CONCLUSIONS
CHAPTER VII

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

But India does not have the policy of compulsory health insurance for its people and even the spread of health insurance was very minimal. Moreover, Insurance was in the hands of only public sector companies from 1973-1999 with respect to general insurance and 1956-1999 for life insurance. In 1999, Insurance Regulatory and Development Authority Act (IRDA Act) was passed opening insurance sector for private sector participation. But even after liberalisation, the growth of health insurance was not as expected. Had Health Insurance portfolio been managed professionally, the growth would have been exorbitant. This research was undertaken
to find out whether Health Insurance Sector could help to bridge the gap in the light of liberalisation as Insurance contributes to social stability by permitting individuals to minimise financial stress and worry.

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

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

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

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

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

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

Chapter Four details about Comparative Study of Health Insurance Schemes in India, this chapter focused on the details of various forms of health insurance schemes in India and select foreign countries to provide insight about various forms of health insurance coverages. Such insight can help to design new plans for health insurance. This chapter was classified into two parts. The first part focused on the various forms of health insurance that exist in India and the second part focused on the health insurance schemes in select countries.
The various health care programmes presently operating in India can be categorised as State-run schemes for formal sector employees; Health Insurance Plan offered by Insurance companies, corporate sector health care programmes; Community and self-financing schemes, primarily for workers outside the formal sector; and micro-credit linked health insurance schemes. Snap shot statistics of membership of various schemes were presented in this chapter. In summary, it can be said that though various schemes are available in India, none of the schemes are very effective, due to the fact that ‘had any of the schemes been effective, it would have served as ideal model for spread of health insurance’. Hence new models are required for India for promoting health insurance by overcoming the demerits of each scheme.

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

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

Thailand has four different kinds of health care financing programmes: voluntary health schemes, mandatory schemes, social welfare schemes, and fringe
benefit schemes presents the coverage of these programmes with their important features. (India also has different types of schemes, but the point is that efficiency of schemes needs to be enhanced.)

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

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

In USA, Healthcare is provided by private hospitals, funded either by individuals, by employers, or by insurance. But comparatively, USA is having well advanced system. India has already started taking clues from its system like introduction of TPAs which is starting point and can lead to HMO models. Health Unite Framework in the lines of HIPAA etc. In future, India has to learn from USA to prepare itself for handling frauds and improving the information technology.
Health care in the UK is provided publicly by the National Health Service (NHS). The scheme provides free health care service to all residents in a network of NHS clinics and hospitals countrywide. It provides for primary, secondary and post-operative care. People must contribute towards dental and optical care according to their means. The government sets the annual NHS budget from tax revenues.

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

Germany does not have national health services like the UK. There are a number of health insurance companies who provide health care for their members. Most of these are government controlled, although some are private companies. Government Insurance Company covers the risk which is not acceptable by private insurance companies. Germany expects its people to be part of private or government schemes. Even if a person drops out from private, he should join government scheme. This gives an idea for formation of health insurance corporation by government.
which can mandatorily insure majority of the population for a small coverage. But given the performance of institutions like ESIC and CGHS, more cautious measures needs to be taken to learn from the mistakes made in the past.

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

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

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

Chapter Five focused on Factors and Expectations influencing Health Insurance in India. This was based on the primary data collected. Primary data was collected from three different segments viz. Existing Policyholder Segment, Group Health Insurance Segment and no policyholder segment.
Based on the primary data collected, analysis of data was made subsequently
hypothesis was tested to check the relationship of key factors like Monthly Income,
Annual Medical Expenses, Exposure to Insurance etc. across segments and places
(urban, semi-urban and rural). Also a cluster analysis was made over these factors to
identify the cluster relationship among these factors and a discriminant analysis was
made over these factors to identify the estimation co-efficient of the factors that can
help in deciding whether a person is likely to purchase health insurance policy or not.

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

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

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

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

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

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

Demographic variables play important role in purchase of health insurance. Cluster analysis of demographic variables revealed that that there can be five different clusters (at the distance between 20 and 25) viz., cluster one having age, work experience, marital status and dependant children, second cluster with segment, occupation and annual medical expenses, sex and adult dependants form the third cluster, Family Monthly Income and Income Tax Assessment Status forms fourth
cluster. Place itself forms a cluster. This gives us an idea of designing variety of products targeting each cluster. Hence plans can be floated specific to a place, specific to Monthly Income and Tax Assessment status etc. It was found that the main reason preventing the people from taking health insurance are ‘Lack of Information’ which means proper marketing programs to create awareness can work for growth of health insurance in India.

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

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

Under Group Health Insurance segment, variety of plans exist wherein some are contributory (employees contribute to premium) and some are non-contributory (employees do not contribute) in nature, the group health insurance coverage also varies from one employer to another employer wherein some are floater policies (sum assured is shared by family members) and some are non-floater policies. It is sad to notice that many of the respondents were not having any idea about health insurance
at all. Majority of the respondents from this segment who are aware about health insurance felt that the group health insurance is sufficient for them which show clearly the lack of proper awareness about the need for additional coverages and lack of understanding about the potential for up-selling. But after proper explanation by the researcher, the respondents felt the need for additional coverages and were prepared to purchase policies to a tune of coverage affordable by them.

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

Under Existing Policyholder segment, 67.1% of the respondents got health insurance coverages through agents that show the power of the channel. Majority of the respondents have taken policies for the purpose of covering medical expenses only which is the prime purpose unlike life insurance wherein income tax exemptions plays vital role. It is also to be noted that Health Insurance Tax exemptions are not attractive enough due to the reasons that health insurance products do not give investment returns.
Majority of the respondents were not aware of the policy condition (60.3%) 'no coverage for pre-existing disease'. This normally leads to lapsation of policies. While purchasing health insurance, majority of people first consider premium as the deciding factor while purchasing health insurance policy. This infers that despite the awareness of various dreaded diseases in the country, people who know the value of health insurance are not aware of proper health risk management. Further, their risk management plans are limited by premium amount. Though affordability plays vital role, proper product designs with affordable premium rates can help the insurance companies to make inroads quickly.

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

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

30.1% of the respondents didn’t bother to make claims; the researcher has found that the reasons are due to the perception of the policyholders that claiming for the expenses is cumbersome procedure, avoiding small claims etc. such feelings didn’t
exist much in Group Health Insurance Segment as the Human Resources Department often come to help the employees and employees are treated with more care by insurance companies and TPA as the claimant forms part of corporate account.

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

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

The reach of advertisements also varied across segments but it is same across places. Same across places is due to the fact of reach of mass media. But difference in the level of awareness across segments is due to lack of proper awareness programs. Though this is a conflicting result (varying between the segment wise result and place
wise result), the same can be attributed to the proportion of people falling under each dimension (places and segment) and reach of mass media.

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

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

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

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

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

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

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

Model based on morbidity features is suggested wherein this model proposes base plan (bH) for primary ailments, secondary plan (sH) for secondary ailments and tertiary plan (tH) for tertiary ailments. Apart from the base plan (bH), lot of endorsements may be offered to the policyholders in the form of riders to choose from. The endorsements may be classified based on the secondary and tertiary medical care treatment offers.
Model based on Portfolio blending features the idea of floating blended products were asked to the respondents especially about the concept of ‘Long Term Policies’ in the similar lines of life insurance plan features and Single Premium policies in the similar lines of bank’s fixed deposit features. It should be noted that prior to liberalisation, similar plans were floated but it ended up in failure. But this time, this type of question is included in the questionnaire to check the response of people across different segments. From the analysis it is found that the response level varies across the different segments. This also gives idea to float return based products wherein extra premium can be invested in equity markets for returns. This will also give more cushions to the insurance companies with more buffer premiums and can also help in reducing claims ratio.

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

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

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

New Channel Models suggested the promotion of Group Channels through Direct mode. This model also suggests better actuarial modelling by merging the data of both Individual and Group Insurance business.
New Promotion Models suggested that promotion only through media alone will not work in country like India. This model suggested Promotion through Media, Promotion through Training, Promotion through Stakeholders, and Promotion through Regulations. The crux of this model is that not to depend only upon media but also upon other stakeholders and proper training programs.

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

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

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

Steps needs to be taken to avoid conflicts between center and states in health care issues as health falls under concurrent list as per constitution of India. Especially
IRDA should be given free hand to decide on health matters relevant to insurance. If it is not possible, a joint committee involving IRDA, Medical Council etc should be constituted which will have a say in the matters related to health care related insurance.

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

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

The move by IRDA to create national data warehouse is a commendable work. But it should get consultations from many stakeholders in creating efficient data warehouse. The work in progress reports of existing working group for health insurance should be published at frequent intervals to invite suggestions from public. The move by IRDA to introduce TPA is also a welcoming issue. But critics exists that these days, TPA do not engage much in cashless hospitalisation, thus defeating the whole purpose of introduction of TPA. This may be due to operational issues in delay in settlement of payments between TPA and hospitals. IRDA should take aggressive steps to minimise the conflict and it should ensure that maximum number of people should get only claims through cashless hospitalisation. Such activities will enhance the confidence of the people to take health insurance policies especially in rural areas,
confidence among people should be built up such that people should feel free to come
to urban to get treatment with a hope of hassle free claims. IRDA should also think
about allowing TPA for minimal marketing activities as promotional issue for health
insurance. The thought of converting TPA to HMO models also needs to be discussed
in the respective forums for more actions.

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

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

Hospitals fees needs to be standardised. Laws should be enacted to impose
strict conditions to use information technology for processing of health data in
hospitals (both public and private). Hospitals should use ICD codes. Steps should be
taken for gradation of hospitals. Fees should be fixed based on gradation. Steps
should be taken to make all hospitals get registered. Doctors and other hospital
personnel should be trained to do good documentation.
There are greater chances for generating revenue for health insurance through health tourism. Government, hospitals and insurance companies should work together in devising new Health Insurance and Tourism plans (HIT plans) and try to market in abroad so that more premium is generated under this which can help to cross-subsidize premium rates for domestic health insurance plans. This research also suggest to look not only external health tourism but also internal health tourism wherein people from some states can be attracted to visit historic cities in India and also get treatment. This also can help in cross-subsidizing the premium rates.

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

In insurance companies proper designing of products should be there and premium should be actuarially calculated premium based on morbidity statistics. Variety of plans on regional basis, segment basis should be floated. Many new segments needs to be identified like among Group Insurance Segment, sub-segments like White collar workers, Blue Collar workers can be identified. Similarly products with investment returns like unit linked products should be launched for health insurance. Opportunities for cross-selling health insurance products along with credit card sales, home loans needs to be considered.

This research suggests a new school of thought to view the population into segments as the expectations are certainly varying among various segments. This is in contrary to the existing approach by insurance companies. This research has identified one importance segmentation viz. Existing policyholder segment, Group Insurance
Segment and ‘No Policyholder’ Segment. This research suggest to look for more up-selling opportunities among existing health insurance policyholder segment and Group Health insurance segment. It also suggest to sub-classify the segments and especially ‘No Policyholder’ segment into various clusters to analyze the characteristics of clusters and float products according to that.

Many of health insurance policies do not have any limits in claim amount with respect to hospitalisation charges, treatment charges etc. hence it happens that for even loose motion and slight fever, people tend to get admitted in hospital and claim to the tune of Rs.15000, which is totally unjustifiable. Insurance companies should immediately start imposing limits on claims under various heads. Also the option of introducing co-insurance concepts aggressively should be considered.

Insurance companies should often visit the health care centers and hospitals to inspect the services and quality of it. It has been observed by the researcher during one of the expert interviews, that some ayurvedic massage centers have registered themselves as hospitals and the policyholders were wooed to have oil massage and sauna bath but given bills as if they have received some treatment. It is sad to notice that insurance mechanism is becoming pleasure mechanism without proper controls. Such activities should be immediately curbed.

It also happens that private hospitals are provided lot of concessions by government with a view that those private hospitals will serve poorer patients at free of cost. This is done because government is not in a position to start hospitals at many areas. Hence if somebody plans to start hospitals in semi-urban and rural areas and select areas of cities. Government provides concession with a condition to private hospitals to serve poor people. But it is sad to notice that many of the private hospitals
provide treatment at free of cost of relatives of employees and other known friends but show in records that they have provided free treatment to poor. Thus, the purpose of concession by government is defeated. Such instances should be avoided in future by creating a proper control and monitoring mechanism.

The legal redressal mechanism in India with respect to health insurance and health care should be given more publicity and separate assistance cell needs to be created. This can boost the confidence of the people and also help in counterchecking the frauds in the industry.

India should aggressively plan for imposing acts similar to HIPAA in USA, though activity under the name of ‘Health Unite Framework’ has already started with the collaboration of Apollo Group, more publicity needs to be given with respect to the functions of this working group, this can help in inviting more suggestions from people from various walks of life thus helping to make it feasible. This research suggest that, government should first creating a health data base with minimal fields and should give a identification number. As and when a person comes for treatment to either public or private hospital, his record should be updated with the required fields. As collecting all the information about a person will take long time, it is better to start with minimal information and then updating it. This information should be portable, this can be worked out in the similar lines of how election commission issued voter identity card in India.

Suggestions are provided earlier in this chapter, regarding the idea for new products. Insurance companies should form common data base which can be shared with all insurance companies to check the credibility and insurability of persons applying for health insurance. Insurance companies should also plan their promotional
strategies varying across places and segments meeting the expectations of the people falling under particular segment and place. Training to agents should be enhanced and it should also be treated as promotion oriented activity.

Life Insurance companies should advise the policyholders purchasing critical illness riders to purchase health insurance coverages also. They should clearly indicate the need for taking separate health insurance policy. Such cross-selling network should be enabled.

IRDA and Insurance companies should try to introduce various types of new distribution channels so that almost all the people of the country have maximum probability of meeting at least a distribution channel member. This research has suggested various new types of distribution channels.

India needs to maintain two indices, one on Overall Medical consumer index and the other on Health Insurance Consumer Index (which can also be at the level of each company). This paper suggests having base year as 2000 (a year after liberalisation) for Health Insurance Consumer index. The base of premium can be the risk premium rates of 2000. This should be mapped with the components of health care sector which form part of premium rates viz. Doctor Fees, Cost of Medicines etc. This Index should be compared with Overall Medical Consumer index to find the difference of how much the consumption varies. Detailed analysis is beyond the scope of this research.

More importantly the increase or decrease of index should be publicised often to the public thereby indicating the increase of treatment cost in the country. Analysis of how such treatment cost can affect their lifetime earnings should be published often.
In the interest of keeping the index at favourable level, it can create a set of whistle blowers in the system against malpractices

Usage of technology can be focused on the following areas of health insurance, which can help to fix limits, reduce administrative expenses. The following dimensions are visualised in this research

Enhanced Networking: Enabling proper network connectivity between the stakeholders, especially between Hospitals, TPA’s and Insurance Companies for quicker processing of cashless claims.

Implementation of core systems: Hospitals should be upgraded with Hospital Management Systems and all the treatments and documentation should have ICD codes.

Insurance companies should implement core systems with rules engine for underwriting and claims.

Common Portals: Common Database depicting the negative list of customers should be initiated in the first phase. Such negative list should also have data from Employers (referring their blacklisted candidates), Financial institutions like Housing Finance companies, Banks etc. Later this can be expanded in terms of credibility and insurability. Search Access should be enabled for all the insurance and TPAs to search for any customer who is already negative listed.

Data Warehousing and Data Mining techniques: Health Insurance involves complex underwriting rules and based on the claims pattern, the rules has to be changed often and also implemented immediately. Data warehousing and Data Mining techniques can help the insurance companies to reveal the hidden secret in the
data related to need for change in underwriting rules and claims procedures. BPM (Business Process Management) components in the software application can help to implement any relevant changes immediately. Such solutions are being developed these days keeping claims leakage management in mind. Such Data Mining operations can also help the insurance companies to identify the involvement of Moral Hazard.

Important and Crucial suggestions are provided., many suggestions in detail are provided throughout this research report. Several minor suggestions are not listed in here, due to limitation in pages and time.

In summary, Health insurance in India is still at cross roads and passing through several turns these days though it has started witnessing slow growth atleast. This explorative research has tried its level best to study various problems of the industry and has tried to solve the problem. Several models and suggestions are provided throughout this research report. Though no single suggestion or model can work \textit{alone}, a combination of few suggestions or models has the potential for great turnaround even that may be a small beginning of a giant process. But it has the capability of prevent several thousands of people from falling below the Poverty line, in bringing smiles among the healthy faces of 100 millions, and of course, the Indian Economy. If some positive change happens somewhere in India based on this research report that will mark the success of this research.