INTRODUCTION
CHAPTER I

INTRODUCTION

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

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

\textsuperscript{1} Human Development Report (HDR) -1998
breadwinner. It acts instrumental in the form of small savings leading to accumulation of large sums, which can be invested in public / private sector thus helping the economy by creating a source of financing for new businesses, for new homeowners, and for farmers and their equipment.

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

Importance of Health Insurance among other forms of Insurance

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

Distinctive Nature of Health Insurance

Health Insurance is a complex subject and can be said that it is not a pure form of insurance by its nature, unlike life insurance. It is not indemnity insurance, as
Health insurance cannot bring back the lost health and it cannot make good all the losses pertaining to health and related expenses. It is also very difficult to estimate the impact of health. Health Insurance also depends upon the other sectors like hospitals, health care, pharmaceutical etc. for effective functioning. The influence of changes in other sectors impact heavily on health insurance and hence pricing of health insurance products largely depend upon the functions of other sectors.

Health Insurance cannot be considered as wholly a life insurance subject or a general insurance subject. Normally life insurance companies are very particular to see whether insurable interest exists at the time of purchase of the policy but non-life insurers will see the same only at the time of claim of the policy. For example, if a person takes out a policy on her husband’s life and later gets a divorce, she is entitled to the policy proceeds upon the death of her former husband if she has kept the insurance in force as the insurance company will see whether the insurable interest exist at the time of inception of the contract. But in general insurance, the insurable interest must exist at the time of loss. For example, if a person say X, has insured his home and sold his home to Y after some time. If fire occurs, X cannot collect the claim, as he no longer has insurable interest in the property. Similarly, Y also cannot claim, as he is not named as an insured under the policy. But in health insurance, the principle of insurable interest is seen both during the inception of the policy and also during claim. Moreover, health insurance covers the features of life insurance and also general insurance. This is the reason why both life and general insurance companies deal with health insurance. In India, life insurance companies have not entered into health insurance segment except offering critical illness riders. There are plans for entering health insurance full-fledged by life insurers in the near future.
Since independence, the health care system in India has been expanded and modernised considerably, with dramatic improvements in life expectancy and the availability of modern health care facilities and better training of medical personnel. At the same time, however, much remains to be done with respect to the accessibility, efficiency and quality of the health delivery system. ‘Health for all’ has been seen as the central assumption of the health sector debate, thus making the government the central player. Though ‘health for all’ objectives are laudable, the overwhelming focus on a public health care delivery system appears somewhat unrealistic, particularly in view of the fact that health spending in India is mostly private.

Health Care Financing - Public Health Investments in India

The public health investment in the country over the years has been comparatively low, and as a percentage of Gross Domestic Product (GDP) has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs. 200. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services are from the resources of the States, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding
has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralised public health services in the country are to improve significantly, there is a need for the injection of substantial resources into the health sector from the Central Government Budget. This approach is a necessity, despite the formal Constitutional provision in regard to public health, if the State public health services, which are a major component of the initiatives in the social sector, are not to become entirely moribund. The NHP-2002 has been formulated taking into consideration these ground realities in regard to the availability of resources.

**Health Care Financing - by Individuals**

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

Supply-side reasons include greater availability of health practitioners both because of the several branches of medicine unique to India and because of the easy and almost unregulated entry of a very large number of private practitioners in each of these branches every year. However, these reasons can at best be a small part of the explanation. Howsoever, easily available health care means, no rational consumer is expected to spend large amounts of his or her income without very good reasons for it. Excessive financial burdens on households arise for a variety of reasons. At one
level, they can be blamed on India’s public health care system, which is under funded and suffers from quality and access problems, forcing consumers to visit the private and relatively more expensive treatments. Recent household-level studies on utilisation of health care indicate that even public care is not all that ‘free’ after all there are many incidental expenses that consumers have to bear on their own.

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

Insurance Market in India

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

The business of life insurance in India in its existing form started in India in the year 1818 with the establishment of the Oriental Life Insurance Company in Calcutta. In 1912, The Indian Life Assurance Companies Act enacted as the first statute to regulate the life insurance business. In 1928, the Indian Insurance Companies Act enacted to enable the government to collect statistical information about both life and non-life insurance businesses. In 1938, the earlier legislation was consolidated and amended to by the Insurance Act with the objective of protecting the interests of the insuring public. In 1946, 245 Indian and foreign insurers and provident societies were taken over by the Central Government and nationalised. LIC formed by an Act of Parliament, viz. LIC Act, 1956, with a capital contribution of Rs. 5 crore from the Government of India. The general insurance business in India, on the other hand, can
trace its roots to the Triton Insurance Company Ltd., the first general insurance company established in the year 1850 in Calcutta by the British. Some important milestones were developed in the twentieth century. In 1907, The Indian Mercantile Insurance Ltd. set up, the first company to transact all classes of general insurance business. In 1957, General Insurance Council, a wing of the Insurance Association of India, framed a code of conduct for ensuring fair conduct and sound business practices. In 1968, The Insurance Act was amended to regulate investments and set minimum solvency margins and the Tariff Advisory Committee (TAC) set up. In 1972, The General Insurance Business (Nationalisation) Act 1972 nationalised the general insurance business in India with effect from 1st January 1973. 107 insurers amalgamated and grouped into four companies viz. the National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd., General Insurance Corporation (GIC) incorporated as a company. In 1999, insurance industry was liberalised again allowing new companies to participate.

**Insurance Sector Reforms**

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

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

Health Insurance Market in India

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

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

What is exciting in the healthcare sector today is the privatisation of the health insurance industry. Privatisation should bring about major changes in the healthcare industry. Insurance will have an impact in terms of standardisation and controlling costs of healthcare. India’s famous 300 million middle classes cannot only afford
health insurance but is actively looking for a healthcare solution like health insurance. The voluntary health insurance market, which is around USD 500 million today has the capacity to grow 30 times to around USD 15 billion in less than 5 years. The growth of health insurance market leveraging on the middle-class segment can help the lower-income segment and BPL segment to avail health insurance coverage at subsidised rates in future.

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

**Impact of Privatisation in Health Insurance**

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

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

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

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

While commenting on problems of TPA, Rajeev Ahuja points out that, while junior level functionaries of Public Sector Units (PSU) operating offices, see TPA as a threat to jobs, the managerial cadre have suspicion fearing the nexus between TPAs
and health care providers. Due to these perceptions, claims settlements are delayed, which defeats the very purpose of existence of TPA. The unregulated health care sector poses vital problems like lack of widespread form of accreditation, clinical protocols and guidelines, quality benchmarks and uniformity of hospital charges. Moreover, the softwares used by such hospitals do not follow the internationally acceptable diseases coding system. This creates the problem for TPA to capture health diagnosis and expense related information in a uniform manner and to make related analysis. There have been complaints from public about TPA regarding the delayed issuance of Identity cards, poor functioning of call centers etc. Thus any move in the direction of promoting health insurance sector in India faces lots of pitfalls and hindrances.

Need for the research study

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

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

The spread of health insurance in the pre-liberalised era was not very prominent. While social insurance schemes like Central Government Health Scheme (CGHS) and Employee State Insurance Scheme (ESIS) suffers from quality of health care delivered, voluntary private health insurance schemes like mediclaim suffer from higher claim ratio.
After liberalisation, though health insurance market in India is estimated to have larger potential, the growth of health insurance market within country is not as expected. Though Insurance companies are showing steady growth in health insurance business (negligible when compared to market potential), exorbitant claims ratio nullify the positive effects of such growth. Hence only way is to improve the customer base aggressively for health insurance and establish more controls over claims ratio.

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

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

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

Hence, there is a need for this research study.

Objectives of the study

The following are the primary objectives of the proposed study:

- To assess the spread of health insurance in India
- To identify the factors that influence health insurance purchases
- To understand the expectations of the people towards health insurance and
To propose new models & methods to promote health insurance in India.

Methodology

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

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

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

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

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

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

The process of primary data collection was started in December 2004, the researcher and enumerator did not demarcate any specific segment or place for data collection but based on the convenience of time and place, either researcher or enumerator collected data irrespective of segment and place. During this process, both the researcher and enumerator faced lots of problems across the segments and places. Many of the respondents in urban areas and semi-urban areas initially hesitated to respond under the perception that the researcher and enumerator are agents of insurance company and trying to persuade for purchase of insurance policy, while people in rural areas perceived that they are government officials. Hence initially it took a few minutes to explain the respondents about the research purpose and gave assurance that they will not be forced to purchase any policy at the end of the interview for data. Some of the existing policyholders complained about the TPAs and insurance companies seriously under the perception that the survey is a masked survey by some
insurance company. A few doctors were also included in the samples, initially none of the doctors agreed for providing data stating that they are too busy to provide data and hence for collecting data from doctors, the researcher selected a new set of doctors and posed himself as patient for general check-up and after getting prescription and paying fees, requested the doctors to co-operate for data collection which was highly successful. Human Resource department of some of the big companies in the region denied permission to collect data from employees but after constant persuading activity, those companies allowed to collect from employees informally and that too near the gate of their premises. On an average, it took nearly 20-25 minutes to collect a response from ‘no policyholder segment’ as it involved lot of educational and awareness creating activity about health insurance. From group health insurance segment also, it took nearly 20-25 minutes to collect data as it also involved education and awareness creation activities about the lacunae in group health insurance coverages and need for extra coverages. With respect to existing policyholder segment, it was very difficult to get the address of policyholder from insurance companies and TPAs, even after getting the address, it was too difficult to get appointment from each policyholder as many of them were very busy and often rescheduled their appointments, hence the researcher and enumerator made several attempts to meet them and collect data, on an average, it took nearly 15-20 minutes to collect data from this segment. Due to the above problems, it took nearly four calendar months to collect data. A target of 300 samples was fixed for this research and actually more than 300 samples were collected across the three segments viz. ‘existing’, ‘group’ and ‘no policyholder’ segment and across places of in and around Bangalore (Urban), Hosur (Semi-Urban) and Krishnagiri (Rural) during the time period of December 2004 till mid of April 2005. Samples were randomly chosen from the population but careful thought was made to ensure that samples are collected
from various strata of the population with varied income size, family size with
different occupation right from street vendors to high-level executives of Multi
National Companies (MNC). Of the 300 samples collected, a few samples were
rejected, as it did not meet the requirements for qualifying sample. At the end of such
qualifying exercise, the sample size across the three segments remained as 73 for
existing policyholder segment, 86 for group health insurance segment and 100 for ‘no
policyholder’ segment.

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

Limitations of the study

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

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

Structure of the Report

The thesis is presented in seven chapters including the present first chapter. First
Chapter gives introduction about the health insurance in India and problems
associated with it, which motivated the researcher to undertake the research.
The Second Chapter presents a review of literature on the Health Insurance sector in India. In this chapter, review of literature is made, not only pertaining to health insurance but also literature on various sectors viz. health care, pharmaceutical, hospital industry etc. that influences health insurance in India.

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

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

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

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

1 Human Development Report (HDR) 1998

2 Rajiv Ahuja, October 2004, The Poor Need Health Insurance Too!, IRDA Journal, Volume II, No.11, pp 15-16