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RELEVANCE AND ROLE OF MEDICLAIM IN ACTUAL LIFE

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Relevance and Role of Mediclaim in Actual Life

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The word insurance truly mentions security. Security against life, heath, family, vehicle, homes, shops, etc. In earlier years, there was no need to this kind of thing for the protection. I am talking about days of our grandfathers or may be even before that. The life was so great and slow, nothing to worry about any future, would involve in their daily occupational jobs like farming and living life in their own way.

But it is said that nothing is permanent. The time has change now. Today we live in a much advance world. The change is faster than time. The daily routine got so much fix that we can't even take out some time to enjoy. People work in office as well as in home too. Social life is like getting extinct from their life. No time to eat even hygienic food on time. Just grabs some cafeteria served items and forget about its effects.

As "no time" kind of thing ruling our life. We almost neglect our health and when any weird kind of stuff happens! Doctor is the second word that comes in our mind. First is the expense if the condition got severe.

We can't change this situation neither can we escape from it. We have to work, look at our family and their future, about your dreams, and so to earn this, we have to get a job that offers salary far from your expectation but if salary is well then the work load will also be high.

In fulfilling our daily task, we forget about our health! So it's better to have insurance that cover us from any issue related to our health. Medical Insurance is an ideal policy that protects us financially from any critical illness or fatal injury through road accident. By paying some amount of premium for limited time, we actually saves a lot of money. If in case our encounter any serious illness or injury, we do not have pay any money for the treatment of that illness. Medical insurance policy actually pays all our hospitalization expenses. So get smart and get one policy for our self and even for our family. Insurance is not a bad option to invest in. It sooner or later benefits us.

Today, health care cost is higher than other individual expenses and it is continuously rising up. Therefore, it is very important to insure by health insurance policy. There are greater chance of having high health care cost for upcoming years and it is depends on illness, injury, hospitalization and other cost of treatment in such condition.

Health insurance is very crucial in the current days to procure future health insurance strategy. It pays for medical necessities like regular health checkup, urgent circumstances and operation cost. Other hand, unexpected hospital visits or hospitalization cannot be avoided and paying for such a bills with no delay, it could finish saving.

Health insurance coverage is wide sometimes and covers almost all scenarios. Company estimate cost of health insurance by medical history, average cost, age, gender and health care inflation.

Health insurance is money save product and can useful when any unexpected situation takes place.

Health for All is still a distant dream in India, with a large proportion of the population still unable to access quality health care. Evidence abounds on the inability of the health system to give affordable, accessible, available and quality care to those who need it the most (World Bank 2001). The Tenth Five–year Plan document admits, "In all states, patients incur out-of–pocket expenses to meet the health care cost in public and privately-funded hospitals….there are massive differences in private spending on health care services in public and private facilities between states….the high and low spending in private and public sector do not always go hand in hand with each other… the poorer segments of population have less access to both public and private sector curative services than the better off sections. The out-of-pocket expense on both public and private facilities for the lowest income quintile is about one-fifth that of the highest quintile population suggesting thereby that the richest quintiles utilize both private and public facilities more than the poorest quintile. The question whether the amount spent by different segments of the population results in their receiving the appropriate care remains unanswered as the country is yet to evolve and monitor appropriate treatment protocols and cost of care for specific illnesses in different settings" (Planning Commission 2004).

Clearly, high out-of-pocket burden of health care continues to be a major issue, and injects further inequities into a system already plagued by access and quality concerns, which impact differentially on the population. In this scenario, how does one hope to achieve the "Health for All" target? While it would be difficult to achieve this target in a very short time, one way of making some progress towards it would be to find ways of extending health coverage to the population. In other words, "Health Coverage for All" could be the tool for achieving Health for All (Gupta and Trivedi 2004).

This in turn raises the following question: how can India achieve the goal of adequate health coverage for its population? Here we argue that since there are practical constraints in scaling up social health insurance as well as stand-alone community health insurance schemes, one way of achieving greater coverage is to use the as-yet untapped potential that exists in the voluntary (commercial) health insurance sector. In particular, it may be necessary to build and promote productive partnerships among different stakeholders involved in the health insurance sector, who are currently by and large working on their own.

Specifically, insurance companies in both the private and public sectors should be involved in productive partnerships with the government, community based organizations and providers in the endeavor to extend health coverage to the population.

Health insurance business in the private as well as the public sector has been increasing both in terms of premiums and numbers. The growth in private sector has been higher than the growth in the public sector; at the same time, a lesser known fact is that the public sector (and now the private sector though to a much lesser extent) has been undertaking innovative partnerships at the community level as well as with state governments, to offer tailor-made health insurance policies at reasonable costs. (Gupta and Trivedi, 2004) There are several successful models that need to be documented and studied. In particular, the policymakers need to study and understand the cases of partnerships involving the insurance sector, the government, the NGO sector or community based organizations that have worked productively in extending health coverage to specified populations. Here, we will argue that such innovations and partnerships are critical in the overall scenario of health coverage and its expansions. Since the voluntary commercial health insurance sector is here to stay and grow, such collaborations can only lead to a win-win situation, with many better off and no one worse off.

The role that companies, that offer voluntary insurance, can play in helping the country achieve greater health coverage. This analysis will involve a closer look at the data of one public sector insurance company – National Insurance Company Ltd. – as a prototype of commercial voluntary insurance, to better understand their role in the health insurance scenario, and examine whether and how they can make a positive difference to the health insurance scenario in India.

We discuss the current health coverage set up in India, and point out the inherent limitations of scaling up in the present scenario. This gives an overview of the state of private/voluntary insurance in India, including the growth in this sector. We introduces one major health insurance product available in the Indian market today – Mediclaim - and explains its features in some detail, and also discusses the growth in demand for this product. We present an analysis of the potential of voluntary health insurance in India using the Mediclaim data collected from National Insurance Company (NIC). With this analysis in mind, this presents a discussion on the financial and other implications around scaling up issues and in particular discusses partnerships that may be required to expand health coverage 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 are 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.

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, delicensing, 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).

Table1		
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 coverages 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 per cent 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. This policy is discussed below.

MEDICLAIM SCHEME

The government insurance companies started first health insurance in 1986, under the name Mediclaim; thereafter Mediclaim has been revised to make it attractive product. Mediclaim is a reimbursement base insurance for hospitalization. It does not cover outpatient treatments. First there is used to be category-wise ceilings on items such as medicine, room charges, operation charges etc. and later when the policies were revised these ceilings were removed and total reimbursements were allowed with in the limit of the policy amount. The total limit for policy coverage was also increased. Now 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.

The current statistics on health insurance indicate that out of 1 billion populations only about 2 million of population is covered by Mediclaim scheme. The reason for lack of popularity of this scheme could be several. The health insurance products are generally complicated and it is suggested that GIC and its subsidiary companies who deal in non-life insurance market which is dominated by mandated insurance such as accident, fire and marine, do not have expertise in marketing health insurance and therefore this scheme is not popular. Health insurance also represents very small percentage of overall business

of GIC and its subsidiaries hence they have also not focused their attention in this area. The GIC companies have little interest and mean to monitor the scheme. It should also be recognized that because of technicalities of health service business there are number of cumbersome rules which have hampered the acceptance of the scheme. It is also reported that in number of cases the applicants of older ages have been refused to become member of mediclaim scheme due to unnecessary conservatism of the companies.

CONSUMER AND SOCIAL PERSPECTIVE ON HEALTH INSURANCE

With the liberalization of insurance and entry of private companies in this business it is very important that specific interventions are developed which focus on increasing the consumer awareness about insurance products. One of the major challenges after privatization of insurance would be how to develop such mechanisms, which help making consumers aware about the various intricacies of insurance plans. As of now information, knowledge and awareness of existing insurance plans is very limited. This is also shown by the study of Gumber and Kulkarni (2000) among the members of SEWA, ESIS and mediclaim schemes. With Consumer Protection Act coming in force it has become easy for aggrieved consumers to complain and seek redressal for their problems. Consumer organizations such as CERC of Ahmedabad have been helping consumers to get due justice in disputes with the insurance companies. Their experience would be varying valuable in guiding development of health insurance plans that are transparent and just.

Many a times the insurance claims are rejected due to some small technical reasons. This leads to disputes. Most of the time the conditions and various points included in insurance policy contracts is not negotiable and these are binding on consumers. There is no analysis on what fair practice is and what unfair practice is. Given that insurance companies are large and almost monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this create confusion and disputes. (Shah M 1999).

The most important area of dispute and unfair treatment is the knowledge and implications of pre-exiting conditions. A number of cases of litigation are disagreement on these pre-existing conditions. These problems also arise because of lack of specification of number of areas and properly spelling out the conditions. This is also because some chronic conditions such as high blood pressure and diabetes can increase the risk of many other disease of organs such as heart, kidney, vascular and eyes diseases. The patients with these pre-existing conditions are denied claims for treatment of complications. This is not fair and leads to disputes.

Health insurance is typically annual and has to be renewed yearly. Policy, which is not renewed in time lapses and a new policy has to be taken out. Medical conditions detected during the interim period are treated as pre-existing condition for the new policy, which is not fair. This is seen as major issue as it changes the conditionalities about what constitutes pre- exiting conditions. Courts, however, have ruled that even if there is delay in renewing the policies it should be considered as renewed policy. In case two doctors give different reports one favoring consumer and other insurance company, the insurance company generally follows the later opinion. There are several such consumer-related issues, which need to be addressed in health insurance.

One of the planks on which the insurance has been deregulated is the gain in efficiency and passing on these benefits to the consumers. It is very unrealistic to assume that insurance companies will be able to gain efficiency, which helps them to reduce the price of schemes. At least one should not be expecting this thing happening in the short-run. But providing full information to the consumer and dealing with claims in a just and expeditious manner is the minimum expected outcome of the deregulation process. Consumer organizations have to play very active role in future development of the health insurance sector in India.

IMPACT OF HEALTH INSURANCE MEDICALAIM ON STRUCTURE AND QUALITY OF PRIVATE PROVISION

The experiences in liberalizing the private health insurance suggest that it has undesirable effects on the costs of health care. The costs of care generally go up. Given the present system of fee for service and current scenario of health infrastructure in private sector, the development of insurance will need improvements in quality and change in structure. The new investments to improve quality will result into high cost and therefore increase in prices of insurance products. There would be developments in the direction of exploring options of managed care, which would help in reducing the costs. The developments would be needed in the direction of strong information base and accreditation system for providers. The structure of the health sector will have to change from multiple-single doctor hospitals and clinics to larger hospitals and polyclinics, which provide services of multiple specialties and can operate at larger scale. This will allow them to provide high quality professional care at competitive prices. As one of the responses to these issues Third Party Administrators (TPA) are rapidly emerging in India. Here we can learn from the models, which have emerged elsewhere. But their applicability to Indian situation needs to be examined carefully.

ROLE OF REGULATORS

The government has established Insurance Regulatory and Development Authority (IRDA) which is the statutory body for regulation of the whole insurance industry. They would be granting licenses to private companies and will regulate the insurance business. As the health insurance is in its very early phase, the role of IRDA will be very crucial. They have to ensure that the sector develops rapidly and the benefit of the insurance goes to the consumers. But it has to guard against the ill effects of private insurance. The main danger in the health insurance business we see 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 relative disadvantage as they will, in future, have to pay much more for the private care. Thus checking increase in the costs of medical care will be very important role of the IRDA.

Secondly, IRDA will need to evolve mechanisms by which it puts some kind of statue in place that 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. They must ensure that companies develop products for such poorer segments of the community and possibly build an element of cross-subsidy for them. Government companies can take the lead in this matter and catalyze new products for the poor and lower middle class as they have done in the past.

Thirdly the regulators should also encourage NGOs, Co-operatives and other collectives to inter into the health insurance business and develop products for the poor as well as for the middle class employed in the services sector such as education, transportation, retailing etc and the self-employed. This could be run as no-profit-no loss basis similar to the scheme pioneered by Indian Medical Association for its members. Special licenses will have to be given to NGO for this purpose without insisting on the minimum capital norms, which are for commercial insurance companies.

MEDICLAIM DATA: OVERVIEW

Mediclaim is the standardized health insurance policy offered by all the public sector companies. It is the largest and oldest voluntary health coverage available in the country, and it is therefore important to study it in detail to understand the voluntary health insurance sector in India. Despite it being the major scheme in India, the data on Mediclaim policyholders is inadequate. The profile of the individuals is available only from the document in which the insured submits the policyholders' details at the time of purchasing the policy. This document has very limited information and lacks the important variables on occupation and socio-economic status. Geographical detail like place of residence is available from the policy document but the data is currently kept in a way that does not allow researchers to classify locations beyond regional offices/major cities. The demographic variables including age, gender and relation of the insured to the policyholder, the claims related variables - claim submission date, cheque date etc. and corresponding amount figures are available in a more systematic manner. However, the details of service providers, place of treatment, and disease related information - while available – is being compiled in a format which makes it difficult to code the variables, and thus, makes this information practically unusable for empirical research. The insurers and the IRDA focus on only premium and claims related data to assess the business implications, and thus maintain the database only of these variables. These data issues, therefore, make it difficult to study empirically, the demand for Mediclaim.

IRDA, recognizing the potential of health insurance and the data needs, has set up a Health Insurance Working Group and within that a Data Sub-group to study the various data-related issues. The sub-group report has several recommendations for streamlining the database and making it much more uniform across insurers. While the insurance companies and TPAs are trying to put this system in place, there is immense scope of improvement in health insurance database management to make the data useful and readily available. The availability of systematic and uniform database, across insurance companies and TPAs is imperative for a better understanding of the growth and potential of health insurance in India. It is not only urgent but also necessary for the IRDA and GIPSA to coordinate and facilitate this process, and to ensure that health insurance (and other insurance as well) database is centralized and accessible for stakeholders, including researchers and policymakers.

SUMMARY AND COCLUSION

In India has limited experience of health insurance. Given that government has liberalized the insurance industry, health insurance is going to develop rapidly in future. The challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without the negative aspects of cost increase and over use of procedures and technology in provision of health care. The experience from other places suggest that if health insurance is left to the private market it will only cover those which have substantial ability to pay leaving out the poor and making them more vulnerable. Hence India should proactively make efforts to develop

Social Health Insurance patterned after the German model where there is universal coverage, equal access to all and cost controlling measures such as prospective per capita payment to providers. Given that India does not have large organized sector employment the only option for such social health insurance is to develop it through co-operatives, associations and unions. The existing health insurance programmes such as ESIS and Mediclaim also need substantial reforms to make them more efficient and socially useful. The study looked at the growth of voluntary insurance in India, and used the Mediclaim data of the National Insurance Company to arrive at some key conclusions:

- Health coverage is still restricted to about 10 percent of the population in India, and there are limits to expansion of Social Health Insurance, social security based health coverage, and stand-alone Community Health Insurance.
- Extending health cover to the entire population is one of the major ways of achieving the Health for All objectives, because it removes an important barrier to health seeking behavior.
- The growth in voluntary health insurance has been significant over the last several years, and it is clear that the potential for growth in health insurance is immense.
- The expansion has been significant in both the public and private sector insurance companies, but the private sector growth rates have been much higher. However, as for market share, the four public sector companies still corner the greater part of the health business.
- However, health business is still a small part of the total non-life insurance business in India.
- The Mediclaim data reveals that the bulk of the policyholders are in the age range of 40-59, which indicates both a likely adverse selection problem from the insurance companies' perspective and an inadequate demand for insurance from the younger age cohorts.
- The age distribution differs across Individual and Group policies significantly, with the Individual policies being much more older-cohort based than the Group policies, where the age distribution is more or less uniform across 20-29, 30-39 and 40-49 age 25 categories, indicating that the Group policies are being able to take advantage of pooling across risk and income categories, as is desirable.
- The gender distribution indicates that females are probably still passive recipients of insurance, being covered mostly through their husbands. This phenomenon is much less visible in case of Group policies, as is expected.
- The data revealed that on an average a much lower household size is operational within policyholders than in the population. Slightly less than 3 members of a household are being covered by insurance on an average, compared to a household size of greater than 5 in India. The average size for Group policy is in fact slightly lower compared to that for Individual policy.
- Per capita premium and sum insured are slightly lower in Individual compared to Group policies.
- Per capita individual premium for Individual policies is Rs. 1282 per annum; the National Sample Survey data indicates that the annual expenditure in the same year could be Rs. 3200 per capita, indicating a substantial saving by individuals (and therefore households) if they go in for health insurance.
- An analysis of the claims and grants data indicated that the grant to premium ratio is around 86 percent, indicating reasonable profit to the insurance company from health insurance.

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