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Focus on
MICROINSURANCE

बीमा विनियामक और विकास प्राधिकरण

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From the Publisher

Insurance in India is driven primarily by either tax incentives or mandated by the financier. Insurance as a measure of protection against adversity is relatively new. It is only now that the people are slowly realizing the value of insurance as a means of protecting the family's income in the event of the unfortunate death or incapacitation of the breadwinner. While this is the state of affairs in the high and middle income groups, the poor are totally beyond the pale of insurance. Ironically it is these sections that are in greater need for insuring their lives, their health and the assets that they have generated during their lifetime. It is common knowledge that the poor are compelled to spend more, in terms of percentage of the total income, on healthcare. The unhygienic environs that they live in, lack of access to nutritious food, and their work environment force them to seek hospitalization; and they end up paying huge hospital bills.

By and large, the people belonging to these vulnerable sections of the society do not realize the importance of having in place an arrangement whereby they can fight such a scenario. As a result, they end up selling their precious assets or borrowing from usurious moneylenders at huge rates of interest. Such events usually lead to disastrous results for them. Further, most of these families are wholly dependent on the earning ability of a single member; and the loss or illness of that member severely cripples their lives.

While many consider purchase of life or health policy as an avoidable expenditure, a large majority have hardly any knowledge about their availability or how they can access that at reasonable cost. The insurers on their part have bypassed these sections on the ground that it is not remunerative to sell insurance to these sections. The Authority, however, feels it is possible for the commercial insurers to sell microinsurance products as a viable business proposition. What is needed is an appropriate strategy and a regulatory environment that facilitates and encourages microinsurance activity. If micro credit could be commercially viable, why not microinsurance?

The IRDA taking note of developments in the micro credit arena has put in place regulations to facilitate the insurers to promote and market microinsurance products. The response so far is quite encouraging. Many of the insurers now consider microinsurance not as an obligation cast on them but as an opportunity to expand their horizons and accelerate growth. The regulations seem to have generated enthusiasm among insurers not only in India but also in the international insurance community as a whole including regulators.

The focus of this issue of the **Journal** is on 'Microinsurance'. India has been historically an agrarian economy predominantly and a large percentage of the population still continues to be dependent on agriculture; and as a result, on the vagaries of nature. Agriculture insurance will be the focus of the next issue of the **Journal**.

C.S. Rao

INSIDE

ISSUE FOCUS

THINKING CAP

Microinsurance – Taking the Initiative Forward …

It is often felt that poverty and insurance do not go together; and insurance is totally beyond the affordability of the poor. In a developing country like India, this statement would hold good - to a certain extent. However, measures should be taken to ensure that it is not wished away as just that; and to bring as many under-privileged people as possible under the ambit of insurance. This is a daunting task and calls for colossal commitment from all the stakeholders. It is these masses who are most vulnerable to the devastation that can be caused by the loss of life, health or an asset.

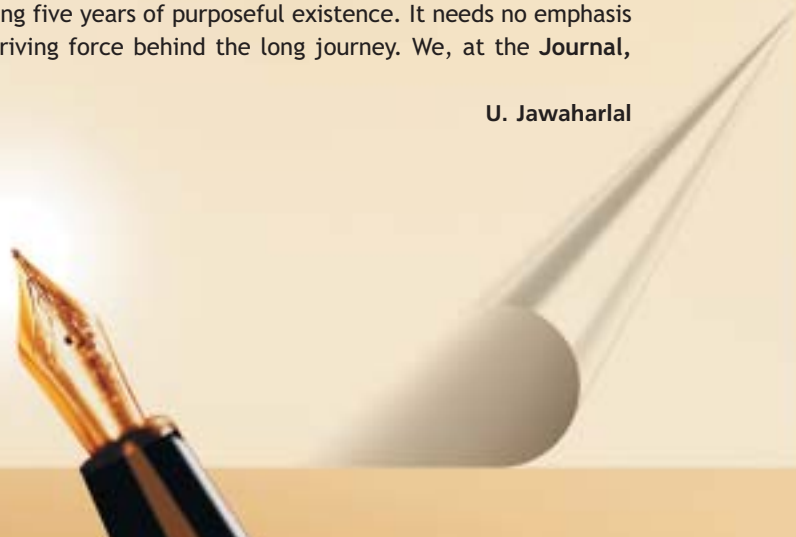
It is very difficult to make these masses understand the importance of having in place a mechanism that protects them from such calamities. Steps should be taken to inculcate in them the habit of buying insurance and not treat it as an investment. Keeping in mind the constraints associated with the task and to provide a fillip to the cause, the microinsurance regulations have been issued with relaxations in the norms; and thus a beginning has been made. It is for the players to take it upon themselves to put their best foot forward in furthering this noble cause. It should not be merely taken as a business opportunity but as a part of their social responsibility as well and efforts should be made to achieve the standards in the true spirit and not merely as a target to be fulfilled. All the other stakeholders have a crucial role to play in ensuring that the task is accomplished.

'Microinsurance' is the focus of this issue of the **Journal.** Considering the huge importance that is associated with the task, we have contributions from experts who have been working in the domain; narrating their experiences and suggesting ways to take the initiative forward. To begin with, we have an article by Dr. David Dror in which he takes a deep look at the Indian scenario and observes that there is a vast potential in the area of micro health insurance in India. The next article is by Dr. N. Devadasan and Dr. Somil Nagpal. The authors, who are both qualified doctors of medicine, are optimistic that micro health insurance schemes can be made sustainable provided they are backed by good design and management. In the next article, the authors Padmashri Dr. H. Sudarshan and Dr. Sylvia Selvaraj talk about their experience in Karuna Trust and its community health insurance programme that has largely been appreciated.

Mr. Gunaranjan, in his article writes about the challenges to be overcome to achieve sustainable and scalable micro-insurance models. In the article that follows, Mr. G.V. Rao emphasizes on the need for understanding the pulse of the masses and accordingly go about the task of inculcating in them the habit of purchasing insurance. Efficient and cost effective delivery of micro-insurance requires specialized skills and institutional capacity in the grassroots-level organizations such as MFIs, NGOs and healthcare providers; and this fact is brought home succinctly by Mr. R.N.K. Prasad. In the last article of the issue focus, Ms. Mukti Bosco takes a look at the challenges facing the healthcare sector in India, particularly the underprivileged sections; and suggests ways to rise up to the challenge.

In spite of the rapid strides of development that India has made more recently in several domains, a large percentage of people are still dependent on the primary sector. Crop failure due to nature's havoc is a regular phenomenon, driving the hard-working farmer community into penury. 'Agriculture Insurance' that could possibly alleviate their hardship to a great extent would form the focus of the next issue of the **Journal**. With this issue, the **Journal** is completing five years of purposeful existence. It needs no emphasis that the readers' feedback has been the real driving force behind the long journey. We, at the **Journal,** would look forward to your continued support.

U. Jawaharlal



Report Card:LIFE

First Year Premium of Life Insurers for the Half Year Ended September, 2007

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		Sept, 07	Up to Sept, 07	Up to Sept, 06	Sept, 07	Up to Sept, 07	Up to Sept, 06	Sept, 07	Up to Sept, 07	Up to Sept, 06
1	**Bajaj Allianz**									
	Individual Single Premium	48.72	242.22	530.08	7931	40112	23476			
	Individual Non-Single Premium	726.41	2011.97	763.92	530863	1503901	467484			
	Group Single Premium	0.99	5.89	2.90	0	0	1	482	4198	1059
	Group Non-Single Premium	2.76	11.02	9.91	26	137	97	143300	374838	273193
2	**ING Vysya**									
	Individual Single Premium	1.73	8.53	16.49	179	697	1156			
	Individual Non-Single Premium	42.86	237.35	164.65	26688	143770	84249			
	Group Single Premium	0.00	0.85	2.31	0	0	0	0	168	517
	Group Non-Single Premium	0.19	2.25	3.70	1	8	24	8961	48246	7052
3	**Reliance Life**									
	Individual Single Premium	18.39	71.35	59.16	3945	14681	9254			
	Individual Non-Single Premium	110.76	470.82	175.22	57137	262830	109619			
	Group Single Premium	46.38	97.95	7.67	13	41	13	15336	57142	8312
	Group Non-Single Premium	0.57	10.19	3.77	5	119	72	3587	176594	89122
4	**SBI Life**									
	Individual Single Premium	108.69	379.42	143.13	15508	53411	20672			
	Individual Non-Single Premium	150.51	606.53	335.80	47047	199477	153163			
	Group Single Premium	16.40	90.90	91.44	0	0	2	9138	47449	57177
	Group Non-Single Premium	16.59	83.45	94.46	3	21	215	54276	210073	565297
5	**Tata AIG**									
	Individual Single Premium	3.68	13.71	2.96	628	2007	77			
	Individual Non-Single Premium	57.36	284.98	225.25	31974	200609	176063			
	Group Single Premium	5.18	32.44	25.31	0	0	4	29747	201618	136546
	Group Non-Single Premium	6.03	20.90	25.55	4	28	55	39297	115645	127717
6	**HDFC Standard**									
	Individual Single Premium	9.08	52.79	57.57	31941	171116	47336			
	Individual Non-Single Premium	146.62	754.25	430.52	44897	248516	114713			
	Group Single Premium	4.06	28.05	38.02	10	65	56	10136	66567	116862
	Group Non-Single Premium	2.07	33.28	21.39	4	20	8	3278	21129	1536
7	**ICICI Prudential**									
	Individual Single Premium	30.91	165.12	132.15	4828	26124	20578			
	Individual Non-Single Premium	525.22	2157.07	1368.42	239413	1072820	637859			
	Group Single Premium	10.87	89.03	73.81	9	98	85	19516	208735	63332
	Group Non-Single Premium**	31.38	202.99	170.79	14	239	181	12579	253615	160408
8	**Birla Sunlife**									
	Individual Single Premium	1.16	10.58	14.49	6541	31251	13852			
	Individual Non-Single Premium	186.05	554.05	259.43	40685	163276	91092			
	Group Single Premium	0.42	1.95	5.25	0	3	0	502	2402	3081
	Group Non-Single Premium	1.43	30.03	40.20	7	63	61	4267	58852	26048

9	**Aviva**									
	Individual Single Premium	1.44	9.69	13.37	218	1446	1166			
	Individual Non-Single Premium	83.09	358.46	272.13	30718	147729	115823			
	Group Single Premium	0.10	1.38	1.54	0	0	1	63	646	862
	Group Non-Single Premium	1.81	17.41	15.03	16	76	37	70667	337794	153722
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	1.61	9.67	19.13	258	1262	2000			
	Individual Non-Single Premium	51.94	234.33	142.70	17207	85675	44746			
	Group Single Premium	1.91	10.09	2.88	0	1	3	19734	83401	14803
	Group Non-Single Premium	3.93	22.91	18.88	23	106	65	54674	225505	104814
11	**Max New York**									
	Individual Single Premium	18.82	97.10	1.90	1323	6306	318			
	Individual Non-Single Premium	89.22	476.42	308.33	60211	316945	235852			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	5.78	20.09	1.62	20	207	28	60672	295861	36860
12	**Met Life**									
	Individual Single Premium	1.68	11.78	2.56	282	1831	512			
	Individual Non-Single Premium	49.03	203.43	85.87	17390	76516	36697			
	Group Single Premium	0.18	4.25	0.00	0	34	0	9799	93342	0
	Group Non-Single Premium	0.00	0.00	8.21	0	0	141	0	0	285562
13	**Sahara Life**									
	Individual Single Premium	2.73	12.27	6.41	716	3199	1639			
	Individual Non-Single Premium	5.38	21.84	1.99	7171	33814	5829			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.94	0	2	2	0	52	103131
14	**Shriram Life**									
	Individual Single Premium	14.26	57.85	11.45	2633	11166	2534			
	Individual Non-Single Premium	11.46	48.41	17.98	7593	30167	25478			
	Group Single Premium	0.02	0.02	0.00	1	1	0	1625	1625	0
	Group Non-Single Premium	0.00	0.00	0.00	1	1	0	571	571	0
15	**Bharti Axa Life**									
	Individual Single Premium	0.16	0.48	0.00	15	45	0			
	Individual Non-Single Premium	5.92	18.24	0.94	5455	17124	203			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Private Total									
	Individual Single Premium	**263.03**	**1142.56**	**1010.82**	**76946**	**364654**	**144570**			
	Individual Non-Single Premium	**2241.82**	**8438.16**	**4553.14**	**1164449**	**4503169**	**2298870**			
	Group Single Premium	**86.51**	**362.80**	**251.13**	**33**	**243**	**165**	**116078**	**767293**	**402551**
	Group Non-Single Premium	**72.55**	**454.52**	**414.46**	**124**	**1027**	**986**	**456129**	**2118775**	**1934462**
16	**LIC**									
	Individual Single Premium	1114.44	7566.62	10712.45	308038	2081317	2618101			
	Individual Non-Single Premium	1029.34	11323.22	9361.01	1499260	13803613	7209571			
	Group Single Premium	411.06	3871.65	3361.62	1935	10460	8163	1783964	10233083	6397374
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**1377.47**	**8709.18**	**11723.27**	**384984**	**2445971**	**2762671**			
	Individual Non-Single Premium	**3271.16**	**19761.37**	**13914.15**	**2663709**	**18306782**	**9508441**			
	Group Single Premium	**497.58**	**4234.45**	**3612.76**	**1968**	**10703**	**8328**	**1900042**	**11000376**	**6799925**
	Group Non-Single Premium	**72.55**	**454.52**	**414.46**	**124**	**1027**	**986**	**456129**	**2118775**	**1934462**

Note: 1.Cumulative premium upto the month is net of cancellations which may occur during the free look period.
2. Compiled on the basis of data submitted by the Insurance companies

Agriculture Insurance Products

Challenges in Designing and Pricing

'AGRICULTURE HAS BEEN THE BACKBONE OF INDIAN ECONOMY FOR AGES. HOWEVER, THE AVERAGE FARMER HAS ALWAYS BEEN CONFRONTED WITH SEVERAL CHALLENGES, MOSTLY BY THE INDOMITABLE WAYS OF NATURE. AGRICULTURE INSURANCE CAN GO A LONG WAY IN PROVIDING A MEANINGFUL SOLUTION TO SOME OF THESE CHALLENGES' OPINES U. JAWAHARLAL.

Historically, India has been an agrarian economy predominantly. Even today, despite all the consolidation that we have achieved in the Services segment; more than 70% of the population is still dependent on agriculture and allied activities. More than 20% of the GDP is contributed by agriculture and the economic growth of the country has a significant dependence on agricultural activities. However, the average farmer in India is still dependent on the nature's strange ways and is not given to be confident about the results of all the hard work that he puts in. Cycles of flood and cyclone; and drought are a regular phenomenon, thereby devastating the farmers' plans and their income streams. In extreme cases of crop failure and the resultant losses, farmers even resort to committing suicides. Although a few of these may be attributed to fatalistic thinking, one should look beyond that and attempts should be made to make a comprehensive assessment of this deep-rooted malady.

For the viability of any insurance product, the actuarial data is of paramount importance. Insurers should undertake to develop a sound actuarial base for designing products in the domain of agriculture insurance. There is need for a thorough analysis of the available data and to extrapolate it with the projections based on the forecasting methods. This, most certainly, is not an easy task; what with the most developed forecasting techniques being put to shame by nature's fury, time and again. Global warming has been said to be having a huge impact on the weather patterns all over the world and this factor should necessarily go into reckoning while designing the products and pricing them.

The soil conditions and the suitability of the climate play a huge role in the success of crops. Besides, such areas as study of the cropping pattern and yield over a period of time also play a crucial role in suitably developing products. It would make a great deal of sense to undertake area-wise studies and setting normal ranges for a given area in order that insurance products would help the farmers and at the same be economically viable. It would also be beneficial to enlist the involvement of the microfinance institutions, NGOs, Self Help Groups etc. working in the area to identify individual and group targets. Above all, the twin challenges that insurers face in the form of Moral Hazard and Adverse Selection have to be tackled properly in order that agriculture insurance products turn out to be successful in the long run.

'Agriculture Insurance', which as yet has not made deep inroads as a part of commercial insurance, will be the focus of the next issue of the **Journal.** We look forward to giving you some quality inputs from experienced practitioners and observers of the domain.

Protecting Agriculture

in the next issue...

Micro Health Insurance in India

Pointers for Progress

DR. DAVID DROR SAYS 'ONE CANNOT EXCLUDE THE POSSIBILITY THAT INSURERS AND OTHERS, INSUFFICIENTLY AWARE OF CLIENTS' PRIORITIES, SEEM TO MISINTERPRET LOW DEMAND AS REFLECTING LOW WILLINGNESS TO PAY, IGNORING THE UNATTRACTIVE VALUE-PROPOSITION OF THE MAIN PRODUCT AND THE DEVASTATING IMPACT ON THE DEMAND SIDE OF "CHERRY PICKING" … ONE CAN WONDER IF THOSE WHO ARE INTERESTED IN MAKING INSURANCE WORK FOR THE POOR IN INDIA MIGHT BE STUCK IN A VICIOUS CYCLE, WHICH LOOKS LIKE THIS: **POOR PRODUCTS →LOW DEMAND →LOW WILLINGNESS TO PAY →LOWERING OF PREMIUMS →FURTHER WORSENING OF INSURANCE PRODUCT OR SERVICE …**

Introduction

The IRDA concept paper[1] that preceded the publication of the IRDA (Micro-insurance) Regulations 2005 explained the objectives underlying those regulations. In the background section of the Concept Paper one can read that: "*Micro-insurance refers to protection of assets and lives against insurable risks of target populations…*" The purpose of this article is to examine the extent to which Micro health insurance products, i.e. health products that comply with the specifications of the IRDA (Micro-Insurance) Regulations 2005, achieve this goal.

We recall the salient features defined in the Regulations:

- Health insurance sold under the "general micro-insurance product" or the "life micro-insurance product" definition must cover ("cap") no less than Rs. 5,000 (per individual) or Rs. 10,000 (per household). Although not specifically stated in the Regulations, it is assumed that this cap applies for the entire period of the contract (rather than to a single episode of illness).
- The minimal period of coverage is one year. The Regulations do not specify the terms for renewal, and this implies that insurers could decide to renew or not to renew any policy at the end of the affiliation period. Incidentally, insurers could also change the terms of the policy and the premium it commands, which *de facto* means that insurers could cherry pick. And insurers can decide whether to accept an offer of insurance in the first place or refuse it.
- Minimum and maximum age of the insured is left to insurers' discretion. The Regulations do not require the insurer to justify such exclusions, or to maintain the same age limitations for all insured.

1.http://www.microhealthinsuranceindia.org/content/e22/e156/e288/e289 conceptpaper_microinsurance_aug182004.pdf

The Regulations do not specify the terms for renewal, and this implies that insurers could decide to renew or not to renew any policy at the end of the affiliation period.

- The Regulations do not define the scope of coverage; therefore, insurers can (and do) exclude certain conditions or pathologies from coverage (both pre-existing and newly diagnosed ones).

Method

We examined the effectiveness of the product in protecting the clients against high expenses related to illness. The analysis of the degree of protection of assets was done by reference to the compensation that would be due under the terms of the most widely sold health insurance product known as '*Mediclaim*' policy', and we looked at its low-cost version known as *Jan Arogya Bima*[2] which is adapted to the caps defined in the Microinsurance Regulations.[3]

For the examination of cases of illness, we used a dataset that includes 4,317 illness episodes that were reported by 3,531 households on illnesses that occurred during the three months preceding a HH survey. The household survey was conducted among low-income persons in five locations in India in 2005 by the project "Strengthening micro insurance units for the poor in India"[4].

Examination of effective protection

It is often claimed that insurance should cover low probability and high cost events. The way to examine the effectiveness of insurance that follows this logic would be to examine events that are low frequency and high costs. In the case of this examination, we look separately at the 10% most expensive illness episodes (top decile) and at hospitalizations in general. How well were they covered under the terms of *Jan Arogya Bima*?

It is often thought that high cost of illness is intimately associated with hospitalizations. However, in our dataset, only 524 illness episodes (12%) seemed eligible; from the total number of 4,317 episodes, only 960 episodes (22%) entailed hospitalization, but 436 episodes with hospitalization originated from excluded pathologies and 3357 episodes did not entail hospitalizations. This means that 3,793 reported illness episodes seemed ineligible for reimbursement. In passing one should add that the cost of the ineligible cases can be very high. This suggests that the limitation of insurance coverage to selective cases of hospitalization fails to provide protection to many other illness episodes, and the qualifying condition for financial

Table 1: Locations included in the 2005 household survey with valid illness episode data

Location	State	District	Rural HH	Urban HH	Illness episodes	Sampled HH Per location
I	Maharashtra	Pune	708		502	708
II	Maharashtra	Pune		700	472	700
III	Bihar	Patna	160		279	
	Vaishali	160		354		
	Khagaria	180		383		
	Muzaffarpur		100	54		
	Nawada	40		28		
	Begusarai	60		131	700	
IV	Tamil Nadu	Theni	722		1445	722
V	Tamil Nadu	Chennai		701	669	701
Entire sample		**2,030**	**1,501**	**4,317**	**3,531**	

2 The programme is sold by all insurance companies in India, with only minor variations. The brief description given here was adapted from one variation, posted on the website of Oriental Insurance Co.): The policy is available to persons between the age of 5 years and 70 years. Children between the age of 3 months and 5 years of age can be covered provided one or both the parents are covered concurrently. Covered Risks: The policy covers hospitalization and domiciliary hospitalization, which extends to 30 days before the hospitalization and 60 days after discharge from hospital; benefits consist of reimbursement of medical expenses incurred in respect of covered disease /surgery while the insured was admitted in the hospital as an in patient. The benefits are up to Rs 5000/- per person per annum. Major Exclusions: Any pre-existing disease, any expense incurred during first 30 days of cover except injury due to accident, all expenses incurred in respect of any treatment relating to pregnancy and child birth. Treatment for Cataracts, Benign prostatic hypertrophy, Hysterectomy, Menorrhagia or Fibromyoma, Hernia, Fistula of anus, Piles, Sinusitis, Asthma, Bronchitis, All Psychiatric or Psychosomatic disorders are excluded from the scope of the cover. Other insurers also exclude circumcisions, dental care, vitamins, arthritis etc.

Source: http://orientalinsurance.nic.in/Policy_Details.asp?dept=48&poltyp=101

3 The simulations were performed with the following assumptions:

a. In all cases that an illness episode was eligible for reimbursement, for the purpose of this simulation it was assumed that the full capped amount can be considered (namely, there was no previous partial reimbursement).

b. Considering that the policy covers all costs related to an eligible hospitalization (including those incurred 30 days before admission and 60 days after discharge), our calculation of the episodes also included related costs e.g. medicines, tests and consultations.

c. We assumed that all persons aged below 5 years and above 55 years were insured, i.e. were not excluded due to age (although such an exclusion is possible under the terms of the Regulations and the typical policy)

d. We assumed that the clause of exclusion due to "pre-existing conditions" did not apply to the illness episodes in this dataset (it is usually very difficult to determine pre-existing conditions in a survey of self-reported illnesses).

4 www.microhealthinsurance-india.org; the data was collected in 2005, and the project was concluded in Dec. 2006. It was jointly implemented by Erasmus University Rotterdam, the University of Cologne and the Federation of Indian Chambers of Commerce and Industry (FICCI), and funded by the EU. Opinions expressed are those of the authors, and do not necessarily engage the institutions that participated in the consortium or funded it.

protection is not the cost (as could be assumed, if the purpose is to *protect the assets of the target population*), but other parameters that do not serve the clients.

One might argue that insurance should only cover the more expensive events; so we now proceed to examine the situation when only the expensive cases (the 10% of cases that cost most, hereafter "top decile") are considered. Of the total 4,317 cases, the top decile included 432 episodes, of which only 266 (62%) involved hospitalizations, but only 209 episodes (48% of the top decile and less than 5% of total number of episodes) were eligible for reimbursement after removing the excluded pathologies. This clearly means that 38% of the top decile would not be eligible for compensation under the terms of the *Jan Arogya Bima* micro health insurance as the high costs were due to expensive outpatient care that did not require hospitalization. The message from this calculation is that about half of the most expensive illness episodes would not be reimbursed even when the households were insured and incurred catastrophic expenses due to hospitalization and other medical needs.

The cost of an illness episode that included hospitalization in this dataset ranged from a low of Rs. 40 (charged for a single night by a charitable hospital) to Rs. 56,400. Once again, if the purpose of insurance is only to cover high-cost events, it is important to look at the impact of the insurance cap on the reimbursement payable by the insurance. In our dataset, the cost of 14% of the 209 cases that involved hospitalizations and were eligible for reimbursement exceeded the cap of Rs. 5,000. Hence, the persons (or households) concerned in these 14% of high-cost events would be required to pay considerable amounts out-of-pocket even if they were insured; and in 6% of the episodes, the insured households would be required to pay out-of-pocket an amount equal to or higher than the benefit they could expect to receive from the insurance.

This simulation illustrates that, all good intentions notwithstanding and admitting that self-reported data regarding illness episodes could be subject to recall bias, the existing health insurance products that suit the conditions of the Micro-insurance Regulations would provide "*protection of assets [and lives] against insurable risks of target populations"* only to about half the cases involving hospitalization, and insufficient protection of assets to the more expensive cases. In passing we add that only about 10% of cases of illness in general would be reimbursable. Such insurance products leave the bulk of illness-related financial risks outside the realm of insurance even for the insured population. One can only wonder whether this is what the Regulator had originally intended.

Are we all "bad risks" in the long term?

There is another major concern: The Micro-insurance Regulations allow insurers to limit the period of cover to one year. Consequently, insured persons cannot be sure about the continuity of their coverage beyond one year, and in particular when they could become "bad risks". From the clients' point of view, this uncertainty dramatically reduces the incentive to insure when people perceive themselves as "good risks" (who are less likely to claim), because the value proposition of insurance to such clients is the long-term protection of their assets. Insurance companies can reduce this value proposition by "cherry picking" (selecting only good risks) and "lemon dropping" (deselecting bad risks), in addition to being allowed to also charge whatever premium they wish for health insurance (in India, health insurance products have not been subject to regulated tariffs even before the "detariffing" was introduced for other classes of risks (e.g. fire or engineering) in January 2007). Such practices further impede the extension of micro-insurance coverage. The argument that the insurance industry needs this protection against the impact of adverse selection by clients seems weak in view of the fact that countries with developed insurance markets restrict preferred risk-selection or disallow it altogether.

Related considerations: premium levels, benefit-package composition, metrics

Unattractive micro-insurance products (demonstrated here only with regard to health insurance) are bound to be associated with low demand, when affiliation is voluntary (as is the case in India). The argument is often leveled that the product must be very limited in order to keep the premium very low. So the question is how much would the target population in India be willing to pay? We explored this question through a unidirectional (descending) bidding game among 3,024 low-income households in

The Micro-insurance Regulations allow insurers to limit the period of cover to one year. Consequently, insured persons cannot be sure about the continuity of their coverage beyond one year, and in particular when they could become "bad risks".

seven rural and slum locations in India in 2005[5]. About two-thirds of the sample agreed to pay at least 1% of annual household income; about half the sample was willing to pay at least 1.35%; and 30% of the sample was willing to pay about 2.0% as premium for health insurance. The nominal median value of the willingness to pay was Rs. 560.

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This declared level of willingness to pay seems surprisingly high in view of the low demand for micro health insurance products in India[6]. Is it possible that the clients are aware of the limitations of the existing products and would like to avail of other products that would suit their level of willingness to pay? This was examined by eliciting clients' priorities in a field experiment that used a game-like decision tool, called CHAT (Choosing Healthplans All Together)[7,8,9].

We field-tested CHAT in Karnataka and Maharashtra in 2005-06 (and in Rajasthan in 2006 with somewhat different metrics) to examine the choices that respondents would make at a premium of Rs. 500 per household per year. With this modest premium, participants could select 34% of the benefit options offered in the exercise. Group decisions were reached by consensus. The most consistent finding has been that respondents selected broad benefit packages at basic coverage levels that reflect high aggregate costs (unavailable on the market today) over narrow packages with higher coverage. Furthermore, close to 100% of respondents included at least basic coverage of medicines and maternity in the desirable benefit-package. Medicines were chosen because they represent a large and frequent expense – comparable to hospitalizations on an aggregated basis[10]; and maternity was chosen because of the high rate of delivery at home and the need for better professional support to mother and newborn.

The other important lesson from our field-work (looking at socio-economic status, cost and incidence of illnesses, willingness to pay, and clients' preferred benefit-package design) is that differences across locations are pronounced and significant[11]. Hence, one can wonder whether a uniform benefit package, such as '*Mediclaim*', *Jan Arogya Bima* or similar micro-insurance versions, could be uniformly and sufficiently attractive all over India, as a standardized approach suggests.

Conclusions

Taking into account estimates of UNDP[12] and projections of McKinsey[13], as well as a surging interest in micro-insurance by MFIs, NGOs, SHGs and some insurers in India, we assume that there is a large potential market for micro health insurance. Bearing in mind the findings on willingness to pay mentioned earlier in this article, and resources that the Government of India is said to make available, e.g. for micro health insurance of rural dwellers (under the National Rural Health Mission)[14], and through other programmes targeting the poor[15], it seems plausible that the large demand could be solvent. Yet, in reality there is low uptake of health insurance.

5 Dror DM, Radermacher R, Koren R: Willingness to pay for health insurance among rural and poor persons: Field evidence from seven micro health insurance units in India. Health Policy, (2007) 82(1):12-27.

6 It should be noted also that respondents in the same survey said that their medical costs were about four time higher; this suggests that (i) while respondents were willing to pay for health insurance, they limited this WTP to about one quarter their health spending; and (ii) that the cost of travel to dispensaries and hospitals, which can be high in rural areas, needs to be considered as well in health insurance.

7 Dror DM, Koren R; Ost A, Binnendijk E; Vellakkal S, Danis M: *Health insurance benefit packages prioritized by low-income clients in India: Three criteria to estimate effectiveness of choice*, Social Science & Medicine, February 2007 **64**(4): 884–896.

8 Danis M, Binnendijk E, Ost A, Vellakkal S, Koren R, Dror DM.: *Eliciting the Health Insurance Benefit Choices of Low-income Populations in India with the CHAT Exercise*, Economic and Political Weekly (Mumbai) **42**(32):3331-3339 August 11-17, 2007.

9 A 6-minute video of CHAT in the field can be found at: http://www.microinsuranceacademy.org

10 Dror, DM: *Health insurance for the Poor: Myths and Realities*, Economic and Political Weekly (Mumbai), 41 (43-44):4541-4544, 6 November 2006 (Myth No. 2 – see figure).

11 Dror, DM: Why "one-size-fits-all" health insurance products are unsuitable for low-income persons in the informal economy in India, Asian Economic Review, **49**(1):47-56, (Hyderabad) April 2007.

12 UNDP: *Building Security for the Poor: Potential and Prospects for Microinsurance in India*, UNDP Human Development Report Unit, Asia and the Pacific, April 2007, ISBN 978-955-1031-16-9.

13 McKinsey Global Institute: *The Bird of Gold: The Rise of India's Consumer Market*; McKinsey & Company, May 2007.

14 http:// http://mohfw.nic.in/NRHM.htm, with links to Mission Statement, Framework for Developing Health Insurance Programmes and progress report

15 Financial Times reported on 3 October 2007 that the Union Government of India plans to subsidize health insurance premiums, through state governments, to the tune of Rs. 550 per household per year.

This analysis of a standard micro health insurance product offers some pointers to the possibility that the crux of the problem lies with the low value-proposition of the supply side. Admittedly, more conclusive analysis would be needed, and it could be done best when real data (that insurance companies possess) would be made available on renewal rates and on the claims ratios paid by insurance companies to their insured under the micro health insurance products. For the time being, one cannot exclude the possibility that insurers and others, insufficiently aware of clients' priorities, seem to misinterpret low demand as reflecting low willingness to pay; ignoring the unattractive value-proposition of the main product and the devastating impact on the demand side of "cherry picking" combined with insufficient choice of micro health insurance products. This error in judgment could lead to another one: that the premium needs to be lowered further. However, further lowering of the premium without re-engineering of the business process is bound to involve concurrent reductions in the quality of the product or its servicing even further, when what is needed is broadening the products to include more benefits types (e.g. outpatient care and medicines) as well as clients' transaction costs (e.g. due to transportation, medical equipment etc.). With these considerations, one can wonder if those who are interested in making insurance work for the poor in India might be stuck in a vicious cycle, which looks like this: ***poor products ® low demand ® low willingness to pay ® lowering of premiums ® further worsening of insurance product or service …***

In parallel, there is an ongoing debate on the question whether subsidies could solve the problem of low uptake. The core issue is, however, not whether subsidies could play a role, but what use of public funds would deliver acceptable, effective, efficient and equitable results for the poor. Subsidizing only the demand for products that do not find takers or that offer insufficient protection is certainly not the only option. A more interesting option could be subsidizing the risk rather than the premium (e.g. by subsidizing the reinsurance of outlier claims costs, or by cross-subsidizing certain types or health risks within the industry-wide pool through some form of risk-adjustment). Such solution would remove the disincentive of insurers to insure everyone (and thus remove cherry picking from the market). Such an option could encourage product innovation based on better market research aimed at improving uptake of (micro) health insurance, when the allocation rule would give more subsidies to products and insurers that demonstrate higher protection actually given to poor clients (based not merely on affiliation but on the ratio of settled claims and/or a broader set of conditions). Without any fundamental change in product design or in business process, why would a simple allocation of funds to pay part of the premium of designated clients (be it directly to insurers or otherwise) change the value-proposition of the products? Hence, we doubt that such a measure could break the vicious cycle of micro health insurance.

Breaking the vicious cycle begins at the cycle's original weak point: unattractive products and insufficient choice to clients must be reversed. Improving the value-proposition and variety of micro-insurance products; and after-sale service is not only fair and desirable, but indispensable for the extension of an insurance market that could reach as vast a size as the number of the underserved poor persons. This is also the key to generating more revenue for insurance.

Change will probably not come by itself. However, the IRDA, the Indian Actuarial Society, the insurance companies and indeed bodies representing the low-income clients could all play a leading role in promoting the conditions that will result in more and better products hitting the market: better product design; better servicing; benchmarking levels of claims-ratios in micro health insurance relative to admin costs and profit-taking; and mitigation of certain supply-side insurance market failures such as "cherry-picking" and "lemon-dropping". The ultimate purpose of such measures would be, as stated in the IRDA Concept Document, to achieve better *protection of assets and lives against insurable risks of target populations.*

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Perspectives and Prospects in Micro Health Insurance

THE INDIAN SCENARIO

DR. N DEVADASAN AND DR. SOMIL NAGPAL

OBSERVE THAT OVER THE LAST SIX DECADES, INDIA HAS ATTEMPTED TO BUILD UP A MASSIVE PUBLIC HEALTH INFRA-STRUCTURE AT PRIMARY, SECONDARY AND TERTIARY LEVEL. THEY FURTHER ADD THAT THE PUBLIC HEALTH SECTOR, HOWEVER, CONTINUES TO BE PLAGUED BY PROBLEMS LIKE POORLY MOTIVATED MANPOWER, INADEQUACY OF FUNDING, SKEWED GEOGRAPHICAL DISTRIBUTION AND OTHER ACCESS ISSUES.

Introduction

Financing of a health system is closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capability to achieve its stated goals (1). In two separate studies commissioned by the Ministry of Health and Family Welfare, Government of India (National Health Accounts Cell, 2006 and the National Commission on Macroeconomics and Health, 2005), the estimated health expenditure in India for the year 2001-02 was calculated as about **4.8% of the GDP** at current market prices (2;3).

Public Expenditure on Health in India

Out of the total health expenditure in the country, the share of public spending, i.e. that of Central, State and Local Governments taken together, is about one-fifth of the total health expenditure (NHA Cell, 2006). The per capita total health spending in India was about US$23 during 1997- 2000 (World Bank 2003). This, when compared to the levels of spending by countries such as Sri Lanka (US$31) and Thailand (US$71) in the same period, is substantially lower. At about 0.9% of the GDP, India's public health spending appears even poorer in comparison with China, Sri Lanka and Thailand, for which this proportion was 1.95%, 1.8% and 3.06% respectively (4).

The low public investment in health and the absence of any form of national social insurance have heightened insecurities, which perhaps is an important reason for community initiatives for financial protection from ill-health. The unpredictability of illness requiring substantial amounts of money at short notice are impoverishing an estimated 2.2% of India's population every year (5;6). Illness, thus, has the potential for catastrophic effects on individuals and their families.

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Provision of Healthcare: Problems of access and service quality

The guide-lines for national health planning in India were provided by a number of committees dating back to the **Bhore committee in 1946**, which laid the foundations of a comprehensive primary health care delivery system in the country, not too different from the National Health Service in UK and other such tax-funded health provision models in many countries. Over the last six decades, India has attempted to build up a massive public health infra-structure at primary, secondary and tertiary level. However, the public health sector continues to be plagued by problems like poorly motivated manpower, inadequacy of funding, skewed geographical distribution and other access issues. In rural and remote areas, even qualified providers from the private sector are also conspicuous by their absence. On top of this, despite a multitude of legislations having been enacted for the health sector, the providers of healthcare in India continue to be poorly regulated, with no checks on pricing and often no checks on service quality. The absence of influence from large organized purchasers of healthcare (like insurance mechanisms) has also contributed to the situation.

Need for Financial Protection and Advantages of Health Insurance mechanisms

Health insurance is not only a mechanism for financial protection of the enrollees to meet costs of healthcare, but it also has the potential to influence provider behaviour. Presence of financial protection could itself contribute to increased access to healthcare (Kutzin, 1998) as the cost barrier is overcome by many who would not be able to afford healthcare otherwise. Further, by acting as large purchasers of healthcare, health insurance schemes could have the negotiating power which can potentially influence provider behaviour, something an individual purchaser of healthcare cannot achieve. It, thus, has implications on the accessibility, costs and quality of healthcare.

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Classifying Health Insurance Systems

Most health insurance plans or schemes could be classified into one of these broad categories, which differ in their ownership, management and even the basis of contributions or premiums collected from the enrollees:

- Private Health Insurance: Voluntary insurance, usually offered by commercial organizations, based on a risk-rated premium, like the Mediclaim product and its variants in India. Being voluntary, the risk of adverse selection against the insurer is strong, and this leads to various exclusions and other clauses being structured in the product.
- Social Health Insurance: Usually mandatory, often focussed on the formal sector, and also usually income-rated (that is, contributions are based on income of the beneficiary, and not the perceived risk).
- Micro or Community Health Insurance: Informal, usually managed by community groups, operated on a not-for-profit basis, and often community rated (every member of the community pays the same or similar premium).

Micro Health insurance - A Historical Perspective

Microhealth insurance schemes have many aliases. In Francophone Africa, they are usually called "*mutuelles*" while in Anglophone Africa, they are named as community health insurance (CHI). The International Labour Organisation prefers to call them micro-health insurance.

The main characteristics of micro-health insurance (MHI) are that they target the informal sector, farmers, labourers, vendors, housewives, etc. Secondly, they are usually not-for-profit enterprises, that plough any excess money back into the fund. And finally, the community usually has a role in initiating, implementing and managing the insurance funds.

MHIs are not a new phenomenon. Way back in the 19th century, at the peak of the industrial revolution in Europe, labourers had no social security measures. To protect themselves from the hardships of illness and death, these labourers instituted local "sickness funds" that collected money for future contingencies. Over years, these sickness funds have federated and merged to form the large health insurance companies that exist today in many European countries (7). Again, this is not limited to Europe. In Asia, the *jyorei scheme* in Japan has a similar history (8). Then of course, there is the famous Chinese Rural Cooperative Medical System (RCMS), where the farmers contributed annually towards a common

health fund that was used to finance the health services in the region (9).

Today, in the light of the governments not being able to provide adequate health services, coupled with the escalating costs in the private health sector, globally the poor have been denied access to health care. And when they do access, the costs are so prohibitive, that the family is pushed into poverty. Peters et al show that 25 – 40% of all (not just the poor) hospitalised patients have to borrow money to meet the medical costs in India (5). This is one of the main reasons why micro-health insurance has been growing as a movement. Many poor families in Africa, SE Asia and now India are being protected by such schemes. In India, the first such scheme was started in 1955 in Kolkata, the Student's Health Home. There was a gradual increase in the number of schemes, but this has shown a phenomenal increase in the past five years. Currently, as per ILO estimates, there are more than 85 such schemes, covering at least 8 million people. Some of these schemes are shown in Figure 1.

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Characteristics of MHI Schemes in India

The lead author of this paper, as part of another research work, studied more than 10 MHI schemes in detail, visiting them, interviewing the managers, field staff and community beneficiaries. We also reviewed existing literature on these schemes. Based on this we describe some of the basic characteristics of these schemes.

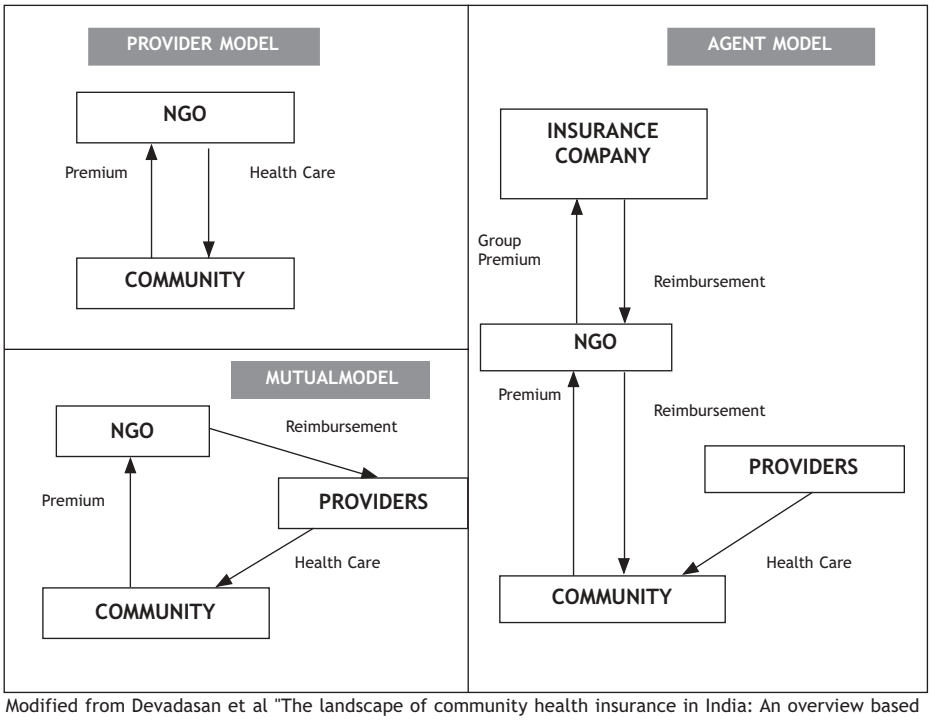
Practically all of them have been initiated by non-governmental organisations (NGOs). These organisations have been working with the 'target' groups for many years providing various development services. Recognising the adverse effect of medical expenses, these NGOs initiated these MHI schemes. There are three basic models within these schemes (Figure 2), depending on the strength of the NGO. In places where the NGO has a strong health service with hospitals etc, they have developed a "provider" model of MHI. Here the NGO is the risk bearer (or 'insurer') as well as the provider of care. In the "mutual" model, the NGO acting as the risk bearer (or 'insurer') only manages the funds, but purchases care from private providers. Finally, and this is a recent phenomenon, many NGOs act more like aggregators (or 'agents'), collecting premium from the community and handing it over to an insurance company. Thus the risk is borne by the company.

The target population for many of these MHI schemes are the poor e.g. farmers, landless labourers, vendors, self help group members, fisherfolk, and even tribal families. SEWA in Gujarat enrols women members of the SEWA Union, while Yeshasvini in Karnataka enrols members of the cooperative societies. ASHWINI has managed to cover more than 15,000 tribals in the Gudalur block of Tamil Nadu. Student's Health Home covers more than 2 million students in West Bengal.

Usually, the NGOs collect the premium from the community on an annual basis. This is collected using existing community mechanisms e.g. through the dairy co-operatives at Tribhuvandas, through the self help groups at KKVS, through the fisherfolk federation at PREM etc. This implies that the cost and additional effort for collection of contributions is minimal. The premium ranges from Rs 20 per person per year to Rs 250 for a family of five. This low premium is in keeping with the economic status of the target population.

Figure 1: ***Location of some of the MHI schemes in India***

Figure 2: ***The three models of MHI schemes in India***



Modified from Devadasan et al "The landscape of community health insurance in India: An overview based on 10 case studies" Health Policy. 2005.

Though another study by Dror et al suggests that the poor in India are willing to pay more than Rs 600 per family per year for health insurance (10), we have found that most of the poor in India are able to pay in the range of Rs 150 to Rs 250 for a family per annum (11). Premiums are usually collected during a specific period and this coincides with period of high economic activity in the community. This is a community rated premium and is applicable irrespective of the risk status of the individual.

For this premium, the insured usually get protected against hospitalisation expenses, similar to the 'mediclaim' policies. While many NGOs also provide primary and ambulatory care, this is usually financed from other sources and not the insurance fund. This naturally makes the entire package more attractive and acceptable to the individual (12). Many of the MHI schemes have realised the need to minimise exclusions, e.g. at Karuna trust, Student's Health Home and ASHWINI, all conditions (including pre-existing ones and deliveries) are covered. In some cases, where the MHI scheme has linked up with an insurance company; there are exclusions, e.g. at SEWA, deliveries are not covered. These schemes usually have an upper limit to the sum assured, and this ranges from Rs 1250 (at RAHA) to Rs 200,000 (at Yeshasvini). Most upper limits of sum assured ranged between Rs 5,000 to Rs 10,000 during the period of our study, and covered most of the hospitalization expenses. However, this low sum assured also implies that the insured patient is not fully protected (13) and needs to make some supplementary out of pocket payment.

Claims and reimbursements are usually managed by the NGO staff. Wherever possible, cashless systems have been introduced, though the reimbursement mechanism also exists especially in the "agent" model. In the SEWA model, the insurance company has delegated this responsibility to the 'insurance committee' of SEWA. This committee meets monthly and processes the submitted claims. These claims are either accepted or rejected and the decision is forwarded to the insurance company who reimburses accordingly. This form of social audit has been very effective in controlling fraud and has balanced the information asymmetry that normally is the bane with insurance products.

The NGO undertakes many of the management tasks including creating awareness, collecting premiums, managing the fund, processing claims and reimbursements; and providing feedback to the community. This reduces the administrative costs considerably. However some tasks like strategic purchasing of health services and monitoring of the scheme is usually neglected.

Adverse selection, moral hazard and cost escalation are some of the problems with health insurance. While even professional insurance companies struggle to mitigate these, the MHI schemes have evolved various innovative mechanisms (Table 1)

Table 1: ***Illustrative list of provisions to mitigate adverse selection and moral hazard in Indian MHI schemes***

Measures to mitigate adverse selection	• Definite collection period • Definite waiting period • Family as the unit of enrolment • Exclusions (in some schemes)
Measures to mitigate moral hazard	• Referral system • Co-payments • Definite upper limits

One of the main criticisms against the MHI movement is the lack of financial sustainability. Many of the earlier schemes were subsidised from other sources of funding, rather than the contributions from the members.

Measures to control costs like use of standard treatment protocols, a case based payment mechanism or medical audits etc are not commonly used by the MHI schemes. Yeshasvini is probably the only scheme that has negotiated for a case based payment mechanism with the private providers.

Micro Health Insurance - Performance:

The above review of many MHI schemes in India suggests that a small revolution is silently taking place in rural India. More and more organisations are using micro health insurance to protect the families from health risks. This appears to be an effective strategy to cover the poor. However, one major question that one has to ask before one talks about scaling up is - "*Do these MHI schemes perform?"* Do they increase access to health care, do they provide protection etc.? While there have been hardly any studies on this aspect, the few that have been done show positive results.

- **Enrolment** - All the schemes have been able to enrol the poorer sections of society. The coverage rates range from 10 to 40% of the target population. In absolute numbers, this could range from 5,000 to 2 million. Most schemes have been successful in enrolling about 10,000 to 20,000 people.
- **Access to care** - There is now empirical evidence to suggest that MHI schemes actually improve the access to health care for the poor (14;15). The poor are able to go to hospitals and get admitted and get the necessary care without the burden of having to find funds at the time of illness. At ASHWINI, a panel survey showed that the admission rate among insured was two times higher than the uninsured. While from the insurance industry's perspective, this may seem to be not-so-good news, from a public health standpoint, this implies that MHI can be used effectively to improve the health status of the poor and suggests that the unmet healthcare need of the community was resolved through better financial access to care.
- **Financial protection** - Ranson was the first to show that the SEWA scheme was instrumental in providing financial protection (16). Since then, another study has demonstrated a similar effect at ASHWINI and KKVS (13). This has important implications as MHI schemes can be considered as important anti-poverty interventions. Given the fact that medical expenses are impoverishing, MHI schemes could prevent many families from slipping down this treacherous path.
- **Sustainability** - One of the main criticisms against the MHI movement is the lack of financial sustainability. Many of the earlier schemes were subsidised from other sources of funding, rather than the contributions from the members. However, increasingly, and especially in the "agent" model, this may not be an issue any more. People pay the premium and since it is spread over a larger pool comprising of a large section of the community, this contributes to making the scheme sustainable.

The Future of Micro Health Insurance

Given the fact that micro health insurance is growing into a sustained movement and allowing for its ability to enrol the poor and provide protection, we feel that micro health insurance should be encouraged by all relevant stakeholders. Like similar support in Europe, Japan, Thailand, Philippines, Rwanda, Uganda etc., there is a case for continued government support, including measures to provide the conditions for these schemes to grow. Direct subsidies of the premiums, a legal framework, providing technical support and even recognition of these entities could be some of these measures.

Growth of Indian MHI scheme into larger entities continues, and can be seen at two levels. One is the internal growth within each scheme, whereby the schemes cover more of their target population. One of the factors which makes this possible is when the premium is made affordable. In a recent exercise at ASHWINI, when the premium was reduced by 25%, the enrolment rate jumped from 35% to 50% of the target population. This underlines the importance of affordable premiums. However, ensuring affordable premiums, to be sustainable, needs to be accompanied with a juggling of the scope of cover, and/or better cost control mechanisms like social audits, and perhaps also with better negotiations with providers of care.

Yet another way of the MHI schemes

growing into larger entities is when these schemes federate (and this process could be facilitated by government) so that they have larger numbers on their side. This could have numerous advantages including lower premiums and administrative costs, improved management capacity, better bargaining power with the insurance companies and hospitals and of course a greater chance of sustainability. This has been the path taken by other countries, like Germany and Belgium.

Conclusions and Lessons Learnt

From the position hitherto discussed, it does become evident that many micro health insurance schemes have not only achieved good enrolment levels amongst their target populations, indicating the existence of demand, but from a policymaker's perspective, these schemes have also improved access to health services for the poor. In a scenario where ill-health has been a major cause for impoverishment, the value of such financial protection doesn't need to be re-emphasized. Also, many schemes have indeed grown larger and have continued to be in existence for many years, indicating that sustainability of micro health insurance schemes can be ensured through good design and management.

A benefit package which meets the need for financial protection (which, indeed, is the key function of insurance) as also addresses the 'felt needs' of the community (like outpatient care, or maternity), needs to be carefully balanced with affordability, as the costs do go up as the scope of the coverage is expanded. It is also visible that community driven cost-control mechanisms (like social audits of claims, pre-determined collection periods, co-payments), as also measures to minimize transaction and administrative costs (for example, through collective payment of premia or deduction at source) or to keep providers' charges under control (like in Yeshaswini) can be devised and are effective in keeping costs (and hence, premiums) at manageable levels. Ultimately, striving to maintain this delicate balance of product features and affordability could well be the key to growth, success and sustenance of the micro health insurance schemes in the country.

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Many schemes have indeed grown larger and have continued to be in existence for many years, indicating that sustainability of micro health insurance schemes can be ensured through good design and management.

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Community Health Insurance

The Experience of Karuna Trust

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WRITE THAT IT IS IMPORTANT TO RAISE AWARENESS IN THE COMMUNITY ABOUT HEALTH IN GENERAL AND INSURANCE IN PARTICULAR. THEY FURTHER ADD THAT INFRASTRUCTURE SHOULD BE ABLE TO PROVIDE SERVICES; AND THIS SHOULD BE ADDRESSED ALONG WITH THE PROVISION OF INSURANCE SERVICES.

Introduction

Macro and micro studies on the use of healthcare services show that the poor, especially the scheduled castes and tribes are forced to spend a significantly higher proportion of their income on health care than those who are better off, pushing their families into further poverty and indebtedness. This is particularly high when availing 'in-patient' care, with 'out of pocket' expenditure being significant even when accessing public care.

Sustainable models of health insurance with poor people paying premiums and obtaining benefits were not considered as a viable option for equitable health distribution and insurance was associated with the upper and middle class as a predominantly city centered facility. (Barnighausen and Sauerborn, 2002).

However, over the last few years, Health Insurance initiatives have been proliferating rapidly. In West Africa, the number of Community Based Health Insurance (CBHI) programs grew from 199 in 2000 to 585 and covered 1.5 million people in 2003 (Bennett, S., Kelley, A. G., and Silvers, B. 2004). The numbers are even more robust in Asia, where the ILO estimates that 7.5 million Indians benefit from about 40 CBHI programs (Cohen 2006), many of which have shown how a replicable, sustainable and a scalable model of community health insurance may be implemented.

Indian policy on Public Private Partnership (PPP)

Under the Tenth Five year plan (2002-07), initiatives have been taken to define the role of Government, private and voluntary organizations in meeting the growing needs for health services in the country. The National Health Policy (2002) also envisaged the participation of the private sector in primary, secondary and tertiary care and recommended suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions. The policy also envisaged the co-option of the non-Governmental sector in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

The Ministry of Health & Family Welfare, Govt. of India has also evolved guidelines for public private partnership in different National Health Programmes like Revised National Tuberculosis Control Program (RNTCP), National Blindness Control Program (NBCP), National Leprosy Eradication Program (NLEP), RCH etc. National Rural Health Mission (2005-2012)

Under the Tenth Five year plan (2002-07), initiatives have been taken to define the role of Government, private and voluntary organizations in meeting the growing needs for health services in the country.

proposed to support the development and effective implementation of regulating mechanism for the private health sector to ensure equity, transparency and accountability.

PPP initiatives seek to improve the efficiency of services by strengthening the management of existing health infrastructure and at the same time widening the range of services and number of service providers by partnering with the private sector.

The **National Population Policy 2000** lists partnership with NGOs as one of the strategic themes in rural development. The overall mission is to provide **'practicing models' in public-private partnership** in each of these districts and hence **influence and facilitate change** in the whole taluk. The work of NGOs is essentially supplementary and complementary in nature to that of the government and NGOs have a comparative advantage of flexibility in procedures, and a rapport with the local population.

Partnerships between the Government and Karuna Trust

- Entrusting Management of PHCs to VOs and Private Medical Colleges. Karuna Trust is managing 25 PHCs in Karnataka and 9 PHCs in Arunachal Pradesh
- Community Health Insurance
- Mainstreaming Traditional Medicine into Primary Health Care
- PPP for Health Sector Reforms : Task Force on Health and Family Welfare
- PPP for Good Governance in Health – Lokayukta

The **Partner Organizations for Community Health Insurance were the** Ministry of Health & Family Welfare, GOI, UNDP, Department of Health & FW, GOK, Karuna Trust, CPD, and National Insurance Company and the objectives were to develop and test a model of Community Health Financing, increase access to Public Health Care, ensure equitable distribution of Health Care through Social Insurance and empowerment of rural poor for better health.

An important feature of the CHI project was the stipulated compulsory use of the government healthcare facilities.

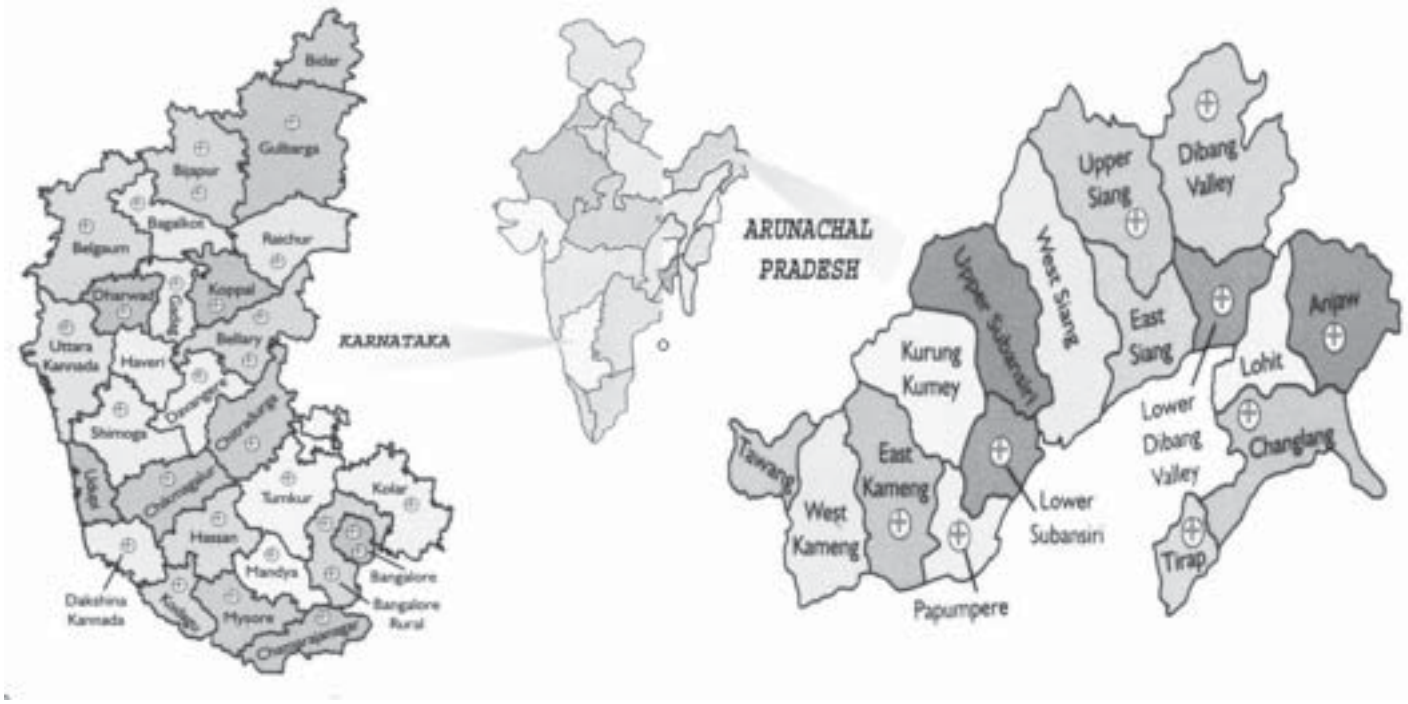
Phases of project initiation

The project was first implemented in 210 villages of T Narsipura taluk, Mysore district and 112 villages of Bailhongal taluk, Belgaum district. The second (extension phase) consisted of 40 villages of Yelandur taluk, 57 podus of BR Hills, Chamarajnagar district and 133 villages of Belgaum taluk, Belgaum district.

Models of Community Health Insurance

Two models were designed primarily to assess if CHI could be introduced in those areas that did not have a good NGO presence. In T Narsipura, Karuna Trust was the implementing agency whereas in Bailhongal, the Zilla Panchayat took on the role of the implementing agency, while Karuna Trust restricted itself to monitoring the program and ensuring smooth flow of funds.

'*Each partner had its own strengths and applied them in its respective area. The government is always a willing partner in schemes that look at the larger good. We had entered into a unique partnership with Karuna Trust and despite procedural and other limitations, we were*



determined to make the partnership work' Dr. SC Dharwad, District Health and Family Welfare Officer, Belgaum

Community Health Insurance- T.Narasipur Model

This model was an NGO and Government collaboration at three levels - community herbal gardens for common ailments, SHGs with Micro-credit for out-patient care, and pre-paid insurance for inpatient care. The rural poor were empowered using participatory rural appraisal, Micro-plans and committees at the Village, sub center and primary health centre, Gram Sabha, Gram Panchayat, Taluk Panchayat and Zilla Panchayat Health Plans.

Project Implementation

The common features of the models were that private health services not covered, baseline surveys were conducted, awareness was generated using street plays, video shows, public announcements, posters, community level meetings and then enrolments were made. To facilitate effective implementation, Project Implementation Committees were sent up in both areas at the taluk and district level consisting of members drawn from the zilla panchayat, the implementing agency and the taluk health office and responsible for implementation and monitoring of number of beneficiaries enrolled, issue of identity cards, settlement of claims, accounting of sums allocated to the hospital as part of insurance payment, overseeing the operation of the revolving fund allocated.

Both models worked with Gram Panchayat functionaries to spread awareness and influence the community on the benefits of CHI. Additionally, Karuna Trust used community platforms like Self Help Groups (SHGs), Village Development Committees and Village Health Committees to spread awareness about CHI.

Details	T. Narsipura model	Bailhongal model
Implementing agency	Karuna Trust	Zilla Panchayat
Duration of Phase II	1st June 04 – 30th May 05	1st Jan 05 – 31st Dec 05
Population covered	1,00,000 SC & STs and below poverty line (BPL) covered	One Lakh SC & STs and 35,000 below poverty line
Main method of raising awareness	Street plays, video shows and community level meetings	IEC activities through hospitals and PHCs with personal interaction by Auxillary Nurse Midwives and Anganwadi workers during community visits.
Phase I		
Duration	1st Sept 02 – 31st Aug 03	(Extended phase) 1st Oct 02 – 31st Sept 03
Number of beneficiaries	655	1719
No. of bed days	5490	12,241
Claims in rupees (Wage loss + Drugs	2,74,500 + 2,74,500	6,12,050 + 6,12,050
Percentage claims	21.4%	77.3%

Salient features of Insurance

Salient features of insurance were a low premium of Rs.22 (initially Rs. 30 in the first year but this was brought down since the claims were only 55%) per person per year, premium costs shared by community, Milk Co-operatives, SHGs, UNDP and GPs with the important feature of a 'no exclusion' policy which included all age groups, pre-existing illness including HIV/AIDS and hospitalization due to any illness. Rs. 50/-was paid to the patient for daily wages lost and Rs. 50/- to the hospital for extra drugs per day of hospitalization with the amount paid to patients every day through the revolving fund at each Hospital. Ambulance services and referrals have also been covered for a maximum of 25 days of hospitalization. The claims are settled by National Insurance Company once a week.

Progress

The progress made so far include improved access to public health care by women and rural poor, availability of essential drugs for the BPL persons, extension to 25 primary health centres in 25 districts of Karnataka, inclusion of HIV/AIDS patients, ensuring sustainability of the project through Self Help Groups and collaboration with the Government of Karnataka under the World Bank project to extend the project to the rest of Karnataka in phases.

This has increased motivation among the Government health staff to deliver better

The premium for the poor should be low and if a bigger package is envisaged, then it should be subsidized.

services. The clause requiring the use of government health facilities led to increased use of and improved perception by the community of Government health services.

> '*I am not scared of illness anymore. Suffering aside, whenever I or anyone from my family fell ill, we were worried about how to afford treatment. We do not worry anymore. We get good treatment, money for medicines and money if we cannot work'* – Savithri Sainappa Birje

Though not directly related to CHI scheme, Karuna trust promotes the concept of herbal gardens for preventive health with training and saplings of medicinal plants being provided to self help groups.

> '*We were not very happy to pay for insurance as we are poor and every rupee is important to us. Later when I was admitted to the hospital for chest pain, I was very happy as I got a good sum of money as compensation when I was discharged. This money more than compensated for what I had spent initially on the insurance'* – Siddamma, Soliga tribe from BR Hills.

Replicability /Upscaling of the model

It is clear that the requirements for Rural Sector Health Insurance should include a low premium or subsidized premium, no exclusion policy that includes all age groups and all illnesses, utilizes both public and private health providers, compensates for daily wages lost for BPL members to cover out of pocket expenditure and taking the responsibility to provide healthcare in backward and remote areas. The premium for the poor should be low and if a bigger package is envisaged, then it should be subsidized.

It is important to raise awareness in the community about health in general and insurance in particular. The infrastructure should be able to provide services and this should be addressed along with the provision of insurance services.

Devadasan et al argue that the main considerations in developing community health insurance is to find an appropriate provider taking into account the unregulated and unaccountable nature of the Indian private health sector, uncontrolled cost escalation without the promise of quality, the legality of these schemes given the new Insurance Act (IRDA Act 1999), financial sustainability and the role of financial subsidy by the government machinery for this equitable health financing mechanism.

The community health insurance programme under Karuna Trust offers a valuable lesson in policy making and for the equitable distribution of health care resources. Some of the conditions that have facilitated the effectiveness of the program for Karuna Trust are an initial strong local presence in the community, widespread dissemination of information about the scheme, involvement of the self-help groups, no exclusion policy (which is an unique feature of Health insurance by Karuna Trust as opposed to other initiatives) and an affordable premium.

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The Challenges of Microinsurance

Some Experiences and Innovations

'THERE IS A HUGE AMOUNT OF RISK INVOLVED IN AGRICULTURE AS MOST FARMERS DO NOT HAVE ASSURED SOURCES OF IRRIGATION AND THE ACTIVITY IS PRONE TO WEATHER RISKS LIKE INADEQUATE RAINFALL' SAYS **GUNARANJAN.**

Inclusive growth is now recognised as a necessary condition to ensure long term sustainability of growth in India. Bringing in financial inclusion for the poor, rural and socially disadvantaged sections of the society is now a major thrust area for policy interventions. The vulnerability of the above mentioned category of households is very high to various risks related to their lives and livelihood activities. Therefore making insurance services available to them becomes a key strategy to ensure that sustainable social protection is offered to these households. The rural and social sector obligations and the microinsurance regulations from IRDA are important steps in the direction of ensuring financial inclusion and social protection for the poor. While enabling regulations are in place and several insurance companies are in operations in India, there is still a need for innovation in products and distribution channels for ensuring the penetration of microinsurance to the masses that need it. And along the way, there is also the challenge of educating the vast majority of population on insurance that has to be addressed. The remaining part of this article covers some of the initiatives taken by BASIX in improving the access to micro insurance for the poor.

BASIX, a livelihood promotion institution set up in 1996, provides both financial and technical assistance services to about half a million households spread over eight states in India. In October 2002, it began its initiative to provide life insurance cover to customers who took micro credit. BASIX took a group policy called Credit Plus from AVIVA which covered its borrower for 1.5 times of the loan amount taken by him or her during the loan tenor. In the absence of any past experience of mortality for the customer profile served by BASIX, the insurance company priced the product conservatively at Rs.8.61per thousand sum insured. By October 2004, an experience of covering more than 50,000 person years was completed. The positive performance of product by this stage allowed the insurance company to lower the premium rate to Rs.6.89 per thousand sum insured. A year later in 2005, over 100,000 person years were covered cumulatively. The claims experience gained till then allowed the insurance company to reduce the premium rate to Rs.3.98 per thousand sum insured. Based on actual performance of the product, BASIX and AVIVA could reduce the premium rate by more than 50% in a three year period. This further allowed BASIX to extend cover to the spouses of

While enabling regulations are in place and several insurance companies are in operations in India, there is still a need for innovation in products and distribution channels for ensuring the penetration of microinsurance to the masses that need it.

the borrowers, and also add a limited health insurance cover from Royal Sundaram, as the premium was much more affordable now. This experience proved that a sustainable approach to pricing of micro insurance, combined with proper administration of the products, allows in the long run adding more value to the small premiums paid by its customers. Another unique feature which was introduced in this group product was that it provided the borrowers the convenience to *pay the insurance premium in small monthly instalments* to the insurance company along with their loan repayments.

By the end of September, 2007, BASIX insured over 500,000 individuals under this microinsurance policy and it aims to cover over one million lives within the next one year. In partnership with insurance companies, BASIX today offers a wide range of micro insurance products covering life and health risks and also various assets in rural areas like livestock, agriculture and non-farm enterprises. In the past five years it has settled claims to over 13,000 households amounting to over Rs.50 million. More than any other marketing effort, it is the demonstration effect created by the settlement of these claims that helps BASIX to enrol more number of customers for micro insurance.

Challenges to be overcome to achieve sustainable and scalable micro-insurance models

- *Creating actuarial data for micro-insurance, rather than searching for actuarial data for getting micro-insurance started.*

  Most poor have not had access to insurance in the past as in the present. This translates into absence of data regarding frequencies of various risks faced by them. In the absence of this data, insurance companies are often constrained to offer products as the availability of historical data is critical to the design of insurance products. This perpetuates the problem of making available insurance products to the poor. To break this deadlock, insurance companies should be willing to introduce products even in the absence of adequate actuarial data. The incentives for doing this would be:

  - It would help to build data on various risks for this segment of the market which is huge. This data and coupled with it, the experience in administering micro insurance policies would serve as an asset for the insurance companies to expand their market in the huge and untapped rural market.
  - The marginal error in pricing micro insurance policies in the absence of historical data would not seriously affect the insurance companies as the financial value of risk in micro insurance policies is very marginal compared to the traditional high value insurance contracts underwritten by insurance companies. This marginal risk too can be mitigated by taking a conservative approach to pricing of the micro insurance policies in the inception years and in reviewing the price, based on actual claims experience in subsequent years.
  - Reinsurers are also beginning to recognise the potential of micro insurance, in order to expand the overall insurance market size. Munich Re and Swiss Re and GIC of India are examples of reinsurers who have been actively studying and promoting micro insurance in the Indian insurance market. The willingness and the interest of these reinsurers provides an opportunity to local insurance companies to enter into the micro insurance market, by ceding a portion of micro insurance risks to global reinsures. The reinsurers would be in a better position to absorb the risks from micro insurance programs where the market experience is still in a very nascent stage.

- *Rationalising underwriting procedures for micro-insurance to make them accessible for target clients*

  A major roadblock for rolling out insurance products for the poor has been the gap between expectations of insurance companies in obtaining and completing a certain kind of paperwork for issuing insurance contracts and what the poor can actually provide. The poor and especially those in the rural areas are in a disadvantaged position in terms of their ability to access hospitals, schools and various public utility service providers. The certificates issued by these institutions often serve as proofs for establishing identity and also age to be considered for an insurance contract. In such scenarios, as in the case of BASIX; the micro insurance service providers have worked with the insurance companies to accept alternative age proofs like declaration of age by community members like SHGs or even

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Confederation of Indian Industry (CII) organized a one-day Health Insurance
'Growth and Challenges .....

Mr. C.S. Rao, Chairman, IRDA seen addressing the gathering on the issue of Regulatory Challenges & Perspectives in Health Insurance.

A view of the Round Table Discussion "Defining the Way Forward" Seen in the photograph (from L to R):
Mr. Sandeep Bakshi, MD & CEO, ICICI Lombard General Insurance Co Ltd.; Mr. K.N. Bhandari, Secretary General, General Insura
Ms. Shikha Sharma, MD & CEO, ICICI Prudential Life Insurance Co Ltd; Mr. Jean-Michel Chatagny, MD, Client M
Mr. A. Vaidheesh, MD, J & J Medical; Ms. Ritu Nanda, Chairperson, Raksha TPA Pvt Ltd; Mr. Daljit Singh, President - Str
Mr. G.C. Chaturvedi, Jt. Secretary, Ministry of Health & Family Welfare, Govt. of India.

e Summit on 5th October 2007 at Mumbai. The theme of the conference was
.... Is there an alternative?'

Photograph shows (from L to R) Dr. Prathap C. Reddy, Chairman, Apollo Hospitals Group; Mr. C.S. Rao, Chairman, IRDA; Mr. A. Vaidheesh, Managing Director, Johnson & Johnson Medical; and Mr. Banmali Agrawala, Managing Director, Wartsila India Ltd., during the Inaugural Session.

nce Council; Mr. M. Ramadoss, CMD, Oriental Insurance Co Ltd; Mr. Yogesh Lohiya, CMD, General Insurance Corporation of India; arket Asia, Swiss Re; Dr. Sushil Shah, Chairman, Metropolis Health Services Ltd; Mr. C.S. Rao, Chairman, IRDA; ategy & Organizational Development, Fortis Healthcare Ltd; Mr. S.V. Mony, Secretary General, Life Insurance Council; and

from Page 23

declaration by the individual or even the household itself to be sufficient for the purpose of extending insurance. This has helped in extending insurance to individuals who would not have otherwise been insured due to non-availability of formal certificates of age and residence.

In the area of health insurance, traditionally insurance companies defined that a hospital should have at least ten beds to be qualified for re-imbursement of expenses. However, most hospitals in rural areas do not have this kind of infrastructure. Therefore to allow customers to take treatment at rural hospitals, the policy conditions have been simplified in health insurance policies so that customers can get admitted and treated at any registered hospital, even if it does not have the mandatory ten bed infrastructure. This kind of flexibility in relooking at traditional procedures in administering insurance policies holds the key to unlock the availability and access of micro insurance to the poor.

The policy conditions have been simplified in health insurance policies so that customers can get admitted and treated at any registered hospital, even if it does not have the mandatory ten bed infrastructure.

Livestock Insurance: Insuring the Wealth of Rural India

After agriculture, it is livestock which is the most common source of income for rural households. Very often it provides a supplementary source of income for rural households, helping them to tide over loss of income from other sources. As per the 17th National Livestock Census conducted in 2003, there were 284 million cattle in India. There was no growth in the cattle population of the country between 1997(when the 16th livestock census was conducted) and 2003. In the year 2002-03, as per the Department of Animal Husbandry & Dairying, Ministry of Agriculture, 18 million cattle were insured, which means that only 6% of the cattle population was insured. There is a large percentage of rural household assets which are uninsured and surely there are challenges in ensuring greater penetration of insurance for the cattle population. Traditionally, livestock insurance has always been seen as an unattractive portfolio for insurance companies due its poor financial performance on account of the behavioural risks associated with both customers and service providers. One of the requisites for offering livestock insurance has been the need for getting a certificate from a veterinary doctor. Many remote places still do not have the services of a veterinary doctor and to get this only adds to the cost for obtaining livestock insurance. To overcome this gap in service providers, which seriously compromises the ability to offer livestock insurance in rural areas; BASIX worked with Royal Sundaram to enable the certification of livestock insured through its field staff who are adequately trained to assess the economics of cattle rearing and the insurable status of cattle. While this arrangement greatly simplifies the ease of insuring animals, great care has also got to be exercised by BASIX staff to ensure that proper controls are in place to ensure that no adverse selection of high risk animals happens. In the event of claim too, if the death certificate cannot be given by a doctor, an inspection and report from a field facilitator approved by the insurance company is considered for settlement of claim.

There have been other key issues which had to be addressed to make cattle insurance more attractive to rural customers:

- *Assessment of market value at the time of claim*: Traditionally, cattle insurance policies are indemnity based contracts, i.e. the claim amount paid is based on the market value of the animal at the time of death of animal. If the value of the animal is greater than the sum insured than only the sum insured is paid. It is known that the market value of milch cattle follows an almost cyclical path based on the reproductive stages that they go through. Thus if the death of the cattle due to any risk occurs when the market value is at the low end of the cycle, then the farmer has a considerable loss of future value. Besides, it is also difficult for the farmer to come to terms with the fact that while he has paid premium for a certain sum insured amount, he only gets an amount less than that. In order to overcome these situations, BASIX worked with Royal Sundaram to convert the policy to a full benefit policy, i.e where the claim paid is equal to the sum insured. To ensure that the principle of indemnity is not compromised, the cattle were insured for about only 80% of the animal value. This also ensured that there was an element of self insurance by the farmer, which would translate into better care of the animal.
- *Reducing adverse selection:* Avoiding adverse selection is major challenge in livestock insurance. A field worker who is not too technically trained in veterinary science cannot easily assess

the exact health status of cattle from mere visual observation. To overcome this challenge, most insurance policies have a window period of 10-15days from the date of tagging after which the risk cover period commences. To further minimise adverse selection, customers are also sometimes incentivised to insure all the cattle in the household by providing a premium discount for insurance of multiple animals.

Since most of the lending in micro finance is not necessarily targeted at a single economic activity, most MFIs have not entered the space of insuring the livestock of their clients. Among those MFIs which do lend to specific activities like purchase of livestock, combinations of factors like:

- High premium rates (can range from 3-8% of insured value)
- Inordinate paper work
- Poor history of claims settlements and
- Issues related to adverse selection

deter them from making livestock insurance compulsory for their clients. Only in specific location where the above issues can be addressed, MFIs encourage their customers to take livestock insurance on a voluntary basis. BASIX has cumulatively insured over 40,000 livestock so far. In the recent two years, BASIX has also begun providing preventive vet care services on a fee basis under its Business Development Services (BDS) program. It currently has close to 50,000 customers who are availing these services. BASIX expects that the BDS services will result in reducing the risk and thereby reducing mortality of livestock owned by its customers. This would eventually translate into reduction of premium rates for livestock insurance, making it more attractive to enrol larger number of customers for livestock insurance.

Innovations in Agricultural Risk management

Agriculture is still the biggest source of livelihood for a majority of the households in the country. However, there is a huge amount of risk involved in agriculture as most farmers do not have assured sources of irrigation and the activity is prone to weather risks like inadequate rainfall. The traditional yield based crop insurance offered to farmers, which currently covers less than 20% of the farming community, suffers on the count of service levels and also its financial sustainability. Alternative models to manage crop risks are now being explored to find a more sustainable approach to managing agricultural risks. Index based weather insurance is now emerging as a promising alternative, as it is actuarially priced and promises timely claims payments to farmers as the claim payout is determined on a particular weather index which is measured on a daily basis.

As most of its customers are dependent on agricultural activities, BASIX undertook several research projects to provide cover for crop risks. These efforts culminated in collaboration with the Commodity Risk Management Group of the World Bank and ICICI Lombard to launch the first index based weather insurance in 2003 in Mababubnagar district of India covering 230 farmers in first pilot program. In subsequent years the index based weather insurance market India has scaled up covering more than 200,000 farmers. Today there are more companies offering weather insurance in India, including the government owned Agriculture Insurance Company. There are also challenges to be overcome to take weather insurance to a larger scale. One of them is to increase the network of weather stations in big way, so that rainfall measured in a particular weather station is better correlated to the actual rainfall in a particular farm. While efforts are underway to improve this infrastructure with the participation of private players like NCMSL apart from IMD, the real scale for weather insurance would come when it is tested as an alternative or to play a complimentary role with the NAIS (National Agriculture Insurance Scheme) with support from the government. The current year has seen some movement in this direction with the announcement of a 100 crore budget for the weather index insurance in the central budget and the recent circular issued by the Ministry of Agriculture in October, 2007, advising some of the states to replace NAIS with index based crop insurance in some selected locations during the Rabi season of 2007-08. With these developments, a unique model of agriculture insurance is now emerging in India.

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To further minimise adverse selection, customers are also sometimes incentivised to insure all the cattle in the household by providing a premium discount for insurance of multiple animals.

The author is Head - Insurance Business, BASIX.

Micro-Insurance In India

What Stimulation Does It Need?

'THE RURAL MASSES NEED A CONVICTION THAT BUYING INSURANCE IS MORE WORTHWHILE TO THEM THAN BEING WITHOUT IT' EMPHASIZES **G V RAO.**

Inculcating a habit among the rural masses to insure the assets, the lives and the health of their families has remained an elusive goal, notwithstanding the recent introduction of specialist insurance regulation that is very insurer-friendly. The task of mobilizing the efforts of insurance units to make this goal partly achievable has yet remained a non-starter. As the 'vantage point' in the previous issue of IRDA Journal says, 'the task is formidable but essential'. What misconceptions of the mental models and physical infirmities have been the hindrances to make even the smallest progress?

Each segmented market, including the rural one, has its particularized system of its specialist needs, values and beliefs, and a particular manner of responding to the stimuli that insurers provide it. Most of them have led their lives without insurance till now. The concept of insurance itself is new to them. The rural masses, therefore, need a conviction that buying insurance is more worthwhile to them than being without it. Who should take responsibility for it is the fundamental question?

The volumes of the likely consumer demands for insurance are likely to be large, if rural segment is brought into the insurance net; but the premium per policy for the supplier may not be quite high. Not cost per policy but margins on volumes should be the primary goal. It should be a long-term corporate strategy of the insurer to create a large future new market that has the potential to pay back in huge premium volumes, provided necessary investments in money, structure, manpower and customer education are undertaken right now. It calls for individualized selling and expects from the marketers an intimate knowledge of the product to be sold and a persuasive ability to carry proof and conviction. How does one build such internal organizational competencies? That is another question.

The article proposes to discuss a few issues concerning the insurance suppliers' reluctance to enter the rural fray and the unexplained, unwillingness of the intended rural beneficiaries to accept the ideas behind the initiatives of insurers. Development of rural markets is one of the avowed goals of Sections 32 B and C of the Insurance Act 1938. There is an element of mandated compulsion to develop an integrated system that includes the rural market. Insurers must keep this aspect in mind in making their annual marketing plans and long term strategies.

Need to understand rural markets

The value and belief systems of the rural people that are targeted for sale of micro-

The volumes of the likely consumer demands for insurance are likely to be large, if rural segment is brought into the insurance net; but the premium per policy for the supplier may not be quite high.

insurance products have to be understood and analyzed. One would also have to evaluate how their needs of 'insurance' are currently being met and from what sources and how much they are costing them now.

What kind of price-value proposition of insurers would make them consider a switch? How could the principle of insurance, wherein premiums are paid upfront for a promise of future financial delivery of an insurer, be sold as an acceptable proposition? Market research to understand the preferences of the rural prospects is required. Others like Hindustan Lever and ITC have made inroads into rural markets in a big way. One could learn a lot from the experiences of others.

What do rural markets need?

The insurance products to be sold have to be acceptable and must be useful alternatives to current sources of need; the premiums must be affordable, when the cost vs. benefits analysis is made. Since both the marketing process and selling the product are new to both, there have to be several nearby information and service centers that could provide information on the products, prices and claims services of insurers.

While these requirements are fundamental to the marketing process of an insurer; for developing a rural entrenchment, these alone are insufficient for sale of micro-insurance products. There has also to be an infrastructure for sales and service acceptable both to the buyers and sellers in place at the grass-roots levels, as visible demonstrations of serious intent of the insurance players.

Role of NGOs

NGOs are suggested by regulation, as one of the most important intermediaries for the insurance marketing process in the rural areas. While the NGOs usually are Good Samaritans, they are not experts in insurance marketing in which money is exchanged for a future financial contingent promise. How can they drum up consumer demand in the first place? What should insurers do to invest their money and time and a committed work force to develop a market environment that is conducive to selling micro-insurance products?

LIC has done a pioneering job in selling life insurance in rural areas. Its agency force has developed personalized relationships with its customers that are the envy of the developed life insurance markets. A life insurance agent is more than an agent; he is a family friend. His advice is sought on several fronts beyond life insurance. It is admittedly not possible to emulate such experiences nor is it cost effective. But the underlying truth should not be lost: trust and being available when needed are the key elements in the relationship.

Selling non-life insurance products, where there is no return of money paid needs more insurance education of buyers. It is insurance pure and simple and not a saving instrument or an asset. How can this information be effectively conveyed? Is there a choice for insurers other than the NGOs? Micro-insurance is not merely an insurance program to be marketed through NGOs but a movement of large expectations to be taken to its full potential. Only the vision of insurers can set limits on the movement.

Popularizing insurance as a habit

Songs, slogans and slide shows should spread the message of what micro-insurance buying can do. Organizing public meetings at which celebrities could participate is another. Insurance selling should not merely be regarded as a program to sell insurance covers but must be regarded as a movement to inculcate the habit of buying insurance to protect the assets and health of the families to cash in on the growing levels of rural incomes in the future.

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It is the inculcation of the habit of buying insurance that should be the primary goal and not the volumes or premiums that would take time to mine from it. Interested insurers must finance such programs as entry curtain raisers for their eventual entry. The soil must be prepared, the seeds have to be sown, the plants have to be nurtured before there can be a harvest. One should not expect a harvest without going through the whole process. The thinking and strategic habits of insurers need big changes first.

How should insurers start?

Another financial commitment that insurers should be prepared to initially make is in the creation of rural health facilities as a model for the rural folk to copy from by demonstrating the usefulness of running healthcare clinics. It is reported that under the scheme called Integrated Management of Childhood Illness (IMCI) protocol, a nurse can be trained in 11 days to complete a diagnosis of a child suffering from pneumonia and diarrhea guided by a flow chart that leaves little room for discretion; and come to the same conclusion as qualified physicians.

Developing new competencies in rural insurance marketing, creating a sustainable infrastructure and raising market awareness for its brand name does require investments in funds and manpower and innovation.

It is reported that in Bangladesh there are about 4500 villager-volunteers that are trained to perform such duties from among the villagers themselves to provide remedial medical advices. It is cited as an example of turning the doctor's arts into a routine program. It can be done in a hut not far from even a hospital.

Funding apart, the diagnostic process alone does not mitigate the difficulties of the medical volunteers, as it is up to the patients and clients to accept the precautionary advices given by them. Superstition is another competition for the acceptance of such advices in addition to the quacks that abound locally. The dissatisfaction of patients when they leave clinics empty handed without medicines is another. Old habits die hard and their eradication needs time, patience and adequate proof. What then are the alternatives?

The question for insurers is: if they should not be funding such beneficial activities in their selfish interests of the future and as an act of their corporate social responsibilities? At least they owe themselves to work out a proposal on a pilot basis in a few selected villages that offer more potential for business.

Developing new competencies in rural insurance marketing, creating a sustainable infrastructure and raising market awareness for its brand name does require investments in funds and manpower and innovation. Insurers should not be shying away from what is expected of them as an integral part of their business strategy.

Innovate solutions

Insurers should work through NGOs in close collaboration. They should become joint owners of health care initiatives. They should work with the villagers to sharpen their elbows and to strengthen their hands, so that they demand what they need and insurers and the NGOs arrange to get what they need. Purchase of medicines and setting up medical clinics can be subsidized through intervention of manufacturers of drugs and the NGOs that know how to negotiate. Negotiate favorable deals with the nearby hospitals for in-patient treatment. Using the healthcare facilities provided for by the Govt. to its full potential is another activity.

Community co-operation and the necessary spirit need to be engendered by interested insurers themselves. Understanding Govt. health policies for the rural poor and enabling the selected NGOs through whom insurers can work to name and shame any misdeeds of officials is also a part of marketing. Becoming community champions for healthcare rather than perform as mere 'sellers of lazy insurance covers' should be the corporate goal.

Final word

Mining for rural insurance prospects, like mining for gold, takes a lot of hard work, patience and money. But one must know initially why and what for one is mining? Where and what to mine and what processes should be used in pursuit of it. But long used to ready markets, where organized buyers of insurance knock on the doorsteps has made the non-life insurers lethargic and less motivated.

Now with rates detariffed and with competition levels rising from many more new entrants, the first searchers of new market space would have the first advantage. To quote CK Prahlad, 'the bottom of the pyramid is large and long; and is currently un-served and under-served.' With 95 percent of Indian population outside the non-life insurance safety net, insurers have a huge challenge and a big opportunity. Looking for opportunities for growth in unexploited markets is a challenge in itself at the best of times.

Micro-insurance business makes it a good commercial proposition to insurers. It would in addition give them even a bigger challenge of developing insurance buying habits among the uninsured public, which is why the markets were originally liberated in 2000 with further tough competition coming sooner.

Selling micro-insurance products in rural areas must be visualized by insurers as not only a commercial activity of theirs but also one that is imbued with a sense of corporate social responsibility. There is no other field that offers both the objectives in one go as the sale of micro insurances.

The author is ex-CMD, Oriental Insurance Company Limited.

Promoting Microinsurance through Capacity Development

MIRC – A New Initiative of Stakeholders

'IF MICROFINANCE CAN HAVE A SALUTARY EFFECT ON THE INCOMES OF THE POOR, THEN MICROINSURANCE CAN HAVE A BENEFICIAL OUTCOME ON PROTECTING SUCH GAINS' AVERS **R N K PRASAD.**

Key risks such as illness, death, natural catastrophes, loss of property etc., confront the rich and poor alike, but their economic impact on the low income population is much greater and can rapidly erode their hard earned incomes and push them back into poverty. And for over 70% of Indian population living in villages, these shocks are known to be frequent resulting in depleted household resources, loss of income and assets, increased indebtedness and quite often untreated health problems. While commercial insurers have managed to reach several million households in the urban areas their outreach, as far as rural and marginalized population go, has been very limited for a variety of reasons.

Microinsurance is a valuable vehicle to reduce the vulnerability of the poor and protect them against specific insurable risks. Microinsurance is a specialized risk protection solution for the low income market in relation to its cost, terms, and coverage and delivery mechanisms. Efficient and cost effective delivery of micro-insurance requires specialized skills and institutional capacity in the grassroots-level organizations such as MFIs, NGOs and healthcare providers; and nuanced understanding of risk mitigation needs of the poor by commercial insurers and the regulator. Successful micro-insurance programs also require a comprehensive database. If Microfinance can have a salutary effect on the incomes of the poor then microinsurance can have a beneficial outcome on protecting such gains. In India, to date, microinsurance efforts had mostly focused on credit, life etc. and less in other general areas and far less on health areas. However, as a distinct risk protection mechnisim, microinsurance sector is receiving greater attention and is seeing heightened activity from MFIs, NGOs, international donors and the Commercial Insurers. With over 90% exclusion rate and several million of those excluded falling within 'insurable' range; the potential for microinsurance is huge in India. Effective regulation, affordable products, low cost distribution and systems, increased skills, sound knowledge and better consumer awareness can all help in converting the current latent demand to a potent demand for

With over 90% exclusion rate and several million of those excluded falling within 'insurable' range; the potential for microinsurance is huge in India.

microinsurance. However, microinsurance faces several demand and supply driven barriers that arise from:

- Attitudes and affordability of the vast majority of the people;
- Pricing and product design due to several reasons, principally lack of cohesive and reliable data on insurable population and assets;
- Inadequate technical knowledge and inappropriate skills
- High distribution and service costs; and
- Poor consumer awareness and knowledge.

Microinsurance Resource Center (MIRC) has been set up by India's leading microfinance organizations and health care NGOs with the necessary help from USAID. ***The overarching theme of MIRC is knowledge development, knowledge management and knowledge sharing***. MIRC has broad geographical spread with its membership coming from across several states in India and the combined outreach of its members is over 2 million beneficiaries. With assistance from an international consulting organization BearingPoint, Inc. and the donor USAID; MIRC has been able to deliver its initial programs on a pilot scale that demonstrated to its members the feasibility of a member managed resource center for all stake holders of the microinsurance sector.

Key Partnerships. MIRC is in dialogue with several stakeholders of the microinsurance sector to establish key partnerships that would foster the development of microinsurance and build necessary capacities with its member organizations and enhance consumer awareness on microinsurance. Given the relative complexity of microinsurance for various risks, MIRC will principally focus on health microinsurance and related risk mitigation programs. MIRC has established necessary relationship with international donors like USAID, CordAid and GTZ, with the first two having already committed to support MIRC with financial grants for a 3 year capacity development initiative. Besides, MIRC intends to work with potential partners such as:

MFIs and NGOs. MIRC is a resource center established by MFIs and NGOs for the benefit of all MFIs and NGOs wherever they are located. As one of the main channels for the delivery of microinsurance and the MIRC programs, MFIs and NGOs will have a large role to play in the development of microinsurance sector and MIRC intends to work with them in building their internal capacities for microinsurance, technical skills and knowledge and generally assist them in enhancing the public awareness on microinsurance.

Insurers. MIRC intends to work with insurers in enabling a cost effective product design, delivery and service of microinsurance to several million beneficiary clientele through well empowered and trained MFI and NGO network of members.

Healthcare Providers. MIRC intends to establish key partnerships and build a network of providers; and in conjunction with them develop standardized treatment protocols, best practices and standardized pricing to enable affordable care and its financing through insurance.

Insurance Regulator and Policy Makers. MIRC intends to work with the regulator and other policy groups in enabling a sound policy direction, building a vibrant microinsurance sector, promote best practices and standards; and in integrating microinsurance with other social security measures of the State and the Central Government.

Donors. MIRC intends to leverage significant resources offered by donors and directing the technical assistance to beneficiary groups in achieving desired social and economic impact in the field of microinsurance.

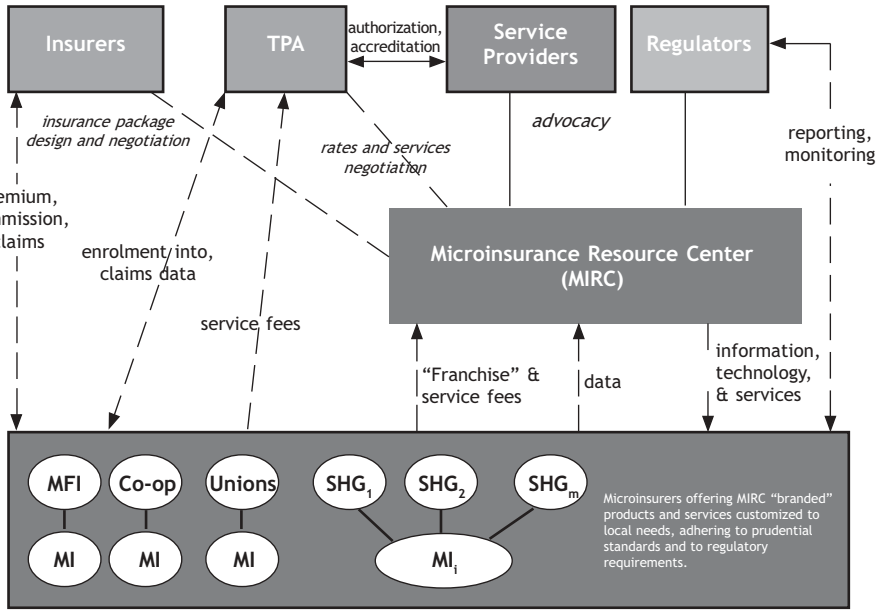
The Concept and the Activities of the MIRC are primarily driven by an analysis of stakeholder needs. The overall objective is to provide institutional support to take insurance to masses. Increased penetration of insurance across regions and income groups is intended to be achieved through building institutional capacity of grassroots-level organizations, providing access to insurance and actuarial services at affordable cost by these organizations, developing warehouse of insurance data and information including data analysis and research facility; and promoting consumer awareness about insurance.

MIRC will provide through its international and national consultants and its own staff

MIRC's initiatives so far

- An institutional gap analysis of current micro-insurance programs of some of its members.
- Development of micro-insurance performance standards for self evaluation of risk and financial management practices, operational efficiencies and client satisfaction by its members.
- Standardized microinsurance data templates and development of a pilot data repository to demonstrate the benefits of data pooling and data sharing to the members.
- A field survey of about 5,000 households in Andhra Pradesh and Orissa to understand issues in insurance access and awareness.
- Development of a long-term business plan for transformation of MIRC into a full-scale resource center.

MIRC - The Concept



the following sector focused and member services that will address the current identified gaps to foster the overall development of microinsurance sector.

Around the world, the inept responses of governments towards addressing the social protection needs of the poor led to the popularization of microinsurance as an alternative solution. As a risk management strategy, microinsuance shows a great promise for the low income population in India. However, the penetration of microinsurance is extremely low. Several demand and supply side challenges have been impeding this sector and for some time, the stakeholders and the donors agree that knowledge development, knowledge sharing and increased coordination amongst various stakeholders would greatly contribute to the microinsurance development in India. This is especially true for health microinsurance, for which few (if any) truly sustainable programs have been observed to date. The market potential for microinsurance is huge in India and it is very likely that the largest microinsurance sector in India will emerge over the next few years. However, currently the sector is in steep learning curve and will require huge amounts of investments in research, technical support, information exchange and consumer awareness. Centers like the MIRC with support from international donors and key partnerships with national institutions are suitably placed in providing this capacity development and become a catalyst for the development of the microinsurance sector.

	SECTOR DEVELOPMENT SERVICES
1.	**Microinsurance statistical service and knowledge-bank**- data generated from members' microinsurance operations databases will be cumulated and used to produce critical industry and actuarial information for pricing of microinsurance products.
2.	**Performance indicators and benchmarking-** performance indicators developed for the pilot project will be used for benchmarking microinsurers' performance in an effort to elevate the industry's standards of performance.
3.	**Documentation of good and bad practices**- in a young industry it is critical to continuously document good and bad practices as well as the innovations and lessons learned.
4.	**Communication and dissemination** of industry knowledge.
5.	**Network of healthcare providers** will be developed which follow standard treatment protocols, standards of quality, and agreed upon tariffs for services. This will reduce costs for services and improve quality of care for the poor.
6.	**Policy development**- MIRC will coordinate with and support organizations engaged in policy development. The statistical service will be a great source of information for policy development.
7.	**Consumer awareness** - MIRC will continue to build on pilot research being conducted to understand microinsurance consumer awareness, and will develop communications strategies to build awareness.
	MEMBER SERVICES
1.	**On-demand statistical service for members** - additional statistical services for practitioners such as disease prevalence profiles of families by area of operation.
2.	**Microinsurance implementation** - comprehensive package of services for microinsurance development including demand research, product design, actuarial services, operations training, forms and operations manuals, MIS setup, etc.
3.	**Microinsurance product enhancement** - similar to implementation services.
4.	**Microinsurance training and capacity** building of practitioners.
5.	**Develop MIS, risk management and actuarial software tools** to assist with data capture and for management of the microinsurance programs.
6.	**A microinsurance diagnostic review and rating service of practitioners** to identify strengths, weaknesses, training needs, etc.

The author is a practicing Chartered Accountant and a Management Consultant; and General Secretary, MIRC.

Prescriptions for a Healthy System

Micro Health Insurance

MUKTI BOSCO ARGUES THAT THIS IS THE TIME FOR ALL THE STAKEHOLDERS TO BE CONVINCED THAT THE SERVICE ELEMENT IN MICRO HEALTH INSURANCE IS VITAL, IF THE INITIATIVE IS TO EMERGE SUCCESSFUL.

As more and more players come into the healthcare sector, and as this sector gains impetus; and with that more management input, well-researched organisation, and increasing funds, it might seem that the answer to the vast challenge facing the sector is in increased efficiency. Instead, it is the argument of the author that this is exactly the time for all players in the sector, including the regulators, to remind themselves about the service element that is essential, indeed, critical. In this article, we take the lessons learnt from our experience in this sector in Healing Fields Foundation (HFF) over the last four years, and seek to apply these insights to the sector in general.

It is a truism that with the huge gap between requirement and coverage in the healthcare sector, there are three challenges facing us - coverage, effective service delivery and a payment system. Within this, insurance has a key role to pay. Given that the overwhelming bulk of the population resides in rural and forest India, and given that this part of the population is not within the magic circle that buys shiny big cars, micro health insurance is a major component of the required health insurance volume of funds.

However, surprisingly, this is not the major factor in the Indian health care sector. There are two, maybe three other factors.

Players in this industry cannot take an easy line and come out on top. An enormous amount of concept propagation and publicity (Awareness creation/capacity building) has to be conducted. While this is costly and time-consuming, it is extremely important for optimum utilisation of the programme that the poor and vulnerable pay through a lot of sacrifice with the hope that it will be useful in times of need and emergency. While this practice is under constant pressure of elimination, to cut cost and time, it took steely nerves and a strong sense of self-belief to resist such pressures. Today, this element of training and propagation of the idea is an integral part of the process, and is one of the hallmarks distinguishing HFF practices from other parallel bodies of practice which have been seen to be one of the reasons for our processes turning out to be slow but successful.

Now a careful definition of a product ensures that the population being serviced gets coverage for the medical conditions identified, while the insurer has a reasonable expectation that the costs involved will be covered by the premia paid and the health provider knows what he will receive for treatment provided.

The second factor that stands out at this juncture as a strategic process which requires attention and nursing is the service factor. Let us try to understand it by taking note of obvious factors which have been identified, but which by themselves or in combination still do not make the difference between success

An enormous amount of concept propagation and publicity (Awareness creation/capacity building) has to be conducted.

There is a real need to ensure that the trust and understanding of a community for its healthcare institution of choice is preserved, and that there is no suspicion of ill-treatment of patients, either due to medical incompetence or due to excessive greed.

of a programme and failure. The difference is the service that we believe we have provided.

The importance of the health-care delivery mechanism, which triggers the insurance mechanism at the time of illness and allows it to be deployed as visualised, is also understood. Again, there are gaps between this broad level of understanding and its useful implementation at field level. A careful rating and evaluation of health-care providers is needed, and again, it is important to have a systematic and rational process which will measure the suitability of a health-care institution for playing a role in this entire eco-system.

This feature ensures that the health-care giver is efficient, both medically and in terms of operating efficiencies and consequently, of costs. As a result, the covered population has a reasonable hope of receiving quality care, while the insurer may expect costs of this level of care to be commensurate with the effort and to be affordable within the premium envelope.

Given that the product has been tuned to the requirements of the population in the specific area covered, and given that health-care institutions have been selected carefully; to enlist only those which are effective, it remains to establish a consensus on the implementation of the scheme. Healing Fields has had success by having at its disposal statistical information, and evaluation methods which enable pre-negotiated expenses for specific covered medical conditions to be negotiated. These pre-negotiated rates ensure that the compact between the target population and the insurer is out in the open, transparent and explicit.

With this, all parties are given reasonable assurance of achieving the goal: the patient/insured community member has a hope of receiving good treatment coupled with the facilitation service at the time of need; the hospital knows it will get paid without delay and will benefit if it keeps its efficiency and medical competence at a high level; and the insurer will have the possibility of a viable business, provided that there is no collusion between patient and healthcare institution or no misuse from the health care institution itself…

Is this then sufficient to make the model perform? Not quite: there are other closures to be achieved. For instance, there is a real need to ensure that the trust and understanding of a community for its healthcare institution of choice is preserved, and that there is no suspicion of ill-treatment of patients, either due to medical incompetence or due to excessive greed. The health care provider being assured of timely payments for quality treatment provided to our clients and, on the other side, we need to get the insurer's confidence, through a clear and transparent process of risk mitigation, conducted by a trusted partner in the system.

By intervening in these areas, the area of interfacing at time of need between health-care institution and insured, and the inspection of claims made by the health-care institution at the end of a course of treatment, or at a logical point therein, to ensure responsibility and an ethical recognition of treatment costs; it is possible to make a significant and qualitative difference not only to the process but also be able to take quality healthcare to the poor and vulnerable and make a difference in their well-being thereby reducing man-days lost in illness and disease. This conclusion, that there was a significant difference, was not accidental, or subjective. Rather, such intervention has led to a visible and significant improvement of those parameters which demonstrate that a population has recognised integrity and worthwhile qualities in a process; and is willing to extend it further, based on a good experience.

The micro-health insurance industry at this early stage of its development is capable of making giant steps forward by cooperation within and outside the industry. Very often, individuals and organisations confuse this need for cooperation with a drive to duplicate and imitate. Creating many examples of identical organisations or systems is not apparently effective. The same defects in organisation and in financial structure, or in regulatory inhibition, will thereby be multiplied and proliferated. Instead, by associating with dissimilar organisations or entities, it is possible to achieve a bringing together of the best aspects of different approaches, and to tap into different layers and different kinds of expertise. This will ultimately create a strong and capable industrial line-up, able to handle the foreseeable rapid developments and changes in the operating environment with confidence and without compromising its commitment to work for the vulnerable sections whose interests lie at the core of their existence.

The author is Founder Secretary General, Healing Fields Foundation, Hyderabad.

Creating Consumer Awarenes

LIFE INSURANCE

THIS ARTICLE IS BASED ON THE SPEECH GIVEN BY **MR. G. PRABHAKARA** AT THE C.D. DESHMUKH SEMINAR AT NATIONAL INSURANCE ACADEMY, PUNE.

In his address to the nation on the eve of nationalisation of life insurance industry, the then Union Finance Minister, Shri C.D. Deshmukh emphasised the need for insurance awareness to the rural masses in the year 1956 itself. To quote from the text "*Into the lives of the millions in the rural areas, it (the nationalisation of life insurance industry) will introduce a new sense of awareness of building for the future in the spirit of calm confidence which insurance alone can give.*" The subject of consumer awareness deserves to be discussed in the present changed environment.

Changing paradigms

The convergence of financial markets is changing the dynamics of life insurance business. A few decades ago, the concept of opting for pure term insurance products with the objective of investing the balance in securities and stock markets was prevalent in certain developed markets. That itself was considered as a hedge against inflation at that point of time. What was considered as a practice in a few advanced markets seems to be becoming reality in the Indian context. With the opening up of the insurance sector, the life insurance market is gradually transforming itself by attaching priority to capital market-linked products over the traditional endowment products. The total unit linked funds under the management of all life insurance companies has grown from Rs.664 crore in 2002-03 to a whopping Rs.64720 crore in 2005-06 i.e., a growth that is nearly hundred fold. As per the provisional figures for the year 2006-07, the New Business premiums mobilised under Unit Linked policies is a whopping Rs.42,912 crore (previous year Rs.22,152 crore) constituting 57% of the total premium This is indication enough of the rapid transformation of life insurance business. However, this development, frankly speaking, cannot be attributed entirely to the presence of proper awareness or understanding of life insurance. There have been reports that capital market linked products like mutual funds and ULIPs were misunderstood as direct investments in stocks and shares of companies in mofussil areas while investing in their NFOs/new product launches. Misunderstanding of this nature on many aspects of innovations in life insurance continues to be widely prevalent. This situation together with the fact of increased product choice identified the need for inculcating consumer awareness. The issue of consumer awareness has a deeper significance in emerging markets as economic growth outweighs the social growth due to absence of awareness levels on the financial tools like life insurance. Changed

The issue of consumer awareness has a deeper significance in emerging markets as economic growth outweighs the social growth due to absence of awareness levels on the financial tools like life insurance.

On their part, insurance companies need to take policy services to the doorsteps of the rural folk to create awareness amongst them.

business styles of life insurers reach the customer faster than the required social changes like insurance education.

Need for creating consumer awareness

Creating awareness on intangible financial services like life insurance is a challenging task. There are two facets to life insurers with reference to the need for creating life insurance awareness. One is business interests and the other is as part of their overall corporate social responsibility. Life insurance is considered as one of the social security tools. Absence of supporting systems on the happening of the contingent risk event may jeopardise the social interests. Life insurance, being the business of large numbers can effectively provide the protective solutions through risk sharing and risk spreading mechanism. Hence, life insurers need to take up the task of creating awareness as part of their corporate social responsibility. With reference to business interests, awareness is an ingredient that enhances the acceptance levels of the life insurance products. The higher awareness levels of targeted market segment prompt life insurers to go in for innovation of products and as a cyclical effect, products designed by life insurers would be accepted across the market. Thus, it is widely accepted that awareness of the need for services like life insurance, their availability and affordability increase the business prospects of life insurers. Awareness could also be regarded as one of the ingredients of infrastructure to the financial markets that support the financial inclusion programmes of governments wherein life insurance deserves to be an integral part. As part of these financial inclusion programmes, microinsurance competently fits to be propagated in the targeted market segments.

Lack of understanding on the available financial services avenues could not transform the age-old luxurious spending patterns in some pockets of the society, leading to over-indebtedness at times, with no provision for old age and health management. It applies to the younger generation whose expenditure levels are high. With a significant young population, our country deserves a special attention to inculcate the financial discipline/saving culture through awareness programmes amongst these sections. With insignificant coverage of pension plans, covering a paltry 10% of the families under occupational pensions, imparting awareness about annuities will reduce the burden of overdependence in the coming decades. Insurance covers the risk of living too long as well. Same is the case with reference to provisioning for health management of individuals. With hardly 1% of population covered under health insurance covers, awareness campaigns need to focus on providing for proper health management as well.

Insurance awareness

Awareness is more a broader concept than education. Education may not necessarily create the required awareness. In a multifaceted society like India where socio-economic factors are predominant, inculcating awareness/values on concepts like life insurance deserves to be taken up on a different footing by adopting a targeted and subjective approach while carrying forward the task of creating consumer awareness amongst different sections of society. Life insurance requirements of rural masses significantly differ from those of the urban population and so does their premium paying capacity. While a section of urbanites discard the risks under the notion of their capacity to absorb them, the rural masses do not prioritise their needs due to other social factors. Since time immemorial, Indian society integrated itself with concepts of social care thereby creating a web of internal security. However, the rural dwellers need to be taught that the changing life styles require every individual to provide a supporting security solution to their families on their own. The option of customising insurance solutions to their local needs through microinsurance deserves to be within the ambit of their knowledge. A majority of rural population tends to rely on the advice of their chieftains. Identifying a cluster of units and its headmen; and imparting the necessary insurance education through them in the form of street dramas, videos and sponsoring documentaries in televisions etc. will help in raising the awareness levels of life insurance. However, enough care may be taken to see that these do not turn to be commercial advertisements, as that may be viewed as tools meant to exploit their wealth. On their part, insurance companies need to take policy services to the doorsteps of the rural folk to create awareness amongst them. Disbursing claim cheques at village level meetings and letting the beneficiaries' share their

experiences will work in favour of the companies. Conducting the worksite workshops, customising insurance solutions to the needs of urban segments etc. would create the desired awareness amongst the urban segments. Creating awareness shall be a continuous process even among those who are already insured.

Insurance intermediaries also play a pivotal role in creating awareness. Despite the development of alternate distribution channels, individual insurance advisors are bound to continue to rule the roost in rendering advisory services on the life insurance front. These intermediaries need to be educated to impart the required awareness in the targeted market segments.

Role of stake holders

The role of government is evident in entrusting the developmental responsibilities to the regulator IRDA, a unique role model to a regulatory body. Development could not be avowed without creating awareness. Social concepts like insurance need to be cultivated from the primary stages of one's life. Introducing insurance as part of the curriculum at the early academic stages motivates the mindset in favour of these conceptual issues. This aspect merits an immediate attention. On its part IRDA, while discharging its regulatory duties adopts a balanced approach by designing the regulatory framework without disregarding the developmental responsibilities. To ensure that the results of growing life insurance market reach the hinterland, regulations on rural and social sector obligations were framed that mandate all life insurers to procure a certain percentage of business from rural areas. Microinsurance regulations pioneered the concept of retailing the life insurance to those segments of markets which were not regarded as potential business pockets. These development-oriented regulations are expected to drive the focussed business approach of life insurers which in turn would help in creating the consumer awareness in the targeted market segments. As expressed earlier, the role of insurance intermediaries is paramount in creating insurance awareness, as these advisors identify and meet the prospects at their doorsteps. An enlightened insurance advisor carries forward the mission with commitment. With this objective, IRDA put in place mandatory training norms and pre-licensing exam requirements for all insurance intermediaries. As part of inculcating insurance awareness, IRDA also launched programmes in Doordarshan and All India Radio that paved the way in increasing the market share of all insurance companies.

Insurance councils as representatives of industry have a role to lead the awareness campaigns. It is believed that the mission statement of Life Council includes 'spreading insurance awareness' and hence there is need for the councils to initiate steps in this direction. The events sponsored by individual companies may be viewed as commercial campaigns to promote the products and their relative impact may vary from that of generic awareness camps run by industry associations. Insurance councils may take up the task of running the generic awareness camps across the country, periodically, by roping in the services of Non Government Organisations and social development portals.

Conclusion

Consumer awareness ensures an effective market discipline as consumers take an informed decision. It could also be regarded as one of the safety nets available to the insurance companies against reputation risk and to regulators against market conduct risk of life insurers. A majority of the new generation insurance companies are in the process of expanding their operations to the nook and corner; and creating awareness should form part of their overall marketing strategy rather than selling insurance products perforce. In the final analysis, it is essential that all the stakeholders of the insurance industry need to carry forward this task as a movement collectively.

The role of insurance intermediaries is paramount in creating insurance awareness, as these advisors identify and meet the prospects at their doorsteps.

The author is Member (Life), IRDA. The views expressed in the article are purely personal.

प्रकाशक का संदेश

भारत में बीमा या तो कर वाहनों से अथवा वित्तिय ऋणदातों से संचालित होता है। बीमा किसी आपदा से आवरण के लिये अपेक्षाकृत नया है। यह केवल अब हुआ है जबकि लोग यह अनुभव करने लगे हैं कि बीमा का मूल्य परिवार की आय, किसी की रोटी कमाने वाले की मृत्यु की स्थिति में कितना है। यह स्थिति उच्च तथा मध्य आय वर्ग की है। गरीब लोग तो बीमा की परिधि से पूर्णतः बाहर हैं। वास्तव में यही वे लोग हैं जिनको बीमा की सर्वाधिक आवश्यकता है क्योंकि उन्होंने अपने जीवन काल में ही संपत्तियाँ तथा स्वास्थ्य को स्थापित किया है। यह साधारण ज्ञान है कि गरीब लोग अधिक खर्च करने के लिये बाध्य हैं कुल आय के प्रतिशत के अनुसार अथवा स्वास्थ्य सेवाओं पर। अस्वस्थ्य पूर्ण वातावरण जिसमें वे रहते हैं, संतुलित भोजन पर पहुँच न होना तथा उनके कार्य का वातावरण उन्हें बाध्य करता है कि उनका अस्पतालीकरण हो तथा वे बड़े अस्पताल में बिल देने के लिये विवश होते हैं।

समाज में बड़े पैमाने पर ऐसे सुभेद्द वर्ग से संबंध रखने वाले लोग ऐसा एक ऐसी व्यवस्था जिससे वे ऐसे परिदृश्य को बदल सकें कि आवश्यकताओं की जरूरत महसूस नही करते। परिणामस्वरूप ये लोग अपनी संपत्तियों को बेचने पर मजबूर हो जाते हैं अथवा अतिब्याजी ऋण देने वालों की चंगुल में फँस जाते हैं। ऐसी घटनाएँ उन्हें नष्ट करने वाले परिणाम पहुँचाती हैं। आगे अधिकांश परिवार एकल व्यक्ति की आय पर निर्भर होते हैं तथा ऐसे व्यक्ति की बीमारी या मृत्यु उनके जीवन को भी विकट बना देती है।

जबकि कई लोग जीवन अथवा स्वास्थ्य पॉलिसी को खरीदना एक खर्च समझते हैं जिसको दूर रखा जा सकता है। बहुत बड़ी संख्या में लोगों को इसकी उपलब्धता का ज्ञान नही है अथवा उचित दर पर इसे कैसे प्राप्त किया जा सकता है। बीमाकर्ता इपने स्तर पर इसे यह कह कर आगे बढ़ जाते हैं कि ऐसे वर्ग को बीमा बेचना लाभप्रद नही है। प्राधिकरण यह अनुभव करता है व्यावसायिक बीमाकर्ताओं के द्वारा माइक्रो बीमा द्वारा लाभप्रद व्यवसायिकता प्राप्त की जा सकती है। जिसकी आवश्यकता है वह है एक उचित नीति तथा एक ऐसा विनियामक वातावरण जो माइक्रो बीमा की गतिविधियों को उत्साह तथा प्रोत्साह प्रदान करती है। जब माइक्रो ऋण व्यावसायिक रूप से सफल हो सकते हैं तो माइक्रो बीमा क्यों नहीं।

आईआरडीए ने माइक्रो क्रेडिट परिधि में विकास को देखा है तथा विनियामकों को ठीक प्रकार स्थापित कर बीमाकर्ता को सुकर बनाया है जिसे माइक्रो बीमा उत्पादों को प्रोत्साह दिया जा सके इसकी अनुक्रिया काफी उत्साहवर्धक रही है। अधिकांश बीमाकर्ता अब माइक्रो बीमा को एक बाध्यता नही समझते जो उन पर थोपी गई है यह एक अवसर है, जिससे वृद्धि को बढ़ाया व बनाये रखा जा सके। ऐसा लगता है कि विनियामक ने उत्साह भर दिया है बीमाकर्ताओं के मध्य न केवल भारत में वरन् अंतरराष्ट्रीय बीमा समुदाय में भी। जिसमें विनियामक भी शामिल हैं।

जर्नल के इस अंक के केंद्र बिन्दु में माइक्रो बीमा है। भारत ऐतिहासिक रूप से कृषि प्रधान अर्थव्यवस्था रही है। बड़ी संख्या में तथा अधिकांश जनता आज भी कृषि कार्यों में संलिप्त है और इसके परिणामस्वरूप लहर की प्रकृति का अनुसरण होता है। जर्नल के अगले अंक के केन्द्र में कृषि बीमा होगा।

सी. एस. राव

सी. एस. राव
अध्यक्ष

"दृष्टि कोण"

एक विनियामक प्राधिकरण के रूप में शायद हम विश्व में पहले होंगे जो माइक्रो इंश्योरेंस विनियमन के साथ सामने आये है। यदि माइक्रो वित्त सफलता प्राप्त कर सकता है ऐसा कोई कारण नही है। माइक्रो बीमा सफलता प्राप्त नही कर पायेगा।

श्री सी एस राव

अध्यक्ष बीमा विनियामक विकास प्राधिकरण (आईआरडीए) भारत

आईएआईएस की मानक स्थापित करने वाली गतिविधि तथा इसकी भूमिका मानकों के अनुपालन को लेकर एक महत्वपूर्ण भूमिका वित्तिय स्थायित्व के लिये प्रदान करती है।

श्री मइकेल फ्लेमी

अध्यक्ष कार्यकारी समिति, अंतर्राष्ट्रीय एसोसिएशन बीमा सुपरवाइजर (आईएआईएस)

वित्तिय संस्थायें जमाकर्ताओं की रक्षा की उत्तरदायी होगी, पॉलिसीधारक या निवेशक से अपेक्षा की जाती है कि वे निगमित प्रशानस के उच्च मानक स्थापित करेंगे जिनकी तुलना अन्य कंपनियों से की जा सकेगी।

श्री लो क्वाक मुन

कार्यकारी निदेशक (बीमा प्रवेक्षण) सिंगापुर की मॉनेटरी एथोरिटी

बीमा कंपनियों को संयुक्त रूप से उत्तरदायी ठहराया जायेगा जो नुकसान उपभोक्ता को होता है। जो उनके विक्रय अभिकर्ताओं के कार्य के कारण होता है। उप्तप्रख्त बीमाकर्ता को किसी भूतपूर्व अभिकर्ता द्वारा किये गये कपट का नुकसान नही होना चाहिये।

सुश्री चन्त्रा पुर्नरिक्षा

थाइलेंड बीमा कमीशन की महासचिव

जागरूकता रखने वाले जो बीमा कंपनियों पर रूकावटें लगाते हैं क्योंकि ये पंजीकृत क्रेडिट कार्य कंपनियों के सदस्य होते हैं और इस प्रकार विधि को तोड़ते हैं कि क्रेडिट कार्ड भुगतान को स्वीकार करने से इंकार करने पर।

श्री पार्क बाउंग माउंग

निदेशक, दक्षिण कोरिया का बीमा प्रवेक्षण विभाग

हमारे सामने अनेक चुनौतियाँ है जिसमें बीमा उद्योग की वृद्धि तथा भौगोलिकता का बदलाव शामिल है। विनियामक समुदाय लगातार वित्तिय बाजार की आवश्यकतायें पूरी करता रहेगा। इसी समय प्रभावशाली रूप से व्यक्तियों तथा व्यवसायिक पॉलिसीधारकों को सुरक्षा प्रदान करता रहेगा।

श्री वाल्टर बैल

अध्यक्ष तथा उपाध्यक्ष एनएआईसी, आईएआईएस कार्यकारी समिति

खाद्य सुरक्षा मापदंड - खाद्य व्यवसाय की अधिसूचना देने की मांग

(केवल आस्ट्रेलिया) आस्ट्रेलिया और न्यूजीलैंड खाद्य मापदंडों की संहिता

पिछले अंक से आगे...

खाद्य सुरक्षा मापदंड - असुरक्षित खाद्य पदार्थों को वापिस बुलाने की व्यवस्था

खाद्य पदार्थों को वापस बुलाना की व्यवस्था किसे चाहिये?

थोक विक्रेताओं, निर्माताओं और आयातकों को खाद्य पदार्थों को वापिस बुलाने की व्यवस्था करनी चाहिये। खाद्य पदार्थों को वापिस बुलाने के कारणों में खाने को जहरीला बनाने वाले बैक्टीरिया या रसायनों या किसी बाहरी पदार्थ से खाद्य पदार्थ का दूषित होना जिससे काना खाने पर किसी को नुकसान पहुँच सकता है शामिल हैं।

यदि आप एक थोक विक्रेता, निर्माता या खाद्य पदार्थ के आयातक है तो आप के पास खाद्य पदार्थों को वापिस बुलाने की व्यवस्था संस्थापित अवश्य होनी चाहिये। जिसका आप बाजार से खाद्य पदार्थ को पुनः प्राप्त करने के लिये प्रयोग कर सकें जब आप के द्वारा दूसरे खाद्य व्यवसायियों या अपने ग्राहकों को भेजने के बाद यदि आपको यह पता चले कि वह खाद्य पदार्थ किसी प्रकार से दूषित है और खाने के लिये खतरनाक है।

यह मांग मापदंड 3.2.2 फूड सेफ्टी प्रेक्टिसेस एंड जनरल रिक्वायरमेंट्स में वर्णित है। आपकी वापिस बुलाने की व्यवस्था अवश्य हो लिखित रूप में होनी चाहिये और आप असुरक्षित खाद्य पदार्थ को वापिस बुलाते हुये लिखित कार्य प्रणाली का अनुसरण करे।

यदि आप का खाद्य सेवा या परचून का व्यापार है जैसे कि सुपर मार्केट, रेस्टोरेंट या दुकान हो तो आपको वापिस बुलाने की व्यवस्था नही चाहिये। जब तक कि आप एक थोक विक्रेता, निर्माता या आयातक न हो। थोक विक्रेता, निर्माता या आयातक सुपर मार्केट में बेचे गये खाद्य पदार्थों को वापिस बुलाने के लिये उत्तरदायी है और रेस्टोरेंट और दुकान में खाना सामान्यतः तुरंत खाया जाता है इसीलिये वापिस बुलाना असाध्य है।

किन्तु खाद्य सेवा व परचून व्यापारियों को दूसरे व्यापार से वापिस बुला लेने में भाग लेना पड़ सकता है। ऐसे में ग्राहक द्वारा लौटाये गये वापिस बुलाये गये समान और वापिस बुलाये खाद्य पदार्थों की पहचान, भंडार और समाप्त करने की कुछ विशेष मांगे लागू होती है। इन मांगो की और अधिक इस तथ्य पत्रिका के भाग जिसका शीर्षक है वापिस बुलाये गये असुरक्षित, अनुचित और लौटाये गये खाद्य पदार्थ को निपटाने में है।

कभी कभी खाद्य व्यवसाय खाद्य पदार्थ को वापिस प्राप्त करने का निश्चय उन कारणों से भी लेते हैं जोकि खाद्य पदार्थ की सुरक्षा से संबंधित नही है, उदाहरण के लिये बांधने या लेबल में सख्ती और ये इसके लिये अपनी वापिस बुलाने की व्यवस्था का प्रयोग कर सकते हैं यद्यपि उनको ऐसा करने का कोई कानूनी वचन नही है।

रेस्टोरेंट और दुकान में खाना सामान्यतः तुरंत खाया जाता है इसीलिये वापिस बुलाना असाध्य है।

वापस बुलाने की व्यवस्था का उद्देश्य

एक वापस बुलाने की व्यवस्था अवश्य ही

- शीघ्रतिशीघ्र असुरक्षित पदार्थों की बिक्री व अगले वितरण को रोके।
- जन साधारण और संबंधित अधिकारियों को समस्या के बारे में बतायें और।
- प्रभावशाली रूप से असुरक्षित खाद्य पदार्थों को वापिस प्राप्त करें।

वापस बुलाने की व्यवस्था के मुख्य लक्षण

एक वापस बुलाने की व्यवस्था में निम्न मुख्य लक्षण होने चाहिये

- वापस बुलाने का उद्देश्य और वापस बुलाने के गुट के सदस्यों की सूची व उनकी जिम्मेदारियाँ ।
- संभावित असुरक्षित उत्पादों से संबंधित खतरों पर निर्णयों के दिशानिर्देशों के क्रमवार कदम।
- वापस बुलाने के विस्तार के निर्णयों के दिशानिर्देशों के क्रमवार कदम उदाहरण के लिये क्या उत्पादन पहले से ही परचून स्तर पर पहुँच गया है और उपभोक्ताओं को बेचा जा चुका है।
- उन अधिकारियों की सूची जिन्हें वापिस बुलाने के बारे में बताता है उदाहरण के लिये आस्ट्रेलिया न्यूजीलैंड फूड एथोरिटी और जिन राज्यों व क्षेत्रों में उत्पादन का वितरण हो चुका है यहाँ के कामनवेल्थ व राज्य व क्षेत्रिय मंत्री जो स्वास्थ्य उपभोक्ताओं के मामलों और न्यायमुक्त व्यापार के लिये उत्तरदायी है।

खाद्य व्यवसायों को खाद्य पदार्थ तैयार करने वाले क्षेत्र या जहाँ पर असुरक्षित खाद्य पदार्थ है वहाँ लोगों को सिगरेट पीना या थूकने से रोकने के लिये व्यावहारिक कदम लिये जाने चाहिये

- उन सब स्थानों का लेखा जहाँ उत्पादन भेजा जा चुका है उदाहरण के लिये थोक के व्यापारी, वितरण केन्द्र सुपर मार्केट, अस्पताल और रेस्टोरेंट ।
- उस जानकारी का लेखा जो दूसरे व्यवसायों और जन साधारण को सहायक होगी उस खाद्य पदार्थ को पहचानने व वापस लौटाने में जिस आप वापस बुला रहे हैं उदाहरण के लिये उत्पादन का नाम, बैच कोड, अंकित तिथि, वापस बुलाने का कारण, कहा खाद्य पदार्थ लौटाना है और अधिक जानकारी के लिये किससे संपर्क करें।
- सुपरमार्केट और अन्य विक्रय स्थलों पर लौटाये गये खाद्य पदार्थ को वापस बुलाने का प्रबंध करना और।
- वापस बुलाये गये खाद्य पदार्थों का कुल जोड और अभी बाजार में कितने हैं का प्रबंध।

खाद्य पदार्थ वापस बुलाने से संबंधित सहायता के लिये उपलब्ध दिशानिर्देश

ए एन जेड एफ ए से खाद्य पदार्थ वापिस बुलाने के दो दिशानिर्देश निःशुल्क मिलते हैं।

- द फूड इंडस्ट्री रिकाल प्रोटोकाल। अभी पुर्नविचाराधीन से आपको वापस बुलान के समय जो कुछ करना चाहिये उस के बारे में आपको सहायता मिलेगी और इसमें वापस बुलाने की व्यवस्था में कैसी जानकारी शामिल हो उसके बारे में अधिक विस्तार है।
- द गर्वनमेंट हेल्थ आथोरिटीस फूड रिकाल प्रोटोकाल में खाद्य पदार्थ वापस बुलाने की दशा में सरकारी जिम्मेदारियों की रूप रेखा।

वापस बुलाये गये असुरक्षित अयोग्य या वापस लौटाये खाद्य पदार्थ का फेंकना

सभी खाद्य व्यवसाय अवश्य निश्चित करें कि जो खाद्य पदार्थ वापस बुलाया गया है उसकी स्पष्ट पहचान हो और अन्य खाद्य पदार्थों से अलग रखा जाये। यह खाद्य पदार्थ को आकस्मिक बिक्री से बचाने के लिये है। आप इस खाद्य पदार्थ को अवश्य अलग से रखें जब तक खाद्य पदार्थ वापस बुलाने वाली कंपनी से आपको निर्देश नही आ जाते कि इसके साथ क्या किया जाये या यदि आपने यह खाद्य पदार्थ वापस बुलाया है तो जब तक आपने इसको फेंकने का फैसला नही किया।

अधिक जानकारी चाहिये?

मापदंडों की प्रतियाँ इनके निर्देश और अन्य तथ्य पत्रिकायें और सहायक सामग्री ए एन जेड एफ ए की वेबसाइट पर मिल सकती है।

जब यह मापदंड हर राज्य व प्रदेश में जारी हो जायेंगे तब खाद्य व्यवसाय सीधे स्थानीय परिषद के वातावरण स्वास्थ्य अधिकारी या अपने राज्य या प्रदेश के स्वास्थ्य या स्वास्थ्य सेवायें विभाग और लोक स्वास्थ्य खंडों से सलाह ले सकते हैं।

राज्य और प्रदेश के स्वास्थ्य विभाग व स्थानीय परिषदों के संपर्क का ब्यौरा एक अलग तथ्य पत्रिका फूड सेफ्टी स्टैंडर्ड सीरिज ऑफ इनफॉरमेशन एंड एडवाइस में है।

खाद्य सुरक्षा मापदंड- स्वास्थ्य और स्वच्छता खाद्य व्यवसायों के उत्तरदायित्व

खाद्य सुरक्षा मापदंड 3.2.2 फूड सेफ्टी प्रैक्टीसेस एंड जनरल रिक्वायरमेंट के अंतर्गत खाद्य व्यवसायों से आशा की जाती है कि यथासंभव निश्चित करे कि उनके खाद्यकर्मी और जो कोई भी उनके प्रागंण में आता है तो खाद्य पदार्थ को दूषित न करें।

खाद्य व्यवसायों की खाद्यकर्मियों के स्वास्थ्य, हाथ धोने की सुविधा प्राप्त कराने, खाद्यकर्मियों को स्वास्थ्य व स्वच्छता कर्तव्यों के बारे में बताने और खाद्यकर्मियों की गोपनीयता रखने के प्रति विशेष उत्तरदायित्व है।

निश्चित करना कि खाद्य प्रांगण पर लोग खाद्य पदार्थ को दूषित न करें

खाद्य व्यवसायियों को इस बात का ध्यान रखते हुये हर संभव व्यावहारिक कार्य करना चाहिये कि प्रांगण में जो लोग हैं खाद्य पदार्थ को दूषित न करें। इसमें खाद्यकर्मियों के अतिरिक्त वे लोग भी शामिल हैं जो उस प्रांगण में आते हैं जैसे कि व्यापारी और आम जनता। उन क्षेत्रों में जहाँ खाद्य पदार्थ खुले में रखे जाते हैं जैसेकि रखोई में, व्यवसाय जो कदम ले सकता है उनमें शामिल है:

- जो लोग खाद्यकर्मी नही है इन्हें खाद्य पदार्थों के कार्यक्षेत्र में आने से रोका जाये और
- जहाँ इन क्षेत्रों में दूसरे लोगों को आने के वैधानिक कारण हैं इन लोगों का यह ध्यान रखते हुये निरीक्षण करें कि वे खाद्य पदार्थों के संपर्क में आने वाली सतहों या असुरक्षित खाद्य पदार्थों के साथ काम न करें पर न छीकें न नाक साफ करें न खाँसी करें।

खाद्य व्यवसायों को खाद्य पदार्थ तैयार करने वाले क्षेत्र या जहाँ पर असुरक्षित खाद्य पदार्थ है वहाँ लोगों को सिगरेट पीना या थूकने से रोकने के लिये व्यावहारिक कदम लिये जाने चाहिये जैसे

- दीवारों पर सिगरेट पीना मना है के इश्तहार लगायें और यदि थूकना समस्या है तो थूकना मना है के भी इश्तहार लगायें और
- निश्चित करें कि इन क्षेत्रों में कोई धूम्रपान की तश्तरी न हो।

खाद्यकर्मियों का स्वास्थ्य और खाद्य पदार्थ के दूषण को रोकना

यह महत्वपूर्ण है कि जो लोग बीमार है या किसी दूसरी दशा से ग्रस्त है वे खाद्य पदार्थों और खाद्य पदार्थों के संपर्क में आने वाली सतहों के साथ काम न करें। यह विशेषतः जरूरी है कि यदि वे काम करते हुये खाद्य पदार्थों को दूषित कर सकते हैं।

यदि खाद्य व्यवसाय को पता हो कि खाद्यकर्मी या किसू अन्य व्यक्ति को जो व्यवसाय के लिए खाद्य पदार्थों के साथ काम कर रहा है। जैसे कि मित्र या रिश्तेदार। कोई खाद्य पदार्थ जनित बीमारी है तो व्यवसाय को चाहिए कि यह व्यक्ति खाद्य पदार्थों या खाद्य पदार्थों के संपर्क में आनी वाली सतहों के साथ काम न करे। खाद्य व्यवसाय इस बात पर

शक कर सकता है कि किसी व्यक्ति को खाद्य पदार्थ जनित बीमारी है यदि वे उल्टी, दस्त, बूखार, बूखार के साथ खराब गले से पीड़ति है।

यदि किसी व्यक्ति को खाद्य पदार्थ जनित बीमारी है और उसे खाद्य पदार्थों के साथ काम करने से बाहर कर दिया गया है तो वह व्यक्ति तब तक काम नहीं कर सकता जब तक कि डॉक्टरी सलाह से यह प्रमाणित नहीं हो जाता कि उन्हें अब खाद्य पदार्थ जनित बीमारी नहीं है।

यदि खाद्य व्यवसाय को पता चल जाए या शक हो कि खाद्यकर्मी या किसी अन्य व्यक्ति को व्यवसाय के लिए खाद्य पदार्थ के साथ काम कर रहा है, उसकी त्वचा पर घाव है या कान रिस रहा है या नाक, आँख से पानी बह रहा है तो खाद्य व्यवसाय को निश्चित करना चाहिए कि यह व्यक्ति खाद्य पदार्थों को दूषण से बचाने के लिए हर संभव प्रयास कर रहा है। उदाहरण के लिए त्वचा के खूले घाव को पन्नी और वाटर प्रुफ कपड़े से ढक देना चाहिए और इसे नाक के बहने को रोकने की दवा लेनी चाहिए।

खाद्य कर्मियों के लिए हाथ धोने के बेसिन

मापदंड 3,2,2 फूड सेफ्टी प्रैक्टसिस एन्ड जनरल रिक्वायरमेंट्स और मापदंड 3,2,3 फूड प्रेमिसिस एन्ड इक्विपमेंट दोनों में ही हाथ धोने की माँगें शामिल है।

खाद्य कर्मियों के लिए हाथ धोने का विवरण मापदंड 3,2,2 फूड सेफ्टी प्रैक्टसिस एन्ड जनरल रिक्वायरमेंट्स में है। इन मांगों को अधिक जानकारी के लिए आप अलग तथ्य पत्रिका - फूड सेफ्टी स्टेंडर्ड्स- हैल्थ एण्ड हाईजीन रेस्पोन्सिबिलिटिज ऑफ फूड हैण्डलर्स में देखें।

मापदंड 3,2,3 फूड प्रेमिसिस एन्ड इक्विपमेंट के अंतर्गत व्यवसायों को हाथ धोने के बेसिन अवश्य प्रदान करने चाहिए जो कि आसान पहुँच में हो और उस स्थान पर हो जहाँ कि खाद्य कर्मियों को हाथ धोने की जरुरत है। उदाहरण के लिए खाद्य पदार्थ तैयार करने के क्षेत्र में और शौचालय के पास। व्यवसायों को इस बात का भी निश्चय करना चाहिए कि बेसिनों में स्वच्छ चलते गर्म पानी की पूर्ति रहे।

इसके अतिरिक्त मापदंड 3,2,2 फूड सेफ्टी प्रैक्टसिस एन्ड जनरल रिक्वायरमेंट्स के अंतर्गत व्यवसायों को निश्चय करना चाहिए कि बेसिनों पर साबून या दूसरे साफ करने वाले पदार्थ प्रदान किए जाएँ और यह देखें कि कर्मचारी अपने हाथ अच्छी तरह से सूखा सकता है उदाहरण के लिए एक ही बार इस्तेमाल करने वाले कपड़े या कागज के तौलिए। यदि यह उचित हो तो वहाँ प्रयोग किए गए तौलियों के लिए एक डिब्बा भी होना चाहिए और व्यवसायों को यह भी निश्चय करना चाहिए कि बेसिनों का उपयोग हाथ, बाजू और मूहँ धोने के अलावा और किसी काम के लिए न हो।

खाद्य व्यवसायों के लिए स्वास्थ्य व स्वच्छता की अन्य जिम्मेदारियाँ

मापदंड 3,2,3 फूड प्रेमिसिस एन्ड इक्विपमेंट के अंतर्गत खाद्य व्यवसायों को निश्चित करना चाहिए कि कर्मचारियों के लिए उचित शौचालय है और उनके निजी सामान व कपड़ों के लिए अलग से रखने के स्थान हैं और कार्यालय के उपकरणों व कागजों और व्यवसाय द्वारा प्रयोग होने वाले रसायनों के लिए भी।

खाद्य कर्मियों को उनकी स्वास्थ्य व स्वच्छता की जिम्मेदारियाँ बताना

खाद्य व्यवसायों को अपने सभी खाद्य कर्मियों को स्वास्थ्य व स्वच्छता की माँगों को बताना चाहिए जो विशेषत: खाद्य कर्मियों पर लागू होती है। ये इसे विज्ञापन या पर्चे या उद्योग प्रशिक्षण विडियो का प्रयोग करके पूरा कर सकते हैं। ये माँगें मापदंड 3,2,3 फूड प्रेमिसिस एन्ड इक्विपमेंट के अंतर्गत हैं। माँगों की अधिक जानकारी के लिए तथ्य पत्रिका - फूड सेफ्टी स्टेंडर्ड्स - हैल्थ एण्ड हाईजीन रेस्पोन्सिबिलिटिज ऑफ फूड हैण्डलर्स में देखें। ये माँगें इस तरह से बनाई गई है जिससे यह निश्चित रहे कि खाद्य कर्मियों को दूषित न करने के लिए जो भी उचित हो करें।

खाद्य कर्मियों की गोपनीयता की सुरक्षा करना

खाद्य कर्मियों को अपने निरीक्षक को अवश्य बताना होगा यदि:

- वे जानते या शक करते हों कि खाद्य जनित बीमारी से ग्रस्त हैं।
- उसकी त्वचा पर घाव है या कान रिस रहा है या नाक, आँख से पानी बह रहा है तो खाद्य व्यवसाय को निश्चित करना चाहिए कि यह व्यक्ति खाद्य पदार्थों को दूषण से बचाने के लिए हर संभव प्रयास कर रहा है।
- उन्हें पता या शक हो कि काम करते हुए उन्होंने खाद्य पदार्थ दूषित कर दिया है।

यदि खाद्य कर्मी अपने निरीक्षक को ऊपरी किसी भी बात को बताता है तो निरीक्षक को खाद्यकर्मी की सहमति के बिना यह जानकारी सिवाय व्यवसाय के मालिक या खाद्य कानून अधिकारी के किसी को भी नहीं देना चाहिए। और खाद्य व्यवसाय भी इस जानकारी का प्रयोग खाद्य पदार्थ को दूषण से बचाने के लिए अलावा किसी और उद्देश्य से न करें।

अधिक जानकारी चाहिए?

मापदंडों की प्रतियाँ, इनके निर्देश और अन्य तथ्य पत्रिकाएँ और सहायक सामग्री एएनजेडएफए की वेबसाईट www.anzfa.gov.in मिल सकती है। जब यह मापदंड हर राज्य व प्रदेश में जारी हो जाएँगें तब खाद्य व्यवसाय सीधे स्थानीय परिषद के वातावरण स्वास्थ्य अधिकारी या अपने राज्य या प्रदेश के स्वास्थ्य या स्वास्थ्य सेवाएँ विभाग और लोक स्वास्थ्य खंदों से सलाह ले सकते हैं।

खाद्यकर्मी या किसी अन्य व्यक्ति को व्यवसाय के लिए खाद्य पदार्थ के साथ काम कर रहा है, उसकी त्वचा पर घाव है या कान रिस रहा है या नाक, आँख से पानी बह रहा है तो खाद्य व्यवसाय को निश्चित करना चाहिए कि यह व्यक्ति खाद्य पदार्थों को दूषण से बचाने के लिए हर संभव प्रयास कर रहा है।

लेखक श्री आर महेन्द्र, सलाहकार जीवन बीमा

बीमा विधि के कुछ महत्वपूर्ण पक्ष

एक नया दृष्टिकोण

डी वरदराजन कहते हैं कुछ कदम उठाये जाने चाहिये बीमा विधि को आधुनिक बनाते हुये उसे सही रास्ते पर लाने के लिये। यह बेकार की तथा अपर्याप्ता को हटाकर किया जा सकता है तथा एक आधुनिक तथा मजबूत बीमा विधि के द्वारा।

प्रस्तावना

यह एक सीधा तरीका है कि बीमा संविदा परम सदभाव के सिद्धांत पर आधारित है। इसीलिये यह बीमा के दोनों पक्षों पर बाध्यकारी है। वह है कि बीमाकर्ता तथा बीमाकृत परम सद्भाव बनायें रखेंगें। यह सभी प्रकार के बीमा पर लागू होता है। बीमा के बहुत से नाजुक तथा महत्वपूर्ण पक्षों के लिये जिनको बीमा अधिनियम 1938 के द्वारा शामिल किया गया है। उन्हें संविदा अधिनियम 1872 के साथ पढ़ना चाहिये तथा बाद के समय में न्यायपालिका द्वारा बताया गया है। (न्यायपालिका विधि बनाते हैं) यह प्रतिफल के लिये जानना योग्यतापूर्ण है। फिर भी जगह की सीमा को देखते हुये यह संभव नही है कि सभी नाजुक पक्षों से निपटा जाये। इसीलिये केवल कुछ महत्वपूर्ण पक्षों पर यह चर्चा की जा रही है।

प्रकटन का कर्तव्य

जब किसी पॉलिसी का प्रस्ताव किया जाता है यह विधि सम्मत रूप से अपेक्षा की जाती है कि प्रस्तावकर्ता उन सभी प्रश्नों का उत्तर सही देगा तथा कोई भी भौतिक सूचना को गलत रूप से सामने नही रखेगा। किसी भी बीमा संविदा में बीमाकृत बीमाकर्ता के प्रति एक कर्तव्य रखता है कि वह सभी भौतिक सूचनाएँ तथा तथ्य प्रस्ताव पत्र में प्रस्तुत करेगा। जब बीमाकर्ता किसी प्रश्न के गलत उत्तर देगा तथा उसके अनुसार बीमाकर्ता को जोखिम स्वीकार करने के लिये सहमत करेगा। संविदा अयोग्य हो जायेगी। यह व्यवस्थापित विधि है फिर भी जैसा कि बाद में देखा गया है कि कई बार यह उपभोक्ता फोरम द्वारा स्वीकृत नही हो पाता यह किसी प्रसंग विशेष में सहायता प्रदान करने के लिये होता है।

बीमा अधिनियम 1938 की धारा 45

बीमा अधिनियम 1938 की धारा 45 जीवन बीमा व्यवसाय को संचालित करने के लिये कुछ बचाव प्रदान करती हो बीमाकर्ता को जीवन बीमा व्यवसाय करने के लिये दावों के बढ़ते रहने के कारण यह धारा दावा निरस्त करने के लिये गलत ढंग से प्रस्तुत की जाती है। इस आधार पर की कथन गलत है। धारा 45 एक ढाल तथा तलवार के रूप में जीवन बीमाकर्ता के पासा है। इस धारा के अनुसार जीवन बीमा की कोई भी पॉलिसी उसके प्रभाव से दो वर्ष की अवधि के बाद प्रश्न नही पूछा जा सकता। बीमाकर्ता द्वारा इस आधार पर की प्रस्ताव पत्र में दिया गया कथन अथवा किसी रिपोर्ट जो कि मेडिकल अधिकारी द्वारा दी गयी हो या मध्यस्थ अथवा बीमाकर्ता के मित्र अथवा अन्य किसी दस्तावेज में जो पॉलिसी जारी करने के मामले में सामने आता हो वह गलत हो, जब तक बीमाकर्ता यह न प्रदर्शन करे की कथन भौतिक आधार पर अथवा ऐसे तथ्य जिन्हें दबाया गया है तथा पॉलिसीधारक द्वारा कोई कपट किया गया हो तथा पॉलिसीधारक कथन करते समय यह जानता था कि यह कपटपूर्ण है फिर भी इस धारा के प्रावधानों के अनुसार एक बीमाकृत को किसी भी समय आयु का प्रमाण मांगा जा सकता है तथा कोई भी पॉलिसी प्रश्न चिन्हित नही की जायेगी। क्या पॉलिसी की शर्तें आयु के अनुसार समाहित हो जायेगी। क्योंकि पॉलिसीधारक की आयु गलत ढंग से प्रस्ताव में बतायी गयी थी।

धारा 45 के प्रावधानों के अनुसार कि यह दो भागो में है पहला भाग इस तथ्य से संबंधित है कि कथन गलत था इत्यादि पॉलिसी लोग होने के दो वर्ष के भीतर (आमतौर से जल्द दावा से जाना जाता है, बीमा दायरे में) तथा दूसरा भाग इस बात पर प्रश्न

जब किसी पॉलिसी का प्रस्ताव किया जाता है यह विधि सम्मत रूप से अपेक्षा की जाती है कि प्रस्तावकर्ता उन सभी प्रश्नों का उत्तर सही देगा तथा कोई भी भौतिक सूचना को गलत रूप से सामने नही रखेगा।

चिन्ह दो वर्ष के बाद लगता है। किसी बीमाकर्ता के लिये प्रश्न करने के लिये सख्त प्रमाण पॉलिसी अवधि के दो वर्ष के भीतर कम ही होते हैं। यह सिद्ध करने का काम बाद के वर्गों में आता है। अन्य शब्दों में धारा 45 के दूसरे भाग में गलत कथन को उपलब्ध करवाने के अंतिरिक्त तथा अवरूद्ध भौतिक सूचना, बीमाकर्ता को यह भी सिद्ध करना होगा (जो कठिन है तथा वह भी एक मृत व्यक्ति के बारे में क्योंकि वह अपना बचाव नही कर सकता)। यह कपटपूर्ण ढंग से पॉलिसीधारक कथन करते समय कि कथन गलत है या उसमें तथ्य छुपाये गये थे प्रकट करना अनिवार्य था। वैसे धारा 45 में एक अलग योग्यता पहले दावों के प्रकाश में तथा अन्य दावों के संबंध में विरूपति हो जाती है यदि कोई व्यक्ति उपभोक्ता फोरम के कडे निर्णयों पर जाये तथा धारा 45 के दूसरे भाग की परख करे जो सेवा में दी गई है जबकि धारा 45 की रक्षा बीमाकर्ता द्वारा ली गई है। लेकिन इस असंगति का प्रारंभ बीमाकर्ता द्वारा निरस्तिकरण के पत्र द्वारा होता है। निरस्ति पत्र जारी करते समय सही प्रकार की रखवाली नही रखी जाती है जब कभी पॉलिसियों पर प्रश्न लगता है दो वर्ष के भीतर गलत कथन सूचना देने के कारण कि यह कपटपूर्ण या पॉलिसीधारक द्वारा तथ्यों को छुपाया गया जो कि भौतिक तथ्य थे जिनका खुलासा किया जाना था। बीमाकर्ता अपनी मदद करते समय अपने जाल में स्वंय फँस जाते हैं जिस प्रकार निरस्तिकरण पत्र देते हैं तथा न्यायालयों उपभोक्ता मामले की रक्षा करने में विफल रहते हैं।

भौतिक सूचना के अनुपूरक होने के कारण दावों के निरस्तिकरण के संदर्भ में जो कुछ भी देखा जाना चाहिये वह यह है कि दर्शायी गयी सूचना तथा बीमा लेखन व्यवहार के लिये बीमाकर्ता द्वारा मांगी जाने वाली सूचना तथा इसके लिये छुपाई गयी सूचना दावे का कारण नही होनी चाहिये। यह व्यवस्थापित विधि है। फिर भी इसमें ढृढता नही है। फोरम के बीच जो उपभोक्ता मामले सुलझाते हैं और कई बार यह फोरम अपने ही पहले पूर्ववर्ती निर्णयों को नही मानते। आजकल यह अप्रासंगिक

पिछले कुछ समय से यह वाद विवाद हो रहा है कि धारा ४५ में संशोधन की बड़ी आवश्यकता है। धारा ४५ के संबंध में दो दृष्टिकोण है

नही है कि दबाई गयी सूचना (मृत्यु का कारण, मृत्यु दावे के मामले में)। फिर भी इस पर ध्यान दिया जाना चाहिये। बीमाकर्ता अपने दायित्वों को जो पॉलिसी से उत्पन्न होते है बचाते हैं (विशेष रूप से उच्च मूल्य की पॉलिसीया) कोशिश करते हैं कि गलत-कथन छिपाने को आधार बनाया जाये जिसका कोई प्रभाव बीमा लेखन पर नही होना था अथवा प्रस्ताव के स्तर पर कोई प्रभाव नही होता। यह अनोखा नही है कि बढ़ती प्रतिस्पर्धा बीमाकर्ता के मध्य आवश्यक रूप की चेतावनी को सामने लाये तथा उसको प्रस्ताव पत्र की परीक्षा तथा बीमालेखन करते समय उपयोग करे।

बाद में प्रस्ताव पत्र में प्रविष्टियों को नाजुकरूप से अथवा नुखताचीन करे जब दावे को दिये जाने का समय हो। जीवन बीमा परिषद को इस पर ध्यान देना चाहिये तथा कार्यकारी कमेटी जो परिषद की है को धारा 64 जे(1)(ओ) बीमा अधिनियम 1938 के प्रावधानों की हैसयित को बदलने के लिये बीमाकर्ता को सलाह देकर मदद करनी चाहिये। आचरण के मानक स्थापित करने के लिये तथा उच्च परिपाटियों के लिये।

क्या धारा 45 में संशोधन होना चाहिये:

पिछले कुछ समय से यह वाद विवाद हो रहा है कि धारा 45 में संशोधन की बड़ी आवश्यकता है। धारा 45 के संबंध में दो दृष्टिकोण है एक कहता है कि बीमाकर्ता को यह अनावश्यक संरक्षण देता है तथा बीमाकृत को नही तथा दूसरा इसके विपरीत सोचता है। भारत के विधि आयने ने अपने सलाहकार पेपर में तथा बाद में आईआरडीए की सलाह के अनुसार इसे विस्तृत रूप से परखा गया तथा इसकी विभिन्न धाराओं पर विचार किया गया। यह सुझाव दिया है कि धारा 45 को संशोधित किया जाये कि कोई भी बीमाकर्ता पाँच वर्ष तक पॉलिसी पर प्रश्न लगा सकता है बिना किसी कारण के। के पी नरसिम्हन समिति ने धारा 45 जिस प्रकार अभी अस्तित्वमें है पर्याप्त राहत किसी असमान्य घटना में प्रदान करता है कि किसी पॉलिसी को गलत सूचना के आधार पर अथवा गलत भौतिक सूचना के अनुसार निपटा जा सके। इसलिये समिति ने इसमें कोई परिवर्तन की संस्तुति नही की।

वर्तमांन पहल: यूके विधि आयोग तता स्कोटिश विधि आयोग

उपभोक्ता विधि आयोग ने एक संयुक्त परामर्श पेपर जुलाई 2007 में जारी किया जिसका विषय बीमा विधि गलत अभ्यावेदन, गैर प्रकटीकरण तथा वारंटी को तोडा जाना अंतरिम प्रावधान के लिये बीमा संविदा विधि के सुधार तथा 16 नवंबर 2007 तक अनुक्रिया प्राप्त करना। इस लेख में वार्ता का विषय के संदर्भ में यह उल्टा सोचा गया कि बीमा सुधार तथा बीमा संविदा विधि के संदर्भ में विशेष पक्ष तथा मुख्य बातों को दो विधि आयोग के सामने लाया जाये।

सलाहकार पेपर का केन्द्र 3 क्षेत्रों पर था:

- संविदा बनाने से पहले गलत बयानी तथा गैर प्रकटीकरण
- वारंटी तथा वैसी दी शर्तें तथा
- ऐसे मामले जहाँ मध्यवर्ती संपूर्ण रूप से या आंशिक रूप से उत्तरदायी हो संविदा पूर्व गलत बयानी तथा गैर प्रकटीकरण के लिये

वर्तमान संधि से व्यवहार करते हुये गलता बयानी तथा गलत प्रकटीकरण के संदर्भ में पेपर कहता है कि विधि उच्च कर लगाये जो बीमा के लिये प्रस्ताव करे। भावी पॉलिसीधारकों से यह माँग की जाती है कि वे स्वेच्छा से वह सभी सूचना उपलब्ध कराये जो बीमाकर्ता के लिये जोखिम के विवेकपूर्ण आंकलन के लिये महत्वपूर्ण होगी। यदि पॉलिसीधारक अपने कर्तव्य में असफल हो जाये और बीमाकर्ता इसका प्रदर्शन कर सके की यदि उस सूचना उपलब्ध करवायी होती तो वह इन्ही शर्तो और निबंधों पर पॉलिसी नही देता तथा पॉलिसी देने से पूर्ण रूप से बचता। इससे कोई अंतर नही पड़ता कि पॉलिसीधारक को वह सूचना जाननी चाहिये अथवा नही अथवा वह बड़े बीमाकर्ता के लिये भौतिक सूचना है।

यहाँ एक वारंटी की विधि का प्रश्न है यह कहता है कि विधि एक मजबूत बीमा की संविदा शर्त वारंटी के प्रति एक दृष्टिकोण रखता है। एक वारंटी भविष्य की और इशारा करती है यह एक वचन है कि कुछ चीजें की जायेगी अथवा नही की जायेगी अथवा कुछ निबंध पूरे किये जायेंगे। संकल्पिक रूप से यह पूर्व अथवा वर्तमान पर लागू होता है यहाँ पॉलिसीधारक यह निश्चय बताता है कि किसी तर्क का ऋणात्मक पहलू नही है।

वारंटी का संपादन अच्छे से किया जाना चाहिये। जहाँ जोखिम भौतिक हो तथा जोखिम हो अथवा नही। बीमाकर्ता को कई दावा भुगतान करने की आवश्यकता नही है जो उल्लंघन की दिनांक के बाद हो। यह उल्लंघन यदि बाद में सही किया गया हो अथवा हानि के प्रश्न से कोई संबंध न रखता हो।

विधि के लागू करने की आलोचना, पेपर जिसकी निष्पति कुछ सिद्धांत रखते हैं तथा लंबे समय के लिये आधुनिक बीमा बाजार के लिये सही हो तथा रह पॉलिसीधारक की यथोचित अपेक्षाओं को देखते हुये मुख्य समस्याओं की इस प्रकार पहचान की जानी चाहिये:

- प्रकटन का कर्तव्य एक पकड के रूप में कार्य करेगा
- पॉलिसीधारक को दावा भुगतान नही किया जायेगा जबकि उन्होनें ईमानदानी तथा यथोचित ढंग से कार्य किया हो
- घलत बयानी का निवारण तथा प्रकटीकरण न करना ज्यादा सख्त होगा
- विधि जिस प्रकार का निवारण गलत प्रकटीकरण के लिये पहले से ही निहित रखता है। बीमाकर्ता वारंटी का प्रयोग भूत तथा वर्तमान के तर्कों को समाहित करने में कर सकता है।
- प्रस्ताव पत्र में एक बयान को वारंटी के रूप में बदला जा सकता है, सख्त शब्दों का प्रयोग करते हुये जो अधिकांश पॉलिसीधारक समझ ही नही पायेंगे।
- जब कभी एक पॉलिसीधारक भविष्य के कार्यवाही के लिये वारंटी प्रदान करता है इससे किसी प्रकार से भंग करना, बीमाकर्ता को आगे की देयता लेने से रोकेगा और ऐसे दावे भी जिनका इस भंग से कोई संबंध नही है।

विधि सुधार के महत्व को कम आंकते हुये सलाहकार पेपर कहता है प्रारंभिक बिन्दु वह जो विधि कहती है उसे उचित संतुलन बीमाकर्ता तथा बीमाधारी के हितों के बीच बनाना चाहिये। यह भावी बीमाधारी को बीमा पर भरोसा दिलाये यह सुनिश्चित करते हुये कि यह उनकी युक्तिसंगत उपेक्षाओं को बीमाकर्ता के संपूर्ण हितों को रखते हुये तथा बेकार की लागत तथा रूकावटों को सामने न रखें। यह भी संबद्धता से स्पष्ट होना चाहिये तथा त्वरित रूप से जानने योग्य होगा। प्रस्तावित सुधार व्यवसाय तथा उपभोक्ता से अलग अलग पेश आते हैं। सलाहकार पेपर की प्रति विधि आयोग की वेब साइट www.lawcom.gov.uk तथा www.scotlawcom.gov.uk पर उपलब्ध है।

निष्कर्ष: बीमा अधिनियम 1938 एक मॉडल है जो अंग्रेजी विधि तथा व्यवहार पर आधारित है। यह आज तक क्षेत्र में है जिसमें समय समय पर छोटे बदलाव हुये हैं पिछले दशकों में। बीमा व्यवसाय में व्यापक परिवर्तन हुये है जिसको उपभोक्ता की मांगो तथा बदलते प्रोफाइल के साथ देखा जाना चाहिये। विशेष रूप से बीमा उद्योग के खोले जाने के परिदृश्य में। पहले से ही कदम लिये गये हैं। विधि को आधुनिक बनाने के लिये तथा एक आधुनिक तथा विशालकाय बीमा विधि को बनाने के लिये। लेकिन सबसे महत्वपूर्ण कारक यह रह जाता है कि विधि कोई भी हो विधि की भावना दिखनी चाहिये। जब तक विधि की भावना नही समझी जायेगी और उस पर उसी के अनुसार व्यवहार नही किया जायेगा सभी दलों तथा व्यवसायियों द्वारा ।

भावी बीमाधारी को बीमा पर भरोसा दिलाये यह सुनिश्चित करते हुये कि यह उनकी युक्तिसंगत उपेक्षाओं को बीमाकर्ता के संपूर्ण हितों को रखते हुये तथा बेकार की लागत तथा रूकावटों को सामने न रखें।

लेखक उच्चतम न्यायालय में अधिवेत्ता हैं तथा बीमा सलाहकार समिति व के पी नरसिम्हन समिति के सदस्य है।

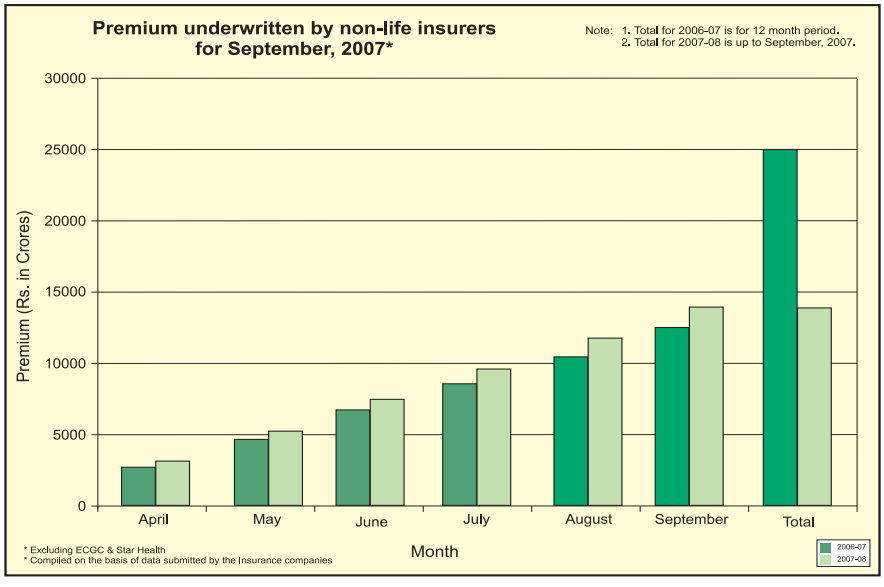
Report Card: General

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF SEPTEMBER 2007

(Rs.in Crores)

INSURER	SEPTEMBER		APRIL - SEPTEMBER		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2007-08	2006-07	2007-08	2006-07	
Royal Sundaram	52.94	44.02	320.87	289.13	10.98
Tata-AIG	53.94	57.08	413.10	400.57	3.13
Reliance General	138.48	104.00	946.44	377.54	150.68
IFFCO-Tokio	75.05	85.66	533.56	656.52	-18.73
ICICI-lombard	262.84	240.65	1726.59	1525.17	13.21
Bajaj Allianz	176.01	132.68	1122.51	846.24	32.65
HDFC CHUBB	14.34	14.76	112.03	91.27	22.75
Cholamandalam	39.98	26.04	266.41	154.12	72.86
New India	471.25	474.88	2666.67	2552.20	4.49
National	287.87	290.14	1954.58	1832.45	6.66
United India	271.51	291.01	1850.87	1779.98	3.98
Oriental	282.81	309.79	1989.48	1979.08	0.53
PRIVATE TOTAL	813.58	704.89	5441.51	4340.56	25.36
PUBLIC TOTAL	1313.44	1365.82	8461.60	8143.71	3.90
GRAND TOTAL	2127.02	2070.71	13903.11	12484.27	11.37
SPECIALISED INSTITUTIONS					
ECGC	55.09	54.72	313.24	293.02	6.90
Star Health & Allied Insurance	3.13	1.24	46.34	3.32	1297.56

Note: Compiled on the basis of data submitted by the Insurance companies.



CIRCULAR

October 15, 2007 42/IRDA/AGENCY/Oct 2007

Re: Reduction in Agent training hours

To

All Insurers / Agents Training Institutes (In-house, Private and Online)

This is with reference to Gazette Notifications regarding IRDA (Licensing of Insurance Agents) (Amendment) Regulation, 2007 and IRDA (Licensing of Corporate Agents) (Amendment) Regulation, 2007, issued on 8th October, 2007 (Copies enclosed) notifying the reduction in training hours.

As informed by Insurance Institute of India, Mumbai the first offline and online exam with the revised syllabus for 50 hours would be conducted from 18th November and 12th November 2007 respectively.

Further guidelines for Insurers and Insurance Training Institutes are given below:

All Insurers are requested:

- to ensure that from 1st November, 2007 all prospective agents/ agents undergo training as per the new syllabus and adhere to the new norms of training hours prescribed in Gazette notification;
- to maintain detailed record of training for all agents sponsored by the Insurer;
- to maintain detailed record of examination for all agents sponsored by the Insurer;
- to submit Quarterly report giving complete details of each person sponsored for examination and training to IRDA;
- to verify the status of Agent Training Institute from IRDA website before sponsoring candidates for training to said Institute;
- to ensure that the candidate sponsored for training by the Insurer passes the Agents pre-recruitment examination within six months of completing his/her training failing which, he/ she would be required to undergo the training again;
- to issue the License to the Agent within 15 days of passing of the examination;
- not to withhold licenses of any agent unless there are serious reasons which need to be duly recorded. The Insurer would be required to send the list of cases wherein the licenses have been withheld every month to IRDA;
- to publish details of agents who are involved in any form of malpractices on the Insurer's website along with the date from which the said agent ceases to be agent of that Insurer.

All Agents' Training Institutes (In-house, Private and On-line) are requested:

- to conduct training from 1st November, 2007 onwards as per the new syllabus prescribed by Insurance Institute of India and according to new schedule of number of hours as per the Gazette notification;
- to maintain detailed record of training imparted to each insurer's candidate;
- to maintain detailed record of faculty employed for imparting training;
- to note that Agents' Training Institutes not submitting Form B (Quarterly Report) by 7th of the next month at the end of each quarter will be deemed to be suspended. The Institutes have to keep acknowledged copy of submission for their records;
- to note that no new applications for Agents' Training Institutes will be accepted from private training institutes except those cases of in-house centres by insurers till such time IRDA does re-assessment of the requirement after the Gazette Notification.

sd/-
(V. Vedakumari)
Executive Director (Admn.)

CIRCULAR

9th October, 2007 40/IRDA/AGENCY/CIR/Oct 2007

Re: Clarification on Minimum Educational Qualifications for the Grant of Fresh Agency Licence

To
All Insurers

This is with reference to Circular dt. 22nd January, 2002 in above regard. Clause (1) of the said Circular is modified as below:

"(1) Higher Secondary Examination (11th Class) / PUC (Pre-University Certificate)/ any other examination passed in the year if it has been considered as the eligible class for getting direct admission to the Degree course of the respective University, may be treated as equivalent"

(V. Vedakumari)
Executive Director

13 - 15 Nov 2007 Venue: Mumbai	Microinsurance Conference 2007 By *CGAP Working Group & Munich Re Foundation*
19 - 20 Nov 2007 Venue: Pune	Seminar on Cyber Forensics By *NIA Pune*
26 - 27 Nov 2007 Venue: Kuala Lumpur, Malaysia	4th Asian Conference on Pensions and Retirement Planning By *Asia Insurance Review*
27 - 28 Nov 2007 Venue: Cairo, Egypt	3rd Seminar on the Regulation of Takaful By *Islamic Financial Services Board/ Egyptian Insurance Supervisory Authority*
28 - 29 Nov 2007 Venue: Guangzhou, China	8th China Rendezvous By *Asia Insurance Review*
29 Nov 2007 Venue: New Delhi	FICCI Conference on Health Insurance By *FICCI, New Delhi.*
03 - 04 Dec 2007 Venue: Dubai, UAE	1st Middle East Healthcare Insurance Conference By *Asia Insurance Review*
13 - 15 Dec 2007 Venue: Pune	Workshop on Motor TP Claims By *NIA Pune*
21 - 22 Dec 2007 Venue: Pune	Seminar on Motor Insurance Underwriting & Claims By *NIA Pune*
24 - 26 Dec 2007 Venue: Pune	Actuarial Practices in Life Insurance By *NIA Pune*

RNI No: APBIL/2002/9589

view point

As a regulatory authority, we are probably the first in the world to come out with micro-insurance regulation. If micro-finance can be successful, there is no reason why micro-insurance cannot be successful.

Mr CS Rao
Chairman, Insurance Regulatory & Development Authority (IRDA), India.

The IAIS's standard-setting activities and its role in facilitating the implementation of standards play an important part in maintaining financial stability.

Mr Michael Flamee
Chair of the Executive Committee of International Association of Insurance Supervisors (IAIS)

Given that financial institutions have fiduciary responsibilities to depositors, policyholders or investors; they are expected to maintain higher standards of corporate governance compared with other companies.

Mr Low Kwok Mun
Executive Director (Insurance Supervision), Monetary Authority of Singapore

Insurance firms will be held jointly responsible for damages incurring to consumers caused by actions of their sales agents. For example, insurers should not evade responsibility for fraud committed by former agents.

Mrs Chantra Purnariksha
Secretary-General of the Office of the Insurance Commission (OIC), Thailand

The watchdog is considering sanctions on the insurance companies since they are registered as franchise members of credit card companies and are thus breaking the law by not accepting credit card payments.

Mr Park Byung-myung
Director of the Insurance Supervision Department, South Korea.

While there are a number of challenges ahead of us including the growth of the insurance industry and changing demographics; the regulatory community will continue to meet the needs of a financial marketplace, while at the same time effectively protecting individual and commercial policyholders.

Mr Walter Bell
NAIC President and Vice-Chair, IAIS Executive Committee.