Volume VI, No. 2

आई आर डी ए
irda

Journal

January 2008

Getting BETTER and BETTER...

बीमा विनियामक और विकास प्राधिकरण

Printed by Alapati Bapanna and
published by C.S.Rao on behalf of
Insurance Regulatory and Development Authority.

Editor: U. Jawaharlal

Printed at Kalajyothi Process Ltd.
(with design inputs from Wide Reach)
1-1-60/5, RTC Cross Roads
Musheerabad, Hyderabad - 500 020
and published from
Parisrama Bhavanam, III Floor
5-9-58/B, Basheer Bagh
Hyderabad - 500 004
Phone: +91-40-66820964, 66789768
Fax: +91-40-66823334
e-mail: irdajournal@irda.gov.in

From the Publisher

Health insurance is the emerging segment in both life and general insurance. As a class, it has surpassed several others although it is of a more recent origin. The rapid growth that it has been recording in recent times also speaks volumes of its importance. In a country where the total coverage of the population under any form of healthcare protection, including state-provided and employer-provided schemes, does not go into double digit figures; a sustained growth is welcome.

Considering the huge potential in the country as also the growing income levels and other visible growth, insurers should ensure that health insurance continues to register a steady rise in the near future. In order to achieve this, there is need for widening the client base – not merely by marketing strategies but by ensuring that more and more people understand the importance of having in place proper health insurance coverage. This would be possible by enhancing the distributors' skills and also ensuring that all the other parties involved viz. the third party administrators, the service providers etc. are geared up to meeting the challenges of this sensitive area of operation.

The real test of success for any class of insurance lies in its ability to sustain individually, without any cross-subsidization from other classes. The process of detariffing has taken care of this aspect to a great extent. An efficient upfront underwriting would go a long way in addressing several problems associated with health insurance. This would minimize, if not avoid the large scale dissatisfaction about the management of the portfolio by the insurers. The service providers, on their part, should make efforts to erase the commonly held belief that they fleece the customers if they have insurance cover. The system can be improved; provided, the insurers, the insured and the service providers jointly put in efforts to remove some of the weaknesses in the existing system.

The focus of this issue of the **Journal** is on 'Health Insurance'. In order that wealth creation and wealth management processes are wholesome, it is very essential to have in place suitable and sufficient insurance coverage; whether it is for an individual or for a corporate entity. 'The role of insurance in Personal Financial Planning' will be the focus for the next issue of the **Journal**.

C.S. Rao

INSIDE

ISSUE FOCUS

FOLLOW THROUGH

Health Insurance
- Key for Betterment of Society

India has made tremendous progress in the field of healthcare over the last few decades. Several nagging problems have been put to rest and we have eradicated some of the killer epidemics (Smallpox, for example). Research in the field of medicine has also been improving, to be in tandem with the developments taking place elsewhere in the globe. Healthcare delivery to the common man, however, has remained a highly debated issue; and there are several millions of people who remain out of access to even the basic amenities as regards personal care and hygiene. One of the reasons assigned for such an unfortunate situation is the vast geographical spread of the population that remains out of reach for regular medical facilities. For an economy that is growing at a faster rate than most developed nations, there is an urgent need for overcoming such irritants.

Another oft-quoted reason for such a situation is the poverty that is the bane of several of these masses. The total percentage of the Indian population that is covered under the umbrella of any form of healthcare protection is pathetically low. While the intention is not to parade insurance as a panacea for all the ills of the society, by improving the numbers of health insurance penetration among a larger section of people who can afford it; we will be creating a platform for the state to concentrate on the less-privileged sections. Unfortunately, health insurance as a viable alternative has not been able to make giant strides of progress, although it has been growing, of late.

A strong factor for the poor performance of health insurance historically has been the moral hazard associated with it. Because of the poor awareness levels about insurance even among the educated elite, exclusive risk coverage schemes have not gained popularity in the Indian domain. Having paid the premium for a certain period, the policyholder imagines an inherent right in the enforcement of a claim. In several instances, he is aided in the process by service providers reportedly; and the entire episode results in a huge claims ratio for the insurers that puts them on the back foot. There is need for all the stakeholders to make the insured understand the basic elements of the insurance coverage. Some areas that insurers on their part may work on are widening the coverage of the policies – perhaps encouraging preventive care among the insured, for one. It is also essential that all the stakeholders join shoulders to take the cause further and ensure that health insurance in India reaches world-class standards.

The focus of this issue of the **Journal** is 'Health Insurance'. The first article of this highly topical issue is by Ms. K. Sujatha Rao, in which she brings in her experiences as a civil servant; and mentions that for the health insurance system to be successful in India, competition in healthcare supply plays a key role. In the next article by Dr. Tilman Ehrbeck, you get to see some global experiences in the area of health insurance; and lessons for the Indian market. The next article is by Mr. Richard Kipp and Mr. Thomas Snook, who emphasize on the importance of data collection and analysis which are so vital for product designing and pricing. There have been quite a few schemes promoted by the government – both at the national and state levels; and they have enjoyed mixed success. The details of many of such schemes with threadbare analysis are brought home succinctly in the next article by Dr. Somil Nagpal, Dr. N. Devadasan and Ms. Nehal Jain. Several NGOs have been very actively working in different parts of the country, promoting the cause of health insurance at the grass-root level. We have a case study of one such NGO working in Gujarat, by Ms. Rameshwari Kharva. In the end, there is an article under the 'follow-through' section by Mr. S.S. Kukreja and Mr. Gaurav Nagar that talks about the role for both the public and private sector insurers in the promotion of agriculture insurance in the country.

To have in place proper insurance covers for various assets is as important for an individual as it is for a corporate entity. The role of insurance in Personal Financial Planning will be the focus of the next issue of the **Journal.**

We wish all our readers a happy and prosperous NEW YEAR 2008.

U. Jawaharlal

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended November, 2007

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		Nov, 07	Up to Nov, 07	Up to Nov, 06	Nov, 07	Up to Nov, 07	Up to Nov, 06	Nov, 07	Up to Nov, 07	Up to Nov, 06
1	**Bajaj Allianz**									
	Individual Single Premium	69.97	366.77	699.79	8217	55272	56079			
	Individual Non-Single Premium	379.16	2712.00	1109.74	255620	1978028	689916			
	Group Single Premium	1.15	8.13	3.54	0	0	1	763	5720	1367
	Group Non-Single Premium	1.06	14.25	14.36	14	172	146	50997	508673	521549
2	**ING Vysya**									
	Individual Single Premium	2.18	14.06	19.38	244	1325	1385			
	Individual Non-Single Premium	44.07	333.85	213.99	24843	201512	113651			
	Group Single Premium	0.00	0.81	2.31	0	0	0	0	183	517
	Group Non-Single Premium	0.13	2.44	5.06	4	15	39	10066	69276	11206
3	**Reliance Life**									
	Individual Single Premium	23.21	120.95	68.10	6250	26017	10679			
	Individual Non-Single Premium	188.52	800.17	251.14	94979	428715	169760			
	Group Single Premium	12.33	148.05	9.37	2	43	15	567	68856	13486
	Group Non-Single Premium	2.69	14.70	5.72	19	169	111	18841	244401	128786
4	**SBI Life**									
	Individual Single Premium	132.23	636.42	234.57	17461	87750	34848			
	Individual Non-Single Premium	210.15	970.33	466.55	58985	306301	211075			
	Group Single Premium	19.06	127.62	126.17	0	0	2	9806	66186	77868
	Group Non-Single Premium	14.91	113.73	176.27	2	36	261	82403	380758	720180
5	**Tata AIG**									
	Individual Single Premium	4.88	22.81	9.51	873	3587	985			
	Individual Non-Single Premium	68.62	415.17	325.12	40190	273968	251606			
	Group Single Premium	5.43	42.85	32.77	3	3	5	20156	255162	167262
	Group Non-Single Premium	0.94	40.35	27.68	6	45	60	11213	138897	159628
6	**HDFC Standard**									
	Individual Single Premium	9.32	72.22	77.95	8378	182459	65856			
	Individual Non-Single Premium	159.36	1086.22	594.00	46483	341849	163551			
	Group Single Premium	4.80	41.00	94.14	12	83	65	12167	84719	128680
	Group Non-Single Premium	3.98	45.59	43.35	8	36	18	2867	31712	38652
7	**ICICI Prudential**									
	Individual Single Premium	28.01	220.72	203.79	4661	34838	30337			
	Individual Non-Single Premium	587.75	3196.78	1907.35	231750	1490421	921173			
	Group Single Premium	57.60	157.64	101.40	10	130	114	72457	327090	105386
	Group Non-Single Premium	25.54	306.96	250.13	17	264	215	29569	309395	211718
8	**Birla Sunlife**									
	Individual Single Premium	2.13	14.31	19.84	7718	46818	28788			
	Individual Non-Single Premium	130.30	827.23	359.07	40053	237721	140044			
	Group Single Premium	0.63	3.06	6.04	0	3	0	333	3797	3498
	Group Non-Single Premium	4.39	52.60	57.58	11	86	108	39416	127641	42944
9	**Aviva**									
	Individual Single Premium	2.11	13.34	18.59	278	1973	1805			
	Individual Non-Single Premium	81.01	506.88	364.45	29294	202807	159930			
	Group Single Premium	0.07	1.60	2.07	0	0	1	70	841	1109
	Group Non-Single Premium	0.81	20.86	17.91	2	84	46	46390	432991	211475

10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	2.62	14.26	22.01	379	1914	2408			
	Individual Non-Single Premium	86.66	381.90	220.70	27216	136503	67228			
	Group Single Premium	2.51	14.46	5.55	1	2	7	16330	117741	29850
	Group Non-Single Premium	2.57	31.40	23.77	25	152	101	34728	306842	156224
11	**Max New York**									
	Individual Single Premium	21.74	137.77	33.40	1562	9134	2379			
	Individual Non-Single Premium	77.09	630.43	403.52	53270	421756	308530			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	5.14	29.97	2.57	9	231	41	22442	355185	47438
12	**Met Life**									
	Individual Single Premium	1.05	14.57	3.75	142	2237	833			
	Individual Non-Single Premium	57.80	315.25	123.42	17803	113765	52595			
	Group Single Premium	0.85	5.48	0.00	3	39	0	18116	129971	0
	Group Non-Single Premium	0.00	0.00	11.11	0	0	163	0	0	317612
13	**Sahara Life**									
	Individual Single Premium	3.20	18.60	8.65	834	4850	2247			
	Individual Non-Single Premium	5.18	33.09	3.22	7032	48120	8466			
	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	18.32	92.55	35.34	3172	17058	7551			
	Individual Non-Single Premium	7.53	66.19	35.81	4786	40610	38141			
	Group Single Premium	0.00	0.02	0.00	0	1	0	0	1625	0
	Group Non-Single Premium	0.00	0.00	0.00	1	2	0	52	623	0
15	**Bharti Axa Life**									
	Individual Single Premium	0.16	0.94	0.00	15	86	0			
	Individual Non-Single Premium	8.92	34.01	1.35	6329	28504	664			
	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
16	**Future Generali ***									
	Individual Single Premium	0.00	0.00	0.00	0	0	0			
	Individual Non-Single Premium	0.00	0.00	0.00	0	0	0			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.55	0.55	0.00	1	1	0	18105	18105	0
	Private Total									
	Individual Single Premium	**321.13**	**1760.31**	**1454.66**	**60184**	**475318**	**246180**			
	Individual Non-Single Premium	**2092.14**	**12309.50**	**6379.42**	**938633**	**6250580**	**3296330**			
	Group Single Premium	**104.45**	**550.73**	**383.38**	**31**	**304**	**210**	**150765**	**1061891**	**529023**
	Group Non-Single Premium	**62.73**	**673.38**	**636.44**	**119**	**1295**	**1311**	**367089**	**2924551**	**2670543**
17	**LIC**									
	Individual Single Premium	1658.75	10820.65	14029.46	448987	2938711	3665654			
	Individual Non-Single Premium	1411.19	13676.29	15869.35	1768684	17160319	10786174			
	Group Single Premium	430.77	4904.95	5320.66	1794	13724	11444	1236583	13281280	8816411
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**1979.88**	**12580.96**	**15484.12**	**509171**	**3414029**	**3911834**			
	Individual Non-Single Premium	**3503.33**	**25985.80**	**22248.77**	**2707317**	**23410899**	**14082504**			
	Group Single Premium	**535.22**	**5455.68**	**5704.04**	**1825**	**14028**	**11654**	**1387348**	**14343171**	**9345434**
	Group Non-Single Premium	**62.73**	**673.38**	**636.44**	**119**	**1295**	**1311**	**367089**	**2924551**	**2670543**

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.
3. * Commenced operations in November, 2007.

Insurance – Essential Part of One's Portfolio

U. JAWAHARLAL MENTIONS THAT IN ORDER TO ENJOY THE COMFORT OF NOT BEING DEVASTATED BY LOSS OF PERSONAL ASSETS, IT IS VERY IMPORTANT TO KEEP IN PLACE PROPER INSURANCE COVERS. HE FURTHER ADDS THAT WEALTH MANAGEMENT IS AS IMPORTANT AS WEALTH CREATION.

A proper planning and budgeting for a corporate body are of vital importance. The risks that are inherent in running a business necessitate that unless there is a planned approach that takes care of both the strategic and tactical needs, it is sure to run into rough weather, sooner or later. Management experts very often compare an entity without sufficient planning to an ocean liner that is merrily cruising along, blissfully unaware of the rocks that it might hit along its path. However, it is not that such a planning is required only for business houses – it is equally important for individuals. Personal financial planning can be considered as the process by which an individual or a family can develop and implement an integrated plan to accomplish objectives. Hence, personal financial planning can be said to be a two-stage process – to identify the overall goals and objectives; and then to develop and implement an integrated plan to achieve them.

In the earlier times, the process of personal financial planning used to be a much simpler task. However, in light of the greater economic uncertainty dealing with such variables as ever-changing interest rates and inflation, personal financial planning has assumed a more complex character. Further, the onset of various financial instruments in the market has added to the complexity of the matter and one has to be an expert in several areas to ensure a balanced personal financial planning for oneself. This is easier said than done.

The role of insurance in wealth management is a monumental one. It is very essential that all the assets created over a period of time with all the hard work are properly protected against the risks associated with their existence. Above all, for individuals it is very important to be insured sufficiently against the unfortunate event of untimely death. There has to be a proper planning that in the event of such a scenario, the dependents continue to maintain the same standard of living. In the case of life insurance, historically the Indian society has suffered from fatalistic overtones; and it used to be very tough convincing individuals about the importance of being insured sufficiently for life. Although there has been a great deal of improvement in this regard, insurance is still not treated as a priority for various reasons. Close on the heels of life insurance, it is vital for individuals to have in place sufficient coverage against the possibility of falling sick. Though for different reasons, health insurance is also a complicated issue when it comes to convincing the masses about its importance.

Similarly, there are several other personal assets that need to be sufficiently and properly covered under suitable insurance policies. In the Indian context, it is mandatory requirement that is a stronger driving force rather than a voluntary participation that makes people resort to insuring their assets. A sense of complacency that nothing happened earlier compels people to believe that no insurance is required. They should learn from the experiences of others and ensure that they continue to enjoy such a comfort. As against only a few coverages earlier, today there are insurance covers for almost all conceivable risks for various assets. Individuals should get to learn about the various packages that insurers offer and protect themselves against the increasingly risky environment that they are living in.

'The Role of Insurance in Personal Financial Planning' will be the focus of the next issue of the **Journal.**

Securing Personal Assets

in the next issue...

CIRCULAR

December 18, 2007 Ref: 048/IRDA/De-tariff/Dec-07

To

The CEOs of All General Insurance Companies,

Sub: Removal of controls on pricing of risks in general insurance business with effect from 1st January, 2008

The issues relating to the removal of controls on pricing of risks in the general insurance business was discussed at a meeting with the CEOs of general insurers at Hyderabad on 14 December 2007.

It was clarified by the Authority at the meeting that the Guidelines on File and Use procedures in respect of general insurance products as detailed in the Authority's circular no. 021/IRDA/F&U/Sep-06 dated 28th September 2006 will continue to apply and insurers shall continue to file the rates and terms that they wish to offer for various products including the products covered by the erstwhile tariffs. The CEOs assured the Authority that the high standards of underwriting and market conduct will be maintained by all insurers even after the price controls are removed.

On the basis of these assurances, the Authority has decided as follows:

Except for Motor Third Party risks, for all other new insurances and renewals effective on or after 1 January 2008, insurers shall be free to quote rates of premium in accordance with the rate schedules and rating guidelines that have been filed with the Authority.

The premium rates for Motor Third Party risks will continue to be regulated by the Authority.

Risks qualifying as large risks under paragraph 19(v) of the circular no. 021/IRDA/F&U/Sep-06 dated 28th September 2006 shall be insured at the rates, terms and conditions and basis of insurance exactly as the rates, terms etc. as developed from the reinsurers with no variation.

Insurers may file a fresh schedule of rates and rating guidelines with the Authority or may maintain the schedules and rating guidelines that have already been filed.

The requirements of the circular no. 021/IRDA/F&U/Sep-06 dated 28th September 2006 with regard to the filing of products and rates schedules and rating guides and manuals shall continue to apply as amended from time to time.

The Authority will accept the rate schedules and rating guides as filed by the insurer on the stipulation that these are in compliance with the underwriting policy as approved by the respective Boards of Directors and on the condition that they are designed so as to produce an operating ratio [incurred claims plus commission and expenses of management] not exceeding 100% on a gross underwriting basis. However, the Authority retains the right to query or require changes to any such rates schedules and rating guides, at its sole discretion.

Any revision in rates shall only be given effect to on renewal date of the insurance and insurers shall not be permitted to cancel existing insurances and replace them by new insurances at revised rates. The insured has, however, the right to require cancellation of his insurance in which case, premium at short period scale as applicable shall be chargeable.

The terms & conditions of cover and the wordings of policies, endorsements, warranties and clauses set out in the erstwhile tariffs shall continue to apply until fresh market wordings are examined and accepted by the Authority after considering the views of various stakeholders.

(C.S. Rao)
Chairman

PRESS RELEASE

December 19, 2007

Insurance Regulatory and Development Authority

IDBI Fortis Life Insurance Co. Ltd, a joint venture life insurance company promoted by IDBI, Federal Bank, India and Fortis Insurance International, Netherlands has been registered as a Life Insurer under Section 3 of the Insurance Act, 1938 with the Authority. The Certificate of Registration (Forms IRDA/R3) has been issued by the Authority today. With this registration, the total number of life insurers registered with the Authority has gone up to 18.

(C R Muralidharan)
Member

NOTICE

20th December, 2007

Re: Elected Council of the Indian Institute of Insurance Surveyors and Loss Assessors

As envisaged in Article 15(6) of the Articles of Association of the Indian Institute of Insurance Surveyors and Loss Assessors, with the completion of the initial membership processing and the successful conduct of the first elections to the Council, the management of the Institute, promoted by IRDA, was formally transferred to the office bearers of the newly elected council at its meeting held at the registered office at Hyderabad on 15.12.2007. The following were elected as the office-bearers from amongst the elected members:

1. Shri M J Dhruva - President
2. Dr. R A Srinivas - Vice-President
3. Shri Arun Kumar - Secretary
4. Shri Jawahar Lal Tiku - Treasurer

(Suresh Mathur)
Nominee Council Member

CIRCULAR

1st January, 2008

To
All Life Insurers
Sub: Benefit illustrations for Unit Linked Products
Please refer to our earlier letter dated No.2/IRDA/ACTL/DC/ 2007-08 dated 17th December, 2007, requesting comments on the captioned draft circular. We are thankful to those who were kind enough in sending their responses.

The purpose of this circular is to provide the prospect / policyholder all relevant information regarding amounts deducted towards various charges for each policy year so that the prospect / policyholder can take an informed decision. The present step will no doubt pave the way towards standardizing the disclosures which would result in greater transparency and enhanced policyholders' confidence. You all will agree that this is crucial at this hour as unit linked products are assuming significant share in the total portfolio. In this context, the following are to be ensured:

a) Life insurance companies are required to confirm to the format (Table-A) enclosed which lists out all charges to be paid and also the amount available for investment in each policy year.

b) Information specific to the particular policy holder only shall have to be used.

c) Insurers must also give figures separately in a table about guaranteed benefits and non-guaranteed benefits for each policy year (Table-B) keeping in view the interest rates as specified by the Life Insurance Council's circular. At present the interest rates used for benefits illustration are 6% p.a. and 10% p.a. respectively. This table (Table-B) is already in practice.

d) The policy holder must sign both Table-A and Table-B along with the sales person on the day when he she signs the proposal form. These tables shall become part of policy document and a copy must be sent to the policy holder along with the policy document.

e) The circular is applicable to all unit linked products (both new and existing) and shall come into force with effect from February 1, 2008.

Please acknowledge the receipt of the circular.

(R. Kannan)
Member (Actuary)

TABLE-A
(Applicable to Linked Products)
(This shall form a part of the policy document)

Proposal No:
Policy No:

PRODUCT FEATURES

1. Name of the Product:
2. Unique Identification Number:
3. Sum Assured:
4. Policy Term:
5. Premium Payment Term:
6. Mode of Premium: *SP/Non SP (If non SP, indicate the mode)*
7. Amount of Installment Premium:
8. **Statement of Charges and Amount for Investment**

(In Rupees)

At the start of the Policy Year	1	2	3	4	5	6	7	8	9	10	and so on
Amount of installment Premium											
Amount of Premium Allocation Charge											
Amount of any other charge (Please specify clearly) a) b) c) d)											
Sub Total											
Total Charges											
Amount allotted for investment											

IN THIS POLICY, THE INVESTMENT RISK IS BORNE BY THE POLICY HOLDER

Note:

1. Some charges are collected immediately after the allocation is made, through cancellation of units. Please specify these charges with rates.
2. Some charges are collected at the end of the year, through cancellation of units. Please specify these charges with rates.
3. Policyholder should receive a document (the glossary for various terms of charges used) from the insurer.

I…….. (Name), having received the information with respect to the above, have understood the above statement before entering in the contract.

Marketing officials'
Signature:
Company Seal:
Place:
Date:

Policyholders' Signature

Health Insurance in India

A Comment

K. SUJATHA RAO AVERS THAT UNIVERSAL SOCIAL HEALTH INSURANCE SYSTEM HAS REMAINED A DISTANT DREAM; AND IN ORDER TO ACHIEVE THAT, IT IS ESSENTIAL THAT THERE IS AN ATTEMPT TO CREATE A STRONG COMPETITIVE ENVIRONMENT, WHICH CAN ONLY BE POSSIBLE WHEN THE PUBLIC SECTOR HOSPITALS PROVIDE EVEN BETTER STANDARDS OF CARE THAN THAT PROVIDED BY THE PRIVATE SECTOR.

It was over a decade ago that the Ministry of Health started to discuss the relevance of health insurance in India. Two workshops were held with lead experts in the field. It was clear then that there were four important issues that required immediate policy attention if universal health insurance were to be an option to public health financing: legal frameworks to regulate the providers in general and the private sector in particular; systems of accreditation to promote quality of care and value for money; organizing information systems to obtain more rigorous estimates of disease incidence; and focusing on prevention of disease.

The above mentioned policy interventions are critical to the feasibility of health insurance in India. Regulation enables provider control, while accreditation assures standardization of service delivery, so necessary for patient satisfaction. Information gives insights on where to focus resources to prevent disease and frequency in occurrence of illness episodes. All these are critical requirements for viability of insurance since it is based on the principle of subsidy between the healthy, the rich and the young; against the ill, the poor and the old. While viability can be assured with reducing the payouts against the sums collected, high premia can be a barrier to get the desired size and composition of the pool. If India continues to struggle in search of a viable health insurance model, despite engaging with this idea for over a decade, it is because of our inadequate understanding of the fundamental drivers of the model.

For ensuring low premia and financial viability, there are four important conditions the health system must fulfill:

- Have the insured stay healthy and avoid illness or risk factors such as by promoting exercise, tobacco control, nutrition, sanitation, access to safe drinking water etc;
- Ensuring providers do not over- or under-treat; and implement safety standards to ensure the hospitalized patients do not acquire new infections which are often harder to treat;
- Have treatment protocols defined and costed to keep control on the costs of care; and
- In a mixed model of care as in India, a strong public sector delivery system which alone can force the private sector to provide standard quality of care at low prices.

The implications of achieving the above mentioned conditions require the redefinition of the role of the state from being a provider of care to a regulator and standard setter. In the absence of the state playing such a role, the patients are getting shortchanged. Today's health insurance system in India is weighted in favour of the providers and the insurance

While viability can be assured with reducing the payouts against the sums collected, high premia can be a barrier to get the desired size and composition of the pool.

companies, and not the patient; and hence does not help achieve the objective of alleviating the overall public health standards and well being in the country. The current system of insurance for an assured sum puts no pressure on the provider to contain costs or on the insurer to ensure containing costs. This combination is the main reason for the wide prevalence of unethical care where procedures and tests are performed even when the patient does not need or claiming reimbursements from insurance companies for services not performed. Government's inability to creating a viable risk pool, by merging the CGHS and ESIS to create a viable structure for social health insurance and following instead a hundred flowers bloom policy is flawed. Small insurance pools with members from the poor quintiles cannot in any substantive manner address the major cause of impoverishment, namely hospitalization. For example, one case of appendectomy can be enough to wipe out the reserve of the family and the risk pool. In such a case limits are placed but are of little value in the absence of cost controls - every limit only enhancing the cost.

The current system of insurance for an assured sum puts no pressure on the provider to contain costs or on the insurer to ensure containing costs.

India has only two options to provide real financial risk protection to its people: having social health insurance by enhancing public investment in health like Canada, Australia or UK. This, though ideal, is not possible as it requires very substantive budgetary outlays which governments cannot afford. The second option is to work within the mixed provider system by creating a strong competitive environment, which can only be possible when the public sector hospitals provide even better standards of care than that provided by the private sector. By mandating health insurance among government employees and the private organized sector, adequate stimulation can be engineered to enable a viable social health insurance. The sooner work is started along these lines and a standalone health sector regulator instituted, the better for achieving our dream of having a universal social health insurance system in the country.

The author is an IAS Officer of the AP cadre and is presently the Director General of the National AIDS Control Organization (NACO). She was earlier the Secretary of the National Commission on Macroeconomics and Health prior to her current assignment. Views expressed are in her personal capacity.

Sustainable
Private Health Insurance
Global Perspectives for India

DR. TILMAN EHRBECK WRITES THAT RISING INCOME LEVELS COMPLEMENTED BY HEALTHCARE AWARENESS ARE BOUND TO GROW OVERALL HEALTHCARE COSTS AS HAS BEEN THE EXPERIENCE IN NEARLY EVERY DEVELOPED COUNTRY, WHERE HEALTHCARE COSTS HAVE BEEN GROWING AT A RAPID RATE FOR DECADES.

As income levels and health awareness rise, the emerging Indian middle class will seek better underlying medical services and cover for the financial risks that come with the more sophisticated and expensive medical care nowadays available. To provide the desired broader coverage in a financially sustainable fashion is both an opportunity and a challenge for India's nascent health insurance industry.

Given its demographics and stage of development, India will need a tailored approach to meet this challenge, and it has the opportunity to learn from relevant international experiences and avoid some of the mistakes made by other countries. This paper discusses the contributions India's private health insurance sector could make. It does not provide a series of specific recommendations but focuses on perspectives and facts on some of the key issues the country's health insurance sector faces to provide context for the discussion in the country.[1]

Against the backdrop of the current industry structure and predominant product offering, three sets of lessons learned from international experiences seem relevant:

- **Capabilities required for a retail health insurance market.** While relatively well penetrated, the employer-based group health insurance market in India is small – it includes less than 10 per cent of the workforce. At the same time, government insurance coverage is limited, and the planned expansion focuses on the poor at the base of the economic pyramid.[2] As a result, the

Given its demographics and stage of development, India will need a tailored approach to meet this challenge, and it has the opportunity to learn from relevant international experiences and avoid some of the mistakes made by other countries.

1 This paper draws on materials the author and his colleagues Dr. Vishal Agrawal, Dr. Viktor Hediger, and Shubham Singhal prepared for the November 2007 FICCI conference on Sustainable Health Insurance.

2 The Government of India has announced plans for subsidised health insurance for the country's poorest citizens in the unorganised sector. If successfully implemented, such a scheme would provide better access and a higher standard of healthcare to a significant portion of the Indian population. A successful national health insurance model for the poor should build on India's successful experiments with micro health insurance covered in the November 2007 edition of the IRDA Journal and leverage three unique strengths of the country: its strong civic institutions, its active and entrepreneurial healthcare markets, and its tradition of decentralisation. In such a model, the government would act as a market maker and regulator. A more comprehensive discussion of this topic is beyond the scope of this paper.

majority of the opportunity lies in privately provided and individually purchased health insurance products for the emerging middle class. To meet its needs requires product and channel innovations and the ability to price risk appropriately.

- **Health insurance coverage beyond hospitalization benefits.** Currently, health insurance products in India narrowly cover hospitalization benefits with a sum-assured limit. India's private health insurance sector could cover a number of secondary and tertiary preventive measures such as screening for cancer or diabetes, and preventive health check ups as well as disease management programs for specific conditions, which would be beneficial for insured and insurers alike.
- **Techniques to manage medical value.** The combination of rising income levels and awareness as well as broader coverage in India is bound to grow overall healthcare costs. This is the experience in nearly every developed country, where healthcare costs have been growing at a rapid rate for decades, for most years well in excess of aggregate inflation. In response, health insurers in other markets are developing new techniques to achieve better medical outcomes at lower costs. A number of the tools developed in that context, such as network tiering for consumers and episode contracting for providers appear relevant for an emerging market setting.

Capabilities Required for Retail Health Insurance

Success in retailing health insurance in India will entail developing new capabilities. These include most importantly product and channel innovation as well as risk-based underwriting.

Product innovation

Individuals face a number of exposures driven by health and health-related events and costs, the risks of which they can bear to differing degrees. These risks range from low ticket-size expenses (e.g., for routine care) to higher ticket-size discretionary expenses (e.g., for elective surgery), catastrophic expenses (e.g., due to major illness, accident), end-of-life care expenses (e.g., due to life-threatening illness), expenses related to chronic diseases and income risk (e.g., disability).

Successful innovation combines the elements of an appropriate financing mechanism, managed care, and advice to help consumers deal with these different types of health-related risks. In the U.S., traditional products have focused on mainly providing insurance as the financial vehicle with select managed care elements. Recently introduced consumer-directed health plans combine savings and insurance vehicles. Other recent innovations such as accelerated payout on life insurance or reverse mortgages help with end-of-life care expenses.

Aligning the financial mechanisms with the needs of diverse consumer segments improves financing efficiency. For example, many consumers are unwilling to purchase long-term care insurance when they are young, as they view it as an unnecessary expense. They are more concerned about meeting mortgage payments or saving for their children's education while the threat of long-term care seems distant. On the other hand, as consumers age and recognise the need for long-term care coverage, they often find the premiums unaffordable or are denied coverage due to medical underwriting. Products that combine savings features with catastrophic coverage for younger families or the monetization of illiquid assets combined with health insurance at an older age would serve the needs of such consumers.

Health insurance products are likely to require additional distribution channels beyond the dominant agency force.

Channel innovation

Health insurance products are likely to require additional distribution channels beyond the dominant agency force. Based on the U.S. experience, several innovations hold promise:

- **Direct-response channels.** These include a captive sales force, call centres, the Internet, direct mail, and television commercials. A leading U.S. player primarily uses the Internet, for example, to sell a product aimed at consumers aged 18 to 29 ("young invincibles") who think they do not need health insurance.
- **Retail stores.** Health insurers in the U.S. are now offering health benefit products through leading retail and pharmacy chains. One of the biggest success stories for payers has been selling Medicare-related products to the elderly through bricks-and-mortar retailers.
- **Affinity-marketing relationships.** Health insurers have entered successful affinity partnerships with diverse players

WHO statistics indicate that 8 million people die prematurely every year in India from diseases that are relatively easily preventable, if certain primary preventive measures were adopted by the public authorities.

such as airlines and the American Association of Retired Persons (AARP).

Different consumer segments have different preferences and attitudes, and health insurers must understand them. Some consumers, for example, want a trusted adviser who can make decisions for them, while others desire information and tools to make their own decisions. Preferences also vary by demographics; for example, older people tend to like greater support. Understanding such preferences is important in building the right channel architecture. Because a consumer's risk profile, i.e. health status is correlated to demographics, the choice of channels can be a significant driver of understanding risk and required pricing.

Risk-based pricing

Product and channel innovations alone are not enough. Health insurers need to understand the risk profile of individuals and their ability and willingness to pay, which often varies by segment and channel. Marrying insights into consumer behaviour with actuarial science could create competitive advantage. For example, if actuaries could determine how consumer behaviour would change *a priori* and build that into product pricing rather than wait for years to study observed behaviour, they could benefit from substantive gains. Insurers in the U.S. have leveraged detailed data to build sophisticated actuarial models that are more powerful by a factor of over 1,000 relative to competitors.

Insurance Coverage Beyond Hospitalization Benefits

Private sector group and individual health insurance coverage in India today focuses on hospitalisation benefits with a limited sum assured. While this provides valuable coverage, preventive care techniques are important to improve medical outcomes and to provide cost-effective health insurance. In India, there remains a huge need for simple primary prevention that largely falls into the public domain. However, the private health insurance can make important contributions at the secondary and tertiary prevention levels.

Primary vs Advanced Prevention

In assessing the cost-benefit equation of a number of techniques and determining who is best positioned to provide these services it is helpful to distinguish between three levels of preventive care:

- **Primary prevention** entails reduction in the level of one or more identified macro risk factors to reduce the probability of the initial occurrence of a disease. Examples include road safety, clean water, food fortification and vaccinations, which are typically Government-led
- **Secondary prevention** aims at detecting a disease at a very early stage to prevent or delay its progression. Examples include screening programs for cancer and diabetes, which could be provided for and funded by the private sector
- **Tertiary prevention** consists of ongoing interventions aimed at decreasing or delaying the severity and frequency of recurrent events of chronic or episodic diseases. Examples include family-oriented disease management therapies for cardio-vascular diseases, or disease management programs for diabetes patients, where again the private sector can play an important role.

WHO statistics indicate that 8 million people die prematurely every year in India from diseases that are relatively easily preventable, if certain primary preventive measures were adopted by the public authorities.

Screening programs

A number of countries have recognized the benefits of health insurance packages that cover not only acute, curative expenses but also focus on secondary prevention measures, such as health screening. In Germany, for example, the statutory health insurance since 2002 covers 5 specific programs including early cancer diagnosis, preventive health check-ups, youth check-ups, dental check-ups for children, and check-ups and screening for children. Private health insurers in Germany are complementing this statutory screening program. One of the leading German private health insurers, for example, offers a special tariff on prevention and screenings designed as supplementary non-obligatory health insurance for Statutory Health Insurance members. Policies cover up to 27 different screenings (depending on age) that are not already covered and cost up to €20.50 per month.

In India, based on our analysis of publicly available data, 3 million premature deaths could be avoided every year via secondary prevention measures of this type, mostly by screening for diabetes and malignant

neoplasms. Secondary prevention measures for the top 10 diseases ranked by cost-effectiveness could prevent or significantly delay 1.9 million premature deaths in India per year.

Disease management programs

Disease management programs are for chronically ill patients and require patients to change their behavior and the way they interact with providers. In a number of countries such programs have been introduced by public and private health insurers to improve medical outcomes and to lower costs. Germany's statutory health insurance program covers more than 3 million patients and six diseases – Type I and Type II diabetes, breast cancer, coronary heart disease, asthma and chronically obstructive lung diseases.

To make these programs successful, a number of incentives were created:

- **Health funds** receive additional premium payments as financial incentives for each patient enrolled in a disease management program as part of the industry-wide risk-balancing scheme; these payments currently range from €2,300 for asthma at the lower end and €6,700 for breast cancer at the higher end of the spectrum
- **Patients** are given incentives through lower co-payments and reduced premium payments
- **Providers** get ongoing fee-for-service compensation. In addition, there are incentives to encourage enrolment and process efficiency, for example, €20 for consulting a patient and introducing them to the program, or a €200 one-time payment for investments into electronic data transmission from the physician's office to data centre.

The cost-benefit equation from a long-term health insurance perspective is different by disease. A number of research studies suggest that the cost-benefit ratios are the highest and clearly positive for diseases like congestive heart failure, asthma and potential diabetes.

Techniques to Manage Medical Value

The combination of rising health awareness and income levels, increased access to insurance and broader coverage in India is bound to grow overall healthcare costs. This is the experience of nearly every developed country, where healthcare costs have been growing at a rapid rate for decades, for most years well in excess of aggregate inflation.

In response, payors in large private health insurance markets such as the U.S. have recently started taking a more integrated approach across the former siloed-functions of plan, design, network, claims, and care management to maximize medical value. Several of the techniques that they are employing could be beneficial to players in emerging markets.

Payor- vs Consumer or Provider-directed approaches

Historically, the emphasis in medical value management in the U.S. has been on "payor-directed" approaches focused on engaging providers (e.g., hospital utilisation review and case management). These approaches will continue to be important for the foreseeable future.

However, a confluence of factors is leading to medical cost-control innovations that are more "self-directed" by providers and consumers: 1) the failure of payor-directed approaches alone to manage medical costs; 2) recognition of broad disparities in provider performance; 3) the increasing proportion of chronic and discretionary care on total medical costs; and 4) new regulations and "ownership" mindsets. Given these factors, payors are supplementing traditional approaches with incentives that stimulate provider and consumer-driven change. Over the long-term, these "self-directed" approaches are likely to accelerate as individuals assume greater ownership and financial stake in their healthcare decisions and transparency in provider performance increases.

"Self-directed" approaches appear well suited for retail-oriented emerging markets. In many of these markets, consumers bear significant medical risk and providers actively compete for patients. Developing economies have the opportunity to leapfrog to deploying self-directed approaches that would promote competition, innovation, and ultimately better medical outcomes at lower costs through appropriate stakeholder incentives.

Influencing providers

In a more "self-directed" model, providers are incentivized to optimize outcomes and

Secondary prevention measures for the top 10 diseases ranked by cost-effectiveness could prevent or significantly delay 1.9 million premature deaths in India per year.

> When consumers have financial stake in their healthcare decisions, they seek more information on their expected liability in advance of receiving care.

utilization through increased transparency gained from quality information and appropriate economic incentives. Tools to achieve this include:

- **Pay-for-performance:** This involves financial or other incentives to high-performing providers at the hospital and physician level. This tool requires cooperation and agreement between payors and providers on the key performance indicators that determine compensation for physicians and facilities. Initial experiments in place today are largely based on process metrics (e.g., did the heart attack patient receive an aspirin?) with true clinical outcomes-based metrics likely to emerge in the future (e.g., what is the morbidity rate after a heart attack?).
- **Episode contracting:** In this case, reimbursements are based on the estimated total cost for an end-to-end set of expenses for a clinical condition. It typically includes all inpatient, outpatient, drug, and diagnostic expenses and is risk-adjusted by several health and demographic factors (e.g., co-morbidities, age, sex). A total care cost estimate that is personalised to the specific consumer and bundles treatment costs over multiple visits for a given illness is the end-game for this approach.

These "self-directed" provider approaches shift incentives away from a fee-for-service reimbursement model to one that is more value-based.

Influencing consumers

For consumers too, the market is moving toward a more "self-directed" approach- members are engaged and incentivized to make utilization, cost, and quality decisions. Tools to influence consumer behaviors include:

- **Consumer decision support:** Such tools enable patients to make better healthcare decisions. When consumers have financial stake in their healthcare decisions, they seek more information on their expected liability in advance of receiving care. As tools emerge that make the dispersion in provider pricing more transparent, early evidence in the US suggests consumers shift strongly to the product that offers the highest perceived medical value
- **Care networks/benefit tiering:** By way of this approach, providers are tiered based upon efficiency/quality information (at the hospital/physician and procedure level), and patients are incentivized to seek to best-value providers. These care networks create value based on performance outcomes rather than simply seeking discounts in exchange for patient volume and prompt payment
- **Wellness/lifestyle programs:** This tool focuses on preventive and promotive measures. It directs members toward healthier lifestyles to prevent the occurrence of disease through increased consumer awareness e.g., general health education, health club memberships, health screenings, weight loss and smoking cessation programs. Shifting focus from "sick care" to true "health care" with programs and benefits across the entire care continuum can minimise downstream costs.

Consumer-driven approaches have the opportunity to be implemented effectively in emerging markets. These markets do not have the legacy of healthcare paternalism that characterizes many developed economies. In addition, more so than the "self-directed" provider approaches, consumer techniques do not rely on sophisticated medical management protocols. In fact, many of the core skill sets to implement them could be leveraged from service vendors emerging in other geographies.

Conclusion

India faces both the opportunity and challenge to develop its own approach to expanding health insurance coverage in a financially sustainable fashion. Experiences of various countries suggest that India's private health insurance sector can make significant contributions in a largely retail-dominated market by tailoring their products to the needs of various consumer segments and by working with healthcare providers to achieve higher-quality medical care in a cost efficient manner.

The author is a Partner in McKinsey & Company's New Delhi office.

Designing New **Health Insurance Products**

Technical Considerations

RICHARD KIPP AND THOMAS SNOOK WRITE THAT IN ORDER TO BE MORE SUCCESSFUL IN THE AREA OF HEALTH INSURANCE, INDIAN INSURERS HAVE TO CLASSIFY THE RISKS IN ACCORDANCE WITH THE INDIVIDUAL'S PROFILE AND PRICE THEM ACCORDINGLY.

There are a number of new benefit structures that are being considered for introduction into the Indian health insurance market or that have recently been introduced into the market. Most of these have been developed by the insurers. Some have been developed at the encouragement of the IRDA. New benefits mean insurers are taking new pricing risk, but there is little data available for the current dominant benefit, Mediclaim; and virtually none for services not currently covered by Mediclaim policies. This means insurers will need to proceed carefully as new benefits are added. This paper discusses key factors that insurers will need to consider when developing pricing.

Among the service scope expansion ideas are (1) hospital cash, (2) critical illness, (3) elderly coverage, (4) comprehensive inpatient and outpatient coverage and (5) disease treatment policies. Other features that are being considered are implementation of deductibles and copays/coinsurance as well as "inside" or sub-limits on daily benefits for hospitalization, consultation fees, and ICU charges. Others talk in more specific terms about expanding benefits to include certain outpatient services like preventive procedures and services.

In each case, actuaries and other financial professionals working for Indian insurers need data of some type to formulate an approach to pricing new coverage where no claims experience exists. Following are some general observations about issues related to the benefits outlined above.

Hospital Cash

In the case of hospital cash benefits, the actuary will need to tailor the pricing assumptions to the target populations being insured. Variables such as age, gender, geographic location, occupation and income level are known to correlate with hospital utilization and hence will be important considerations in pricing this benefit. The cash benefit usually makes a payment to a person that is hospitalized at some scheduled amount, typically on a per day basis and usually is limited to 60-90 days of cover per hospitalization. Certain types of hospitalization stays are excluded for specific surgeries and hospitalizations that commence within 30 days of policy issuance.

As with all medical insurance policies, careful benefit design is crucial. Moral hazard is a concern. For example, an insurer will not want to offer a hospital cash benefit that covered more than the expected patient out-of-pocket expenses during a hospital stay; otherwise the patient would stay to gain financially by being in the hospital! The key here is not to create an incentive to such a degree that it encourages hospital admissions,

Actuaries and other financial professionals working for Indian insurers need data of some type to formulate an approach to pricing new coverage where no claims experience exists.

thus causing losses for the medical insurance plan and the hospital cash plan.

Pricing the hospital cash benefit requires a sense of the expected number of admissions in a given population and the expected length of the hospitalization. Both are typically triggers that dictate the cash payout. Indian admission rates for the Mediclaim population appear to be in the 5-7% range at this time and expected lengths of stay per hospitalization in the 5-8 day range. The cash benefit is often offered in tandem with a critical illness rider to a life policy, but is also offered on a stand alone basis by some. This combined benefit could actually be used as a replacement for a Mediclaim policy. If you start with a Mediclaim policy and add sub-limits you can mimic a hospital cash policy's features. In pricing, though, you would also need to reflect any changes in the target demographics for this policy when compared to the Mediclaim insured base.

The co-pay encourages the policy holder to shop for the most cost effective treatment as well as to scrutinize hospital bills, since they are paying for a portion, usually 20%.

Plans for the Elderly

These plans offer coverage to a group of people that were traditionally considered a high risk group. The structure of the coverage is much like a Mediclaim policy but with somewhat tighter limits on payment for treatment costs and lower sum insured amounts. Special attention is paid to diseases of the elderly in setting limits. For example payment for treatment prostate disease might have a separate sub-limit. The expansion into this market will have to be done carefully given that the cost relativity for someone in the 60's might be 4-6 times that of a 25 year old. Recognition of that fact in the pricing and underwriting of these policies will make it possible for insurers to venture into this market. In addition, products which have a significant co-pay are favored by insurers when providing cover to the elderly. The co-pay encourages the policy holder to shop for the most cost effective treatment as well as to scrutinize hospital bills, since they are paying for a portion, usually 20%. By involving the policy holder in cost sharing the insurer seeks to leverage the policy holder's abilities in managing cost of treatment. Another alternative adopted by insurers is to limit cashless coverage to a specific amount, say Rs.1 lac, and provide additional cover in the form of a reimbursement benefit. This also involves the policy holder in cost management as they are paying a component out of pocket initially.

Critical Illness

Critical illness benefits are most commonly sold by life insurers as riders to life policies. They are usually structured in a way which pays a defined percentage of the policy amount in the event a policyholder is diagnosed with one of several designated critical illnesses. Some insurers are offering these policies on a stand alone basis.

Precise definitions of the covered illnesses and good underwriting are extremely important when this benefit is sold. The potential for adverse selection at issue is very great, and it is important that an insurer undertake the necessary efforts to determine if an applicant already has one of the covered diseases. Asymmetric information regarding a patient's condition would make offering these riders untenable. While these coverages are quite common in private health insurance markets around the world, it is not a widely held benefit and little data exists to validate the assumptions regarding disease probabilities. This alone justifies a cautious approach to underwriting and pricing these benefits.

Disease Benefits

A variation on the critical illness rider offers coverage for the treatment of the disease conditions as opposed to a cash payout if the diagnosis is present. Payment is made under the terms of these policies only to indemnify the insured for the cost of treatments. As with the Critical Illness benefit, adverse selection is always of great concern under these policies, and so offering these benefits requires skillful and expert underwriting.

Just as in the Critical Illness benefit, it is important to have some sense of the prevalence and incidence of the covered diseases. The Indian incidence rates, for these diseases, are not well known, particularly in an insured population. Public health officials have made estimates for the overall population of the prevalence of critical illnesses (see Table 1). Incidence of disease and the related treatments are of utmost interest to insurers. The mere existence of a disease in a population does not necessarily translate into incidence of treatment at any given point in time, given some people are asymptomatic and go from day to day without using the healthcare system.

Covering all outpatient expenses in addition to inpatient expenses would be a huge broadening of the scope of policy benefits and would represent a major shift in the philosophy of health insurance in India.

these patients is achievable and worthwhile. If a clinical management approach is used, the overall cost of the case may be reduced. Such is the case with the Diabetes benefit currently being offered by Star in Chennai. Diabetes lends itself nicely to a case management approach.

If a terminal illness is involved, then helping to arrange for hospice or other end-of -life support may also help to provide more efficient and appropriate care to covered individuals.

Outpatient Benefits

Inclusion of non-inpatient benefits is an interesting issue in the Indian context. Historically, Mediclaim has covered only inpatient facility and professional claims along with some of the pre-admission and post admission expenses. Covering all outpatient expenses in addition to inpatient expenses would be a huge broadening of the scope of policy benefits and would represent a major shift in the philosophy of health insurance in India. Those companies in India that have experimented with such policy broadening have experienced huge increases in claim volumes and the associated administrative expenses. To this point, the focus has been on offering policies which protect the policyholder from costly care that might threaten a person's financial security. This has been done with an indemnity policy that has a sum insured cap on the insurer's liability. If outpatient services are covered, additional care must be taken when underwriting and pricing the policy. Experience in other markets around the world shows that such policies can be overused or used for illnesses that could have (and would have in the absence of insurance) been self-treated or financed out of pocket. Even younger, healthier policyholders are likely to avail themselves of the services covered under these policies.

Table 1- CRITICAL ILLNESS PREVALENCE

Disease Name	Per 1000	
	India	US
Cancer	0.945	0.439
Coronary Artery Disease	4.000	48.500
Cardiac Valve Replacement	1.156	Very low
Major Organ Failure and Related Transplant Surgeries	Very low	0.000
Stroke and Paralysis	2.030	16.949
Cardiac Valve Replacement (rheumatic heart disease)	1.156	Very low
Renal Failure	7.852	1.443
Multiple Sclerosis	Very low	1.429

Source: *Various sources including Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, India. ammu@ndb.vsnl.net.in and the World Health Organization.*

However, since most of the typical diseases covered by these policies (i.e., cancer, cardiac failure, myocardial infarction, kidney failure, major organ failure and related transplant surgeries, stroke, paralysis, coronary artery disease and related bypass graft surgery, cardiac valve replacement and multiple sclerosis) involve hospitalizations at some point during the course of treatment, current Mediclaim and other Indian insurance data could be used to develop estimates of incidence rates. Using that information and actuarial judgment, reasonable prices can be assigned to these policies.

One important policy structure issue is whether to sell these policies on a sum insured basis as is Mediclaim, or on some other basis. Additionally, it will be essential for the insurers to consider whether case management or disease management of

Pricing Expanded Health Services

There are many pricing considerations for expanded health benefits. They include:

- the diagnoses covered
- the procedures covered
- the service area of the policyholder(s)
- provider fees for services rendered and cost sharing with the policyholder

- underwriting and risk assessment processes used
- whether it is a large group, small group or individual policy
- the place the service is rendered
- new claim volumes and the associated cost of processing
- pre-submission review and management of the claim

Naturally, data and a general rating model will be needed to estimate the rates for a given policy. The basic formula for calculating the claim cost component of a policy rate is:

Cost per service x *Number of services per policyholder = Cost per policy for some unit of time (usually a month or year).*

The statistics – cost per service and number of services – can be greatly influenced by the pricing considerations mentioned above. For example, it is not uncommon to see hospital inpatient utilization rates vary by 50% or more among geographic regions of the same state.

Typically, the starting costs for developing a company's internal tariff rates would be organized by types of service as shown below in Table 2. Table 2 is a very basic and simplified example of an "actuarial cost model", of the sort the actuary uses to price health insurance benefits. The types of service shown are separated into three broad categories first. They are Facility, Physician and Other. The Facility costs are simply the costs for the use of the facilities such as room and board for inpatient and emergency or outpatient surgical suite for example. Physician charges are for any service or procedure ordered or performed by a physician. The other category would be a collection of everything else and might include such services as pharmaceuticals or medical devices.

In Tables 2, 3 and 4, we show purely illustrative costs for the various service types and utilization rates that reflect very approximate expectations of usage for inpatient and outpatient services. These data are not intended to be used as a basis for rating and are shown only to illustrate the data that is needed, and how it is typically used in an actuarial analysis. When rating an actual insurance product, an insurer should carefully develop assumption values which reflect their own policies' benefit levels and negotiated costs with their providers, along with their best estimates of the impact of all of the rating factors mentioned above.

Imagining for the sake of illustration that the costs in Table 2 are roughly representative of an Indian insurer's costs to provide an unlimited payment for most health care costs, you can see that by adding the new benefits you would nearly quadruple the cost of coverage.

Looking at the Table, one can see that inpatient facility costs represent about 20% of the overall cost of these benefits. This is important because these are the primary costs covered, along with a portion of what is shown here as physician cost, by Mediclaim policies in India today. Together these costs combined might be about 30% of total potential costs. Expanding benefits as illustrated here will greatly increase both the cost to policyholders and the insurer's exposure to risk. Consequently, insurers will want to introduce policyholder cost sharing along with inside limits on the payout for some of the expanded benefits

Table 2- ILLUSTRATIVE COST OF BENEFITS BY TYPE OF SERVICE

Type of Service Hospital	Unit	Cost per Service INR	Services per Policyholder	Annual Cost per Policy- INR	Cost Per Month
Inpatient	Admission	50000	0.06	3000	250
Outpatient	Case	900	1.20	1080	90
Total Facility				4080	340
Physician					
Visits		400	5	2000	167
Procedures		4000	0.7	2800	233
Tests		750	7	5250	437.5
Total					
Physician				10050	837.5
Other					
Pharmacy	Script	75	20	1500	125
DME		1200	0.1	120	10
Glasses	500	0.2	100	8	
Other		200	0.2	40	3
Total Other				1760	147
Grand Total				15890	1324

as the new benefits are introduced into the market. Pricing such cost sharing requires another, different actuarial tool called a "claims probability distribution".

In the Table that follows, we present an example of a claims probability distribution (CPD). The Table shows, for various categories of claim size, the probability of a claim of a given size and the average cost of those claims. This distribution is intended to represent the full benefit potential cost of claims with no policy-holder cost sharing, as there would be with a Mediclaim policy. This CPD can then be used to calculate the impact of deductibles, coinsurance and sum-insured maximums on expected policy claims cost. In addition to modeling the impact of benefit changes one must deal with the other rating factors mentioned above. For example the underwriter must account for the difference in benefit usage between a person that has an INR 20,000 sum-insured and a 5 lac sum-insured. Benefit usage would likely be somewhat more conservative under the lower benefit as the insured individual must be more conscious of his benefit utilization than the individual with the larger policy.

Table 4 is an illustrative Mediclaim pricing for a very low benefit level. It shows how one might use the claim probability distribution to model the cost of an INR 20000 sum-insured policy that covers a full scope of services. The pure benefit difference between the theoretical full benefit cost of INR 15,890 and the INR 20,000 benefit cost of INR 9,250 is about 40%. This measures only the difference in expected costs attributable to the benefit cap under equal utilization rates. The expected costs would be further reduced by a factor of 10-15% to reflect the impact of the lower benefit maximum in reducing benefit utilization rates. In this way, the actuary can develop an expected claim cost for use in the insurer's rate calculations.

The pricing shown in Tables 2, 3, and 4 is a very important scheme for insurers to become familiar with. Compiling the necessary data to analyze costs for the new services will be challenging. Creating a model of those costs which can be tested and improved as experience emerges will be crucial for the industry success in the Indian health insurance market over the long term.

Table 3- ILLUSTRATIVE CLAIM PROBABILITY DISTRIBUTION

INR Range	Average Cost per Claim	% of Claims	Cost per Policy per Annum	Cost per Policy per Month
0	0	35.00%	0	0
1-5000	4000	10.00%	400	33
5001 - 10000	7800	10.00%	780	65
10001 - 15000	12800	10.00%	1280	107
15001 - 20000	17900	10.00%	1790	149
20001 - 25000	22900	10.00%	2290	191
25001 - 30000	28500	10.00%	2850	238
30001 +	130000	5.00%	6500	542
Average	24446	100.00%	15890	1324

Table 4- PRICING A INR 20,000 INR SUM-INSURED POLICY

INR Range	Average Cost per Claim	% of Claims	Cost per Policy per Annum	Cost per Policy per Month
0	0	35.00%	0	0
1-5000	4000	10.00%	400	33
5001 - 10000	7800	10.00%	780	65
10001 - 15000	12800	10.00%	1280	107
15001 - 20000	17900	10.00%	1790	149
20001 - 25000	20000	10.00%	2000	167
25001 - 30000	20000	10.00%	2000	167
30001 +	20000	5.00%	1000	83
Average	14231	100.00%	9250	771

Potential Impact on Trends

A thorough and comprehensive analysis of claim cost trends is vital to the health insurance pricing process. Trend analysis typically combines a review of historical experience over some time period along with a consideration of the factors that may cause costs to change going forward. In a market with new, broader benefits being frequently introduced, it will be extremely important to parse the historical data into homogeneous sub-classes to understand the drivers of change.

For example, consider three years of claims costs data, in which the underlying benefit mix includes various proportion of the following benefits:

- Hospital Inpatient and Outpatient Only (H)
- Hospital plus Physician (H+P)

- Hospital plus Physician and Other (H+P+O)

Let's say for this example that in Year 1, the enrollment was 100% in Hospital Only benefits, Year 2 the enrollment mix was 80% Hospital Only and 20% Hospital plus Physician and in year 3 the mix was 70% Hospital Only, 20% Hospital plus Physician and 10% Other. Let's assume further for the sake of simplicity that there is no underlying cost trend. As illustrated in Table 5 below, any analysis that is done using total cost in aggregate across all benefits (without segregating claims into benefit categories) will show that there was an apparent trend.

In the example shown above, we calculate Weighted Average Cost by multiplying the monthly costs by benefit type by the percentage of the population holding that benefit type. For example: .8 x 340 + .2 x 1177.5 = 506.

Table 5 - ENROLLMENT % AND COST BY YEAR

	Year 1	Year 2	Year 3	Monthly Costs By Benefit Type from Table 2
H	100%	80%	70%	340
H+P	0%	20%	20%	1177.5
H+P+O	0%	0%	10%	1324
Weighted Average Cost	340	506	606	
Apparent Trend		506/340	606/506	
Percent Increase	-	49%	20%	

Having a good data management and analysis capability will be essential in the coming months and years. This capability has not been universally held by all insurers in the past, although many improvements have been made in the quality of the data being captured and in the reporting of that data by some.

So, from the example, we see a 49% growth trend from Year 1 to Year 2, but this trend is wholly attributable to the expansion of additional benefits to 20% of the insured population. The actual underlying (secular) trend in the example is 0%. While this is an exaggerated example to illustrate the concept, it will nonetheless be extremely important for an insurer to be able to differentiate and categorize data into meaningful groups to enable appropriate analysis.

In addition to the data analysis issue, enrollees in these broader benefits will most likely behave very differently than those that held the Mediclaim policy. Historical experience over the years in other markets shows that, absent any other controls, enrollees with richer benefits will exhibit higher utilization rates than those with less rich benefits. This phenomenon (commonly called "induced utilization") will affect the trends that are developed from historical data, since higher utilization rates will result in higher claim cost trends. Having a good data management and analysis capability will be essential in the coming months and years. This capability has not been universally held by all insurers in the past, although many improvements have been made in the quality of the data being captured and in the reporting of that data by some.

Underwriting Tools for the New Benefits

We have identified two key components necessary to successfully introduce expanded benefits into the Indian health insurance market: the ability to model expected costs, and the ability to track claims experience and trends by homogeneous groupings as it emerges. The third and final component presented in this paper is the ability to identify, classify and select risks to be insured.

Today, Indian insurers are using medical information to a limited extent to underwrite individuals and small groups. The most often used tool for managing risk selection is the denial of claims for pre-existing conditions. While effective, this approach has caused much concern in the market because of poor communication and buyer expectations. A person buying a policy may not know if a future medical service will be covered.

The current definition of a pre-existing condition subject to exclusion in India is any condition that would have been present at the time of policy purchase, even if the patient was asymptomatic at

that time and did not know they had the problem. This is considerably more onerous than the definition used in other countries, where the definition of a pre-existing condition is based on the time between last treatment and the new claim. If that period is 12 months, or longer, the condition is not considered pre-existing. In some policies there is a 3-, 6-, or 12-month "look back" from the enrollment date to establish if a diagnosis or treatment had been given. Under a look-back provision, a condition must have been diagnosed or treated within the look-back period to be considered pre-existing for purposes of the coverage exclusion. Additionally, usually there is no more than a 12-month exclusion after policy issue for future treatments relating to conditions that are found in the look-back period.

If pre-existing condition exclusions are to be brought more in line with the global standard, this will make the exclusions less effective at controlling risk. As a result, Indian insurers will need to do more effective medical underwriting to classify the risk of an individual or group. Classifying risk allows an insurer to charge an appropriate premium rate, devise an appropriate benefit structure, or in certain cases decline to issue coverage to risks it believes are uninsurable. To do this, medical data will have to be easily captured and translated into risk scores that measure the morbidity level of an individual or group relative to the insurer's entire book of business or some other norm.

The development of a risk score methodology is a complex task to which insurers and other experts have devoted a great deal of time, thought and research. One approach (common for individual and small group coverage, but not common for larger employer coverage) is to conduct an analysis of the medical history and conditions that become known to the insurer via the application form. A risk score is assigned based on specific medical conditions and other criteria present in the applicant. An insurer will use an analytical tool, or "underwriting guideline" to develop an estimate of the impact that medical condition will have on future claim costs.

Below we show a sample underwriting guideline for aneurysm. It requires a series of questions be asked and answered about the course of the problem and the patient's current symptoms. Armed with this information a risk score can be assigned to the individual that would translate into a rate or benefit adjustment, or that would indicate the individual be declined coverage.

Aneurysm

A sac formed by the dilatation of the wall of an artery or the heart. The causative reason may be congenital, (e.g., anterior cerebral artery), traumatic (e.g., popliteal in a football player), or diseaserelated, (e.g., cardiac aneurysm).

In Table 6, you see first the medical definition of an aneurysm, followed by a

Table 6 - RISK CLASSIFICATION USING DEBITS TO REFLECT FUTURE COSTS

	Elapsed Time	Debit Points	Riders	Debit Points w/ Riders
Development				
1. Age at onset				
2. Symptoms				
3. What vessel is involved?				
Is the heart involved?				
4. Etiology				
5. Hemorrhage?				
Rating				
Cerebral artery ("berry")		500		
Unoperated	<2 years	100		
Operated	>2 years	15		
Aortic, abdominal, thoracic		500		
Unoperated	<2 years	175		
Operated	>2 years	125		
Peripheral artery		200		
Unoperated	<1 year	75		
Operated	13 years	35		
>3 years	STD			
Cardiac or ventricular		SA+100		

Source: *Milliman Medical Underwriting Guidelines (MUGs)*

In a growing market, it will be important to systematize and automate the data collection and risk scoring process as much as possible. Additionally, the risk score assigned to an individual must be translated in a well-defined, objective, and formulaic way into the rate or benefit decision for that policy.

set of questions that an underwriter should use to gather sufficient information regarding an applicant who has indicated that he/she has had an aneurysm in the past. A trained, experienced underwriter can use this information to assess the risk to the insurer of enrolling the applicant. Following those questions are a list of specific types of aneurysm and their time since onset. For each, the guidelines assign "Debit Points", the analytical score which indicates the relative risk of the individual to the insurer. In the Table, "STD" means the person has achieved the same risk score as a "standard" person. "SA" means symptom of another condition.

A complete set of underwriting guidelines will include underwriting considerations and debit points assigned for hundreds of the most common and significant medical conditions. Only then will the tool be able to provide enough guidance to the underwriters to protect the insurer from a wide range of potential risks and for them to deal with risk classification in a systematic way.

In a growing market, it will be important to systematize and automate the data collection and risk scoring process as much as possible. Additionally, the risk score assigned to an individual must be translated in a well-defined, objective, and formulaic way into the rate or benefit decision for that policy. Typically such formulas are designed by an insurer's actuary working in conjunction with underwriting staff.

Conclusion

The expansion and liberalization of medical and health related benefits seem inevitable in the Indian market. Actuaries and underwriters will play an important role ensuring the ongoing solvency and financial capacity of the health insurance industry by protecting insurers from adverse selection and bad pricing decisions. Investing in the creation of actuarial pricing models and accumulating and analyzing data to help inform the process of benefit expansion will save the insurance industry several lakhs of rupees over the short and long term. Creating disciplined, objective, and to the extent possible, automated processes to assist the actuarial and underwriting functions in advance of the new health benefits will be the key to long term success.

Richard Kipp is the Managing Director of Milliman in India and can be reached at richard.kipp@milliman.com. Tom Snook is a principal with the Phoenix, USA office of Milliman and can be contacted at tom.snook@milliman.com.

Health Security for All

Government Initiatives in Health Insurance

DR. SOMIL NAGPAL, DR. N DEVADASAN AND NEHAL JAIN NARRATE THE DETAILS OF THE VARIOUS GOVERNMENT SCHEMES IN HEALTHCARE PROTECTION - SOME OF WHICH HAVE BEEN SUCCESSFUL AND OTHERS NOT SO. THEY OPINE THAT THE INITIATIVES WHICH PARTICULARLY ADDRESS THE HEALTH NEEDS OF THE VULNERABLE GROUPS ARE ESSENTIAL FOR A MORE WIDESPREAD FORM OF HEALTH SECURITY.

Introduction

This article attempts to trace the recent government initiatives, by central, state and local government bodies, in providing health insurance coverage within their respective jurisdictions. The paper also briefly touches upon the widely recognized government-mandated schemes - CGHS and ESIS - targeted at the government employees and the formal sector respectively; and then moves on to discuss schemes with more inclusive coverage, including those aimed at rural and poor households.

Employees' State Insurance Scheme (ESIS)[1]

Formal systems for Health Insurance and health related social security in India began with the inception of the Employees' State Insurance Scheme, introduced vide the ESI Act, 1948, which provides for both cash and medical benefits to its members. It covers about 35.5 million beneficiaries, which includes workers employed in the formal sector and their dependents, in organizations which meet certain criteria in terms of size of the unit and the wages of the workers. ESIS provides for comprehensive health services through a network of its own dispensaries and hospitals, and the network is supplemented by Authorized Medical Attendants and private hospitals as per need.

The coverage includes OPD and IPD services, and a variety of cash benefits to compensate for loss of pay and other eventualities. The scheme is financed by a contribution from employers, employees and by the central and state governments. The contribution by employers and employees is the largest source for finance, which in turn is a defined percentage of the wages of the employees. Of late, the ESI Corporation managing the ESI scheme has been recording a sizeable surplus every year, which has been linked to the contributions by higher paid workers, currently those drawing up to Rs.10,000 per month.

ESIS provides for comprehensive health services through a network of its own dispensaries and hospitals, and the network is supplemented by Authorized Medical Attendants and private hospitals as per need.

1 Internet. http://esic.nic.in accessed on 12th December 2007.

The UHIS also provided a useful model for many subsequent state government and community initiatives in health insurance to build upon.

Central Government Health Scheme (CGHS)

CGHS was introduced in 1954 and is a contributory health scheme providing comprehensive medical care to the central government employees and their families - both serving and retired, Members of Parliament, Supreme Court and High Court judges; and certain other categories of beneficiaries[2]. CGHS has over 44 lakh beneficiaries, and is financed largely by the Government of India budget, while the government employees also contribute a nominal amount (currently ranging from Rs 15 to Rs 150 per month) from their salaries based on their scale of pay. The coverage is comprehensive and includes both outpatient care and hospitalization. Outpatient care is provided through CGHS dispensaries located in major cities. It also uses the facilities of the government and approved private hospitals to provide inpatient care and reimburses the expenses to the patient or the hospital, as the case may be.

Universal Health Insurance Scheme (UHIS)[3]

It was in 2003 that the Ministry of Finance announced, with ambitious targets, the rolling out of a new health insurance scheme to address the needs of all sections of the society. The scheme was named the Universal Health Insurance Scheme, and was implemented through the four public sector general insurance companies. The policy, which was modeled on the existing 'Mediclaim' health insurance product, provided reimbursement of hospitalisation expenses up to Rs.30,000/- to an individual or as a floater over his family (subject to certain sub-limits on bed costs, surgeon/ anesthetist fee, any one illness etc.), in addition to some personal accident and disability cover. The premium of Rs 365 per person and Rs 545 per family was subsidized for those below the poverty line, and the net premium for this group, after subsidies, is presently Rs 165 per individual and Rs 245 for a family of 5.

The scheme, however, remained far from universal, and the enrolled numbers were a miniscule fraction of the target population. The scheme was, however, significant in its intent - that of the union government to promote and subsidize an affordable health insurance product. The UHIS also provided a useful model for many subsequent state government and community initiatives in health insurance to build upon.

Enabling Provisions in National Rural Health Mission (NRHM)[4]

In 2006, the Ministry of Health and Family Welfare published a Framework for developing Health Insurance programs, under the umbrella of the National Rural Health Mission (NRHM) which stated that in addition to strengthening public health facilities, health insurance would also be used to remove financing barriers and improve access to healthcare, for financial protection and to improve quality of healthcare. The framework also clearly laid down certain pre-requisites for such government subsidized health insurance schemes and made a provision for subsidizing such health insurance initiatives undertaken by the states, within the NRHM framework.

Some states have already proposed and even initiated health insurance schemes with funding support from Government of India under this NRHM framework. In other cases, certain schemes have been initiated by states and local government bodies from within their own resources also. Increasingly, there is willingness and support available from the government to make financial protection through the health insurance mechanism more widely

2 Internet. http://mohfw.nic.in/cghs.htm accessed on 11th December 2007

3 Govt of India. Budget documents for 2003-04. Also based on information at websites of the public sector insurance companies.

4 Internet. www.mohfw.nic.in/NRHM/Documents/framework_for_health_insurance.pdf accessed on 13th Dec 2007

available. Some such schemes are discussed in more detail below.

Critical Illness and Personal Accident Scheme, Assam[5]

This is a combined critical illness indemnity cover for specified diseases (sum insured of Rs 25,000) along with an accidental death and disability cover (sum insured of Rs 50,000), fully paid for by the Government of Assam. The policy covers the entire electorate of the state along with their dependents, of ages 3 years to 80 years, barring government employees and those earning more than Rs 2 lakhs a year, which means about 30 million people. The scheme, designated Mukhyamantri'r Jibon Jyoti Bima Achoni is implemented through Revenue Circle Officers of the state who receive and scrutinize claims and pass them on to the insurer for reimbursement. Against a premium of Rs.25 crore (including tax), the claims paid during Aug 2005 to July 2006 amounted to Rs.9 crore for over 4,200 claimants[6].

An independent Sanjivni Trust was set up which managed the entire scheme. All members of the cooperative societies in the state were eligible to enroll for this scheme and the enrolment unit was the family.

Sanjivni Scheme, Punjab

The government of Punjab launched the *Sanjivni health care scheme for members of rural cooperatives in Punjab* in April 2006. For this an independent Sanjivni Trust was set up which managed the entire scheme. All members of the cooperative societies in the state were eligible to enroll for this scheme and the enrolment unit was the family. The premium was Rs 400 per family and it covered all surgical treatment up to Rs.2 lakh per family. Deliveries were also covered up to Rs 10,000 per delivery and Rs 25,000 per family. Patients had to use empanelled hospitals only. The Sanjivni trust had empanelled all the government hospitals in the state as well as 307 private hospitals. The empanelment criterion was based on infrastructure, and there was no conspicuous attempt at cost control mechanisms. A TPA was employed to administer the scheme and provide cashless services and a large private insurance company was the insurer of this scheme.

In the first year (April 2006 – March 2007), 2 lakh families (out of 18 lakh cooperative members) joined this scheme. The premium collected was Rs.8 crore. Unfortunately, because of the lack of cost control measures in the design of the scheme, the claim experience of the scheme was very adverse, and approximately 5384 claims amounting to Rs.35 crore were made in the first year itself. This high claims ratio was a major setback to the scheme. The Sanjivni trust and the insurance company are involved in negotiating a new premium, but in the meantime, the scheme has been discontinued.

Kudumbashree, Kerala

The Comprehensive health insurance scheme for BPL families was developed by the Government of Kerala, specifically its Kudumbashree unit. These neighbourhood units were a well organized group of BPL women who were the recipients of various government development programmes. The Kerala government planned to introduce health insurance for these women and their families in order to protect them from high medical expenses and resultant impoverishment.

They attempted to improve on the design of the Universal Health Insurance scheme (UHIS) and planned to also cover pre-existing diseases, maternity and mental illness, while minimizing exclusions. They also added additional benefits like personal accident cover (up to Rs. One lakh) as well as bystander allowance (Rs 50 per day up to a maximum of Rs 350) and domiciliary hospitalization (up to Rs 6000) as part of the package design.

A large private insurer was willing to insure this product and also quoted a premium of Rs 399. The government of Kerala planned to raise this premium from various sources and would itself pay Rs 33 per family covered, and requested the local governments to pay another Rs 33 while each family in turn was also to pay Rs 33.

5 Government of Assam, Planning and Development department. Guidelines for Mukhyamantri'r Jibon Jyoti Bima Achoni 2005-06. Aug 2005.

6 Internet. Policy Reforms Options Database, India available at http://www.cbhi-hsprod.nic.in/ret.asp accessed on 12th December 2007.

The rest Rs 300 was supposed to come from the Government of India – which was expected to be agreed upon on the same lines as the Ministry of Finance's subsidy to the UHIS.

The local government's and the families' contribution was collected through the Kudumbashree mechanism. About 16 lakh members were enrolled by paying their contribution of Rs 33. However, as the largest planned source of funds, the Government of India, refused to pay Rs 300 as subsidy (largely because the scheme was a modified one and not the UHIS, which also meant the insurer was a private insurance company and not a public sector insurance company as was the case in UHIS), this scheme did not take off and is yet to see the light of the day.

Senior Citizens Health Insurance Scheme, Indore Municipal Corporation[7]

Pandit Deendayal Upadhyaya Senior Citizen Health Insurance Scheme of Indore Municipal Corporation (IMC) is a group health insurance scheme, which is fully funded by the corporation and is made available free of cost to the senior citizens between 60-80 years residing in Indore city. The scheme covers hospitalization for a sum insured of Rs 20,000, with sub-limits of Rs 4000, 7000 and 12000 based on the nature of hospitalization (conservative, minor surgery or major surgery respectively) and with coverage for all pre-existing diseases and no first-year exclusions. The scheme began in 2003-04 and is presently in its fifth year. Services are available through a network of hospitals in Indore, administered by a TPA, and cashless services are available in network hospitals up to the specified sub-limit. The premium paid by IMC for 2007-08 is Rs 395 per beneficiary, including taxes and TPA costs. The members getting hospitalized are required to pay a deductible of Rs 500 per hospitalization, which is taken in the corpus of IMC to partially pay for the next year's insurance.

The members getting hospitalized are required to pay a deductible of Rs 500 per hospitalization, which is taken in the corpus of IMC to partially pay for the next year's insurance.

Since the amount of reimbursement to the hospital or the individual is fixed, it serves as a strong incentive to control costs, as any additional costs are payable by the insured. Thus, to minimize his own expenditure, the beneficiary would need to avail of services in charitable or medical college hospitals. The scheme has thus been able to demonstrate viability even at this pricing of the premium and the claim ratios have been well under control. And while there are logistics and other issues which need to be streamlined further, the scheme has demonstrated that even a local government can garner resources for health security of its vulnerable groups.

Rajasthan Swasthya Bima Yojana

The Government of Rajasthan has very recently launched the Rajasthan Swasthya Bima Yojana on 8th December 2007 after months of intensive planning and preparation to design a patient friendly product. All BPL families in the five pilot districts of Rajasthan are covered under this scheme. The premium of Rs 480 is partly paid by the Government of India (Rs 300) and the Government of Rajasthan (Rs 180). The State Insurance & GPF Dept is the insurer for the scheme. Patients can go to either private or public providers to access hospital care. The sum assured for general illnesses is Rs 30,000 per family while for critical illnesses it is Rs 1.35 lakhs per family per year. Additionally, the insurance includes provision for diet of patient at the facility and transport cost is covered up to Rs 100 per hospitalization. Pre and post hospitalization expenses are also covered. Hospitals are in the process

7 IRDA. Report of the Committee on Health Insurance for Senior Citizens. IRDA, Nov 2007.

of being empanelled and a Standard treatment guidelines as well as a fixed tariff plan for more than 700 procedures have been made as cost control mechanisms.

The Medicare Relief Societies (a.k.a. Rogi Kalyan Samitis) will administer the scheme in the public hospitals, while a selected TPA will do so at the Private hospital level. The remaining districts are planned to be covered in a phased manner based on the implementation experience.

The Rashtriya Swasthya Bima Yojana (RSBY)

This is the most recent health insurance scheme from the Government of India's stable. It plans to cover all the BPL families in the country in a phased manner, and is implemented by the Ministry of Labour. In the initial year (2008 – 2009), 120 districts are being covered by this scheme in 28 states. An insurance company will be selected by the states based on open bidding and will both insure as well as administer the scheme. The BPL family (up to a maximum of 5 members) can enroll by paying Rs 30 as registration fee. In return they will be given a smart card that has their photograph, as well as their family details and thumb print impression.

The BPL patient can avail services from empanelled private hospital after validating his identification through the smart card. The smart card also debits his account for the expenses incurred and will inform the insurance company about this pending claim. If the insurance company accepts the claim, then the financial transaction is done through a transfer of funds.

Both private and public hospitals will be reimbursed by this scheme, provided that they have the prescribed facilities and are willing to accept the tariff plan as proposed by the insurance company.

While the owner of this scheme is the state government, there is a considerable premium subsidy (up to 75%) by the central government. There has been much back end work done already to ensure that this scheme is operational on April 1st 2008.

Lessons Learnt and the Road Ahead

The above discussion and illustrative examples of government initiated health insurance schemes makes it evident that there is certainly a growing interest in central, state and local governments to explore alternative mechanisms for providing health security to their people. Thus, while publicly funded health systems have been created and have their own importance in the system, there is certainly a role for plugging in many access issues through the mechanism of health insurance.

While publicly funded health systems have been created and have their own importance in the system, there is certainly a role for plugging in many access issues through the mechanism of health insurance.

It is access issues which play an important role in the utilization of benefits offered by health insurance. Thus, if a poor rural family is covered against hospitalization, but the nearest eligible hospital is too far or if the family is expected to pay first and seek reimbursement later, such factors act as a strong deterrent against utilization of healthcare even when it is essential. On the other hand, proximity to services, nil or low co-payments and low opportunity costs of seeking care, availability of cashless facility etc are factors which can drive up utilization and even lead to over-utilization.

The examples above also illustrate the importance of careful designing of any health insurance product before implementing the same, particularly in respect of providing checks and balances for adverse selection (in cases where the coverage is voluntary), cost escalation, moral hazard and malpractices, which need to be carefully addressed as much at the design stage as through subsequent monitoring and modifications of the scheme. Indeed, a scheme which does not continue for long could shake the confidence of the target beneficiaries in the health insurance system and could be detrimental to the health system and to health insurance. Similarly, as health insurance influences the behaviour of insured persons as well as providers, it could be used as a means to improve access and to encourage availability of services. However, on the other hand, a poorly

The other important area that needs to be addressed by future schemes launched by the government is the importance of a formal mechanism or structure to take ownership of the scheme, perhaps even to administer the scheme.

designed product could lead to cost escalations and may take healthcare out of the reach of the uninsured and also lead to a heavy social burden for meeting costs of healthcare.

While many states did enlist their public facilities as providers for their health insurance schemes, perhaps greater initial efforts would be needed to provide a level playing field to the public/ government hospitals- which could include, for example, co-payments for using private hospitals, or alternative remuneration mechanisms for public sector facilities, so that utilization of public health infrastructure also improves along with improvement in access for the citizens.

Cost control mechanisms in the design of the scheme, which prevent misutilization or overutilization of the benefits; and on the other hand, clauses in insurance covers which provide for refund/ discounts in premium for very favourable claim experience, are perhaps both necessary for long-term sustainability of these health security measures. This could include, among others, careful negotiation and contracting with providers to ensure quality, access and affordability.

Another key area to derive maximal benefits from mass health insurance schemes purchased by governments is to ensure adequate awareness amongst the beneficiaries who stand covered. While the ideal way to ensure awareness of such a scheme could well be collecting a contribution in the premium, even if it is a small amount, the administrative costs of such collection of small amounts have to be kept in mind. Also, some government schemes have been launched based on enrolment - where the beneficiary fills in a form, and so becomes aware that he is part of such a scheme. However, in many cases, premiums are paid by the government as a lump sum amount or deducted by a co-operative from its member's account, and the intended beneficiary may never even be aware of his being part of a health insurance scheme. This naturally impacts utilization, and claim ratios in initial periods remain low.

The other important area that needs to be addressed by future schemes launched by the government is the importance of a formal mechanism or structure to take ownership of the scheme, perhaps even to administer the scheme. It is not enough to design a good product, but it is also important to govern and monitor it closely. The UHIS was one such scheme that was launched without a clear administrative agency. The RSBY is hoping that the smart card will reduce the need for administration, and we wait with bated breath to see the initial implementation experience.

In the final analysis, while the ideal of a universal health insurance system may still be a far way off, these initiatives which particularly address the health needs of the vulnerable groups are certainly welcome and could indeed pave the way for a future, more widespread form of health security. There are lessons to be learnt from each scheme, and if those lessons are indeed learnt and utilized, the government interventions in ensuring health security for all would indeed be far more consequential and useful for the health system.

Dr. Somil Nagpal is Special Officer-Health Insurance, IRDA. Dr N Devadasan and Ms Nehal Jain are with the Institute of Public Health, Bangalore. Views expressed by the authors are in their personal capacity and do not reflect the organizations with which they are presently or previously affiliated.

A Case Study for **Micro Health Insurance**

VimoSEWA's Cashless Hospitalization

RAMESHWARI KHARVA DETAILS THE PURPOSEFULNESS OF CASHLESS HOSPITALIZATION AND OBSERVES THAT THE INITIAL HARDSHIP ASSOCIATED WITH ITS IMPLEMENTATION HAS BEEN WORTH ITS WHILE.

Background

SEWA, (Self Employed Women's Association) is working to organize self-employed women to make them fully employed and self-reliant. In the SEWA union, more than 120 categories of workers have been organized and mainly divided into categories like home based workers; street vendors; service providers and manual laborers; and producers.

VimoSEWA is the insurance unit of SEWA (a member based organization of Self-Employed Women Workers). SEWA's insurance program started in the early 1990's in response to our members' continuing quest for social protection and self-reliance. In 1992, SEWA's Integrated Social Security Scheme was initiated with coverage for life, asset loss, widowhood, personal accident, sickness and maternity benefits.

Health Insurance Programme

The integrated scheme incorporates health insurance as a crucial programme. The most important need and in other words the risk that SEWA members are facing is expenditure incurred on sickness. So to provide protection for such risks, heatlh insurance was included in its package. Under health insurance, it has been providing hospitalization insurance to its members.

Earlier system of claim reimbursement

Hitherto, under the health insurance scheme if a member was hospitalized, she could go to a provider of her choice. At the time of hospitalization, she had to pay out of her own pocket for expenses incurred. She then had to submit her hospitalization related documents to the VimoSEWA. The claims committee at Vimo SEWA examined these documents and reimbursed the member for admissible claims.

Piloting of Cashless system of reimbursement

One of the research initiatives of VimoSEWA highlighted some problems with this system. The most important problem was that when a member gets hospitalized, initially she needs to have cash in hand and besides, collection and submission of documents prevented some members from taking advantage of our services.

To reduce these barriers, VimoSEWA piloted a system of prospective reimbursement for its health insurance claimants in 2004. The system was initiated in eight rural talukas (blocks) which had a high number of insurance members. Under this system, claimants could get reimbursed while they were still in hospital. Also, the VimoSEWA local leader used to assist the member in getting the documents. However, to avail this benefit, members had to seek

The integrated scheme incorporates health insurance as a crucial programme. The most important need and in other words the risk that SEWA members are facing is expenditure incurred on sickness.

hospitalization in selected hospitals. The reason for offering this facility in selected hospitals was two-fold. For one, it would be logistically impossible for VimoSEWA *aagewans* to reach the various hospitals used by SEWA members. Secondly, the hospitals were selected on the basis of quality of services and charging reasonable rates. If members could be steered to the selected hospitals, VimoSEWA could make a more concerted effort to ensure quality services at reasonable costs for its members.

Introducing Cashless system in Ahmedabad city

Based on the positive experience of prospective reimbursement in rural areas of Gujarat, in January 2006, VimoSEWA introduced the system in Ahmedabad city - it was renamed 'cashless (CL) hospitalization'. VimoSEWA members could choose to use this new system of claim reimbursement or use the previous system. The objectives continued to be the same that VimoSEWA had in rural areas, viz.

- To facilitate access to hospitalization by providing immediate cash for hospitalization expenses
- To reduce the burden of collecting the required hospitalization documents for submitting a claim
- To direct members to inpatient facilities with acceptable levels of quality
- To avoid unnecessary hospitalization and cases of moral hazards by the medical practitioners
- To reduce the claim ratio; and
- To reduce administrative cost of claim servicing.

Hospital Selection criteria

The first step was to select hospitals to be included in the system. VimoSEWA's health claims database provided an initial list of hospitals used by VimoSEWA's members. We also conducted focus group discussions in the communities where our members reside to know more about their preferences for hospital care and the reasons for the same. A short listing of hospitals was then prepared which includes government, trust and private hospitals. VimoSEWA decided to select either government or trust hospitals; private hospitals were selected only in areas where no suitable government or trust hospitals were available. In these hospitals, special care was taken to negotiate the costs that VimoSEWA members would be charged for treatment. Criteria for hospital selection were as follows:

- Popularity of the hospital among members
- Member density in and around the hospital location (5-7 kms)
- Availability of doctors, specialists and services at the hospitals
- Availability of low cost quality care.

Hospitals linked with Cashless Reimbursement in Ahmedabad in 2007

Presently, the number of Trust, Government and Private Hospitals in Ahmedabad city is as follows:

Trust	Government	Private
15	4	3

In rural areas also, the ratio of trust hospitals is higher.

Trust	Government	Private
9	3	3

Process of Cashless Claim Reimbursement

Step 1

Insured goes to one of the selected hospitals.

Step 2

A family member makes a phone call to the 'Sthanikben' (local leader, specially assigned the task of cashless servicing)

We also conducted focus group discussions in the communities where our members reside to know more about their preferences for hospital care and the reasons for the same. A short listing of hospitals was then prepared which includes government, trust and private hospitals.

using the information on the pamphlet given to her. If the sthanikben responsible for the hospital is not available on the phone, the member can call up any of the other eight listed sthanikbens.

(Note: In Ahmedabad city we have 6 such sthanikbens handling 22 hospitals and in rural block, there is one sthanikben per taluka.)

The sthanikben tells the member (over phone) to keep ready a photocopy of the insurance receipt and the original bills for the costs incurred by the member until then.

Step 3

Sthanikben visits the patient/member at the hospital after ensuring that the member has spent at least 24 hours in the hospital. She collects a copy of the vimo receipt from the member and also information on the diagnosis of the patient,

expected duration of hospital stay and estimated cost of treatment. She enters this information in a prescribed format.

Step 4

Sthanikben comes to Vimo office with the information and the claims team scrutinizes the documents to decide if the claim is payable (In rural blocks, sthanikben verifies the claim on phone only). If so, the sthanikben collects cash to be paid to the patient. If the claim is not payable, then the member is informed about the same along with the reasons for the claim getting rejected. If a decision on the claim cannot be taken immediately, the member is informed about the same and she is advised to submit the claim as a 'regular' claim.

Step 5

If the claim is payable, the sthanikben makes a first installment cash payment to the member. The member is instructed to contact the sthanikben as soon as the discharge notice is given, so that the final payment can be made at that time. The member is thus paid in a minimum of two and maximum of three installments. If the hospitalization period is prolonged, then the member is made an interim payment. As far as possible, all payments are made at the hospital itself; however, sometimes the sthanikben has to go to the member's home to settle the payment. This occurs if the member does not inform the sthanikben on being discharged or if certain bills are submitted post-hospitalization. The member's signature is taken on the cash voucher on receipt of the payment.

Step 6

On making all the payments, the sthanikben submits the cash voucher and corresponding documents to the claims team at Vimo SEWA.

Step 7

The cashless case is considered closed when the member is reimbursed completely (as per the eligible amount); and all corresponding documents and original bills are submitted to the claims team.

The cashless case is considered closed when the member is reimbursed completely (as per the eligible amount); and all corresponding documents and original bills are submitted to the claims team.

Initial challenges

In 2006, the first year of the cashless programme in Ahmedabad city, this method of reimbursement was optional for members. In 2007 it was made mandatory and members were required to go only to one of the selected hospitals and use the CL reimbursement system.

During the first year of the system in Ahmedabad city, 24% of the total claimants used this facility. The same process is practised now where members do not have choice of hospitals, they have to go to the selected hospitals by VimoSEWA.

During the first eight months of 2007, the challenges we faced are listed below.

- Sthanikbens unable to make contact with hospitalized members:
  - Members would sometimes phone from a public call booth. However, before they could give the complete information about the hospital name, ward number, bed no. etc., their money would run out. It therefore became difficult for the Sthanikben to locate the members.
- Members contacting their local aagewans instead of the sthanikben:
  - The other problem we faced was that the members would phone up their local aagewans i.e. the person from whom they had purchased the insurance instead of phoning the sthanikben. The information either does not reach the sthanikben or reaches her too late to service the claim in the hospital..
- Delayed information to sthanikben:
  - Many members would call the Sthanikben at the time of discharge. Under such circumstances, the sthanikben cannot reimburse the members in the hospital because she did not have any time to verify and process the claim.

Addressing the challenges

The solution for the above problems was to strengthen the education given to members. As a result of this, after eight month of the cashless system, 60% of total cashless claims are reimbursed through using the proper channel.

Experience of Cashless Hospitalization in Ahmedabad City

- Although the aim was to have 100% cashless system in 2007, by the end of August 2007, 51% of the total claimants have utilized this system. However, there has been a steady increase in the proportion of cashless claims as can be seen in the figure below.

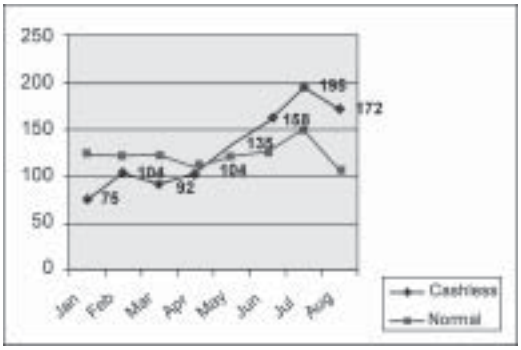
Month	Cashless claims	Normal claims	% of Cashless
Jan	75	124	38%
Feb	104	122	46%
Mar	92	123	43%
Apr	104	110	49%
May	135	121	53%
Jun	158	127	55%
Jul	195	149	57%
Aug	172	106	62%
Total	**1035**	**982**	**51%**

Claim experience: Cashless Vs. Normal (Ahmedabad City)

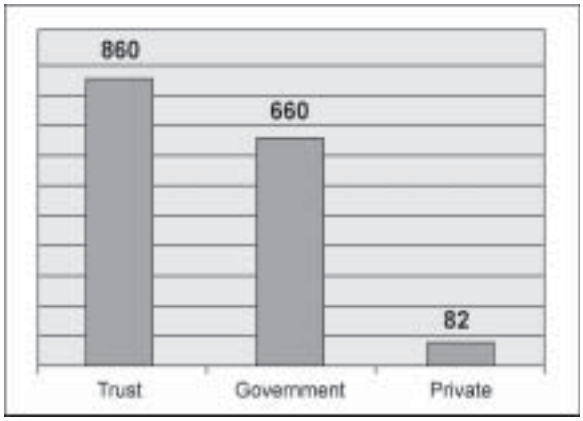
Servicing cost per claim

- At the same time, looking at the cost effectiveness of this system, the cost of servicing cashless claims is Rs.278/- per claim as against Rs.342/- of normal claim cost. So, cashless not only provides the immediate reimbursement to the members but also helps in reducing the cost for the organization.

Month	Cashless	Normal
Jan	502/-	360/-
Feb	353/-	372/-
Mar	329/-	482/-
April	351/-	404/-
May	262/-	291/-
June	228/-	295/-
July	188/-	238/-
Aug	216/-	336/-
Total	**278/-**	**342/-**



- The average claim cost has decreased from Rs.1841/- of regular claims to Rs.1761/- of cashless claims.
- The cashless system has reduced the claim processing period as it takes only the number of days the member is hospitalized while in the normal system, it takes more than that.
- The rejection rate for cashless hospitalization is 3% as against 18% for normal claims. The response of the hospitals cannot be ignored, as doctors are in direct contact of our sthanikbens. In government hospital, it is very difficult to get the written diagnosis on the visit report of SEWA but as our sthanikben visits the hospital on a regular basis, they have very good rapport with the hospital staff and thus they can easily get the written diagnosis.
- The Trust and Private hospitals assist the SEWA members in terms of reducing the hospital charges and also in providing proper documents.



Hospital Preference

The graph clearly shows that trust hospitals (N=860) and government hospitals (N=660) are preferred to private providers (N=82). Amongst all the hospitals, a government hospital has the highest number of claims (258). Thus cashless system has been successful in making its members access low cost quality care at reasonable rates.

Future Plans

In short, cashless hospitalization has been the most successful programme of VimoSEWA and it has achieved almost all the mentioned objectives. We are proceeding in the direction of minimizing the servicing and average claim payout as much as we can, by organizing regular meetings and workshops with the doctors of tie-up hospitals.

The cashless system has reduced the claim processing period as it takes only the number of days the member is hospitalized while in the normal system, it takes more than that.

The author is Training Co-ordinator, VimoSEWA.

Agriculture Insurance in India

Associated Problems

S.S. KUKREJA AND GAURAV NAGAR WRITE THAT IN ORDER TO PROVIDE SUPPORT TO THE FARMING COMMUNITY IN A TRUE SENSE, AGRICULTURE INSURANCE PRODUCTS NEED TO BE ACTUARIALLY BASED AND REALISTIC IN THEIR DESIGNING.

Agriculture, the backbone of India, provides gainful employment to more than two thirds of the population and contributes about 30% of GDP. It also earns valuable foreign exchange and supplies raw materials to various key industries apart from fulfilling food requirements of the country. The combination of high concentration of manpower in agriculture sector, mostly unorganized, with high density of poverty is a cause calling for various risk mitigation mechanisms.

Life in rural India inherits a lot of risks and farmers are at the mercy of vagaries of nature. The farming community is exposed to both controllable risks (like sickness, medical emergencies which can be mitigated by ploughing in own resources) and uncontrollable risks like droughts, cyclones etc. which deliver heavy punitive damages and require insurance protection.

Need for Agriculture Insurance in India

Agricultural activities are prone to various risks like floods, droughts, weather vagaries, pests, diseases etc. Weather, which plays a great role in the success of cultivation, is a risk which cannot be controlled or averted. Farming, particularly in India, is heavily dependent on monsoon. In such a scenario it is necessary to have a mechanism like crop insurance which enables them to transfer their agricultural risks to a third party. Apart from above cited risks, farmers are also exposed to risks which pertain to their income generating assets like tractor, cattle etc. Since the definition of agriculture comprises many ancillary activities like pisci-culture, seri-culture, poultry etc; it is imperative that the benefits of insurance reach the masses in lean periods who are not just involved in direct crop cultivation but also in allied activities.

Agricultural Risks

Risks in agriculture can be broadly classified into two types of risks:-

- Pre-cultivation & Growth Phase risks (Production risks): It involves weather vagaries, pests and diseases, improper cultivation practices, paucity of resources etc.
- Post cultivation risks (Market risks): Refers to losses due to adverse market dynamics, improper prices, glut, speculation activities of traders etc.

Agriculture Insurance Programs in India

Typically, risks which pertain to farming can be categorized into two broad categories; a) Crop based b) Non Crop based. Our discussion in this paper will address the former.

Crop based risks basically involves those factors which have a bearing on the crop due to adverse conditions and are beyond the control of human beings. It also includes acts of God like heavy or no rainfall, droughts, cyclones etc.

Agricultural activities are prone to various risks like floods, droughts, weather vagaries, pests, diseases etc. Weather, which plays a great role in the success of cultivation, is a risk which cannot be controlled or averted.

Crop insurance in India has been a widely discussed concern in esoteric circles where it lost direction due to being buried in maze of paperwork or destined for failure due to ill conceived, non-scientifically drafted schemes. Hardly any of the schemes had adequate risk spread with solid actuarial premium indexing.

The schemes have correctly focused on homogeneous area approach instead of individual farmer approach due to lack of dependable historical yield data for a

particular farmland to arrive at sound actuarial premium rates. The Central Government's pilot schemes did not find many takers amongst the states due to high financial implications since the governments had to act as reinsurers. In this backdrop of repeated ineffectiveness of the schemes, the Agricultural Price Commission, in 1970, revaluated the economic, administrative, financial and actuarial dimensions of the crop insurances in India. It found the schemes as waste of scarce financial resources and advised for abandoning the enterprise. Those were days of collectivist economic policies and socialist planners kept harping back, in political tones, on the necessities of such measures. As a result, schemes kept on popping on ad-hoc basis until 1985 when CCIS (Comprehensive Crop Insurance Scheme) was ushered in on the basis of learning from PCIS (Pilot Crop Insurance Scheme). Based on homogeneous area approach, it was a multi institutional agencies participation scheme involving Govt. of India & State Govt Agriculture Departments, Banking Institutions & GIC. CCIS was implemented from season of Kharif 1985 to Kharif 1999, which was later replaced by National Agriculture Insurance scheme (NAIS).

CCIS was an optional scheme for states. Fifteen states and two UTs adopted the scheme to be implemented in their respective states. (Source AIC).

Main features of CCIS were:

- Premium rates were 2% for Cereals and millets; and 1% for pulses and oil seeds. 50% of the premiums payable were subsidized and shared equally by state and central government;
- Premium and claims were shared in 2:1 ratio;
- Max. Sum Insured was 100% of crop loan which was later increased to 150%;
- Mandatory for farmers availing short term crop loans.

Since inceptions till the end of CCIS in 1999 the following nos. were achieved:

Farmers covered : 76,265,438

Total Area covered : 1, 27,570,282 hectares

Total Sum insured : Rs .24949 Crores

Total Insurance charges : Rs 403.56 Crores

Total Claims : Rs. 2303.45 Crores

Claim Ratio : 1:5.71

(Source - AIC)

In 1999, CCIS was replaced by National Agricultural insurance scheme (NAIS) or Rashtriya Krishi Bima Yojna (RKBY). NAIS was considered to be an improved version of CCIS, but there were certain limitations to it. NAIS was implemented by GIC. The main feature of the scheme was to protect farmers against losses suffered by them due to crop failure on account of natural calamities such as drought, flood, hailstorm, cyclone etc. It was presumed that NAIS will weed out the limitations of CCIS in the long run on the basis of sound groundwork, learning lessons from past experiences and with the help of rates derived from sound historical data and sound actuarial rates.

Since inceptions till the year 2005, AIC data reports progress of NAIS as follows:

Farmers covered : Rs. 75112215 lakhs

Total Area covered : 121,686,846 hectares

Total Sum insured : Rs .7, 075,773 lakhs

Total premium : Rs 2, 22,774 lakhs

Total Claims paid : Rs. 6, 82,938 lakhs

(Source- AIC)

Reasons for failures of Government aided Programs

Financially these programs had yielded enormous losses to government. One of the prominent features of all the above programs is that they had been highly subsidized. Government not just paid premiums but also bore administrative costs and thus their total costs exceeded their incomes, thus creating an invisible barrier for private players to try their hands in agriculture insurance.

Major reasons why crop insurance failed are as follows

- Lack of sound administrative practices by insurers,
- Insurance of uninsurable risks,
- Involvement of insurers with farmers for falsified claims due to lack of control,
- Use of insurers for political reasons,
- No portfolio/risk management,
- Lack of actuarial rates,
- CCIS considered as bancassurance,

CCIS Vs NAIS

Parameters	CCIS	NAIS
Farmers covered	Loanee Farmers	Compulsory for loanee farmers / optional for non loanee farmers
Crop Covered	Food crops & oilseeds	All CCIS crops + Annual commercial / horticulture crops
Premium subsidy	50% subsidy for small and marginal farmers	50% in first year for small and marginal farmers but to be phased out in five years.
Limit of sum insured	Rs.10000 per farmer	Up to the value of 150% of average yield. However sum insured exceeding value of threshold yield shall attract premium at actuarial rate
Participation by farmers	Compulsory for loanee farmers optional for non loanees	Compulsory for loanee farmers and
Approach	Area approach	Area approach. However in case of localized calamities, individual assessment in limited areas
Admin exp	GOI to reimburse 50% of expenses	GOI to reimburse 100% which is to be reduced on sunset basis. From 6th year onwards, all expenses to be borne by implementing agencies

One of the problems in index based weather insurance is that an individual can suffer a loss but still may not get a claim because the risk trigger did not occur.

- Lack of agricultural knowledge for insurer,
- Subsidy a major barrier for private players,
- Underestimation of risk assessment and occurrence.

Role of Private sector in Agriculture Insurance

With the opening up of insurance sector in 2000, the scenario of insurance industry has taken a dramatic turn. There exists a vast potential in rural and semi urban, particularly in agriculture where benefit of insurance is highly solicited but not reached. It is to be mentioned that despite regulatory requirements, companies are not taking much initiatives to spread their reach in rural sector. Most of their initiatives are just to fulfill the regulatory requirements of IRDA. One of the prominent features of rural sector is that of strong saving habits, and hence providing a huge potential to various industries including insurance. But lack of cost effective service delivery model and perception of huge investments in the sector deters them to exploit the opportunities.

Role of private sector in agriculture insurance had been limited to certain index based weather schemes. It started in year 2003 when ICICI Lombard, a private general insurance company, started its pilot program on rainfall insurance to protect the farmers of specified crop against deviation in rainfall. Since it was a pilot approach, the numbers were limited. Following the path, during Kharif 2004, IFFCO-Tokio General Insurance, another private general insurance company, launched its own variant of index based rainfall insurance program during kharif season, initially in four states and as on date in ten states. Having learnt valuable lessons from such enterprises, pilots are now being done on protection from weather vagaries occurring during Rabi crops.

Private weather insurance products have been gaining momentum in agricultural market. Some of the prominent features of these products are:

- Point of sale policy issuance - receipt cum policy,
- Policy and promotion in vernacular language,
- Revision of policy every year based on past data /experiences,
- Local IMD weather station to be considered as reference stations.

Issues with private weather insurance schemes which curtail expansion in wider geographical areas are as:

- Service and claims issues,
- Price not affordable,
- Farmers perceiving insurance as investment with sure returns instead of risk mitigation tool,
- Absence of relevant weather data,
- Absence of government infrastructure in setting up weather stations to be used as reference weather stations,
- Misappropriate data correlation with risk occurrence,
- Small Holding size and wide variety of agricultural practices,
- Moral hazards.

Road ahead

From the era of multi crop insurance, we have come to Index based weather insurance schemes. It is visualized that Index based weather contracts will eliminate the drawbacks associated with conventional weather products. Rainfall insurance products are best example of such products. Farmers get benefited if rainfall goes beyond a threshold level with stipulated compensation amount. This will eventually help in reduction of moral hazard, adverse selection and transaction costs. One of the problems in index based weather insurance is that an individual can suffer a loss but still may not get a claim because the risk trigger did not occur. A farmer availing rainfall insurance can lose his crop but may not get compensated since the reference data station figures remain above trigger point. Agriculture insurance products, which are to be offered, must be able to suit the farmers' needs. It is highly desirable that Government should utilize its money in setting up of agriculture infrastructure and research which will eventually have long term effects instead of financing the premiums. Premiums should be based on sound actuarial data with rational risk management techniques. Research costs of crop insurance programs, education of farmers about value of rainfall insurance, ensuring secured rainfall stations, legal and regulatory frameworks etc are some of the issues which require considerable deliberation form the government's side.

During Rabi 2007, a weather-based agricultural insurance scheme, where premiums are evenly subsidized by the Union Government and States has been rolled out across select districts in 12 states as part of a new initiative by the Government to offset risks underlying Indian farming. This is the first occasion that the government is using private insurers for a subsidized agricultural insurance package.

Mr. S.S Kukreja is Vice President & Head-Rural , Masses & Cooperatives, IFFCO Tokio General Insurance Company Private Ltd; and Mr. Gaurav Nagar is Assistant Manager-Rural , Masses & Cooperatives, IFFCO Tokio General Insurance Company Private Ltd. The views and opinions expressed in the article are those of the authors and not of any organization or institution.

प्रकाशक का संदेश

साधारण तथा जीवन बीमा क्षेत्र में स्वास्थ्य बीमा एक नया क्षेत्र है। एक वर्ग के रूप में पिछले कुछ समय में इस क्षेत्र में सतत् वृद्धि भी इसके महत्व के बारे में बड़ी मात्रा में बोलती है। ऐसे देश में जहाँ किसी भी प्रकार के हैल्थ केयर सुरक्षा के लिए कुल आवरण जिसमें राज्य द्वारा दिया गया तथा नियोक्ता द्वारा दी गई योजनाएं शामिल है। वह दोहरी इकाई में नही पहुँच पाती एक सतत् वृद्धि का स्वागत है।

देश में बड़ी संभाव्यता को देखते हुए तथा बढ़ते हुए आय स्तर को व वृद्धि को देखते हुए बीमाकर्ताओं को यह सुनिश्चित करना चाहिए की स्वास्थ्य बीमा लगातार निश्चित वृद्धि आने वाले भविष्य में भी रखे। इसे प्राप्त करने के लिए ग्राहकों के आधार को बढ़ाना होगा न केवल विपणन नीतियाँ बनाकर वरन् इसे सुनिश्चित करके की ज्यादा से ज्यादा लोग स्वास्थ्य बीमा आवरण के महत्व को पहचान सके यह संभव हो सकेगा यदि वितरण के कौशल तथा अन्य सभी संबंधित पक्ष जैसे तृतीय पक्ष प्रशासक सेवा उपलब्ध करवाने वाले इत्यादि इसके लिए तैयार रहे कि प्रचालन के नाजुक क्षेत्रों के लिए।

किसी भी वर्ग के बीमा की सफलता इस बात पर निर्भर करती है कि वह व्यक्तिगत के लिए कितना स्वंय निर्भर होती है, बिना किसी प्रकार की सहायता लिए बिना। प्राशुल्क मुक्ति ने इस बात की काफी हद तक देख-रेख की है। स्वास्थ्य बीमा के संबंध में एक प्रभावशाली बीमा लेखन प्रणाली कई समस्याओं के समाधान के संबोधन में मददगार होगी।

यह अगर बीमाकर्ता के बड़े पैमाने पर प्रबंधन के पोर्टफोलियो से संबंधित शिकायतों को समाप्त न कर सके लेकिन कम अवश्य करेगी। सेवा प्रदान करने वाले अपने स्तर पर ऐसे प्रयास करें कि ऐसी छवि की वे ग्राहकों को दबाते है यदि उनके पास बीमा आवरण दें इसे मिटाया जा सके प्रणाली को सुधारा जा सकता है, जबकि बीमाकर्ता, बीमाकर्ता सेवा प्रदान करने वाले संयुक्त रूप से प्रयास करे कि इस प्रणाली में व्याप्त कमियों को समाप्त किया जा सके।

जर्नल के इस अंक के केन्द्र बिन्दु में स्वास्थ्य बीमा है। इसे जानते हुए कि संपत्ति बनाना तथा संपत्ति का प्रबंधन प्रक्रिया संपूर्ण है यह भी जरूरी है कि आवश्यक तथा पर्याप्त बीमा आवरण प्रदान किया जाए, चाहे वह व्यक्ति के लिए हो अथवा किसी निगमित इकाई के लिए। व्यक्तिगत वित्तिय योजना में बीमा की भूमिका जर्नल के अगले अंक के केन्द्र बिन्दु में होगा।

सी. एस. राव

सी. एस. राव
अध्यक्ष

दृष्टि कोण

संयुक्त राज्य में चोरी की शिनाख्त करना सबसे बढ़ता हुआ अपराध बनता जा रहा है जो सभी आयु के उपभोक्ताओं को प्रभावित करता है। उपभोक्ताओं के लिए यह महत्वपूर्ण है कि अपनी सुरक्षा कैसे करे तथा इसके शिकंजे में आने के जोखिम को कैसे कम करे।

सुश्री सैंडी प्रैगियर

एनएआईसी की अध्यक्ष तथा कनसास बीमा कमिशनर

पिछले दो वर्षों में बीमा कंपनियों ने अपने निवेश पोर्टफोलियो से बड़े पैमाने पर राशि अर्जित की है जिसके लिए चीन को बढ़ती हुए बाजार को धन्यवाद देना चाहिए। यहाँ तक कि उनके पोर्टफोलियो ही उनके लाभ कमाने के स्त्रोत बन गये है... तक बीमा लेखन व्यवसाय से लाभ कमाना कठिन हो गया है।

श्री ली केम्यू

उपाध्यक्ष चीन बीमा विनियामक कमिशन

भारत में हैल्थ बीमा के बाजार सतत् विकास के कारण तथा बीमित व्यक्ति के लंबे समय के हित को ध्यान में रखते हुए हितधारियों का यह दायित्व है कि वे हैल्थ केयर प्रणाली को धारणता प्रदान करे।

श्री सी एस राव

अध्यक्ष, बीमा विनियामक विकास प्राधिकरण, भारत

पूंजी का प्रभावशाली विकल्प पुर्नबीमा है तथा सभी दावाकर्ताओं तथा पालिसीधारकों के हित में यह है कि वे बीमाकर्ता की दावा दायित्व को उसे भी जो पुर्नबीमाकर्ता से प्राप्त होना है संरक्षण प्रदान करे जो आस्ट्रेलिया में ठीक प्रकार सुरक्षित है।

श्री जान ट्रावोब्रीज

सदस्य आस्ट्रेलिया प्रूडेंशियल रेगुलेशन अथोरिटि

आज बीमा कंपनियों से धनराशि, पेंशन से धनराशि यहाँ तक खुदरा निवेशक से राशि आधारभूत संरचना के विकास के लिए जो देश के आर्थिक विकास के लिए आवश्यक है उपलब्ध है।

श्री कोला लूयू

कार्यकारी निदेशक, सिंगापुर मॉनेटरी अथोरिटि

बढ़ती समृद्धि तथा वृद्ध होती जनसंख्या सेवा निवृत्ति योजना तथा स्वस्थ देखभाल के लिए नये अवसर खोलेगी, भूमंडलीकरण तथा वाणिज्यक गतिविधियों को सामने आना जोखिम प्रबंधन के लिए स्थान प्रदान करेगा तथा बढ़ता जोखिम जलवायु बदलने तथा पालिसी के अतिसूक्ष्म परिवर्तन की मांग पैदा होगी।

श्री क्लेमेंट च्यूंग

कमिशनर ऑफ इंश्योरेंस, हांग कांग

ग्राहक जागरूकता बनाना जीवन बीमा

यह लेख श्री जी प्रभाकरा के नेशनल इंश्योरेंस अकादमी, पुणे में सी डी देशमुख सेमिनार में दिये गये व्याख्यान पर आधारित है।

1956 में देश में जीवन बीमा के राष्ट्रीयकरण की संध्या पर केन्द्रीय वित्त मंत्री श्री सी डी देशमुख ने बीमा जागरूकता विशेष रूप से ग्रामीण क्षेत्रों तक पहुँचाने पर बल दिया। उनके कथन से ग्रामीण क्षेत्रों में लाखों जिंदगियाँ को शामिल किया जाना चाहिये, यह (जीवन बीमा उद्योग का राष्ट्रीयकरण) एक नये प्रकार की जागरूकता को सामने लायेगा एक शांत विश्वास जो केवल बीमा ही उपलब्ध करवा सकता है। ग्राहक जागरूकता विषय पर चर्चा बदलते वातावरण में आवश्यक है।

बदलता परिवेश

वित्तिय बाजारों के उभरने के साथ ही जीवन बीमा व्यवसाय के परिवेश में बदलाव आया है। कुछ दशक पहले शुद्ध टर्म बीमा उत्पाद को लेना इस उद्देश्य के साथ की शेष राशि को अन्य प्रतिभूतियों अथवा शेयर बाजार में लगाया जाये यह कुछ विकसित बाजारों में प्रचलित था। यह भी ऐसा समझा जाता था कि मुद्रास्फिति को देखते हुए बहुत बड़ा है। जो विकसित बाजार में परिपाटी थी वह भारत में एक वास्तविकता बनती दिख रही है। भारत में बीमा क्षेत्र के खोले जाने के साथ जीवन बीमा बाजार धीरे धीरे परिवर्तित होता जा रहा है जिसमें प्राथमिकता पूंजी बाजार से संबंध रखने वाले उत्पादों से है। सभी जीवन बीमा कंपनियों से यूनिट संबंद्ध उत्पादों में 2002-03 में 664 से वर्ष 2005-06 में विकास होकर 64720 करोड़ की विस्तृत वृद्धि हुई है। 2005-06 में 64720 एक वृद्धि जो सौ गुणा है। 2006-07 के प्राथमिक आंकडों से यूनिट संबंध नये व्यवसाय के प्रावधान आंकडें 42912 करोड़ (पिछले वर्ष 22152 करोड़) जोकि 57 प्रतिशत की कुल प्रीमियम में वृद्धि है। यह एक प्रतीक है किस प्रकार जीवन बीमा प्रीमियम में सतत् परिवर्तन हुआ है। सच कहें तो यह विकास पूर्ण रूप से बीमा की जागरूकता के फैलने से नही हुआ है। ऐसी रिपोर्ट है कि पूंजी बाजार यूनिट संबंद्ध उत्पाद तथा यूलिप को शेयर बाजार में प्रत्यक्ष निवेश समझा जाने की भूल की जाती है। ऐसे दूर-दराज के क्षेत्रों में निवेश करते हुए एनएफओ नये उत्पाद के समय हो रहा है। जीवन बीमा के नवभेष उत्पादों की प्रकृति के संबंध में ऐसी भ्रांतियां फैली है। स्थिति इस तथ्य के साथ कि बढ़ती उत्पाद चुनाव के लिए ग्राहक जागरूकता का बाजार को विकसित करने में गहरी भूमिका है जब आर्थिक विकास सामाजिक विकास को जागरूकता की अनुपस्थिति में वित्तिय औजार जैसे जीवन बीमा में झलकता है। बदलता हुआ व्यवसाय ढंग जीवन बीमाकर्ताओं का जिसमें सामाजिक बदलाव जैसे बीमा शिक्षा से पहले ग्राहक तक पहुँचा जाये।

ग्राहक जागरूकता बनाने की आवश्यकता

अस्पर्श करने वाली वित्तिय सेवाओं जैसे जीवन बीमा के लिए जागरूकता फैलाना एक चुनौती पूर्ण कार्य है। बीमा जागरूकता फैलाने के संबंध में बीमाकर्ताओं के पास दो तथ्य हैंः पहला व्यवसाय में रूचि तथा दूसरा उनकी कुल मिलाकर सामाजिक उत्तरदायित्व। जीवन बीमो एक सामाजिक सुरक्षा औजार समझा जाता है। ऐसी प्रणाली जिसमें जोखिम के लिए समर्थन नही हो वह समाजिक हित को नुकसान पहुँचाएगी। ज़ीवन बीमा बड़ी संख्या का व्यवसाय होने के कारण प्रभावशाली रूप से जोखिम बाँटने तथा जोखिम को फैलाने के तंत्र से प्रभावशाली उत्तर प्रस्तुत

जीवन बीमा बड़ी संख्या का व्यवसाय होने के कारण प्रभावशाली रूप से जोखिम बाँटने तथा जोखिम को फैलाने के तंत्र से प्रभावशाली उत्तर प्रस्तुत कर सकता है।

> गाँव में दावा चैक का भुगतान मिटिंग तथा लाभार्थी का प्रचार उनके अनुभव को बांटना, सब कुछ कंपनियों के हित में काम करेगा।

कर सकता है इसलिए जीवन बीमाकर्ता को यह कार्य लेना चाहिए। जिससे वे निगमित सामाजिक उत्तरदायित्व के चलते जागरूकता फैलायें। जहाँ तक व्यवसाय हित का प्रश्न है जागरूकता एक आंतरिक कारक है जो बीमा उत्पाद के स्वीकृति के स्तर को बढ़ा देती है। लक्षित बाजार के उच्च जागरूकता स्तर जीवन बीमाकर्ता को प्रोत्साहित करते हैं कि वे उत्पाद में नुवदेय लायें तथा एक नाजुक प्रभाव, उत्पाद के डिजाइन में जीवन बीमाकर्ता द्वारा लाया जाये तो उसे संपूर्ण बाजार में स्वीकार किया जायेगा। अतः यह वृहत रूप से स्वीकार्य है की जागरूकता की जरूरत जैसे जीवन बीमा के लिए जरूरी है उनकी उपलब्धता तथा वहनक्षमता व्यवसाय के जीवन बीमा प्रभाव को बढ़ा देता हैं। जागरूकता को योगक के रूप में ढाँचागत के रूप में वित्तिय बाजार तथा वित्तिय में वह कार्यक्रम जिसमें सरकार शामिल है। जिसमें जीवन बीमा एक आंतरिक भाग के रूप में शामिल होता है। इन बाजारों में माइक्रो बीमा पूर्ण रूप से प्रचार-प्रसार के लिए एक महत्वपूर्ण लक्ष्य के रूप में शामिल होते हैं।

उपलब्ध वित्तिय सेवा के विकल्पों की जानकारी की कमी बदल नही सकती सदियों पुरानी एश्वर्य से भरे खर्च के पेटर्न समाज के कुछ भागों के लिए जो कई बार ऐसी स्थिति में ले जाते हैं जहाँ बड़ी आयु में स्वास्थ्य प्रबंध के लिए कोई प्रावधान नही होता। यह युवा वर्ग पर भी लागू होता है जिनके खर्च का स्तर ऊँचा है। एक पर्याप्त युवा जनसंख्या हमारे देश की विशेष ध्यान यह शामिल करने के लिए कि विशेष कार्य किये जायें जिसमें वित्तिय अनुशासन / बचत संस्कृति जागरूकता के कार्यक्रमों द्वार फैलाया जाये इन वर्गो के बीच। पेंशन योजना में अपर्याप्त आवरण केवल 10 प्रतिशत परिवारों को पेशे की पेंशन उपलब्धता है को जागरूकता बीमा के बारे में जिससे उनका स्वंय पर निर्भरता आने वाले दशक में कम हो सके। बीमा लंबे समय तक जीवित रहने का जोखिम भी उठाता है। यही मामला स्वास्थ्य प्रबंधन व्यक्तिगत के संदर्भ भी है जबकि केवल एक प्रतिशत स्वस्थ योजना में आवरण प्राप्त है। जागरूकता अभियान को आवश्यकता है कि ठीक प्रकार स्वास्थ्य के इस पहलू को बताते हुए स्वास्थ्य प्रबंधन पर ध्यान दें।

बीमा जागरूकताः जागरूकता शिक्षा की उपेक्षा एक बड़ा कारक है। शिक्षा जरूरी नही है कि आवश्यक जागरूकता को बनाये। विस्तृत समाज जिस प्रकार भारत का है जहाँ सामाजिक-आर्थिक कारक महत्व रखते हैं जिसमें शामिल है जागरूकता कारक को मूल्य जैसे जीवन बीमा को अलग परिपेक्ष में देखा जाना चाहिए एक लक्ष्य तथा वस्तुपूरक ढंग की आवश्यकता है जो ग्राहक जागरूकता को आगे ले जाये जो समाज के विभिन्न वर्गो के लिए होगा। ग्रामीण समाज की जीवन बीमा आवश्यकता शहरी लोगों से काफी अलग है इसी प्रकार उनके प्रीमियम देने की क्षमता। जबकि शहरों के एक भाग का जोखिम उनकी जोखिम सहन करने की क्षमता में निहित है ग्रामीण अन्य सामाजिक कारणों के कारण बीमा को प्राथमिकता की सूची में नही रख पाते। सदियों से भारतीय समाज एक ऐसे समाज के रूप में रहा है जहाँ सामाजिक देख रेख होती है जिससे एक आन्तरिक सुरक्षा का जाला बुन जाता है। जबकि ग्रामीण जनता को यह सीखना चाहिए बदलता हुआ रहन सहन का ढंग यह आवश्यकता उत्पन्न करता है कि प्रत्येक सुरक्षा समाधान को अपने तथा अपने परिवार के लिए अपनाये।

बीमा के समाधानों को स्थानीय आवश्यकताओं के अनुसार माइक्रो बीमा में अपनाये जाने के लिए ज्ञान की आवश्यकता है अधिकांश ग्रामीण जनता अपने कर्णधारों की सलाह पर निर्भर रहना होता है। एक इकाई को जानना तथा उसके मुखिया की पहचान तथा आवश्यक बीमा शिक्षा को उनके द्वारा नुक्कड नाटकों द्वारा वीडियो तथा डोक्यूमेंट्री जो टेलीविजन पर है को प्रायोजन देना इत्यादि मदद करेगा। जीवन बीमा के जागरूकता स्तर को सुधारने में बहुत सी केयर इसके लिए ली जानी चाहिए कि यह व्यावसायिक विज्ञापन न बन जाएँ, क्योंकि इसे देखा जायेगा एक ऐसे औजार के रूप में जो उनकी संपत्ति को हथियाना चाहता है। अपने स्तर पर बीमा कंपनियों को पालिसी सेवा उनके दरवाजे पर पहुँचाना चाहिए जिससे उनके द्वारा जागरूकता बनायी जा सके। गाँव में दावा चैक का भुगतान मिटिंग तथा लाभार्थी का प्रचार उनके अनुभव को बांटना, सब कुछ कंपनियों के हित में काम करेगा। कार्य स्थल पर कार्यशाला आयोजित करना, बीमा समाधानों को आवश्यकता उपयोगी बनाना जो शहरी क्षेत्र के

लिए है वह आवश्यक जागरूकता शहरी क्षेत्र में फैलायगी, जागरूकता फैलाना एक सतत प्रक्रिया है उनके बीच जो पहले से बीमा ले चुके हैं।

बीमा मध्यवर्ती एक केन्द्रीय भूमिका जागरूकता फैलाने में निभा सकते हैं। वैकल्पिक वितरण चैनल के विकसित हो जाने के बावजूद भी व्यक्तिगत बीमा सलाहकार आवश्यक रूप से जीवन बीमा में अपनी सेवाएँ देते रहेंगे। इन मध्यवर्तियों को शिक्षा देकर जागरूकता को लक्षित बाजार वर्ग तक पहुँचा जा सकता है।

हितधारियों की भूमिका

सरकार की भूमिका विकास के उत्तरदायित्व को पूरा करने के लिए विनियामक आईआरडीए एक विशेष विनियामक संगठन है। विकास को जागरूकता फैलाये बिना प्राप्त नही किया जा सकता है। सामाजिक कारक जैसे बीमा को प्राथमिक स्तर से संस्कृति में जीवन में एक बार परिवर्तन करना होगा इसमें शामिल है पाठ्यक्रम में जल्द शिक्षा के स्तर पर शामिल करना, शिक्षा स्तर पर प्रेरणा निर्माण के स्तर पर मुद्दे को संबोधित करेगी। यह पहलू अपनी विशेषता के लिए ध्यान चाहता है। आईआरडीए के स्तर पर अपने कर्तव्यों का निर्वहन करते समय एक संतुलित योजना की आवश्यकता है जो विनियामक का ढांचा बिना विकास के उत्तरदायित्व को दूर करते हुए पूरा करे। यह सुनिश्चित करने के लिए की बीमा के विकास के निर्णय अंदरूनी स्तर तक पहुँचे विनियामक ग्रामीण तथा सामाजिक क्षेत्र की बाध्यतायों के लिए योजना तैयार करे जो सभी बीमाकर्ताओं की प्रक्रिया में विशिष्ट प्रतिशत व्यवसाय के लिए ग्रामीण बीमा के लिए बाध्यकारी हो। सूक्ष्म बीमा विनियनम ने जीवन बीमा के खुदरा व्यापार पर विजय प्राप्त की है जो क्षेत्र बाजार में क्षमता व्यवसाय के क्षेत्र नही समझे जाते थे।

> **आईआरडीए ने अपने कार्यक्रम दूरदर्शन तथा ऑल इंडिया रेडियो पर जारी किये जिसने सभी बीमा कंपनियों के बाजार अंश को बढ़ानें में मदद दी है।**

यह विकास उन्मुखी विनियमन से अपेक्षा है कि लक्ष्य निर्धारित व्यवसाय जीवन बीमा के लिए लगायेंगे जो बदले में एक ग्राहक जागरूकता बनाने में मदद करेंगे। जैसा कि पहले भी कहा गया है कि बीमा मध्यवर्तियों की भूमिका बीमा जागरूकता फैलाने में महत्वपूर्ण है जैसे यह सलाहकार जाने जाते हैं तथा पूरा करते हैं आवश्यकताओं को दरवाजे पर। एक जानकार बीमा सलाहकार अपने मिशन को एकाग्रता से पूरा करता है। इस उद्देश्य के साथ आईआरडीए ने बाध्यकारी प्रशिक्षण मानकों को तथा पूर्व लाइसेंस परीक्षा आवश्यकताओं को सभी बीमा मध्यवर्तियों के लिए आवश्यक किया है। बीमा जागरूकता फैलाने में एक भाग के रूप में आईआरडीए ने अपने कार्यक्रम दूरदर्शन तथा ऑल इंडिया रेडियो पर जारी किये जिसने सभी बीमा कंपनियों के बाजार अंश को बढ़ानें में मदद दी है।

उद्योग के प्रतिनिधियों के रूप में बीमा काउंसिल की भूमिका जागरूकता अभियान को बढ़ाने की है। यह विश्वास किया जाता है कि जीवन काउंसिल का मिशन वाक्य बीमा जागरूकता को फैलाना। अतः काउंसिल के लिए यह आवश्यकता है इस क्षेत्र में कदम उठाये जायें। कार्यक्रम जो व्यक्तिगत बीमा कंपनियों द्वारा प्रायोजित किये जाते हैं उनको देखा जा सकता है। व्यावसायिक अभियान के द्वारा उत्पादों को प्रोत्साहन देने के लिए तथा उनके अपेक्षाकृत प्रभाव निर्भर करता है उद्योग द्वारा जागरूकता फैलाने के लिए, बीमा काउंसिल यह कार्य हाथ में ले सकता है कि देशी जागरूकता को संपूर्ण देश में फैलाया जाया। समय समय पर गैर सरकारी संस्थाओं के सामाजिक विकास के पोर्टल का उपयोग करते हुए।

निष्कर्षः उपभोक्ता जागरूकता एक प्रभावशाली बाजार को अनुशासित करने में महत्वपूर्ण निर्णय भी जोड़ा जा सकता है जो विनियामित बाजार में साख के जोखिम के लिए होता है और वह भी बाजार के साथ जीवन बीमाकर्ता के लिए। अधिकतर नये युग की बीमा कंपनियाँ अपने प्रचालन को विस्तार देने में लगी है हर क्षेत्र और किनारे पर और जागरूकता फैलाना कल विपण्णन निति का एक भाग हो सकता है बीमा बेचने के अपेक्षाकृत जिसमें उत्पादों को दबाव के साथ बेचा जाता है। अंतिम विश्लेषण में यह आवश्यक है कि बीमा उद्योग के हितकारी इस कार्य को ठीक प्रकार से करेंगे।

लेखक आईआरडीए में सदस्य (जीवन) है यहाँ उद्दृत विचार उनके अपने हैं।

सामुदायिक हैल्थ बीमा - करूणा ट्रस्ट का अनुभव

डा एच सुदर्शन तथा डॉ सिल्वा सिल्वाराज लिखते हैं यह महत्वपूर्ण है कि समुदाय में जागरूकता को हैल्थ बीमा तथा साधारण व बीमा के लिए बढ़ाया जाये। वह आगे यह जोड़ते हैं आधारभूत ढांचा इन सेवाओं को उपलब्ध करवाने में सक्षम हो तथा इसको बीमा सेवा के प्रावधानों के अनुसार संबोधित किया जाना चाहिए।

प्रस्तावना

हैल्थ कैयर सेवाओं पर किये गये सूक्ष्म तथा अति सूक्ष्म अध्ययन बताते हैं कि गरीब विशेष रूप से अनुसूचित जाति व अनुसूचित जानति एक बड़े भाग को उनके अपेक्षाकृत जो भले चंगे है से ज्यादा धन राशि खर्च करने को बाध्य होते हैं। यह जब और भी अधिक होता है जब अस्पताल में भर्ती मरीज की देखभाल की जाती है तथा सार्वजनिक देखभाल के समय भी जेब से भरने वाले खर्च काफी भाग में होते हैं।

हैल्थ बीमा के धारण योग्य प्रतिमान जिसका प्रीमियम गरीब लोग भरे तथा उसके लाभ उठाये को एक अर्थक्षम विकल्प के रूप में स्वास्थ्य के बराबर वितरण के रूप में तथा बीमा नगर के उच्च तथा मध्यम वर्ग तक ही सीमित रहा (बर्नगुहनसेंन तथा सायुरबोर्न 2002)

पिछले कुछ वर्षो में स्वास्थ्य बीमा की पहल तीव्रता से फैल रही है। पश्चिम अफ्रीका में समुदाय आधारित स्वास्थ्य कार्यक्रमों की संख्या में वर्ष 2000 में 199 से बढ़ कर वर्ष 2003 में 585 हो गई जिसमें 15 लाख लोग शामल थे (बैनेट, एस, कैली, ए जी तथा सिल्वर्स बी 2004) एशिया में यह संख्या और भी विराह है आईएलओ के अनुमान के अनुसार 75 लाख लोग सीबीएचआई के 40 कार्यक्रम से लाभांवित हुए है (चौहान 2006) इनमें से अनेकों ने यह प्रदर्शित किया है कि इस कैसे दोहराया जाये धारणीय तथा मापनिय आदर्श को

> **स्वास्थ्य तथा परिवार कल्याण मंत्रालय भारत सरकार ने भी निजी सार्वजनिक क्षेत्र के लिए मार्ग निर्देश तैयार किये हैं जो विभिन्न राष्ट्रीय स्वास्थ्य योजनाओं के लिए है**

समुदाय की स्वास्थ्य बीमा के लिए अनुपालित किया जाना चाहिए।

भारत की सार्वजनिक निजी सहभागिता (2002-07) दसवीं पंचवर्षीय योजना में सरकार की भूमिका को परिभाषित करने की पहल की गई निजी तथा स्वंयसेवी संस्थाओं द्वारा देश की बढ़ती हुई स्वास्थ्य आवश्यकताओं के संबंध में। राष्ट्रीय स्वास्थ्य नीति 2002 ने भी निजी क्षेत्र के प्राथमिक माध्यमिक तथा तृतीयक देखभाल तथा सलाह दी है कि उपयुक्त अधिनियम जो कम से कम आधारभूत संरचना तथा गुणवत्ता के मानक क्लिनिकल प्रतिष्ठान तथा मेडिकल संस्थानों के लिए होने चाहिये नीति और गैर सरकारी क्षेत्र के राष्ट्रीय आपदा नियंत्रण कार्यक्रम में सहयोग को भी प्रोत्साहन देती है जिससे यह सुनिश्चित किया जा सके की मानक उपचार प्रोटोकाल दैनिक अभ्यास में लागू किया जाए।

स्वास्थ्य तथा परिवार कल्याण मंत्रालय भारत सरकार ने भी निजी सार्वजनिक क्षेत्र के लिए मार्ग निर्देश तैयार किये हैं जो विभिन्न राष्ट्रीय स्वास्थ्य योजनाओं के लिए है जैसे पुर्नवर्ति राष्ट्रीय क्षय रोग नियंत्रण कार्यक्रम, राष्ट्रीय अंध निवारण नियंत्रण कार्यक्रम, कुष्ठ रोग निवारण कार्यक्रम, आरसीएच आदि। 2005-2012 का राष्ट्रीय ग्रामीण स्वास्थ्य मिशन में प्रस्ताव है कि विकास और प्रभावशाली अनुपालन को विनियामक तंत्र द्वारा निजी स्वास्थ्य क्षेत्र से अंश, पारदर्शिता तथा उत्तर देने की क्षमता को बताता है।

पीपीपी प्रोत्साहक ने कोशिश की है वर्तमान स्वास्थ्य कार्यक्रम की प्रभाव को प्रबंध को अधिक मजबूत बनाना से जो कि वर्तमान स्वास्थ्य ढाँचा तथा इसी समय सेवाओं के विस्तार तथा सेवा उपलब्ध करवाने के लिए निजी क्षेत्र की भागीदारी को सुनिश्चित करना।

राष्ट्रीय जंसंख्या नीति 2000 ने साझेदारी को स्वंय सेवा संस्थाओं के साथ ग्रामीण विकास के प्रभावशाली नीतिगत आधार के साथ प्रस्तुत किया है। संपूर्ण मिशन व्यवहारिक मॉडल को सार्वजनिक निजी साझेदारों को प्रत्येक जिले के लिए तथा परिणाम स्वरूप तालुकों में उपलब्ध सुविधाओं पर प्रभाव डालना है। स्वंय सेवी संस्थाओं का कार्य आवश्यक रूप से सहभाग तथा प्रकृति से साथ देने वाला रहा है जिससे यह सुनिश्चित किया जा सके कि सरकार स्वंय सेवी संस्थाओं को प्रतिस्पर्धात्मक लाभ प्रक्रिया को आसान बनाने के लिए तथा स्थानीय जनता से तारतम्य करने से है।

करूण ट्रस्ट तथा सरकार के बीच साझेदारी

मैं 25 पीएचसी तथा अरूणाचल प्रदेश में 9 जीएचटी का प्रबंधन देख रहा है।

- सामुदायिक स्वास्थ्य बीम।
- प्राथमिक स्वास्थ्य देख-रेख में मुख्यधारा परंपरागत दवा का लाना।
- पीपीपी स्वास्थ्य क्षेत्र सुधारः स्वास्थ्य पर टास्क फोर्स तथा पारिवारिक कल्याण
- पीपीपी अच्छी प्रशासन स्वास्थ्य तथा लोकायुक्त के लिए।

> सीएचआई प्रोजेक्ट का एक उज्जवल पहलू यह था कि आवश्यक रूप से सरकारी स्वास्थ्य सेवाओं का उपयोग किया जाये।

साझेदार संस्था सामुदायिक स्वास्थ्य बीमा के लिए स्वास्थ्य तथा पारिवारिक कल्याण मंत्रालय, भारत सरकार, यूएनडीपी स्वास्थ्य विभाग तथा एफडब्ल्यू, जीओके, करूणा ट्रस्ट सीपीडी तथा नेशनल इंश्योरेंस कंपनी तथा इसका उद्देश्य सामुदायिक स्वास्थ्य फाइनेंस को एक मॉडल के रूप प्रदर्शित करना, समान स्वास्थ्य देखभाल वितरण को सुनिश्चित करना, सामाजिक बीमा के द्वारा तथा ग्रामीण निर्धन के लिए अच्छई स्वास्थ्य सेवाएँ उपलब्ध करवाना।

सीएचआई प्रोजेक्ट का एक उज्जवल पहलू यह था कि आवश्यक रूप से सरकारी स्वास्थ्य सेवाओं का उपयोग किया जाये।

प्रोजेक्ट को प्रोत्साहन देने के फेज प्रोजेक्ट सर्वप्रथम नरसिंहपुर तालुका मैसूर के 210 गाँव में लागू किया गया साथ ही बेलगाम जिले की बैधुगोल तालुका के 112 गाँवों को शामिल किया गया। दूसरे फेज में विस्तार कार्यक्रम के रूप में यंलडूर तालुका के 40 गाँव, बी आर हिल्स के 57 पोहूस चमानुगजना जिले के कखा 133 गाँव बेलगाम तालुका, बेलगाम जिले के शामिल किये गये।

सामुदायिक स्वास्थ्य बीमा का मॉडल

जिन क्षेत्र में स्वंय सेवी संस्थाओं की उपलब्धता नही थी वहाँ दो मॉडल डिजाइन किये गये जिससे सीचआई को लागू किया जा सके। नरसिंहपुरा टी में करूणा ट्रस्ट अनुपालन एजेंसी था जबकि बैथुगोल में जिला पंचायत ने अनुपालन एजेंसी का स्थान लिया। करूणा ट्रस्ट ने अपने आप को कार्यक्र के देख-रेख के लिए सीमित किया तथा नीधि के सरल बहाव को सुनिश्चित किया।

डॉ एस सी धारवाड़, जिला स्वास्थ्य कखा परिवार कल्याण अधिकारी बेलगाम कहते हैः प्रत्येक भागीदार की अपनी शक्ति तथा उन्हें संबंधित क्षेत्रों में लागू किया गया। सरकार इन योजनाओं में सदैव एक दिलचस्पी लेने वाली भागीदार होती है जोकि बड़ी अच्छाई को देखती है। हमने एक विशेष भागीदारी में करूणा ट्रस्ट के साथ परिणामस्वरूप इसके कदम रखा है कि प्रकियाएँ तथा अन्य सीमाएँ है। हम इसके लिए प्रतिबद्ध है की साझेदारी कार्य करें।

सामुदायिक स्वास्थ्य बीमा टी नरसापुर मॉडल

यह मॉडल तीन स्तर पर सरकार तथा स्वंय सेवी संस्थाओं के बीच सहयोग है - सामुदायिक हर्बल बगीचा आम बीमारियों के लिए, एसएचजी के साथ माइक्रो क्रेडिट बाह्य रोगी की देखभाल के लिए तथा आंतरिक रोगियों के लिए पहले से दिए गये धन द्वारा। ग्रामीण निर्धन को सशक्त किया गया माइक्रो योजना तथा ग्रामीण समितियों के द्वारा, सह केन्द्र तथा प्राथमिक स्वास्थ्य केन्द्र, ग्राम सभा, ग्राम पंचायत, तालुका पंचायत तथा जिला पंचायत स्वास्थ्य योजनाओं के द्वारा।

प्रोजेक्ट अनुपालन

मॉडल की सामान्य विशेषताएँ है कि निजी स्वास्थ्य सेवाएँ आवरित नही थी, मान्य रेखा सर्वे किये गये, जागरूकता को फैलाय गया जिसमें नुक्कड नाटक, वीडियो शो, सार्वजनिक घोषणाएँ, पोस्टर सामुदायिक स्तर बैठकें तथा नामांकन किये गये जिससे प्रभावशाली अनुपालन किया जाए। प्रोजेक्ट अनुपालन कमेटी को तालुका तथा जिल स्तर पर भेजा गया जिसमें जिला पंचायत, अनुपालन एजेंसी तथा तालुका स्वास्थ्य अधिकारी को शामिल किया गया। जिनको अनुपालन तथा नामित किये गये लाभार्थियों को जाँचना था, पहचान पत्र जारी करना, दावा विवरण दिये गई राशि का लेखा अस्पताल के लिए एक बीमा राशि देने के लिए, कुल मिला कर प्रचलन को देखना और राशि को देखना।

बीमा के महत्वपूर्ण कारक

बीमा की विशेषता मात्र 22 रूपये (प्रथमतः रूपये 30 पहले वर्ष में उसे 55 प्रतिशत दावे होने के कारण घटा कर 22 रूपये किया गया) एक व्यक्ति के लिए, प्रीमियम की लागत को समुदाय, दुग्ध सहकारी, समितियों, एसएचजी, यूएनडीपी तथा जीपी की मुख्य विशेषताओं के साथ किसी भी अपवर्जन के साथ लागू किया गया। पालिसी जिसमें शामिल था सभी आयु वर्ग, पहले से होने वाली

विवरण	टी नरसिंहपुर मॉडल	बाथोंगल मॉडल
अनुपालन एजेंसी	करूणा ट्रस्ट	जिला परिषद
फेज २ की अवधि	1 जून 04-30 मई 05	1 जनवरी 05- 31 दिसम्बर 05
जनसंख्या आवरण	1,00,000 अनु जा, जन जाति तथा गरीब रेखा से नीचे का आवरण	एक लाख अनु जा, व जनजाति तथा 35,000 गरीबी रेखा से नीचे
जागरूकता फैलाने का मुख्य ढंग	स्ट्रीट योजना, वीडियो शो तथा सामुदायिक बैठक	आईईसी गतिविधियाँ, अस्पताल तथा पीएचसी के साथ व्यक्तिगत संपर्क, आंगनवाड़ी, मिडवाइफ, नर्स द्वारा समुदाय भ्रमण के समय

फेज १

अवधि	1 सितम्बर 02- 31 अगस्त 03	विस्तार फेज 1 अक्टूबर 02-31 सितम्बर 03
लाभार्थी संख्या	655	1714
कुल बेड दिवस	5490	12241
रूपये में दावा वेतन हानि + ड्रग	274500 + 274500	612050 + 612050
प्रतिशत दावा	21.4%	77.3%

मैं बीमारी से अब डरता नही हू, उसके दर्द को छोड़कर जबकि मैं या अन्य कोई मेरे परिवार में बीमार पड़ता था हमें घबराहट होती थी कि इस इलाज का खर्च कैसे उठाया जायेगा। हमें अच्छा इलाज मिलता है दवाइयों के लिए धन तथा धनराशि यदि हम कार्य नही कर पाते-सावित्री सेनप्पा बिरज

बीमारी जिसमें एचआईवी / एफआईडीएस तथा बीमारी के कारण अस्पतालीकरण शामिल है। रूपये 50 मरीजों को दैनिक मजदूरी की हानि के लिए दिये गये तथा अस्पताल को रूपये 50 अतिरिक्त ड्रग के लिए प्रतिदिन के हिसाब से दिये गये मरीज को दैनिक रूप से अस्पताल के रिवोलविंग फंड के द्वारा भुगतान किया गया। एंबुलेंस सेवा तथा सलाहकार में अधिकतम 25 दिन के अस्पतालीकरण को शामिल किया गया। दावों को प्रत्येक सप्ताह नेशनल इंश्योरेंस कंपनी में निपटाया गया।

प्रगतिः अब तक हुई प्रगति के अनुसार शामिल है सार्वजनिक स्वास्थ्य केयर में महिलाओं तथा ग्रामीण गरीब को शामिल करना। गरीबी रेखा से नीचे रहने वालों के लिए आवश्यक दवाइयों की उपलब्धता। विस्तार 25 प्राथमिक केन्द्रों में 25 जिलों में कर्नाटक में किया गया। जिसमें एचआईवी/ एचआईडीएस के मरीजों को इस आश्वासन के साथ शामिल किया गया। प्रोजेक्ट की सफलता स्वंय मदद ग्रूप तथा उनमें कर्नाटक सरकार के साख सम्नवय से विश्व बैंक के अंतर्गत है जिससे प्रोजेक्ट को विभिन्न क्षेत्रों में कर्नाटक में फैलाया जा सके।

इसने सरकार के मध्य प्रेरणा को स्वास्थ्य स्टाफ को बढ़ाया है जिससे बेहतर सेवाएँ प्रदान की जा सके। कारण शामिल है कि सरकार की स्वास्थ्य सेवा सुविधाओं का उपयोग करके समुदाय की सरकार की सुविधाओं के प्रति देखने का नजरिया सुधारा जाए।

मैं बीमारी से अब डरता नही हू, उसके दर्द को छोड़कर जबकि मैं या अन्य कोई मेरे परिवार में बीमार पड़ता था हमें घबराहट होती थी कि इस इलाज का खर्च कैसे उठाया जायेगा। हमें अच्छा इलाज मिलता है दवाइयों के लिए धन तथा धनराशि यदि हम कार्य नही कर पाते-सावित्री सेनप्पा बिरजे

यह प्रत्यक्ष रूप से सीएचआई योजना से संबंध नही रखता, करूणा ट्रस्ट हर्बल बगीचे के विचार को प्रोत्साहन देता है जिससे स्वास्थ्य को सुधार जाये। दवाइयों के पौधों की पौध तैयार करने की प्रशिक्षण देकर जो एक स्वंय सेवी ग्रुप को दी जाती है।

हम बीमा के लिए धनराशि देने में प्रसन्नता नही अनुभव करते तथा प्रत्येक रूपया हमारे लिए महत्व रखता है। बाद में जब मैं अस्पताल में भर्ती हुआ अपनी छाती के दर्द के कारण, मैं बहुत प्रसन्न था क्योंकि मुझे मुवाअजे के रूप में एक बड़ी राशि मिली थी जब मुझे अस्पताल से छुट्टी मिली। धनराशि मुआवजे से ज्यादा जो मैनें खर्च किया था बीमा को प्रारंभ करने के लिए।

सिंदबा, बी आर हिल्स की जनजाति

मॉडल को दोहराना / उच्च स्तर पर ले जाना

यह स्पष्ट है कि ग्रामीण क्षेत्र के स्वास्थ्य बीमा की आवश्यकता में निम्न प्रीमियम अथवा सहायता प्राप्त होनी चाहिए। कोई भी अपवर्जन जिसमें शामिल हो सभी आयु के तथा बीमारी के लोग, उपयोग ही सार्वजनिक तथा निजी स्वास्थ्य से उपलब्ध करवाने वाले, दैनिक मजदूरी की प्रतिपूर्ति जो रह गये उसे जेब खर्च के रूप में दिया जाये तथा पिछड़े तथा दूर-दराज के क्षेत्रों में जरूरत है। गरीबों के लिए प्रीमियम काफी कम होना चाहिए तथा बड़ा पैकेज चाहिए इसलिए इसे सहायता की जरूरत है।

यह महत्वपूर्ण है कि समुदाय में जागरूकता स्वास्थ्य साधारण रूप से तथा विशेष रूप से बीमा फैलाया जाये। आधारभूत ढाँचे में यह शक्ति होनी चाहिए कि वह सेवा प्रदान कर सके तथा इसे संबंधोति किया जाना चाहिये बीमा सेवा के प्रावधानों के साथ।

देवादेसम इटीएल यह तर्क देते हैं कि विकासशील देशों में मुख्य बनाने योग्य बात सामुदायिक स्वास्थ्य बीमा के संबंध में एक ठीक ठाक सेवा उपलब्ध करवाने वाले को ढूंढना है इसे देखते हुए कि गैर विनियामित तथा गैर जवाब देह प्रकृति का भारतीय निजी सेवा का स्वास्थ्य क्षेत्र लागत बढ़ाने का अनियंत्रित तंत्र बीमा क्वालिटी को आश्वासित किये, इन योजनाओं की वैधानिक स्थिति जिसे नये बीमा अधिनियम (आईआरडीए अधिनियम 1999) में दिया गया है। वित्तिय स्थिरता तथा सरकारी तंत्र का वित्तिय सहायता में भूमिका जिससे समान स्वास्थ्य वित्तिय तंत्र स्थापित किया जा सके।

सामुदायिक स्वास्थ्य बीमा कार्यक्रम करूणा ट्रस्ट के अन्तर्गत ने एक महत्वपूर्ण नीति बनाने में जिससे समान रूप से स्वस्थ्य सेवा के स्त्रोतों का बंटवारा किया जा सके। कुछ शर्तें जिन्होनें इस कार्यक्रम के प्रभाव में सहायता प्रदान की करूणा ट्रस्ट के लिए उनकी प्रारंभ में स्थानीय उपलब्धता समुदाय जो वृहत रूप से सूचना को इस योजना के बारे में बताया गया। जिसमें स्वंय मदद के ग्रूप को शामिल किया गया। कोई अपवर्जन की नीति नही (यह करूणा ट्रस्ट के स्वास्थ्य बीमा की विशेषता है जो अन्य प्रोत्साहनों से बिलकुल अलग है) वह भी बहुत वहन योग्य प्रीमियम पर।

लेखक - पद्मश्री डॉ एच सुदर्शन, मानद सचिव, करूणा ट्रस्ट तथा विवेकानंद गिरिजन कल्याण केन्द्र तथा प्रोफेसर आईजीएनओयू डॉ सिल्वा सिल्वाराज, करूणा ट्रस्ट के स्वास्थ्य तथा शोध्य संचालक।

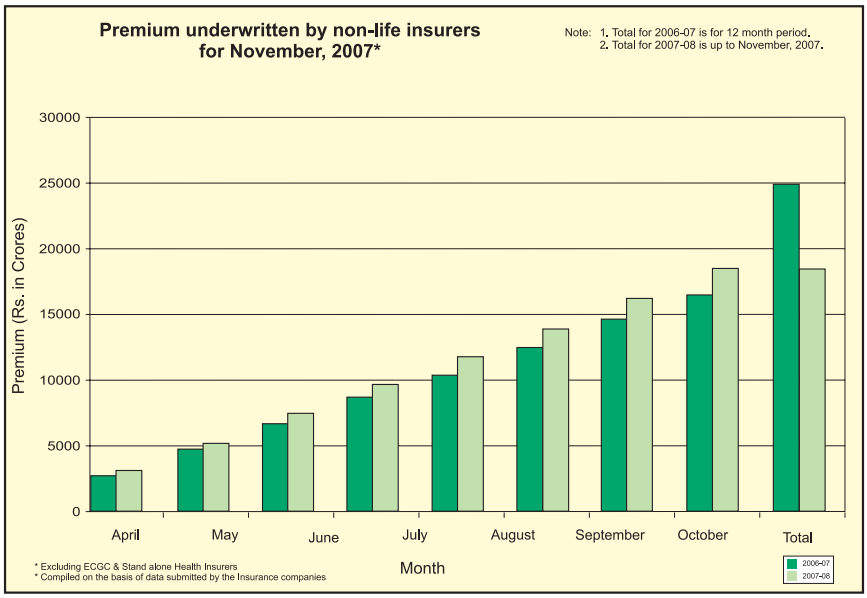
Report Card: General

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

(Rs.in Crores)

INSURER	NOVEMBER		APRIL - NOVEMBER		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2007-08	2006-07	2007-08	2006-07	
Royal Sundaram	60.45	47.67	439.76	388.84	13.09
Tata-AIG	55.28	62.45	527.69	520.12	1.46
Reliance General	186.68	75.19	1315.36	520.85	152.54
IFFCO-Tokio	97.49	84.18	708.35	813.15	-12.89
ICICI-lombard	283.98	243.33	2348.10	2078.69	12.96
Bajaj Allianz	190.45	153.32	1515.52	1158.87	30.78
HDFC General	18.63	16.31	148.18	125.88	17.71
Cholamandalam	34.23	23.73	349.02	206.68	68.87
Future Generali*	0.86		0.86		
New India	403.32	356.98	3520.36	3316.14	6.16
National	316.00	291.34	2591.89	2428.54	6.73
United India	303.64	313.88	2443.45	2351.60	3.91
Oriental	276.11	305.36	2600.49	2650.47	-1.89
PRIVATE TOTAL	928.04	706.18	7352.84	5813.07	26.49
PUBLIC TOTAL	1299.07	1267.56	11156.19	10746.75	3.81
GRAND TOTAL	2227.12	1973.74	18509.02	16559.81	11.77
SPECIALISED INSTITUTIONS					
Credit Insurance					
ECGC	55.38	51.79	420.26	391.67	7.30
Health Insurance					
Star Health & Allied Insurance	3.55	0.78	98.45	14.61	573.75
Apollo DKV*	0.02		0.02		
Health Total	3.57	0.78	98.47	14.61	573.87

Note: Compiled on the basis of data submitted by the Insurance companies
** Commenced operations in November, 2007.*



'Micro-insurance Conference 2007' was jointly hosted by CGAP Working Group on Micro-insurance and Munich Re Foundation, and supported by IRDA; at Mumbai between 13th and 15th November, 2007.

Mr. P. Chidambaram, Hon'ble Minister of Finance, Government of India lighting the lamp at the inaugural session. Also seen in the picture are (from L to R): Mr. Thomas Loster - Chairman, Munich Re Foundation, Germany; Mr. C.S. Rao - Chairman, IRDA, India; and Mr. Michel Flamee, Chair of Executive Committee of the IAIS, Switzerland.

Mr. C.S. Rao delivering the Welcome Address.

Outlook Money and NDTV Profit organized a summit at Mumbai on 26th October, 2007.

Mr. G. Prabhakara, Member (Life), IRDA speaking on 'Safeguarding Customer Interest through Better Intermediation'.

(from L to R): Mr. Kshitij Jain, CEO, ING-Vysya Life Insurance Co.; Ms. Monica Halan, Editor, Outlook Money; Mr. G. Prabahakara; Ms. Shikha Sharma, MD & CEO, ICICI Prudential Life Insurance Co.; Mr. Nandagopal, CEO, Reliance Life Insurance Co.; and Mr. Trevor Bull, CEO, Tata AIG Life Insurance Co.

10 Jan 2008 Venue: Kolkata	**Indian Insurance Industry - Road Ahead** By *Indian Chamber of Commerce*
14 - 15 Jan 2008 Venue: Kuala Lumpur, Malaysia	**Insurance & Takaful Fraud Conference** By *Insurance Services Malaysia Berhad*
17 - 18 Jan 2008 Venue: NIA, Pune	**3rd Seminar on Health Insurance and Care** By *Institute of Actuaries of India, Mumbai*
21 - 23 Jan 2008 Venue: New Delhi	**1st India Rendezvous 2008** By *Asia Insurance Review, Singapore*
28 - 29 Jan 2008 Venue: Macau	**ASHK Regional Conference** By *Actuarial Society of Hong Kong*
30 Jan - 1 Feb 2008 Venue: Jakarta, Indonesia	**8th CEO Insurance Summit in Asia** By *Asia Insurance Review, Singapore*
7 - 8 Feb 2008 Venue: Mumbai	**10th Global Conference of Actuaries** By *International Actuarial Association & Institute of Actuaries of India*
11 - 16 Feb 2008 Venue: Pune	**Management of Marine Insurance (Cargo & Hull)** By *NIA Pune*
12 - 13 Feb 2008 Venue: Dubai, UAE	**Takaful Conference on Islamic Investment Management** By *Asia Insurance Review, Singapore*
26 - 28 Feb 2008 Venue: Bahrain	**GAIF Conference** By *General Arab Insurance Federation*
3 - 4 Mar 2008 Venue: Singapore	**Asian Conference on M&As, Commutations & Run Offs** By *Asia Insurance Review, Singapore*

RNI No: APBIL/2002/9589

view point

Identity theft is one of the fastest growing crimes in the United States, affecting consumers of all ages. It's critical for consumers to know how to protect themselves and reduce the risk of becoming a victim.

Ms Sandy Praeger

NAIC President and Kansas Insurance Commissioner

In the last two years, insurance companies have made huge gains from their investment portfolios thanks to (China's) booming market. So much so that their portfolios have become the main source of their profits... making it quite difficult for them to make profits from the underwriting business.

Mr Li Kemu

Vice-Chairman of the China Insurance Regulatory Commission

For the continued development of the health insurance market (in India), and also to protect the long-term interests of the insured persons; there is a responsibility on all stakeholders in the system for ensuring sustainability of health insurance.

Mr CS Rao

Chairman, Insurance Regulatory & Development Authority, India

Reinsurance is effectively a substitute for capital and it is in the interests of all policyholders and claimants that the funds to support insurers' claims liabilities, including amounts recoverable from reinsurers, be properly secured in Australia.

Mr John Trowbridge

Member, Australian Prudential Regulation Authority

Today, funds from insurance companies, pension funds and even retail investors are made available for financing the infrastructure development needed for any country's continued economic growth.

Mr Kola Luu

Executive Director, Monetary Authority of Singapore

Rising affluence and aging population will open up new opportunities in retirement planning and health maintenance; globalization and convergence of commercial activities will make room for enterprise risk management; and emerging risks from climate change and pandemics will generate demand for innovative and sophisticated policy coverage.

Mr Clement Cheung

Commissioner of Insurance, Hong Kong