Healthcare Sector in India

Indian economy is moving from an emerging market to a developed market. There is changing demographic profile and socio-economic environment. With emergence of nucleus smaller family units "joint-family-as-a-social-security-net" set-up has been weakened. Simultaneously, the increased longevity, now 65 years, has raised the need for adequate provision of security for the aged. The current trend towards urbanization and migration of the rural population to metros and large cities in search of a better standard of living has also brought in changes the socio-economic environment. Because of the demographic changes and changing life styles there is growing need of the people for houses, health care and insurance.

As per the CII-Mickinsey report on health care in India, the health care market is estimated to grow from Rs 69,000 crore to Rs 1,56,000 crore by 2012. For insurance companies there are plenty of opportunities. They can evolve strategies by translating these opportunities into actual purchase of health insurance products by building suitable underwriting systems.

Healthcare Sector Facts :

1. Healthcare sector in India is fragmented between the Centre and the State Governments. While Insurance falls under the union list, the public health and sanitation, hospitals and dispensaries fall under the state list. The medical profession and drugs fall under the concurrent list, where both the Centre and State Governments are responsible. So the overall legal framework relating to the regulation of healthcare is complex.

2. Until 1978, 70 per cent of the hospital beds were in the public sector and in 2005, 85 per cent of the hospital beds are in the private sector.

3. Healthcare expenditure in India is around 5.2 % of its GDP, of which 0.9 % is made by the Govt. and 4.3 % is from private. While the Govt. spending on health care is on primary care and preventive programmes, the private spending is mainly for curing. The Govt. spending is very low among developing countries. WHO has recommended the Govt. to spend at least 5% of GDP on health care!

4. Per capita total health expenditure is about Rs 550, ie US $ 12.51. It is very low as compared to Korea US$148.37, Malayasia US $ 58.51 and Thailand US$ 32.79.

5. As per the World Bank Report 2002 almost one quarter of Indians who are hospitalized in India slip into poverty every year as a direct consequence of medical

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expenses they incur. More than 40% of the people hospitalized borrow money and sell their assets to cover up the cost of health care. Health care expenditure is the second reason for the rural indebtedness. Health insurance is the best alternative for funding health care expenses and also solving poverty problem.

6. Health insurance products are mainly sold by non-life insurers, but in recent years life insurers too are offering life insurance products with health riders.

7. The life segment of Indian insurance industry is still significantly influenced by the "tax savings" component than risk component. The penetration is very low in per sonal life through health care etc by non-life insurance companies.

8. Health insurance segment is one of the fastest growing segments next to Motor port folio for non-life insurers.

9. Besides private sector and public sector health insurance companies, the Governments also provide health insurance under different schemes.

Health Insurance Meaning and Objectives:

According to the Registration of Indian Insurance Companies Regulations 2000, "Health Insurance or Health Cover means the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans basis, including assured benefits and long term care".

The objectives behind health insurance are to provide protection against financial loss caused by unforeseen health problems by meeting health care expenses, to provide relief from anxiety and mental tension, to improve the standard of living by providing financial security and to assist the economic development by investing mobilized funds.

National Health Policy, 2002 (NHP)[1]

Achieving an acceptable standard of good health across the general population of the country is the main objective of the National Health Policy, 2002 (NHP). Improvement in the health status of the population is sought to be achieved through improvement in health services in the country with a special focus on underserved and underprivileged segments of the population. Larger investment in health sector is needed even to maintain the current health situation, as the technology required for tackling resistant infections and non-communicable diseases are expensive and result in escalation of health care costs.

The NHP-2002 envisages increasing public health investment from the current level of 0.9 per cent of GDP to 2 per cent of GDP by 2010. The total expenditure of Government (both Central and States) on health was Rs.36,803 crore in 2003-04 (4.5 per cent of total expenditure), as against Rs.34,358 crore (4.6 per cent) in 2002-03. The Central Government's expenditure (plan and non-plan) on health and family welfare was Rs.6846 crore in 2003-04 as against Rs.6075 crore in 2002-03.

Health Insurance Market[2]

Till April 2000, it was Life Insurance Corporation of India (LIC) and General Insurance Corporation of India (GIC) with its four subsidiaries (viz. National Insurance Company, New India Assurance Company, Oriental Insurance Company and United India Insurance Company) were operating in a monopoly position in life and general insurance business, respectively. And since Dec 2000, these four are independent entities and GIC is a National Re-insurer. The private players started invading insurance sector from October 2000. As of Dec 2005, the number of private players in the life insurance sector has been fourteen and eight in non-life insurance. These private players are besides LIC in life insurance and four public sector companies (erstwhile subsidiaries of GIC), ECGC (Export Credit Guarantee Corporation Ltd), and Agriculture Insurance Company of India Ltd (AIC) in non-life insurance.

Public Sector Health Insurance:

In 1986 these public sector four general insurance companies introduced the mediclaim policy and collected a cumulative premium of Rs.25 crore in the first year of the scheme's operation. For the year 2002-03 the health insurance segment crossed the Rs.1000 crore mark. Overall, the health insurance portfolio has increased by 50 per cent over the premium underwritten in the previous year. It would, however, be pertinent to note that this increase has come partly on account of revision in mediclaim premium and additional 6 per cen Third Party Administration (TPA) costs by way of administrative charges being levied on the insured[3]. The business figures for 2003-04 indicate that the health insurance segment has shown a healthy 18 per cent growth at Rs.1370.14 crore from Rs.1160.17 crore in the previous year[4].

Now, four public sector companies offer the following variants of health insurance policies:

1. Mediclaim Policy – for general public
2. Jan Arogya Policy – for economically weaker sections
3. Community Based Universal Health Insurance Scheme –group scheme for people below poverty line (BPL)[5].

The public sector non-life insurers accounted for 89.19 per cent of the health premium as against 93.37 per cent in the previous year 2002-03. In absolute terms the premium underwritten by them increased to Rs.1222.15 crore in 2003-04 from Rs.1083.29 crore in the previous year,

exhibiting a growth of 13 per cent. As against this, the premium underwritten by the eight private sector insurers increased to Rs.147.99 crore in 2003-04 from Rs.76.88 crore in the previous year, exhibiting a growth of 92 per cent. Their market share in the year 2003-04 had increased to 10.81 per cent as against 6.63 per cent in the previous year.

Private Sector Health Insurance:

The private sector insurers have also launched variants of mediclaim policy with different nomenclatures, including :

1. Health Insurance (Shield) – The mediclaim policy has features such as reimburse ment of hospitalization even if it is for a period of less than 24 hours, extension of personal accident cover, cashless facility, etc.
2. Critical Illness policy – A defined benefit policy under which the insurer pays the sum assured on the diagnosis of ten identified critical diseases.
3. Hospital Cash Policy – The insurer pays a fixed amount up to a pre-determined limit for each day spent in the hospital, irrespective of the actual amount spent on treatment.
4. Health Insurance Scheme for workers of the handloom and allied industries, intro duced by the Development Commissioner of Handlooms, Ministry of Textiles, and this scheme is developed and implemented by ICICI Lombard Health Insurance

Public and Private Sector Life Insurers:

In addition to the health cover provided by the non-life insurers, a beginning has been made by the life insurers to provide health cover to the policyholders through riders. A range of products providing comprehensive cover, critical illness cover, hospitalization, family floater products, and Group Health Schemes are also available. In the year 2003-04 life insurance companies introduced Unit linked insurance products, which offer flexibility of investment choices to the policyholder and come with additional riders, including health riders. There is growing trend in this business in the current financial year 2004-05, nearly 25% of the first year premium has come from Unit linked policies.

Health Insurance Coverage:

The coverage of population, under various health insurance schemes (see Table 1) is limited to the extent of 15 per cent.

SNo	Health Insurance Schemes	Beneficiaries (lakh)
1	Employees' State Insurance Scheme (ESIS)	03.4
2	Central Government Health Scheme (CGHS)	40.0
3	Railways Health Scheme (RHS)	12.0
4	Non life insurance companies health cover and Life insurers providing health cover with riders (in recent years)	25.0
5	Health Insurance Scheme for workers of the handloom and allied industries introduced by Development Commissioner of Handlooms, Ministry of Textiles [6]	12.0

[1] Extracted from IRDA Report 2003-04, Page Nos 39-40

[2] Bancassurance in India by Dr. J.G.Naik, from Edited Book "Managing Finance and Growth-Challenges and Opportunities" by Dr Chinmoy Sahu et al. Jan 2006.

[3] IRDA Report 2002-03

[4] IRDA Report 2003-04

[5] IRDA Report 2003-04

"The Community Based Universal Health Insurance Scheme was launched by the Prime Minister of India during the current financial year 2003-04, in July, 2003.The public sector general insurance companies were encouraged to design a community-based universal health insurance scheme during 2003-04. Under this scheme a premium equivalent to Re.1 per day (or Rs.365 per year) for an individual, Rs.1.50 per day for a family of five, and Rs.2 per day for a family of seven are eligible for reimbursement of medical expenses up to Rs.30,000 towards hospitalization, a cover for death due to accident of Rs.25,000 and compensation due to loss of earning at the rate of Rs.50 per day up to a maximum of 15 days. To make the scheme affordable to the below poverty line (BPL) families, the Government has announced a subsidy of Rs.100 per year towards their annual premium. Under the Community-based 'Universal Health Insurance Scheme' launched by the four public sector non-life insurance companies in July 2003, 4.17 lakh families involving 11.62 lakh persons have been covered during 2003-04".

[6] *"Government weaves health insurance cover for handloom workers" IRDA Journal Dec2005. This scheme is developed and implemented by ICICI Lombard Health Insurance for the Central Government, Ministry of Textiles. Medical cover will be effective for the weaver, his spouse and two children. For a contribution of Rs. 200 by the weaver, he and his family will be covered for Rs. 15,000 while the Development Commissioner (Handloom) will bear the remaining premium contribution of Rs. 800. The other features of the scheme include OPD treatment up to 50 percent of the sum insured, all pre-existing diseases covered, cashless hospitalisation across the country in more than 2,500 hospitals, express reimbursement/ settlement of claims and other covers like maternity, pre and post-hospitalisation expenses and domiciliary treatment covered.*

Third Party Administrators (TPAs):

TPAs form bridge between the claimant, the medical services provider and the insurer in such a way that all parties are satisfied and nobody makes losses. Various services provided by the TPAs include enrolment, claims administration, call center services and access to provider networks that allow administration of health insurance products. The facilities also enable the insured to access hospitals, diagnostic centers, physicians and other health service providers. TPAs to provide cashless facility, initiatives to promote health insurance, permitting life insurers to provide health riders up to 100 per cent of the basic sum insured in the policy.

IRDA (Insurance Regulatory and Development Authority) has issued regulations with respect to TPAs. As per the regulations TPAs will be issued license for a period of three years. The regulatory framework envisages TPAs to provide professional inputs to processing of claims and facilitate the system of cashless services to the insured. TPAs are also expected to provide easy access to health services and spread health insurance.

Issues before Health Insurance Sector:

Various issues which need to be addressed to ensure access to medical cover to a wider cross section include:

1. The insurance coverage of population is scanty, restricted, costly and poorly administered.Those covered have only an omnibus policy with no element of risk differentiation.

2. The growth of this particular line of business is hampered due to multiple complaints about servicing the insured, including repudiation of claims due to conditions/exclu sions in the policy; non-settlement of claim/delay in settlement of claim; cancellation of policy without giving any notice; settlement of claim for lesser amount; refusal to renew policy in case of adverse claims experience; non-issue of list of hospitals; im proper guidance by 24 hour help lines; inaccessibility of toll-free numbers; non-receipt of settlement cheques within the stipulated time; non-receipt of photo identity cards; wrong insertion of photos/names in the identity cards; loading at the time of renewals (whether claim/no claim); and hike in premium for introduction of TPAs.

3. The first set of TPA licenses were issued during 2001-02. Though, Twenty four TPAs have been granted registration by the IRDA as on 31st March, 2004 only twelve are active in the business, six of them are stabilizing their operations, while the rest (six) have yet to commence their operations. Based on the availability of infrastructure

with the TPAs, insurers have allocated the portfolio to them.

4. The functioning of TPAs has been a matter of concern which needed to be addressed. There is lack of awareness about the various facilities of TPAs. In some cases over or under utilization of the capacity of TPAs is reported. There is no system to assess the costs involved in the administration of TPA services and the remuneration or fees to be charged by TPAs from the insurance companies.

5. There is no reliable basis to measure premium cost in relation to specific risk/occurrences and the policyholders have no choice of cover, specific to their requirement.

6. Insurance companies have no interface with hospital establishments in determining the reasonableness of charges relative to quality of medical care provided. There are no benchmarks and no standards for billing for these services.

7. The cost of health care delivery is passed on to the policyholder. Owing to the hidden costs in health care delivery system, without any audit or authentication of their reasonableness, health insurance comes with a big price tag. Additionally, there is no mechanism to check these against established standards, and no benchmarks have been attempted/ established.

8. Another area is creation and maintenance of database in the health insurance industry. In the absence of data insurers service providers and facilitators are handicapped in standardization of rates and service charges.

Desired Measures:

In a large diverse and complex country like ours, no single health insurance model can be successfully implemented. There is need for proper regulation of the health care and insurance. IRDA should take measures to coordinate efforts of various stakeholders, general public confidence building, reduce pressure on government run hospitals, reduce probability of rejecting genuine claims, standardization in treatment of similar diseases, removal of costs of moral hazards, and build up a comprehensive data warehouse to facilitate decisions on pricing of insurance products and hospitalization services.

The insurers should introduce new, tailor-made and cost effective policies to meet the needs of all the segments of the society. Allowing life insurers to sell health insurance; developing standard commission rates; review of capital requirements for setting up health insurance companies, ensuring the involvement of service providers, extending insurance cover to the under privileged

and assisting States in developing options to provide insurance to the population are other options for health insurance sector to grow. Obligations for the insurers, to cover a certain minimum number of lives under the health insurance policies and to collect a certain percentage of gross premiums underwritten through the health insurance segment, on the lines of those specified for the rural and social sector coverage could be laid down.

There is need for community-based health care. The self-funded health plans by major employers also need to be regulated. These steps may go a long way in improving penetration and coverage in the health segment.

References:

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2. IRDA Report 2003-04

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Author
Dr. Janardhan G Naik
M.com, LL.B, AICWA,Ph.D
Professor, Head Dept of Accountancy
Gogte College of Commerce, Belgaum – 590 006
Cell : 9448578089
Fax : 0831 2485983
Email: jgnaik52@yahoo.com