Assessing Private Health Insurance in India

Potential Impacts and Regulatory Issues

The entry of private health insurance companies in India is likely to have an impact on the costs of health care, equity in the financing of care, and the quality and cost-effectiveness of such care. However, an informed consumer and well-defined and implemented insurance regulation regime will ameliorate some of the bad outcomes. Regulation relating to benefit-packages, restrictions on risk selection and consumer protection would be clearly useful; also required are improved enforcement of regulatory regimes, creating large insurance buyer groups, and better coordination between IRDA and other regulatory bodies. New legislation in improving standards in health care provision may also be needed.

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I Introduction

The passage of the Insurance Regulatory and Development Authority (IRDA) Bill (in its new '*avatar*') in December 1999 in the Indian parliament marked a definitive point in the move towards the privatisation of the insurance sector in India [*Asian Age* 1999, Government of India 1999a]. Up to then, the provision of various types of formal insurance was under the exclusive control of the public sector [Government of India 1999a,1999c]. The bill allows for the entry of private sector entities in the Indian insurance sector, including health insurance, and envisages the creation of a regulatory authority that would oversee the operations of various players in the insurance market [Government of India 1999a].

The private corporate sector has, understandably, been quite enthused by this development. Several large health care providers and international health insurance companies have already positioned themselves to enter the market as soon as it is open to the private sector and the story is similar for their potential Indian partners [Sinha 1999a]. Global insurance giants have entered into pacts with Indian partners and domestic firms and are actively carrying out epidemiological mappings of the Indian population, investing in hospitals and conducting market surveys. One private consulting firm estimates that the health insurance market will grow to five times its current levels by the year 2005 [Dhawan 1999].

In contrast to the hectic activity in the corporate sector, the government appears to have been lethargic in anticipating developments, at least as far as health insurance is concerned. For instance, the IRDA bill itself contains no reference whatsoever to the health sector or to health insurance [Government of India 1999a]. Nor is health mentioned in the nearly 175 pages of the Insurance Act of 1938, an amended version of which will come into force once the IRDA Bill is effected, and presumably is included under "miscellaneous insurance business" [Government of India 1999a,d].[1] This is broadly reflective of the policy environment in India, where health insurance continues to be neglected. As another example, in a report prepared by a government of India committee on insurance reform, there was exactly one reference to health insurance, on page 97 of a 104-page report [Government of India 1994].

The apparent lack of attention to health insurance in Indian government policy documents may reflect a somewhat sanguine view of the functioning of markets in health care provision, insurance and elsewhere.[2] The many problems with quality and consumer satisfaction in the existing Indian health system may have led to a belief that the entry of private insurance, especially in its managed care form [such as Health Maintenance Organisations (HMOs)] would lead to social net gains [Sinha 1999b, Srivastava 1999, *The Times of India* 1999a]. It may also be the case that the government expects any pertinent regulatory issues to be taken care of by the Insurance Regulatory and Development Authority (IRDA). The IRDA is supposed to protect the interests of policy-holders, promote efficiency in the conduct of (all) insurance business, regulate the rates and terms and conditions of policies offered by insurers and direct the maintenance of solvency margins (for further details, refer to Government of India 1999a, pp1-4).[3]

Whatever the reasons underlying the government approach towards the entry and functioning of the private health insurance sector in India, it is not always the case that private provision of health insurance works to promote the standard objectives of health policy.[4] This is apparent from the economic theory of health insurance that points to problems of excess usage of health facilities, increase in inappropriate care, adverse selection and risk selection and their implications for the standard goals of health policy [see Section II below for further details]. Moreover, the experience with private health insurance in developing countries such as Chile and Uruguay bears out some of these concerns [Medici et al 1997, Ferreiro 1999]. Even a well-designed regulatory set up for private health insurance such as in the United States may not yield entirely satisfactory outcomes. It has often been suggested that the high proportion of health expenditures to GDP [14.5 per cent in 1995, World Bank 1997][5] and the presence of 40-50 million uninsured Americans is associated with the strong presence of private health insurance in the US [Chollet and Lewis 1997, World Bank 1993]. Of course, all of this depends on the actual

size of the private health insurance market that emerges, and a small size signifies smaller effects, at least in the short run.

In this paper we assess whether the regulatory steps envisaged in the IRDA Bill including especially the provision for entry of private firms will influence the progress towards achieving India's health policy goals, and the likely direction that this effect will take. The relevant policy goals for this purpose are assumed to be a health care system that is not too costly, of good quality, and with an equitably distributed burden of health care spending.[6] Taking the size of the private insurance sector as a given, we will first revisit the relationship between the increased spread of private health insurance and costs of health care, the quality of care, and the distribution of the burden of health care spending. Apart from indicating the implications of private health insurance for India, this analysis will also highlight the potential role of alternative regulatory tools that can be effectively utilised to address adverse implications (if any) of its spread. Second the paper will describe the existing regulatory structure in India as it relates to health care provision and private health insurance and discuss its ability to promote national health policy goals. This is used to draw inferences about the potential impact of the entry of private health insurance in India and to suggest an agenda for regulatory reform in the health sector.

Our main conclusions are as follows. A review of the theoretical and empirical literature suggests that private health insurance may turn out to be somewhat more inequitable than a system of social insurance of comparable coverage, although the implications for cost and for the quality of care are less certain. It does appear, although, that many of the cost enhancing effects of private insurance and some of its impacts on the distribution of the burden of care can be ameliorated by appropriate regulation, if properly implemented. However, the regulatory setup as currently envisaged in the IRDA bill and related legislation faces several constraints including the fact that the regulatory authority will probably not take an active interest in regulatory issues specific to health insurance, given both the historical neglect of this issue among policy-makers and pronouncements attributed to members of previously 'interim' IRDA.[7] More importantly, the powers vested in the IRDA may not be sufficient to bring about the regulatory changes needed, even if taken in their broadest meaning and assuming an activist approach on its part. Important regulatory issues that IRDA could take up would require complementary regulations in health care provision to work effectively and these may not be under its control. In some cases, new legislation may have to be undertaken by the Indian parliament. In others, better enforcement of existing regulation by other organisations may be needed (as for accreditation, standards for medical institutions and malpractice), a problem given the long history of poor performance. Finally, the IRDA is even less likely to be able to influence the impacts of private health insurance on the public health system and on the resultant quality of care available there. As a consequence the effects of the introduction of private health insurance in India may turn out to be more unfavorable than they otherwise would be, although their magnitude will be small in the short run.

I
Private Health Insurance: Cost, Quality and Equity

This section has three parts – focusing on the relationship between the spread of private health insurance and issues of cost, quality and the equity in the health sector, respectively. The section relies heavily on the seminal work of Arrow (1963) and recent surveys of related literature by Einthoven (1997), Chollett and Lewis (1997), Musgrove (1996) and others.

Aggregate Costs of Health Care

In theory, the introduction of private health insurance can contribute to increasing the aggregate costs of health care in several different ways. Most of the arguments in favour of increasing health care due to private health insurance have to do with some disparity in the information available to parties involved in transactions in the health care and health insurance markets.

In interactions between health care providers such as doctors, and patients it is a given that the former have much better information about their patients' health status and future course of treatment than the latter. This, together with the prospect of being ill and accompanying psychological costs and loss of earnings makes the demand for health care fairly dependent on the course of treatment recommended by a physician. One consequence is that in a regime of pure indemnity insurance providers have an incentive to provide more care than may be medically appropriate. For the same reason, the patient or, insurers for that matter, may be less willing to question the qualifications of the doctor as to his or her expertise [Arrow 1963: 371-73]. The problem will be especially likely to arise in situations where the patient can choose his or her doctor and treatment freely and then present the bill to the insurer for reimbursement.[8]

The transaction between the insurer and the insured in the health market suffers from an asymmetric information problem as well. Once insured, an individual faces a reduced incentive to take precautions against poor health, much as a person with house fire insurance is likely to take less precaution in storing hazardous materials in her house. A sick person may also feel less compelled to control her consumption of health care and expensive diagnostic examinations if medical care costs are covered by insurance. Moreover, doctors and hospitals may only be too willing to provide enhanced care in view of the discussion of the previous paragraph. Thus an increase in insurance coverage could lead to an increased demand for health facilities and personnel and push up the cost (price) of providing health care.

The arguments outlined above hold true for any type of insurance regime, public or private, so it is unclear on this basis alone whether costs are likely to be higher in a private insurance system in comparison to public sector dominated financing.[9] It might be argued, however, that public operated insurance schemes, which typically involve dual functions of the financing and provision of services may involve a myriad of restrictions on health care utilisation, especially referral to higher order care and overall budgetary limits.[10] In India government employees covered under the Central Government Health Scheme (CGHS) cannot obtain reimbursements for private care unless appropriate referrals have been obtained from authorised medical practitioners or the director of CGHS (Government of India, various; see also Table 1). A similar set of rules appears to hold for the state supported Employees State Insurance Scheme (ESIS) for workers employed in the organised sector in India (Table 1). This process assumes that there is an effective referral process that curtails the usage of public facilities, or private care if permitted under the public scheme. Under CGHS, only about 6 per cent of the total expenditure is accounted for by outside/private referrals suggesting that the process for

external referrals may be effective in India [Garg 1999b: 34].[11] However, this appears not to be the case for referrals within the public system where the utilisation patterns are biased towards public hospitals as against primary care facilities [World Bank 1995, Mahal et al 2000].

Managed care institutions such as HMOs that have emerged in the private sector combine the roles of the provider and the insurer and can therefore serve to cut costs. The cost-cutting mechanisms could include stricter referral processes, payments based on diagnostically related groups, capitation payments, and other methods of managing utilisation of health care services [Einthoven 1997, Phelps 1997]. In the US such systems covered nearly 60 per cent of the population in 1995, with the population coverage having expanded at rates of 12 per cent per annum during the previous decade [Einthoven 1997]. Similar institutions can be found in many other countries including Israel, and on a miniscule scale, in India [Gupta et al 1992, Chinitz 1995]. There is some evidence to suggest that the emergence of HMOs has led to cost-containment in the US. California, the state which experienced the fastest growth of HMOs during the 1980-91, also saw the slowest expansion in the cost of care among all states at 3.7 per cent per annum in the same period, compared to the US annual average growth of 6.4 per cent [Phelps 1997].

To the extent that private insurance in the form of managed care can yield low cost outcomes in comparison to a fee-for-service system the relevant issue for policymakers and regulators is to devise methods to promote its emergence. At one level such institutions might be thought to be a logical market outcome given their lower costs and no obvious declines in consumer satisfaction relative to fee-for-service systems. However, the experience of the US suggests that such an outcome is not a fait accompli. HMOs faced stiff resistance from medical associations and legislatures until the 1970s and afterwards, much of this resistance having to do with the prevailing "guild free choice" model that supported the idea of free choice of health care providers by consumers. Indeed, right up until the 1980s many states outlawed settings whereby employers could offer their workers preferential terms of coverage if they used specific providers with whom they had a contract on grounds of being discriminatory against providers [Einthoven 1997: 198-99]. HMOs got a boost in the US when laws were passed requiring employers to offer at least one HMO option to their employees and as the government began offering its own employees the option of such plans [Einthoven 1997:212-13]. Further evidence on this issue is available from the health reform experience of Chile where ISAPREs (private insurers) have functioned mainly as pure third-party payers [Baeza 1998; Ferreiro 1999].

A second form of information asymmetry common to insurance markets is the fact that individuals are likely to know much more about their health status and future needs than insurers. Thus people expecting to incur significant health expenditures in the near future will figure disproportionately among those who choose to get insured. This causes profit-oriented private insurance companies to adopt procedures that are often expensive to weed out bad risks via a process called 'risk selection'. In Chile, for instance, whereas the population over 60 accounts for 9.5 per cent of the country's population, the share of the 60 year-plus group in the population insured with private insurers was only 3.2 per cent, with the rest being covered by the public sector [Baeza 1998:18]. Similarly, the average family size in Chile is four members, whereas the average among ISAPRE members is only 2.3 [Ferreiro 1999].

The 'administrative' costs resulting from this process of risk selection – essentially a deadweight loss – can be quite high relative to expenditures and usually passed on to customers in the form of higher loading charges.[12] Those unable to obtain insurance at the higher premiums may then go back to the free public health system if the public system is open to all, or to out-of-pocket payments. In sum, overall health care costs would be higher than under a comparable public insurance system where membership into the insurance scheme may be compulsory for designated

Table 1: Characteristics of Two Public Insurance Schemes

Type of Insurance	Contribution	Reimbursement	Entitlements	Eligibility
ESIS	Employees: 4.75 per cent of wages Employers: 1.75 per cent of wages All contributions are deposited by the employer; State governments contribute a minimum of 12.5 per cent on ESIS health expenditures in their respective states (Garg 1999b, p 30). See also section 59A (Government of India 1999g, pp 51-52).	Does not disallow reimbursement of medical treatment *outside* of *allotted facilities*. For instance, the Employees State Insurance Act, 1948 states that entitlement to medical benefits does not entitle the insured to "claim reimbursement for medical treatment...except under regulations." (Government of India 1999g, p 50). See also Chapter III, 28(v) and ESI (General) Regulations, 1950 (Government of India 1999g, p 156).	Depending on "allotment" as per the ESI Act. 1 Outpatient medical care at dispensaries or panel clinics; 2 Consultation with specialist and supply of special medicines and tests in addition to outpatient care; 3 Hospitalisation, specialists, drugs and special diet. 4 *Cash benefits*: Periodical payments to any insured person in case of sickness, pregnancy, disablement or death resulting from an employment injury.	Employees (and dependants) working in establishments employing ten or more persons (with power) or twenty or more persons (without power) and earning less than Rs 6,500 per month (Garg 1999a, p 85).
CGHS	Pay/pension Rs/month) Contribution (Rs/month) < 3,000 15 3,001-6,000 40 6,001-10,000 70 10,001-15,000 100 >15,000 150 The bulk of the resources (85 per cent) come from general revenues of the central government (Garg 1999b, p 34)	1 Reimbursement of consultation fee for up to four consultations in a total spell of ten days (on referral); 2 Cost of medicines; 3 Charges for a maximum of ten injections; 4 Reimbursement for specified diseases/ailments.	1 First level consultation and preventive health care services through dispensaries and hospitals under the scheme; 2 Consultation at a CGHS dispensary/polyclinic, or CGHS wing at a recognised hospital; 3 Treatment from specialist through referral, emergency treatment in private hospitals and outside India.	Employees of the central government (excepting railways, armed forces, pensioners and Delhi administration), pensioners widows of central government employees, Delhi police employees, defence employees and dependants residing in 24 specified locations (see Government of India, various)

groups, unless outweighed by the inefficiencies of a public sector bureaucracy.[13] Regulatory methods to prevent risk selection must, per force, face up to the problem of adverse selection (of poor risks disproportionately seeking insurance) which may have implications for the financial viability of an insurance company. In this sense, market outcomes that lead to insuring large groups are desirable so that there is little to suspect a preponderance of poor risks in the applicant pool.[14] Indeed, there is clear evidence that larger groups face lower administrative costs. In the US, loading charges (defined as (premiums/claims) less 1) typically range from 40 per cent for individual insurance to 5-8 per cent for group insurance [Phelps 1997:346; see also Table 2]. In India, insurance plans offered by the General Insurance Corporation (GIC) offer discounts over individual premium rates that range from 15 per cent to 67 per cent for groups of size 50,000 or more.[15]

Regulations that cap total overhead expenditure of insurance companies would likely promote group insurance business than the administratively more costly individual-based insurance [Government of India 1999d].[16] Employment-based group insurance can also be promoted by insurance contribution-linked tax benefits given to employers without corresponding tax liabilities for the employees (but not if premiums are paid by employees), as in the US [Phelps 1997:349-54].[17] In India, however, tax benefits can accrue both to employers and employees depending on who pays the premium.[18] In this setting employer-paid premiums may still be desirable as a means to promote group insurance if corporate tax rates are higher than personal income tax rates or if there are returns to scale to employers from administering group insurance.

Large group insurance is unlikely to address all motivations for risk selection. It will not, for example, address the problem of risk selection across small employment groups and the self-employed if there are profitable opportunities in those areas. It will also not adequately address the possibility of selecting among individuals who change jobs or whose insurance comes up for renewal. Regulations that curb the denial of insurance coverage to these groups may affect the costs of selecting among risks, for instance by inhibiting insurer motivation to acquire individual-specific utilisation data from other companies or carrying out expensive pre-selection tests.

In developing countries, there is one other information-related factor that could potentially lead to high health care costs. This has to do with the financial health of health insurance companies. In the absence of minimum capital reserves and incomplete epidemiological information about the population, there is a risk that insurance companies could be guessing wrong and charging premiums that are much lower in comparison to the benefits offered in a competitive environment.[19] The problems would be exacerbated if get-rich quick companies were to invest their premium income in high-risk assets that are not aligned to insurance claim liabilities. The importance of health insurance and the dependence upon it of a large cross-section of the population means that the government is unlikely to accept even short-run scenarios where the companies can become bankrupt.[20] As a consequence the government or the insurance sector may be ready to incur additional amounts in expensive bailout packages for sick health insurance firms, creating a disincentive for individual firm managers to perform financially, since their downside risks are covered to some extent.

Worldwide, governments have sought to address these concerns by setting a minimum set of conditions relating to management and personnel, actuarial analyses, solvency, working capital and investment profile; and a system for dealing with liquidations/takeovers. In most cases, there is a national level regulator to oversee the implementation of these conditions. Some of the relevant regulations prevalent in the US and the European Community are summarised below in Section III.

In sum, even though costs of care and private insurance may be positively linked, regulation can help contain some of these costs, especially one that promotes financial solvency, large group insurance and HMO type organisations.

Aggregate Cost Implications Cross-Country Evidence

In this subsection we examine cross-country data to check if increased health spending per capita is associated with increased private insurance, all else remaining the same.We use information on per capita income, health care expenditures and private and public insurance coverage for about 31 developed and developing countries for this purpose (for details about the sample of countries and data sources, refer to Table 3). Of course, a macro-assessment of the cost impact of the private insurance sector using national level data is not straightforward since it is likely to be confounded by income effects, the type of public insurance available, the nature and implementation of regulations and the like. Our preliminary analysis does not rule out the possibility that private insurance may have a much smaller impact on health spending than one would suspect.

Column 1 of Table 3 reports the results of a regression of the natural log of health spending per capita on the proportion of population covered by private insurance. The magnitude of the coefficient suggests that health spending per capita is positively associated with the proportion of population covered by private insurance. Indeed, a 1 percentage point increase in the proportion of population covered by private insurance is associated with a 7.8 percentage point increase in the costs of health care per capita.

Health spending, however, depends on many factors including income. Increased income may also lead to increased demand for insurance, both public and private. Increased incomes may also lead to greater out-of-pocket health spending. Thus, at the very least, the regression analysis would have to control for the overall level of insurance (and/or income) in examining the impact of private health insurance. Doing so reduces the coefficient on private

Table 2: Administrative Costs of Operating Health Insurance Programmes: Private and Public Insurers

Country	Costs of Administering Insurance (As Per cent of Expenditures)	
	Private	Public
Chile	18.5	1.8
Sweden	na	1.5-5.0
UK	na	10.0 (GP Fundholdings)
US	5.5-40.0	2.1 (Medicare)
India	20.0-32.0	5.0-14.6

Notes: For the United States, the range in the private sector reflects low costs for group insurance to high costs for individual insurance; for India the range in the private insurance represents the different experiences of the four subsidiaries of the GIC; for the public sector insurance in India the lower bound for the range are the costs of CGHS and the upper bound for ESIS (Garg 1999); for Sweden, the range reflects public schemes operating in city councils and among those relating to private doctors; GP = General practitioner.

Sources: Chile (Baeza 1998, Ferreiro 1999); India (Garg 1999; communication with Anurag Kaul (New India Assurance Company)); Sweden (Rehnberg 1997); US (Rehnberg 1997); UK (West 1997).

insurance to statistical insignificance at the 5 per cent level and its magnitude becomes small as well. Column 2 of Table 3 indicates that an increase in the proportion of population covered by private insurance of 1 percentage point is associated now with only a 0.7 per cent increase in the costs of health care per capita, if variations in income are controlled for. The results remain unchanged even if we control for the type of health insurance coverage in operation – that is, whether is an alternative or merely a supplement to an existing system of public health insurance (Table 3).

Is this result reasonable? The US is often held up as an outstanding example of a country with 'very high costs' of health care, a fact that is often linked to its predominantly private health insurance system. In particular, the US has a high spending on health per capita (US$3,828 in 1995) in comparison to other OECD countries such as France (US$2,600), Japan (US$2,947), and especially the UK (US$1,205) and Canada (US$1,814) (World Bank 1997). On the other hand, it is worth noting that with some notable exceptions such as the UK, the rate of growth of health care costs in the US has often fallen below that of many of the OECD countries. California, a state with a long experience in managed care experienced even lower rates of growth in health costs during the 1980s and 1990s. Thus, a popular text on health economics for undergraduate students remarks that "The very strong relationship between per capita medical care spending and per capita income is all the more remarkable, given the wide diversity in health care systems…" [Phelps 1997: 621].

Table 3: Health Spending Per Capita and Private Insurance Coverage – Cross-Country Regressions

	Dependent Variable: Log Health Spending Per Capita (US$)			
Regressors	(1)	(2)	(3)	(4)
Constant	3.86	-5.02	-4.83	-4.83
	(0.35)	(0.48)	(0.48)	(0.46)
Private health insurance coverage (per cent of population)	0.08		0.007	0.007
	(0.01)		(0.004)	(0.005)
Log of per capita income (US$)		1.27	1.24	1.23
		(0.06)	(0.06)	(0.06)
Dummy for type of private health insurance				-0.005
				(0.189)
Sample size	31	31	31	31
R-squared	0.42	0.93	0.94	0.94

Notes: Robust standard errors reported in parentheses.
Type of private insurance: 1 for countries where private insurance is offered as an alternative to social insurance or public scheme; 0 for countries where private health insurance can only be offered as a supplement to a public insurance scheme.
Countries included in sample: Australia, Germany, Ireland, Netherlands, UK, US (OECD); Argentina, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Gautemala, Jamaica, Honduras, Mexico, Peru, Uruguay (Latin America and the Caribbean); Ivory Coast, Egypt, Jordan, Kenya, South Africa, Zimbabwe (Africa and the Middle East); India, Indonesia, Philippines, Sri Lanka, Thailand (Asia); and the Czech Republic.
Sources: Chollet and Lewis (1997); World Bank (1997).

Quality and Cost-effectiveness of Health Care

In the sense used here, *quality* refers to the level of competence with which a given examination and treatment protocol is implemented by provider(s) – be it medical examinations, diagnostic tests, the quality of administered drugs, and hospital care generally. *Cost-effectiveness* refers to the efficacy of the treatment itself, by a comparison of expenditures in relation to outcomes.

In a free market with no uncertainty about the outcomes of treatment, one might expect higher quality treatment to be undertaken (subject to the usual constraints) as fully informed consumers choose the most effective doctors and medical facilities ignoring the rest. However, a major problem in the health care market is precisely the uncertainty about outcomes on the part of the consumer of services, a fact noted by Arrow nearly 40 years ago [Arrow 1963]. Alternatively, institutions might develop to label/certify doctors and health care facilities, without necessarily excluding them from service provision, so as to address this problem of lack of information with the consumer (see Phelps (1997s), for examples from the US). In this case, one would naturally expect greater demand for certified personnel and facilities and the gradual sidelining of others not so certified. This depends on the extent to which the consuming public is capable of taking informed decisions and whether it considers the certifications credible. Finally, there could be licensure that excludes everyone other than those meeting certain standards from practising medicine.

The contribution of an insurance scheme, whether public or private, to improving the quality of health care depends on whether the scheme is able to influence the process of labelling or licensure of medical personnel and facilities or the entry of highly skilled individuals in the health sector.

As noted previously, the increased provision of private insurance may increase the demand for health care and so push up its price. While this would improve opportunities for high-quality individuals who might have otherwise sought employment in other sectors, it would also increase the supply of low skilled individuals into the health sector, unless appropriate screening takes place. That is, the mere increase in returns to health care provision in this sector may not increase average quality and may even reduce quality at the margin. This is already occurring in the guise of doctors with degrees in Indian systems of medicine practising modern (allopathic) medicine [Nandraj and Duggal 1996].

Insurance companies could contribute to enhancing quality if, for example, they put quality-determined restrictions on the nature of expenses they would reimburse.[21] In the case of HMOs and other managed-care institutions, they could empanel only those doctors who meet certain qualification and treatment guidelines [Einthoven 1997]. By enhancing the returns of such doctors over that of others they could increase the demand for such qualifications over time. The same could presumably be done for institutions such as hospitals and diagnostic centres. Moreover, by restricting the use of unnecessary expensive care through guidelines for referrals and hospital stays managed care could also promote cost-effective treatment guidelines.

Many of the steps that appear necessary may well occur in a market, without any prompting by regulatory authorities. There are, however, three areas of concern. First, it is not obvious that arguments that hold for HMOs also hold for indemnity based insurance. In the case of indemnity insurance, an expansion in coverage if accompanied by an increase in demand for care induced by physicians and lack of resistance to it by private insurers and patients could lead to enhanced use of expensive care and diagnostics without any change in health outcomes.[22] It also does not follow that an indemnity system would cater only to highly skilled personnel and institutions. This problem cannot be readily addressed by competition if consumers of health care are unable to readily distinguish among different insurance plans and premiums charged by managed care institutions and indemnity-type insurance. Indeed it might even appear that indemnity type insurance is more consumer friendly by not putting restrictions on whom to

consult and get treated by. Even otherwise, effective competition from managed care organisations might be slow to emerge if there is resistance from associations of medical personnel, consumers and employers (for examples from the US, see Einthoven (1997)). Moreover, the formation of panels and exclusive contracting with doctors characteristic of managed care may be problematic if there are pre-existing laws against restrictive pricing practices. For instance, the GIC is exempt from the provisions of the Monopoly and Restrictive Trade Practices [MRTP] Act [Government of India 1999h: 5-8]. To the extent that preferential treatment for panel doctors associated with HMOs can be interpreted as a form of restrictive trade practice, the MRTP Act would hinder the development of managed care in India, apart from giving GIC an unfair advantage in the insurance market. In these circumstances licensure and its strict implementation are clearly necessary.

Second, there is the possibility that insurers in managed care type systems sacrifice quality of care in exchange for lower costs by empanelling lower quality [and cheaper] doctors and facilities if there is a low level of quality awareness among consumers and if laws against malpractice do not exist or are poorly enforced.[23] Again, this would not happen in a market where information about alternative plans and quality of care is readily available and comparable even if malpractice law was difficult to enforce. One way around this would be regulation that promotes uniform benefits packages and information provision to consumers of care.

Third, if private health insurance leads to increased incomes among private providers of care, it may affect the quality of medical personnel available in public sector facilities. High returns in the private sector would lead to their exit from relatively low paying public sector jobs as well as reduce the number of new entrants into public sector jobs and there is some anecdotal evidence that this is already taking place [Naylor et al 1999: 4, 7]. Consequently, it can be expected that their departure would adversely affect the remaining users of public health facilities if replacements are unavailable.

The experience of US clearly suggests that HMOs provide as good if not better care than their pure indemnity counterparts whether measured in terms of client satisfaction or in health outcomes [Einthoven 1997; Phelps 1997]. However, for this to work in India would require providing information about insurance packages to consumers so as to promote more effective competition, addressing the legal issue of restrictive practices and better enforcement of standards on accreditation and laws on malpractice. In any event, it would still not address the problem of worsening quality for users of the public health care system.

Equity Implications

The indicator of equity we use here is the distribution of the financial burden of health care spending. Would the entry of private health insurance companies worsen the distribution of the burden of health care spending in India? This can happen for two main reasons. First, private insurance companies may find it profitable to undertake risk selection so as to insure low risk individuals and exclude the high risk ones from insurance.[24] This means that the benefits of a reduced financial burden of health care and enhanced risk protection due to the spread of health insurance accrue precisely to those people who are least likely to get sick and least in need of risk protection. In Chile the ISAPREs (private managed care) insure a dispropor-

Table 4: Selected List of Legislation/Rules Linked to Consumer Protection in India

Legislation	Objective	Powers/Functions/ Procedure	Monitoring/Implementing Authority
Consumer Protection Act, 1986	To protect consumer rights such as: 1 Protection from marketing of services hazardous to life 2 Right to be informed about quality, quantity, standard, price and purity for protection against unfair trade practices 3 Seek redressal against Unfair trade practices or Exploitation of consumers	A complaint under the Act can be made when there is a deficiency in services – any fault, shortcoming, inadequacy in quality of medical or insurance services, or if an excessively high price is being charged. To observe principles of natural justice and to award appropriately, compensation to consumers.	Central and State Consumer Councils 'promote' various objectives related to consumer rights District, State and National Consumer Commissions function as quasi-judicial forums to address consumer complaints. Orders of the National Commission can be appealed only in the Supreme Court.
MRTP Act, 1969	Prevention of concentration of economic power, control of monopolies and prohibition of monopolistic and restrictive trade practices	Conduct inquiries into monopolistic and restrictive trade practices based on complaints by the government, own information, or a consumer, or an association or consumers or traders. Can award compensation for any loss or damage resulting from unfair trade practice.	Monopolies and Restrictive Trade Practices Commission.
Employees' State Insurance Act, 1948 (Section)	Address consumer (and other) complaints	Complaints about treatment received; benefits not received; eligibility, etc.	Medical Benefit Council Medical Appeal Tribunal Employees' Insurance Court
CGHS Rules	Address consumer (and other) complaints	Complaints about treatment received, benefits not received, eligibility, etc.	Internal dispute resolution mechanism
Arbitration and Conciliation Act, 1996	Address Consumer (and other complaints) generally, but also GIC specifically	All complaints and demands for compensation	Arbitration Tribunal
Indian Contract Act 1872; Code of Civil (Criminal Procedure)	Consumer complaints	For breach of contract, deficiency in services, damages, dispute of facts, negligence and so on	Judicial system /Courts
Drugs (Control) Act, 1950	Control over sale and price of drugs	Fix maximum prices and maximum quantities that may be sold General limitations on the quantity that may be possessed at any one time	Chief Commissioner Drug Controller of India
Indian Medical Council Act, 1956	Defining a professional code of conduct	Taking doctors' off the registry roles for violation of rules of conduct	State medical councils Medical council of India

Sources: Aggarwal and Chaudhri (1998); Reddy (1997); Government of India (1999c); Bhat (1996).

tionately large number of people in the economically well-off groups, leaving the worst-off to the public insurance system [Baeza 1999]. In this sense, private insurance enhances inequity, unless there is access to public services of reasonable quality as a last resort. If private insurance and subsequent private care expansion attract doctors and other skilled medical personnel away from public health facilities, it would imply the worsening of quality of care available to precisely those who are denied this insurance. Second, if entry of private insurance raises the overall costs of health care for reasons discussed previously, patients who cannot afford to buy insurance would have to pay larger amounts out-of-pocket.

As against this, an expansion in private insurance, while leading better-off groups to consume high quality private care, potentially improves access to (somewhat) lower quality public sector facilities for the worse-off groups [see, for example, Besley and Coate 1991; Gertler and Sturm 1997]. This process might well reduce the financial burden of care to the poorer groups, but requires the assumption that a shift out of public care by the rich will leave the magnitude of public expenditure unaffected.

In an Indian setting, it can be argued that the burden of health care spending is already quite unequally distributed so that the introduction of private insurance will not make much of a difference. For instance, in their study of five Indian states, Pravin Visaria and Anil Gumber found that health expenditure as a proportion of total expenditure quintiles of the lowest expenditure quintile was typically higher than the average for all quintiles, in both rural and urban areas [World Bank 1995:194]. This is not surprising in a regime where more than 80 per cent of all health care spending is out-of-pocket. Moreover, work by the author using the 1995-96 round of the National Sample Survey (NSS) reveals that within public facilities, the economically well-off use a disproportionately large amount of inpatient care suggesting that they corner a large part of the public health spending as well [Mahal et al 2000]. To the extent that the poor are unable to access the best doctors/specialists in the public sector anyway, it may not make much difference to them if these medical personnel are lured away by the private sector with the entry of private insurance, political ramifications apart.

Internationally, the empirical evidence suggests that private health insurance will probably be less inequitable compared to a system that relies heavily on out-of-pocket payments, such as India's. A recently completed study of OECD countries found that private insurance as a means of financing health care has fairly large adverse redistributive effects across income groups in countries where it plays a major role, such as the US and Switzerland, but that in general out-of-pocket payments were even less equitable [van Doorsaler et al 1999]. Can we say with certainty what will happen in India? It would depend on how the different effects outlined above play out. In a separate paper I have tried to estimate the magnitude of the private health insurance market and the distribution of public services in a setting where richer groups have superior access to public facilities. I estimate the market for private health insurance to be as large as 24 to 40 times its existing levels, but find that its effects on low-income groups' access to public facilities to be small, all else the same [Mahal 2001]. The major reason for this finding is the disproportionate access of the rich to publicly provided care, a factor that would also influence (lower) their perceived benefits from shifting to privately purchased insurance.

In the end, the effect of private health insurance on the distribution of the financial burden of care would depend on the competing influences of two factors – the improved distribution of the burden of spending within richer/healthier groups versus increased inter-group inequality across the rich-poor divide.

From a regulator's standpoint, steps to address inequality-enhancing effects of private insurance may include limiting the number of insurance packages offered together with some controls on prices, or linking the expansion of insurance business to a certain proportion of insurance business being undertaken among backward areas and communities. But this may end up harming the health and subsequent growth of the health insurance industry itself, leaving direct financial support for financial payments as one of the few options available.

It is at this point worth noting that the effects highlighted above would depend directly on the size of the private health insurance market that emerges. We believe that the private insurance market would be about Rs 2,400 to Rs 4,000 crore, not very large when compared to the overall size of the Indian health sector spending [Mahal 2001]. Thus, whatever the direction of the above effects, their magnitude will probably be small in the short run.

III
Health Insurance Regulation: Challenges for India

The main lessons from the theoretical and empirical literature are essentially the following. In an ideal world with well-informed consumers who can evaluate alternative health care and insurance packages, with proper legal protection and affordable care, private insurance may not be harmful for cost and quality, although its impact could still be adverse from an equity point of view. The previous section also suggests that there are specific things the government could do to yield better outcomes. These include steps to ensure financial stability of insurers, enhance consumer protection, control risk selection and strengthen legislation complementary to health insurance such as malpractice law and accreditation.

This section has two parts. The first focuses on regulation that relates specifically to insurance and compares the standard approach worldwide with the regulatory system in India.[25] The second describes existing Indian legislation regarding quality standards and discusses the problems faced in its enforcement.

'Model' versus the Situation in India

In line with the preceding discussion, we will focus on the following five topics. The topic has to do with the regulatory agency and its powers. In each case, there is a general description of existing (or recommended) practices in other countries followed by a brief discussion of the relevant regulatory features in India.

- Financial requirements (for entry, operation, and exit);
- Consumer protection;
- Risk Selection/Fairness (underwriting, rating standards)
- Benefits;
- Regulatory agency: Overview.

Financial Stability

The key issue here is to balance the requirements of financial stability with that of enhanced competition, since very strict financial standards may leave few insurers in the marketplace. Extreme competition of the 'cut-throat' variety may lead to financial instability and

bankruptcies (see, for example, Ranade and Ahuja 2000).

(a) Capital and Solvency Requirements

Current regulatory practice is for insurers to meet minimum capital requirements *and* surplus (over liabilities) requirements known as the solvency margin. The first establishes a floor for insurers wishing to enter the market and remaining there. The second takes into account the insurer's size and risk profile. For example, the larger its estimated liabilities, the greater will be the surplus requirement. This is obviously a better indicator of the company's solvency than a system relying on solely on some fixed minimum capital requirement.

In the US the trend is towards using a 'risk-based capital standard' (RBC). The RBC formula takes consideration of possible risks from lower asset values, higher rates of morbidity and mortality, lower interest risk, and other business risks. In the European Union, the 'solvency margin' is calculated as the higher of the claims basis (23-26 per cent of average claims in the last 3-7 years) or the premium basis (16-18 per cent of retained premiums).[26] A reduction is allowed for reinsurance, up to a maximum of 50 per cent of the solvency margin (EC 1999). The limit on using reinsurance for calculating solvency margins is to avoid creating incentives for the insurer to take on more risk.

The Indian regulatory structure under the IRDA Bill has similar features. Under the 1938 Insurance Act, the solvency margin (assets *less* liabilities) was given as a percentage of retained/net premiums (gross premiums less reinsurance payments), of the order of 20 per cent [Government of India 1999d]. The IRDA Bill of 1999 provides for a minimum lower bound of rupees 50 crore for the solvency margin along with a requirement of 20 per cent of net premiums, or 30 per cent of the average of net incurred claims in the three preceding years [Government of India 1999d:28]. This is in addition to an entry requirement of a minimum capital of rupees 100 crore.[27] In this sense, many of the provisions of the IRDA Bill parallel the regulatory features of other countries and they may become even more alike as the regulatory authority gets a sense of conditions in the insurance market over time.

As in other countries there are a number of restrictions on the nature of investments that can be undertaken by an insurance company in India and the Insurance Act of 1938 sets these out in more detail in sections 27B and 28B [Government of India 1999d; Tapay 1999]. The IRDA bill also prohibits the investment of funds outside of India [inserted as Section 27C in the Insurance Act].

(b) Accounting and Auditing

A second condition has to do with periodic reviews of an insurer's financial condition, including audits, submission of annual reports and so on. In the US, insurance regulators have broad powers of changing the management and financial practices should the need arise [Chollet and Lewis: 88]. Establishing and evaluating the solvency status of an insurer requires a uniform set of accounting procedures and methods by which contracts issued by an insurer can be translated into assets and liabilities.

Under the Insurance Act of 1938 and the IRDA Bill the controller of insurance [now the Insurance Regulatory Development Authority] has wide powers just as in the US and elsewhere. These include auditing by qualified actuaries, periodic submission of reports, appointing directors or taking over management, requesting information and even shutting down the operations of the insurance company through a court order [Government of India 1998b, 1999d].

Organisational Restrictions

In many countries, insurers cannot undertake additional business that is not directly linked to insurance as, for example, banking. The main regulatory concern is that insolvency of one business

Table 5: Legislation Related to Standards in the Health Sector

Legislation	Objective	Powers and Functions	Quality Controls	Implementing/Monitoring Authority
The Bureau of Indian Standards Act, 1986	Provide for the establishment of a Bureau for the harmonious development of activities of standardisation, marking and quality certification of goods	Coordinate activities of any manufacturer or association or consumer(s) engaged in standardisation and improvement of quality Grant, renew, suspend, or cancel licences for use of standard mark. Inspect samples, establish laboratories for standardisation and quality control Address consumer complaints about quality of a product	Establish and publish Indian standards in relation to any article or process Specify a standard mark to be called the "Bureau of Indian Standards Certification Mark"	Bureau of Indian Standards
Drugs and Cosmetics Act, 1986	Quality control of drugs	Power to deem a drug misbranded, adulterated, spurious and to prohibit import, manufacture and sale of certain drugs	Define standards of quality, adulterated, misbranded and spurious drugs	Inspectors for this purpose appointed by central and state governments
Nursing Home Registration Acts (Delhi, Maharashtra, Bengal)	Registration of private hospitals	Maintain a register of private hospitals; may enter and inspect a nursing home; inspect any records; cancel registration if not meeting the provisions of the Act.	None specified	Municipal Authority/ State Government
Indian Medical Council Act/Nursing Council Act, 1947/ Pharmacy Act 1948/ Indian Medical Degrees Act 1916. and various.	Create minimum and uniform quality standards	Various Councils (Medical, Nursing, Pharmacy, Dental, Indian Systems): Give recognition to institutions that train medical personnel; maintain uniform standards; maintain registry; define a professional code of conduct for doctors; take doctors off the rolls for violation of code of ethics	May prescribe standard curricula for training of medical personnel; conditions for admission; examination standards	Indian Medical Association; Medical/ Nursing/Pharmacy Councils of India and respective State Councils.

Sources: Sunil Nandraj (personal communication); Aggarwal and Chaudhri (1998); Government of India (various).

may cause the insolvency of the other [Chollet and Lewis 1997]. An argument against this restriction is that given banks, insurance companies and stock markets essentially are markets that deal with risk, an artificial separation may neither be desirable in the interests of efficiency, nor feasible [Ranade and Ahuja 2000]. Restrictions may also include specifying some desirable citizenship or residency status, ownership in the insurance company, and experience with similar business elsewhere [see also EC 1999:6].

Similar restrictions can be found in the Insurance Act, 1938, although there is no linkage to any specific industry or sector [Government of India 1999c].

Exit and Guarantee Fund

Exit rules are to ensure orderly exits from the market. The insurer who plans to leave the industry may have to give a timely notice to the regulator and submit plans for payment of all liabilities prior to the exit date. In the event of company insolvency, the practice often is that *all insurers* participate (contribute to) in the formation of a Guarantee Fund. The means of participation could be taxes on insurance premiums of the insurers. Generally, the fund does not pay out the full liabilities but only some portion of it to the insured. This is to address any problems of moral hazard on the part of insurers.

While there is an extensive discussion of liquidation of a company (voluntary or court-ordered) under the Insurance Act of 1938, there is no mention of a Guarantee Fund under Indian law. However, there appears to be some discussion about the setting up a guarantee fund in the IRDA (communication with T Raghavan, *Business Standard*).

Consumer Protection by the Regulatory Agency

Generally, insurance regulation with regard to consumer protection revolves around (a) the marketing and language of insurance contracts; and (b) the relationship between insurers and providers.

(a) Marketing and Language of Insurance Contracts

This category covers the language of insurance contracts in that it be easy to understand along with the terms used – benefits package, premium rate, deductibles, and so on. It also includes regulation relating to unfair trade practices such as misrepresentation, discrimination, inducements, and failure to maintain records. Moreover qualifications of insurance agents and their mode of functioning may also fall in this category. Tapay (1999) documents a case where the US government prohibited agents from specifically looking for healthy patients to enrol.

The Insurance Act of 1938 addresses directly only two concerns relating to consumer protection. It does so first by detailing the procedure by which insurance agents are licensed including the requirement that they have not been previously convicted of "…criminal breach of trust, or cheating or forgery…" or of participating in "…fraud, dishonesty, or misrepresentation…" [Government of India 1999d: 62]. Second, it imposes limitations on commissions that agents can be given or the incentives they can offer to clients while selling insurance [Government of India 1999d: 56-60]. The IRDA Bill gives authority to the regulator to specify a code of conduct for agents but no further specifics are provided. It also allows for a tariff advisory committee to oversee premium rates, insurance plans and to prevent discrimination [Government of India 1999c:9].

There is also other legislation in India that addresses the issue of consumer protection somewhat more forcefully. Apart from a regulatory authority, Indian consumers also have access to consumer courts under the Consumer Protection Act of 1986, protections under contract and tort law in the Code for Civil Procedure, and the Arbitration and Conciliation Act of 1996. These are discussed further below.

(b) Relationship between Insurers and Providers

The aim is to ensure that health care providers remain professionally independent of the providers in a managed care system. In its absence, providers may be under pressure not to recommend expensive treatments. In the US, regulations permit any provider to join a plan if he or she accepts its payment conditions. Similarly, they allow providers to work with patients outside their plan (the provider cannot be locked in by the HMO or other form of managed care organisation).

Unfortunately, consumer protection laws in India have little to say on the relationship between the insurer and the provider. It may be that some of the practices described above could potentially fall into some version of 'unfair trade practices' which belong in the realm of the MRTP (Monopoly and Restrictive Trade Practices) Act [Government of India 1999h]. At the present time, there is no case law to support or dispute this assertion. The bulk of the existing case law deals with fraudulent claims or delays in clearing claims by the insurer [see, for example, Aggarwal and Chaudhri 1998].

Table 4 summarises some of the major features of law related to consumer protection in India. The two most common avenues for relief in the arena of medical care are the Consumer Protection Act and various civil courts (see, for example, Reddy 1997). Unfortunately, the experience with the Indian court system is not very positive which, by all accounts, are characterised by lengthy delays on account of problems with procedural law and a massive backlog of cases.[28] Given these problems, it is not surprising that the various consumer commissions established under the Consumer Protection Act (COPRA) of 1986 have begun playing a key role in protecting consumer rights, in spite of their relatively recent origin. The main rationale for COPRA was that it could offer a quicker and cheaper way for consumers to address their grievances. Certainly, a number of cases related to insurance and medical negligence have reached these courts [Aggarwal and Chaudhri 1998, Vats 1997, VOICE 2000]. Recent evidence suggests that problems with backlogs have begun to occur in consumer courts as well, due to an inadequacy of 'judges' and to the increase in the burden of cases. According to one recent study of medical cases in consumer forums, more than 90 per cent took one year or longer for completion, compared to the mandated 90 days! [VOICE 2000:1].

Risk Selection/Fairness

Regulation in this area has taken two main forms in the United States: [a] restriction of underwriting/risk selection; and [b] restriction on prices based on health status.

(a) Underwriting Restrictions

These restrictions may involve a *guaranteed issue* of certain plans (or all plans) to all applicants, without regard to their risk profile. A variation on this may be *guaranteed renewal* where the insurer can underwrite applicants at the time of first issue but not on subsequent renewals. In case only a few select plans are subject to this restriction it will be the case that these

plans will become much more expensive if the risk composition of the plan determines its price. Of course, if all plans were subject to this restriction there would be the problem of adverse selection. Ways to get around this would be the exclusion of 'pre-existing' conditions, or having open enrolment only at certain times of the year.

A variation of the restrictions noted in the previous paragraph is the portability requirement. These are often used along with pre-existing exclusion restrictions. For example, as long as a reasonable continuity is maintained in coverage a second insurer cannot impose a pre-existing exclusion on a person who has already exhausted a similar exclusion with another insurer. Other restrictions could relate to insurer requests for medical history, application forms for insurance coverage, and so on.

(b) Community Rating and Rate Review

Community rating is the requirement that premiums be based on some broad geographic or demographic criterion rather than on individual health status. This is likely to be somewhat inefficient since it involves a degree of cross-subsidy across participants.

Another approach to this is controlling the premium rates directly by requiring government approval for rate levels and increases. The normal method to do this is by examining 'loss ratios' – the proportion of claims to premium income – and putting a bound on them.[29]

By restricting risk selection, the expectation is that insurers will compete in quality and prices. However, this may be particularly problematic in countries newly opened to the private insurance sector, as problems of adverse selection could overwhelm the small number of companies who first enter the market. As in the previous section, there is currently no legislation in India that has specifics on underwriting restrictions. However, a tariff advisory committee and the IRDA have the power to issue guidelines relating to non-discrimination and the "…control and regulation of rates, advantages, terms and conditions…"[Government of India 1999c: 9; Government of India 1999d].

Benefits

With regard to benefit packages there are two issues of interest: (a) a minimum package of services available to everyone, and (b) catastrophic insurance.

(a) Uniform Minimum Benefits Package

Given a uniform minimum benefits package that is accessible to all applicants, insurance companies would have a tendency to offer additional products to appeal to low risk applicants, or indulge in underwriting. Both options would increase costs and promote inequity – the latter by way of higher administration costs as well as increased premiums for the relatively more sick, and the former in terms of higher premiums for the sick the increased difficulty in choosing among options on account of greater variety. Thus, it would seem that the regulation on benefits package ought to accompany some sort of market 'managing' regulation in the sense of Einthoven (1997) or Medici et al (1997) that creates large buyers in the insurance market. The presence of large buyers could help enforce rules among insurers, in exchange for the volume of business they can bring. Examples of this are the social insurance schemes of the type in Netherlands and Israel [Chinitz 1995; West 1997; Ham 1997]. In each case, a (uniform) basic package of services is provided by a set of sickness funds with compulsory enrolment in at least one of them. Funds from a central source follow the individual and there is some risk-adjusted capitation payment to curtail risk selection. As a consequence, there is increased likelihood of competition in quality and less of risk selection.

(b) Catastrophic Insurance and Emergency Care

These can only be covered through reinsurance of various kinds in view of the rarity with which they occur. Unfortunately, in developing countries, private reinsurance is typically difficult to obtain because of the poor quality of actuarial data on rare events [Chollet and Lewis 1997: 94]. Reinsurance could be promoted in the form of more relaxed solvency margin requirements as in the European Community.

There is no legislation in India relating to benefits packages of either type. The only pertinent statement is in the Insurance Act of 1938 stating that the Tariff Advisory Committee (and the Insurance Regulatory and Development Authority under the IRDA Bill) will oversee rates, benefits and other activities of insurers. The IRDA Bill, however, does allow not only the entry of re-insurers in the Indian insurance market but also relaxes solvency margin requirements [Government of India 1999c].

Regulatory Authority: Overview

There are two issues of relevance here – (a) what are the main functions of this authority? and who does what? (b) how will the authority be funded?

(a) Main Functions

The two main functions relate to market standards (including consumer protection) and to overseeing solvency and financial regulation. In the US, the states have the primary responsibility for regulating insurance, including solvency and financial standards. In the European Union, supervisors in each country enforce country-specific market standards, but the financial standards are similar for all EU countries [Tapay 1999].

(b) Funding

Funding could be obtained from sources such as a premium tax (about 2 per cent of annual premiums in the US), allocation from general funds to the insurance department, a 'dedicated funding system' whereby fees, fines and other income generated by it are placed in a separate fund.[30]

Unlike the previous two sections, the Insurance Act of 1938 and the IRDA Bill of 1999 have much to say on the nature and functions of the regulatory authority. In some cases, the authority is wielded directly by the so-called 'controller of insurance' or the IRDA. In other cases it is committees predominantly composed of insurers and headed by the controller. For details see Government of India (1999c,d). As per the Indian Constitution the authority to regulate insurance is centralised in the IRDA and the central government, with little control by Indian states.[31] As to funding, the IRDA has the authority to levy fees or other charges to carry out its functions and can have access to grants from the central government.

Summary Remarks

The general picture that emerges is that legislation (existing and proposed) concerning health insurance in India is fairly comprehensive even in comparison to a model set of regulations when focusing on auditing, financial controls, investment guidelines and licensing regulations. There is much less regulatory focus, however, on

the consumer of insurance products and on overall goals of health policy in the form of regulation that curbs risk selection, protects consumers, promotes HMOs and the like. To be sure, both the Insurance Act of 1938 and the IRDA Bill are sufficiently comprehensive (ambiguous!) to allow increased focus on these issues, yet problems remain. Leaving lack of specificity to one side, discussions about managing the demand side of the market invariably have implications for revamping large government supported social insurance schemes such as the Central Government Health Scheme (CGHS) and Employees State Insurance (ESI), the latter being directly government by an act of parliament over which IRDA has no authority. Regulating the relationships between insurers and providers or controlling rates would have implications under the MRTP Act and that too is parliamentary legislation.

Finally, the IRDA has little or no authority over various types of legislation that relates to quality of health inputs and it is to that we now turn. To be fair, most insurance regulatory regimes have little to say about quality of care, that aspect presumably being taken care of by other legislation or by the market, we noted earlier that insurance may have adverse implications for quality of care received in developing countries such as India, unless safeguards exist. It is to this regulatory aspect that we briefly turn to next.

Regulations on Care Standards and Protection against Medical Malpractice in India

The discussion of the previous two sections points to the importance of the following types of legislation for health insurance to function properly: Quality of medical personnel and quality of health infrastructure.

There is an extensive literature that summarises the poor quality of health care currently available to seekers of health care in India. For instance, patients both rich and poor tend to overwhelmingly favour the private sector when it comes to ambulatory care [ASCI 1996; World Bank 1995]. This suggests the generally poor perception of the state of medical consultation available in the public sector, a fact confirmed by large shortfalls in personnel, equipment, and medicines in public facilities reported in primary health centres and sub-centres [Naylor et al 1999; World Bank 1995]. The situation is no better for workers with access to facilities under the Employees State Insurance Corporation (ESIC). ESI facilities are well known for their unresponsive staff and their poor state of equipment [ASCI 1996; Wadhawan 1987]. Finally, the private sector itself is known for providing low quality health care. A study in two districts of Maharashtra found a large number of doctors practising modern medicine without being qualified to do so, several hospitals that did not have even the basic infrastructure and personnel to carry out their functions, and operating without any licenses or registration [Nandraj and Duggal 1996]. More recent studies of private medical hospitals in Calcutta and Bombay further confirm the poor state of private sector facilities, apart from highlighting the frequency of medically unnecessary procedures carried out on patients [Nandraj, Khot and Menon 1999].

The problems with quality have to do with a lack of well-defined laws and when such laws exist, their poor enforcement, whether on account of judicial delays and low levels of self-regulation by the medical community. Table 5 presents legislation related to the maintenance of quality standards in the health sector – whether for medical facilities, or for medical personnel. There is some legislation that seeks to maintain quality among medical personnel (including practitioners of traditional medicine) at various levels – both at the central and provincial levels. Typically, this legislation involves the setting up of bodies (or councils) that oversee the maintenance of quality in new entrants to the profession, maintenance of membership records of the profession and, through codes of conduct and sanctions, maintenance of standards among existing members. Although quite widespread and covering the various Indian states, the record of these councils in ensuring continued good behaviour is quite poor [Jesani, Singhi and Prakash 1997]. Moreover, there is other evidence of problems in that many practitioners of traditional systems practice modern (allopathic medicine) without any sanctions. Nor is there effective enforcement of malpractice laws against errant doctors because of doctors' unwillingness to depose against their peers [Bhat 1996].

The problem with quality control is somewhat worse in the case of health infrastructure. Up until recently, the only relevant legislation was the Nursing Home Registration Act, in a small group of states – Delhi, Maharashtra and Bengal [Nandraj, Khot and Menon 1999].[32] The focus of these laws is primarily on registration of facilities, although the Delhi legislation specifies quality standards for these facilities [Nabhi Publications 2000: 12]. In any event, the enforcement of even these laws has been poor – records of private facilities are generally incomplete and the few existing studies typically find substandard facilities, understaffing and generally low quality of care provision. There was no law with respect to diagnostic centres until recently. In fact, the Delhi Shops and Establishments Act specifically excludes medical facilities [Nabhi Publications 2000]. Now however, at least in a proposed Delhi Private Medical Establishments 'Act' [Aggarwal and Chaudhri 1998] would also seek to impose quality standards on diagnostic centres. Moreover, the Environment Act (1986) may have implications for X-ray centres by setting conditions on polluting emission of radioactive particles [Government of India 1999i: 79].[33] Implementation, however, is another matter.

IV
Conclusion

Our assessment is that the entry of private health insurance could have adverse implications for some of the goals of health policy, particularly for equity. However, an informed consumer and well-defined and implemented insurance regulation regime could potentially address many of the bad outcomes. There are areas where regulation with regard to health insurance would be clearly useful – in instituting benefit packages, restrictions on risk-selection procedures, and addressing aspects of consumer protection.

Addressing these issues, however, requires meeting at least following challenges. The first and most compelling one is based on the observation that in a regime with poor enforcement, this would simply complicate the picture without yielding any direct benefits. Even Consumer Protection Act of 1986 (COPRA) that was meant to address the rights of consumers through the establishment of special consumer courts has suffered from delays of various kinds [Bhat 1996a, *The Hindu* 1999]. There is, therefore, no reason a priori to expect that health insurance regulation enforcement would do any better. It might be argued that as an independent regulator, the Insurance Regulatory and Development Authority (IRDA) would have much greater leeway in implementing its own guidelines. However, the recent experience of another such institution in the telecommunications sector (Telecommunications

Regulatory Authority of India (TRAI)) suggests that this is, by no means, certain.

Second, it is also the case that some of the regulatory changes envisaged in health insurance also appear to require as a necessary condition more fundamental changes in the existing publicly financed and provided care. In particular, for uniform benefit packages to work and for competition to kick in among insurance companies, large buyer groups may have to be created on the pattern of the US and various European countries. One interesting possibility is revamping the Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS) to divest them of their provision function. But these could imply large legislative shocks to the existing system and meet strong political resistance. On the other hand, it may be that the actual costs are not as high as the perceived costs – they might well be small if one considers the general lack of satisfaction with CGHS and ESIS facilities. Similarly, better coordination between the activities of the IRDA and other bodies such as the Monopoly and Restrictive Trade Practices Commission (MRTP) may have to be achieved.

Third, insofar as legislation on quality standards in health care provision is concerned, the IRDA faces an even greater challenge since many of the laws and their implementation are in the hands of individual states as a constitutional requirement. Moreover, all evidence indicates that these are incomplete in scope, poorly designed, and hardly ever implemented. This makes the design of insurance policy more difficult and suggests taking a comprehensive and long-term look at issues of health insurance and care provision in India.

It may be some time before these regulatory challenges can be met. In the interim, India may have to face up to some of the negative consequences that we discussed earlier. The actual magnitude of these effects may well depend on the size of the insurance market that emerges. One estimate of this market size by the author is INR 30 to 40 billion in terms of annual premium income [Mahal 2000]. Even at 30 to 40 times its current size, it is still quite small, only about 6 per cent of existing levels of health spending. EPW

Notes

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1 Section 2.13[B] of the Insurance Act refers to "'miscellaneous insurance business' as the business of effects contracts of insurance which is not…included in…" [Government of India 1999d: 4].

2 This is obviously not a view shared by employees of the public sector insurance companies Life Insurance Corporation (LIC) and General Insurance Corporation (GIC), some two hundred thousand of whom went on strike on October 29, 1999 (*Business Standard* 1999)!

3 Statements by IRDA officials such as "the IRDA will deal firmly with those…who violate laws" likely form the basis for this position (*The Times of India* 1999b).

4 We shall not be concerned here with other impacts of reforming private insurance on the economy, such as enhancing the investment climate, infrastructure investment and employment [Sinha 1999c; Srivastava 1999].

5 This is much higher than the proportion for other OECD countries ranging typically from 7 per cent to 10 per cent of GDP [World Bank 1997].

6 Equity in health care can have many meanings including in terms of health outcomes, access to, and utilisation of health care facilities [Musgrove 1996]. However, most of the measures are likely to be correlated with equity in the burden of health spending.

7 For instance the IRDA does not plan to interfere in the premiums set by insurance companies for their policies, leaving that to "market competition" (*The Times of India*, November 10).

8 The insurers can, under an indemnity system, rely on a co-payments or co-insurance to curtail consumer use of care, however.

9 Of course, in the existing scenario where the bulk of health expenditures in India are out-of-pocket (nearly 80 per cent [World Bank 1995], use may be limited much earlier by household or local community resources in comparison to a setting with expanded insurance, public or private.

10 Of course, a similar argument could hold for the private sector if increased costs lead to increased premiums and a smaller amount of insurance purchased than it would otherwise be.

11 This does not rule out inequities arising in the sense that a small segment of the beneficiary pool may be using a disproportionately large amount of the external referrals.

12 Loading charges can also include profit margins.

13 One key exception to the argument in favour of lower administration costs in social insurance is a system where social insurance takes the form of a contribution into a national fund, payments out of which are made to various 'private' entities to insure the contributors. In this case, risk selection by these entities would continue unless appropriate regulatory measures are adopted.

14 With the assumption that the group insured was formed for reasons other than to seek health insurance.

15 These are the rates for Group Mediclaim Insurance plans (communication with Rashmi Sharma, New India Insurance Company).

16 Under the insurance rules of 1939, management expenses for 'miscellaneous' insurance cannot exceed the sum of agent commissions (limited to 10 per cent of gross premiums) and a number ranging from 20-35 per cent of gross premiums depending on the volume of business. There are some exceptions for newly established companies, however [Government of India 1999e: 21-23].

17 This is likely to be the case if employers find it administratively costly to deal with individual insurance packages, e g, if wage differentials based on insurance contributions were to be instituted. Individual policies account for only 6 per cent of the entire privately insured population in the US [Phelps 1997:349].

18 Communication with Sikandar Khan (Member of Income Tax Tribunal).

19 The problem is likely to be exacerbated in an environment with many competitors so that scale economies in administering insurance may not be possible [Baeza 1998; Musgrove 1996:54].

20 The market would work by eliminating inefficient firms over time but in the case of insurance this may be a cost too high to bear for the government.

21 To some extent, this already exists under GIC plans. Under the Jan Arogya Scheme for instance, reimbursement for medical expenses depends on whether on whether the medical facility used was registered with local authorities and had a qualified medical practitioner, in the sense of being registered with the appropriate provincial medical council (Rashmi Sharma, National Insurance Company of India).

22 This tendency towards low cost-effectiveness may be curtailed, to some extent, by the role of adverse selection, and its consequences – likelihood of the more sickly remaining uninsured, or paying higher premiums [Musgrove 1995].

23 For the generally poor state of the law on malpractice in India, see section III below.

24 Via exclusion conditions, tiered or durational rating [Chollet and Lewis 1997].

25 This section relies heavily on Chollet and Lewis (1997) and Tapay (1999).

26 Some countries use 'gross' premiums to calculate solvency margins. This penalises companies that have reinsurance [Tapay 1999].

27 There is a 50 per cent upper limit on the amount of reinsurance that can be used to calculate net premiums for calculations of the solvency margin, just as in the European Community [GOI 1999d].

28 According to one estimate it would take nearly 324 years to clear the existing backlog! [Debroy 1999].

29 A number of states in the US have loss-ratio restrictions [Chollet and Lewis 1997].

30 In 1997, premium volume in life and health insurance was US$340 billion.

31 Items 43 and 47 (Union list) of Schedule VII of the Indian Constitution (Government of India 1996).

32 More recently, some states have begun taking steps to introduce fresh laws regarding private establishments [Aggarwal and Chaudhri 1998; Nandraj, Khot and Duggal 1999].

33 There is also legislation on pre-natal diagnostic techniques [Aggarwal and Chaudhri 1998].

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