# KEYNOTE ADDRESS

*on*

# 'EVOLUTION AND DEVELOPMENT OF HEALTH INSURANCE IN INDIA'

*by*

**DR. SOMIL NAGPAL**

**HEALTH SPECIALIST, SOUTH ASIA REGION**

**WORLD BANK, NEW DELHI**

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**At VISAKHAPATNAM**
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**INSURANCE INSTITUTE OF INDIA**
**PLOT C-46, 'G' BLOCK, BANDRA-KURLA COMPLEX**
**BANDRA (EAST), MUMBAI-400051.**

*About the Keynote speaker*

**Dr Somil Nagpal**
**MBBS, MHA, MBA, F.I.I.I.**

A medical doctor from MGM Medical College, Indore , he is also an MBA in Financial Management from National Institute of Financial Management; MHA-Health Care Management from Tata Institute of Social Sciences and a Fellow of the Insurance Institute of India. He has been involved as a resource person/ expert for the World Health Organization and for the Union Ministry of Health and Family Welfare in the areas of Health Insurance, Health Costing and National Health Accounts. He has been a visiting faculty to various Government, non-Government and International Organizations, and management institutions.

He has been involved with the Health Insurance sector of India for the last 6 years. He is currently with the World Bank, New Delhi as Health Specialist. Before this assignment, he was with IRDA as Special Officer-Health Insurance.

He has authored various publications on his areas of interest, which have been published in highly recognized periodicals, books and journals.

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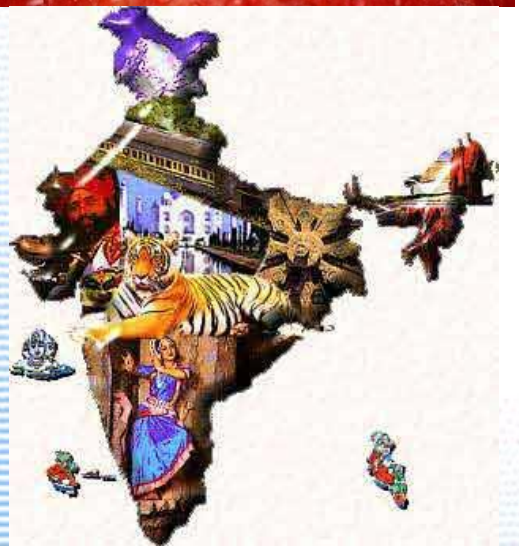
# Evolution and Development of Health Insurance in India

**Keynote Address in the 55th Annual Conference of Insurance Institute of India**

**4th September 2010**

**Dr Somil Nagpal**

Health Specialist,

South Asia Region

The World Bank

# What is Health Insurance

A way to distribute the financial risk associated with the variation of individual's health care expenditures by pooling costs over time (pre-payment) and over people (pooling)" (OECD 2004).

**Private Health Insurance:** Coverage of a defined set of health services financed through private payments in the form of a premium to the insurer. The insurer, a non-governmental entity, assumes much or all of the risk for paying for those services

# Quick facts on Health Expenditure in India…

Health expenditure in India (2004-05) is **4.2% of the GDP*** and about Rs. 2.2 lakh crores today.

Over **three-fourths** (78%) of all health spending is private (71% of total is by households)*

More than **40 percent** of the people hospitalized had to borrow money / sell assets to cover expenses

A quarter of those hospitalized fall **below the poverty line** because of high costs #

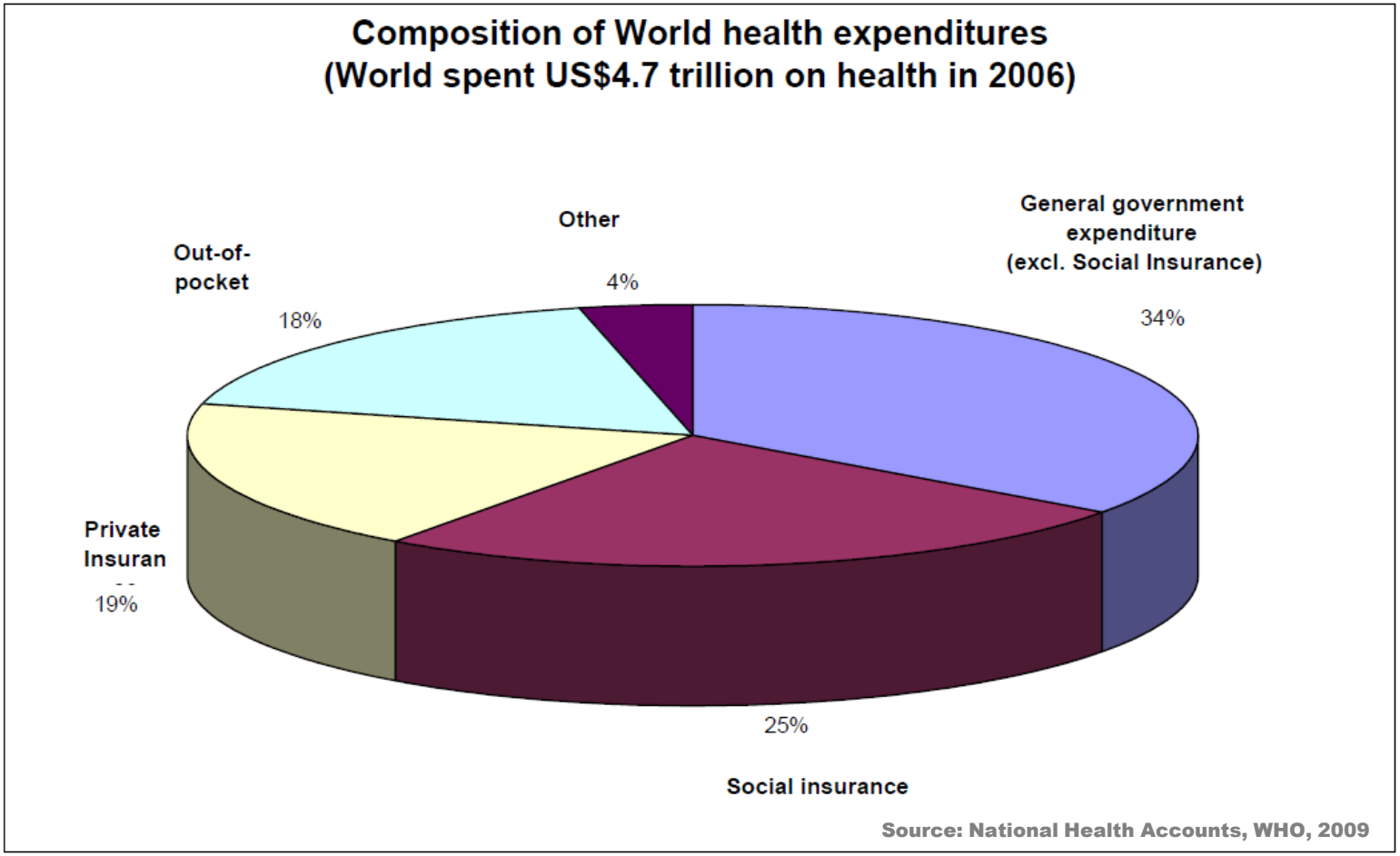
Medical care is one of the 3 main causes of impoverishment in the country.

Recent NSSO data (60th round) indicates a large share of consumption expenditure is on health **(13% in rural, 10% in urban)**

*National Health Accounts for India 2004-05. Govt of India, Ministry of Health and Family Welfare. New Delhi: 2009

# Peters D, Yazbeck A, Sharma R, Ramana G, Pritchett L, Wagstaff A. Better Health Systems for India's poor. Washington: World Bank, 2002

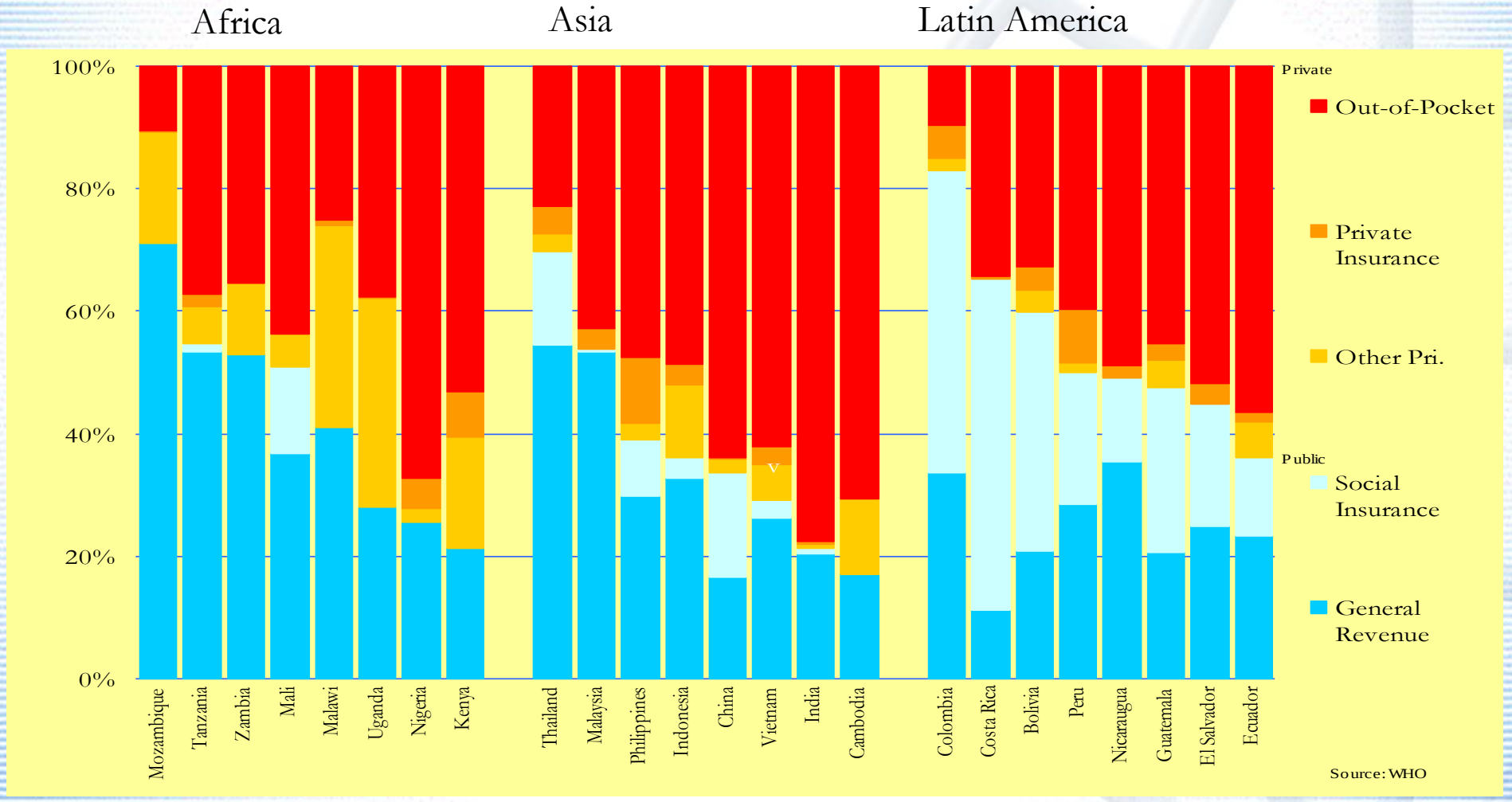
# India v/s Global Health Expenditure




**Rough Estimates for India's Health Expenditure in 2006-07: About 40 Billion USD**

**India's Social + Pvt Health Insurance Market in 2006-07: A little higher than 1 Billion USD**

# Increasing Pooled Financing as Countries Move to Middle Income

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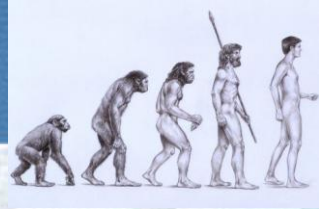


# Evolution of H I in India

- Earliest mention of insurance mechanisms - Manu (*Manusmrithi),* Yagnavalkya (*Dharmasastra*) and Kautilya (*Arthasastra)*
- Formal Insurance sector – Earliest commercial companies started in early 19th century
- Insurance Act, 1938 set the regulatory framework
- ESI Act, 1948 CGHS was established in 1954.
- Nationalization (1956/1973) and again opening up the sector for private participation (2000) were landmark events in the sector
- First standard health insurance product launched by the GIC in 1986- Hospital indemnity product - the '**Mediclaim'** policy

# ESIS and CGHS: Social Health Insurance

Typically, like other such SHI schemes, India's ESIS is:

- Mandatory for the specified groups.
- Premium is income rated- Employers (4.75% of wages) and Employees (1.75%)
- Supplemented by the Central and State governments.

Health services are delivered through its **own network** of dispensaries and hospitals, supplemented by some outsourced Authorized Medical Attendants and private hospitals.

Also has '**Cash Benefits**' which compensate for loss of wages due to disease/ disability/ death.

Covers over **50 million** persons presently.

CGHS, for Central Government employees, covers 3.2 million persons. It has its own dispensaries while hospital services are outsourced.

Both provide comprehensive ambulatory and hospital care without any annual limits.

# Community Health Insurance

India has been a global ‘Laboratory’ to understand and experiment with community H I.

Usually small schemes, community-based and with a not-for-profit motive.

In principle, managed by community members, and accountable back to members. ‘Facilitators’, usually NGOs, may play an important role.

May outsource part (or all) of risk and/or health services provision through tie-up with hospitals, insurers.

Provided valuable inputs for development of models like Arogyashri and RSBY (discussed later)

- **e.g. Gujarat: Self Employed Women’s Association (SEWA)**
- **Maharashtra: Sewagram, Wardha**
- **Gujarat: Tribhuvandas Foundation (TF), Anand**

# Private Health Insurance

Voluntary, with over 300 products from over 30 insurers competing in the market today.

Exclusions, wait periods, sub-limits and other policy conditions are structured by insurers to avoid adverse selection, information asymmetry and moral hazard. Not well understood by customers- issue of confidence

Cover about 60 million people presently (excluding Government-funded schemes), roughly equally shared between Corporate (group) insurance plans and Retail (individual/family) plans. Retail is the fastest growing segment, contributing to major share of incremental growth

Also forms the mechanism for mass Government schemes like RSBY, Arogyashri and Kalaignar, which cover over 120 million people today, and many Community based H I schemes.

# Govt Health Insurance Schemes

Government Funding for Health Insurance schemes

Through Pvt Insurers, risk transferred

- RSBY
- Rajiv Arogyashri
- Kalaignar

Using Insurance Intermediaries (no risk transfer)

- Yeshaswini
- Vajpayee Aarogyashri

Directly managed

- ESIS
- CGHS
- ECHS

# Multi-Faceted Involvement of Government in the Sector

**Statutory regulatory authority, IRDA,** under a Parliamentary Act

**Tax concessions** under the Income Tax act – indirect subsidy

**Subsidizing** premium in voluntary health insurance e.g. Universal Health Insurance Scheme (UHIS)

**National Rural Health Mission**, promotes health insurance schemes

Government also **owns the largest players** in the sector, 61% of the health insurance business in 2007-08

**Increasingly important buyer of insurance: RSBY, Arogyashri, Kalaignar**

Directly linked to health insurance is the role of the Government in the **health sector itself**, where the Government is also the single largest provider of healthcare in India, particularly for inpatient care

Government (in this case, states) are also regulators for the health sector, and associated sectors like pharmaceuticals.

# Growth Trends, Reach, Coverage

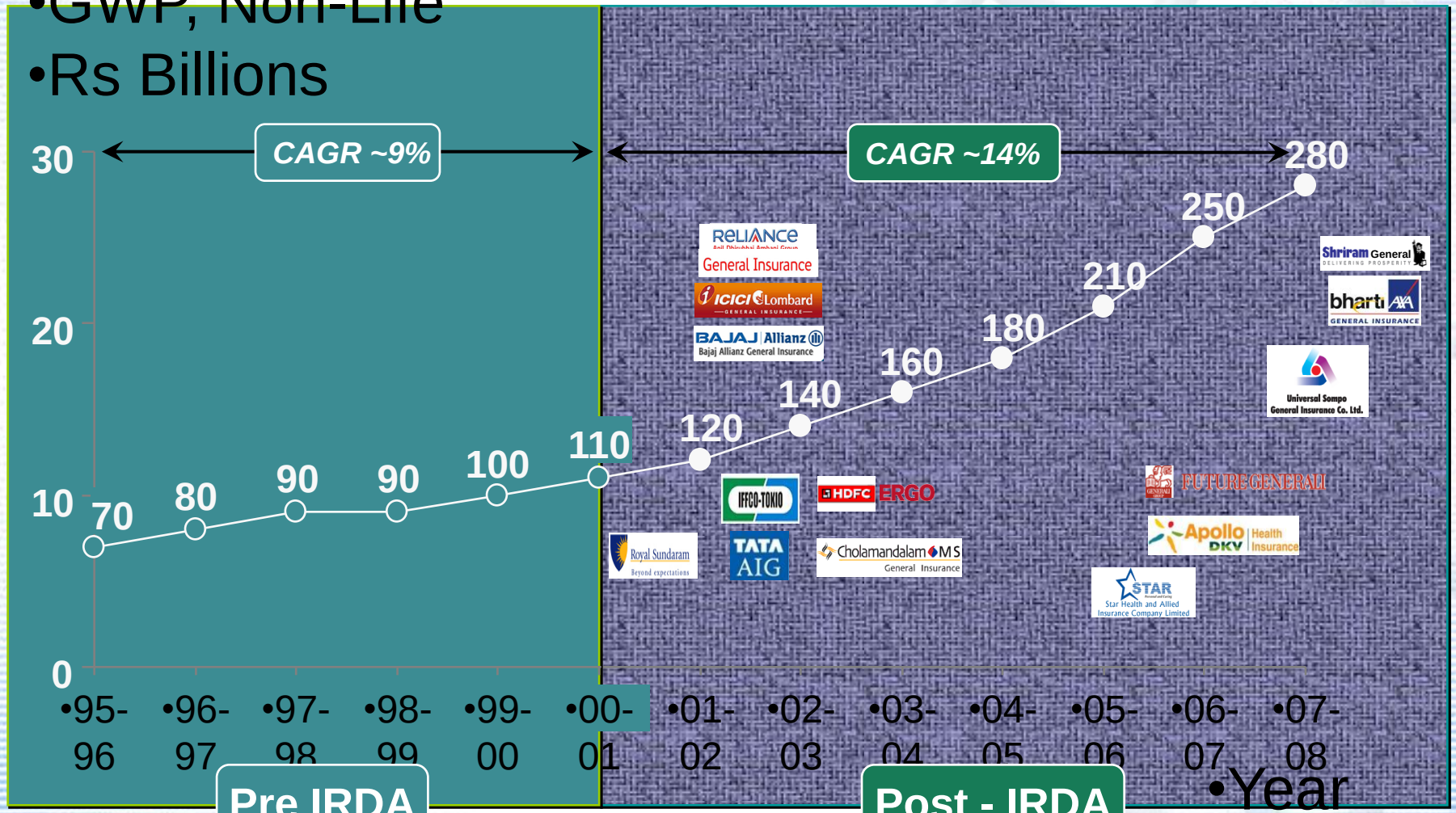
- **Fastest growing** segment in the general insurance industry in India- in 2009-10, industry premium revenue has grown about **12-fold** from a level of Rs. 6750 million in 2001-02 to Rs 83000 million, in just 8 years*.
- SHI enrolments are also static or gradually rising.
- Insurance and other forms of health protection **presently reach 230-240 million people in the country**.
- Insurance currently pays **less than one-tenth** of all hospitalization expenditure in the country* but the share is much larger for hospitals in metro cities and large towns, where it could be **30-40%.**
- Even for those covered, **not everything is covered**. e.g. Only SHI schemes cover OPD costs, Arogyashri only covers expensive procedures. Thus, there are substantial out of pocket payments even for those covered by insurance.



*Source: IRDA Journal and IRDA Annual Reports. Includes figures for health insurance products of non-life and life insurers.

# General Insurance Industry as a Whole, over the years…

- GWP, Non-Life
- Rs Billions




Source: IRDA data, Graph adapted from BCG presentation in FICCI Insurance Summit 2008

# Some factors driving growth

Increasing **awareness** of Health Insurance

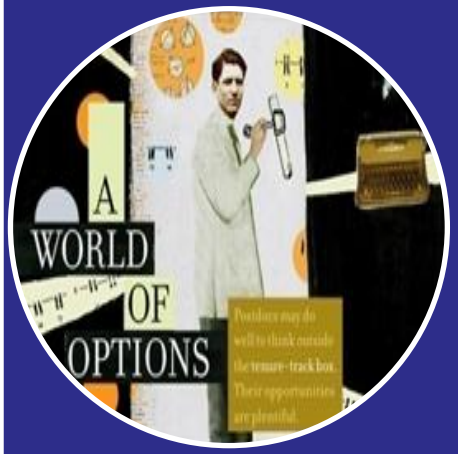
Rising **healthcare costs** and increasing presence and use of private sector have increased need for health insurance

Availability of health insurance products for groups like **Senior Citizens and Children-** these segments are growing faster on a lower base.

**Government schemes** like RSBY and Aarogyasree, contributed in terms of premium and even more so in lives covered

**Detariffing** of the general insurance industry (which has increased emphasis and efforts by insurance companies towards health insurance and other personal lines of business)

**Rationalization** of premium rates (e.g. trend of upward revision in respect of Group Health policies)

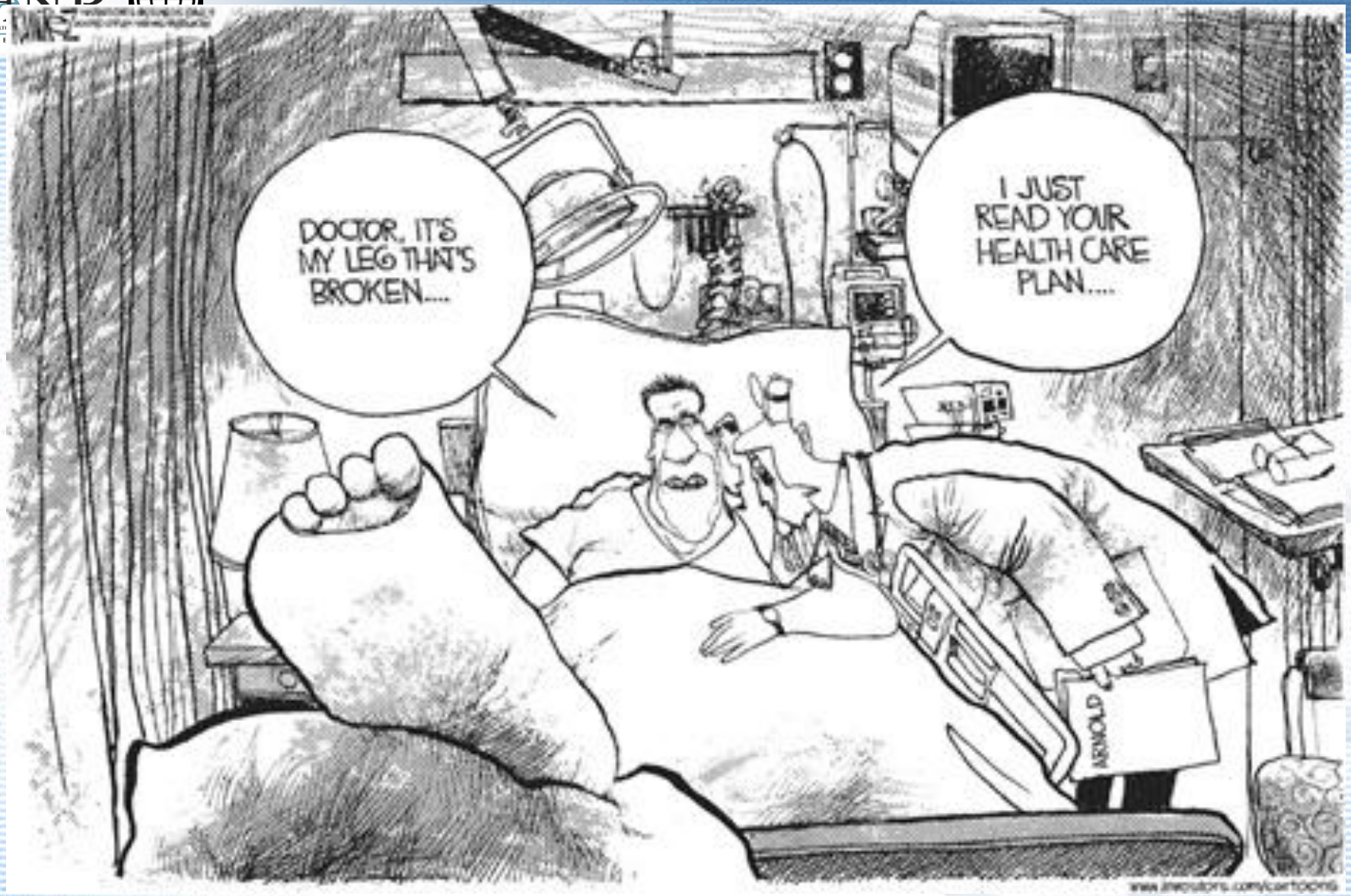



While product variety available has increased substantially now, the **hospitalization indemnity-based annual contract** predominates, except in SHI.

Products now available include:

- Individual and Group Floater Indemnity products
- Critical Illness Indemnity and Benefit products
- Hospitalization Benefit and Surgical Benefit products
- Hospitalization Daily Cash Benefit products
- High Deductible and Top-Up covers
- Products with Personal Accident coverage
- Micro health insurance products
- Overseas travel and International comprehensive coverage products
- Disease Management products
- Specific disease products- Cancer, HIV, Diabetes
- Products for different age groups- Senior Citizens, children
- Dental insurance
- Products with outpatient coverage in some form

Concerns on **consumer understanding of product scope and options.**


DOCTOR, IT'S MY LEG THAT'S BROKEN....
I JUST READ YOUR HEALTH CARE PLAN....
ARNOLD

# Scope for Distortions in Industry Behaviour

OPD treatment– even if expensive- is not covered in most Indian products. **Incentives to admit even if not required** (though some clauses safeguard this), in addition to over-provisioning/ over-charging issues generic to fee-for-service system.

Level Playing Field issues: Government-funded insurance schemes allow the same payout for public hospitals which **already have supply subsidies**. Plus, **patients may prefer private providers** if the choice is cost-neutral to them.

**Provider regulatory framework** being weak, allows supply induced demand, no checks on quality or quantity of services provided (& billed).

# Prospects: Projected Coverage and Reach


Government Scheme- RSBY- aims to cover all poor **(300 million)** by 2012, **plus other groups like NREGA, Asha workers**

More state governments (e.g. Karnataka) introducing own schemes- may add **another 100 million** persons in next 2-3 years.

McKinsey/KPMG etc have forecasts of a **Rs 250-300 billion health insurance market by 2015**, at a CAGR of 25-30% (for perspective, current CAGR for 2001-02 to 2007-08 is 39%)

India's GDP estimates for 2015 ~ INR 100 trillion. At about 4%, total health expenditure will be in the range of Rs 4 trillion. A 10% share of health expenditure routed through health insurance would mean **Rs 400 billion.**

**Several standalone health insurers** have entered Indian market (Star, Apollo, BUPA+Max, Religare) and many others believed to be on the anvil.

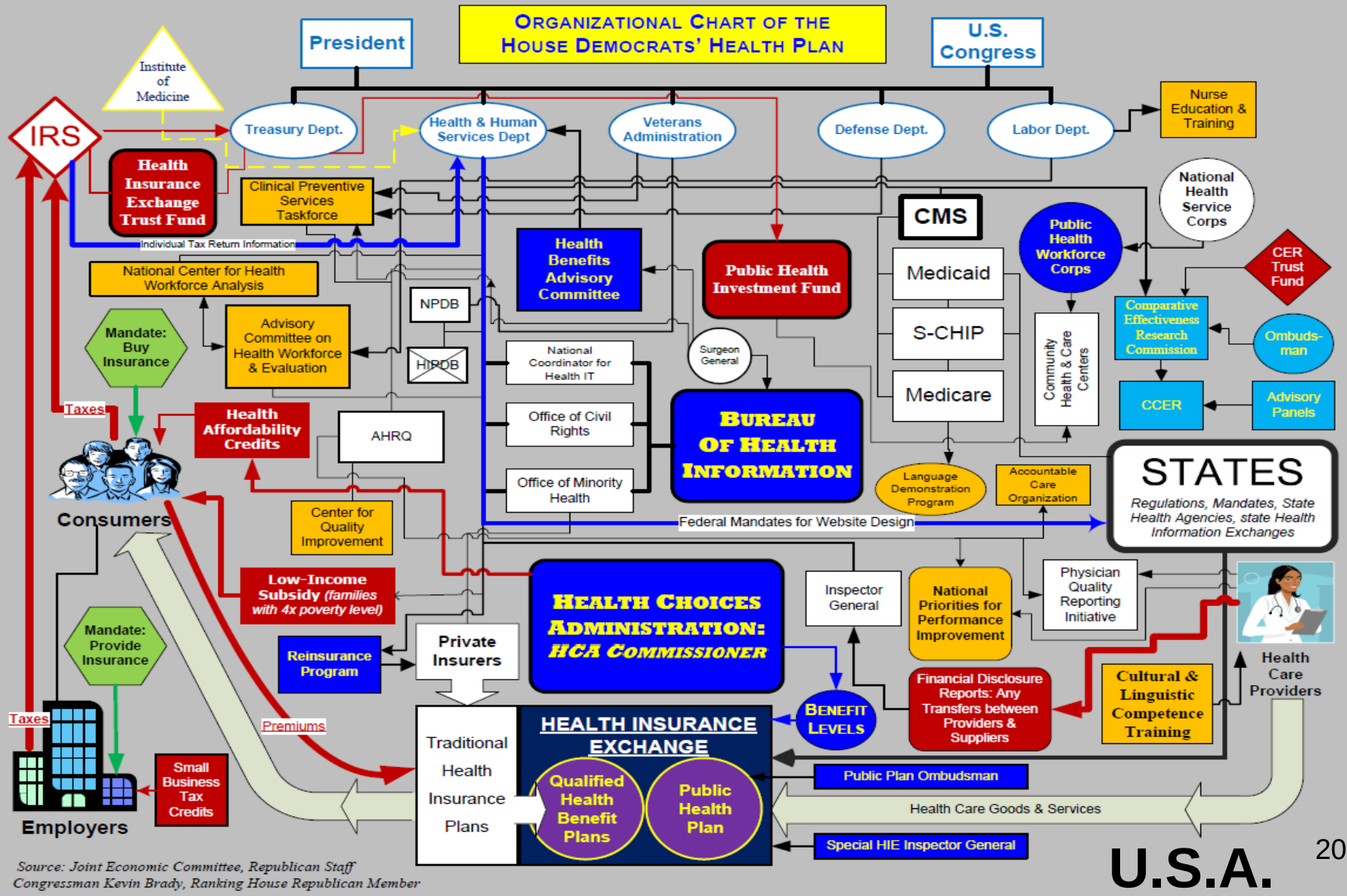
# Need for Regulation of Private Health Insurance

- The **complexity** of health insurance business makes it very vulnerable to the effects of **poor corporate governance**.
  - Regulation prevents, monitors and brings corrective changes.
- **Market Failures** in Health Insurance require regulatory intervention
  - e.g. to harmonize/achieve desired social objectives, most notably equitable access to health insurance
- Even when strong, **self regulation** may not work where it comes at a price to be borne by the industry.
- Need for **standards** and benchmarks that attempt to correct inefficiencies and disaggregated efforts
- Regulation is key to **customer's confidence** in the 'promise' of health insurance.

***Regulator has different incentives than the insurers and thus can be more effective in these respects.***

***Welfare loss to society from absence of regulation could be greater than the aggregate costs in compliance of regulations.***

# Can you over-complicate health insurance regulation?




*Source: Joint Economic Committee, Republican Staff*
*Congressman Kevin Brady, Ranking House Republican Member*

# Regulatory Structure

- **Statutory Base**: Legal sanctity, independent financing sources and adequate 'teeth' for the regulator
- **Administrative Location:**
  - Office within a Health or Insurance Agency:
    - Small country context with limited regulatory manpower, or
    - Dealing with integrated insurers which have non-health businesses
  - Independent Health Insurance Agency
- **Licensing and Registration**:
  - Management background and integrity, financial strength, business plans
- **Financial Regulation**:
  - Prudential regulations, Accounting Rules, Reporting requirements, Monitoring
- **Product Regulation**
  - Filing/approval requirements, transparency and fairness requirements
- **Price Regulation**
- **Market Conduct** Examinations
- **Enforcement**: Essence of regulation- all regulations and monitoring systems are meaningless without enforcement.

# Regulatory initiatives in India

Health occupies prominent attention in IRDA's developmental agenda

The Authority had set up a National Health Insurance Working group in 2003 – sub groups on Data, Standalone health insurers and Product innovation

Health data repository at the TAC, and Revision in the formats for health data. The 2007-08 summary tables are already published on website. Over 100 million records on policies, members and claims.

Joint Initiatives with Industry Chambers- CII and FICCI- Multi-stakeholder Working Groups working on standardization initiatives.

Instructions on Renewability of Health Insurance policies

Instructions for Senior Citizens' coverage

Committee to evaluate the performance of TPAs and suggestions on operational efficiencies and fraud mitigation.

# Unique Partnership Initiative: Multi-stakeholder industry groups

In a strong collaborative venture between the Public and Private sectors- industry bodies like FICCI and CII, along with IRDA, have taken numerous initiatives on specific areas of health insurance

**Modality**: multi stakeholder working groups comprising of representatives from insurers, TPAs, hospitals and other stakeholders, co-ordinated by IRDA and industry bodies

**Each of these working groups addresses a critical piece of the overall approach** envisioned by the Regulator. Regulator gains from sectoral expertise and capacity in pvt sector.

Regulator is the common thread across these working groups in ensuring **smooth co-ordination and also that there is no duplication** of efforts across the industry's various initiatives

# Standardization in Progress

Standard Treatment Guidelines for commonest cause of insurance claims

Standard list of excluded expenses

Standard pre-authorization and claim forms for the industry

Customer Information Sheet annexed to policies

Standard definitions for key terms

Common Hospital ID and Hospital Masters

Standard wording and coverage for Critical Illnesses

+ New initiatives- Promoting Quality through Health Insurance, Standard Billing Codes

**Expected Spinoff**: Minimize confusion, enhance comparability, ensure transparency and fair practices, yield data for industry's development

# Challenges and Road Ahead


**Health System Issues:**

- Healthcare costs
- Regulation of providers
- Accreditation/ Grading/ Quality issues

**Consumer Awareness and Empowerment**

- Decrypting the jargon
- Product innovation to match consumer needs
- Simplification and standardization of key terms
- Process efficiencies
- Performance benchmarks for operations and service
- Transparency and best practices
- Leveraging technology

Minimizing moral hazard in the system

Increasing reach, access and affordability




# Thank You….

snagpal@worldbank.org

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