CHAPTER – II

HEALTH INSURANCE – AN OVERVIEW

According to World Health Organization figures (2002), total health expenditures of about Rs.103000 crore represent 6.1% of India’s GDP. Of this, over Rs.81050 crore representing 4.8% of GDP is the share of private expenditures and only the rest Rs.21950 crore representing 1.3% of GDP is public expenditure. Of the private expenditure of Rs.81050 crore, 98.5% are out-of-pocket spending of users. In other words, 77.5% of total expenditure for health care costs (Rs.79830 crore) is paid by individuals or households and this huge expenditure does not pass through any pooling mechanism.1

Using the private sector in India implies out-of-pocket expenditure at the time of illness. This may have two outcomes – either the patient does not access care or the patient accesses care but is impoverished in the process.2

Those who do access care are pushed below the poverty line. Studies have shown that more than 40% of hospitalization patients borrow money or sell assets to meet medical costs. In the process, an average of 24% of hospitalized patients become impoverished.3 Thus it appears that India’s poor have problems with

1 http://164.100.24.208/ls/CommitteeR/PU/11threp.pdf
accessing hospital care. And those who do access health care have the risk of falling into latrogenic poverty.⁴

One possible solution to this problem is to reduce the financial barrier through health insurance. Unfortunately, currently only about 10% of the population is protected under any health insurance coverage.⁵

The key factor in establishing equity in access to healthcare and health outcomes is the proportion of public finance in total health expenditures. The greater the proportion of public finances the better the access and health outcomes and it lowers the levels of poverty. India, where public finance accounts for only 16% of total health expenditures, has poor equity in access to healthcare and health outcomes in comparison to China, Malaysia, South Korea, Sri Lanka where public finance accounts for 30% to 60% of total health expenditures.⁶

2.1 FORMS OF HEALTH INSURANCE

Health Insurance can take various forms. It can be (1) Mandatory/social, (2) voluntary, (3) Employer–provided, or (4) community-based, depending upon the relationship between the insurer and the insured, and also on the type of service provider.

2.1.1 SOCIAL / MANDATORY INSURANCE

Social / mandatory insurance is provided by the Employees’ State Insurance Scheme (ESIS) covering low-income employees of the organized industrial sector. The Central Government Health Schemes (CGHS) provide cover for central government employees.

2.1.1.1 EMPLOYEES’ STATE INSURANCE SCHEME

Formal systems for Health Insurance in India began with the inception of the Employees’ State Insurance Scheme. Established in 1948, the Employees State Insurance Scheme provides for both cash and medical benefits. It was introduced as a social security blanket for workers employed in the formal sector, in organizations which meet certain criteria for enrolment, and these criteria have been revised from time to time.

Employees’ State Insurance Scheme applies to power using factories employing 10 persons or more and non-power & other specified establishments employing 20 persons or more.7

The “appropriate Government” - State or Central - is empowered to extend the provisions of the ESI Act to various classes of establishments, industrial, commercial, agricultural or otherwise in nature. Under these enabling provisions, most of the State Governments have extended the ESI Act to certain specific classes of

7http://www.actuariesindia.org/GCA/10th%20GCA/Papers/Health,%20Long%20Term%20Care,%20Mortality%20&%20Morbidity/43_Emerging%20Health%20Insurance%20in%20India-An%20Overview_J%20Anitha_10th%20GCA.pdf
establishments such as shops, hotels, restaurants, cinemas, preview theatres, motor transport undertakings and newspaper and advertising establishments employing 20 or more persons.

As provided under the ESI Act, the scheme is administered by a duly constituted corporate body called the Employees’ State Insurance Corporation (ESIC). It comprises members representing Central and State Governments, Employers, Employees, Parliament and the medical profession. Union Minister of Labour functions as Chairman of the Corporation whereas Director General as chief executive discharges the duty of running the day-to-day administration.

A Standing Committee representing all stakeholders is elected from the body corporate for managing the affairs of the scheme and monitoring the progress of implementation of various decisions and policies etc. from time to time.

The Medical Benefit Council, a statutory body advises the Corporation on matters related to administration of medical benefit under the ESI scheme.

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.

The Employees State Insurance Scheme provides for comprehensive health services through a network of its own dispensaries and hospitals, supplemented by
Authorized Medical Attendants and private hospitals to serve needs which cannot be met by its own network.

The ESI Scheme is mainly financed by contributions raised from employees covered under the scheme and their employers, as a fixed percentage of wages. As of now, the rates of contribution are:

i. Employees’ Contribution: 1.75% of wages

ii. Employers’ Contribution: 4.75% of wages

Employees’ earning up to Rs.40/- a day as wages are exempted from payment of their part of contribution. The State Governments bear one-eighth share of expenditure on Medical Benefit within the per capita ceiling of Rs.600/- per annum and any additional expenditure beyond the ceiling.

The Employees’ State Insurance Scheme covered about 33 million beneficiaries in 2005-06.

2.1.1.2 CENTRAL GOVERNMENT HEALTH SCHEME

The Employees’ State Insurance Scheme was soon followed by a scheme for central government employees. The Central Government Health Scheme (CGHS) was introduced in 1954 as a contributory health scheme to provide comprehensive medical care to the central government employees and their families.

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8 http://esicoimbatore.org/forms/forms/charter.pdf
The list of beneficiaries includes all categories of current as well as former central government employees, members of Parliament, Governors, accredited journalists, Supreme Court and High Court judges, and certain other categories of beneficiaries.

Central Government Health Scheme has over 44 lakhs beneficiaries and is financed largely by the Government of India budget, while the government employees also contribute a nominal amount (ranging from Rs.15 to Rs.150 per month) from their salaries based on their scale of pay. Here also, the coverage is comprehensive and includes both outpatient care and hospitalization. Outpatient care is provided through CGHS dispensaries, located in major cities. It also uses the facilities of the government and approved private hospitals to provide inpatient care and reimburses the expenses to the patient or the hospital, as the case may be.\textsuperscript{10} Benefits under the scheme include medical care, home visits/care, free medicines and diagnostic services.

The Central Government Health Scheme has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out of pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80\% of the cost is reimbursed if referral is made to private facility, when such facilities are not available with the CGHS).\textsuperscript{11}

\textsuperscript{11} ibid.,
2.1.2 VOLUNTARY HEALTH INSURANCE

Voluntary health insurance schemes include Mediclaim, Universal Health Insurance Scheme, and Scheme of private insurers. These are available mainly through insurance companies.

2.1.2.1 MEDICLAIM

The government insurance companies started first health insurance in 1986, under the name Mediclaim. The evolution of the voluntary health insurance sector in India started with the introduction of the Mediclaim policy by GIC in 1986-87.\textsuperscript{12}

Mediclaim is a reimbursement base insurance for hospitalization. It does not cover outpatient treatments.

A person between 3 months to 80 years of age can be granted Mediclaim policy up to maximum coverage of Rs.5 lakh against accidental and sickness hospitalizations during the policy period as per latest guidelines of General Insurance Corporation of India. This scheme is offered by all the four subsidiary companies of GIC. Mediclaim scheme is also available for groups with substantial discount in premium.

Mediclaim has provided a model for health insurance for the middle class and the rich. It covers hospitalization costs, which could be catastrophic.

But given the premium on higher side, it has remained limited to middle class, urban tax payers segment of the population. There are also problems and negative

\textsuperscript{12} http://www.iegindia.org/dis_95.pdf
unintended consequences of this scheme. There are reported fraud and manipulation by clients and providers, which have implications for the growth and development of this sector. The monitoring systems are weak and there are chances that if the doctor and patient collude with each other, they can do more harm to the system. There is also element of adverse selection problem as the scheme is voluntary. As the scheme reimburses charges without limit, it also has pushed up the prices of services in the private sector.\textsuperscript{13}

The Mediclaim policy will be admissible only if hospital or nursing home is a registered body with local authorities or should have at least 15 in-patient beds. The Mediclaim policy started with the cover to protect the hospitalization costs, but over the period, the definition of hospitalization has been changed keeping in view the technological advancements and procedural protocols for treatment of various illnesses. For example, in case of dialysis, eye surgery, dental surgery, kidney stone removal where insured is discharged on same day, the stay in hospital is not considered necessary. Also, cases are considered where due to technological advances, hospitalization required is less than 24 hours. Mediclaim also covers pre-hospitalization and post-hospitalization expenses up to 30 days.

The policy has also 30-day exclusion clause. This means that any disease contracted by the insured person during first 30 days from the commencement date of policy will not be considered for reimbursement. However, under certain condition where it was not possible to know the existence of the disease at the time of initiation

\textsuperscript{13} http://www.iimahd.ernet.in/~dileep/PDF%20Files/Insurance.pdf
of policy the policy still holds. In some specific cases, the policy has also one-year exclusion clause. These conditions have been incorporated to minimize the problem of adverse selection.\footnote{http://www.iimahd.ernet.in/publications/data/2001-08-02RameshBhat.pdf}

Since its inception, Mediclaim policy has undergone several structural changes; currently, it can be classified broadly in two segments viz. Individual and Group policies.

The Group policies are mainly meant for the corporate houses, where generally these are offered as health benefits to the employees. However, as it emerged from the various discussions with TPAs, and also from the data, several corporate companies prefer to buy ‘Individual policies’ for their employees. The incentive for doing this may lie in the fact that the agents’ commission is much less in the group policies than in the individual policies, and there are off-the-record reports that agents do influence some companies to buy the coverage under the ‘Individual’ type for financial benefits.\footnote{ibid.,} The immediate implication of this is that not all the ‘Individual policies’ are based on the idea of willingness to avoid health costs, but like Group policies, a part of the Individual policies comprise policyholders who are receiving health benefits from the employers.

Individual policies are divided into three categories: Individual policies, ‘Individual policies, Group’, and ‘Individual policies, Group-self’. The first sub-category is the true representation of individuals who have bought the policy to avoid
health costs and paid for it. The difference in the later two ‘group-like’ individual policies is that the ‘Individual policies, Group’ comprise policies where family members of the employees of the organization are covered under different ‘Individual’ policies (unlike Group policy where one policy covers several individuals), whereas in the ‘Individual policies, Group-self’, the relation code for all the cardholders is ‘self’. This may include special cases where only employee (and not the family) is covered.

2.1.2.2 UNIVERSAL HEALTH INSURANCE SCHEME

One of the health schemes introduced by the Government is the Universal Health Insurance Scheme. While the Government announced the scheme, its launch was entrusted to the four public general insurers.

The Universal Health Insurance Scheme was launched on 14 July 2003. It was meant for individuals, a family of five and a family of seven. Under this scheme, for a premium of Rs.365 per year per person, Rs.548 for a family of five and Rs.730 for a family of seven, health care for an assured sum of Rs.30000 was provided.\(^ {16}\)

Below Poverty Line families were given a premium subsidy of Rs.200 per annum. The scheme was redesigned in May 2004 with higher subsidy and restricting eligibility to Below Poverty Line families only. The subsidy was increased to Rs.200, Rs.300 and Rs.400 to individuals, families of five and seven, respectively.\(^ {17}\)

\(^ {16}\)http://www.whoindia.org/LinkFiles/Commision_on_Macroeconomic_and_Health_Health_insurance_in_India.pdf
\(^ {17}\)ibid.,
To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of the family eligible as against the Mediclaim Policy which is for an individual member.

Yet, in the last two years of its implementation, the coverage has been around 10000 Below Poverty Line families in the first year and 34000 in the second year till 31 January 2005.\textsuperscript{18}

\section*{2.1.3 EMPLOYER-BASED INSURANCE}

Employer-based insurance is provided by Public and Private sector companies including Defence, Railways, and Security Forces. The companies offer facilities by way of lump sum payments, reimbursement of employees’ health expenditure or coverage under one of the public / private insurance plans.

\section*{2.1.4 COMMUNITY BASED HEALTH INSURANCE SCHEMES}

Community Based Health Insurance (CBHI) schemes are provided either by Trusts, hospitals or NGOs. In this case, communities as may be sponsored by the state government, local government, NGOs and other groups can be insured by means of limited contributions by the participating members and subsidy from the government targeted to this end from tax earnings.

Through a prepayment and risk pooling mechanism, the poor are able to meet their health needs with minimum burden at the time of use. However, while currently

\textsuperscript{18} ibid.,
there are more than 20 such schemes in India, there is very little empirical evidence about their performance.\textsuperscript{19}

Two types of CBHI schemes that are observed in India are: where an NGO acts as an intermediary between a formal insurance provider and the insured community and where the NGO itself provides insurance to the target community. In the latter case, where an NGO itself insures the target population, the NGO may itself be the health service provider or may have an arrangement with the health service provider.

Generally, CBHI scheme is organised through an NGO that is conversant with the target community. A CBHI scheme where an NGO mediates between community members and the formal insurance provider seems to combine the participatory feature with the efficiency aspect characteristic of the formal insurance provider.

CBHI scheme is more appropriate in reducing informational asymmetries. CBHI schemes also help in influencing provision of health services. By its very nature, CBHI scheme can be designed to meet health care needs that are specific to a community.\textsuperscript{20}

In India, community health insurance started way back in Kolkata in 1952 which was part of a student’s movement. The scheme, which is called the Student’s Health Home (SHH), caters to the schools and universities students of West Bengal.

\textsuperscript{20} http://www.icrier.org/pdf/wp123.pdf
Currently there are more than 20 documented CHI programmes, of which five were initiated between 2001 and 2003.\textsuperscript{21} The mechanism for providing health insurance in community based health insurance schemes is different from normal market based schemes like Mediclaim. Though the basic principle of covering future risks by paying premium in advance is same in all health insurance schemes, CBHI schemes are tailored for local needs and provide health insurance at low cost.

CBHI schemes in India can be divided in three broad categories based on who is the insurer: Healthcare Provider, Health Insurer, and Healthcare Intermediary.\textsuperscript{22}

In Type I (or Provider design), the hospital plays the dual role of providing health care and running the insurance programme. There are five programmes under this type: ACCORD, MGIMS, RAHA, SHH, VHS.

In the provider model, the hospital organizes the health insurance and is also the provider of care. It has advantages in that the cost of treatment is usually low. But at times, the quality of care is low. And usually, most hospitals do not have much links with the community. So the coverage of the population is low.

In Type II (or Insurer design), the voluntary organization is the insurer, while purchasing care from independent providers. The insurer model is one where the NGO acts as the insurer and organizes the insurance. It collects premium from the community and then contacts specific hospitals to provide the care. The main


\textsuperscript{22} ibid.,
advantage is that the scheme is tailor made to meet the requirements of the community. The main disadvantage is that the insurance fund is in danger of becoming bankrupt. The NGO rarely has the technical and managerial capacity to manage an entire health insurance programme and make the adequate requirements. There are two programmes under this type: DHAN, Yeshaswini.

Type III model (or Intermediate design) is the linked model which is similar to the insurer model, but the NGO insures with an insurance company. This means that there is more financial sustainability as the risk is spread over a larger pool. Here the voluntary organization plays the role of an agent, purchasing care from providers and insurance from insurance companies. However, the scheme is very rigid and depends on the insurance company. There are five programmes under this type: BAIF, Buldhana, Karuna Trust, Navsarjan, SEWA.

The table below indicates that these three categories are quite distinct from each other in terms of the function of the agency. An agency here can be a NGO, Trust, Hospital or Cooperative etc. Their role can vary from performing as intermediary where both treatment and insurance are provided by intermediary itself or where the treatment and insurance are provided by third party.
### TABLE 2.1

**TYPES OF CBHI SCHEMES IN INDIA**

<table>
<thead>
<tr>
<th>Types of CBHI</th>
<th>Healthcare Provider</th>
<th>Health Insurer</th>
<th>Healthcare Intermediary</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Examples)</td>
<td>ACCORD, MGIMS, RAHA, SHH, VHS</td>
<td>DHAN, Yeshaswini</td>
<td>BAIF, Buldhana, Karuna Trust, Navsarjan, SEWA</td>
</tr>
<tr>
<td>Role</td>
<td>Plays role of both insurer and provider</td>
<td>Plays role of insurer</td>
<td>Plays role of agent</td>
</tr>
<tr>
<td></td>
<td>Provide Healthcare</td>
<td>Provide Insurance</td>
<td>Purchase care from providers</td>
</tr>
<tr>
<td></td>
<td>Running Insurance scheme</td>
<td>Purchase care from independent provider</td>
<td>Purchase insurance from insurance companies</td>
</tr>
<tr>
<td>Transaction costs</td>
<td>Low</td>
<td>Low</td>
<td>Low-medium</td>
</tr>
<tr>
<td>Membership Size (size of risk pool)</td>
<td>Important</td>
<td>Important</td>
<td>Not important</td>
</tr>
<tr>
<td>Inpatient / Outpatient Care</td>
<td>Is NOT an issue</td>
<td>Is an issue</td>
<td>Is an issue</td>
</tr>
<tr>
<td>Benefit on provision side</td>
<td>Significant</td>
<td>Low</td>
<td>Negligible</td>
</tr>
<tr>
<td>Informational Problems</td>
<td>Not an issue</td>
<td>May be an issue</td>
<td>Is an issue</td>
</tr>
<tr>
<td>Payment Mechanism</td>
<td>Cashless System Mostly</td>
<td>Mostly Fixed Indemnity</td>
<td>Mostly Fixed Indemnity</td>
</tr>
<tr>
<td>Nature of Pool</td>
<td>Geography Based</td>
<td>Membership / Geography Based</td>
<td>Memberships / Geography Based</td>
</tr>
</tbody>
</table>

It is to be noted that CBHI schemes have their own problems which are non-availability of good providers, lack of professional management, financial sustainability issues and non-recognition by IRDA.\textsuperscript{23}

The government is keen to increase the insurance coverage and has even introduced special health insurance packages for the poor.

2.2 VALUES IN HEALTH INSURANCE

2.2.1 SOLIDARITY

Solidarity is one of the fundamental bases of a health insurance programme, especially social health insurance and community health insurance programmes. It operates less in private health insurance schemes. It is defined as \textit{“the awareness of unity and a willingness to bear its consequences.”}\textsuperscript{24} It means that people accept that the size of the return may not match the resources they have put in the system.

A successful health insurance programme requires people to contribute, knowing fully well that their contribution may not help them directly, but will help others who require the support.\textsuperscript{25}

2.2.2 RISK POOLING / SHARING

Related to solidarity is risk pooling. It implies that there is sharing of risks between the high risk and the low risk populations. This is traditionally shown as risk

\begin{itemize}
\item \textsuperscript{23} www.iimahd.ernet.in/publications/data/2006-07-02rbhat.pdf
\item \textsuperscript{24} http://www.whoindia.org/LinkFiles/Health_Insurance_Health_Insurance_Training_Manual.pdf
\item \textsuperscript{25} http://www.whoindia.org/LinkFiles/Health_Insurance_Operational_Guide_Chapter_01.pdf
\end{itemize}
sharing between the healthy and the sick, between the rich and the poor and between the economically active and economically inactive. Risk sharing builds on the concept of solidarity, where people are willing to contribute for the sake of others.

2.2.3 EQUITY

Under optimal conditions, health insurance is more equitable than direct out-of-pocket payments and can be as progressive as tax based financing. When, for a particular income level, equal contributions by members are used to meet the unequal needs of these members there is horizontal equity. When across income levels, unequal contributions are used equally to meet the needs of the members there is vertical equity.

2.3 ELEMENTS OF A HEALTH INSURANCE PROGRAMME

The various elements that make up a health insurance scheme indicate the design features of health insurance and vary from situation to situation. Here, an attempt is made to describe a generic design of a health insurance programme.

2.3.1 COMMUNITY

Every health insurance scheme requires people to contribute towards the health insurance fund. This may be in the form of groups e.g. civil servants in a country, employees in the formal sector or villagers from a particular village. Or it may be random individuals as in a private health insurance scheme.

2.3.2 PROVIDERS

These may be public or private providers, e.g. in Belgium, the insurance companies contract with both public and private providers. In India, social health insurance for industrial workers contracts only with the public providers.

2.3.3 ORGANIZER

The organizer is the institution that manages the funds. It could be an entity within the government, or a para-statal body, or a private company or a voluntary organization or even a community based organization. The organizer could also take the risk, and then it becomes the insurer. On the other hand, the organizer may want to link up with an insurance company, so that the risk is with the company. The organizer’s main role is to organize the insurance, collect and pool the revenue and purchase health care. Sometimes, the provider acts as the organizer, thus playing a dual role.

2.3.4 PREMIUM

Premium is the amount collected from the insured. It may be collected annually or monthly. The premium is determined by the size of the benefit package.

2.3.5 BENEFIT PACKAGE

The benefit package is the return for the contribution. Usually, a benefit package contains events that are of low probability but high cost e.g. hospitalization. However, there are many schemes that provide for just the opposite, events that are of high probability and low cost, e.g. outpatient visits. As the benefit package increases,
the premium also rises proportionately. Most private health insurance schemes usually exclude some conditions from the cover. For example, many insurers do not cover treatment of HIV-AIDS. Similarly, treatment of chronic conditions or very expensive procedures is excluded.

2.3.6 PAYMENTS

There are basically two ways of settling insurance claims. One is the third party payment mechanism, where the insurer pays directly to the provider. This form of reimbursement has the least burden for the patient. On the other hand, many private health insurance schemes have an indemnity mechanism, where the patient pays the bills upfront and is reimbursed by the insurer after submitting the bills and documents. The disadvantage is that the patient has to make arrangements for paying the bill. This can have repercussions, both on access to health care and financial protection.

2.3.7 ADMINISTRATION

The insurer usually has to perform many administrative functions apart from the onerous task of managing the funds. These include

• Creating and maintaining insurance awareness among the insured

• Fixing premiums and benefit packages

• Processing claims

• Negotiating with providers
• Redressing grievances

• Providing feedback to the insured

2.3.8 RISK MANAGEMENT

Health insurer has many risks to manage including moral hazard, adverse selection, fraud and cost escalation. An effective programme would introduce measures to minimize these risks.

2.3.9 MONITORING THE PROGRAMME

Health insurance programmes need to be closely monitored on different parameters. The most important indicators that need to be analyzed regularly include percentage of people insured from the target population, percentage of people who have accessed health care, profile of the people who have accessed health care, monthly progress of the claims and reimbursements sent by different providers, claims Ratio, status of the insurance fund and report of the rejected claims.

2.4 INDIAN HEALTH INSURANCE INDUSTRY

The Indian insurance industry began as a freely competitive market. It was subsequently nationalized and then recently liberalized again, coming full circle.

The insurance business in India can be broadly divided into two categories:

• Life Insurance

• General Insurance
The life insurance business, which started in 1818 with the establishment of the Oriental Life Insurance Company of Calcutta, was nationalized in 1956 when the central government took over 245 Indian and foreign insurers and provident societies.

Additionally, the LIC was formed by an Act of Parliament (LIC Act 1956), with a capital contribution of Rs.50 m from the Indian government.

The first General Insurance Company in India – Triton Insurance Company Limited – was set up in 1850 with dominant British control. Its first Indian counterpart, the Indian Mercantile Insurance Company Limited, launched its operations in Bombay in 1907.

Although the general insurance business was not nationalized along with life insurance, a code of conduct for fair and sound business practices was framed in 1957 by the General Insurance Council (a wing of the Insurance Association of India). In 1968, the Insurance Act was amended to provide for greater social control over the general insurance business. In 1971, the management of non-life insurers was taken over by the Government of India. The general insurance business was nationalized in 1973 by the General Insurance Business (Nationalization) Act, 1972.

As a result, 107 insurers (including both Indian and foreign companies) were amalgamated and grouped into four companies – National Insurance Company Limited (NIC), New India Assurance Company Limited (NIACL), Oriental Insurance Company Limited (OIC) and United Indian Insurance Company Limited (UIIC) – with the General Insurance Corporation of India (GIC) as the holding company.

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The GIC was incorporated as a company in November 1972 and it commenced business on January 1, 1973. GIC has been acting as the Indian re-insurer since then. The Government of India subscribed to the capital of GIC while GIC subscribed to the capital of the four companies.

Subsequently, in pursuance to the announcement made by the Union Finance Minister in his Budget Speech of 1998-99, the Insurance Regulatory & Development Authority (IRDA) Bill, 1999, was passed by both Houses of Parliament. The Bill was assented to by the President and notified on December 29, 1999. With the Insurance Regulatory and Development Authority Act, 1999 coming into force, the insurance industry has been opened up for the private sector. The Act provides for the establishment of a statutory IRDA to protect the interests of insurance policy holders and to regulate, promote and ensure orderly growth of the insurance industry. The IRDA was formed by an Act of Parliament on April 19, 2000.

In November 2000, the Government of India restructured the general insurance industry by notifying GIC as the ‘Indian Re-insurer’. The notification followed the request of the Insurance Regulatory and Development Authority (IRDA) for bifurcation of the reinsurance business from the general insurance business of GIC.

The General Insurance Business (Nationalization) Amendment Act, 2002 was passed by both Houses of Parliament and assented to by the President of India on August 7, 2002. Consequently, GIC now undertakes only reinsurance business, while
the four public sector undertakings (Public Sector Units) – NIC, NIACL, OIC and UIIC – continue to handle the general insurance business.

Following the notification, the administrative link that existed between the four nationalized companies and the GIC ended. The four Public Sector Units are now broadly run as board managed companies.

Further, GIC has now ceased to do any direct business in India, except for crop insurance. It has also diversified into acceptance of life re-insurance business. As the sole re-insurer in the domestic re-insurance market, GIC provides re-insurance to the direct general insurance companies in the Indian market. It leads many of the domestic companies’ re-insurance programmes and facultative placements.

Following the passage of the IRDA Act, private players were allowed into the insurance business in 2000. By the end of 2006, the life insurance business in India was conducted by 14 companies – one public sector company (LIC) and 13 private sector players. The general insurance business in India was carried out by 12 companies – 4 Public Sector general insurance companies, and 8 registered companies in the private sector.

Till 2006, as is the case internationally, insurers were not allowed to offer composite (life and non-life) products. However, life insurance companies are at present allowed to add health riders to their life policies and purchase these from general insurers. The IRDA also considered the introduction of composite policies in the micro-insurance (Rs.5000 to Rs.50000 of sum assured) sector.
In 2006, the government also allowed foreign players into the market but limiting the FDI to 26% of equity. As a result, foreigners were obliged to enter the market via the joint venture route, with Indian partners providing the remaining 74% of the capital.

Although private insurance companies have commenced operations since 2001, the nationalized insurance companies dominate the market.

2.5 HEALTH PREMIUM OF NON-LIFE INSURERS – PUBLIC AND PRIVATE

The health premium garnered by the public and private sector health insurance companies showed that there had been a steady increase in the mobilization of health premium by both the sectors.

In 2001-02 the health premium collected by the public sector health insurance providers was Rs.755.3 crore while the private sector health insurance providers had collected a health premium of Rs.18.7 crore.

The year on year the health premium collection by the public sector health insurance providers showed that the increase in health premium had been 31.72% in 2002-03, 13.37% in 2003-04, 21.08% in 2004-05 and 25.86% in 2005-06.

The year on year the health premium collection by the private sector health insurance providers showed that the increase in health premium had been 161.50% in 2002-03, 108.38% in 2003-04, 198.14% in 2004-05 and 77.35% in 2005-06.
However, it is to be noted that the private sector companies have the advantage of being latecomers with a lower base; so any increase over these levels would look substantial.

**TABLE 2.2**

HEALTH PREMIUM OF NON-LIFE INSURERS – PUBLIC AND PRIVATE

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rs.</td>
<td>% change</td>
</tr>
<tr>
<td>2001 – 02</td>
<td>755.3</td>
<td>--</td>
</tr>
<tr>
<td>2002 – 03</td>
<td>994.9</td>
<td>31.72</td>
</tr>
<tr>
<td>2003 – 04</td>
<td>1127.9</td>
<td>13.37</td>
</tr>
<tr>
<td>2004 – 05</td>
<td>1365.7</td>
<td>21.08</td>
</tr>
<tr>
<td>2005 – 06</td>
<td>1718.9</td>
<td>25.86</td>
</tr>
</tbody>
</table>

*Source: http://www.usaid.gov/in/Pdfs/promise_reality.pdf*

2.6 INCURRED CLAIMS RATIO – PUBLIC Vs. PRIVATE HEALTH INSURERS

The information on claims ratio was available for public sector health insurers since 2002-03. However, this information was not available for private sector health insurers on account of their practice to include health segment under miscellaneous category until the end of 2005.

In the case of public sector health insurers, the incurred claims ratio happened to be about 92% in 2002-03, about 96% in 2003-04, about 119% in 2004-05 and
154% in 2005-06. The higher claim ratio had been posing a severe financial threat to the public sector health insurers.

As per the data available for private health insurers, the incurred claims ratio for them was about 95% in 2005-06.

**TABLE 2.3**

**INCURRED CLAIMS RATIO – PUBLIC Vs. PRIVATE HEALTH INSURERS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public (%)</th>
<th>Private (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 – 02</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>2002 – 03</td>
<td>91.62*</td>
<td>NA*</td>
</tr>
<tr>
<td>2003 – 04</td>
<td>96.37*</td>
<td>NA*</td>
</tr>
<tr>
<td>2004 – 05</td>
<td>118.80*</td>
<td>NA*</td>
</tr>
<tr>
<td>2005 – 06</td>
<td>153.89**</td>
<td>94.63**</td>
</tr>
</tbody>
</table>


**2.7 HEALTH SEGMENT MARKET SHARE – PUBLIC Vs. PRIVATE**

It is interesting to note that the market share in health portfolio of the public sector insurers had been gradually decreasing over the past 5 years since 2001-02.

In 2001-02, the public sector health insurers accounted for 98% of the health segment market and a meager 2% was held by private health insurers.
In 2002-03, the share of public sector insurers in health segment was 95% and that of private sector insurers was 5%.

The share in the health segment in the case of public sector insurers got reduced to 92% in 2003-04, 82% in 2004-05 and further to 76% in 2005-06. As a result, the private sector health insurers had improved their share in health segment from just 2% in 2001-02 to 24% in 2005-06.

### TABLE 2.4

**HEALTH SEGMENT MARKET SHARE – PUBLIC Vs. PRIVATE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public (%)</th>
<th>Private (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 – 02</td>
<td>98</td>
<td>2</td>
</tr>
<tr>
<td>2002 – 03</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>2003 – 04</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>2004 – 05</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>2005 – 06</td>
<td>76</td>
<td>24</td>
</tr>
</tbody>
</table>

*Source: http://www.usaid.gov/in/Pdfs/promise_reality.pdf*

### 2.8 PROPORTION OF HEALTH BUSINESS SEGMENT IN TOTAL NON-LIFE BUSINESS

In terms of share of the business, health insurance remains a small segment for non-life insurance companies.
In the case of public sector insurers, the health segment was 7.3% of total business in 2002-03, 8.8% in 2003-04, 9.8% in 2004-05 and the health portfolio had grown to 11.5% in 2005-06.

The health portfolio had got a higher momentum for private sector health insurers, where the proportion had more than doubled from 4.6% in 2002-03 to 9.9% of the total business in 2005-06.

**TABLE 2.5**

**PROPORTION OF HEALTH BUSINESS SEGMENT IN TOTAL NON-LIFE BUSINESS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 – 02</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>2002 – 03</td>
<td>7.3*</td>
<td>4.6*</td>
</tr>
<tr>
<td>2003 – 04</td>
<td>8.8*</td>
<td>6.3*</td>
</tr>
<tr>
<td>2004 – 05</td>
<td>9.8*</td>
<td>8.6*</td>
</tr>
<tr>
<td>2005-06</td>
<td>11.5**</td>
<td>9.9**</td>
</tr>
</tbody>
</table>

*Source: [http://ieginmain.org/dis_95.pdf](http://ieginmain.org/dis_95.pdf)  
**Source: [http://www.irdaonline.org/irdaconline/journals/irda_aug06.pdf](http://www.irdaonline.org/irdaconline/journals/irda_aug06.pdf)*

**2.9 CHALLENGES BEFORE HEALTH INSURANCE SECTOR**

The challenges and difficulties before the Indian companies in spreading health insurance in India range from a basic lack of focus to technical and infrastructure shortcomings to certain regulatory deficiencies.
2.9.1 LACK OF FOCUS

The general insurance companies have been concentrating mostly on fire, engineering, and marine. They ignore other portfolios including health, shopkeeper’s liabilities, shopkeeper’s insurance and insurance for households.

The general approach of the general insurance companies has always been to look at these big portfolios because they are the ones that are going to give them the volumes as far as the premium is concerned. So, they are concentrating not on individuals but on corporate entities for purpose of obtaining business. As a result, the health insurance has not taken off for a long time.

For the first time, at the instance of the Government of India, the general insurance companies started the health portfolio in the Eighties as a Mediclaim Policy. The same Mediclaim Policy is continuing in some form or the other, so far, with some minor modifications.

The lack of focus on health insurance was due to the tariff pricing of some general insurance segments and the absence of stand-alone health insurance companies.

2.9.2 LACK OF CO-ORDINATION

The subject of health insurance is handled by many Ministries / Departments/ Public Sector Corporations and Private Sector companies. The Ministry of Health & Family Welfare (MOHFW) looks after the Central Government Health Scheme (CGHS), which was started in 1954. The Ministry of Labour looks after the
Employees State Insurance Scheme started in 1948. The Ministry of Finance looks after the Universal Health Insurance Scheme, which was launched in 2003. They are operating in a very compartmentalized manner. Instead of collaborating and cooperating with each other quickly to deliver products, they seem to be in their cocoon.

2.9.3 LACK OF DATA

The lack of vital data on morbidity across-demographic groups is coming in the way of insurers in formulating health schemes and in determining premium as per industry specific requirements.

The health insurance industry, like all other insurance lines, is driven by data. Data facilitates the scientific evaluation and quantification of risk. Such scientific analysis is required for an insurance company to be able to meet its mission of providing financial protection against adverse events to those it insures.

One of the reasons that health insurance may not have grown in India as rapidly as was hoped, is the fact that the companies may not have had adequate data to evaluate risk scientifically. We have seen reports that show very high claims ratio experience for health insurers in the past.

Given this experience, it is understandable that insurers may be reluctant to market a broader range of health insurance products. With improved data, Indian
insurance companies will be better able to design more flexible products which will naturally attract a wider clientele.27

2.9.4 LACK OF AWARENESS

One main hindrance to the successful promotion of various health covers by the insurers was the lack of awareness about the need, availability and benefits of health insurance amongst a large majority of population in India.

The concept of Health Insurance is still not very clear to the prospective clients. Some of them believe that once the premium is paid, all their health care is taken care of. Others believe that health insurance cover can be availed once they are diagnosed for some serious medical treatment. Most of them are unable to comprehend pre-existing diseases and feel that the once the policy is bought it should be ‘all risk’ cover. This misunderstanding often creates problems at the time of settlement of claims. Hence wrong messages are spread that health insurances do not really help those in need and therefore discourages people from buying the policy.

2.9.5 POVERTY

Lack of premium paying capacity amongst a sizable number of the population in India is another reason coming in the way of implementation of health insurance schemes in the country.

27 http://www.expresshealthcaremgmt.com/20041015/conversation02.shtml
2.9.6 LACK OF PROPER REGULATIONS IN THE HEALTH SECTOR

Regulatory shortcomings relating to the health sector in India is another major hindrance to a healthy growth of health insurance in the country.

2.9.7 LACK OF HEALTH INFRASTRUCTURE

Lack of adequate hospitals and other health care facilities is yet another commonly cited difficulty being faced by the insurance companies in spreading health insurance covers. The major area of concern is the lack of health infrastructure in the rural and semi-urban areas. Moreover poor quality & inadequate healthcare services of Government facilities compel the masses to go to private healthcare providers, which is a costly affair.

2.9.8 LACK OF PRODUCT VARIETY

One of the concerns for the slow progress of health insurance sector have been on the lack of variety of health covers to meet specific requirements of various strata of population such as the aged, youth, people with pre-existing diseases and for conditions which need no hospitalization.

2.9.9 LACK OF PROFITABILITY

One of the challenges to the spread of health insurance is the loss proneness of this business.

As far as insurance for the poor is concerned, insurance is a pooling of resources. A large number of people should pay the premium for meeting the claims
of a few. If a larger number of young people who are entering the job take the insurance policy, it could cover the medical expenses of others that are in the age group of 50 to 60 years.

However, for various reasons, it is difficult to make the people insured at young stage. The average age of the insured persons is above 45 – 50 years. So, the very ‘insurance’ concept of pooling various resources from many people and serving the few is not done in this case because the ‘probability’ factor of people suffering is much more in the higher age group.  

2.9.10 RURAL PENETRATION

The lack of rural penetration was one of the biggest challenges coming in the way of spread of health insurance in India. A major portion of the rural market has been uncovered although they are also exposed to risks similar to or even higher than their urban counterparts.

With a very high percentage of the population, residing in rural India, which is plagued by high poverty levels and risk-bearing vagaries, rural penetration, remains a daunting challenge to most insurers.

The ratio of rural Indian population is very high and it has grown insurance needs; therefore, it is a fact that the potential growth of insurance industry lies in the rural market, both for life and general (non-life) insurance. Insurers can look upon the rural market as an opportunity and not an obligation.

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28 http://164.100.24.208/ls/CommitteeR/PU/11threp.pdf
To summarize, the people below the poverty line in India have problems with accessing hospital care. Those who do access health care are impoverished in the process. Health insurance can reduce the financial barrier. Unfortunately, only about 10% of the population is covered by health insurance in India. Though the private health insurance companies have commenced operations since 2001, the nationalized insurance companies dominate the market. Lack of focus, lack of data, lack of awareness, lack of profitability are some of the pressing problems of Indian health insurance sector.