

## Health Insurance Evolution in India: An Opportunity to Expand Access

To make the most from the evolving health care framework, private health insurance companies in India must embrace evolving technology and create an integrated ecosystem to expand access to healthcare.

### Executive Summary

For the last century, healthcare delivery and financing in India has been shrouded by life insurance challenges and importantly, shares key landmarks with general insurance.

Despite some progress, the current state of India's healthcare outcome leaves much to be desired. It has glaring challenges around high out-of-pocket spending, inequality of services, and fragmented social and regulatory standards. Since 2001, medical insurance has gained ground amid the proliferation of private health insurance (PHI) entities. However, it still remains a minor contributor in the current healthcare ecosystem.

Amid its ongoing transformation, a government-driven universal healthcare delivery and financing model is likely. However, PHIs still have a key role to play in shaping goals of access, cost and quality. With healthcare financing opening to private players, current challenges offer opportunities. A strong synergy between private and public players, complementing each other is a major objective. A focused approach encompassing public and private sectors and leveraging

emerging technology will play a disruptive role in the healthcare transformation ahead.

PHIs need to carefully design and implement their strategies in a 1.3 billion-strong population segmented in various strata. There are key trends around operational efficiency, integration and standardization and customer awareness - of which PHIs should be cognizant. Their response to these trends will likely define the cornerstones of success stories in India.

### From the Beginning

Since India's independence in 1947, the government sector has been the backbone of the healthcare ecosystem, including healthcare delivery and insurance. The term "insurance" is primarily associated with life insurance - the most popular form of insurance in India (around 570 million insurable lives in 2011.) There are two reasons for this- first, with low life expectancy (37 years in 1951) and a tight-knit family structure, people primarily sought financial security. Second, life insurance has been traditionally positioned as a tax-planning tool.

Health insurance evolved slowly in tandem with general insurance (See Figure 1) with both sharing key landmarks. The growth of healthcare delivery too was limited in the pre-liberalization (pre-1991) era. However, after economic liberalization in 1991, care delivery equipment, methodology, and process sharing from developed nations became mainstream. With the improvement in healthcare delivery and increase in disposable income, life expectancy had increased to 65 years by 2011. The Insurance Regulatory and Development Authority (IRDA) legislation in 2000 served as a key milestone in healthcare insurance. It opened up the health insurance industry to private players. Health insurance membership quadrupled between 2007 and 2011 (300 million in 2011) and is expected to be 600 million by 2015.

### Current State of Health Insurance

Currently, healthcare delivery and financing is marked by around 72%<sup>2</sup> out-of-pocket spending. India's per capita spending on healthcare of \$109 (See Figure 2, next page) is much lower than the global average of \$863.<sup>3</sup> India trails in health

outcomes behind its South Asian neighbors like Sri Lanka and Bangladesh, which have comparable per capita income.<sup>4</sup> There is a wide gap in healthcare delivery for the insured and for the total population.

Health insurance is dominated by government schemes. The major public health insurer in India is the government-owned General Insurance Corporation (GIC) and its four subsidiaries with about 60% market share. However, Private Health Insurers (PHIs) expanded rapidly in tier-1 and tier-2 cities post 2005 with products centered around 'in-patient reimbursements' and 'cash-less payments'.

Health insurance in India, which covered around 11% of the population by August 2005, is provided through voluntary (2%) and mandatory (9%) health insurance schemes.<sup>5</sup> The market share of PSU insurers in health insurance decreased from 64% in 2006-07 to 57% in 2008-09. The average annual premium growth in private sector was 47% compared with the PSU insurers'

### Parallel between general insurance and health insurance

	General Insurance	Health Insurance
Pre-Independence	<p><b>1818:</b> Life Insurance in its current form was introduced in 1818 when Oriental Life Insurance Company began its operations in India.</p> <p><b>1850:</b> General Insurance was however a comparatively late entrant in 1850 when Triton Insurance company set up its base in Kolkata.</p>	<p><b>1912:</b> Health insurance introduced when the first insurance act was passed.</p> <p><b>1947:</b> In 1947, the "Bhore Committee Report" - make recommendations for the improvement of health care services in India.</p> <p><b>1948:</b> The central government introduced the employees' State Insurance Scheme (ESIS) for blue-collar workers employed in the <b>private sector</b>.</p>
Nationalization	<p><b>1956:</b> Life Insurance was the first to be nationalized in 1956. Life Insurance Corporation of India was formed by consolidating the operations of various insurance companies.</p> <p><b>1973:</b> General Insurance followed suit and was nationalized in 1973. General Insurance Corporation of India was set up as the controlling body with New India, United India, National and Oriental as its subsidiaries.</p>	<p><b>1954:</b> The Central Government Health Scheme (CGHS) for central government employees and for their families.</p> <p><b>1986:</b> Mediciam was introduced. Started by government insurance companies in 1986.</p>
Liberalization	<p><b>1991:</b> The process of opening up the insurance sector was initiated against the background of Economic Reform process. Malhotra Committee was formed during this year who submitted their report in 1994.</p> <p><b>1999:</b> Insurance Regulatory Development Act (IRDA) was passed.</p> <p><b>2001:</b> Indian Insurance was opened for private companies and Private Insurance Company effectively started operations.</p>	<p><b>1999:</b> Marked the beginning of a new era for health insurance in the Indian context. With IRDA, the insurance sector was opened to private and foreign participation.</p> <p><b>2003:</b> Introduction of UHIS - early attempts by government to introduce health insurance for informal sector. UHIS was a hospitalization indemnity product voluntarily purchased from any state-owned insurer at a heavily subsidized price (e.g., Rs. 165, less than US\$4 a year).</p>

Figure 1

growth rate of 27% for the period 2006-07 to 2008-09 which indicates growing presence of private insurance in India.

Most health insurance products offered by private entities are similar to the government-defined product, Mediclaim, and are indemnity-based. Given its high premiums, most Mediclaim and similar policy holders belong to the middle and upper class.

While the urban population has witnessed a proliferation in the means of healthcare financing and delivery over the past two decades, the rural population lacks basic healthcare delivery and financing. Community health insurance schemes sponsored by the government and non-governmental organizations (NGOs) are evolving to cater to the needs of the rural population. However, healthcare delivery and finance still leave much to be desired.<sup>6</sup>

### Key Challenges in the Healthcare Ecosystem

- Affordability and accessibility chasm:** There is a large gap between healthcare delivery and financing in urban areas and rural areas. While a majority of the population resides in rural India (68.4 %), only 2% of qualified doctors are available to them.<sup>7</sup> The rural population relies heavily on government-funded medical facilities. This gap is exacerbated because the private and public systems do not complement each other. Affordable care (government hospitals or community-based care) suffers from quality issues and is unable to cater to the basic healthcare needs of the population. While some private care delivery centers and profes-

sionals are accessible to the needy, they are not affordable for a majority of the population.

- High variation in quality of services:** Often an individual has to reach out to multiple levels of care delivery providers (professionals, physicians, government hospitals, and private providers) to seek care for the same episode. This leads to compartmentalized care with cost and quality concerns. Moreover, issues with medical procedures account for a large share of adverse drug events (around 19.1 % in New Delhi, according to a recent study)<sup>8</sup>. Overall deaths in India due to adverse drug reactions are estimated to be 400,000 annually.<sup>9</sup>
- Medical health insurance penetration:** Health insurance is a minor contributor in the healthcare ecosystem.<sup>10</sup> Insurance payment structures are based on an almost retrospective arrangement of indemnity-based payments. Indian insurance has been limited to critical illness coverage for inpatient surgical procedures and often one-time lump-sum payouts.
- Associated social facilities:** Inadequate social determinants of health such as nutrition, food security, water and sanitation is a major hindrance in the success of healthcare delivery and financing.<sup>11</sup>
- Absence of regulatory and standardized operating procedures:** There is a need for a strong regulatory framework to organize and standardize healthcare delivery and financing. The dominant reimbursement method is fee for service (FFS) which differs from provider to provider. Providers are the dominant entities and influence the pricing and contract arrangement.

### Healthcare Financing and spending

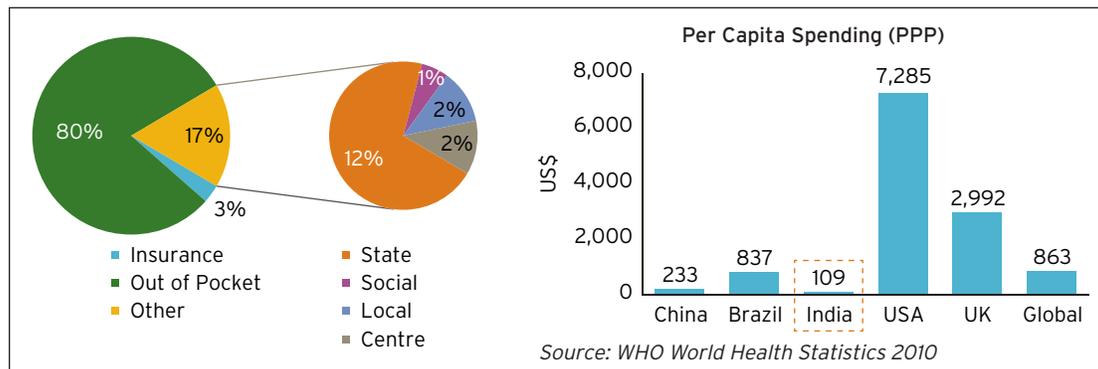


Figure 2

- Lifestyle changes:** There have been disruptive lifestyle changes in the country over the past two decades mainly due to the rapidly evolving urban economy and the Indian middle class. It is estimated that around 130 million people may suffer from lifestyle diseases such as diabetes and obesity in the next few years, leaving a \$160 billion hole in the national economy between 2010 and 2015.<sup>12</sup>

### Evolving Future Model

A recent study by a High Level Expert Group (HLEG) commissioned by the government evaluated Indian healthcare and proposed a government-driven framework for a Universal Healthcare (UHC) system. The goal of the UHC system is to ensure equitable access for all Indian citizens to affordable, accountable, appropriate health services of assured quality and redefine public health services addressing the wider determinants of health. The government will be the primary guarantor and enabler. Healthcare services to all citizens covered under UHC are proposed to be made available through the public sector and contracted-based private facilities (including NGOs and nonprofits).

We envisage the following two scenarios (See Figure 3), which differ primarily in terms of participation of private entities.

- Scenario 1:** Entities in the UHC system must ensure that at least 75% out-patient services and 50% in-patient services are

offered to citizens under the National Health Package (NHP). For these services, they should be reimbursed at standard rates as per levels of services offered, and their activities should be appropriately regulated and monitored to ensure that services guaranteed under the NHP are delivered cashless with equity and quality. For the remainder of out-patient (up to 25%) and in-patient (up to 50%) coverage, service providers can offer additional non-NHP services beyond the NHP package.

- Scenario 2:** Entities participating in UHC shall provide only the cashless services related to the NHP and no other services that would require private insurance coverage or out-of-pocket payment.

### Our Perspective

While scenario 1 makes it easier for the government to contract 'in-private' service providers, it may compromise quality of care. The second option may not be desirable to private entities. However, in both scenarios, citizens are free to supplement NHP services with paid voluntary medical insurance from insurance entities.

While the HLEG proposed a government-driven healthcare transformation, there are numerous challenges. The enormous requirements of financing, infrastructure, design, process definition, quality, staffing, and implementation can inhibit implementation in both scenarios. In such an event, a third scenario will evolve (See Figure 3). In scenario 3, PHIs are likely to

### Likely future model

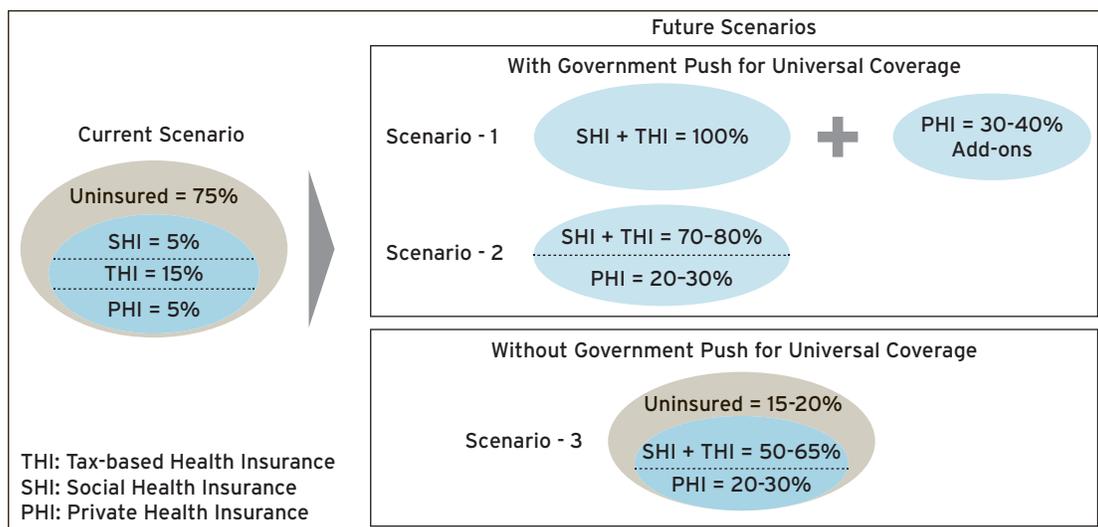


Figure 3

proliferate and cater to the needs of the population. A relatively smaller (15-20%) uninsured population will still exist.

Regardless of which model eventually evolves, private entities both in delivery and financing have an opportunity to execute government contracts covering NHP and beyond. The guaranteed payment assurance through NHP will be the key value proposition on which new insurance models and care delivery will thrive. Cost standardization across services will result in a level playing field for PHIs.

In the future models, the role of healthcare entities will undergo several changes. Increasing disposable income, a desire for better quality health services and increase in life expectancy will drastically increase the demand for health insurance. In addition, transformative market forces are re-shaping the future of healthcare and these transformative forces can be leveraged to respond to and exploit market opportunities.

- **New virtualized ways of working:** New business models of delivering care are evolving via the virtualization of processes (the “anywhere, anytime worker”) and business models (Anything as a Service - AaaS) with consumer-centric mobility paradigms are gaining ground.
- **Increasing globalization:** It is no longer a tactic but is core to business success. Performing end-to-end business processes as if they were done in one location, labor arbitrage and global network-operating systems are helping organizations control cost and improve competencies.
- **Disruptive innovation:** Medical diagnostics, artificial intelligence and big data are sparking disruptive innovations that are redefining care paradigms.
- **Demographic shifts:** Millennials grew up with the internet and have increased expectations; technology adoption rates are increasing exponentially for all age groups.

Technology will be a key enabler in this transformation and will serve support differentiation among various players. Disruptive emerging technologies such as cloud computing, mobility solutions, telemedicine, and social computing are poised to enter mainstream operations.

Healthcare delivery and financing is at an inflection point with an expected CAGR of around 23%. Private healthcare entities will play a key role in providing comprehensive coverage. We see five key characteristics of the Indian healthcare delivery and financing that impact PHIs.

- **The efficiency marathon:** In the transformation ahead, enhanced and efficient business models will emerge with a focus on lower expense ratios and a common platform for business operations. Health insurance entities are moving towards complex benefit designs to lower risks and improve their bottomlines. With an enhanced focus on outcomes, we are likely to see membership shift to private insurers. With a larger member base, bargaining power will shift from providers to health insurance players. It is likely that the efficiency chase would lead to a disruption in the ecosystem resulting in a divestment of the public entities.
- **Participation of private players:** Currently, PHIs accounts for about 5% of the covered population; this can increase to around 30% by 2020. The key is to devise products and services to cover out-of-pocket expenses, primarily due to outpatient services and inadequate coverage.

The recent changes in FDI (2012) norms open up the health insurance market to global players. The health insurance market in most developed countries is on the verge of saturation. However, the health insurance sector in India has plenty of potential. It is very likely that there will be a proliferation of cashless and outpatient-based plans followed by other innovations in areas such as health and wellness. An example would be standardizing claims reimbursements for major illnesses, grouped based on the type of the disease. PHIs can leverage best practices from other markets including process and technology to get a jumpstart in a 1.3 billion market.

- **Integration of players and standardization of care delivery:** The emerging healthcare models will see closer integration of players to penetrate the semi-urban and rural sectors. Health insurance and pharma players are likely to drive the evolution of an integrated healthcare model with increased transparency and accountability. Professional drug delivery mechanisms will emerge with a consequent decline in buying drugs over the counter.

» **Standardization and role of hospitals/care providers:** Coordinated and regulated models will evolve with a focus on standardizing care delivery platforms and the reimbursement rates. We are likely to see an emergence of standard reimbursement rates in the industry. It is highly likely that remote health diagnosis and monitoring will become mainstream, with private hospitals already betting on it.

» **Role of third-party administrators (TPAs):** Recent IRDA draft regulations such as stipulations around check issuance effectively marginalize the role of TPA. Private insurers are likely to shift their administrative controls in-house and focus on consumer centric operations.

- **Increasing use of technology in care delivery:** Healthcare Information Technology spending is expected to be around \$609.5 million in 2013<sup>13</sup> and touch ~\$1.8 billion by 2020. Healthcare delivery and remote healthcare paradigms are set for major technology transformation. Technology will find new avenues in broker channels, wellness, and self-health management. Healthcare entities will deal with lifestyle diseases through a consumer-centric care management approach. Healthcare transformation is likely to parallel the mobile penetration in India (2000-2010), leapfrogging multiple technology evolution cycles with proliferation in the first round followed by consolidation in the second.
- **Create awareness and differentiation:** In a survey conducted by NCAER for IRDA in 2012,<sup>14</sup> most people link insurance with death. Of those surveyed, only 54% were aware of health insurance which implies that the difference between health and financial security is not well understood. Effective campaigns highlighting the differences between health and financial security are necessary to highlight the need for health insurance among the population.

Private insurance players will redefine their core competencies with consumer-centric themes. To cater to a diverse population, healthcare entities need to estimate risk and subsequently position products through an effective under-writing process to the exact needs of the population segments - urban rich, urban middle class, urban poor, rural rich, rural middle class and rural poor. Against a fast-changing business landscape, players need to continually evaluate and redefine competencies. Distinguishing core and non-core competencies will aid in appropriate partnership with other entities and form the basis of differentiation. The success stories will have targeted products with a standalone health insurance business or a separate line of business for health insurance.

### Gearing up for a Major Change

The Indian healthcare Industry is estimated to grow to ~\$280 billion by 2020, up from \$79 billion in 2012. With over 70% 'out-of-pocket' expense burden on the consumers, the market is ripe for health insurance entities including global players. The industry is likely to undergo major reforms. Whichever model evolves, it is clear that the entire healthcare financing and delivery system is poised for a major change.

Healthcare transformation must focus on the three key goals of access, cost, and quality. Entities will encounter multiple challenges in catering to the needs of the 1.3 billion population, stratified on culture, economy, and means. Private entities need to complement public initiatives to develop a comprehensive healthcare delivery and financing system. Targeted product development, proximity to the consumer, and championing efficiency will be the critical success factors. A focused approach encompassing public and private sectors, and leveraging emerging technology will play a disruptive role in the healthcare transformation ahead.

## Footnotes

- <sup>1</sup> <http://pib.nic.in/newsite/erelease.aspx?relid=77883> - Press Information Bureau, Government of India
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- <sup>5</sup> [http://saiindia.gov.in/english/home/Our\\_Products/Audit\\_report/Government\\_Wise/union\\_audit/recent\\_reports/union\\_performance/2010\\_2011/Commercial/Report\\_no\\_10/chap5.pdf](http://saiindia.gov.in/english/home/Our_Products/Audit_report/Government_Wise/union_audit/recent_reports/union_performance/2010_2011/Commercial/Report_no_10/chap5.pdf)
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- <sup>13</sup> Forrester report on Healthcare trends in Emerging markets; Cognizant analysis
- <sup>14</sup> [http://www.irda.gov.in/ADMINCMS/cms/Uploadedfiles/INSURANCE\\_AWARENESS\\_insdie\\_report\\_final\\_for\\_mail.pdf](http://www.irda.gov.in/ADMINCMS/cms/Uploadedfiles/INSURANCE_AWARENESS_insdie_report_final_for_mail.pdf)

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