Health Insurance in India
Opportunities, Challenges and Concerns

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1. Introduction

Over the last 50 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators (Satia et al 1999). In case of government funded health care system, the quality and access of services has always remained major concern. A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. However, with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

The new economic policy and liberalization process followed by the Government of India since 1991 paved the way for privatization of insurance sector in the country. Health insurance, which remained highly underdeveloped and a less significant segment of the product portfolios of the nationalized insurance companies in India, is now poised for a fundamental change in its approach and management. The Insurance Regulatory and Development Authority (IRDA) Bill, recently passed in the Indian Parliament, is important beginning of changes having significant implications for the health sector.

The privatization of insurance and constitution IRDA envisage to improve the performance of the 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. The recent policy changes will have been far reaching and would have major implications for the growth and development of the health sector. There are several contentious issues pertaining to development in this sector and these need critical examination. These also highlight the critical need for policy formulation and assessment. Unless privatization and development of health insurance is managed well it may have negative impact of health care especially to a large segment of population in the country. If it is well managed then it can improve access to care and health status in the country very rapidly.

Health insurance as it is different from other segments of insurance business is more complex because of serious conflicts arising out of adverse selection, moral hazard, and information gap problems. For example, experiences from other countries suggest that the entry of private firms into the health insurance sector, if not properly regulated, does have adverse consequences for the costs of care, equity, consumer satisfaction, fraud and ethical standards. The IRDA would have a significant role in the regulation of this sector and responsibility to minimise the unintended consequences of this change.

Health sector policy formulation, assessment and implementation is an extremely complex task especially in a changing epidemiological, institutional, technological, and political scenario. Further, given the institutional complexity of our health sector programmes and the pluralistic character of health care providers, health sector reform strategies in the context of health

insurance that have evolved elsewhere may have very little suitability to our country situation. Proper understanding of the Indian health situation and application of the principles of insurance keeping in view the social realities and national objective are important.

This paper presents review of health insurance situation in India - the opportunities it provides, the challenges it faces and the concerns it raises. A discussion of the implications of privatization of insurance on health sector from various perspectives and how it will shape the character of our health care system is also attempted. The paper following areas:

- Economic policy context
- Health financing in India
- Health insurance scenario in India
- Health insurance for the poor
- Consumer perspective on health insurance
- Models of health insurance in other countries

This paper is partly based on a deliberations of a one day workshop (IIMA 1999) and a conference held at 11M Ahmedabad (IIMA 2000) in 1999-2000 on health insurance involving practicing doctors, representatives from government insurance companies, medical associations, training institutes, member-based organizations and health policy researchers. Workshop and conference were part of the activities of Health Policy Development Network (HELPONET) and is supported by the International Health Policy Program. The paper also draws on several published and unpublished papers and documents in the area of health insurance.

2. Economic policy context and imperatives of liberalization of insurance sector

There are several imperatives for opening of the insurance and health insurance sector in India for private investment. Here we review some of these imperatives.

Economic policy reforms started during late eighties and speeded up in nineties are the context in which liberalization of insurance sector happened in India. It was very obvious that the liberalization of the real (productive) and financial sector of the economy has to go hand in hand. It is imperative that these sectors are consistent with policies of each other and unless both function efficiently and are in equilibrium, it would be difficult to ensure appropriate economic growth. Given these facts liberalization of both sectors has to proceed simultaneously.

Indian economic system has been developed on paradigm of mixed economy in which public and private enterprises co-exist. The past strategies of development based on socialistic thinking were focusing on the premise of restrictions, regulations and control and less on incentives and market driven forces. This affected the development process in the country in serious way. After the economic liberalization the paradigm changed from central planning, command and control to market driven development. Deregulation, decontrol, privatization, delicensing, globalization became the key strategies to implement the new framework and encourage competition. The social sectors did not remain unaffected by this change. The control of government expenditure, which became a key tool to manage fiscal deficits in early 1990s, affected the social sector spending in major way. The unintended consequences of controlling the fiscal deficits have been reduction in capital expenditure and non-salary component of many social sector programmes. This has led to severe resource constraints in the health sector in respect of non-salary expenditure and this has affected the capacity and credibility of the government health care

system to deliver good quality care over the years. Given the increasing salaries, lack of effective monitoring and lack of incentives to provide good quality services the provides in the government sector became indifferent to the clients. Clients also did not demand good quality and better access, as government services were free of cost.

Under this situation more and more clients turned to the private sector health providers and thus the private sector healthcare has expanded. Given the socialistic political thinking and populist policy it has been generally difficult for any government to introduce cost recovery in public health sector. Given that government is unable to provide more resources for health care, and institute cost recovery, one of the ways to reduce the under-funding and augment the resources in the health sector was to encourage the development health insurance.

Another imperative for liberalization of the insurance sector was the need for long-term financial resources on sustainable basis for the development of infrastructure sector such as roads, transports etc. It was realized that during the course of economic liberalization, the funds to development the infrastructure also became a major constraint. Country certainly needed infrastructure development. For this the finances are major constraint. In these investments the benefits are more social than private. The major concern was how these finances can be made available at low costs. In past the development of social sector were financed using government channeled funds through various semi-government financial institutions. Under the liberalized economy this may not be possible. One hope is that if the insurance sector develops rapidly under privatization then it can provide long-term finance to the infrastructure sector.

The financial sector, which consists of banks, financial institutions, insurance companies, provident funds schemes, mutual funds were all under government control. There was less competition across these units. As a result these institutions remained significantly less developed in their approach and management. Insurance sector has been most affected by the government controls. Government had significant control on the policies these insurance companies could offer and utilization of the resources mobilized by insurance companies. One can see that most of the insurance products (e.g., life insurance products) were promoted as mechanisms to improve the savings and tax shelters rather as risk coverage instruments. Other segments of the insurance products grew because of the statutory obligations (e.g., Motor Vehicle, Marine and Fire) under various acts. The management and organization of insurance sector companies remained less developed and they neglected new product development and marketing. Thus one of the hopes in opening of the insurance sector was that the private and foreign companies would rapidly develop the sector and improve coverage of the population with insurance using new products and better management.

Last imperative for opening of the insurance sector was signing the WTO India. After this there was little choice but to open the entire financial sector - including insurance sector to private and foreign investors. (Dholakia 1999).

3. Health sector and its financing: present scene and issues for the future

During the last 50 years India has developed a large government health infrastructure with more than 150 medical colleges, 450 district hospitals, 3000 Community Health Centers, 20,000 Primary Health Care centers and 130,000 Sub-Health Centers. On top of this there are large number of private and NGO health facilities and practitioners scatters though out the country. Over the past 50 ears India has made considerable progress in improving its health status. Death

rate has reduced from 40 to 9 per thousand, infant mortality rate reduced from 161 to 71 per thousand live births and life expectancy increased from 31 to 63 years. However, many challenges remain and these are: life expectancy 4 years below world average, high incidence of communicable diseases, increasing incidence of non- communicable diseases, neglect of women's health, considerable regional variation and threat from environment degradation. It is estimated that at any given point of time 40 to 50 million people are on medication for major sickness in India. About 200 million workdays are lost annually due to sickness. Survey data indicate that about 60% people use private health providers for outpatient treatment while 60 % use government providers for in-door treatment. The average expenditure for care is 2-5 times more in private sector than in public sector.

India spends about 6% of GDP on health expenditure. Private health care expenditure is 75% or 4.25% of GDP and most of the rest (1.75%) is government funding. At present, the insurance coverage is negligible. Most of the public funding is for preventive, promotive and primary care programmes while private expenditure is largely for curative care. Over the period the private health care expenditure has grown at the rate of 12.84% per annum and for each one percent increase in per capital income the private health care expenditure has increased by 1.47%. Number of private doctors and private clinical facilities are also expanding exponentially. Indian health financing scene raises number of challenges, which are:

- increasing health care costs,
- high financial burden on poor eroding their incomes,
- increasing burden of new diseases and health risks and
- neglect of preventive and primary care and public health functions due to under funding of the government health care.

Given the above scenario exploring health-financing options becomes critical. Health Insurance is considered one of the financing mechanisms to over come some of the problems of our system.

4. Health Insurance scene in India

Health insurance can be defined in very narrow sense where individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at time of use of services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter- broader interpretation of health Insurance is more appropriate.

Health insurance is very well established in many countries. But in India it is a new concept except for the organized sector employees. In India only about 2 per cent of total health expenditure is funded by public/social health insurance while 18 per cent is funded by government budget. In many other low and middle income countries contribution of social health insurance is much higher (see Table I).

Table 1 Percentage of total health expenditure funded through public/social insurance and direct government revenue		
Country	**Social Health Insurance**	**Government Budget**
Algeria	37	36
Bolivia	20	33
China	31	13
Korea	23	10
Vietnam	2	20
India	2	18
Source: As cited in Naylor et al. 1999.		

It is estimated that the Indian health care industry is now worth of Rs. 96,000 crore and expected to surge by 10,000 crore annually. The share of insurance market in above figure is insignificant. Out of one billion population of India 315 million people are estimated to be insurable and have capacity to spend Rs. 1000 as premium per annum. Many global insurance companies have plans to get into insurance business in India. Market research, detailed planning and effective insurance marketing is likely to assume significant importance. Given the health financing and demand scenario, health insurance has a wider scope in present day situations in India. However, it requires careful and significant effort to tap Indian health insurance market with proper understanding and training.

There are various types of health coverages in India. Based on ownership the existing health insurance schemes can be broadly divided into categories such as:

Government or state-based systems
Market-based systems (private and voluntary)
Employer provided insurance schemes
Member organization (NGO or cooperative)-based systems

Government or state-based systems include Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS). It is estimated that employer managed systems cover about 20-30 million of population. The schemes run by member-based organizations cover about 5 per cent of population in various ways. Market-based systems (voluntary and private) have Mediclaim scheme which covers about 2 million of population. There are many employers who reimburse costs of medical expenses of the employees with or without contribution from the employee. It is estimated that about 20 million employees may be covered by such reimbursement arrangements. There are several government and private employers such as Railway and Armed forces and public sector enterprises that run their own health services for employees and families. It is estimated that about 30 million employees may be covered under such employer managed health services (Ellis et al. 1996).

General Insurance Corporation (GIC) and its four subsidiary companies and Life Insurance Corporation (LIC) of India have various health insurance products. These are Ashadeep Plan II and Jeevan Asha Plan II by Life Insurance Corporation of India and various policies by General Insurance Corporation of India as under: Personal Accident Policy, Jan Arogya Policy, Raj Rajeshwari Policy, Mediclaim Policy, Overseas Mediclaim Policy, Cancer Insurance Policy, Bhavishya Arogya Policy and Dreaded Disease Policy (Srivastava 1999).

The health care demand is rising in India now days. It is estimated that only 10 per cent of health insurance market has been tapped till today. Still there is a scope of rise up to 35 per cent in near

future. The most popular health Insurance cover is Mediclaim Policy. This policy is discussed below.

5. Mediclaim scheme

The government insurance companies started first health insurance in 1986, under the name mediclaim; thereafter Mediclaim has been revised to make it attractive product. Mediclaim is a reimbursement base insurance for hospitalization. It does not cover outpatient treatments. First there is used to be category-wise ceilings on items such as medicine, room charges, operation charges etc. and later when the policies were revised these ceilings were removed and total reimbursements were allowed with in the limit of the policy amount. The total limit for policy coverage was also increased. Now a person between 3 months to 80 years of age can be granted mediclaim policy up to maximum coverage of Rs. 5 lakh against accidental and sickness hospitalisations during the policy period as per latest guidelines of General Insurance Corporation of India. This scheme is offered by all the four subsidiary companies of GIC. Mediclaim scheme is also available for groups with substantial discount in premium.

The current statistics on health insurance indicate that out of 1 billion population only about 2 million of population is covered by Mediclaim scheme. The reason for lack of popularity of this scheme could be several. The health insurance products are generally complicated and it is suggested that GIC and its subsidiary companies who deal in non-life insurance market which is dominated by mandated insurance such as accident, fire and marine, do not have expertise in marketing health insurance and therefore this scheme is not popular. Health insurance also represents very small percentage of overall business of GIC and its subsidiaries hence they have also not focused their attention in this area. The GIC companies have little interest and means to monitor the scheme. It should also be recognized that because of technicalities of health service business there are number of cumbersome rules which have hampered the acceptance of the scheme. It is also reported that in number of cases the applicants of older ages have been refused to become member of mediclaim scheme due to unnecessary conservatism of the companies.

Another area of less popularity of the. Mediclaim is the lack of appropriate marketing efforts in selling these products. To popularize the schemes It IS Important that proper marketing is done. To make the scheme more acceptable government has exempted the premium paid by individuals from their taxable income. This provides 20-40% subsidy on the premium to taxpayers.

Mediclaim has provided a model for health insurance for the middle class and the rich. It covers hospitalization costs, which could be catastrophic. But given the the premium is on higher side it as remained limited to middle class, urban tax payers segment of the population. There are also problems and negative unintended consequences of this scheme. There are reported fraud and manipulation by clients and providers, which have implications for the growth and development of this sector. The monitoring systems are weak and there are chances that if the doctor and patient collude with each other, they can do more harms to the system. There is also element of adverse selection problem as the scheme is voluntary. As the scheme reimburses charges without limit it also will pushed up the prices of services in the private sector. Our analysis of mediclaim data from one center indicates wide variation of charges for same operation in the same city. Anecdotal evidence from doctors also indicates that charges are increased if patients are insured. All these effects will tend to increase the prices of private health care thus hurting the uninsured.

6. Employee State Insurance (ESI) Scheme

Under the ESI Act, 1948 ESI Scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It also provides medical care to employees and their family members without fee for service. When implemented for the first time in India at two centres namely Delhi and Kanpur simultaneously in February 1952, it covered about 1.2 lakh employees. Presently the scheme is spread over 22 states and Union territories across India covering 91lakh employees and more than 350 lakh beneficiaries. The Act compulsorily covers: (a) all power using non-seasonal factories employing 10 or more persons; (b) all non-power using factories employing 20 or more employees and (c) service establishments like shops, hotels restaurants, cinema, road transport and news papers are covered. ESIC is a corporate semi-government body headed by Union Minister of Labour as Chairman and the Director General as chief executive. Its members are representatives of central and state governments, employers, employees, medical profession and parliament.

The financing of the scheme is done by Employees State Insurance Corporation (ESIC) which is made up of contributions from: (a) employees who contribute at the rate 1.75 per cent of their wages (if daily wage is Rs.25 or less, his contribution is waived); (b) employers who contribute at the rate of 4. 75 per cent of total wage bills of their employees to contribution on behalf and for employees having daily wage ofRs. 25 or less; and (c) State Governments contributes 12.5 per cent of total shareable expenditure worked out by prescribed ceiling on expenditure which is Rs. 600 per insured person per annum and expenditure incurred outside/over and above the prescribed limit.

The State Government runs the medical services of this scheme of social insurance meant for employees covered under the ESI Act 1948. This scheme - compulsory and contributory in nature - provide uniform package of medical and cash benefits to insured persons is implemented through special ESI hospitals and diagnostic centers, dispensaries and panel doctors. The existing facilities under the ESIS are provided in Table 2.

The delivery of medical care is through service (direct) system and/or panel (indirect) system. It provides allopathic medical care, but medical care by other systems like ayurvedic and homeopathy in the states is also provided as per the state government decision. The medical care consists of preventive, promotive, curative and rehabilitative types of services are provided by the scheme through its own network or through arrangements with reputed government or private institutions by concept of proper referral system and regionalisation.

Table 2
Existing infrastructure under ESIS in India

Particulars	
No. of Centers	632
No. of Insured Persons/Family Units	84,45,000
ESI Hospitals	125
Number of ESI Hospital Beds	23,334
ESI Dispensaries	1,443
Insurance Medical Officers	6,220
Insurance Medical Practitioners	2,900

Preventive services include immunization, maternal and child health, family welfare services. Promotive services include health education and health check-up camps. Curative services include: dispensary care, hospital care, maternity care, supportive services including diagnostic centre, drugs, dressings, surgical procedures, dental care, prosthesis and other appliances. Rehabilitative services include: physical rehabilitation, economical rehabilitation, and provision of artificial aids (social, psychological rehabilitation)

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

- large number of employers try to avoid being covered under the scheme,
- a large number of posts of medical staff remains vacant because of high turnover and lengthy recruitment procedures,
- there is duality of control,
- rising costs and technological advancement in super specialty treatment,
- management information system is not satisfactory.
- there is low utilization of the hospitals
- the workers are not satisfied with the services they get.
- in rural area the access to services is also a problem.

Some of the state governments have to subsidize the scheme heavily even though the ESI Corporation, which is the financial arm of the system, has much surplus funds. All these problems indicate an urgent need for reforms in the ESI scheme (Vora, 2000).

Some of the options for reforms in ESI scheme could be: making the scheme autonomous-managed by workers and employers while government only retails controls through a guiding framework as is the case with German Sickness Funds. Secondly the scheme should be made open for non-organized sector through fixed income based contribution. This will extend the benefits of the scheme to many more people. The government should set the patient care standards and monitor outcomes as well as patient satisfaction. The management of the health facilities also needs to be improved substantially. The financial management of the scheme also needs improvement.

7. Health insurance for poor by NGOs

With 70 per cent of population in India living in rural areas and 95 per cent of work-force working in unorganized sectors, and disproportionately large percentage of these populations living below poverty line, there is strong need to develop social security mechanisms for this segment of population. This need for security is further increased because the poor are the most vulnerable for ill health, accidents, death, desertion, social disruptions such as riots, loss of housing, job and other means of livelihood. There are some efforts in this direction of providing social security to the poor by a few NGOs. The most prominent among them is that of Self-Employed Women's Association (SEWA). The other scheme by government insurance companies developed to focus on poor is called Jan Arogya Bima Policy which was introduced in 1995 and covers expenditure up to Rs. 5000 for a premium of Rs. 70 per annum.

It is estimated that about 5 million people are covered under various NGO insurance schemes. The experience from other countries suggest that in developed countries such as USA, UK, the health insurance have grown out of small non-profit schemes. A large share of health insurance market in USA is in not-for-profit sector. There is need in India to promote these schemes as they address the needs of the poor. Over the last few years in India small and big NGO's like

Tribhuvandas, SEW A, ACCORD etc. have implemented the insurance schemes. Many of these schemes are designed to meet the needs of the poorer segments of the community. They have developed several innovations such as

- mechanism of monitoring the performance,
- pricing of various services,
- integration of various risks in one single product,
- linking of insurance schemes with savings,
- coverage of many services not included in market based schemes such as maternity services, transportation, coverage of risks such as from riots, floods etc.

Some NGOs have developed special linkages with public health systems, private facilities and also accessed resources through insurance companies.

7.1 SEWA's Health Insurance and Social Security Schemes for the Poor

Poor women are the most vulnerable sections of a developing society. SEW A - a membership based women workers' trade union, has developed an initiative to protect the poor women from financial burdens arising out of high medical costs and other risks. Each member has option to join the programme by paying Rs. 60 per annum and it provides limited cover for risks arising out of sickness, maternity needs, accidents, floods and riots, widowhood etc. The scheme is also linked with saving scheme. Members have the option to either deposit Rs. 500 in SEW A Bank and interest on this deposit will cover the annual premium or pay annual premium of Rs. 60. The scheme has 30,000 members and is expected to grow to 50000.

In the beginning the SEW A started this programme with the support of one of the public sector insurance companies. The experience of SEW A has been that the insurance companies are not well equipped to handle the present day complexities of health insurance particularly in context of lower income group needs. Given the bureaucratic rigidities in settling the claims, procedures, which one has to follow, and poor monitoring mechanisms make it difficult for the poor to continue with these schemes. For example, the patients belonging to lower income groups opting for the schemes would need systems which are simple, flexible, prompt, relevant, having less paper work and have fewer tiers. The design of the product including what it covers, scope of coverage and at what premium are important considerations for people belonging to lower income groups.

SEWA experience suggests that the design of the insurance products have to be integrated with several add-ons that may be priced differently. For example, health risk coverage should include sickness as well as maternity aspects. SEW A experience illustrates that other aspects of risk which need coverage include natural and accidental death of women and her husband, disablement, loss because of riots/flood/fire/ theft etc. The overall premium has to be low. There has been lot of emphasis and education in the community on understanding the concept of insurance. This awareness is growing. The linkage with the providers has been critical aspect in keeping this cost of scheme down. At the same time the member has complete choice in selecting the provider but the reimbursement is limited. It has been observed that costs in private are more than 5 times than what they are in public sector hence developing linkages with the public facilities are therefore critical. This also depends on quality of care at public facilities. The overall experience of SEW A's health insurance has been encouraging. Women have started to seek health care and have been asking to enlarge the scope of the scheme. The scheme has tried to address the special needs of women health by allowing the other systems of medicine,

which is quite popular in various places and paying for maternity related expenses which are not covered by Mediclaim scheme. The scaling up of the scheme and increasing the coverage is the most important management and organizational challenge. Recent study of the members of the SEW A scheme by Gumber and Kulkarni (2000) also indicate its usefulness.

7.2 Other NGO health insurance schemes

Over the last several year there has been efforts to develop health insurance by various small NGOs. Some of the prominent among them have been ACCORD in Karnataka, Tribhuvandas foundation, Aga Khan Health Services, India (AKHSI) and Nav-sarjan in Gujarat, and Sewagram medical college Maharashtra. ACCORD works with tribal population in forested areas ofKarnataka, AKHSI works with Ismaili population in North Gujarat, Tribhuvandas Foundation works in villages of Kheda district where there are strong milk producing unions of Amul Dairy Cooperative, Nav-sarjan works with schedule castes in 2000 villages of Gujarat. Ranson (1999) has reviewed NGO efforts in India in this field. There are some common features of NGO schemes. The coverage of these schemes vary and most use their own health workers to provide primary care and have tied up with a hospital to provide secondary care. Premiums are low, generally fixed and not related to risk. Most schemes have limited coverage and some also provide wider services besides health and treatment. All these organizations had good track record of services in the community and then added on health insurance on their existing activities hence they did not have to establish credibility with the community. The key feature among them was low premium and low coverage. These NGOs have shown that it is possible to develop a model of health insurance for the poor without much subsidy. The experience also suggests that if a credible NGO exists then it is not difficult to develop health insurance as an add on benefit. What is unclear and need to be researched is that what amount of total health expenditure does these scheme covers for the poor given that their coverage is limited.

8. Consumer and social perspective on health insurance

With the liberalization of insurance and entry of private companies in this business it is very important that specific interventions are developed which focus on increasing the consumer awareness about insurance products. One of the major challenges after privatization of insurance would be how to develop such mechanisms, which help making consumers aware about the various intricacies of insurance plans. As of now information, knowledge and awareness of existing insurance plans is very limited. This is also shown by the study of Gumber and Kulkarni (2000) among the members of SEWA, ESIS and mediclaim schemes. With Consumer Protection Act coming in force it has become easy for aggrieved consumers to complain and seek redressal for their problems. Consumer organizations such as CERC of Ahmedabad have been helping consumers to get due justice in disputes with the insurance companies. Their experience would be varying valuable in guiding development of health insurance plans that are transparent and just.

Many a times the insurance claims are rejected due to some small technical reasons. This leads to disputes. Most of the time the conditions and various points included in insurance policy contracts is not negotiable and these are binding on consumers. There is no analysis on what is fair practice and what is unfair practice. Given that insurance companies are large and almost monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this create confusion and disputes. (Shah M 1999)

The most important area of dispute and unfair treatment is the knowledge and implications of pre-exiting conditions. A number of cases of litigation are disagreement on these pre-existing conditions. These problems also arise because of lack of specification of number of areas and properly spelling out the conditions. This is also because some chronic conditions such as high blood pressure and diabetes can increase the risk of may other disease of organs such as heart, kidney, vascular and eyes diseases. The patients with these pre-existing conditions are denied claims for treatment of complications. This is not fair and leads to disputes.

Health insurance is typically annual and has to be renewed yearly. Policy, which is not renewed in time lapses and a new policy has to be taken out. Medical conditions detected during the interim period are treated as pre-existing condition for the new policy, which is not fair. This is seen as major issue as it changes the conditionalities about what constitutes pre- exiting conditions. Courts, however, have ruled that even if there is delay in renewing the policies it should be considered as renewed policy. In case two doctors give different reports one favouring consumer and other insurance company, the insurance company generally follows the later opinion. There are several such consumer-related issues, which need to be addressed in health insurance.

One of the planks on which the insurance has been deregulated is the gain in efficiency and passing on these benefits to the consumers. It is very unrealistic to assume that insurance companies will be able to gain efficiency, which helps them to reduce the price of schemes. At least one should not be expecting this thing happening in the short-run. But providing full information to the consumer and dealing with claims in a just and expeditious manner is the minimum expected outcome of the deregulation process. Consumer organizations have to play very active role in future development of the health insurance sector in India.

There are several social issues such as exclusions of sexually transmitted diseases, AIDS, delivery and maternal conditions etc. These are not socially and ethically acceptable. "Insurance companies much take care of all the risks related to health. The companies may charge additional premium for certain conditions. Secondly the present mediclaim policy premiums are high and do not differentiate between people living in urban and rural areas where the costs of medical care are different. Thus the present policy is less attractive to poor and rural people. The tax subsidy provided to the mediclaim is also going largely to the rich who are the taxpayers. The newer health insurance policies have to improve upon the shortcoming of the existing policies.

9. Impact of Health insurance on structure and quality of private provision

The experiences in liberalizing the private health insurance suggest that it has undesirable effects on the costs of health care. The costs of care generally go up. Given the present system of fee for service and current scenario of health infrastructure in private sector, the development of insurance will need improvements in quality and change in structure. The new investments to improve quality will result into high cost and therefore increase in prices of insurance products. There would be developments in the direction of exploring options of managed care, which would help in reducing the costs. The developments would be needed in the direction of strong information base and accreditation system for providers. The structure of the health sector will have to change from multiple-single doctor hospitals and clinics to larger hospitals and polyclinics, which provide services of multiple specialities and can operate at larger scale. This

will allow them to provide high quality professional care at competitive prices. As one of the responses to these issues Third Party Administrators (TPA) are rapidly emerging in India. Here we can learn from the models, which have emerged elsewhere. But their applicability to Indian situation needs to be examined carefully. These aspects of the health sector will need detailed study.

We lack adequate information base to operate insurance schemes at large scale. The insurance mechanism prevalent in many developed countries has their history. Health reforms experiences in many countries are replete with the suggestion that the systems cannot be replicated easily. Self-regulation is an important in any market driven system. The regulation from outside does not work. Implementation of regulation in this sector is difficult. We significantly lack mechanisms and institutions, which would ensure self- regulation and continuing education of provides and various stakeholders. The accreditation systems are hard to implement without mechanisms to self-regulate. For example it took 35 years in US to put the accreditation system effectively in place. For example, it has been difficult for many States in India to put nursing homes legislation in place. Given the deterioration on standards in medical education, lack of regulation by medical council and rising expectations of the community it is difficulty to ensure quality standards in Indian health care system. Given this situation health insurance systems will have to deal with this complex issue of quality of care in years to come.

10. Role of regulators

The government has established Insurance Regulatory and Development Authority (IRDA) which is the statutory body for regulation of the whole insurance industry. They would be granting licenses to private companies and will regulate the insurance business. As the health insurance is in its very early phase, the role of IRDA will be very crucial. They have to ensure that the sector develops rapidly and the benefit of the insurance goes to the consumers. But it has to guard against the ill effects of private insurance. The main danger in the health insurance business we see 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 relative disadvantage as they will, in future, have to pay much more for the private care. Thus checking increase in the costs of medical care will be very important role of the IRDA.

Secondly, IRDA will need to evolve mechanisms by which it puts some kind of statue in place that 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. They must ensure that companies develop products for such poorer segments of the community and possibly build an element of cross-subsidy for them. Government companies can take the lead in this matter and catalyze new products for the poor and lower middle class as they have done in the past.

Thirdly the regulators should also encourage NGOs, Co-operatives and other collectives to inter into the health insurance business and develop products for the poor as well as for the middle class employed in the services sector such as education, transportation, retailing etc and the self employed. This could be run as no-profit-no loss basis similar to the scheme pioneered by Indian Medical Association for its members. Special licenses will have to be given to NGO for this purpose without insisting on the minimum capital norms, which are for commercial insurance companies.

11. Experience of health insurance in other countries: US & Germany

Various developed countries have differing insurance system to cover health risks. It is useful to contrast the American private health insurance system to German Social health insurance system. Table 3 gives this comparison.

It is clear from the above that the German system is clearly superior to the American system. German system is social health insurance based on some key principles of solidarity, delegation and free choice, while American system is based on private market philosophy (Reinhard 1999, Stierle 2000). Thus the German system is much more suited to the needs of the developing countries. But some of the prerequisites of the German system are not present in India. For example for social health insurance to work the work force has to be organized and working in formal sector so that their incomes are clear and there is a mechanism for payroll deduction of the contribution. It also needs a well-developed regulatory framework and culture of solidarity and self-regulation so that well off section of the community is willing to pay for the costs of sickness. Universal compulsory social health insurance is not possible in India at this stage but NGOs and workers in the formal sector can for organizations to try out such social health insurance in India. Experiences from other countries such as Malaysia and Philippines needs to be studies (Malayasia 1999, Philippines 1999); so that we can develop a model based on good innovations from various countries while keeping the realities of Indian health system.

Table 3

Key Features	American system	German System
Owners of health insurance	Private companies	Sickness funds composed of Members who are workers of one type - as in a cooperative
Coverage, and access to health care	70 % of population covered, access to health care unequal	99.5% of population covered and access to every one is equal
Premium based on	Actuarial risk (Age, sex, disease)	Income - % of pay roll. Shared equally by employer and employees
Selection and refusals	Do occur	Not allowed by law
Reimbursement to providers	Based on costs and per cases/procedure basis	Outpatient is on prospective per capita basis, in-patient per day, per case basis.
Nature of subsidy (risk pooling)	From healthy to sick	Healthy to sick, high income to low income, young to old, small families to big families
Choice of providers	Yes - but being restricted in HMO system	Yes - wide choice
Coverage & co-payments	Limited to medical care and co-payments high	Coverage very wide and co-payment low
Nature of competition	Between companies	Not much - recently between sickness funds.
Nature of regulation	Minimal by government, mostly by market forces	Self-regulation by autonomous bodies under overall framework of social legislation
Effect of medical costs	Highly inflationary - recently this effect is reduced due to various controls	Inflationary effect limited due to prospective per capita payment.

. 12. Conclusion

In India has limited experience of health insurance. Given that government has liberalized the insurance industry, health insurance is going to develop rapidly in future. The challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without the negative aspects of cost increase and over use of procedures and technology in provision of health care. The experience from other places suggest that ifhealth insurance is left to the private market it will only cover those which have substantial ability to pay leaving out the poor and making them more vulnerable. Hence India should proactively make efforts to develop Social Health Insurance patterned after the German model where there is universal coverage, equal access to all and cost controlling measures such as prospective per capita payment to providers. Given that India does not have large organized sector employment the only option for such social health insurance is to develop it through co-operatives, associations and unions. The existing health insurance programmes such as ESIS and Mediclaim also need substantial reforms to make them more efficient and socially useful. Government should catalyze and guide development of such social health insurance in India. Researchers and donors should support such development.

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