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EVOLUTION OF HEALTH INSURANCE IN INDIA

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ABSTRACT

Health Insurance can be broadly defined as a financial mechanism that exists to provide protection to individual and house holds from expenses incurred as a result of unexpected illness or injury. Under this mechanism, the insurer agrees to compensate or guarantee the insured person against loss by specified contingent event and provide financial coverage for which the insured party pays a premium.

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Heath is clearly not the mere absence of disease. Good Health confers on a person or groups freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care. and current bio-medical understanding about health and illness.
The topic outlines evolution of health insurance, Various schemes of health insurance, health insurance for senior citizens implications of privatization on health insurance and role of IRDA.

INTRODUCTION

The concept of Health Insurance was proposed in the year 1694 by Hugh the elder Chamberlen from Peter Chamberlen family. In 19th Century "Accident Assurance" began to be available which operated much like modern disability insurance. This payment model continued until the start of 20th century. During the middle to late 20th century traditional disability insurance evolved in to modern health insurance programmes. Today, most comprehensive health insurance programmes cover the cost of routine, preventive and emergency health care procedures and also most prescription drugs. But this is not always the case.

Healthcare in India is in a state of enormous transition: increased income and health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy, and the introduction of private healthcare financing drive the change.

Over the last 50 years, India has achieved a lot in terms of health insurance. Before independence, the health structure was in dismal condition i.e. high morbidity and high mortality and prevalence of infectious diseases. Since independence, emphasis has been put on primary health care and we made considerable progress in improving the health status of

the country. But still, India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators.

Health insurance, which remains highly underdeveloped and less significant segment of the product portfolios, is now emerging as a tool to manage financial needs of people to seek health services.

The new economic policy and liberalization process followed by Government of India since 1991 paved the way for privatization of insurance sector in the country. The Insurance Regulatory and Development Authority (IRDA) bill, passed in Indian parliament, is the important beginning of changes having significant implications for the health sector.

Health Insurance is more complex than other segments of insurance business because of serious conflicts arising out of adverse selection, moral hazard, unavailability of data and information gap problems. Health sector policy formulation, assessment and implementation are an extremely complex task, especially, in changing epidemiological, institutional, technological and political scenario. Proper understanding of Indian Health situation and application of principles of insurance, keeping in view the social realities and national objectives, are important.

Health Insurance Scenario in India

Health is a human right. It's accessibility and affordability has to be ensured. The escalating cost of medical treatment is beyond the reach of common man. While well to do segment of the population both in Rural and Urban areas have accessibility and affordability towards medical care, the same cannot be said about the people who belong to the poor segment of the society.

Health care has always been a problem area for India, a nation with a large population and larger percentage of this population living in urban slums and in rural area, below the poverty line. The government and people have started exploring various health financing options to manage problem arising out of increasing cost of care and changing epidemiological pattern of diseases.

The control of government expenditure to manage fiscal deficits in early 1990s has let to severe resource constraints in the health sector. Under this situation, one of the ways for the government to reduce under funding and augment the resources in the health sector was to encourage the development of health insurance. In the light of escalating health care costs, coupled with demand for health care services, lack of easy access of people from low income group to quality health care, health insurance is emerging as an alternative mechanism for financing health care.

Indian health financing scene raises number of challenges, which are:

- Increase in health care costs
- High financial burden on poor eroding their incomes
- Need for long term and nursing care for senior citizens because of increasing nuclear family
- system
- Increasing burden of new diseases and health risks

- Due to under funding of government health care, preventive and primary care and public health functions have been neglected

In the above scenario, exploring health financing options became critical. Naturally, health insurance has emerged as one of the financing options to overcome some of the problems of our system.

In simple terms, health insurance can be defined as a contract where an individual or group purchases in advance health coverage by paying a fee called "premium". Health insurance refers to a wide variety of policies. These range from policies that cover the cost of doctors and hospitals to those that meet a specific need, such as paying for long term care. Even disability insurance, which replaces lost income if you cannot work because of illness or accident, is considered health insurance, even though it is not specifically for medical expenses.

Health insurance is very well established in many countries, but in India it still remains an untapped market. Less than 15% of India's 1.1 billion people are covered through health insurance. And most of it covers only government employees. At any given point of time, 40 to 50 million people are on medication for major sickness and share of public financing in total health care is just about 1% of GDP. Over 80% of health financing is private financing, much of which is out of pocket payments and not by any pre-payment schemes. Given the health financing and demand scenario, health insurance has a wider scope in present day situation in India. However, it requires careful and significant efforts to tap Indian health insurance market with proper understanding and training.

Various Health Insurance Products Available in India

The existing health insurance schemes available in India can be broadly categorized as:

1. Voluntary health insurance schemes or private-for-profit schemes
2. Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)
3. Insurance offered by NGOs/Community based health insurance
4. Employer based schemes

Voluntary Health Insurance Schemes or Private-For-Profit Schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools similar risks and insures them for health related expenses. The main distinction is that the premiums are set at a level, which are based on assessment of risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of consumer's income.

In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) provide voluntary insurance schemes.

The most popular health insurance cover offered by GIC is Mediclaim policy

Mediclaim policy: - It was introduced in 1986. It reimburses the hospitalization expenses owing to illness or injury suffered by the insured, whether the hospitalization is domiciliary or otherwise. It does not cover outpatient treatments. Government has exempted the

premium paid by individuals from their taxable income. Because of high premiums it has remained limited to middle class, urban tax payer segment of population.

Some of the various other voluntary health insurance schemes available in the market are :- Asha deep plan II , Jeevan Asha plan II, Jan Arogya policy, Raja Rajeswari policy, Overseas Mediclaim policy, Cancer Insurance policy, Bhavishya Arogya policy, Dreaded disease policy, Health Guard, Critical illness policy, Group Health insurance policy, Shakti Shield etc.

At present Health insurance is provided mainly in the form of riders. There are very few pure health insurance policies under voluntary health insurance schemes.

Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

Employer State Insurance Scheme (ESI):- Enacted in 1948, the employers' state insurance (ESI) Act was the first major legislation on social security in India. The scheme applies to power using factories employing 10 persons or more and non-power & other specified establishments employing 20 persons or more. It covers employees and the dependents against loss of wages due to sickness, maternity, disability and death due to employment injury. It also covers funeral expenses and rehabilitation allowance. Medical care comprises outpatient care, hospitalization, medicines and specialist care. These services are provided through network of ESIS facilities, public care centers, non-governmental organizations (NGOs) and empanelled private practitioners. The ESIS is financed by three way contributions from employers, employees and the state government.

Even though the scheme is formulated well there are problem areas in managing this scheme. Some of the problems are :-

- Large numbers of posts of medical staff remain vacant due to high turnover and low remuneration compared to corporate hospitals.
- Rising costs and technological advancement in super specialty treatment.
- Management information is not satisfactory.
- The patients are not satisfied with the services they get
- Low utilization of the hospitals
- In rural areas, the access to services is also a problem

All these problems indicate an urgent need for reforms in the ESIS Scheme.

Central Government Health Insurance Scheme (CGHS):- Established in 1954, the CGHS covers employees and retirees of the central government and certain autonomous and semi autonomous and semi-government organizations. It also covers Members of Parliament, Governors, accredited journalists and members of general public in some specified areas. Benefits under the scheme include medical care, home visits/care, free medicines and diagnostic services. These services are provided through public facilities with some specialized treatment (with reimbursement ceilings) being permissible at private facilities. Most of the expenditure is met by the central government as only 12% is the share of contribution.

The CGHS has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out of pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80% of the cost is reimbursed if referral is made to private facility, when such facilities are not available with the CGHS).

Universal Health Insurance Scheme (UHIS):- For providing financial risk protection to the poor, the government announced UHIS in 2003. Under this scheme, for a premium of Rs. 165 per year per person, Rs.248 for a family of five and Rs.330 for a family of seven , health care for sum assured of Rs. 30000/- was provided. This scheme has been made eligible for below poverty line families only. To make the scheme more saleable, the insurance companies provided for a floater clause that made any member of family eligible as against mediclaim policy which is for an individual member. In spite of all these, the scheme was not successful.

The reasons for failing to attract rural poor are many:-

- The public sector companies who were required to implement this scheme find it to be potentially loss making and do not invest in propagating it. To meet the target, it is learnt that several field officers pay the premium under fictious names.
- Identification of eligible families is a difficult task
- Poor find it difficult to pay the entire premium at one time for future benefit, foregoing current consumption needs.
- Paper work required to settle the claims is cumbersome
- Deficit in availability of service providers
- Set back due to health insurance companies refusing to renew the previous year's policies.

In 2004, the government also provided an insurance product to the Self Help Group (SHG) for a premium of Rs.120 and sum assured of Rs.10000/-. However, the intake is negligible. The reasons for poor intake are similar to those cited above.

Insurance offered by NGOs/Community based health insurance

Community based schemes are typically targeted at poorer population living in communities. Such schemes are generally run by charitable trusts or non-governmental organizations (NGOs). In these schemes the members prepay a set amount each year for specified services. The premia are usually flat rate (not income related) and therefore not progressive. The benefits offered are mainly in terms of preventive care, though ambulatory and inpatient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with for profit insurers for the purchase of custom designed group insurance policies.

- CBHI schemes suffer from poor design and management. Often there is a problem of adverse selection as premiums are not based on assessment of individual risk status. These schemes fail to include the poorest of the poor. They have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

- Some of the popular Community Based Health Insurance schemes are: - Self-Employed Women's Association (SEWA), Tribuvandas Foundation (TF), The Mullur Milk Co-operative, Sewagram, Action for Community Organization, Rehabilitation and Development (ACCORD), Voluntary Health Services (VHS) etc.

Employer Based Schemes

Employers in both public and private sector offers employer based insurance schemes through their own employer. These facilities are by way of lump sum payments, reimbursement of employees' health expenditure for out patient care and hospitalization, fixed medical allowance or covering them under the group health insurance schemes.

The Railways, Defense and Security forces, Plantation sector and Mining sector run their own health services for employees and their families.

General Insurance Vs. Life Insurance

Several life insurance companies have of late plunged into the health segment, which till recently was dominated by general insurance companies. Among others, ICICI Prudential has launched Hospital Care and Crisis Cover and Bajaj Allianz, the Care First plan. Life Insurance Corporation, too, plans to roll out products soon. But, are these products any different from those offered by the general insurance companies, popular as mediclaim policies.

A comparison between Health Insurance offered by a Life and General Insurer

Nature of the contract	Life Insurer	General Insurer
Period of coverage	Contracts are usually made for a long period.	Contracts are usually, though not invariably, made for a short period of one year or less and at the end of that period are renewable by mutual consent of the insurer and the insured.
Obligation of the insured	Once the contract has been made, the insured is generally under no obligation to report any changes of circumstances affecting the risk insured unless a change in the actual nature of the contract is requested by the insured.	At each renewal there is an onus on the insured to observe utmost good faith in informing the insurer of any changes in circumstances which may affect assessment of the cost of the risk borne by the insurer.
Premiums	The premiums for a life assurance contract remain fixed over the term of the contract	The premiums may vary at each renewal to reflect changes in individual circumstances

Benefit payout	Pays a lump sum, irrespective of whether the policyholder has incurred those expenses on his hospital stay	Pays claims according to the hospital expenses that a person incurs, depending, of course, on the amount of cover that a policyholder has taken.
Valuation of Liabilities	A deterministic approach (the life & morbidity table) may be adequate for the valuation of life assurance liabilities	A stochastic approach (with statistical models more complicated than the life and morbidity table) has to be considered for general insurance
Taxation	Portion of premium paid in respect of health insurance covering the assessee as well as any member of the family is deducted from taxable income under section 80D	Premium paid in respect of health insurance policies is deducted from taxable income under section 80D

Advantages of Health insurance offered by Life insurer: Because of the long term nature of the plans, the policy holder can plan in advance his future medical/care expenses. But it is not so under General insurance. Since, the general insurance policies are subject to renewal every year, if the policy holder has been making several claims and is considered a risk, the general insurance company may deny renewal or renew it for a much higher premium.

Advantages of Health insurance offered by General insurer: Though a lump sum amount is paid by life insurers and is of long term nature, this comes with a cost. They charge bigger premiums compare with the General insurers. In addition, most general insurance companies offer medical charges up to 30 days before a person is hospitalized and pay the claims if a person has been undergoing treatment at home - also called domiciliary hospitalization. The life insurers seem to lack this facility at this point in time

Health Insurance for Senior Citizens

Ageing health policy questions are now frequently raised in India. India has not yet found a clear, fair and adequate system for financing the growing demand for long-term care as the population ages. The migration of population for jobs and livelihood from rural areas to urban areas and between cities has led to the breaking down of the age old traditional "joint" or "extended" family system in India. This system provides a good supporting structure for the care of older persons by keeping families together, pooling financial resources and making family members available in case of need. This weakening in the traditional support systems for older people is expected to lead to a rapid increase in the demand for formal care provided by institutions such as nursing and residential homes and also services provided in the community.

At present, there are no social schemes or federal or central government mechanisms for funding of health care for the aging population. The reliance is currently on private sector, voluntary organizations and indigenous programs that deliver 80% of health care (the remainder is in the form of Government hospitals and Municipal corporations). The medical

infrastructure to handle substantial number of older adults is lacking. There is no provision for organized long term care for chronically sick, except for the upper middle class and the rich who can afford to provide good care at home with some professional help. Hence, there is a need for innovative, cost effective health insurance products for senior citizens which cater effectively to their needs.

Implications of Privatization on Health Insurance

The privatization of insurance sector and constitution of IRDA envisage improving the performance of state insurance sector in the country by increasing benefits from competition in terms of lowered costs and increased level of consumer satisfaction. However, the implications of the entry of private insurance companies in health sector are not very clear. There are several contentious issues pertaining to development in this sector and these need critical examination. Role of private insurance varies depending on the economic, social and institutional settings in a country or a region.

Critics of private insurance argue that privatization will divert scarce resources away form the pool, escalate health costs, allow cream skimming and adverse selection. According to this view, private health insurance largely neglects the social aspect of health protection. In the contrast, supporters of private health insurance claim that private insurance can bridge financing gaps by offering consumers value for money and help them avoid waiting lines, low quality care and under the table payments-problems often observed when households can use public health facilities for free or participate in mandatory social insurance schemes. Both the arguments are correct in the sense, private health insurance can be valuable tool to compliment or supplement existing health financing options only if they are carefully managed and adapted to local needs and preferences.

India, with relatively developed economy and a strong middle class population, offers most promising environment for private health insurance development. Currently, private health insurance plays only a marginal role in health care systems but it is gradually gaining importance. Private health insurance is certainly not the only alternative or the ultimate solution to address alarming health care challenges in India. However, it is an option that warrants- and already receives-growing consideration by policy makers in the country. Thus the question is not if this tool will be used in the future but whether it will be applied to the best of its potential to serve the needs of the country's health care system.

Role of Regulator

As Health Insurance is in its very early phase, the role of IRDA will be very crucial. It has to ensure that this sector develops rapidly and benefit of insurance goes to the consumers. It has to guard against the ill effects of privatization. Unless privatization and development of health insurance is managed well it may have negative impact of health care, especially to a large segment of rural population in the country. If it is well managed then it can improve access to care and health status in the country rapidly. Experience from other countries suggest that the entry of private firms into the health insurance sectors, if not properly regulated , does have adverse consequences for the cost of care, equity, consumer satisfaction, fraud and ethical standards. Some of the areas of concern which the regulator has to look into are:

- Many times the insurance claims are rejected due to small technical reasons. This leads to disputes

- Various conditions included in the insurance policy contract is not negotiable and these are binding on consumer
- There no analysis on what is fair practice and what is unfair practice
- The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions.
- The main danger in the health insurance business is that the private companies will cover the risk of middle class who can afford to pay high premiums. Unregulated reimbursement of medical costs by the insurance companies will push up the prices of private care. So large section of India's population who are not insured will be at a relatively disadvantage as they will, in future, have to pay more for the private care.

IRDA has stipulated regulations for both life and non-life insurance companies in many aspects of business but the same is lacking in respect of health insurance business. Given the health insurance is assuming greater significance, it is time for the regulator to etch a frame work for operating the health schemes. IRDA will have to evolve mechanism so that the private insurance companies do not skim the market by focusing on rich and upper class clients and in the process neglect a major section of India's population.

In a view to ensure that the rural and less-developed areas do not fall prey to a step-motherly treatment in penetration of health business, the Regulator may ensure, in line with its rules jotted down for private life and non-life insurers, that minimum annual targets are given to the benefit providers so that at any given point in time, a decent portfolio of health coverage's represent the rural sector .

IRDA should ensure and encourage different organizations and private insurers to develop products for the poorer segment of the community and if possible build an element of cross subsidy for them.

The IRDA will have a significant role in regulating the health insurance sector and safe guarding the interests of the policy holders by minimizing the unintended consequences.

CONCLUSION

Health insurance is like a knife. In the surgeon's hand it can save the patient, while in the hands of the quack, it can kill. Health insurance is going to develop rapidly in future. The main challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without negative aspects of cost increase and overuse of procedures and technology in provision of health care.

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