Chapter 3

Health Insurance Marketing in India- An Overview

3.1. Introduction

The present research work attempts to investigate the various aspects of health insurance marketing. Therefore it is quite relevant to examine a theoretical framework of the different areas of health insurance marketing in India and Kerala in particular. This has been attempted in this chapter.

The Indian healthcare Industry is estimated to grow to $240 billion by 2019, up from $79 billion in 2012. With over 69 Percent of ‘out-of-pocket’ expense burden on the customers, the market is ripe for health insurance entities including international players. The industry is likely to undergo major changes in the future. Whichever model evolves from time to time, it is clear that the entire healthcare financing and delivery system is poised for a major change. The way change happens depends upon the academic and industrial debates and deliberations taking place in the different contexts. This work is an attempt in this direction.

Since India’s independence in August 1947, the public sector has been the strength of the healthcare ecosystem, including healthcare delivery and financing. The term “insurance” is primarily connected with life insurance – the most popular form of insurance in the world. There are a couple of reasons for this basically, with low life expectancy and a water tight family structure, people primarily expects financial security. Second, life insurance has been traditionally positioned as a tax-planning tool. India presently faces a serious issue of having to deal with a substantial burden of both infectious and
chronic ailments, and of medical care being available only to a small section of the population.

The economic system in India has adopted a mixed economic policy since its independence where the private and public sector co exists. The same is seen in the provision and financing of health care facilities also. The public or Government funded healthcare facility is available only to an abysmally low section of the population which basically covers the low income earners and to the government employees. There exist various schemes like, Employer-based Schemes, Mandatory schemes run by Governments like Employees State Insurance Scheme, Central Government Health Scheme, Aam Aadmi Bhima Yojana and Rashtriya Swasthya Bhima Yojana. Insurance offered by Non Government Organizations (NGOs) like Self Employed Women’s Associations and Private Health Insurance Schemes, the health Insurance market in India covers only about 24 Percent of the total population as per the May 2016 data announced by Government of India in the Indian Parliament.

3.1.1. National Health Accounts

Indians spent seven times more on private hospital care and thrice as much on transporting patients compared to government hospitals, according to the National Health Accounts (NHA) estimates for the financial year 2013-14. The data was recently prepared and published by the Health Ministry after a decade specifically on 2003-04. The estimates disclose that households spent Rs 64,628 crore on private hospitals compared to just Rs 8193 crore on Public hospitals. A total of Rs 18149 crore was spent on patient transportation services, like use of an ambulance or other vehicles. Considering all the available revenue sources, including government funding expenditure on private hospitals-Rs 88552 crore-was double that on government hospitals-Rs 41797 crore.
The National Health Accounts monitors the flow of resources in the Country’s health system. The report presents the details of health finances in regular intervals. India primarily relies on commercial health insurance since 1986 and more after the opening of the sector in 2000 to private and foreign players. Rather than pooling monetary resources across social strata’s for risk protection, and quickly moving towards tax-funded health care, government policy has created fragments with low level of insurance coverage. Even as a model of the U.S health care financing system, commercial health insurance in the Country is seriously deficient. It covers only catastrophic expenditure, such as the cost of highly restricted hospital treatment, which is offered without cost and quality regulation. It also lacks the external audits which are followed in many parts of the world. Outpatient treatment and routine treatments are not covered also.

A Country with 128 crore population with a major Percentage of this population living in urban and rural areas especially slums are living below the poverty line need better and useful policies and better and affordable care. Healthcare Management and health care financing has always been a dynamic and complex task in India. The structure and working of the present schemes plays a significant role in the future for effective and efficient health care management in India.

Penetration and awareness of health insurance in India is much lower than the global average. Health insurance coverage is estimated at around 24 Percent of total population. However, majority of the health insured in India are covered under Government supported health insurance programs or community-based health insurance like Smile India and the coverage of commercial health insurance is estimated to be around 8 Percent. The health care financing system in the Country is dependent on government allocations prominently through the budgets and private funding. The Government allocation in health is expected to increase from year to year but due to fiscal
constraints there are limitations in ensuring universal coverage through Government run schemes.

The role and significance of private insurance providers and private financing is increasingly important in recent years. More alarming concern is the inefficient functioning of the publicly funded health care system in India. They are not in a position to ensure quality healthcare in case of any critical illness or communicable ailments occurring. This creates the scope and also challenges for existing and new health insurance undertakings. Thus, privately owned health insurance companies are able to sell health insurance to large number of families who would like to have quality healthcare facilities. This population includes high net worth individuals, rich and poor, urban, semi urban and rural people.

Source: National Health Accounts 2013-14
Due to the absence of effective regulation of private health care facilities, healthcare costs are comparably high, and by that private health insurance companies take benefit of that. In recent times, health care has become unaffordable and has given rise to serious quality and access issues. Health insurance is an effective and efficient arrangement practiced in other parts of the world to provide and ensure universal health coverage for the people in those Countries may be United States, Norway etc to cite a few. It is also a risk offsetting mechanism. Before the 1970s planners and beaurocrats in the planning commission and the Government machinery were following socialistic thinking and the main focus is on restrictions, regulations and control. This affected the planning and development process in the Country in a serious way.

But later it has given way to market initiated development and provision of different kinds of incentives. After the economic liberalization there was a strategic change to market driven and market oriented development. Liberalisation, globalisation, privatisation and integration became the prominent strategies to execute the new system, to enhance economic development and promote competition amongst the different players in the concerned industry. The reconstruction of India’s healthcare infrastructure, along with the emergence of medical tourism and telemedicine has a bearing to create strong demand within the sector and its related industries.

3.1.2. Trends in Health Insurance

Post liberalisation of insurance sector in the year 2000, the insurance industry in India has recorded significant growth. The Indian insurance
industry is expected to grow to US$ 270 billion by FY2019, due to the strong economic growth and higher personal disposable incomes in the Country. The industry has been spurred by product and process innovation, dynamic distribution channels, coupled with targeted publicity and promotional campaigns by the insurance providers.

During April 2015 to February 2016, the life insurance segment in India recorded a new premium income of Rs 1.072 trillion showing a growth rate of 18.3 Percent age. The general insurance industry which includes health insurance recorded a 14.1 Percent growth in Gross Direct Premium underwritten in Financial Year 2016 up to the month of February 2016 at Rs 864.2 billion. India's life insurance industry is the biggest in the world with about 360 million policies which shows consistent increase and expected to increase at a Compound Annual Growth Rate (CAGR) of 12-14 Percent over the next ten years. The insurance industry plans to increase penetration levels to six Percent age by 2020.

The Country’s insurance market which includes life, non life and health insurance is expected to increase in size over the next few years from its present size of US$ 60 billion. During this period, the life insurance market is expected to cross US$ 160 billion. The general insurance business in India is presently at Rs 78,000 crore premium per annum. The industry and is growing at a healthy rate of 17 Percent per annum. The Indian insurance landscape at present is a huge business opportunity waiting to be tapped and harnessed in its truest manner. India presently holds for less than 1.6 Percent of the world’s total insurance premiums and about 2 Percent of the world’s life insurance premiums despite being the second most populous and fastest growing nation. The nation is the fifteenth largest insurance market in the world in terms of premium underwritten, and has the capacity to grow exponentially in the coming few years.
Currently, healthcare scenario in India is marked by around 69 Percent spending from the pockets of the households rather than other sources like health insurance. India’s per capita spending on healthcare facilities of $109 is much lower than the international average of $863. India in its health outcomes are lagging behind its South Asian neighbors like Sri Lanka and Bangladesh, which have comparable per capita income. There is a widening gap in healthcare delivery for the insured and also for the entire population. Health insurance is dominated by government supported schemes and programs which mostly addresses the health care requirement of the vulnerable sections of the society.

The major public sector health insurer in India is the government-owned General Insurance Corporation (GIC) and its four subsidiaries with about 50 Percent market share. However, Private Health Insurers expanded rapidly in tier-1, tier-2 and tier 3 cities post liberalization of the sector with products and services centered on ‘in-patient reimbursements’ and ‘cash-less hospitalization’. The market share of Public Sector insurers in health insurance decreased from 65 Percent in 2007-08 to 50 Percent in 2015-16. The average annual premium growth in private sector was 47 Percent compared with the PSU insurer’s growth rate of 27% for the period 2007-08 to 2015-16 which indicates growing presence and numerous role of private insurance in India.

Most health insurance products provided by private undertakings are similar to the government-supported product; mediclaim introduced by the public sector undertakings, and are indemnity-based. Due to the high premiums, most mediclaim and similar policy holders belong to the middle and upper middle class which completely neglects the poor and downtrodden in the Country.
Community health insurance schemes sponsored and supported by non-governmental organizations and charitable institutions are evolving to meet the needs of the entire rural pockets. However, provision of health care and financing of health care still need relentless push to reach the desired state. Health insurance emerged quickly along with general insurance with both sharing key developments and landmarks.

However, after economic reforms especially liberalisation and globalisation by the Narasimha Rao Government, care delivery equipment, methodology, and process sharing from developed and fast growing nations became the buzzword and come to the mainstream. With the improvement in healthcare facilities and increase in disposable income of the people, average life expectancy had increased to 65 years by 2011 in India and 76 years in Kerala. The Insurance Regulatory and Development Authority (IRDA) legislation in 2000 served as a key milestone in the history of health insurance in India. It opened up the health insurance industry to private and foreign players with limits. Health insurance penetration quadrupled between 2011 and 2014 (400 million in 2011) and is expected to be 900 million by 2018.

Fig.3.2. Growth Rate in Non life insurance
3.2. Evolution of Health Insurance

The concept of Health Insurance was coined in the year 1694 by Hugh the elder Chamberlen from Peter Chamberlen family. In 19th Century “Accident Assurance” began to be available in the market. Accident assurance is operated much like present disability insurance available in the market. This business model continued until the beginning of twentieth century. During the late 20th century traditional disability insurance evolved in to modern health insurance programmes. Later part of the 20th century witnessed that most health insurance schemes cover the cost of preventive and emergency health care requirements.

Today the health insurance even covers the outpatient treatments. But this is not always the case and the system is still in an evolving stage. Healthcare in India is in a state of enormous transition. Over the last 70 years, India has achieved a lot in terms of health care and health insurance. Before independence and in the early 50s, the health system was in dismal condition. It is evident from the figures of high morbidity and high mortality rate in the Country and the prevalence of infectious diseases.

Since the independence in 1947, the focus has been put on primary health care and the nation made remarkable progress in improving the health status of the people through different policy interventions. But still, India is way behind many fast developing Countries such as Mexico, China, and South Africa and even under developed nations like Bangladesh and Thailand in health indicators. Health insurance, which remains highly underdeveloped and less significant segment of the product portfolios, is now emerging as a tool to manage financial needs of people to seek and better health services.
3.3. Health Insurance- Global Context

While attempting to study anything in a national or regional level it is advisable to understand the global practices. It will help to channelize the study in a direction which will help to device a model according to the existing situations in a Country.

3.3.1. Germany

Europe is always ahead in ensuring better human development index for its citizens. Health insurance was started in Germany at the beginning of 1995. Up to that date, health insurance had not been a public concern like retirement and public health care. According to German law, children are obliged to support and assist their parents in old age, to the degree that their own resources are sufficient. Only if family income and wealth has proved to be insufficient the elderly may apply for income support from the government. The German insurance is a Pay as you go (PAYG) system where risks are pooled amongst the population and also contributed by the Government. The benefits are independent of earlier contributions made by the people enrolled in the scheme. It follows the motto ‘Pay as You Go’ in which current contributors pay for current recipients of care. One peculiarity of this insurance component is that it has defined contributions and defined benefits at the same time.

For that section of population dependent on income support from the government, the concerned province may decide between paying the contributions on behalf of the individuals concerned and taking the risk of having to pay for their care. As it is a Pay As You Go system, the Health insurance has not been able to build up more than a small section of the population again offering only a small financial balance. According to the law, the balance must be sufficient to continue to make payments for 45 days.
It is expected to be the moment it is sufficient to cover the related benefits. It takes few years to qualify for benefits in the normal case. Apart from that, the only qualifying requirement is the need for care and the benefits are paid independent of age.

Three kinds of benefits are offered along with this insurance: professional domiciliary care, institutional care, and benefits in cash. The above mentioned different kinds of benefits may be combined according to the requirements also. Benefits are not dependent on the income of the individual is the core attraction of this programme. People applying for benefits are examined by a doctor and then divided into three groups. The critical factors are the person’s ability to perform activities of daily living (ADL), together with the time that these activities are estimated to consume. Mental impairments are not taken into account. The learning of this scheme to India is about the need for public funded health insurance scheme to be initiated at the cost sharing basis.

3.3.2. Japan:

Since Japan became industrialized quite late after the Second World War it has developed social security systems slightly later than most other developed Countries. It is the fastest ageing society in the world because of its developed health care system. Family structure changed as traditional caring arrangements based on three-generation households and obligations on children to look after their parents showed signs of changes. Following a long discussion, mandatory health insurance scheme was passed in the Japanese parliament. The said insurance is financed by 50 % from taxes and the rest from insurance premiums. The tax revenues are collected by 50 % from national taxes, and local and regional taxes contribute with 25 % each. Premiums are collected from people aged 40 years and over. Family members
are automatically covered in the scheme without having any further enrolment.

Unlike the German system there are no cash benefits provided in the scheme. When the private Long Term Care insurance was started, several large for-profit companies made huge investments in home services. It is done in the anticipation of enhanced demand due to the increased freedom to choose providers. However, recipients have proved to be more conservative than expected, and stayed with their former providers. This has incurred some losses on private corporations offering home care. This is unlike the system being followed in India where at every point of time people would be in hardships to enrol the family members. Again it is limited to many restrictions regarding number of family members, employment status, need for care etc.

3.3.3. United States

The United States had a quite ambitious and unique social welfare programme for their citizens already around the half of the twentieth century. At this time, more than one quarter of federal expenditure was dedicated to pensions for civil war veterans and their families. Long term health care through health insurance and other modes makes up a small but major part of public spending in the America. Financing in the United States, funds for health and long-term care for elderly is provided from public as well as private sources. Public funding is based on Medicaid and Medicare programmes prominently run by public sector undertakings. The private element consists of private insurance as well as out-of-pocket payments. Medicaid is a tax-based programme designed and implemented for low-income earners or poor people. It covers hospital care (both outpatient and inpatient) as well as home care. Even if the Medicaid programme was not basically designed to concentrate on help for the elderly, it has evolved into
an important element in long-term care financing. Medicare is a national social insurance programme.

Estimates based on the Government studies itself show that as much as 20% of the elderly population is refused long term care insurance. Benefits offered by private long-term insurance policies vary from state to state and from province to province. Some only include nursing home care, whereas others only cover home care. Typically, only care given by nurses or doctors is covered. Normally policies offer fixed one time compensation if care is needed. Benefits are paid for a limited time; e.g. five years or remaining life years. The financing of health insurance is a very topical issue in the United States. Even after getting the Congress assent in 2012, the Affordable Care Act still undergoes financing and related constraints. Weaknesses in the existing system have received particular attention, and there is widespread concern that health insurance may become more problematic under the burden of ageing.

3.3.4. United Kingdom:

The British health insurance system is evolved during the post-war era. The core principle of the system is that the local authorities provided care in residential homes, whereas the National Health System takes care of particularly frail people. In the UK there are two main sources of health care funding (apart from Customers themselves), namely local authorities and the National Health System. Local authorities (Municipalities) are responsible for the bulk of public spending on long term care and health care, and their share has increased in the last many number of years. Local authorities have two main sources of funding for health care requirement - government grants and municipal taxes. Government grants are decided annually by the Government and then distributed to the concerned authorities according to a resource
allocation formula fixed in advance in regular intervals. Since 1991, there is also a market for private health insurance that is growing slowly.

The predominant ones are nursing homes and residential homes. Residential homes provide board and personal care only, whereas nursing homes provide daily nursing care and thus are more targeted at people with severe disability. In the last decade, there has been a consistent increase in the number of multipurpose homes, offering both residential and nursing care. The system for financing and provision in the United Kingdom has been criticized on several grounds.

3.3.5. Developing and Under Developed Nations

When we look into some of the underdeveloped or developing nations the structure is more over same and can be presented this way. Thailand has three different kinds of health care financing programmes:

1. Voluntary Health Schemes,
2. Mandatory Schemes and
3. Social Welfare Schemes

Sri Lanka's health care expenditure is characterised by high government expenditure and involvement, low private, and low insurance expenditures. But India being a larger Country than Sri Lanka, it is practically impossible in the current scenario to have a model like Sri Lanka. But many states in India are of size of Sri Lanka hence Government can introduce test strategies wherein it calls to implement similar models in some of the states.

The pattern of health care delivery and financing in Latin American nations differs according from Country to Country prominently based on the size of the Country (both in terms of growth in population and geographical size) and the income level. While presenting in a larger perspective, there are
mainly two types of managed competition, which are emerging in Latin America, one is where government is the sponsor and the other is where private employers are the sponsors. Like varied models existing across Countries in Latin American Countries, India can take learning’s from it by varied models across states, but again there are hurdles due to constitutional and regulatory factors.

From the international perspective of health insurance in the world it is clear that it is high time for a Country like India to provide free or tax based health care at least to the senior citizens as an experiment. It may be quite exaggerating to think universal health coverage in a Country like India where public spending as of now is abysmally low. The Country can only go for a public private combination so that gradually health cover can be provided to all the sections in the society.

3.4. History of Insurance in India

In India, insurance has a deep-rooted history. It finds mention in the writings of Manu *Manusmriti*, Yagnavalkya (*Dharmasastra*) and Kautilya (*Arthasastra*). The writings talk in terms of pooling or combining of resources that could be re-distributed in times of emergencies such as earthquakes, floods, epidemics and famine. This was definitely a pre cursor to modern day insurance. Ancient Indian history has preserved the earliest symbols of insurance in the form of marine trade loans and carriers’ contracts. Insurance in India has developed over time mainly drawing from other Countries, England and USSR in particular.

1818 saw the advent of life insurance business in India with the inception of the Oriental Life Insurance Company in Calcutta, the commercial capital of India at that time. This Company continued its business until 1834 and compelled to stop business due to some unforeseen reasons. In 1829, the
Madras Equitable had started transacting life insurance business and offering life insurance products in the southern part of the country. 1870 saw the passage of the British Insurance Act in the British Parliament. In the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency to cater the requirement of the Central India. This time, however, is dominated by global companies which did good and profitable insurance business in the Country, namely Albert Life Assurance, Royal Insurance, Liverpool and London Globe Insurance and the Indian companies were up for hard competition from the international entities.

In 1914, the British Government has begun preparing and publishing returns of insurance companies in India. The Indian Life Assurance Companies Act 1912 was the first statutory measure to regulate and control life insurance business in India. In 1928, the Indian Insurance Companies Act was enacted to enable Government of India to collect and compile statistical information about life and non-life insurance business transacted in India by Indian and international insurance firms including provident insurance societies. In 1938, with a view to protect the interest of the entire population and insurers, all the existing legislations was consolidated and amended by the Insurance Act, 1938. The Insurance Act 1938 contains extensive and elaborate provisions for effective regulation over the business of insurers and all the stakeholders including the insured in the sector.

The Insurance Amendment Act of 1950 abandoned all the Principal agencies associated or connected with insurance industry. However, there were a large number of insurance companies in the industry and the level of competition is very high. There were also complaints of unfair and unhealthy business practices in the sector. The Central Government, therefore, decided to nationalize insurance business to tackle the existing situations and to create
a level playing field. An Ordinance was issued on 19th January, 1956 nationalising the Life Insurance sector and Life Insurance Corporation was formed in the same year. The Life Insurance Corporation took over 154 Indian insurers, 16 non-Indian insurers as also 75 provident societies—245 Indian and foreign insurers in total. The LIC had monopoly till the time of economic reforms of early ninety nine tees. After the economic reforms the insurance sector was reopened to the private sector.

The history of general insurance goes back to the Industrial Revolution in the Western Europe and Britain and the corresponding growth of cross border sea trade and commerce in the 17th century. The general insurance has begun in India as a legacy of British colonial rule and occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British in the similar lines of other financial intermediaries. In the year 1907, the Indian Mercantile Insurance Ltd was incorporated. This was the first company to transact all categories of general insurance business in the Country.

1957 is remarkable in the insurance by the inception of the General Insurance Council, an associate of the Insurance Association of India. The General Insurance Council has adopted and insisted a code of conduct for the insurers for ensuring fair conduct and sound business practices. In 1968, the Insurance Act was amended to regulate, control and manage investments, to ensure capital adequacy and set minimum margin requirements. The Tariff Advisory Committee was also set up as a continuum to these developments.

In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business is nationalized. It was done with effect from 1st January, 1973. 107 insurers were amalgamated and formed four subsidiary companies. The companies are the New India Assurance Company Ltd, the Oriental Insurance Company Ltd, National
Insurance Company Ltd and the United India Insurance Company Ltd. The General Insurance Corporation of India was incorporated as a company in 1971 and it started business on 1 January 1973.

The process of re-opening of the sector had begun in the early nineteen eighties as part of economic and financial sector reforms. The last decade and more has seen it been opened up substantially to ensure a level playing field. In 1993, the then Government set up a committee under the chairmanship of RN Malhotra, former Governor of Reserve Bank of India, to study and propose recommendations for reforms and fast sweeping changes in the insurance sector. The objective was to complement the reforms initiated in the financial system of the nation. The committee submitted its report within one year and suggested the opening of the sector to private and foreign players with some restrictions. The committee also suggested that foreign companies are allowed to enter in to the market by floating Indian companies, preferably a joint venture with Indian partners.

As a follow up to report of the Malhotra Committee, in 1999, the Insurance Regulatory and Development Authority (IRDA) were constituted as an autonomous body to regulate and develop the insurance sector in the Country. The Insurance Regulatory and Development Authority was incepted as a statutory body in April, 2000. The key objectives of the IRDA consist of promoting healthy competition in order to enhance Customer satisfaction through better and enhanced Customer choice and lower premiums. It also focuses on ensuring the financial viability of the insurance market and the business model of the companies.

The Government through IRDA opened up the market in August 2000 with the invitation for application for registrations by all kind of insurers including foreign players. Foreign companies were allowed ownership of up to 26 Percent as an experiment. The Authority has effectively utilised the
power to frame regulations under Section 114A of the Insurance Act, 1938 as per the varying requirements in the segment. IRDA from 2000 onwards framed various regulations ranging from incorporation and establishment of companies for conducting insurance business to the protection of policyholders’ interest. In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies. Simultaneously General Insurance Corporation was converted into a national re-insurer for enhanced risk protection to other smaller entities. It has also decided to focus on areas like aviation insurance. The Parliament passed a bill de-linking four subsidiaries from GIC in July, 2002.

In 09-09-2016 there are 28 general insurance companies including the Export Credit Guarantee Corporation and Agriculture Insurance Corporation of India and 24 life insurance companies operating in the Country. This consists of public sector, private sector and foreign players. The insurance sector is a colossal one and is growing at a quick compounded annual growth rate (CAGR) of 15-18 Percent in the last 5 years. Together with banking services, insurance services add about 7% to the Country’s Gross Domestic Product. A well-developed and evolved insurance sector is a boon for economic development and growth of the Country. It provides long-term funds for infrastructure and industrial development of the nation. Insurance industry also strengthens the risk taking and pooling capacity of the Country as a whole.

Despite some progress made in the recent years, the existing state of India's healthcare outcome place much below the expectations and estimations. It faces severe challenges around high out-of-pocket spending (69 Percent as of September 2016), inequality of services by hospital intermediaries and insurance companies and inconsistent regulatory standards. Since 2000, health insurance has gained momentum due to the entry and
proliferation of private health insurance companies including standalone companies. However, it still remains a minor contributor in the present healthcare scenario in the Country.

Amid its ongoing developments, a government-driven universal healthcare system is likely to evolve. However, Public Health Insurers under the leadership of General Insurance Corporation still have a significant role to play in addressing goals of access, equity, cost and quality. With the present healthcare ecosystem opening to private and foreign players, existing challenges becomes opportunities. The major objective for a better growth is the strong synergy between private and public players, complementing each other. A focused approach consisting of public and private sectors combining emerging technology will play a prominent role in the healthcare transformation in the future.

Public Health Insurance need to carefully design and implement their strategies in a 1.3 billion-strong population segmented in various strata. There are key trends around operational efficiency, integration and standardization in the system. Customer awareness of Public Health Insurers should be cognizant in this manner. Their response to these trends may likely define the cornerstones of success stories in the Country.

3.5. Insurance Industry in India

The insurance industry of India consists of 52 insurance companies of which 24 are in life insurance business and 28 are general insurance business (motor, health, marine, crop insurance, fire etc). Among the life insurers, Life Insurance Corporation (LIC) is the only public sector company which was formed by amalgamating all the existing insurance companies in 1955. Out of the 28 general insurance companies, there are six public sector insurance undertakings, which include two specialised insurers, Agriculture Insurance
Company Ltd for Crop Insurance and Export Credit Guarantee Corporation of India for Credit Insurance. Apart from this, there are 5 private sector insurers which are registered to underwrite policies exclusively in Health, Personal Accident and Travel insurance industry.

They are Star Health and Allied Insurance Company Ltd, Apollo Munich Health Insurance Company Ltd, Max Bupa Health Insurance Company Ltd, Religare Health Insurance Company Ltd and Cigna TTK Health Insurance Company Ltd. Apart from the 52 insurance companies, there is a national re-insurer, i.e., the General Insurance Corporation of India. Other stakeholders in Indian Insurance market include approved insurance agents, licensed Corporate Agents, Brokers, Common Service Centres, Web-Aggregators, Surveyors and Third Party Administrators.

3.5.1. Individual Agents

An individual agent is one who has completed the prescribed training, passed the examination and been duly permitted and licensed by the regulator to sell insurance policies to the public and provide all related assistance, after sales service including assisting at the time of a claim. The licence may be for granted life insurance, general insurance or both. In addition to representing one life insurance company and one general insurance company an agent can also represent and work for one standalone health insurance Company. They can also act as the insurance agents of Agriculture Insurance Company of India for selling crop insurance and Export Credit Guarantee Corporation of India for selling their insurance.

It is the duty of the buyers/policyholders of the insurance company to ensure the authenticity of licence. Many IRDA licensed insurance agents also represent other financial sector for selling related financial products. Most of the insurance agents work for entities like mutual funds or the National Small
Savings Organisation and help the prospective investors to buy or invest in their products and schemes.

3.5.2. Corporate Agents

Corporate entities represent an insurance provider and sell its policies. Usually they are engaged in a particular business and sell insurance policies to their existing Customers. For instance, a travel agent may provide a travel insurance policy or a vehicle dealer vehicle financier may offer a motor insurance policy. When a bank becomes the corporate agent of an insurance company it is called as a banc assurance arrangement. Banks provides insurance policies to their Customers based on their expertise of their situation and requirements. Corporate Agents like the individual agents may represent one life insurer, one general insurer and one standalone health insurer like Star Health. In addition they can sell and deal with two specialised insurance companies, Export Credit Guarantee Corporation and Agriculture Insurance Corporation of India for a better and expanded business. It is permitted based on the regulations of 2000.

3.5.3. Surveyors

Surveyors and Loss Assessors are service providers to a non-life insurance company. Surveyors do their business usually at the time of a fire or vehicle insurance claim. They carry out claim surveys and estimate the quantum of loss. They follow the terms and conditions of the contract for fixing the claim. Based on the report given by surveyors claim settlement is done by the companies.

3.5.4. Third Party Administrators

Third Party Administrator (Health Services) is comparatively a recent entrant in health insurance intermediation. They assists the insurance
companies for processing health insurance claims and offering facilities like cashless treatment in the network of hospitals. They assist the companies and policyholders in the settlement of claims in a time bounded manner.

3.5.5. Referral Providers

A referral provider provides data of its clients to an insurance provider who wishes to sell policies to them. They are not directly selling the policies. Referral providers introduce its clients to the insurer and provide space in its office for the employees of the insurer for the marketing of their insurance products. It helps for the display of marketing material to help the insurer market and sell policies.

3.5.6. Web Aggregators

Web Aggregators compile and provide information about the insurance policies of various companies on a website. This platform helps the policyholders to compare and take informed decisions. This intermediary is emerging quickly because of its novel use.

3.5.7. Insurance Repositories

Insurance Repositories acts as the custodian of insurance policies in electronic form on behalf of Insurance Companies. This intermediary emerged due to the advent of information technology. It helps in creating a paperless world in health insurance.

3.5.8. Insurance Marketing Firm

Insurance Marketing Firm is a new distribution channel. Their core function is to solicit or procure insurance products to tap the untapped insurance market and to enhance the risk pooling mechanism. It also
distributes other financial products by employing individuals licensed to market, distribute and service such other financial products like mutual funds.

3.6. Health Insurance - The Concept

The term ‘Health Insurance’ is a type of insurance that covers the medical expenses in health care. A health insurance policy is a contract between an insurer and an individual / group in which the insurer agrees to provide specified health insurance cover at a particular “premium” subject to terms and conditions mentioned in the policy document. A Health Insurance Policy normally cover the expenses reasonably and necessarily incurred under the below mentioned heads in respect of each insured person subject to overall ceiling of sum insured (for all claims during one policy period).

a) Room rent

b) Nursing expenses

c) Fees of surgeon, anaesthetist, physician, consultants, specialists

d) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, diagnostic materials, X-ray, Dialysis, chemotherapy, blood transfusion, cost of outpatient consultancy cost of organs and similar expenses.

The Sum assured may be on an individual basis or on floater basis for the family as a single unit. It also offers to groups working for achieving a common objective may be like working for a company. Health Insurance policies like other forms of insurance may offer cumulative bonus for every claim free year, the sum insured is increased by a certain Percentage at the time of renewal. The increase is subject to a maximum Percentage. In case of a claim, cumulative bonus is reduced by 10% at the next renewal. Health care expenses incurred during a specified number of days before the
hospitalization and after the hospitalization from the date of discharge may be considered as part of the claim provided the expenses relate to the disease / ailment. Insurance companies have tie-up arrangements with a large number of hospitals. If policyholder takes treatment in any of these hospitals, there is no need for the insured to pay hospital bills. The Insurance Company, through its Third Party Administrator (TPA) or directly as in the case will arrange direct payment to the concerned hospital.

Expenses beyond sub limits prescribed by the insurance provider in the policy or treatments not covered under the policy have to be settled by the insured directly may be sometimes called as co payments. The insured can avail treatment in a non-listed hospital in which case the insured has to pay the bills first and then seek reimbursement from Insurance Company. There will be no cashless facility available in those hospitals. Add-ons are provided by insurance companies to offer additional benefits and to attract more Customers to health insurance. There are also stand alone policies that are designed to give benefits like hospital cash, critical illness benefits, surgical treatment benefits etc. These policies can either be taken separately or in addition to the hospitalization policy.

Health insurance policies are issued for a period of one year. The common form of health insurance policies in India cover the expenses incurred on hospitalization. New variety of products are now available like critical illness policy which offer a range of health covers, depending on the need and requirement of the insured. It is also designed based on the market requirements. The health insurer provides direct payment to hospital (cashless facility) or reimburses the expenses related to the disease and injuries or disburses a fixed amount of money on the happening of an illness. The kind and amount of health care costs that will be covered by the health plan are decided in advance to reduce the disputes likely emerge in the future. Buying
health insurance policies protects the people from the sudden, unexpected costs of impatient or outpatient treatments (or other covered health events, like critical illnesses) which would otherwise make a major hole into the household savings.

Most often it leads to indebtedness which is evident in many cases throughout the Country. Everyone is exposed to various health hazards and a medical emergency can cause indebtedness to more than seventy percent of the population without any prior warning. Healthcare is increasingly becoming expensive, with the advent of technology, new treatment procedures. Modern medicines have also driven up the costs of healthcare.

While these high treatment expenses may be beyond the reach of the major segment of the population probably the working class, providing the security of health insurance is more necessary. Health insurance policies are available from a sum insured of Rs 5000 in micro-insurance policies/community based health insurance schemes to even a sum insured of Rs 50 lakhs or more in certain critical illness plans. While most insurance companies offer health insurance policies for a duration of one year, there are policies that are issued for two, three, four and five years duration also. Nowadays there are insurance companies having plans which could extend even longer in the duration.

A hospitalization policy covers, fully or partly, the actual cost of the treatment for healthcare treatments during the policy period except the exclusions and the beginning waiting period. This is a wider form of coverage applicable for various hospitalization expenses, including expenses before and after hospitalization for some specified period. Such policies may be available on individual sum insured basis, or on a family floater basis where the sum insured is shared across the family members like parents, spouse, children, dependents etc.
Another type of policy, the hospital daily cash benefit policy, provides a fixed daily sum assured for every day of hospitalization. There may also be coverage for a higher daily benefit in case of Intensive Care Units admissions or for specified illnesses or ailments. A Critical Illness benefit policy provides a fixed lump sum amount to the insured in case of diagnosis of a specified illness or on undergoing a specified procedure. This amount is helpful in overcoming or reducing various financial consequences associated with a critical ailment. Usually, once this lump amount paid, the plan ceases to remain in force.

There are also other types of policies called surgical cash payment which provide lump sum payment on undergoing a specified surgery and others designed to the requirements of specific target audience like senior citizens or children below the age of 14. Health insurance providers from the public and private sector have tie-up arrangements with several hospitals all over the Country as part of their networking. Number of hospitals empanelled by the companies is seen as a yardstick for the selection of a particular company even.

Under a health insurance policy offering cashless facility, a policyholder may take treatment in any of the network hospitals. Payment for the healthcare facilities are paid to the hospital directly by the Third Party Administrator, on behalf of the health insurance provider. Even after the introduction of Third Party Administrators there are companies who directly deal with the policyholders. However, expenses beyond the limits or sub-limits allowed by the insurance policy or expenses not covered under the policy have to be settled by the insured or policyholders directly with the hospital. Cashless facility, however, is not available if you take treatment in a hospital that is not in the network. Health insurance comes with attractive tax benefits as an added incentive to the policyholders. Majority of the population
is availing health insurance policy because of this attraction as it is evident in many studies.

There is an exclusive section in the Income Tax Act of 1961 which offers tax benefits for health insurance premium, which is Section 80D, and which is unlike the section 80C applicable to life insurance. Section 80C is given with other form of investments/expenditure which also qualify for the same kind of deduction. Currently, buyers of health insurance who have purchased the policy by any payment mode other than cash can avail of an annual deduction of Rs. 15,000 from their taxable income for payment of Health Insurance premium for self, spouse and dependent children.

For senior citizens (now the age limit is 60 years), this deduction is more by Rs 5000, and so it amounts to Rs. 20,000. Further, since the financial year 2008-09, an additional Rs 15,000 is available as deduction for health insurance premium paid on behalf of parents, which again is Rs 20,000 if the parents are senior citizens. While checking the factors affecting the amount of premium charged by the companies based on underwriting, age is a major factor in all policies. The older you are the premium cost will be higher because there are more chances of you get into illnesses. Previous medical track record is another crucial factor that determines the amount of premium. If no prior ailment and treatment exists, premium will automatically be lower in all the cases by all the companies.

Claim free years can also be a factor in determining the cost of the premium. Companies normally pass the benefit to the policy holders with certain Percentage of discount at the time of renewal. This will automatically help people reduce the amount of premium and also help the companies to retain the Customers. The Insurance Regulatory and Development Authority (IRDA) the regulator of insurance in India has issued a circular to permit portability in insurance. It is effective from 1-7-2011, which directs the
insurance companies to permit portability from one insurance company to another company.

It also allows moving from one plan to another, without making the insured to lose the renewal credits or bonus for pre-existing conditions, enjoyed in the previous policy. However, this credit is limited to the sum assured (including Bonus) under the existing policy. Any number of claims is permitted in the present form of health insurance during the policy period within the sub limit mentioned in the policy. However the sum assured is the maximum amount of claim possible under the insurance policy.

Some health insurance companies through some of their selected schemes pay for specified expenses towards the health check up once in a few years depends on the premium and the policy framework of the company. Usually this is available once in four years. Family Floater is one single policy that takes care of the health care expenses of the entire family. The family floater policy has one single sum insured, which can be availed by any/all insured persons in any proportion subject to maximum of overall limit of the policy sum insured. Quite often family floater plans are better than buying separate individual policies from the perspective of the policyholders. Because of this reason this kind of policy outsmarts the individual policies in number and in penetration. Family Floater plans take care of all the healthcare expenditure during unexpected ailments, surgical procedures and emergency situations for all the members in the family as agreed by the insurer and insured in the contract.

The Customer Affairs Department of the Insurance Regulatory and Development Authority (IRDA) has introduced the Integrated Grievance Management System (IGMS) for meeting its prime objective of policyholders’ protection. It is an online system to track the complaints and for registration of grievances by the aggrieved party. The insured must
register the grievance first with the insurance company rather than directly approaching IRDA portal. In case the policyholder is not satisfied with its disposal of complaint by the company, the insured may take it to IRDA through Integrated Grievance Management System by accessing www.igms.irda.gov.in.

In case the insured is not able to access the insurer’s grievance system directly, IGMS provides a platform to register the grievance with the insurer. Apart from registering the grievance through IGMS, policyholders have several channels for grievance registration. It can be done through convenient forms like e-mail (complaints@irda.gov.in), letter (address your letter to Customer Affairs Department, Insurance Regulatory and Development Authority, 3rd Floor, Parishram Bhavan, Basheerbagh, Hyderabad) or simply call IRDA Call Centre at Toll Free 155255 through which the regulator shall, free of cost, register the grievances against insurance companies as well as help track its status. IRDA employs qualified people in the call centre to assists the policyholders by filling up the complaints form on the basis of the call.

Wherever required, IRDA may even help in filing of complaints directly with the insurance companies as the first port of call by giving policy related information. IRDA Call Centre offers a true alternative channel for prospects and policyholders, with comprehensive tele communication facilities, serving as a 12 hours x 6 days service platform from 8 AM to 8 PM, Monday to Saturday in the national language, English and various other Indian languages.

When a complaint is registered with IRDA, it starts facilitating resolution by taking it up with the insurance company. The company is given 15 days time to resolve the complaint. If sufficient resolution is not received from the company IRDA carries out investigations and enquiries. Further,
wherever applicable, IRDA advises the complainant/policyholder to approach the Insurance Ombudsman in terms of the Redressal of Public Grievances Rules, 1998.

3.7. Out-of-Pocket Expenditure

In a Country where less than 25 Percent of its 130 crore population has some form of health insurance coverage, the potential for the health insurance segment remains high and increasing day by day. There is an urgent need to increase the health insurance coverage in the Country as out-of-pocket payments (the amount paid from the pocket of the patient when availing the health treatments) are still among the highest in the world. Furthermore, according to the facts and figures available with of the World Health Organization (WHO), in 2015, India has spent only 1.9 Percent of gross domestic product (GDP) on the health sector which is the lowest amongst the BRICS (Brazil, Russia, India, China, South Africa) member Countries which the Country is always comparing all its macroeconomic parameters.

Amongst the BRICS nations, in 2013-2015, Russia’s out-of-pocket expenses stood highest at 67.9 Percent closely followed by India (69 Percent), China (58.8 Percent), Brazil (42.8 Percent), and South Africa (10.8 Percent). On the other hand, these expenses in developed economies of US and UK were comfortably poised at 17.9 Percent and 43.1 Percent respectively. High out-of-pocket expense is definitely the reflection of low health insurance coverage in India. The Country doesn’t have a suitable kind of insurance to meet the requirement of the different sections and thus people end up paying from our own pockets. Once the penetration of health insurance increases, out of pocket payments will come down as evidenced from the other nations in the world.
While taking stock of reasons behind this situation in India, Antony Jacob, CEO, Apollo Munich Health Insurance, said, “Only about 23-24 Percent of population has some form of health insurance coverage, including those who are covered through some form of government schemes. People are yet to accept health insurance as a financial and hedging tool for medical emergencies and health care spending may be impatient or outpatient. They usually procrastinate when it comes to buying health insurance unless they are faced by a challenging situation.

Although the Indian health insurance market still lags behind other developed and developing Countries in terms of penetration yet the health insurance penetration is rising. It continues to be one of the most fast growing sectors in the Indian insurance industry with gross written premiums for health insurance increasing from year to year. The health insurance premium has registered a compounded annual growth rate (CAGR) of 32 Percent for the past ten financial years as per the underwriting premium figures published by the regulator IRDAI.

Health insurance segment still remains an unexplored territory in India. Madan Mohan at Religare Health Insurance asserted, health insurance has become one of the most significant segments in the insurance industry today. The segment is expected to grow significantly in the next couple of years based on reasons like increasing disposable income, life style diseases, emergence of nuclear family etc. As spending on healthcare in India is expected to double in the very near future, stakeholders believe that health insurance will definitely become the biggest contributor in the non-life segment.

In the existing scenario, the health insurance industry is dominated by four public sector entities (National, New India, Oriental, and United India) that collectively hold 50 Percent market share. The rest of the share is with
the private sector players, of which four are standalone health insurance players (Star Health, Apollo Munich, Max Bupa, and Religare Health). Standalone health insurers have got a boost by the move taken by Insurance Regulatory and Development Authority (IRDA) in early 2013. IRDA has classified health insurance as a separate category and has permitted the insurers to have tie-up with banks. All the four exclusive health insurance companies have started tying with the banks across the Country. It helped all the companies to expand and increase their reach with the help of pan India network of banks. That helped the companies to move in to a different level of thinking about the core and non-core issues. The penetration of health insurance is now expected to increase with banks pushing for it through bancassurance tie-up.

Table 3.1

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Source: World Health Organisation
3.8. Health Insurance Milestones in India

3.8.1. General Insurance

1818: Life Insurance in India was started by the establishment of Oriental Life Insurance Company in 1818.

1850: General Insurance was started by the establishment of Triton Insurance Company in 1850. Its Head Quarters was at Kolkata, the commercial capital of India at that time.

1956: Life Insurance is the first to be nationalized in 1956 by passing an Act in the Indian Parliament. Life Insurance Corporation of India was formed by consolidating the operations of 245 insurance companies, some of them Indian and others foreign. It is the sole provider of insurance coverage in the Country until the formation of GIC in 1972.

1973: General Insurance was nationalized in 1973 with the formation of GIC. General Insurance Corporation of India is established as the parent company with New India, United India, National and Oriental as its four subsidiaries to focus on four different parts of the Country.

1991: The process of opening up the insurance sector was begun in the background of Economic and financial sector Reforms process. Liberalization helped the sector lot in terms of new products, new regulations and a new environment. Malhotra Committee was formed during this year to further recommend suggestions for the improvement in the sector.

1999: Insurance Regulatory Development Act (IRDA) was passed in the Parliament. It is treated as the major milestone in the insurance industry. It paves the way for a new regulation according to the changing requirement in the economic system.
2001: Indian Insurance was opened for private players. Subsequently private insurance Companies started operations to tap the most untapped segment in the financial system.

3.8.2. Health Insurance

1912: Health insurance is introduced in to the Country by the passage of the first insurance Act.

1947: Committee was constituted under the Chairmanship of Bhore to make recommendations for the improvement of health care facilities and services in India. The committee suggested a sweep change in the existing mode of health delivery and financing.

1948: The Central Government introduced the Employees State Insurance Scheme for blue-collar workers employed in the private sector. It offers medical facilities through large number of hospitals established throughout the Country. It has a role in creating a better model but it also failed to meet the growing expectations in healthcare delivery.

1954: The Central Government Health Scheme (Central Government Health Scheme) for the eligible central government employees and for their dependents. This scheme covered almost all the central government employees. But it also failed in making deeper in roads according to the requirements of the Country.

1986: Mediclaim was introduced collectively by Public sector insurance companies. The scheme is very successful in creating awareness on the concept of health insurance. The premium charged is also affordable to major sections of the people. The scheme is taken as a base for the future schemes introduced by public and private sector companies in India. The mediclaim policy is introduced in 1986.
1999: the year is marked as the beginning of a new era for the development of health insurance in the India. IRDA, the insurance regulator opened the sector to private and foreign players.

2003: Introduction of Universal Health Insurance Scheme. It is marked as one of the earlier attempts by government to offer health insurance for employees in the unorganized sector. Universal Health Insurance Scheme was a hospitalization indemnity product offered through the state-owned insurers at a heavily subsidized price.

3.8.3. Recent Government Initiatives

The Government of India has taken a number of initiatives for the growth and development of insurance industry. Some of them are as follows:

- Union Budget 2016-17 granted permission to foreign investment through automatic route (the route which does not require prior permission of the Government) for up to 49 Percent subject to the guidelines on Indian management and control, to be verified by Foreign Investment Promotion Board and IRDA.

- Service tax on single premium annuity policies has been reduced from 3.5 Percent to 1.4 Percent of the premium paid. It is not applicable to all the annuity policies but in certain cases.

- In order to attract investors towards insurance companies Government insurance companies has been told to initiate activities for listing of the companies in the stock exchanges.

- Service tax on service of life insurance business provided by way of annuity under the National Pension System is exempted. The prerequisite for the regulation is the regulation by Pension Fund
Regulatory and Development Authority (PFRDA). This decision of service tax waiver has come into effect from 1 April 2016.

- The Insurance Regulatory and Development Authority of India have formed committees to explore and study the ways to promote e-commerce in the insurance sector. It is done with an objective of increasing the insurance penetration and brings financial inclusion in the Country.

- IRDA has issued regulation, in the name IRDAI (Obligations of Insures to Rural and Social Sectors) Regulations, 2015 as a continuation to the amendments brought under section 32 B of the Insurance Laws (Amendment) Act, 2015. These regulations impose obligations on insurance providers to offer insurance cover to the rural and financially weaker sections in the society.

- The Government of India introduced two insurance schemes. The first is Pradhan Mantri Suraksha Bima Yojana (PMSBY), which is a Personal Accident Insurance Scheme. The second is Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), which is the government’s Life Insurance Scheme. Both the schemes offer basic insurance at minimal rates. It can be easily availed of through various government agencies and private sector outlets. Definitely seen as a small step to cover the downtrodden on the Country.

- The Government of India on a pilot basis launched a first of its kind banking and insurance services helpline for farmers in the state of Uttar Pradesh. This system helps individuals to lodge their banking and insurance related complaints on a toll free number.

- The equity investment in insurance increased. The select committee of the Rajya Sabha gave its approval to increase stake of foreign
investors. The increase is expected to bring 49 Percent equity investment in insurance companies. The focus is to bring more capital to the sector to enhance efficiency and effectiveness of the companies.

- Government of India has launched an insurance pool to the tune of Rs 1,500 crore. This is mandatory under the Civil Liability for Nuclear Damage Act (CLND) for all the companies involved in the inception and running of nuclear plants in the Country.

**Market Size & Forecasts**

The Indian healthcare insurance industry is worth INR 60,497 crores with a compounded annual growth rate of approximately 42.3 percent between 2008 and 2015. The market penetration is will be 3 folds higher in 2015. The main factors of growth are increased awareness. According to World Bank Report, 95% of Indians will face financial crunch in case of any critical illness. Hence the need for Health Insurance.

**Fig. 3.3. Market Size of health insurance Business in India**

Commercial health insurance in India has conventionally experienced two problems.
Adverse selection: only those who currently need care are more likely to insure themselves, rather than everyone. This reduces the risk pool size and affects the viability of insurers business. The insurer responds by screening beneficiaries to reduce exposure and protects returns, defeating the insurance objective.

Moral hazard: patients and care providers like hospitals increases claims without cost concerns. If there is any attempt to regulate providers by the Government or any competent authority, health care providers respond with cost-cutting measures that harm patients. As economists Kenneth arrow pointed in 1963, demand for medical care is inconsistent and unpredictable, unlike the steady demand for food and clothing.

This makes healthcare unlike other goods in the market, and to look for the possibility of sustainable commercial health insurance models to meet the requirements of Indian masses.

3.8.4. Recent Developments in Health Insurance

Health is a human right. Its accessibility and affordability has to be ensured by the Government through proper arrangements. The increasing cost of healthcare treatment is beyond the reach of an average Indian as most of them are living below poverty line. While financially well off segment of the population accessibility and affordability towards medical care and treatments the same cannot be said about the people who belong to the other segment of the society. Health care has always been a problem for India, a nation with a large population and large Percentage of 130 crore population living in urban slums and in rural area, below the poverty line. The Governments and people have started exploring various health financing options to manage the problems arising out of increasing cost of care. The Country is also facing the
changing epidemiological pattern of diseases and transition of family structure which leads to the emergence of communicable diseases.

The efforts of the Union Government to reduce the fiscal deficits in the eve of economic reforms in 1990s has lead to severe resource constraints and subsequently witnessing a reduced budget allocation in the health sector. Under this situation, one of the ways for the Government to overcome the problems of underfunding and mobilize the resources in the health sector was to encourage the development of health insurance. In the light of increasing health care costs, coupled with rising demand for primary, secondary and tertiary health care services, issue of accessibility to low income people, problems connected to the quality care, health insurance is emerging as an alternative mechanism for financing and supplementing the existing health care system.

Due to the deficiency of government funding in health care public health functions have been neglected which necessitates the need for exploring health financing options. Naturally, health insurance has emerged as one of the financing options to overcome major problems of the existing system. In its simplest form, health insurance is a contract where an individual or group purchases in advance health coverage by paying a fee called premium. Health insurance policies are at different kinds based on the varying requirements of the population especially based on the care requirement and income difference. For instance policies that cover the healthcare cost of doctors and hospitals/clinics to those that meet a specific need, such as paying for long term care/to meet the outpatient expenditure is available.

Even disability insurance, which replaces lost income if you cannot work because of some unexpected happenings or accident, is treated health insurance, even though it is not directly addressing the treatment expenses. Health insurance is very well established in many nations, across the
developed developing and under developed but in India it still remains an underdeveloped or less tapped market. Less than 25 Percent of India’s 1.30 billion people are covered with some sort of health insurance. And most of it covers only civil servants or government employees and recently the weaker sections through some government supported schemes in a minimum level. At every given point of time, 50 to 60 million people need some kind of treatment for major sickness.

The share of public financing in total health care is just about 1.5 Percent age of Gross Domestic Product which is par below the requirements of the Country. Over 82 Percentage of health financing is private financing, much of which 69 Percent are out of pocket payments. It is that section to be covered through some pre-payment schemes like health insurance. Given the existing health financing and demand scenario, health insurance has a wider scope in India. However, it requires careful and significant efforts to tap Indian health insurance market. It requires employment of a workforce with proper understanding and training.

At present, healthcare financing is marked by around 69 Percent out-of-pocket spending as per the national health estimate statistics published by Government of India in the month of august 2016. India’s per capita spending on healthcare of $109 is much lower than the international average of $863. India is lagging behind in health outcomes even behind its South Asian neighbors like Sri Lanka and Bangladesh, which have better per capita expenditure. There is a huge gap in healthcare delivery for the insured and for the total population. Health insurance is dominated by government run schemes which are largely handicapped due to the resource constraints and ineffective management.

The major public health insurer in India is the public sector General Insurance Corporation (GIC) and its four affiliates with about 70 Percent age
market share in 2012 but subsequently reduced to 51 Percent in 2015. Private Health Insurers (PHIs) expanded quickly in metropolitan and other cities after 2012. Their products are centered on ‘in-patient reimbursements’ and ‘cash-less payments which reduces the hassles connected to re-imbursements of claims. Health insurance in India, which covered around 24 Percentage of the population by August 2016, is provided through voluntary (11%) and mandatory (13%) health insurance schemes. Voluntary schemes are provided by for profit companies and mandatory schemes are provided by Government.

The market share of Public Sector insurers in health insurance decreased from 64 Percent in 2006-07 to 51 Percent in 2015-16. The average annual premium growth in private sector was 47% compared with the government owned insurers growth rate of 27% for the period 2006-07 to 2015-16. This figure shows the growing presence of private insurance in India or otherwise the scope of more Customers by focused services and marketing. Most of the health insurance products offered by private sector companies are similar to the government-defined products. Mediclaim is the most imitated version of health insurance and are indemnity based.

Given its high premiums, most of the policy holders belong to the middle and upper middle class resulting the neglect of lower segment of the population which definitely affects even the business model of insurance companies in the future. While the urban population has experienced an increase in the means of healthcare system performance since the independence of the Country, the rural population lacks basic healthcare treatments even after the twenty five years of economic reforms. Community health insurance schemes sponsored by the government and non-governmental organizations (NGOs) are evolving to cater to the needs of the rural population. However, healthcare delivery and finance still needs improvement to reach the desired level.
3.9. Structure of Health Insurance in India

The existing health insurance schemes in India can be broadly classified as:

1. Mandatory health insurance schemes or government run schemes,
2. Insurance offered by NGOs/Community based health insurance,
3. Employer based schemes,
4. Voluntary health insurance schemes or private-for-profit schemes,

3.9.1. Mandatory health insurance schemes (ESIS, CGHS etc)

These schemes are started by Governments meant for some specified group of people like government employees, workers in the unorganised sector as specified by government and based on the earnings of the employees. And also there are schemes run by different state governments in different parts of the Country. Some of the prominent schemes are explained below

a) Employees’ State Insurance Scheme (ESIS)

The employers’ state insurance (ESI) Act was the first major legislation on social security in independent India, enacted in 1948. Employees State Insurance Corporation administers the scheme based on the provisions of the ESI Act. The Corporation is located in Ministry of Labour and Employment, Government of India. The scheme applies to power using factories employing 10 persons or more and non-power and other specified establishments employing 20 persons or more. It covers employees and the dependents against loss of wages due to sickness, maternity, disability and death due to employment injury.

It also covers funeral expenses and rehabilitation allowance. Medical care comprises outpatient care, hospitalization, medicines and specialist care.
These services are provided through network of ESIS facilities, public care centres, non-governmental organizations (NGOs) and empanelled private practitioners. The ESIS is financed by three way contributions from employers, employees and the state government. Even though the scheme is formulated well there are problem areas in managing this scheme.

Total number of beneficiaries under this scheme as of March 31, 2014 is 7.58 crore. The scheme covers all the states in India except Manipur, Sikkim, Arunachal Pradesh and Mizoram. Some of the problems of the scheme includes large numbers of posts of medical staff remain vacant due to high turnover and low remuneration compared to corporate hospitals. Management information is not satisfactory. The patients are not satisfied with the services they get low utilization of the hospitals. In rural areas, the access to services is also a problem.

The scheme provides these benefits to the members:

- **Medical benefits**: full medical care is provided without any ceiling to an insured person and his family members.

- **Sickness benefit**: it is in the form of cash compensation at the rate of seventy percent of wages for a maximum period of 91 days in a year. There is some minimum contribution requirement to qualify for this benefit.

- **Maternity benefit**: maternity benefit is payable for three months which is extendable by one more month. It requires medical advice from a physician regarding the need.

- **Disablement benefit**: the benefits are divided as temporary disablement benefit and permanent disablement benefit. Certificate from the medical board is required to avail this benefit.
- Dependant’s benefit: this benefit is provided to the dependants of a deceased. The basic requirement for this where the death is supposed to occur due to occupational hazards or occupational hazards.

- Other benefits: it includes funeral expenses (an amount of Rs 10000), confinement expenses, vocational rehabilitation, physical rehabilitation and old age medical care.

**b) Central Government Health Scheme (CGHS)**

The scheme is introduced by Government of India in 1954. The Scheme covers employees and retirees of the central government and certain autonomous and semi autonomous organizations. It provides health cover to the employees of selected semi government organisations. It also covers Members of Parliament, Governors, accredited journalists and members of general public in some specified areas. The eligibility of enrolment are announced by the Central Government according to the changing requirements in the economy. Benefits under the scheme consist of impatient treatments in the hospitals, home care, free medicines and diagnostic services like scanning.

These services are provided through public facilities. Some specialized treatments are permissible at private hospitals also. Most of the expenditure is met by the central government as only 12 Percent is the share of contribution by the employees. The uniqueness of the scheme is the diversified health services provided through Allopathic, Ayurveda, Unani, Siddha and Homeopathic systems of medicine. Clinics and dispensaries were established throughout the Country for providing the healthcare service under this scheme. The facilities are provided through wellness centres and polyclinics. It provides dispensary services, family welfare, consultation facilities by
specialist Doctors, various diagnostic tests. Dispensaries re treated as the backbone of the Health Scheme.

The Scheme has been criticized from many angles. The point of view of quality and accessibility is a big question mark. This accessibility issue has escalated due to the resource constraints of the Government and withdrawal of Government from basic health care. Employees undergo lack of modern healthcare facilities in Government hospitals. Employees and policyholders have complained of high out of pocket expenses while availing the facility from the private hospitals. It is basically due to slow reimbursement and incomplete coverage for private health care (as only 70 to 80 Percent of the health spending is reimbursed if referral is made to private facility, when such facilities are not available with the Central Government Health Scheme).

c) Universal Health Insurance Scheme (UHIS)

The government introduced the Scheme in 2003. The basic purpose is to cover the entire population under some form of health insurance. Financial risk protection can be availed by the poor, for a premium of Rs. 165 per year per person, Rs.248 for a family of five and Rs.330 for a family of seven. Health care for sum assured of Rs. 30000/- was provided under this scheme. This scheme has been made eligible for below poverty line families only. To make the scheme more attractive, it has been introduced as a floater policy. The insurance companies provided for a floater clause that made any member of family eligible for treatment. This scheme differs from mediclaim policy which is offered to an individual member.

In spite of all these, the scheme was not successful and effective in ensuring better health insurance coverage. The reasons for failing to attract and even retain the rural poor are many. The public sector companies who were required to implement this scheme find it to be potentially loss making.
The companies do not invest in propagating and marketing it in its truest extend. To meet the target, it is learnt that several field officers pay the premium under fictitious names.

Identification of eligible families is also a difficult task. Poor people find it difficult to pay the entire premium at one time for future benefit, foregoing current consumption needs. Paper work required to settle the claims is also more difficult from the perspective of the poor. Set back occurs as most of the health insurance companies refusing to renew the previous year’s policies. This scheme is discontinued and started a new scheme called Rashtriya Swasthya Bhima Yojana which has now crossed its enrolment in to 4, 33, 30, 405. This scheme achieved better inroads in comparison to many other schemes. It shows the chance of success when the Government is serious and if there is collective efforts by the Central and state Governments.

d) Rashtriya Swasthya Bhima Yojana

Unorganised workers social security act is the base of RSBY. One of the most important policy milestones in the unorganised workers social security Act enacted by the Central Government to provide for the social security and welfare of the unorganised workers. This act recommends that the central government provide social security schemes to mitigate risks due to disability, health shocks, maternity and old age which all unorganised workers get exposed into and are likely to suffer from. It is initially designed for people below poverty line but now expanded to some defined categories like building and other construction workers, licensed railway porters, street vendors, beedi workers, sanitation workers, mine workers, rickshaw pullers, taxi drivers etc.
3.9.2. Insurance offered by Non Government Organisations:

Community based schemes are typically designed to target the poorer population living in communities basically in rural parts of the Country. Such schemes are generally run by charitable organisations or non-governmental organizations (NGOs). In these form of insurance the members pay a set amount each year for some pre determined health care services. The premiums are usually at flat rate (not income related). Most of the scheme premiums are not progressive from year to year. The benefits offered are mainly in terms of preventive care, though ambulatory and inpatient care is also covered at a restricted level. Such schemes are financed through nominal subscription, government grants and donations from different walks of life.

Community Based Health Insurance schemes are now negotiating with commercial insurers for the purchase of custom designed group insurance policies. CBHI schemes suffer from poor design and unscientific management in many cases. Often there is a problem of adverse selection as premiums are not based on assessment of individual risk status. There is lack of underwriting in this form of insurance.

These schemes fail to include the poorest of the poor because of its member restrictions. They have low membership base and require extensive financial support from the Governments. Other issues relate to sustainability and expansion of such schemes. Some of the popular Community Based Health Insurance schemes are: - Self-Employed Women’s Association (SEWA), Tribuvandas Foundation (TF), The Mullur Milk Co-operative, Sewagram, Action for Community Organization, Rehabilitation and Development (ACCORD), Voluntary Health Services (VHS).
3.9.3. Employer Based Schemes:

Employers in both public and private sector offer health insurance schemes to their employees. Nowadays many successful multinational companies offer health insurance coverage to attract and retain the skilful employees in the company. These facilities are by way of lump sum payments, reimbursement of employees’ health expenditure for outpatient care and hospitalization, fixed medical allowance or covering them under the group health insurance schemes. The Railways, Defence and Security forces, Plantation sector and Mining sector run their own health services for employees and their families.

3.9.4. Voluntary Health Insurance Schemes or Private-for-Profit Schemes:

![Pie chart A](image1.png)

**Fig. 3.4. Market Share of Insurance Companies**

This part of the chapter attempts to understand the health insurance management practices pursued by the public and private sector undertakings in the Country. It also tries to explore the critical factors in management of
intermediation and challenges and professionalism in the commercial health insurance management in the Country.

Commercial health insurance players may redefine their core competencies with Customer-centric themes in the due course of evolving the segment. To cater to a diverse population, healthcare entities need to calculate risk and subsequently position products and policies through an effective under-writing process to the exact needs of the population segments. The population in the Indian context consists of urban rich, urban middle, urban poor, rural rich, rural middle and rural poor. Against a fast and dynamic business landscape, players need to continually monitor and redefine competencies. Distinguishing core and non-core competencies may aid in appropriate partnership with other entities.

It may be the basis of differentiation between the different players and different schemes. The sector started offering targeted products and schemes with standalone health insurance business for health insurance.

In private insurance, buyers are willing to pay premium to an insurance company that pools similar risks and insures them for health related expenses. The main distinction is that the premiums are set at a level, which is based on assessment of risk status of the Customer (or of the group of employees). The level of benefits provided is different from other forms rather than as a proportion of Customer’s income. It is assessed by qualified underwriters employed by the companies. The underwriting is done on the basis of age and even the genetic conditions of the prospective Customer.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) provide voluntary insurance schemes. The most popular health
insurance policy offered by General Insurance Corporation and the affiliates is Mediclaim policy. Mediclaim policy was introduced in 1986. It reimburses the hospitalization expenses owing to illness or injury suffered by the insured, whether the hospitalization is domiciliary or otherwise. It does not cover outpatient treatments.

Government has exempted the premium paid by individuals from their taxable income by incorporating the necessary provisions in the Income Tax Act. Because of high premiums it has remained limited to middle class, urban tax payer segment of population. And also availability of health insurance policies under voluntary health insurance schemes need improvement in terms of number, in terms of features and in terms of other benefits attached to the product.

3.9.5. List of Registered Insurance Companies in India

Insurance Regulatory and Development Authority categorised the registered insurance companies into two. Namely non life insurance companies and life insurance companies

3.9.5.1. List of Non-Life Insurance Companies in India

1. Apollo Munich Health Insurance Co. Ltd.
2. Bajaj Allianz General Insurance Co. Ltd.
4. Cholamandalam MS General Insurance Co. Ltd.
5. Cigna TTK Health Insurance Co. Ltd.
6. Export Credit Guarantee Corporation of India Ltd.
7. Future Generali India Insurance Co. Ltd.
8. HDFC ERGO General Insurance Co. Ltd.
9. ICICI Lombard General Insurance Co. Ltd.
10. IFFCO Tokio General Insurance Co. Ltd.
11. L and T General Insurance Co. Ltd.
12. Liberty Videocon General Insurance Co. Ltd.
14. Max Bupa Health Insurance Co. Ltd.
16. The New India Assurance Co. Ltd.
17. The Oriental Insurance Co. Ltd.
18. Raheja QBE General Insurance Co. Ltd.
20. Religare Health Insurance Co. Ltd.
21. Royal Sundaram Alliance Insurance Co. Ltd.
22. SBI General Insurance Co. Ltd.
25. Tata AIG General Insurance Co. Ltd.
26. United India Insurance Co. Ltd.
27. Universal Sompo General Insurance Co. Ltd.

3.9.5.2. List of Life Insurance Companies in India

1. Aegon Life Insurance Co. Ltd.
2. Aviva Life Insurance Co. India Ltd.
4. Bharti AXA Life Insurance Co. Ltd.
5. Birla Sun Life Insurance Co. Ltd.
7. DHFL Pramerica Life Insurance Co. Ltd.
8. Edelweiss Tokio Life Insurance Co. Ltd.
9. Exide Life Insurance Co. Ltd.
10. Future Generali India Life Insurance Co. Ltd.
11. HDFC Standard Life Insurance Co. Ltd.
12. ICICI Prudential Life Insurance Co. Ltd.
13. IDBI Federal Life Insurance Co. Ltd.
15. Kotak Mahindra Old Mutual Life Insurance Ltd.
16. Life Insurance Corporation of India
17. Max Life Insurance Co. Ltd.
18. PNB MetLife India Insurance Co. Ltd.
20. Sahara India Life Insurance Co. Ltd.
21. SBI Life Insurance Co. Ltd.
22. Shriram Life Insurance Co. Ltd.
24. Tata AIA Life Insurance Co. Ltd.

Source: www.irdai.gov.in

3.10. Third Party Administrators

As a measure to address and solve many issues in the sector insurance intermediaries such as Third Party Administrators were formed after the formation of IRDA. They were expected to play a significant role in the growth, development and management of healthcare system in the Country. TPAs are a separate entity that coordinates between insurer, insured and hospitals. They arrange for cashless hospitalization and closely monitor the employment of facilities and services in the hospitals. Health insurance companies generally make tie up with TPAs for the back office function of managing claims and reimbursements. The company acting as TPA must incorporate as per the guidelines of IRDA. Third Party Administrators have to
fulfil certain requirements and observe the code of conduct specified by the regulator from time to time.

Third Party Administrator (TPA) is a company/agency/organisation holding license from Insurance Regulatory Development Authority (IRDA) to process claims. TPAs deal with corporate and retail policies in addition to providing cashless facilities. They are acting as an outsourced entity of an insurance company for better management of their business and their Customers. TPAs function as an intermediary between the insurance provider and the insured in times of cashless hospitalisation. Introduced by the IRDA in 2001, TPAs handle different pertinent aspects of insurance as listed below:

1. Processing of claims and settlement,
2. Accepting intimations, Approving cashless claims,
3. Disbursing the claims, Utilization review,
4. Provider network, Enrolment, Premium collection,
5. Cashless hospitalisation
6. Value added services such as the following:
   
   a) Ambulance service, specialised consultation, Availability of beds, 24-hour toll-free help lines
   
   b) Lifestyle management, Wellbeing programmes, Medicine supplies, Health facilities and Database maintenance

3.10.1. Need for Third Party Administrators:

According to the experts in the insurance industry, TPAs can bring in the following changes:

- Greater efficiency (delivery of services)
- Increased standardisation (procedures and due diligence)
- updating knowledge base of healthcare services
➢ Renovated management system
➢ Higher penetration of health insurance
➢ Minimize costs/expenditure in treatments
➢ Introduce and develop protocols to streamline investigation
➢ Avoiding unnecessary delays in claim settlement
➢ Ensuring lower insurance premiums.

Any way since the inception, there is much discrepancy between the aims and the ground realities of functioning of Third Party Administrators. As a result, the planners and think tanks in the industry are still deliberating on the integrity and relevance of TPAs in the growing and complex health insurance sector in the Country. The institutionalisation of TPAs, therefore, needs to be moulded a lot to reach the desired level of growth.

3.10.2. Revenue model of Third Party Administrators:

There is a view that the organisation and revenue generation model of Third Party Administrators may determine the extent of the success of this experience in the Country. TPA’s major revenue comes in the form of fees or commission on premium, which is standardised and fixed by the IRDA. The other sources of revenue of TPAs consist of the following:

➢ Benefit management
➢ Network management
➢ Data management
➢ Medical service management
➢ Claim administration

3.10.4. Health services by TPA

Servicing of claims under health insurance contracts by way of pre-authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the pre determined terms and conditions of the
respective policy. It must be done within the framework of the guidelines issued by the insurers for settlement of claims. Servicing of claims for hospitalization cover, if any is available for personal accident policy and domestic travel policy.

Facilitating and assisting the company in carrying out of pre-insurance medical examinations. It is done in connection with the underwriting of health insurance policies for the calculation of risks in the contract and subsequently fix the amount of premium. Third Party Administrator may provide insurance related services to an insurer under an agreement in connection with the life insurance business provided that a TPA can extend this service for life insurance policies also.

TPA may render health services for foreign travel policies. TPA may render health services to the health policies issued by Indian insurers offering medical treatment or hospitalization outside India. It also includes servicing of health care requirements of foreign travellers holding a foreign travel policy issued by foreign insurers. The policyholders may be travelling to India provided that such services shall be restricted to the health care required to be attended during the course of the visit of the foreign travellers in India.

A TPA can act as a health care provider of health services to more than one insurer. Similarly an insurer may appoint more than one Third Party Administrator for rendering health care services to its policyholders or claimants.

3.10.5. Compulsory Registration for Health Services by TPA

Insurance Regulatory and Development Authority stipulates compulsory registration for the TPAs to carry the business on behalf of the insurers. IRDA issues a valid certificate of registration for a specified period and can be renewed. The main and core object of the registration with the
Authority, shall be to exclusively to carry out business of providing health services to the claimants. A Third Party Administrator shall not engage in any other business except the listed activities permitted by the competent authority. Every TPA and applicant applying for registration as TPA from IRDA shall have the words ‘Insurance TPA’ in its name. It is to remind the TPAs to engage or proposes to engage in the business of TPA for rendering health services connected to insurance only.

The clause of Insurance TPA has been introduced later and the existing TPAs may fulfil this norm and change their name by incorporating words 'Insurance TPA' within a period of one year from the date of notification of these Regulations. IRDA has the power to even suspend the registration of TPAs in case of violation of registration requirements specified in the Act or the notifications issued from time to time. The clauses in the certificate of registration are also significant in the business of TPAs.

3.10.6. Challenges for TPAs:

According to experts and from the experience, there are several constraints to the effective functioning of TPAs in the present insurance environment in the Country. Some of the problem areas in the health insurance sector in the Country adversely affect TPA-related services. These are listed below:

Information asymmetry among the different stakeholders: Weak networking and liaison between the stakeholders. Inordinate delay due to hospital related issues in the issuance of identity cards. Lack of standardisation in terms of billing and other matters exists. Under reporting and moral hazard across health providers are prevalent. Illegal connection between corporate hospitals and insurance companies (i.e., low claim ratio for individual policyholders and high claim ratio for corporate policyholders)
IRDA has to frame regulations for TPAs for the effective management of health insurance in the Country. There need arrangements in place to effectively appraise the performance of TPAs. IRDA, assesses TPAs based on the latter’s financial performance. It is done in terms of fees mobilised as a proportion of policy premium rather than Customer satisfaction. There is, therefore, a view that TPAs shall be evaluated/accredited on the basis of quality of services provided

Low awareness about TPAs amongst prospective Customers/policyholders is also an important challenge before the regulator and TPAs. According to the recent studies, most of the policyholders are unaware of the extra premium charged by insurance companies for TPA services which is a violation of the IRDA rules. Likewise, the awareness campaigns conducted by TPAs on matters like cashless hospitalization, sub limits and claim settlement procedures in insurance policies are not reaching many policyholders.

Policyholders’ still depend on insurance agents rather than Third Party Administrators in times of claim settlement. Policy holders took the policy through online channels faces difficulties due to the low awareness. In many cases, policyholders do not see TPAs as distinct entities. Insurance agents see and place the TPAs as a threat to their business also.

Hospitals have no substantial evidence to prove that Third Party Administrators increased their patient turnover. There are problems in taking policy decisions for expanding or making changes in the way TPAs are introduced into the existing health insurance environment. Experts point out that TPAs need to invest in developing human capital rather than limiting the investment in technology to improve their delivery of services and to rein the operating and other costs. Inadequate knowledge about the provisions and benefits of Third Party Administrators amongst policyholders must be initiated to overcome this issue in health insurance intermediation.
Healthcare providers look for well-trained functioning of TPAs for combining the back end and front end activities in health insurance. It helps the hospitals to effectively deal with the operational inefficiencies in the system. Poorly developed and less evolving protocols and systems instil little confidence amongst the different stakeholders even the Government. TPAs have several in-house experts such as legal experts, IT professionals, doctors, management consultants and hospital managers given that claims management and settlement requires bargaining power and negotiation skills, i.e., combination of technical and management skills. But the question of the employment of this technical and managerial team comes into force many a times because of low claim ratio still existing in the sector.

Hospitals which have updated technology and a robust health delivery mechanism in place are more likely to pave way for hassle-free claims settlement offered by TPAs. While the basic purpose of the formation of Third Party Administrators is to minimise the claim period, claims processing, in several cases, is riddled with inordinate delays. The insured lacks adequate knowledge about empanelled hospitals for cashless services. Many hospitals also report additional expenditure incurred by them for a better coordination with TPAs for efficient delivery of insurance services to the Customers.

3.10.7. List of the Third Party Administrators in India:

1. Medi Assist India TPA Pvt. Ltd
2. United Healthcare Parekh TPA Pvt. Ltd
3. E Meditek (TPA) Services Ltd
4. MD India Healthcare (TPA) Services (Pvt.) Ltd
5. Family Health Plan (TPA) Ltd
6. Focus Healthservices TPA Pvt. Ltd
7. Vidal Health TPA Private Limited
8. Heritage Health TPA Pvt. Ltd.
3.11. Recent Trends in Health Insurance

Participation of private players: Currently, Private Health Insurance accounts for about 8 Percent of the insured population and by different estimates on the industrial trends this can increase to around 30 Percent by 2020. The key is to devise products and schemes to reduce out-of-pocket expenses, basically for tapping the untapped market and inadequate coverage. The recent changes in Foreign direct investment in 2016 norms open up the health insurance market completely to global players which is going to bring sweep changes.

The health insurance market in most developed Countries is on the verge of saturation and maturity. However, the health insurance sector in India has plenty of scope in depth and breadth. It is very likely that there will be increase in the number of cashless plans, reimbursement schemes and outpatient plans followed by a culture of innovations which is the hallmark of every evolving segment. It may to extend to related areas like health care management and health care financing.

The emerging healthcare models are seeing closer integration of players: Integration through cooperation is the right strategy to penetrate the
semi-urban and rural areas. Health insurance companies, pharmaceutical companies and health care providers are likely to drive the emergence of an integrated healthcare model. It requires increased transparency and accountability in all its activities. Professional drug delivery mechanisms may emerge by combining the scope of technological advancement with a consequent decline in buying drugs over the Counter. It leads to overcome the existing issues like over exploitation and under delivery in health care management. Well organised and well regulated models may evolve with a focus on standardizing care delivery and system of reimbursement. Remote health diagnosis and monitoring has come to mainstream with multi specialty hospitals in metropolitan cities already focussing and started it.

Role of third-party administrators (TPAs): The management of health care needs the strengthening of TPAs. As it is a mechanism requiring corrections based on marketing requirements checks and balances in the Indian context. Servicing of claims under health insurance contracts by way of pre-authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the pre determined terms and conditions of the respective policy.

It must be done within the framework of the guidelines issued by the insurers for settlement of claims. Recent IRDA draft notifications such as stipulations around check issuance effectively reduced the role of TPA as cited by many recent surveys. Private insurers are likely to shift their administrative controls in-house by employing trained and qualified workforce. It requires the distinction of core and non core activities by the insurance companies.

Increasing use of technology in health care: Technology have already started inroads in to the new avenues in insurance intermediation, streamlining back end operations and health care management. Healthcare
entities dealing with lifestyle diseases need early incorporation of technological developments as evident in some entities. Customer centric technology focussed health care management approach is very essential today because of the changing demographic profile of the Indian population. Healthcare information technology spending is expected to quadruple to $1.8 billion by 2019.

Healthcare delivery and remote healthcare dimensions are undergoing major technology transformation. Healthcare transformation is similar to the mobile penetration happened in India (2010–2016), incorporating multiple technology evolution cycles. Health insurance management may witness proliferation in the first round followed by consolidation in the second round.

Increasing awareness and differentiation: In a survey conducted by NCAER for Insurance Regulatory and Development Authority of India in 2012, most people connect health insurance with death. Only 57 Percent participated in the survey are not aware of the different uses of health insurance which implies that the difference between health and financial security is not well understood. It is basically because of the communication problems exist in the health insurance management. Effective and popular campaigns highlighting the differences between health and financial security are necessary. This will highlight the need for health insurance among the population for creating a healthy population.

The term health insurance means any form of insurance whose payment is contingent on the insured incurring additional expenses or losing income because of incapacity or loss of good health, payment provoked because of physical or mental incapacity which prevents the insured from being able to work. If the incapacity prohibits the insured’s activities of daily living, it is called long term care insurance and if the insured incurs hospital, physician, or other health care expenses it is called medical expense
insurance. The market penetration of commercial health insurance is very low in relation to the huge population in India. The health insurance industry is one of the fastest growing segments among other non-life insurance segments in the Country.

The growth dilemma: Health insurance industry in the Country is forecasted worth Rs.6, 489 crores with a compounded annual growth rate of approximately 42.3 Percent between 2012 and 2016. The market penetration is three folds higher in 2016 as per the recently released statistics from IRDA. According to World Bank Report 99 Percent of Indians face financial crunch due to some critical illness mainly due to the emergence of communicable and lifestyle diseases. Hence, the need for Health Insurance market in India is unique and has a strong growth potential than the other insurance markets. It is even more than comparison as most of the markets in the world are nearing to saturation.

India’s health insurance market has witnessed significant structural, regulatory and institutional changes since the insurance sector opened to private and foreign players in 2000. The number of persons covered has been growing at a rate of 30 Percent year after year and premiums have increased by 40 Percent annually. IRDA has worked extensively to build a strong and conducive environment in health insurance. IRDA formulated effective regulations and notifications for the development of the segment. Creation of information database will definitely help the companies to overcome the growth dilemma in health insurance.

Emerging branch of insurance: Health insurance is defined as an arrangement to provide financial and other assistance to required segment of the population by pooling the risks and distributing the costs among the policyholders. It manages and covers these costs and risks of providing healthcare services. Health Insurance is offered by employers, through state
and central government programmes, through associations, NGOs and from commercial health insurance companies. Health insurance is a special and evolving branch of insurance.

The total insurance premium in the Country is projected to grow Rs.22,30,000 crores by 2017-2018. Total non life insurance premium is expected to increase at a rate of 35 Percent for the period spanning from 2014-15 to 2017-2018. Major portion of this growth is expected to be contributed by health insurance. Health insurance is expected to become the second largest business for in the insurance industry after motor vehicle insurance in next couple of years. The rising price of healthcare has positively influenced the growth rates within the private health insurance market.

More Customers are now coming to the market as a way of covering the escalating costs in health care services. In certain cases, health insurance is taken to receive world class treatment in affordable cost. According to Federation of Indian Chamber of Commerce and Industries (FICCI), the healthcare sector would require around $ 32 billion - $ 41 billion in the next 10 years, as the industry matures and major part of this is expected as premium contribution by the policyholders. There is buoyancy in the health insurance segment, as it is becoming corporatized and due to the increased competition between the public, private and foreign companies. The more organized and regulated the sector becomes, the more efficiently it will be managed.

Investment Potential: Investors are increasingly recognizing the potential in health insurance and started investing in health insurance. India is now at the verge of an unprecedented growth for the next 5 to 7 years and health insurance is prominently one of the major contributors in the growth story. However, if the nation wish to make use of this opportunity in the
changing business landscape, it is necessary for all the stakeholders especially the regulator and other prominent parties to work together.

The stakeholders may take some key initiatives that will form the buildings blocks and take the insurance industry in to the expected direction. Leading credit rating agency and investment consultant KPMG in its recent report on ‘Health insurance –Road Ahead’ said that achieving this growth will depend on the ability of the important stakeholders namely Government, IRDA, healthcare providers and insurance companies.

The complementary role of NGOs/ SHGs, TPAs, distribution channel partners, health centres and the media is necessary to strengthen the industry according to the changing requirements of growth and development. The segment recently started providing long term returns to its stockholders may be in a slow pace and is surely expected to increase in the near future. Moody’s in its report emphasizes that the “Pillars of Change” such as increasing public and Customer awareness, standardization and accreditation of healthcare providers, newer and innovative healthcare infrastructure and building of a health insurance database are crucial to create a robust health insurance industry. However, these pillars need to be supported and facilitated by the “Enablers for Growth” such as technology, innovation around products, pricing and distribution channels in order to encourage the growth of the industry in the coming years.

Reforms in the segment: Various stakeholders need to initiate significant reforms and actions towards achieving the desired growth and development of the health insurance industry. Although India’s healthcare system has gradually improved in the last few decades, it continues to lag behind when compared with its comparable emerging Countries in the world. By understanding the urgent need for reforms Government and other stakeholders have taken several measures like relaxed FDI requirement. The
The poor state of healthcare in India is attributed mainly to the lack of government funding on healthcare initiatives.

Estimates reveal that the per capita spending on healthcare by the Central Government and state Governments is far below international standards and benchmarks. As health is placed in the concurrent list of Indian constitution both the Governments are required to pay attention but time bounded funding is not happening in the segment. If India wants to achieve a more desirable proportion (currently 69 Percent) of out-of-pocket expenditure, as in China (55 Percent), it would demand renewed and a different participation from public, private or a combination of these sectors, with commercial health insurance playing a significant and prominent role (Neville M. 2014).

Health care Infrastructure: India’s healthcare infrastructure has shown consistent improvement in the recent past, but much remains to be accomplished. Despite a steady increase in the establishments of health care institutions in the Country, there still remains a severe shortage of hospitals, clinics, sub-centres, primary health centres, and community health centres. Lack of sufficient healthcare is reflected in the low density of healthcare workforce and less qualified employees as seen in a recent report of World Health Organisation.

The public healthcare establishments consists of a large number and a variety of institutions like dispensaries in the primary level, secondary healthcare providers in the district level, small hospitals providing tertiary care, multispecialty hospitals providing specialist services, medical colleges, paramedical training colleges, diagnostic centres etc. Despite the size and reach of the public healthcare system, India scores poorly on most generally accepted health indices like average life expectancy, maternal mortality rate etc.
Public Private Partnership in health care: The Indian health care system have been critically reviewed by World Bank, Ministry of Health and family welfare and Planning Commission of India in regular intervals and pointed the issues of equity and accessibility in the system. These studies have documented many serious issues with respect to equity, accessibility, efficiency and quality of the health delivery system. They have also made several policy recommendations to reduce and overcome these problems.

All the reviews and studies explained the growing importance and role of the private sector in addressing India’s healthcare needs. Public-Private Partnerships (PPP) have also seen as one viable method for ensuring growth and equity in the healthcare while keeping public goals in mind. The main objectives of public private partnerships are to improve quality, accessibility, and acceptability, adoption of advanced technology, reduced cost and efficiency of healthcare services.

Role of State Governments: While different states in India have different levels of success in the implementation of health care initiatives and health insurance programmes, it is believed that the various State Governments’ may continue to take on an increasing role in India’s healthcare system. The public and private health insurance sectors in India have witnessed strong growth in recent times especially because of the newer and effective roll out of health insurance schemes by various State Governments. If it continues, in the same momentum it may help in the creation of an efficient platform in health insurance in the near future. Projections based on a large-scale health care utilization survey of 2013, about seven Percent of the household income is spent on curative care which amounts to Rs. 450 per capita per annum.

However the burden of expenditure on health care is unduly more on households engaged in the informal sector. It indicates the potential for
combining the mandatory and voluntary comprehensive health insurance schemes for the different sections of the society.

Government run Schemes: Overall, the health insurance coverage is very low and Government is the sole mechanism to take initiative in the present landscape of the Country. Only sixteen Percent of the Indian workforce is covered by some form of health insurance like Central Government Health Scheme, Employees State Insurance Scheme, Rashtriya Swasthya Bhima Yojana and Mediclaim where a majority of them belong to organized sector.

In comparison to the Employees State Insurance Scheme and also to the community-based schemes, the private players and commercial products cover only a small amount of benefits i.e. only hospitalization. Almost all the schemes irrespective of the company come with unreasonable amount of premium with a lot of exclusions and sub limits. Previous studies have shown that the current voluntary health insurance plans follows almost the same kind of plans introduced by Government or public sector companies.

Health care Developments: Healthcare, which is a US $ 75 billion industry in India, is expected to reach over US$ 150 billion by 2017 and US$170 billion by 2018, according to a recent report in their report - (India Healthcare Trends 2014). The segment offers immense potential to health insurance as the Country has many trends corresponding to the fastest economic growth. The Country has growing elderly population which is expected to be more than 20 Percent of the population by 2030, emergence of nuclear family and rise in the employment and income levels.

To meet this growing requirement the Country needs US$50 billion annually for the next 5 years, say Confederation of Indian Industry (CII) Study. The Indian health insurance business is growing at the rate of 37
Percent. According to a study by the New Delhi based Chamber of Commerce and Industry the sector is projected to grow to US$135.5 billion by 2016. The sector has been attracting huge investments from domestic players as well as foreign investment firms. The government along with the involvement from the private sector is planning to invest US$ 1 billion to US$ 2 billion in an effort to make India one of the top five global pharmaceutical innovations by 2020.

Health for all by 2020 is the government’s new slogan. So, there is an urgent need to energize the health insurance sector. This would also help to mitigate the rising healthcare cost and facilitate access to the best and quality care. Health care insurance rightly provides the mechanism for both individuals and families to mitigate the financial burden of meeting healthcare expenses. In the present context, therefore, a well-designed and affordable health insurance policy is needed.

But all this calls for right designing of product, right pricing of the product and right promotional efforts on the part of insurance companies to meet the growing and changing needs and demands of the Customers. Without access to such insurance, many people are unable to obtain treatment or they incur debts to pay hospital bills. Recent trends in health care platform in India have to be seen as an opportunity to grab the sector and to understand the pulse of the market.

3.12. Health insurance and Pharmaceutical Business in India

Indian pharmaceutical market is expected to break into the top 10 markets in the world in value with the total sales reaching US$ 26 billion by 2016, as per a recent article by IMS Health. It is interesting to note here that the development of this kind is expected to be fuelled by the rise in health insurance in India coupled with the related developments in the health care.
The regulator and the market experts in the Country are expecting over 14-15 Percent annual growth in the health insurance market. This exponential figure is possible based on the compounded annual growth rate of 32 Percent achieved by the sector continuously for the last eight years.

Factors like the change in government focus, increasing government funding, rising standards and quality of care and overall boom in the opportunities for access to necessary treatment are expected to play a crucial role in shaping a dynamic and sophisticated marketplace for healthcare in the Indian market. The pharmaceutical market in India is currently worth Rs 74,117 crore for the 12-month period ended May 2014 and is currently ranked on the 12th position, up from the 15th spot with sales of US$ 6 billion. This growth is incomparable with the growth in other economies.

It may be noted that the 2016 growth forecasts comes as an encouraging sign especially because the value erosion that is expected to take place because of the expanded price controls. In fact, the World Bank has projected a growth of covering at least 50 Percent of Indian population by the end of 2017 by some form of health insurance including the government run schemes. Undoubtedly, health insurance is one of the most critical and significant areas in the rapidly growing healthcare market.

With initiatives like Rashtriya Swasthya Bima Yojana as a concerted effort of different Governments in the centre and state, the Governments have been trying to improve the healthcare scenario in the Country. For the uninitiated, RSBY is a health insurance scheme for below poverty line families and the dependents launched by the government of India. In fact, this policy is expected to hold a major share in ensuring sustainable healthcare in the changing healthcare equation in the Country. This scheme is even replicated by many commercial health insurers of public and private sector in
slight variations. It has given an input into how much the rural people can pay for the treatments.

As per the IMS Health data, health insurance business premiums are expected to reach Rs 35,000 crore by 2015, registering an increase of 312 Percent from 2012. It is encouraging to note here that health insurance coverage grew about 445 Percent between 2004 and 2011 in India which is remarkable when comparing with the earlier years of growth. The wide opportunity created by the rise in the health insurance market is expected to be a welcome sign for both Indian and international drug companies. At the same time, this is expected to improve the healthcare scenario in the Country as well.

3.13. Problems of Health insurance in India

Insurance is a complex business neither buyer nor seller appear to have much information as they need. By going through some of the problems in the Indian insurance market information problems are prominent and needs immediate attention by the policyholders. Information problems are Asymmetric information problem arises when one party to a transaction has relevant information that the other does not have. Four types of major problems exist in the present health care scenario namely:

a). Lemons problems,

b). Adverse selection problems,

c). Moral hazard problems,

d). Principal-Agent problems.

a) Lemons problems: Lemons problem is where the insurance Customer knows less than the seller, about the seller and its products. This happens because of the basic nature of health insurance contract that makes a present promise of future performance on the occurrence of stipulated events.
The lemons problem in the insurance industry acts as the basis for the majority of insurance regulation happened in India. Insurers and their representatives mostly agents have little incentive to disclose adverse information to potential Customers because doing so may affect their business too. Hence Government intervenes to rectify these unequal positions between insurance buyer and seller by making certain disclosures mandatory. Government recently announced different measures to monitor insurer’s financial condition and by regulating and controlling insurer marketing practices.

b). Adverse selection problem: This arises when the buyer knows more than the seller about his or her own condition. This problem persists worldwide and is the main reason why insurers seek such extensive information about the insured. Insurance company collects as much information as possible about the insured to assess the loss potential of the insured. Insurance companies employ underwriting for risk assessment of insured. This extensive information helps them to charge equitable prices that reflect the expected value of expected loss which may or may not happen.

The price charged will be fair to the insured and to others in the insurance pool; hence the premium one pays is based on their potential loss.

If some insured are able to secure a price that is lower than the expected value of their losses, they impose costs on other insured. It causes a distortion of pricing the insurance product. Adverse selection can cause the insurance mechanism to break down altogether which is evident in many cases. The major challenge for insurers is to obtain sufficient information to assess insurability. The companies must be in a profitable position to do this without incurring unwarranted expenses. The adverse selection problem is another reason for the commercial insurers to refuse certain insurance offers.
It affects the Customer satisfaction and Customer retention in health insurance.

c) Moral hazard problems: Moral hazard is the tendency of individuals to change their behaviour because of insurance. This is a critical problem for insurers in health insurance. The insured may select a multi-specialty hospital and undergo unnecessary medical treatments and tests. Policyholders sometimes with the help of hospitals may extend their stay in the hospital just because they have health insurance. One of the major tasks of claims settlement department is to discourage and identify incidents of moral hazard. This may sometimes be practiced with the help of hospitals too.

This issue is cited way back in 1963 as a major challenge in health insurance. Unless and otherwise this problem can be addressed effectively the profitability and viability of the companies will be greatly affected. This problem is unique in this form of insurance because of the specific nature of health insurance where the hospitals decide the claim and the insurer pay the claims. A humble attempt is done in this study to examine the role of hospitals in this regard.

d) Principal-Agent Problems: The term agent refers to anyone acting for another. A serious information problem in health insurance can arise when one person represents another. The insurance business for a long time works through this business model of having insurance agent as the sole intermediary to offer the policy. Recently the information communication technology especially the internet is trying to supplement the role but the penetration is very low. But still the proportion of people using internet is very less for availing insurance policy. The person whom the agent represents is the principal. The principal-agent problem arises when the agent knows more about his or her own actions than does the principal. The agent’s
incentive is to maximize his or her personal gain which is not always compatible with simultaneously maximizing the principal’s gain.

Principal-agent problems lurk behind innumerable insurance relationship, operations and practices. The principal agent problem is twofold. The first one is the issue of how to ensure that agents do not misrepresent or with hold required information about the company or its products from Customers. The second one is the misrepresentation or withholding of key information about the Customers from the company. Non alignment of principal agent relationship is the major problem in this regard. As salespeople are interested in making the sale to seek a commission their personal interests may not align with the interests of the insurance Company (Kenneth Black, Jr. Harold D. Skipper).

3.14. Health Insurance underwriting

Underwriting is a function that encompasses the entire spectrum of assessing the risks in its totality and the arriving at a decision on premium (G. V Rao 2010). Health insurance offers protection against the financial loss that arises from the happening of unexpected events affecting an insured whether individual or group. This benefit is offered in exchange for the payment of an amount called premium. The claim settlement is based on the terms and conditions of the insurance contract.

By pooling a large number of similar/ different risks into a pool of homogeneous risks and uncertainty to a single insured are transferred to any one of the participants in the pool. Hence, the features of the pooled risks must be similar or is made as homogeneous as possible, through the intervention of the professional underwriter. An underwriter’s understanding of the concept of insurance is therefore different from that of the other insurance professionals in the industry. The purpose of insurance is to offer
financial protection to property, persons earning and liabilities against some unexpected events. Buying insurance does not create any value or gain to an insured.

Insuring is just an act of buying financial protection against probable loss situations. The underwriter quantifies this probable loss. An underwriter analyses and evaluates the risk and exposures of potential clients through some scientific mechanism. They decide how much coverage the client should receive, how much they must pay for it, or whether even to accept the risk and insure them. Underwriting involves measuring risk exposure and determining the premium that needs to be charged to insure the risk of the insured. Health insurance underwriting mainly deals with the risk of morbidity- the Count and severity of it. In individual health insurance, medical underwriting becomes essential to reduce the risk of adverse selection against the insurer.

A high degree of medical underwriting does not find favour with insurance regulators and insuring public as well. Existing health status and age are the prominent underwriting considerations for individual health insurance. Present health status, individual and family medical history enables an underwriter to determine presence of any pre-existing diseases. The underwriters eventually estimate the probability of future health problems that may require hospitalization or other health care expenditure. Current health status and age are key underwriting factors for assessment of insurability of an individual for health insurance.

Moral hazard is a serious concern in underwriting of health insurance. Moral hazard relates to non-disclosure of pre-existing diseases at the time of buying health insurance, getting hospitalized to claim for reasons not covered under a hospitalization cover, over-utilisation of benefits are some of that to Count a few. Premiums for health insurance in India are determined
primarily by two factors: the age of the insured and the amount of insurance chosen. Unlike life insurance, there is no differential rating between genders in India.

Under most health insurance policies, entry age for coverage ranges from 3 years to 55 years, although some insurers cover a new-born child provided that the parents are simultaneously covered. Coverage is extended to 85 years if it is continuous and the claims ratio is deemed acceptable by the insurance company. With continuing adverse claims ratios, government insurers are taking steps to minimize their losses.

Profitability of some non life insurance companies got eroded, among other reasons, owing to higher claims on health portfolios in the quarter ended 30th April, 2016. The insurer had to re-price its health portfolio and also significantly reduced its exposure to the unprofitable growth in mediclaim.

The companies are compelled to do this because of the increasing losses happened to many companies especially due to wrong underwriting. The educational institutions offering the kind of courses to produce professional underwriters are also very less in India. Even those qualified need exposure and experiences to become a qualified and professionally updated underwriter. It is quite exaggerating to expect it at the early because of the evolving nature of the industry.


Underwriting for group health insurance is different due to many reasons. Even the regulation applicable to this kind of underwriting is different. Group health insurance is underwritten mainly on the basis of the law of averages. While accepting a group for health insurance, the insurer takes into account the existence of a few members in the group who may have
severe and frequent health problems. Underwriting of group health insurance requires analyzing the characteristics of the group.

This process basically aims to evaluate its conformance with the insurance providers underwriting guidelines as well as the guidelines laid down for group insurance by the Insurance Regulatory and Development Authority. Underwriting practice for group health insurance according to the existing regulation in the Country requires evaluating the proposed group on various parameters like:-

- Type of group, size of the group, type of industry, eligible lives for health coverage, whether the coverage is required to the entire group or there is an option for group members to opt out, the level of coverage – may be like uniform or stratified.

- Composition of the group in terms of gender, age, income levels of group members, employee turnover rate in the company, whether premium paid entirely by the company/ group holder or requirement of members to participate in premium payment.

- Past claims experience of the proposed group by treating every member as a single unit rather than treating the group as a single unit.

3.14.2. Genetics in Underwriting

Use of genetic information of individuals for health risk assessment for underwriting of health insurance is on the cards of the insurance companies. This is not mandatory by any of the existing regulations but the chance of it emerging in line of international developments is highly likely. The discovery of human DNA (Deoxyribonucleic acid), which ‘contains the genetic instructions used in the development and functioning of all known living
organisms and some viruses provides an innovative and effective tool to underwriters and actuaries. It helps the companies for the assessment of health status of an individual of a group. Science and Scientists now seems to be moving towards the belief that gene abnormalities cause all ailments or they strongly influence the ability of the body to recover from disease or ailments.

Gene abnormalities can be broadly classified as inherited or acquired/developed (resulting from mutations caused by aging or the environment or other factors). Adopting newer and scientific methods for assessing the risk and underwriting it with appropriate conditions constitutes the prominent functions of an insurance company. Regulators at different levels have a significant role to play in ensuring that insurers operate within the parameters of underwriting prudence. This prudence basically to keep the company solvent at all times and in their business of covering risks do not become a risk themselves. Proper assessment of risk and underwriting it with suitable mechanisms and adequate pricing without fear or favour constitutes the core function of an insurance company (Aloke Gupta).

3.15. Healthcare system in India

Health care in India consists of primary, secondary and tertiary care institutions. This institutions are manned by medical and paramedical personnel appointed based on their requisite qualification prescribed by Indian Medical Association and related entities. Medical colleges and professional training institutions are established basically to train the man power and give the required inputs to all other institutions in health care. The main objective of any healthcare system in the Country is to facilitate the achievement of an optimal level of health to the people of the Country.

It can be ensured through the delivery of services of appropriate quality and reasonable price. Increased awareness about the technological
advances for management of health problems, renewed expectations of the people and escalating cost of healthcare are some of the challenges that the healthcare system have to address at the early.

Healthcare delivery system will have to gear up and initiate necessary preventive and curative healthcare for the people in the Country. Healthcare has always been a difficult area for a Country like India, as major part of the population is living in urban slums and rural areas. Health insurance protects people against huge financial problems resulting from unexpected illness or injury.

An effective and efficient health care management system ensures the combining of resources to cover the various kinds of risks. Health insurance in India whether mandatory or voluntary is at an initial stage and contributes to only a small proportion of the health expenditure. The government through its schemes such as Employees State Insurance Scheme, Central Government Health Scheme, and the Mediclaim policy offered by public insurance companies, has played a significant role in increasing the insurance coverage from time to time. NGOs and community-based organizations such as Self Employed Women’s Associations (SEWA), Action for Community Organization, Rehabilitation and Development, too offer a number of schemes to the poor and the marginalised groups to meet the high cost of healthcare and accessing least basic health care.
Under the existing private medical health insurance scheme, which is based on the principle of indemnity, policy holders at the time of healthcare emergencies can choose between cashless facilities or reimbursement. Earlier people choose reimbursement and now almost all the policy holders prefer cashless hospitalization in the network of hospitals due to the increase in the number of hospitals and due to the cumbersome procedures related to reimbursement. But the procedures for getting this facility are still difficult and so people prefer not to avail the schemes. Besides having cost-escalating characteristics, these schemes are inefficient and have a number of limitations.

Insurance companies have to deal with unregulated hospitals or clinics who work in an environment where there are no prescribed standards, quality...
benchmarks and treatment protocols, and where variable billing systems and significant price variations across providers exists which is reflected by the adverse claim ratios. And there are many cases where hospitals tend to charge the patients covered by insurance more than the actual expenditure.

**Fig 3.6. Statistics on Doctor’s and Nurses**

### 3.16. Opportunities in the Health sector

This portion of the chapter covers the various opportunities in healthcare to throw insight for the insurance companies to step up their business and use the opportunities at the earliest to its fullest extent. It subsequently helps the people to reduce the escalating medical costs. Rising income levels, stressful work environment and the resultant food habits brings along with it health problems and other disorders. Along with spiralling inflation, health cost is also escalating upwards. A major part of a salaried person’s life is devoted in securing the financial future of the family and dependents. Rising healthcare costs have increased the need for health insurance. One of the oldest and most popular risk-mitigating tools is
insurance, which provides the family with financial protection for unexpected contingencies.

Prior to the economic and financial reforms of 1991, life insurance was the only insurance product in one’s portfolio. With liberalization, privatisation, globalisation and stabilisation along the technological advances there has been a strategic shift in the focus of the people in insurance related matters. Hence, medical insurance has made a strong entry into the financial planning portfolio of middle income and salaried professionals. In the earlier days it was manageable to meet the healthcare expenses from one’s own pocket, whereas the rising healthcare cost today can put a significant dent in one’s finances, and even wipe away years of savings.

With specialized healthcare technology enabling quality treatment and general price rise, the cost of care has also become very expensive and unaffordable to a large portion of the population. Healthcare is an expensive affair making it extremely important to invest in health insurance to protect the family. Additionally for taxpayers, health insurance also carries a tax exemption under section 80(D) of the Income Tax Act 1961. The prospectus of growth in health insurance business in India is tremendous.

India one of the fastest growing economies in the world spends about 7 Percent of GDP on healthcare out of which 1.6 Percent is in the Government sector and 5.4 Percent in private sector ([Parekh 2003]. Public funding towards the health care constitutes only one Percent of Gross Domestic Product. This has made out-of-pocket spending to be the dominant component, funding 69 Percent Age healthcare expenditure in Financial Year 2016-17. Health expenditure is expected to grow at 35% per annum. Even though insurance industry was opened up to private sector in 2000, the penetration of medical insurance still remains very low.
It is estimated that only a small portion of the Indian population are covered under some sort of healthcare whether it is private health insurance or government schemes. Despite such a high share of expenditure by individuals, there is growing evidence that the level of health care spending in terms of quality and access is becoming more and more problematic because of inadequate financing (Randall p. Ellis, Moneer Alam, Indrani Gupta 2000). This highlights the need for alternative financing at a much higher level. Rural health insurance may be as mandatory also needs to be encouraged.

Companies with long term capital commitments and long term investment interest can make benefit from the Indian health care scenario. India is now poised as the cheapest destinations for many industrial activities and that has to be replicated in health care also. It needs huge investment and it needs concerted and focussed efforts from the Government and other stakeholders in the health care.

3.17. Challenges in Health Care

In its recent assessment of the Indian economy, the Organization for Economic Co-operation and Development (OECD) identified India’s poor health outcomes as one of our major developmental challenges in the twenty first century. India is a lagging behind in health outcomes not just by international or OECD standards, but also by the standards of the developing or emerging nations like Mexico or Brazil. In 2015, India witnessed 355 deaths per 1, 00,000 persons due to communicable diseases alone, much higher than the global average of 200. India faces a higher disease burden than other emerging economies such as China, Malaysia, South Africa, Mexico and Sri Lanka, as the charts below illustrate. Even SAARC nations such as Nepal and Bangladesh have a better record in health compared to India.
Fig 3.7. Health Care Expenditure as % of GDP in India

While India has made rapid strides in raising economic growth closer to seven Percent since 2004 and lifted millions out of poverty, progress in improving health outcomes has been slow and inconsistent. As a result, India continues to experience an extraordinarily high disease burden, which blocks the productivity of workers and even managers and lowers their earnings capacity.

Low level of public investment: at a time where the moving towards universal health coverage to its citizens India allocates only a small Percent to health care management in the Country. According to a 2013 World Bank estimate, India losses 5 Percent of its gross domestic product (GDP) annually because of the premature deaths and preventable ailments. An important reason behind the poor health of the average Indian is the low level of Government investments. It is evident in the investment in preventive health facilities such as sanitation and waste management, as well as in medical care facilities such as primary health centres and health professionals. Even when public health facilities are available, they are often of poor quality and standards. The poorest income classes receive fewer benefits from the public health system than their peers.
Missing focus on Quality: The lack of quality health services and medical professionals and the absence of health insurance compel the poor to spend heavily on private medical care which is perceived to be of good quality but with huge financial commitments. According to a 2011 research paper by Sumitra Chattergy of the Tata Institute of Social Sciences, Mumbai, out-of-pocket health expenditures accounted for nearly one-sixth of India’s poverty burden. The high costs of healthcare also act as a constraint to the poor people in seeking treatment, leading to delays and escalating health problems.

The public health care in the Country is witnessing inefficiencies and lack of physical infrastructure. The mismatch between demand and supply of healthcare services and infrastructure has triggered the emergence of private participation in the provision of healthcare. Foreign and domestic investment in health care is increasing but the magnitude is lesser than the requirement of the economy. As it is a case of foreign investment it has its own inherent limits and if not managed properly it may create a negative effect for the economy. The establishment of multispecialty hospitals is increasing throughout the Country but it is essential to ensure investment in all the sectors coming under healthcare, so that there would be inclusive development.

Social Security Schemes: Providing a security net for ensuring availability of quality healthcare to the population is the prime goal of every nation. India is one of the fastest growing economies in the world, but it is lagging behind many developed and developing Countries in relation to the health care security and the development of health care facilities. Government is facing budgetary deficiency in expanding the social security schemes and ensuring health care to the entire population in the Country. The time bounded corrections are not incorporated to many of the schemes and it is cited as one of the reasons where the schemes are not effective in most parts of the nation. The higher limits and related conditions for enrolment are also a problem for the social security schemes.
Often an individual has to reach out to multiple levels of care providers (Professionals, Doctors, Public hospitals, and Private providers) to seek care for the same reason. This leads to compartmentalized care with cost escalation and quality dilemmas. Moreover, issues with medical procedures account for a large share of negative drug events (around 24.1 Percent in Mumbai, according to a recent study). Overall deaths in India due to adverse drug reactions are estimated to be 5,00,000 annually. People are not even aware about many schemes and it leads to inefficient management of many schemes by the Government officials and others.

Affordability and accessibility issue: There is a huge gap between healthcare delivery and financing in semi urban areas and rural areas in comparison to urban areas. While a majority of the population resides in rural India (69.4 Percent) and most out of that engages in farming, only 2 Percent of qualified doctors are available to them. The rural population relies heavily on government funded medical facilities and traditional forms of treatments which have its own in built issues. This gap is increasing because the private and public systems do not complement each other. They are working in parallel and even catering to the different segments of the population based on the income level of the individuals.

Government hospitals or community-based care suffers from quality issues and is unable to cater to the basic healthcare needs of the population. While some private care delivery centres and professionals are accessible to the needy, they are not affordable for a majority of the population.

Health insurance penetration: Health insurance is a minor contributor in the healthcare ecosystem. The penetration is still less than 25 Percent of the population. Insurance payment structures and insurance business models in the Country are based on an almost retrospective arrangement of indemnity-based insurance payments. Indian insurance has been limited to critical illness
coverage for inpatient surgical procedures probably. It is often onetime lump-
sum payouts. The different kinds of health insurance even offered by
government are not able to cover the insurance needs of the people.
Especially in a Country where the needs are multiple and diverse based on
cultural differences, regional differences and income differentials companies
may evolve newer schemes and ewer methods to penetrate the market in a
war footing.

Social determinants of Health: Social determinants of health such as
nutrition, food security, availability of pure water and sanitation are major
hindrance in India since the independence of the Country for the creation of a
better health care system. It is a major causative factor in the success of
healthcare delivery and financing. Certain states fair well in this regard due to
better government interventions and policy matters but the major portion of
the nation is out of the cover. Education and literacy level of the people is also
a hindrance in this regard. Multiple interventions of different Governments
have started showing symptoms of improvement and achievement of UN
sustainable development goals may be a new path in this direction.

3.18. Regulations in Health Insurance:

IRDA Act, 1999 formed IRDA as the regulator of insurance business
in India irrespective of the kind of insurance. Health insurance is also
regulated by IRDA by necessary interventions and notifications according to
the requirement of the economy. As Health Insurance is in its very early
phase, in comparison to other forms of insurance like life and motor insurance
the role of IRDA is very crucial. Hence the basic function of the regulator is
attempted in this portion.
3.18.1. Insurance Regulatory and Development Authority of India

Insurance Regulatory and Development Authority (IRDA) Act, 1999 spells out the Mission of IRDA as: “to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto”

3.18.2. Functions and Duties of IRDA

Section 14 of the IRDA Act, 1999 lays down the duties, powers and functions of Insurance Regulatory and Development Authority of India as

- Registering and regulating all forms of insurance companies
- Protecting the interests of policyholders by monitoring the developments in the industry
- Licensing and issuing norms for insurance intermediaries like Third Party Administrators and insurance underwriters
- Promoting professional organisations in insurance as a promotional measure and to ensure the earlier adoption of professionalism in various segments of insurance.
- Regulating and overseeing premium rates in insurance to ensure the balance between the profitability of the insurer and payment capacity of the insured.
- Monitoring the terms and conditions in non-life insurance covers so as to reduce the future disputed between the parties in the insurance contract.
- Insisting and monitoring financial reporting norms of insurance companies in every quarter as part of corporate governance.
- Regulating investment of policyholders’ funds by insurance companies. Special care is always taken to keep the equity between the
profit potential of the investment and safety parameters of the investment.

- Ensuring the maintenance of capital adequacy and solvency margin by insurance companies for meeting the unexpected claim demands and for keeping in pace with the risk profile in health insurance in the wake of rising health care cost.
- Ensuring insurance coverage in rural areas and of vulnerable sections of society with the help of the Governments and also by mandatory requirements from the part of commercial insurers.

IRDA has to ensure that the insurance sector develops rapidly and benefit of the development goes to the Customers living even in remotest parts of the Country. It has to take precautions against the ill effects of unhealthy competition and systemic growth in the segment.Unless the development of health insurance is managed well it may have negative impact for health care, especially to a larger segment of rural, uninsured population in the country. A well structured and well regulated system can improve access to care and subsequently improving the health outcomes in the country rapidly.

Some of the areas of concern which the regulator has to look into are: Many times the insurance claims are rejected due to small technical reasons. This leads to disputes. Various conditions included in the insurance policy contract are not negotiable and these are binding on Customer. There no analysis on what is fair practice and what is unfair practice. The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions.

The main danger in the health insurance business is that the private companies will cover the risk of middle class who can afford to pay high premiums. Unregulated reimbursement of medical costs by the insurance
companies will push up the prices of private care. Large section of India’s population who are not insured will be at a disadvantage as they will, in future, may have to pay more for the private care.

IRDA has stipulated regulations for both life and non-life insurance companies in many aspects of business but the same is lacking in respect of health insurance business. Given the health insurance is assuming greater significance; it is time for the regulator to etch a frame work for operating the health schemes. IRDA will have to evolve mechanism so that the private insurance companies do not skim the market by focusing on rich and upper class clients and in the process neglect a major section of India’s population.

In a view to ensure that the rural and less-developed areas do not fall prey to a step-motherly treatment in penetration of health business, the Regulator may ensure, in line with its rules jotted down for private life and non-life insurers, that minimum annual targets are given to the benefit providers so that at any given point in time, a decent portfolio of health coverage’s represent the rural sector Insurance regulator shall ensure and encourage different organizations and private insurers to develop products for the poorer segment of the community and if possible build an element of cross subsidy for them. The IRDA will have a significant role in regulating the health insurance sector and safe guarding the interests of the policy holders by minimizing the unintended consequences.

3.19. Privatisation of Health Insurance

The privatization of insurance sector and constitution of Insurance Regulatory and Development Authority of India is expected to improve the performance of health insurance sector in the Country by increasing benefits from competition. It is expected that lowered costs and enhanced level of Customer satisfaction would be the immediate effect of privatisation.
However, the implications of the entry of private insurance companies in health sector are not very clear even after sixteen years of the entry. There are several controversial issues pertaining to development in this sector and these need critical examination.

Role of private insurance varies depending on the economic, social and institutional settings in a Country or a region. Critics of private insurance argue that privatization will divert scarce resources away from the pool, escalate health costs, allow cream skimming and adverse selection. According to this view, private health insurance greatly neglects the social aspect of health protection. In the contrast, supporters of private health insurance claim that private insurance can bridge financing gaps by offering customers value for money and help them avoid waiting times, low quality care and under the table payments. Problems often observed when households can use public health facilities for free or participate in mandatory social insurance schemes as of their view.

Both the arguments are correct in the sense, private health insurance can be valuable tool to compliment or supplement existing health financing options only if they are carefully managed and adapted to local needs and preferences. India, with relatively developed economy and a strong middle class population, offers most promising environment for private health insurance development. Presently, private health insurance plays only a marginal role in health care systems but it is gradually gaining importance.

Private health insurance is certainly not the only alternative or the ultimate solution to address alarming health care challenges in India by the present trends in the system. However, it is an option that warrants and already receives-growing consideration by policy makers in the Country. Thus the question is not if this tool will be used in the future but whether it
will be applied to the best of its potential to serve the needs of the Country’s health care system.

3.20. Health Insurance in Kerala

Kerala as one of the richest state in the Country is leading in out of pocket spending in health insurance for the last couple of years. The national average and state average is beyond comparison where the national average stood at Rs 95 and the state average stood at Rs 244. Educated individuals in the state of Kerala expect health insurance to be a better product rather than the existing kind of product portfolio. Presence of large number of private multi specialty hospitals, health consciousness among the major section of the population, presence of higher level of awareness, closer networking between the people etc are some positive factors in the state of Kerala.

Almost all the national health insurance companies have presence in Kerala, but the growth rate is not up to the mark. As most of the population is out of the eligibility criteria for the social security schemes of Central or state Government the only viable solution is commercial health insurance. There lies the business opportunity for the commercial health insurance.

3.21. Profile of the selected companies

Based on the market share and incurred claim ratio two companies were selected for detailed study in this work as seen from the discussions in the first chapter. A brief description bout the companies are given below for a better understanding on the vision, mission, strategies, business practices and Customer focus of these companies.

3.21.1. United India Insurance Company Ltd

United India Insurance Company Limited is incorporated as an insurance company on 18th February 1938. General Insurance Business in
India is nationalized in 1972. 12 Indian Insurance Companies, 4 Cooperative Insurance Societies and Indian operations of 5 Foreign Insurers, besides General Insurance operations of southern region of Life Insurance Corporation of India were taken over and merged with United India Insurance Company Limited. After Nationalization United India has grown exponentially and has 20300 employees in its payroll spread across the Country providing insurance cover to more than 1.2 Crore policy holders. The Company has different variety of insurance products to provide insurance cover from bullock carts to satellites.

The company has been in the forefront of designing and implementing complex covers to large Customers, as in cases of Indian Oil Corporation, GMR- Bangalore International Airport Ltd, Chathrapathi Shivaji Mumbai International Airport Ltd etc. The company have been also the pioneer in taking Insurance to semi urban and rural masses with large level implementation of Universal Health Insurance Programme of Government of India and Vijaya Raji Janani Kalyan Yojana (covering around 45 lakhs women in the state of Madhya Pradesh), Tsunami Jan Bima Yojana (in 4 states covering 4.59 lakhs of families), National Livestock Insurance and many such schemes.

3.21.2. Star Health and Allied Insurance Company Ltd

The company commenced its operations in 2006 with the business interests in Health Insurance, Overseas Mediclaim Policy and Personal Accident. With no other insurance category to focus and divide our attention, the company use the resources to focus on service excellence, design products and use core competency of innovation to deliver the best to its customers. At Star Health Insurance, the company offers a wide range of health insurance products at affordable prices to make health insurance every human being’s right. And this company, single-mindedly dedicated to health insurance.
The company have built a promising path for the future with a capital base of Rs.733 crores. The company has emerged as India’s first stand-alone Health Insurance Company, dealing in personal accident, mediclaim and overseas travel insurance. Under a decade, they have progressed by leaps and bounds. With a nationwide customer base to boast off, the company have raised the benchmark of the health insurance sector. Every successful story has been a stepping stone that has made us one of India's trusted specialists in health insurance with quality service at the best rates for customers from all backgrounds is the mission of the company.

3.22. The Concept of Service Quality

A clear and precise understanding on service quality is essential to move forward in a work on effect of service quality in health insurance. This portion of the chapter is devoted to discuss the basic concept of service quality. Service quality Customer Satisfaction and Service Quality are leading components in the system of external relations of every organization especially service organisations. Nowadays they largely determine its competitiveness. The desire to manage relationships with Customers and other clients leads to the fact that organizations are starting to pay attention to the designing, development and implementation of service standards. Customers do not buy goods or services, they buy the benefits goods and services provided them with.

They buy offerings consisting of goods, services, information, personal attention and other components. Customers are lifeblood of any organization, and without them, a firm has no revenues, no profits, and therefore no market value. To satisfy its customers, the company should listen and accept customer’s feedback and improve service and goods if it is required to be so. Service quality must be determined by certain external and internal factors of the organization.
Customer Satisfaction and Service Quality depend a lot on organization Standards of the company where they are applied. Latest might work as a great benefit to improve the profit and Customer loyalty (Ronzina 2010). Service quality is a complex and dynamic construct, which has been the focus of a number of studies in the services marketing literature. Two schools of thought dominate this literature: the Nordic school of thought and the North American school of thought. Specifically, the Nordic school of thought is based upon Gronroos's (2005) two-dimensional model while the North American school of thought is based upon Parasuraman et al.’s (1985) in (Karatepe 2013) five-dimensional SERVQUAL model. Other significant conceptual and analytical studies in this research stream suggest that service quality comprised of service product, service environment, and service delivery, or consists of interaction quality, physical environment quality, and outcome quality.

3.23. Different Perspective of Service Quality

The word quality means different things to people according to the context. David Garvin identifies five perspectives on service quality.

1. The transaction view of quality is synonymous with innate excellence: a mark of uncompromising standards and high achievement. This viewpoint is often applied to the performing of visual arts. It is believed that people learn to recognize quality only through the experience gained from repeated exposure and managers. Customers will also know quality when they see it is not very helpful.

2. The product-based approach says quality as a precise and measurable variable. Differences in quality, it is argued, reflect differences in the amount of an ingredient or quality possessed by the product or service. Because this
view is totally objective, it fails to account for variations in the tests, needs, and preferences of individual Customers or even entire market segments.

3. **User based definitions** starts with the premise that quality lies in the eyes of the beholder. These definitions equate quality with optimum satisfaction. This subjective, demand oriented perspective recognizes that different Customers have different wants and needs.

4. **The manufacturing based approach** is supply based and is concerned primarily with engineering and manufacturing policies and practices. It also states that quality is also operation driven.

5. **Value based definitions** define quality in terms of value and price. By considering the trade off between perception and price, quality comes to be defined as “affordable” by the Customer.

3.24. **Customer Satisfaction**

A comprehensive definition of Customer satisfaction in term of pleasurable fulfilment is given by Oliver. Satisfaction is the Customer’s fulfilment response. It is judgment that a product or service feature, or the product or service itself, provided (or is providing) a pleasurable level of consumption-related fulfilment, including levels of under-or over fulfilment”.

Customer Satisfaction and Service Quality depend a lot on organization Standards of the company where they are applied. Latest might work as a great benefit to improve the profit and Customer loyalty. Service quality is a complex and dynamic construct, which has been the focus of a number of studies in the services marketing literature. Two schools of thought dominate this literature: the Nordic school of thought and the North American school of thought. Specifically, the Nordic school of thought is based upon two-dimensional model while the North American school of thought is based upon Parasuraman et al.’s in five-dimensional SERVQUAL model. Other
significant conceptual and analytical studies in this research stream suggest that service quality comprised of service product, service environment, and service delivery, or consists of interaction quality, physical environment quality, and outcome quality.

3.25. SERVQUAL Instrument

In the mid 1980s Berry and his colleagues Parasuraman (1985) and Seithaml (1985) began to study service quality determinants and how Customer evaluates the quality of services based on the Perceived Service Quality concept. The 10 determinants were found to characterize Customers’ perception of the service. One of the determinants, competence, is clearly related to the technical quality of the outcome, and another, creditability, is closely connected to the image aspect of perceived quality. However, it is interesting to observe that the rest of the determinants are more or less related to the process dimension of perceived quality.

As a result of later study 10 determinants of service quality were decreased to the following five:

1. **Tangibles.** This determinant is related to the appeal of facilities, equipment and material used by a service firm as well as to the appearance of service employees.

2. **Reliability.** This means that the service firm provides its Customers with accurate service the first time without making any mistakes and delivers what it has promised to do by the time that has been agreed upon.

3. **Responsiveness.** This means that the employees of a service firm are willing to help Customers and respond to their requests as well as to inform Customers when service will be provided, and then give prompt service.
4. **Assurance.** This means that employees’ behaviour will give Customers confidence in the firm and that the firm makes Customers feel safe. It also means that the employees are always courteous and have the necessary knowledge to respond to Customers’ questions.

5. **Empathy.** This means that the firm understands Customers’ problems and performs in their best interests as well as giving Customers individual personal attention and having convenient operating hour.

SERVQUAL is an instrument for measuring how Customers perceive the quality of a service. This instrument is based on the five determinants mentioned above and on a comparison between Customers’ expectations of how the service should be performed and their experiences of how the service is rendered (disconfirmation or confirmation of expectations). Usually, 22 Variables are used to describe the five determinants and respondents are asked to state (on a seven-10 point scale from “Strongly Disagree” to “Strongly Agree”) what they expected from the service and how they perceived the service. Based on the discrepancies between expectations and experience over 22 Variables, and overall quality score can be calculated. The more this score shows that experiences are below expectation, the lower the perceived quality. However, more important that calculating the overall score may be the score on the individual attribute scales, perhaps summarized over determinants.

To avoid communication gaps and other service failures Gonzalez and Garzia (2008) suggests that it is important for the organization to know and understand what the Customers are thinking about their service so that failures can be avoided and improvements can be made. They need to know which Variables to measure and which factors that can be taken from different tools to understand Customer satisfaction. Time and costs also directly effects
Customer satisfaction. Hence, a quick response can be critical for satisfying the Customer.

According to Parasuraman et al. (1991), companies can get their competitive advantage by using the technology for the purpose of increasing service quality and augmenting market demand. For decades, many researchers have developed a service perspective which describes that the concept of service quality should be generally approached from the Customer’s view point because they may have different values, different style of assessment, and different situations. Parasuraman, Zeithaml and Berry (1990) states that service quality is an extrinsically perceived attribution based on the Customer’s experience about the insurance service that the Customer perceived through the service encounter.

According to the study conducted of Kumra (2008), service quality is not only involved in the final product and service, but also involved in the production and delivery process, thus employee involvement and active engagement in product and process redesign and commitment is important to produce final insurance products or services.

3.26. Different Perspective of Service Quality

The word quality means different things to people according to the context of application. David Garvin identifies five perspectives on quality.

1. **The transaction view** of quality is synonymous with innate excellence: a mark of uncompromising standards and high achievement. This viewpoint is often applied to the performing of visual arts. It is believed that people learn to recognize quality only through the experience gained from repeated exposure and managers. Customers will also know quality when they see it is not very helpful.
2. **The product-based approach** says quality as a precise and measurable variable. Differences in quality, it is argued, reflect differences in the amount of an ingredient or quality possessed by the product or service. Because this view is totally objective, it fails to accounts for variations in the tests, needs, and preferences of individual Customers or even entire market segments.

3. **User based definitions** starts with the premise that quality lies in the eyes of the beholder. These definitions equate quality with optimum satisfaction. This subjective, demand oriented perspective recognizes that different Customers have different wants and needs.

4. **The manufacturing based approach** is supply based and is concerned primarily with engineering and manufacturing policies and practices. It also states that quality is also operation driven.

5. **Value based definitions** define quality in terms of value and price. By considering the trade off between perception and price, quality comes to be defined as “affordable” by the Customer.

3.27. **Service-based Component of Quality**

Lovelock and Wirtz (2007, P.420) describe that researchers argue that the nature of service quality requires a distinctive approach to indentify and measure service quality. The intangible, multifaceted nature of many services makes it harder to evaluate the quality of a service compared to products. Because Customers are often involved in service production, a distinction needs to be drawn between the process of service delivery and the actual output of the service which is called technical quality. Other researchers suggest that the perceived quality of service is the result of an evaluation process in which Customers compare their perceptions of service delivery with the expected outcome.
3.28. Perceived Service Quality

Fiore and Kim (2007) present a conceptual model that concerns the influences on the consumption experience by environmental variables such as physical elements of the service environment, individual variables, individual Variables and person-environment variables or situations. The physical environment has the possibility to provide ideas about the influence of Customer perceptions on the brand building. Zeithaml and Bitner (2000) argue that Customers do perceive quality in multiple ways and they also have perceptions about multiple factors when quality is measured and assessed.

Minor et al (2004) has put forward that the environment definitely influences customer satisfaction. For example, the environment of a service organisation will affect customer satisfaction. The terms quality and satisfaction are often used interchangeably.
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