new entities after liberalisation. At the end of September 2009 there are 22 life insurance and 21 (list of private and public, life and non-life insurance companies is given in Annexure III) non-life insurance companies operating in private sector competing with LIC and GIC and its four subsidiaries. Analyst found that the private insurance players have established their own identities in the Indian market in a short period of time. India has the world’s top companies like AIG, New York Life, ING, Lombard, Aviva, Ergo, MetLife, etc., competing in the same market. The private sector players have seen 200% growth in the second year of liberalisation. This has doubled their share from 3-4% in the first year itself. The current annual growth in the average insurance premium in India has been 8.2% compared with the global average of 3-4%.4

The year 2000 was a landmark in the history of Indian Insurance Industry. The industry was thrown open for the private players. Detariffication from January 1, 2007 will totally change the complexion of non-life industry. Increase in the FDI ceiling from 26% to 49% adds to this interest.

1.1(viii) HEALTH INSURANCE

Health insurance is a method to finance healthcare. The I.L.O. defines health insurance as "the reduction or elimination of the uncertain risk of loss for the individual or household by combining a large number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (I.L.O., 1996). To put it more simply, in a health insurance programme, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g. hospitalisation).

The essentials in a health insurance programme are prepayment and risk pooling. The main advantage of a health insurance programme is that of prepayment. Individuals or families pay when they are healthy and are able to pay. However, when they are affected by illness, the
insurance fund can be used to finance their healthcare needs. Thus there is no burden at the time of illness.

Yet another essential is that of risk pooling. There are three types of risk pooling:

- **Between sick and the healthy:** When a group contributes towards a health insurance fund, it is not clear who will fall sick. While most will remain healthy, some will fall sick. However, the funds from all the contributors are used to finance treatment of the sick.

- **Between the rich and the poor:** A group of people, who contribute towards an insurance fund, should ideally belong to different socio-economic strata. So the rich, by paying more, will cross-subsidize the poor.

- **Between the active and inactive:** While it is usually the employed that contribute, their contribution should be used to finance their own healthcare as well as that of children and the elderly.

Health insurance functions when there are large numbers enrolled. This is because with large numbers, the chances of adverse events are reduced and so is the outflow from the insurance fund.

There are some important values in health insurance – an important one is that of solidarity. A successful health insurance programme requires people to contribute, knowing fully well that their contribution may not help them directly, but will help others who require the support. Without this value, a health insurance programme is doomed to fail as people will insist on withdrawing at least their contributions from the fund. This will destroy the concept of health insurance and will result in bankruptcy of the programme.

Yet another value, rarely talked about is one of equity. A health insurance programme should ideally promote both horizontal equity and vertical equity. This promotes cross-subsidy between equals and also between unequal.

A health insurance programme usually has two main functions (Kutzin):

1. To increase the access to healthcare.

2. To protect household from high medical expenses at the time of illness.
The basic elements in a health insurance programme are shown in the figure 1. A health insurance programme requires an insurer who takes the risk and organises the health insurance programme. There should be a community that will pay the premium and enrol into the health insurance programme. And finally, patients in the community need to avail of services of healthcare providers (Doctors/Hospitals) when they fall sick. The insurer should organise to pay the providers for the service rendered. Other than these six core element, there are three subsidiary elements – that of administering the programme, that of managing the risk, and finally of ensuring quality both in the healthcare as well in the health insurance programme. It is essential that these nine elements should be in a place for a health insurance programme to be successful.

There are some risks that are peculiar to health insurance:

- **Adverse selection** – Normally we expect that both the healthy and sick would enrol in a health insurance programme. However, if poorly designed, there is a chance that the sick will enrol in larger numbers as compared to the healthy. Thus the programme becomes unviable as the outflow exceeds the inflow.
Cream skimming (risk selection) – This is the opposite of adverse selection and occurs when insurance companies selectively choose low risk individuals and reject the high-risk individuals.

Moral hazards – This takes place when the fact of being insured changes the behaviour of the patient or the provider. There are two types of moral hazards. In the supply side moral hazards, we find that the provider tends to intervene unnecessarily or charge higher bills for an insured patient. In the demand side moral hazard, the patient tends to demand more care, or indulges in risky behaviour, because of the insurance status.

There are broadly three types of health insurances:

- **Social health insurance**: A compulsory health insurance, usually for the formal sector. Here the employee contributes through payroll deduction and the employers provide a grant. This is used to finance healthcare of the employees, their dependants and, as in many European countries, the rest of the population. There are two mandatory and contributory health insurance schemes in India – the CGHS for the government of India's civil servants and the ESIS for the low paid industrial workers.

- **Private health insurance**: A voluntary health insurance wherein people can enrol and purchase the insurance of their liking, paying a risk rated premium, e.g. mediclaim.

- **Community health insurance**: It is defined as any not for profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risk. This definition includes mutual health organisations (NHO), local health insurances and micro health insurances.

1.1(ix) GLOBAL INSURANCE INDUSTRY

In 2006, the global insurance premiums increased to USD3,723.4 billion, where USD1,514.09 billion was attributable to non-life and USD2,209.32 billion to life business. The total premium volume grew by 5% in 2006 with life premiums increasing by 7.7% and non-life premiums by 1.5%. The Macroeconomic environment in 2007 across the globe is characterised by marginally slower economic growth and rising inflation driven by steep
increase in food and energy prices. Key interest rates diverged, but were generally low. Though strong at the end of 2007, stock markets fell in early 2008. In this backdrop worldwide insurance premium amounted to US Dollar 4061 billion in 2007 as against US dollar 3723 billion in 2006. Of the total premium, life insurance premium amounted to US Dollar 2393 billion and the remaining US Dollar 1668 billion by general insurance business. The premiums are shown in Table 1.1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-Life Insurance</th>
<th>Life Insurance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-05</td>
<td>1,397.52</td>
<td>1,866.64</td>
<td>3,264.16</td>
</tr>
<tr>
<td>2005-06</td>
<td>1,442.26</td>
<td>2,003.56</td>
<td>3,445.82</td>
</tr>
<tr>
<td>2006-07</td>
<td>1,514.09</td>
<td>2,209.32</td>
<td>3,723.40</td>
</tr>
<tr>
<td>2007-08</td>
<td>1,668.00</td>
<td>2,393.00</td>
<td>4,061.00</td>
</tr>
</tbody>
</table>

Source: IRDA Annual Report 2007-08

In emerging markets, strong economic development and introduction of mandatory cover such as Motor Third Party Liability (MTPL) and health were the key drivers for growth. Strong underwriting discipline and absence of major catastrophe delivered profits in 2006. The non-life insurance premium from industrialized countries has increased by 0.6% in 2006 as compared to a decrease of 0.8% in 2005. At this level, the global total premium increased 3.3 percent in real terms in 2007 compared to 5.0 percent in 2006. The growth in life insurance premium was about 5.4%. While the premium grew by 4.7% in industrialized countries, it grew by 13.1% in emerging market economies (in 2007) as against 21.1% in 2006. The global non-life insurance business grew by 0.7% in 2007 as against 1.5% in 2006. (Table 1.2).
### Table 1.2: Real premiums growth in 2006 and 2007 as compared to the previous year (In %)

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Industrialized countries</td>
<td>6.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Emerging markets</td>
<td>21.1</td>
<td>10.8</td>
</tr>
<tr>
<td>Total</td>
<td>7.7</td>
<td>1.5</td>
</tr>
</tbody>
</table>

|                  |      |      |
| Life Insurance   |      |      |
| Industrialized countries | 4.7  | -0.3 |
| Emerging markets | 13.1 | 10.2 |
| Total            | 5.4  | 0.7  |

Source: IRDA Annual Report 2007-08

The industry is undergoing a phase of consolidation through M&A that totalled USD12.3 billion in 2006. Insurance companies are now shifting their attention towards the emerging markets as these remain significantly less exploited than markets in major industrialized countries. As shown in table 1.3 total premiums as percent to GDP of different countries is very less in case of emerging markets like Africa, Asia etc.

The major players in insurance include ING Group, American International Group, Allianz Insurance, Assicurazio Generali, Berkshire Hathaway, Munich Re, AXA, Aviva, Nippon Life Insurance and Zurich Financial Services. Life and non-life business are categorized in accordance with standard European Union (EU) and Organization for Economic Cooperation...
Table 1.3: Total Premiums as percent of GDP in 2006 of different countries

<table>
<thead>
<tr>
<th></th>
<th>Life Insurance</th>
<th>Non-life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>3.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Latin America and</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Caribbean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>5.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Asia</td>
<td>5.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Africa</td>
<td>3.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Oceania</td>
<td>3.4</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: Cygnus Research, Health insurance in India 2007

And Development (OECD) conventions. According to these international conventions, accident and health insurance is a part of non-life insurance, regardless of the classifications used in the individual countries.

Innovative products and distribution still remain the key areas of success. Banc assurance is gaining prominence all over. Banks’ entry as a new distribution channel would help in the growth of insurance industry. Companies are also enhancing their sales force by making use of the new distribution channels like the Internet and transforming agents into financial advisors to offer better services.

The environment for global insurance business would continue to be demanding in the years to come. Operating costs is increasing, capital remains tight and investment returns low, while a number of regulations require stronger financial reporting and controls. However,
insurance companies are outsourcing majority of their non-core activities to offshore third party entities or to their own captives in order to remain competitive and profitable.

**Insurance Industry Segments**

There are two types of insurance companies operating in the market. First one is the life insurance that includes personal life and annuity. Second is the non-life insurance that includes agriculture, automobile, casualty, health, fire and marine, liability, and worker’s compensation.

Figure 1.2: Global Insurance Industry Segments

![Global insurance industry segments](image)

Source: Cygnus Research on Health Insurance in India, 2007

In the global scenario, 59.34% of market is occupied by life insurance and remaining 40.66% is occupied by non-life insurance.

**Indian Healthcare Industry**

The Indian healthcare industry is witnessing the expansion of private corporate hospitals and a switch to newer technologies such as telemedicine and non-invasive methods of surgery. The Indian healthcare industry consists of two segments: pharmaceuticals and healthcare. The
latter comprises hospitals, medical equipment manufacturers, health insurers and educational institutions.

Market Size and Growth

The Indian healthcare industry is growing at an annual rate of 20%. The size of the industry is estimated to be INR2,527.15 billion in FY2007 with a growth of 20% compared to the estimated value of INR2,105.96 billion in FY2006.

Table 1.4 Indian Healthcare Market Size from FY 2003 to 07

<table>
<thead>
<tr>
<th>Year</th>
<th>INR bn</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-03</td>
<td>1,341.24</td>
</tr>
<tr>
<td>2003-04</td>
<td>1,545.91</td>
</tr>
<tr>
<td>2004-05</td>
<td>1,754.97</td>
</tr>
<tr>
<td>2005-06</td>
<td>2,105.96</td>
</tr>
<tr>
<td>2006-07</td>
<td>2,527.15</td>
</tr>
</tbody>
</table>

Source: Cygnus research 2007, Health Insurance in India

The public expenditure in FY2007 is expected to be 18% and private accounts (private insurance plus private out of pocket expenditure) 82% of the total healthcare expenditure (Figure 1.3) (Source: Cygnus Research 2007). The reasons behind the growth of private healthcare services include quality medical care, latest technology, better service and attractive schemes.

Figure 1.3: Pattern of Healthcare Expenditure (FY2007)
Hospitals

Hospitals are categorized into Government and Private. Due to the lack of infrastructure facilities, the government hospitals are not being accepted by the public. Some of the institutes like All India Institute of Medical Sciences (AIIMS), Nizam Institute of Medical Sciences (NIMS) and Regional Medical Colleges and Research Institutes account for the largest share of Central Government spending on health. All medical colleges collaborate with teaching hospitals, district hospitals and primary healthcare centers (PHC) in their respective states. The advanced technology in Private hospitals has made the public accept it in the urban sector. A major part of the private funds are spent on vaccines, hospitals and the welfare of pregnant women and children, which has also added advantage to the private hospitals.

Healthcare infrastructure

Post-independence, India’s healthcare infrastructure has improved dramatically. The country has been dotted with rural primary healthcare centers (PHC) from the past ninth five-year plan. The current healthcare infrastructure, however, is unable to meet the needs of growing population. According to the Organization of Pharmaceutical Producers of India (OPPI), India’s healthcare infrastructure included 262 medical colleges as on Sep 30, 2006 with an annual intake of 29,872 students in FY2006. There are 70 medical practitioners for every 100,000 population in the country in FY2006.

An extensive government healthcare infrastructure comprising 22,669 PHCs and 1.45 lakh sub-centres in semi-urban and rural areas and 3,910 community health centres were working for the welfare of Indian people up to March 31, 2007 (Table 1.5). The average rural people covered from 2001 to Mar 31, 2007 under sub centres, PHCs and CHCs were 5,121; 32,754 and 189, 895 respectively. There were 4,357 ESI doctors (as on Mar 31, 2007) working in India and 1,453 posts were vacant which need to be filled. Doctors with recognized medical qualifications have to register with state medical council in their respective states.
### Table 1.5: Public healthcare physical Infrastructure in Urban and Rural Areas of India

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical colleges</td>
<td>262*</td>
<td></td>
</tr>
<tr>
<td>ESI Doctors</td>
<td>4,357#</td>
<td></td>
</tr>
<tr>
<td>Total Rural and Urban Hospitals (including CHC)</td>
<td>7,029#</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health centers (CHC)</td>
<td>3,910#</td>
<td></td>
</tr>
<tr>
<td>Primary health centers (PHC)</td>
<td>22,669#</td>
<td></td>
</tr>
<tr>
<td>Sub-centers</td>
<td>1,44,988#</td>
<td></td>
</tr>
</tbody>
</table>

Source: India stat * As on Sep 30, 2006 #Up to Mar 31, 2007
<table>
<thead>
<tr>
<th>Year</th>
<th>2000-2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>Number: 645825, Density (per 10000 population): 6</td>
</tr>
<tr>
<td>Nursing and Midwifery personnel</td>
<td>Number: 1372059, Density (per 10000 population): 13</td>
</tr>
<tr>
<td>Dentistry personnel</td>
<td>Number: 61424, Density (per 10000 population): 1</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>Number: 50393, Density (per 10000 population): 1</td>
</tr>
<tr>
<td>Other Health Service Providers</td>
<td>Number: 1752027, Density (per 10000 population): 16</td>
</tr>
<tr>
<td>Hospital Beds (per 1000 population)</td>
<td>7</td>
</tr>
</tbody>
</table>

Disease Pattern

India is a vast country with varied climatic zones and population consisting of different races. Increased access to quality healthcare services is among the goals of social development programmes currently underway. Technological advances and extension in infrastructure network have led to a decline in mortality rate. Communicable diseases, however, continue to be the leading cause of morbidity and mortality while higher life expectancy and epidemiological transition is increasing the prevalence of non-communicable diseases. The incidence of chronic diseases such as cancer, cardiovascular, neurological and ophthalmic disease is more in urban areas. Some of the major epidemics, which are commonly seen these days, are shown in Table 1.7.

<table>
<thead>
<tr>
<th>Table 1.7: Major epidemics commonly seen these days in India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
</tr>
<tr>
<td>Dengue</td>
</tr>
<tr>
<td>Filariasis</td>
</tr>
<tr>
<td>Japanese Encephalitis</td>
</tr>
<tr>
<td>Kala-azar</td>
</tr>
<tr>
<td>Chikun Gunia</td>
</tr>
<tr>
<td>Swine flu</td>
</tr>
</tbody>
</table>

Healthcare Segments

Health tourism, telemedicine, hospital services, health service outsourcing and health insurance are the major sectors of healthcare.

a) Health Tourism

Health tourism is one of the fastest growing sub segments of Indian tourism industry. Many state governments are relaxing regulations to attract patients from other countries. Low costs;
qualified super-specialty physicians and surgeons; high-quality corporate hospitals; good
connectivity by air, train and road; and robust telecommunication facilities are attracting
patients from developing and developed countries. These patients mostly hail from member
countries of South Asian Association for Regional Cooperation, Middle East and Africa. The
number of patients arriving from the UK and the US is also increasing.

b) Telemedicine

The concept of telemedicine, though 30 years old, has gained importance in the past decade.
The utilization of information technology for medical diagnosis, treatment and patient care is
called telemedicine. It consists of customized medical software integrated with computer
hardware and medical diagnostic instruments connected to the commercial VSAT.

Although telemedicine finds use in all medical specialties, current applications are
concentrated in radiology, pathology, cardiology and medical education. The greatest impact
of telemedicine is perhaps in fulfilling its promise to improve the quality, increase the
efficiency, and expand the access of the healthcare delivery system to the rural population. It
enables a physician or specialist at one site to deliver healthcare, diagnose, provide
intraoperative assistance, therapy, or consult with another physician or paramedical personnel
at a remote site. Reports of telemedicine implementations are appearing in orthopedics,
dermatology, psychiatry, oncology, neurology, paediatrics, internal medicine, ophthalmology
and surgery. Those trends, combined with the increased availability of telecommunications
facilities, indicate that telemedicine will become more common.

c) Hospital services

Private players account for almost 78% of the healthcare delivery market. The hospital
service providers are increasing every year as healthcare market is increasing. A number of
MNCs are entering into India in the form of joint venture (JV) to capture the untapped
market. The existing players are investing large amounts in expanding. Some of the new
players like Delhi-based Apollo Tyres have plunged in with the launch of a project, Artemis
Health Institute in Gurgaon. The Paras Group has opened Paras Hospitals, a 250bed multi-
specialty tertiary care hospital in Gurgaon. The hospital is equipped with six state-of-the-art
operation theatres, 48 critical care beds, special ICUs and NICUs, sophisticated diagnostics
including a 1.5 Tesla Magnetic Resonance Imaging (MRI). Some of the new entrants during
FY2006 - FY2008 are shown in Table 1.8.
d) Health service outsourcing (BPO)

The Indian BPO industry has grown at an impressive rate in recent years, capitalizing on the success of the Indian IT industry. According to National Association of Software and Services Companies (NASSCOM), the IT-enabled services (ITES)-BPO industry in India is expanding in geographical as well as service terms. The verticals that are growing rapidly include banking, finance, insurance, telecom, healthcare and hospitality. The size of the insurance BPO market (including health), according to NASSCOM figures, was USD6.3 billion in FY2006. The same study also confirmed that banks, financial services and insurance companies in the US saved over USD6 billion between 2000 and 2004 by

<table>
<thead>
<tr>
<th>New hospital</th>
<th>Investment proposed (INR m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artemis</td>
<td>5,000</td>
</tr>
<tr>
<td>Medicity</td>
<td>6,500</td>
</tr>
<tr>
<td>Emaar MGF</td>
<td>30,000</td>
</tr>
<tr>
<td>Pacific Healthcare</td>
<td>750</td>
</tr>
<tr>
<td>Parkway Group</td>
<td>2,000</td>
</tr>
<tr>
<td>Columbia Asia</td>
<td>6,600</td>
</tr>
<tr>
<td>Prexus Health, USA</td>
<td>2,500</td>
</tr>
<tr>
<td>Paras Hospital</td>
<td>1,000</td>
</tr>
</tbody>
</table>

Source: Business Standard, September 2008
outsourcing to India. Apollo Health Street (AHS) is the global healthcare BPO service provider in India. AHS offers BPO services to US healthcare providers and payers in order to save time and money, by remotely executing non-core health information management activities such as medical transcription, coding, revenue cycle management and claims processing.

1.1(x) HEALTH INSURANCE IN INDIA

In the new economic policy of government of India, the insurance sector reforms are part of overall liberalisation process of the policy framework. The reforms, which started during late eighties and continued in nineties, the focus on insurance has been a logical extension.

Our economic system has been developed on paradigm of mixed economy in which public and private enterprises co-exist. The strategies of development were based on the premise of restrictions, regulations and control and less on incentives and market driven variables. This affected the development seriously. After the change in the paradigm in which the market driven factors are given prominent importance, the changes were obvious next step.

Deregulation, decontrol, privatisation, licensing, globalisation became the key strategies to implement the new framework and encourage competition. The reasons that prompted the government to bring changes in the insurance sector are well known. While the public sector insurance companies made enormous contributions in the spread of awareness about insurance, and the expanded market, it was recognised that their reach was still limited, the range of products offered restricted and the service to the consumers inadequate. It was also felt that the rapid economic growth witnessed in 90’s couldn’t be sustained without a thriving insurance sector. It was also recognised that India had a vast potential that is waiting to be tapped and this could be achieved when sufficient competition is generated and it is exposed to the developments in the rest of the world. The insurance sector was therefore opened up for private sector participation with provision for limited foreign equity.

The new economic policy and liberalisation process followed by the government of India has changed the face of insurance sector in the country. Health insurance, which has highly remained underdeveloped and a less significant segment of the product portfolios in the Indian market, is poised for a fundamental change in its approach and management. During the passage of Insurance regulatory authority bill in parliament, a clause was inserted which indicated that preferential treatment would be given at the time of registration of new insurers.
to those who will underwrite health insurance. The IRDA act marks an important beginning for changes having significant impact on health insurance sector.

During the last 60 years India has developed a large government health infrastructure with more than 150 medical colleges, 450 district hospitals, 3000 community health centres, 20,000 primary health care centres and 1,30,000 sub health centres. On top of this there are large number of private and NGO health facilities and practitioners scattered throughout the country. Over the past 60 years India has made considerable progress in improving health status. Adult Mortality rate has reduced from 282 in 1990 to 215 per thousand population in 2007; for males it was 306 per thousand in year 1990 which reduced to 250 in 2007, similarly in females also it reduced from a figure of 257 to 177 per thousand population in respective years (as seen in Table 1.9); infant mortality rate reduced from 82 in 1990 to 54 per thousand in 2007, life expectancy at births increased from 57 years in 1990 to 64 years in 2007; health life expectancy at birth is 56 years. However, many challenges remain and these are; life expectancy 4 years below the world average, high incidence of communicable diseases, neglect of women’s health, considerable regional variation and threat from environment degradation. It is estimated that at any given point of time 40 to 50 million people are on medication for major sickness in India. About 200 million workdays are lost annually due to sickness. Data as provided in the study Health insurance in India: Opportunities, Challenges and Concerns by Ramesh Bhat and Dileep Mavalankar (2007) indicates that about 60% people use private health providers for outpatient treatment while 60% use government providers for in-door treatment. The average expenditure for care is 2-5 times more in private sector than in public sector. The ministry of health and family welfare had a worse record in respect of healthcare. It has not been able to use Rs. 851 crore of its budget in 2005-06. The year before the unspent sum was Rs. 1159 crore. It is not the case that the government is not able to meet the targets for want of funds but the departments have surrendered huge money since they could not draw up timely plans to spend them.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Expectancy at birth (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36.0</td>
<td>53</td>
<td>57</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td>Female</td>
<td>37.4</td>
<td>55</td>
<td>57</td>
<td>62</td>
<td>65</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>36.7</td>
<td>54</td>
<td>57</td>
<td>61</td>
<td>64</td>
</tr>
<tr>
<td><strong>Healthy Life Expectancy at Birth (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>56</td>
</tr>
<tr>
<td>Female</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>57</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>56</td>
</tr>
<tr>
<td><strong>Infant Mortality Rate (probability of dying between birth and age 1 per 1000 live births)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>145</td>
<td>109</td>
<td>82</td>
<td>66</td>
<td>54</td>
</tr>
<tr>
<td>Female</td>
<td>147</td>
<td>111</td>
<td>84</td>
<td>68</td>
<td>55</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>146</td>
<td>110</td>
<td>83</td>
<td>67</td>
<td>54</td>
</tr>
<tr>
<td><strong>Under 5 mortality Rate (probability of dying by age 5 per 1000 live births)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>n.a.</td>
<td>n.a.</td>
<td>109</td>
<td>86</td>
<td>67</td>
</tr>
<tr>
<td>Female</td>
<td>n.a.</td>
<td>n.a.</td>
<td>124</td>
<td>97</td>
<td>77</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>n.a.</td>
<td>n.a.</td>
<td>117</td>
<td>91</td>
<td>72</td>
</tr>
<tr>
<td><strong>Adult Mortality rate (probability of dying between 15 and 60 years per 1000 population)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>n.a.</td>
<td>n.a.</td>
<td>306</td>
<td>289</td>
<td>250</td>
</tr>
<tr>
<td>Female</td>
<td>n.a.</td>
<td>n.a.</td>
<td>257</td>
<td>220</td>
<td>177</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>n.a.</td>
<td>n.a.</td>
<td>282</td>
<td>256</td>
<td>215</td>
</tr>
</tbody>
</table>

**Source:** World health Statistics 2009 (World Health Organisation) n.a. not available

India is the fifth largest country in terms of purchasing power parity and is considered one of the fastest emerging economies in the world. However, its heath status remains a major concern. Infant mortality rate of India is as high as 54 in 2007 while it is around 23 for China. (Complete table is given in Annexure IV). India stands at a humble 127th position in the Human Development Report 2008. The health indicators also appear to be sombre. The total health expenditure in India is at 3.6% of the Gross Domestic Product (GDP) in 2006, out of
which General Government Expenditure on Health as % of Total expenditure on health is 21.8 in 2000 which increased to 25 in 2006 (Refer Table 1.10, for complete table see Annexure V). The per capita spending on health was $86 in 2006. As compared to this, other developing countries like Brazil and Jordan in the moderate development slot spend 7.5% and 9.7% of their GDP on health. Their per capita spending on health is also higher at $674 and $435 respectively in 2006.

While the modest position on the human development front may be seen as a failure of economic planning pursued so far, it is also reminiscent of the tremendous potential for the health care industry in India. Presently, estimated at Rs. 1,500 bn, the industry is banking high on the annual income of Rs. 8,200 bn generated by 140 million upper and middle class people, which is steadily growing at a rate of 4% per annum. In addition to this domestic potential, opportunities in health care tourism presently at Rs.1.5bn and growing at a whopping 30% annually, augurs well for the healthcare industry.

The scenario for the health insurance also appears to be upbeat. As the health insurance product has been in operation in the Indian market for the last 18 years, one would have expected a significant presence of health insurance in the Indian healthcare industry, particularly when over 2-3rd of the total health spending is done out of people’s pockets. The statistics available as of now however, are far from encouraging. As we can see from the Table 1.10 General government expenditure on health as % of Total expenditure on health was 25% in 2006 while private expenditure on health was 75%. Out-of-pocket expenditure as % of private expenditure on health is 91.4%. Health insurance constitutes only 1.2% of the total spending on health. This signifies an enormous potential for health insurance even at the current size of the healthcare industry.

With just 10.8 million people covered under health insurance, 95% of the insurable population of 240 million is still waiting to be insured. Going by this, the premium potential for health insurance at existing rates is an unbelievable Rs. 345 bn against the current level of Rs. 17.32 bn. This is double the current general insurance market of Rs. 170 bn.8
Table 1.10: Health Expenditure in India in the FY 2000 and 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenditure on Health as % of Gross Domestic Product</td>
<td>4.3</td>
<td>3.6</td>
</tr>
<tr>
<td>General Government Expenditure on Health as % of Total Expenditure on Health</td>
<td>21.8</td>
<td>25.0</td>
</tr>
<tr>
<td>Private Expenditure on Health as % of Total Expenditure on Health</td>
<td>78.2</td>
<td>75.0</td>
</tr>
<tr>
<td>General Government Expenditure on Health as % of Total Government Expenditure</td>
<td>3.3</td>
<td>3.4</td>
</tr>
<tr>
<td>External Resources for Health as % of Total Expenditure on Health</td>
<td>0.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Social Security Expenditure on Health as % of General Government Expenditure on Health</td>
<td>5.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Out-of-Pocket Expenditure as % of Private Expenditure on Health</td>
<td>92.1</td>
<td>91.4</td>
</tr>
<tr>
<td>Private Prepaid Plans % of Private Expenditure on Health</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Per capita Total Expenditure on Health at Average Exchange Rate (US$)</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Per capita Total Expenditure on Health (PPP int. $)</td>
<td>63</td>
<td>86</td>
</tr>
<tr>
<td>Per capita Government Expenditure on Health at Average Exchange Rate (US$)</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Per capita Government Expenditure on Health (PPP int $)</td>
<td>14</td>
<td>22</td>
</tr>
</tbody>
</table>


Insurance sector in India is small but growing at very big pace. The insurance companies in general have experienced a significant growth during last decade in India. The impetus for this growth came from new economic policies and liberalisation of insurance sector. There are 21 general insurance companies in India and out of which 19 are offering health insurance products. However, given the complexities of health insurance, only few companies have ventured into offering health insurance products. In health insurance, 27 third party administrators (TPAs) function as intermediaries in this sector. It is estimated that
there are 11.2 million health insurance policyholders out of whom almost 87% have bought Mediclaim policies from four public sector general insurance companies. Total premium collected by these four companies was around 11.29 bn. The claim ratio of the insurers offering health insurance products has been rising over the years and it was 96% during 2003-04.9

Notwithstanding these mind-boggling statistics, the evolution of health insurance over the last two decades has been laggard, to say the least. Although health insurance has grown at an exciting rate of 28% in 2004-05, which is more than double the industry growth rate, its small base hardly adds up to a respectable figure in relation to the mammoth potential. Even today, the health insurance constitutes a paltry 10% of the total industry revenue and has not kept pace with the expansion of the healthcare industry on the whole. Despite insurance being the buzzword of the decade and the top corporates jumping on bandwagon health insurance, it has not assumed the adequate exposure in India. Health being one of the largest industries in the world, with global turnover of 2.75 trillion USD,10 its negligence in India is quite disappointing.

Thus there is a need to study the reasons behind such a dismal performance in the field of health insurance and find the factors that affect the demand of health insurance in India. What are the factors responsible for affecting the insurance purchase decision? What are the changes to be brought about to improve the functioning of the healthcare sector? What are the measures to be taken up to allure the corporate to take up the health insurance? How much effect the change in the insurance sector has had on the health insurance? Finally an analysis of the future prospects of health insurance in a country with an expected middle class of 500 million consumers in the next few years needs to be done.

Hence, the researcher presents a comprehensive study on “Changing face of the Insurance sector with special reference to Health Insurance” that throws light on the problems being faced by insurance sector which led to its liberalisation and how it will make an impact on the neglected part of insurance in India i.e. health insurance.
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