

Emerging Health Insurance in India – An overview

By J Anita

Introduction

Evolution of Health Insurance

The concept of Health Insurance was proposed in the year 1694 by Hugh the elder Chamberlen from Peter Chamberlen family. In 19th Century "Accident Assurance" began to be available which operated much like modern disability insurance. This payment model continued until the start of 20th century. During the middle to late 20th century traditional disability insurance evolved in to modern health insurance programmes. Today, most comprehensive health insurance programmes cover the cost of routine, preventive and emergency health care procedures and also most prescription drugs. But this is not always the case.

Healthcare in India is in a state of enormous transition: increased income and health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy, and the introduction of private healthcare financing drive the change.

Over the last 50 years, India has achieved a lot in terms of health insurance. Before independence, the health structure was in dismal condition i.e. high morbidity and high mortality and prevalence of infectious diseases. Since independence, emphasis has been put on primary health care and we made considerable progress in improving the health status of the country. But still, India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators.

Health insurance, which remains highly underdeveloped and less significant segment of the product portfolios, is now emerging as a tool to manage financial needs of people to seek health services.

The new economic policy and liberalization process followed by Government of India since 1991 paved the way for privatization of insurance sector in the country. The Insurance Regulatory and Development Authority (IRDA) bill, passed in Indian parliament, is the important beginning of changes having significant implications for the health sector.

Health Insurance is more complex than other segments of insurance business because of serious conflicts arising out of adverse selection, moral hazard, unavailability of data and information gap problems. Health sector policy formulation, assessment and implementation are an extremely complex task, especially, in changing epidemiological, institutional, technological and political scenario. Proper understanding of Indian Health situation and application of principles of insurance, keeping in view the social realities and national objectives, are important.

This paper attempts to discuss the following areas:

- Review of health insurance scenario in India
- Various Health Insurance products available in India
- Comparison of health insurance offered by a Life and General Insurer
- Health Insurance for senior citizens
- Need for Long term care plans
- Models of Long term care in other countries
- Health Ratios
- Implications of privatization on health insurance
- Role of IRDA

HEALTH INSURANCE SCENARIO IN INDIA

Health is a human right. It's accessibility and affordability has to be ensured. The escalating cost of medical treatment is beyond the reach of common man. While well to do segment of the population both in Rural and Urban areas have accessibility and affordability towards medical care, the same cannot be said about the people who belong to the poor segment of the society.

Health care has always been a problem area for India, a nation with a large population and larger percentage of this population living in urban slums and in rural area, below the poverty line. The government and people have started exploring various health financing options to manage problem arising out of increasing cost of care and changing epidemiological pattern of diseases.

The control of government expenditure to manage fiscal deficits in early 1990s has led to severe resource constraints in the health sector. Under this situation, one of the ways for the government to reduce under funding and augment the resources in the health sector was to encourage the development of health insurance.

In the light of escalating health care costs, coupled with demand for health care services, lack of easy access of people from low income group to quality health care, health insurance is emerging as an alternative mechanism for financing health care.

Indian health financing scene raises number of challenges, which are:

- Increase in health care costs
- High financial burden on poor eroding their incomes
- Need for long term and nursing care for senior citizens because of increasing nuclear family system
- Increasing burden of new diseases and health risks
- Due to under funding of government health care, preventive and primary care and public health functions have been neglected

In the above scenario, exploring health financing options became critical. Naturally, health insurance has emerged as one of the financing options to overcome some of the problems of our system.

In simple terms, health insurance can be defined as a contract where an individual or group purchases in advance health coverage by paying a fee called "premium". Health insurance refers to a wide variety of policies. These range from policies that cover the cost of doctors and hospitals to those that meet a specific need, such as paying for long term care. Even disability insurance, which replaces lost income if you cannot work because of illness or accident, is considered health insurance, even though it is not specifically for medical expenses.

Health insurance is very well established in many countries, but in India it still remains an untapped market. Less than 15% of India's 1.1 billion people are covered through health insurance. And most of it covers only government employees. At any given point of time, 40 to 50 million people are on medication for major sickness and share of public financing in total health care is just about 1% of GDP. Over 80% of health financing is private financing, much of which is out of pocket payments and not by any pre-payment schemes. Given the health financing and demand scenario, health insurance has a wider scope in present day situation in India. However, it requires careful and significant efforts to tap Indian health insurance market with proper understanding and training.

VARIOUS HEALTH INSURANCE PRODUCTS AVAILABLE IN INDIA

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

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

1. Voluntary health insurance schemes or private-for-profit schemes:

In private insurance, buyers are willing to pay premium to an insurance company that pools similar risks and insures them for health related expenses. The main distinction is that the premiums are set at a level, which are based on assessment of risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of consumer's income.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) provide voluntary insurance schemes.

The most popular health insurance cover offered by GIC is Mediclaim policy

- **Mediclaim policy:** - It was introduced in 1986. It reimburses the hospitalization expenses owing to illness or injury suffered by the insured, whether the hospitalization is domiciliary or otherwise. It does not cover outpatient treatments. Government has exempted the premium paid by individuals from their taxable income.
 - ✓ Because of high premiums it has remained limited to middle class, urban tax payer segment of population.
- Some of the various other voluntary health insurance schemes available in the market are :- Asha deep plan II , Jeevan Asha plan II, Jan Arogya policy, Raja Rajeswari policy, Overseas Mediclaim policy, Cancer Insurance policy, Bhavishya Arogya policy, Dreaded disease policy, Health Guard, Critical illness policy, Group Health insurance policy, Shakti Shield etc.
- At present Health insurance is provided mainly in the form of riders. There are very few pure health insurance policies under voluntary health insurance schemes.

2. Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

- **Employer State Insurance Scheme (ESI):**- Enacted in 1948, the employers' state insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power using factories employing 10 persons or more and non-power & other specified establishments employing 20 persons or more. It covers employees and the dependents against loss of wages due to sickness, maternity, disability and death due to employment injury. It also covers funeral expenses and rehabilitation allowance. Medical care comprises outpatient care, hospitalization, medicines and specialist care. These services are provided through network of ESIS facilities, public care centers, non-governmental organizations (NGOs) and empanelled private

practitioners. The ESIS is financed by three way contributions from employers, employees and the state government.

✓ Even though the scheme is formulated well there are problem areas in managing this scheme. Some of the problems are :-

- Large numbers of posts of medical staff remain vacant due to high turnover and low remuneration compared to corporate hospitals.
- Rising costs and technological advancement in super specialty treatment.
- Management information is not satisfactory.
- The patients are not satisfied with the services they get
- Low utilization of the hospitals
- In rural areas, the access to services is also a problem

All these problems indicate an urgent need for reforms in the ESIS Scheme.

- **Central Government Health Insurance Scheme (CGHS):-** Established in 1954, the CGHS covers employees and retirees of the central government and certain autonomous and semi autonomous and semi-government organizations. It also covers Members of Parliament, Governors, accredited journalists and members of general public in some specified areas. Benefits under the scheme include medical care, home visits/care, free medicines and diagnostic services. These services are provided through public facilities with some specialized treatment (with reimbursement ceilings) being permissible at private facilities. Most of the expenditure is met by the central government as only 12% is the share of contribution.

✓ The CGHS 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).

- **Universal Health Insurance Scheme (UHS):-** For providing financial risk protection to the poor, the government announced UHS in 2003. Under this scheme, for a premium of Rs. 165 per year per person, Rs.248 for a family of five and Rs.330 for a family of seven , health care for sum assured of Rs. 30000/- was provided. This scheme has been made eligible for below poverty line families only. To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of family eligible as against mediclaim policy which is for an individual member. In spite of all these, the scheme was not successful.

✓ The reasons for failing to attract rural poor are many :-

- The public sector companies who were required to implement this scheme find it to be potentially loss making and do not invest in propagating it. To meet the target, it is learnt that several field officers pay the premium under fictitious names.
- Identification of eligible families is a difficult task
- Poor find it difficult to pay the entire premium at one time for future benefit, foregoing current consumption needs.
- Paper work required to settle the claims is cumbersome
- Deficit in availability of service providers
- Set back due to health insurance companies refusing to renew the previous year's policies.

- In 2004, the government also provided an insurance product to the **Self Help Group (SHG)** for a premium of Rs.120 and sum assured of Rs.10000/-. However, the intake is negligible. The reasons for poor intake are similar to those cited above.

3. Insurance offered by NGOs/Community based health insurance

Community based schemes are typically targeted at poorer population living in communities. Such schemes are generally run by charitable trusts or non-governmental organizations (NGOs). In these schemes the members prepay a set amount each year for specified services. The premia are usually flat rate (not income related) and therefore not progressive. The benefits offered are mainly in terms of preventive care, though ambulatory and inpatient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with for profit insurers for the purchase of custom designed group insurance policies.

- ✓ CBHI schemes suffer from poor design and management. Often there is a problem of adverse selection as premiums are not based on assessment of individual risk status. These schemes fail to include the poorest of the poor. They have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.
- Some of the popular Community Based Health Insurance schemes are: - Self-Employed Women's Association (SEWA), Tribuvandas Foundation (TF), The Mullur Milk Co-operative, Sewagram, Action for Community Organization, Rehabilitation and Development (ACCORD), Voluntary Health Services (VHS) etc.

4. Employer based schemes

Employers in both public and private sector offers employer based insurance schemes through their own employer. These facilities are by way of lump sum payments, reimbursement of employees' health expenditure for out patient care and hospitalization, fixed medical allowance or covering them under the group health insurance schemes.

The Railways, Defense and Security forces, Plantation sector and Mining sector run their own health services for employees and their families.

GENERAL INSURANCE VS. LIFE INSURANCE

Several life insurance companies have of late plunged into the health segment, which till recently was dominated by general insurance companies. Among others, ICICI Prudential has launched Hospital Care and Crisis Cover and Bajaj Allianz, the Care First plan. Life Insurance Corporation, too, plans to roll out products soon. But, are these products any different from those offered by the general insurance companies, popular as mediclaim policies?

A comparison between Health Insurance offered by a Life and General Insurer

Nature of the contract	Life Insurer	General Insurer
Period of coverage	Contracts are usually made for a long period.	Contracts are usually, though not invariably, made for a short period of one year or less and at the end of that period are renewable by mutual consent of the insurer and the insured.
Obligation of the insured	Once the contract has been made, the insured is generally under no obligation to report any changes of circumstances affecting the risk insured unless a change in the actual nature of the contract is requested by the insured.	At each renewal there is an onus on the insured to observe utmost good faith in informing the insurer of any changes in circumstances which may affect assessment of the cost of the risk borne by the insurer.
Premiums	The premiums for a life assurance contract remain fixed over the term of the contract	The premiums may vary at each renewal to reflect changes in individual circumstances
Benefit payout	Pays a lump sum, irrespective of whether the policyholder has incurred those expenses on his hospital stay	Pays claims according to the hospital expenses that a person incurs, depending, of course, on the amount of cover that a policyholder has taken.
Valuation of Liabilities	A deterministic approach (the life & morbidity table) may be adequate for the valuation of life assurance liabilities	A stochastic approach (with statistical models more complicated than the life and morbidity table) has to be considered for general insurance
Taxation	Portion of premium paid in respect of health insurance covering the assessee as well as any member of the family is deducted from taxable income under section 80D	Premium paid in respect of health insurance policies is deducted from taxable income under section 80D

Advantages of Health insurance offered by Life insurer: Because of the long term nature of the plans, the policy holder can plan in advance his future medical/care expenses. But it is not so under General insurance. Since, the general insurance policies are subject to renewal every year, if the policy holder has been making several claims and is considered a risk, the general insurance company may deny renewal or renew it for a much higher premium.

Advantages of Health insurance offered by General insurer: Though a lump sum amount is paid by life insurers and is of long term nature, this comes with a cost. They charge bigger premiums compare with the General insurers. In addition, most general insurance companies offer medical charges up to 30 days before a person is hospitalized and pay the claims if a person has been undergoing treatment at home - also called domiciliary hospitalization. The life insurers seem to lack this facility at this point in time.

HEALTH INSURANCE FOR SENIOR CITIZENS

Ageing health policy questions are now frequently raised in India. India has not yet found a clear, fair and adequate system for financing the growing demand for long-term care as the population ages. The migration of population for jobs and livelihood from rural areas to urban areas and between cities has led to the breaking down of the age old traditional "joint" or "extended" family system in India. This system provides a good supporting structure for the care of older persons by keeping families together, pooling financial resources and making family members available in case of need. This weakening in the traditional support systems for older people is expected to lead to a rapid increase in the demand for formal care provided by institutions such as nursing and residential homes and also services provided in the community.

At present, there are no social schemes or federal or central government mechanisms for funding of health care for the aging population. The reliance is currently on private sector, voluntary organizations and indigenous programs that deliver 80% of health care (the remainder is in the form of Government hospitals and Municipal corporations). The medical infrastructure to handle substantial number of older adults is lacking. There is no provision for organized long term care for chronically sick, except for the upper middle class and the rich who can afford to provide good care at home with some professional help. Hence, there is a need for innovative, cost effective health insurance products for senior citizens which cater effectively to their needs.

LONG TERM CARE

This paper focuses primarily on long-term care as the subject of long-term care (LTC) is receiving increasing attention both in the research community and by Government because of the belief that an ageing population will greatly swell the demand for long term care services and create huge public expense. One of the issues which need to be determined is by how much demand will increase; another is to address the ambiguity over whether long-term care is a response to a medical condition, a social need or both. The corollary is to decide how the burden is to be shared between the individual, the family and the state.

Before going on to discussing what different nations are doing, it is essential we first appreciate the nature and significance of long-term health care.

Long-term care is administered to people who have reached a stage in life in which they are dependent on others for social, personal and medical needs. It is usually associated with the very old, but, in fact, could begin at any age depending on the reasons for their disability – perhaps a road accident, a mental or a congenital condition. An important social objective for long-term care is to ensure that people are given the opportunity to choose where their care is delivered. Given that older people prefer to remain at home the availability and affordability of help to support this is crucial.

Various countries have different insurance systems to cover LTC. India is acquainted with short-term health schemes provided by non-life insurers and the government. The need of the hour in India, keeping in view the increasing tendency to opt for nuclear family system and increased longevity, is a comprehensive long term health care facility for all. If we look at most developed economies (a microcosm of which is discussed here below), we see that most of these nations have a working and workable LTC system for the benefit of its citizens, primarily the senior citizens. Experiences from other countries need to be studied, so that we can develop a model based on good innovations from various countries while keeping the realities of Indian health system.

MODELS OF LONG TERM CARE IN OTHER COUNTRIES

GERMANY

- Mandatory long-term care (LTC) insurance was introduced throughout Germany at the beginning of 1995. Up to that date, long-term care had not been a public concern like pensions and health care.
- According to German law, children are obliged to support their parents in old age, to the degree that their own resources are sufficient. Only if family income and wealth has proved to be insufficient can the elderly may apply for income support.

Financing

- The German insurance is a **Pay as you go (PAYG)** system where risks are pooled and benefits are independent of earlier contributions. 'Pay as You Go' in which current contributors pay for current recipients of care.
- One peculiarity of the LTC insurance component is that it has defined contributions and defined benefits at the same time. This means that total benefits and total contributions must match on average, and so far this requirement seems to have been met.
- All employees as well as individuals with some other kind of income have to be insured. In addition, voluntary insurance is offered to some groups.
- Employers and employees pay the same percentage of the wage. Retired people also contribute to the insurance. Civil servants since they are not part of the social health insurance programme are obliged to take up private insurance, and get part of the contribution paid by their employer.
- For people dependent on income support, the local authority concerned may choose between paying the contributions on behalf of the individuals concerned and taking the risk of having to pay for their care.
- Because it is a PAYG system, the LTC insurance has not been able to build up more than a small financial balance. According to the law, the balance must be sufficient to continue to make payments for 1.5 months; at the moment it is sufficient to cover three.

Benefits

- It takes five years to qualify for benefits. Apart from that, the only qualifying requirement is the need for care, so benefits are paid independent of age. Three kinds of benefits are offered: professional domiciliary care, institutional care, and benefits in cash. Different kinds of benefits may also be combined.
- Benefits are not dependent on the income of the individual.
- People applying for benefits are examined by a doctor and then divided into three groups. The critical factors are the person's ability to perform activities of daily living (ADL), together with the time that these activities are estimated to consume. Mental impairments are not taken into account.

JAPAN

- Since Japan became industrialized quite late, it also developed social security systems slightly later than most other developed countries.
- Family patterns changed as traditional caring arrangements based on three-generation households and obligations on children to look after elderly parents showed signs of breaking down.
- In 1997, following a long discussion, a mandatory long-term care insurance was passed in the Japanese parliament.

Financing

- The LTC insurance is financed by 50 % from taxes and by 50 % from insurance premiums. The tax revenues are collected by 50 % from national taxes, and local and regional taxes contribute with 25 % each. Premiums are collected from people aged 40 years and over. Family members are automatically covered.
- For the elderly, premiums are deducted from pensions. These premiums are also income-related.
- The LTC insurance is administered by municipalities.

Benefits

- Eligibility for benefits from the LTC insurance is solely based on need. Thus, the financial position and family structure of the insured are not taken into account. The LTC insurance covers institutional as well as home-based care, and clients in all categories except the least needy may choose between them.
- There are three kinds of institutions: former social service nursing homes, formerly health-insurance financed homes for elderly and medical nursing care facilities. Home care services included are nursing care, rehabilitation, medical advice and various community services.
- Unlike the German system there are no cash benefits provided in the scheme.
- When the private LTC insurance was introduced, several large for-profit corporations made huge investments in home services in the anticipation of increased demand due to the increased freedom to choose providers. However, recipients have proved to be more conservative than expected, and stayed with their former providers. This has incurred some losses on private corporations offering home care.

UNITED STATES

- The United States had a quite ambitious social welfare programme for elderly already around the turn of the twentieth century. At this time, more than one quarter of federal expenditure was dedicated to pensions for Civil War veterans and their families.
- Long-term care makes up a small but increasing part of public spending in the United States.

Financing

- In the United States, funds for health and long-term care for elderly is provided from public as well as private sources. Public funding is based on **Medicaid and Medicare** programmes, whilst the private element consists of private insurance as well as out-of-pocket payments.

- **Medicaid** is a tax-based programme designed for low-income earners. It covers hospital care as well as home care. Even if the Medicaid programme was not originally designed to concentrate on help for the elderly, it has evolved into an important pillar for long-term care financing
- **Medicare** is a national social insurance programme. Contributions are paid either as 'Medicare tax' while working, or by continuing to pay premiums after retirement. Medicare compensates nursing home costs if the insured has been treated in a hospital for at least three days. Medicare only reimburses costs for doctors' and nurses' services. Home care is only provided if the client needs skilled nursing care and is homebound. However, for clients meeting the requirements, personal care services may be provided as well. Medicare home services are provided for free
- In recent years, a private market for long-term care insurance has emerged in the United States. Private insurance companies – there are more than 100 of them – offer complementary insurance for costs related to long-term care. The insurance products are designed for cases where benefits from Medicare have been exhausted, and where the insured is not entitled to Medicaid benefits. Insurance is voluntary, and has normally been taken out individually.
- Before signing up, the policyholder goes through a medical examination. The insurance company also requests information regarding the customer's consumption of medical services, his or her lifestyle and physical or mental disabilities, if any. Contributions are based on these data, and sometimes they become prohibitively high. Estimates show that as much as 20 % of the elderly population would be refused long term care insurance.

Benefits

- Benefits offered by private long-term insurance policies vary. Some only include nursing home care, whereas others only cover home care. Typically, only care given by nurses or doctors is covered. Normally, policies offer a fixed per diem compensation if care is needed. Benefits are paid for a limited time; e.g. five years or remaining life years

The financing of LTC is a very topical issue in the United States. Weaknesses in the existing system have received particular attention, and there is widespread concern that LTC may become more problematic under the burden of ageing.

United Kingdom

- The main principle of the British LTC system as it evolved during the post-war era was that local authorities provided care in residential homes, whereas the NHS took care of particularly frail people.

Financing

- In the UK there are two main sources of LTC funding (apart from consumers themselves), namely local authorities and the NHS. Local authorities are responsible for the bulk of public spending on LTC, and their share has increased in the last few years.
- Local authorities have two main sources of funding - government grants and council taxes. Government grants are decided annually by the central government and then distributed to the individual authorities according to a resource allocation formula.

- Since 1991, there is also a market for private LTC insurance that is growing slowly
- The first private insurance policies for LTC costs were introduced in 1991 and there is now a wide variety of policies offered on the market. There are two main types of insurance on offer. The first one is pre-funded plans that are purchased by healthy people to protect them against future costs of LTC. The other type is 'immediate needs' plans that are purchased by people that are already disabled to insure the risk of uncertain survival duration. The payment of pre-funded benefits is normally conditioned on failure of a certain number of ADL:s and not on personal circumstances – such as whether the client lives at home or in an institution. Maximum benefits are normally limited

Benefits

- State financing covers residential as well as domiciliary care. Local authorities are obliged to provide assessment of need by a case manager. The case manager suggests a package of services appropriate for the client in question.
- The majority of care is provided in the person's own home. Home care is defined as services which assist the client to function as independently as possible and/or continue to live in their own home. Services may involve routine household tasks within or outside the home, personal care of the client or respite care in support of the client's regular careers.
- Institutional care is provided in several different kinds of homes. The predominant ones are nursing homes and residential homes. Residential homes provide board and personal care only, whereas nursing homes also provide daily nursing care and thus are more targeted at people with severe disability. In the last decade, there has been a steady increase in the number of dual homes, providing both residential and nursing care.

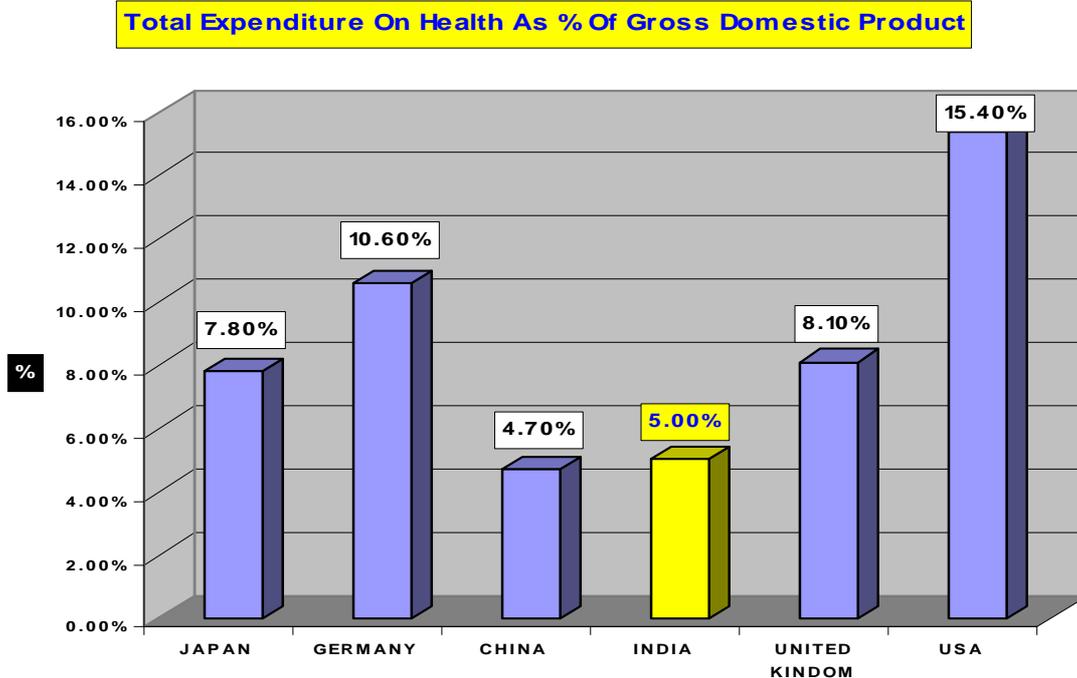
The system for financing and provision in the United Kingdom has been criticized on several grounds. For example, it has been accused of offering poor co-ordination between different financing bodies and thus providing incentives for cost shifting.

Furthermore, there has been broad agreement that the system is unfair since it penalizes savers and fails to offer comprehensive coverage despite the fact that public financing is universal through the tax system.

HEALTH RATIOS

Source: 2007 WHO fact sheet based on 2004 data

Figure 1



- From **figure 1** it can be seen that the expenditure on health as a % of GDP is only 5% in India which is much lower than that of developed countries but is comparable with China.
- Considering that India is one of the rapidly growing economies, the share of Health in GDP is quite low. This may be attributed to lack of awareness in general population of health schemes and not understanding the significance of health protection.
- Industry sources estimate that health care spending in India will increase by around 12% annually over today's value of US\$23 billion (roughly 5.2% of GDP).

Figure 2

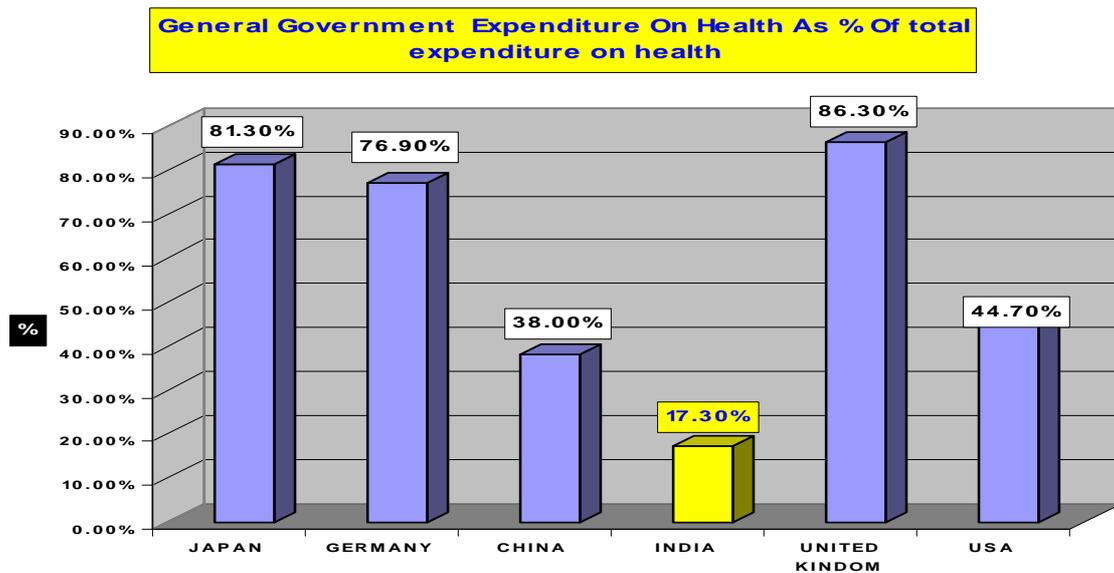
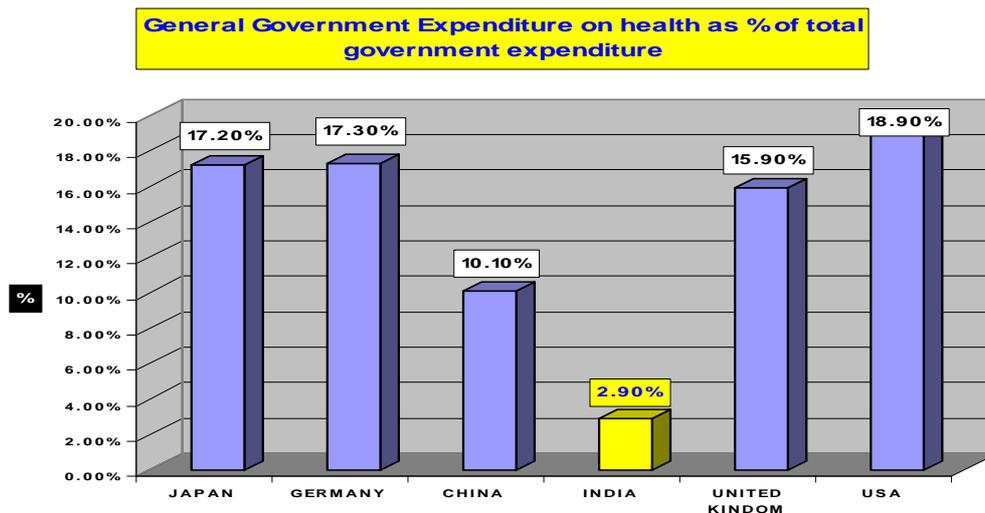
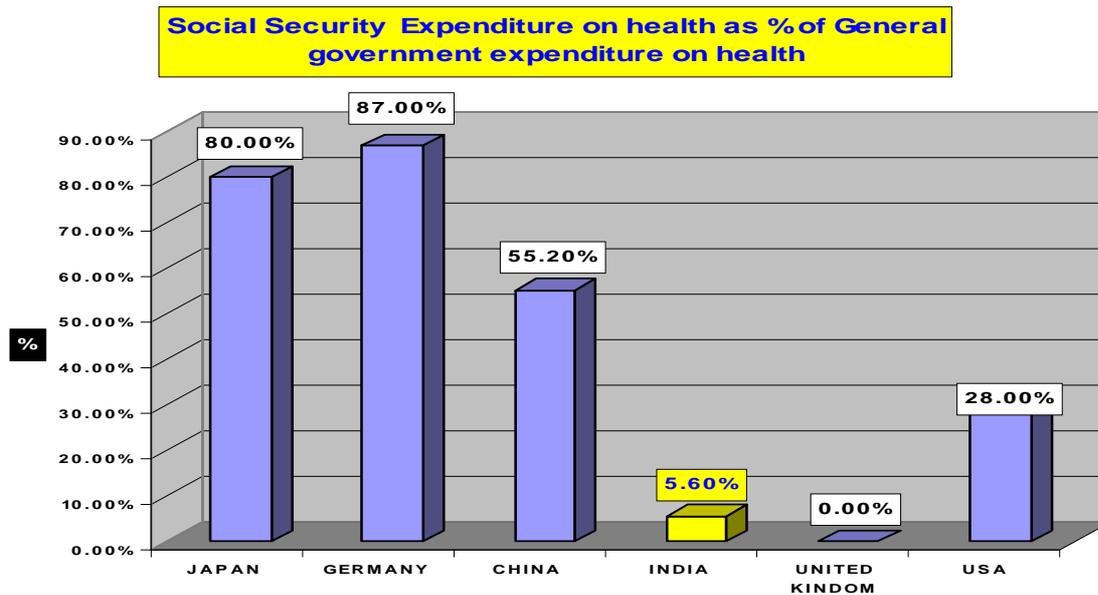


Figure 3



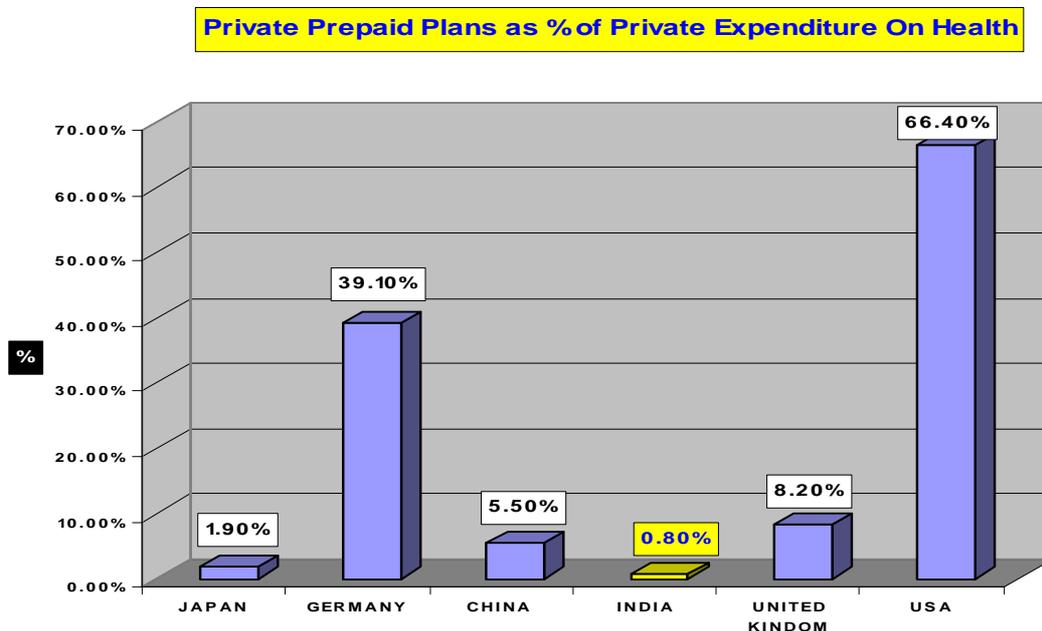
- From figures 2 & 3 it can be seen that general government expenditure on health as % of total expenditure on health and as a % of total government expenditure is much lower than even China.
- This shows that in India, Private health Expenditure dominates Government expenditure.
- The government funds allocated to health care sector have always been low in relation to the population of the country.
- We see that Government of India has earmarked a meager 3% of total expenses on Health
- This may be understandable considering that we have very less social-security schemes in place.
- This is another sad observation considering that India's is second most populated country in the world with the maximum of people below the poverty line.
- More focus on infrastructure development during the recent times may be the reason.
- Alternatively, indirect support coming from private schemes can be a reason too.
- A more active penetration into the rural areas can improve the percentage over time

Figure 4



- Social security expenditure is also much lower compared to other countries except UK
- This Chart can be interpreted in conjunction with Figure 2 above.
- This may be due the bottlenecks we discussed above on Government Schemes.

Figure 5



- This can be justified keeping in view the nascent stage of insurance industry in India which is steadily yet confidently picking up.
- However, rural awareness and utilization of these schemes are still disappointing.

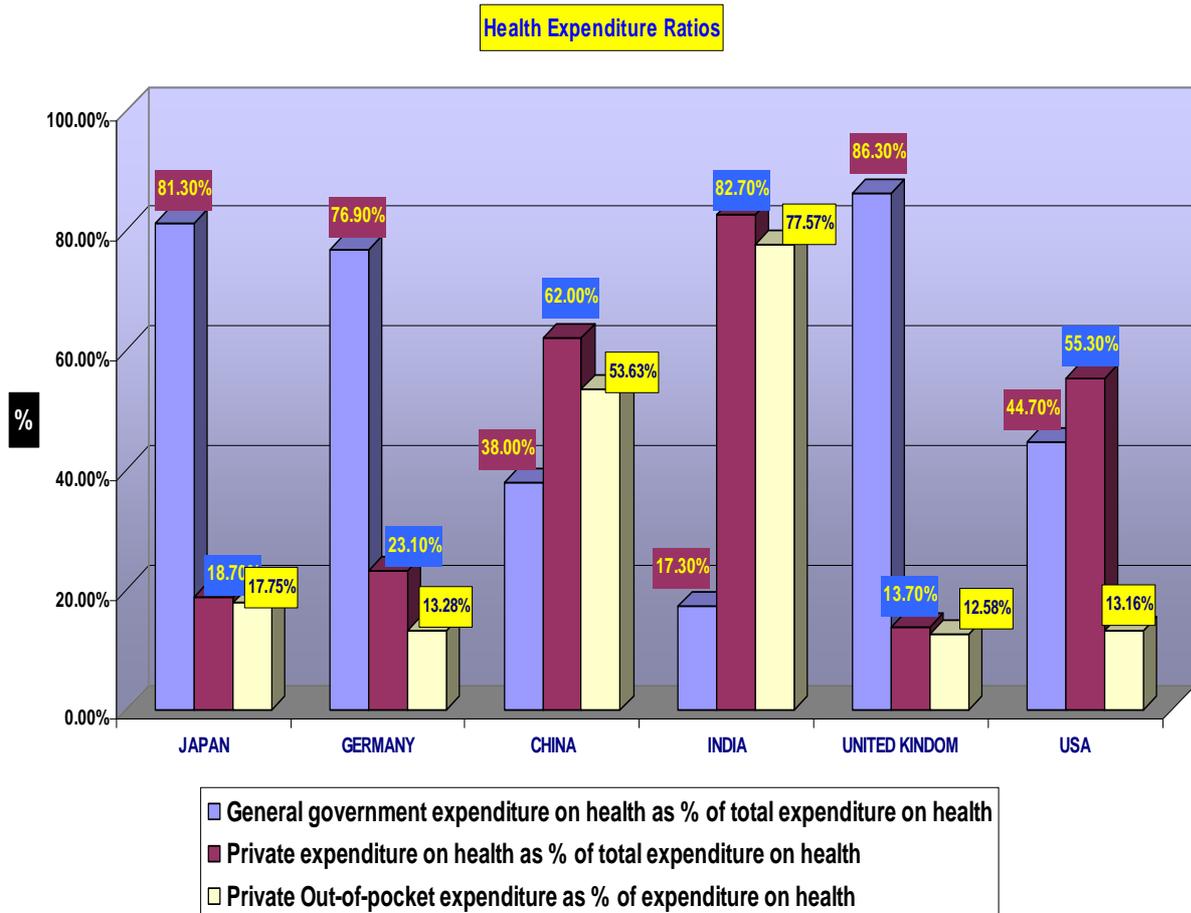


Figure 6

- Over 80% of health financing is private financing, much of which is out of pocket payments and not by any pre-payment schemes.
- With insurance industry opening up and non-life sector being detariffed, we can hope to see an influx of many competitive products in the near future.
- Given the health financing and demand scenario, health insurance has a wider scope in present day situation in India. However, it requires careful and significant efforts to tap Indian health insurance market with proper understanding and training

IMPLICATIONS OF PRIVATIZATION ON HEALTH INSURANCE

The privatization of insurance sector and constitution of **IRDA** envisage improving the performance of state insurance sector in the country by increasing benefits from competition in terms of lowered costs and increased level of consumer satisfaction. However, the implications of the entry of private insurance companies in health sector are not very clear. There are several contentious issues pertaining to development in this sector and these need critical examination. Role of private insurance varies depending on the economic, social and institutional settings in a country or a region.

Critics of private insurance argue that privatization will divert scarce resources away from the pool, escalate health costs, allow cream skimming and adverse selection. According to this view, private health insurance largely neglects the social aspect of health protection. In the contrast, supporters of private health insurance claim that private insurance can bridge financing gaps by offering consumers value for money and help them avoid waiting lines, low quality care and under the table

payments-problems often observed when households can use public health facilities for free or participate in mandatory social insurance schemes. Both the arguments are correct in the sense, private health insurance can be valuable tool to compliment or supplement existing health financing options only if they are carefully managed and adapted to local needs and preferences.

India, with relatively developed economy and a strong middle class population, offers most promising environment for private health insurance development. Currently, private health insurance plays only a marginal role in health care systems but it is gradually gaining importance. Private health insurance is certainly not the only alternative or the ultimate solution to address alarming health care challenges in India. However, it is an option that warrants- and already receives-growing consideration by policy makers in the country. Thus the question is not if this tool will be used in the future but whether it will be applied to the best of its potential to serve the needs of the country's health care system.

ROLE OF REGULATOR

As Health Insurance is in its very early phase, the role of IRDA will be very crucial. It has to ensure that this sector develops rapidly and benefit of insurance goes to the consumers. It has to guard against the ill effects of privatization. Unless privatization and development of health insurance is managed well it may have negative impact of health care, especially to a large segment of rural population in the country. If it is well managed then it can improve access to care and health status in the country rapidly. Experience from other countries suggest that the entry of private firms into the health insurance sectors, if not properly regulated, does have adverse consequences for the cost of care, equity, consumer satisfaction, fraud and ethical standards. Some of the areas of concern which the regulator has to look into are:

- Many times the insurance claims are rejected due to small technical reasons. This leads to disputes
- Various conditions included in the insurance policy contract is not negotiable and these are binding on consumer
- There no analysis on what is fair practice and what is unfair practice
- The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions.
- The main danger in the health insurance business is that the private companies will cover the risk of middle class who can afford to pay high premiums. Unregulated reimbursement of medical costs by the insurance companies will push up the prices of private care. So large section of India's population who are not insured will be at a relatively disadvantage as they will, in future, have to pay more for the private care.

IRDA has stipulated regulations for both life and non-life insurance companies in many aspects of business but the same is lacking in respect of health insurance business. Given the health insurance is assuming greater significance, it is time for the regulator to etch a frame work for operating the health schemes.

IRDA will have to evolve mechanism so that the private insurance companies do not skim the market by focusing on rich and upper class clients and in the process neglect a major section of India's population.

In a view to ensure that the rural and less-developed areas do not fall prey to a step-motherly treatment in penetration of health business, the Regulator may ensure, in line with its rules jotted down for private life and non-life insurers, that minimum annual targets are given to the benefit providers so that at any given point in time, a decent portfolio of health coverage's represent the rural sector

IRDA should ensure and encourage different organizations and private insurers to develop products for the poorer segment of the community and if possible build an element of cross subsidy for them.

The IRDA will have a significant role in regulating the health insurance sector and safe guarding the interests of the policy holders by minimizing the unintended consequences.

Conclusion:

Health insurance is like a knife. In the surgeon's hand it can save the patient, while in the hands of the quack, it can kill. Health insurance is going to develop rapidly in future. The main challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without negative aspects of cost increase and overuse of procedures and technology in provision of health care.

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