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REVIEW ARTICLE

# HEALTH INSURANCE IN INDIA

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# Health Insurance in India

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Social security for medical emergencies is not new to the Indian ethos. It is a common practice for villagers to take a 'piruvu' (a collection) to support a house- hold with a sick patient. However, health insurance, as we know it today, was introduced only in 1912 when the first Insurance Act was passed (Devadasan 2004). The current version of the Insurance Act was introduced in 1938. Since then there was little change till 1972 when the insurance industry was nationalized and 107 private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). Private and foreign entrepreneurs were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered under any form of health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country. The Indian health insurance scenario is a mix of mandatory social health insurance (SHI), voluntary private health insurance and community-based health insurance (CBHI). Health insurance is thus really a minor player in the health ecosystem.

## SOCIAL HEALTH INSURANCE

Universal coverage has two dimensions: health care coverage (adequate health care) and population coverage (health care for all) and, coupled with the societal values that underpin it, leaves essentially two financing options—general taxation and SHI. The former implies financing care entirely from general revenue; its viability as the single mechanism to finance universal health coverage is necessarily limited in an environment of competing demands on a severely limited tax base. The SHI is based on income-determined contributions from mandatory membership of, in principal, the entire population with the government subsidizing the financially vulnerable sections. While the SHI is an effective risk-pooling mechanism that allocates services according to need and distributes the financial burden according to the ability to pay (thereby ensuring equity in access), such schemes are difficult and expensive to implement where a majority of the workforce is unemployed or employed in the informal sector.

## THE INSURANCE REGULATORY AND DEVELOPMENT ACT (IRDA) 1999

The IRDA was passed in December 1999 by Parliament. The Act allows for the entry of private sector entities in the Indian insurance sector, including health insurance, and envisages the creation of a regulatory authority. The IRDA is supposed to protect the interests of the policy-holders, promote efficiency in the conduct of insurance, regulate the rates and terms and conditions of the policies offered by insurers and direct the maintenance of solvency margins.

The IRDA provides sufficient protection for capital and solvency margins. There is an entry requirement of a minimum capital of Rs 100 crore. Then there is a minimum lower bound of Rs 50 crore for the solvency margin along with a requirement of 20% of net premiums or 30% of the average of net incurred claims in the 3 preceding years. The IRDA has wide powers for accounting and auditing insurers. The Insurance Act does not allow the insurers to undertake additional business that is not directly linked to insurance. It discusses the liquidation of a company but does not talk of a Guarantee fund.

The IRDA specifies a code of conduct for the insurance agents and also allows for a Tariff Advisory Committee to oversee premium rates, insurance plans and to prevent discrimination. However, there is no specific clause for the consumer, who has to use the CPA of 1986 to redress any complaints. The IRDA does not have much to say about the relationship between the insurer and the provider.

Though the Tariff Advisory Committee can make recommendations the IRDA also does not have much to say about rating the premium. The IRDA does not also specify the benefit packages. It however allows for the entry of re-insurers in the market. Its main two functions are maintaining market standards, and overseeing solvency and financial regulations.

Conclusion: The legislation concerning health insurance in India is fairly comprehensive even in comparison to a model set of regulations when focusing on auditing, financial controls, investment

guidelines and licensing regulations. There is much less regulatory focus on the consumer of insurance products and the overall goals of health policy in the form of regulation that curbs risk selection, protects consumers, promotes HMOs, etc. It also cannot involve in the relationship between insurers and providers (which comes under the MRTP Act) or the expansion of ESIS (which is the ESIS Act).

In India health insurance is not given much importance. The IRDA itself contains no reference whatsoever to the health sector or to health insurance. Nor is health mentioned in the nearly 175 pages of the Insurance Act of 1938. This broadly reflects the policy environment in India, where health insurance continues to be neglected. Even in GOI's report on Insurance reforms (1994), there was precisely one reference to health insurance.

## PRIVATE HEALTH INSURANCE

Since the liberalization of the insurance industry in 2000 India has been promoting private players to enter the health insurance sector. With the enactment of the IRDA, the industry now has a regulatory framework to protect the interests of policy holders. This was followed by another landmark decision in 2001 establishing Third Party Administrators (TPAs) to facilitate speedier expansion by providing an administrative–intermediary structure to the insurance industry. There are, at present, 12 general insurance companies and 25 TPAs. The total number of insurance holders is reported to be 112 lakh with almost 90% enrolled with the four public sector insurance companies. These four companies collected a premium of Rs 1128.64 crore under Mediclaim. Of the 102 lakh enrolled by these four companies (excluding GIC, Employment Guarantee Corporation, AICL), which are permitted to market health insurance products, Mediclaim alone accounts for 97 lakh persons, the rest being enrolled under other insurance schemes such as Jan Arogya, etc. During 2003–2004, the claim ratio was about 96.34%. The industry, however, believes that the overall claim ratio is expected to go up from around 130% to 300%–350% in the next three years.

The question that arises is whether promoting the private commercial insurance sec- tor will help India achieve its health objectives of equity, efficiency and quality? What are its implications? Should India consider other options, or is this a case of one size fitting all? International experience and economic theory on private insurance markets however show evidence of widening inequity, excessive utilization, adverse selection, increase in inappropriate care, risk selection increasing overall cost of care and in a highly competitive, voluntary market, high administrative costs, unviable risk pools, under- cutting and unrealistic pricing leading to market instability and bankruptcies. Private commercial-led health insurance systems resulting in, etc.—factors that contributes to inflation in costs. Yet of the 39(2001) countries having private insurance contributing to 5% of the total health expenditure, 46% were low and middle income countries where private insurance is perceived as an important source of health financing (Sikhri 2005), contributing to about 5%–20% of the country's total health spending. Private insurance in these countries arose in response to increased expectations of affluent classes, covering the healthiest and the wealthiest resulting in limited social gain. Therefore, no country relies on private insurance to resolve the problems of financial risk protection for the poor and the ill. And regulation is required to minimize some of the adverse impacts.

## HEALTH IMPROVEMENT IN INDIA

Over the last 50 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators (Satia et al 1999). In case of government funded health care system, the quality and access of services has always remained major concern. A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. However, with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

The new economic policy and liberalization process followed by the Government of India since

1991 paved the way for privatization of insurance sector in the country. Health insurance, which remained highly underdeveloped and a less significant segment of the product portfolios of the nationalized insurance companies in India, is now poised for a fundamental change in its approach and management. The Insurance Regulatory and Development Authority (IRDA) Bill, recently passed in the Indian Parliament, is important beginning of changes having significant implications for the health sector.

The privatization of insurance and constitution IRDA envisage improving the performance of the 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. The recent policy changes will have been far reaching and would have major implications for the growth and development of the health sector. There are several contentious issues pertaining to development in this sector and these need critical examination. These also

highlight the critical need for policy formulation and assessment. Unless privatization and development of health insurance is managed well it may have negative impact of health care especially to a large segment of population in the country. If it is well managed then it can improve access to care and health status in the country very rapidly.

Health insurance as it is different from other segments of insurance business is more complex because of serious conflicts arising out of adverse selection, moral hazard, and information gap problems. For example, experiences from other countries suggest that the entry of private firms into the health insurance sector, if not properly regulated, does have adverse consequences for the costs of care, equity, consumer satisfaction, fraud and ethical standards. The IRDA would have a significant role in the regulation of this sector and responsibility to minimize the unintended consequences of this change.

Health sector policy formulation, assessment and implementation is an extremely complex task especially in a changing epidemiological, institutional, technological, and political scenario. Further, given the institutional complexity of our health sector programmes and the pluralistic character of health care providers, health sector reform strategies in the context of health insurance that have evolved elsewhere may have very little suitability to our country situation. Proper understanding of the Indian health situation and application of the principles of insurance keeping in view the social realities and national objective are important. Here we discuss health insurance situation in India - the opportunities it provides, the challenges it faces and the concerns it raises. A discussion of the implications of privatization of insurance on health sector from various perspectives and how it will shape the character of our health care system is also attempted.

## ECONOMIC POLICY CONTEXT AND IMPERATIVES OF LIBERALIZATION OF INSURANCE SECTOR

There are several imperatives for opening of the insurance and health insurance sector in India for private investment. Here we review some of these imperatives.

Economic policy reforms started during late eighties and speeded up in nineties are the context in which liberalization of insurance sector happened in India. It was very obvious that the liberalization of the real (productive) and financial sector of the economy has to go hand in hand. It is imperative that these sectors are consistent with policies of each other and unless both function efficiently and are in equilibrium, it would be difficult to ensure appropriate economic growth. Given these facts liberalization of both sectors has to proceed simultaneously.

Indian economic system has been developed on paradigm of mixed economy in which public and private enterprises co-exist. The past strategies of development based on socialistic thinking were focusing on the premise of restrictions, regulations and control and less on incentives and market driven forces. This affected the development process in the country in serious way. After the economic liberalization the paradigm changed from central planning, command and control to market driven development. Deregulation, decontrol, privatization, deli censing, globalization became the key strategies to implement the new framework and encourage competition. The social sectors did not remain unaffected by this change. The control of government expenditure, which became a key tool to manage fiscal deficits in early 1990s, affected the social sector spending in major way. The unintended consequences of controlling the fiscal deficits have been reduction in capital expenditure and non-salary component of many social sector programmes. This has led to severe resource constraints in the health sector in respect of non-salary expenditure and this has affected the capacity and credibility of the government health care system to deliver good quality care over the years. Given the increasing salaries, lack of effective monitoring and lack of incentives to provide good quality services the providers in the government sector became indifferent to the clients. Clients also did not demand good quality and better access, as government services were free of cost.

Under this situation more and more clients turned to the private sector health providers and thus the private sector healthcare has expanded. Given the socialistic political thinking and populist policy it has been generally difficult for any government to introduce cost recovery in public health sector. Given that government is unable to provide more resources for health care, and institute cost recovery, one of the ways to reduce the under-funding and augment the resources in the health sector was to encourage the development health insurance.

Another imperative for liberalization of the insurance sector was the need for long-term financial resources on sustainable basis for the development of infrastructure sector such as roads, transports etc. It was realized that during the course of economic liberalization, the funds to development the infrastructure also became a major constraint. Country certainly needed infrastructure development. For this the finances are major constraint. In these investments the benefits are more social than private. The major concern was how these finances can be made available at low costs. In past the development of social sector were financed using government

channeled funds through various semi-government financial institutions. Under the liberalized economy this may not be possible. One hope is that if the insurance sector develops rapidly under privatization then it can provide long-term finance to the infrastructure sector.

The financial sector, which consists of banks, financial institutions, insurance companies, provident funds schemes, mutual funds were all under government control. There was less competition across these units. As a result these institutions remained significantly less developed in their approach and management. Insurance sector has been most affected by the government controls. Government had significant control on the policies these insurance companies could offer and utilization of the resources mobilized by insurance companies. One can see that most of the insurance products (e.g., life insurance products) were promoted as mechanisms to improve the savings and tax shelters rather as risk coverage instruments. Other segments of the insurance products grew because of the statutory obligations (e.g., Motor Vehicle, Marine and Fire) under various acts. The management and organization of insurance sector companies remained less developed and they neglected new product development and marketing. Thus one of the hopes in opening of the insurance sector was that the private and foreign companies would rapidly develop the sector and improve coverage of the population with insurance using new products and better management.

Last imperative for opening of the insurance sector was signing the WTO India. After this there was little choice but to open the entire financial sector - including insurance sector to private and foreign investors. (Dholakia 1999).

## HEALTH SECTOR AND ITS FINANCING: PRESENT SCENE AND ISSUES FOR THE FUTURE

During the last 50 years India has developed a large government health infrastructure with more than 150 medical colleges, 450 district hospitals, 3000 Community Health Centers, 20,000 Primary Health Care centers and 130,000 Sub-Health Centers. On top of this there are large number of private and NGO health facilities and practitioners scatters though out the country. Over the past 50 years India has made considerable progress in improving its health status. Death rate has reduced from 40 to 9 per thousand, infant mortality rate reduced from 161 to 71 per thousand live births and life expectancy increased from 31 to 63 years. However, many challenges remain and these are: life expectancy 4 years below world average, high incidence of communicable diseases, increasing incidence of non-communicable diseases, neglect of women's health, considerable regional variation and threat from environment degradation. It is estimated that at any given point of time 40 to 50 million people are on medication for major sickness in India. About 200 million workdays are lost annually due to sickness. Survey data indicate that about 60% people use private health providers for outpatient treatment while 60 % use government providers for in-door treatment. The average expenditure for care is 2-5 times more in private sector than in public sector.

India spends about 6% of GDP on health expenditure. Private health care expenditure is 75% or 4.25% of GDP and most of the rest (1.75%) is government funding. At present, the insurance coverage is negligible. Most of the public funding is for preventive, promotive and primary care programmes while private expenditure is largely for curative care. Over the period the private health care expenditure has grown at the rate of 12.84% per annum and for each one percent increase in per capital income the private health care expenditure has increased by 1.47%. Number of private doctors and private clinical facilities are also expanding exponentially. Indian health financing scene raises number of challenges, which are:

- increasing health care costs,
- high financial burden on poor eroding their incomes,
- increasing burden of new diseases and health risks and
- neglect of preventive and primary care and public health functions due to underfunding of the government health care.

Given the above scenario exploring health-financing options becomes critical. Health Insurance is considered one of the financing mechanisms to overcome some of the problems of our system.

## HEALTH INSURANCE SCENE IN INDIA

Health insurance can be defined in very narrow sense where individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at time of use of services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter-broader interpretation of health Insurance is more appropriate.

Health insurance is very well established in many countries. But in India it is a new concept except for the organized sector employees. In India only about 2 per cent of total health expenditure is funded by public/social health insurance while 18 per cent is funded by government budget. In many other low and middle income countries contribution of social health insurance is much higher (see Table I).

| Table 1 | | |
|---|---|---|
| Country | Social Health Insurance | Government Budget |
| Algeria | 37 | 36 |
| Bolivia | 20 | 33 |
| China | 31 | 13 |
| Korea | 23 | 10 |
| Vietnam | 2 | 20 |
| India | 2 | 18 |

*Source: As cited in Naylor et al. 1999.*

It is estimated that the Indian health care industry is now worth of Rs. 96,000 crore and expected to surge by 10,000 crore annually. The share of insurance market in above figure is insignificant. Out of one billion population of India 315 million people are estimated to be insurable and have capacity to spend Rs. 1000 as premium per annum. Many global insurance companies have plans to get into insurance business in India. Market research, detailed planning and effective insurance marketing is likely to assume significant importance. Given the health financing and demand scenario, health insurance has a wider scope in present day situations in India. However, it requires careful and significant effort to tap Indian health insurance market with proper understanding and training.

There are various types of health coverage in India. Based on ownership the existing health insurance schemes can be broadly divided into categories such as:

Government or state-based systems

Market-based systems (private and voluntary) Employer provided insurance schemes

Member organization (NGO or cooperative)-based systems

Government or state-based systems include Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS). It is estimated that employer managed systems cover about 20-30 million of population. The schemes run by member-based organizations cover about 5 percent of population in various ways. Market-based systems (voluntary and private) have Mediclaim scheme which covers about 2 million of population. There are many employers who reimburse costs of medical expenses of the employees with or without contribution from the employee. It is estimated that about 20 million employees may be covered by such reimbursement arrangements. There are several government and private employers such as Railway and Armed forces and public sector enterprises that run their own health services for employees and families. It is estimated that about 30 million employees may be covered under such employer managed health services (Ellis et al. 1996).

General Insurance Corporation (GIC) and its four subsidiary companies and Life Insurance Corporation (LIC) of India have various health insurance products. These are Ashadeep Plan II and Jeevan Asha Plan II by Life Insurance Corporation of India and various policies by General Insurance Corporation of India as under: Personal Accident Policy, Jan Arogya Policy, Raj Rajeshwari Policy, Mediclaim Policy, Overseas Mediclaim Policy, Cancer Insurance Policy, Bhavishya Arogya Policy and Dreaded Disease Policy (Srivastava 1999).

The health care demand is rising in India now days. It is estimated that only 10 per cent of health insurance market has been tapped till today. Still there is a scope of rise up to 35 per cent in near future. The most popular health Insurance cover is Mediclaim Policy.

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