

# Health Insurance to Managed Care

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The loss of "money paid to cover medical expenses" is a cause of worry for anyone. When insurance companies undertake to provide protection against such loss, they charge premium to issue what is known as indemnity cover for Health Insurance. Even this Health Insurance does not have mass penetration in India.

The scene in developed countries is much different. Instead of indemnity cover Health Insurance, we hear of managed healthcare or simply managed care. In UK, they call it Care Management. The rapidly changing healthcare environment is a challenge. It requires the talents of a national cadre of professional healthcare managers. Professionalism in managed care demands a full beam of explicit and implicit knowledge. The commercial spectrum of managed care is not yet fully explored in India.

## **Popping out from History**

Elsewhere in the World, particularly in USA, Disability Income Policies of late seventeenth century provided protection against loss of income in case of accident disability of an industrial worker. Montgomery Ward and Company introduced first group health insurance plan (1910) again for compensation against loss of income due to illness or injury. Blue Shield Plan (1929) was presumably the first real hospital oriented healthcare plan. A construction contractor Henry J.

Kaiser designed a group practice prepayment healthcare plan for construction workers under advice from Dr. Sidney Garfield (1933). This effort blossomed into one of the largest Health Maintenance Organisations (HMO) called Kaiser Permanente. By 1990, USA alone accounted for US\$ 675 billion expenditure in healthcare, which has crossed a trillion dollars by now.

The first step, naturally enough, is to build a sound understanding of the main factors that influence such a magnitude of expense. A related question crops up. Is it expired cost or active cost or a continuum between the two semantics?

Some of the major factors contributing to the rising healthcare costs include:

- Widening potentially beneficial treatments due to progress of technology;. Inflation;
- The cost of medical services;
- Consumers demand for better care;
- A maturing population;
- Cost shifting or least resistance cross subsidization;
- Increase in medical lawsuits;
- Lack of awareness of medical costs; and
- Catastrophic and terminal illnesses.

Making sense out of this kind of

complexity may seem intimidating, but it can be done by:

- Conceptualizing the drivers of cost. The goal is to develop hypotheses about the aspects of supply and demand that interact to define price and impact price.
- Making simplifying assumptions that permit these drivers to be quantified. It is simply not possible to do a "perfect" analysis that incorporates every variable; the challenge is to design a model that is "good enough"
  - one consistent with available data, but not so elaborate in its causal linkages that can never be quantified. When this simplification is done well, the results will closely track the way the real world operates.
- Quantifying these drivers and then using them to verify or modify the initial cost estimates - an effort that will often demand considerable data collection and hard work.
- Working backwards in value chain to identify the activities that will add up to this cost at a point of time.
- Developing a consensus model for managing these costs and activities that, consume such costs. Like any other sustainable development, managed healthcare should confine the three states of the financial equity:
  - Integrational equity, where the future generations should benefit to at least same, if not to a greater extent than the present generation from the consensus model;
  - Social equity, where the problems

of the society should not turn endemic if not assuaged due to the manifestations of the results of the consensus model; and

- Virtuous equity, where a self-reliant economic cycle is clearly discerned in what may be termed as a forward-forward time horizon. The first forward ensures the time for streamlining the adjustments and the second forward for harnessing the opportunity to grow and replenish.

Finding the right or standardized price of healthcare based on a standard Operating practice is impossible due to following reasons:

- Providers' services are perishable;
- Receivers' service requirements are uncertain;
- Healthcare services have a high impact cost;
- Receivers' service requirements and liquidities for fee-for-service may not match;
- Receiver may not know provider's capabilities;
- Provider may need to outsource the capital. expenditure with onus of a repayment schedule or escrow arrangement;
- Providers and receivers may not network.

There are a host of players in the process of managed healthcare. Comprehensive healthcare management has developed a strong vocabulary for itself. The integrated delivery system is littered with terms such as:

- *HMO-Health Maintenance Organisations*
- *PSO-Provider Sponsored Organisations*
- *IPA-Independent Provider Association;*
- *PPO-Preferred Provider Organisations;*
- *TPA - Third-Party Administrators;*
- *MSO-Managed Service Organization;*
- *HHS - Home Health Service;*
- *RHC - Rural Health Clinics;*
- *RRC - Rural Referral Centre;*
- *PoS - Point of Service;*
- *FFS - Fee-for-Service;*
- *PPS - Prospective Payment System.*

The discovery-driven Managed Healthcare arena is ever expanding with management activities like:

- *Provider Network Design and Implementation;*
- *Provider Reimbursement Models;*
- *Managed Care Contract Analysis and Development;*
- *Re-engineering Management;*
- *Quality Management;*
- *Utilization Management;*
- *Due Diligence Investigations;*
- *Strategic Planning Positioning;*
- *Compliance Program Development and Review;*
- *Direct Negotiation Participation;*
- *Payment Management;*
- *Risk Management/Risk Sharing Strategy Development and Implementation; Reinsurance Program Development;*

- *Managed Care Information System Management;*
- *Healthcare Reforms Compliance;*
- *Total Health Management including Disease and Case Management;*
- *Mergers and Acquisitions;*
- *Strategic Sales and Outsourcing.*

### **Health Insurance Revisited**

The 21<sup>st</sup> century is poised to become the most exciting era in healthcare. Already, we have witnessed remarkable improvements in caring for and sometimes preventing some of nature's greatest threats. The emergence of protease inhibitors has created new hope for patients with HIV. An increasing focus on reducing children's exposure to lead has helped doctors make significant strides against birth defects. World is sitting with hope from the stupendous outcome of the 'genome' project. Mankind can read the literature of its creation.

Underlying these exciting developments is a paradigm shift in definition of "health." Just a few decades ago, we identified health as merely the absence of disease. Doctors concentrated on fighting acute illnesses such as influenza, polio and smallpox that threatened entire communities.

As biomedical science became more advanced, however, physicians became increasingly effective in treating or eliminating those threats with "silver bullets" such as antibiotics.

In modern times, we have learned to fight many of these age-old health problems. But we still face lingering, chronic illnesses that are harder to

treat. Often, these problems are not rooted in bacteria or viruses. Instead, they are the result of several complex factors, including genetics; lifestyle choices and failures of the body's own immune system.

Today, these chronic illnesses like asthma, diabetes and cardiovascular disease account for 80 percent of all healthcare expenditures. We now recognize that making a person truly healthy requires a marriage of body, mind and environment all aligned toward the ongoing goal of wellness.

This new knowledge has spawned significant changes in how healthcare services are delivered and organized. Now that we understand the importance of ongoing prevention and health education, healthcare requires change in process and system to support lifelong wellness instead of simply looking at doctors, medicines and hospital bills for people who are already sick.

### **What it portends in Near Future**

In as few as 5 years, healthcare marketplace will undergo a dramatic transformation from a fragmented, fee-for-service, biomedical model to a prepaid system based on coordination, health management and wellness. In many cases, this transformation requires health plans to invest tremendous amounts of capital in information systems, re-engineering programs and mergers designed to achieve economies of scale. At the same time, employers and other purchasers are demanding increased value for their healthcare rupees. To meet these demands, health plans must find

effective, valid ways to measure the efficiency of their processes and the clinical outcomes of the care they provide.

Today's General Insurance companies in India are poised to launch new kinds of managed care products; expanding their geographic markets; and forming strategic alliances with healthcare providers, pharmaceutical companies, information management vendors and even competitors. The system must help companies reduce costs, gain access to new markets and achieve their business and statutory objectives just as they are committed to finding new ways to provide high-quality, affordable healthcare coverage.

The good news is that the system known as "managed care" is evolving into the management of care - a concept that focuses on maintaining health for all, instead of merely restoring it for the sick. In years to come, insurers will expand their role as mere claims payers; they are going to build comprehensive, integrated health management systems that provide physicians and other healthcare professionals the data, technology, and back-office support they need to keep pace with a rapidly changing environment and an increasing pace of scientific discoveries.

Effective health plans serve as partners in care management by encouraging patients to receive important screenings and tests; developing innovative, customized programs for those with chronic illnesses; and helping physicians learn about new treatments. Health plan expertise in information analysis, financial

management, and benefits administration make it possible for physicians, hospitals, and other health professionals to manage the growing need for information and better understand the appropriateness of the care they provide. Healthcare leaders, indeed all citizens will be involved in one of the great social experiments in history. The impending revolution in our healthcare system is probably the most profound social redesign this country will be undertaking since it became independent. We have to demonstrate desire for a competitive, market-based healthcare system instead of a biomedical approach. We seek an environment in which health plans compete not just on price but also on quality of outcomes. We want to preserve our country's low cost tradition of clinical treatment while continuously improving the process of care, fostering innovation, promoting consumer choice, and providing top-notch customer service.

### **Background of Healthcare**

Govt. spends about 1.7% of Gross National Product (GNP) on healthcare. Private spending is further 4.3% of GNP. Thus total of 6% of GNP is spent on healthcare. This is far below the 10-12% in developed countries. Thus, majority of the population is deprived of healthcare-public or private.

Although health insurance is growing @ 16 to 18% p.a., the base is not even 1 % of the upper middle-class population.

Responsibility for public health expansion is jointly shared by Central and State governments. The goals and strategies are set through the Central Council of Health and Family Welfare. This council is the main formal vehicle for establishing the structure of the public healthcare delivery system as well as National Health Policy.

The public health system is not able to keep pace with the changing needs of population due to rapid urbanization. Although India is welfare oriented, there is no Social Security Safety net, no health insurance for the majority of the population. Private Sector involvement is therefore being sought.

Following are the major sectors in the present day healthcare system in India:

- A. Public Sector - Govt. run hospitals, dispensaries, clinics, primary healthcare centres para-medical and other programs.
- B. Non-profit Sector - Voluntary health programs, charitable institutions, missions, churches and trusts.
- C. Organized Public Sectors - General practitioners, private hospitals, nursing homes and Registered Medical Practitioner.
- D. Informal Private Sector - Practitioners with no professional qualifications, faith healers, tantriks, herbalists, priests, hakims and vaidis (includes organizations providing allopathic, homeopathic and traditional medicines for payment or otherwise).

	<i>Poor</i>	<i>Middle</i>	<i>Lower Middle</i>	<i>Upper Middle</i>	<i>Wealthy</i>
	<i>(Figures in %)</i>				
<i>Public</i>	13	13	12	8	0
<i>Traditional</i>	1	3	1	3	0
<i>Self-medicated</i>	14	9	6	4	5
<i>Private</i>	72	75	80	85	95

The department of Central Government Health Scheme (CGHS) provides comprehensive medical facilities to 8.5 million Central Govt. Employees in India. This includes in-patient, out-patient treatment, medicines, lab-investigations, X-rays, home visits, emergency treatment and ante-natal care.

The expanding middle class population requires new health insurance programs, which has led to better quality of medical treatment within the reach of the middle class.

### **Existing Health Insurance Scenario**

1. The Mediclaim provides reimbursement of hospitalization and domiciliary Hospitalization expenses i.e. expenses for treatment of such illness which would normally require hospitalization but which is treated at home under certain compelling circumstances as per doctor's advice only. The treatment taken in India qualifies for reimbursement. Under Third-Party Administration (TPA) system, there is initiation of a cashless service in case of hospitalization to a limited extent.
2. Prior to 1986, medical insurance was restricted to employees of

corporate bodies on group basis. Since there was a need to offer medical insurance to individuals and because the insuring public demanded introduction of some sort of health coverage for individuals, insurance cover under the brand name of Hospitalisation and Domiciliary Hospitalisation was introduced in 1986. An incentive was provided in the form of tax relief on premium to encourage more people to take this cover.

3. The scheme was revised in 1991 and marketed under the brand name of Mediclaim. The main difference this time was the abolition of separate limits for major and minor surgeries and offering just one hospitalization limit.

In an attempt to make the policy more customer-friendly, it was revised again in 1996. Under this cover the insured was all owed to choose the Sum insured, premium being calculated on the basis of age of the proposer as also the Sum Insured opted for. The table below traces the innovations in medical insurance due to inadequacies of Mediclaim scheme in India:

Limitations in Mediciclaim	Solutions Introduced
New born not covered	Cradle Care
As age increases income drops, premium increases	Bhavishya Arogya 1990
No cover for overseas travels	OMP/VYM
Premium only an outgo if no claims lodged	SCUP, Asha Deep,jeevan Asha, Nav Prabhat
Does not offer cash benefits for costs of convalescence, change of life style, change of career, specialized treatments and equipments	Dreaded Disease Cover
Attendants' costs, donor's expenses, ambulance charges not covered	Tertiary Care
Dental treatment excluded	Smile Care
Spend first claim later reimbursement policy	Hospital tie up & later TPA as an intermediary
Health cover not suitable for economically backward class	Jana Arogya
Renewal hassles & possibility policy discontinuity	Long Term Hospitalization
Cost not covered - hospice care, private nursing, health check up; admission to hospital not assured; provider vigilance not offered; cashless service; health tips and guidance not given	Health Quarter Plan
For negotiations possible in group policies	Group Tailored covers

- The Group Mediciclaim policies can be issued on the lines of individual Mediciclaim policies with group discount, bonus/malus and maternity benefits.
- Bhavishya Arogya Policy with single sum insured - A deferred treatment plan for long-term care at old age. The life time sum

insured of Rs.50,000. The sum insured can be enhanced in multiples of Rs.10,000, at a cost of 20%. Additional premium four years before the commencement of retirement age.

- Senior Citizen's Unit Plan (SCUP) - a plan launched by Unit Trust of India and New India Assurance

Co., Annuity linked retirement, hospitalization benefit - up to Rs.5,00,000. A combined limit for lifetime for investors and spouse.

7. Group Mediclaim Policy for Credit Card holders;
8. Cancer Insurance Policy for the members of Indian Cancer Society, Cancer Insurance Policy for the members of Cancer Patients Aid Association.
9. Overseas Mediclaim Policy for Indians travelling to destinations outside India on short trips.
10. Workmen's Compensation Insurance - Covering accidents on duty and occupational diseases to workmen (statutory requirement as per WC. Act, 1923).
11. Tailor-made Policies for Organised Groups and Corporates - only those policies existing at the time of introducing mediclaim in 1986 are still in operation subject to 80:20 basis on premium and claims.
12. Jan Arogya Policy for economically poor class - sum insured of Rs.5,000 per year.
13. Asha Deep with Profit-I of LIC - Limited disease cover and life cover lumpsum payment on contracting the disease.
14. Asha Deep with Profit-II of LIC - Limited disease cover and life cover lumpsum payment on contracting the disease.
15. The Birthright Insurance Scheme - Policy to be issued to expectant mother up to 3 months pregnant.

Four plans of sum insured of Rs.10,000 to Rs.75,000. Covers treatments for congenital anomalies, permanent partial disability and permanent total disability of the child.

16. Floater sum insured with family as a unit.
17. E.S.1.S. for industrial workers - Covers half monthly wages, treatment with nominated doctors & E.S.1.S. hospitals) occupational diseases. A compulsory insurance by statute for industrial workers with a basic salary of up to Rs.2,500 p.m. A State-owned Corporation administers it.
18. CGHS - Central Government Health Scheme covering about 9 million employees giving treatment in nominated hospitals. The scheme is suffering from a lot of administrative problems and they are looking out for alternatives.
19. Self-Reimbursement Schemes - Several organisations reimburse medical costs to their employees with stipulated limit/without any limit. They do not have any insurance protection plans and are looking for alternatives.
20. The latest effort is introduction of Universal Health insurance scheme so regally announced by the Finance Minister but so difficult to realize in actual field setting not necessarily for the inherent flaw in the scheme but due to go-to-market model not in tune with the infrastructure and business attitude.

## **Product Range in Healthcare to Suit Various Segments**

Following nine products are suggested in Managed Healthcare to suit various segments:

### **1. Long-Term Hospitalization/ Domiciliary Hospitalization Insurance Policy**

Presently, there is Medclaim Policy, which is issued for a period of 1 year with a sum insured option up to a defined limit, which varies from time to time. Policy has to be renewed every year and many people find it difficult on account of various reasons. Hence a Long-Term Hospitalization/ Domiciliary Hospitalization Insurance Policy with an option of 1 year, 5 years, 10 years will be very successful in the market.

### **2. Tertiary Care Insurance**

For those who feel that claiming on insurance policy is a hassle, but they would like to fall back up on insurance help for major expenses, a policy with the following major ailments is perceived as a necessity among the insuring public. This policy can also be sold to State Govt. Employees and the Business Community.

Nine Major Ailments to be covered:

- i.** Nephritis and renal failures due to any reason, leading to kidney failure and kidney transplant.
- ii.** Cerebral or Vascular Strokes.
- iii.** Open and Close Heart Surgery.
- iv.** Malignancy, which is confirmed by Histopathological report.
- v.** Encephalitis (Viral).

**vi.** Neuro Surgery.

**vii.** Total replacement of the joints.

**viii.** Liver Disorder (Hepatitis B and C) associated with complications like cirrhosis.

**ix.** Grievous injury including multiple fracture of long bones, head-injury leading to unconsciousness, burns of more than 40% injury requiring artificial ventilatory support plus vertebral column injury.

Sum insured may vary based on actuarial principles. Policies can be issued for 1 year, 5 years, or 10 years depending on the option exercised by the insured.

### **3. Long-Term Retirement Benefit Plan**

At present, there are Bhavishya Arogya policy and Senior Citizen Unit Plan. Under both these plans persons above 55 years of age cannot be covered. Policy covering the following category of persons will be widely acceptable in the market. Plan may be marketed to individuals as well as corporates:

- a)** Employees who are presently in service and would like to contribute to the Scheme whilst in service and provide as a retirement benefit.
- b)** Those who are on the verge of retirement and are planning for their retired life.
- c)** Those already retired but could not provide for their old age medical requirements, as there were no suitable plans available at the time when they were in service.
- d)** Insured who is covered under this scheme is offered the benefit of

reimbursement of hospitalization expenses for the complete lifetime. The amount covered ranges from Rs.1 lakh up to Rs.10 lakh.

**e)** Higher medical reimbursement benefit plan can be offered to employees who are young and who may retire at the age of 60. This special scheme will take care of increased medical costs due to inflation.

**f)** The retirement age (benefit commencement age) will have to be chosen at the time of joining the Scheme. No change of selected retirement age will be permitted.

**g)** The benefits can be availed of starting from the selected date of retirement age and, thereafter continues for the whole life.

**h)** The single life time limit can be availed jointly by the employee and his -spouse.

#### **4. Seafarer's Health Policy**

On all India basis, the total potential is 100000 for a family having 4 to 6 members each. Hence the total potential is an average of Rs.20,000 per family premium, which will amount to Rs.2 billion. There are over 40,000 seafarers in Mumbai alone.

There are different categories of seafarers:

**1)** Those who are employed on temporary basis and are normally on duty for 6 months and off-duty for the remaining period of the year.

**2)** Permanent employees of the shipping company.

The nature of their duty involves being

on voyage for continuous periods extending from three to fifteen months.

They are covered for their medical expenses whilst on duty, which is paid by their employers i.e. shipping companies. However, when they are on off-duty, they may not be covered by any medical or accident benefit policy. The existing health insurance policy does not meet this requirement.

Therefore, it is felt necessary to design a suitable product to take care of the specific requirement of seafarers.

After extensive discussions and market study it was found that the seafarers would prefer to have long-term off-duty coverage since they would not like to bother with renewing their policy annually. Besides, at the time of annual renewal they may be on duty abroad.

Most of the seafarers are economically well placed and would be willing to insure themselves against any medical exigencies. Further as per their employment contract/conditions they may not be covered by any post retirement health package scheme. They are in need of a Health Insurance Package policy, which can cover them and their family members both during the service period as well after retirement.

Following combinations of policy can be issued:

**1)** Hospitalization/Domiciliary Hospitalization policy for 1 year, 5 years, and 10 years, covering:

- Seafarer's off-duty cover
- Family to be covered continuously during the policy period.

2) Personal accident continuous cover (for seafarer and family)

3) Long-term retirement benefit plan, (Seafarer and spouse to be covered).

### 5. **Destination India**

30 million non-resident Indians visit India once in 2 years for short duration. Many people from abroad visit India regularly. They stay for short duration as well for long durations. Many come as tourists and on official/Business purposes. Because of change of climatic

conditions and other factors they may be exposed to various health hazards.

"Destination India" is a travel insurance product for overseas people travelling to India. It is a package policy specially designed keeping the requirements of this section of population in mind.

It is a short period policy offered for a maximum period not exceeding 180 days. The principal features of the new policy may be as under:

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#### **Destination India Benefits Schedule**

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a	Personal Accident	INR 1,000,000
b	Medical & Repatriation	INR 500,000
c	Personal Baggage	INR 25,000
	Single Article Limit	INR 5,000
	Valuables Limit	INR 5,000
d	Delayed Baggage	INR 2,500
e	Loss of Passport	INR 2,500
f	Personal Liability	INR 1,000,000
g	Hijack Benefit (Per day up to 5 days)	INR 1,000

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### 6. **Cancer Medical Expenses Insurance Policy**

Cancer can strike anyone of us at any age. At any point of time, around 15 lakh persons suffer from cancer in India. The incidence of cancer is on the rise and in the years to come one in fifteen persons in urban areas and one in twenty-five persons in rural areas will likely get cancer in their lifetime. Generally speaking, cancer is termed as an illness with no cure. Fortunately today, cancer in many instances is curable if detected early enough. However, the exorbitant cost of

treatment is coming in the way of providing the best that is available in the treatment of this disease.

Cancer Medical Expenses Insurance Policy has to be revised to assist general public to reimburse the cost of medical expenses incurred in the treatment of cancer. It is betterment of cancer policy devised earlier for Indian Cancer Society as well as Cancer Patients Aid Association. The policy is designed for individuals as well as groups. Membership of any cancer society or cancer association is not a prerequisite. Moreover, person/persons

proposed have to give declaration that he/they is/are in good health and are not suffering from cancer.

Policy to cover expenses reasonably and necessarily incurred for treatment of cancer (Hospitalization as well as outpatient) Cancer means malignant neoplasm of Buccal, Cavity and Pharynx, Digestive Organs, Respiratory system, Bone, Skin, etc.

### **7. VRS Superannuation Plan**

Public Sector Undertakings are declaring Voluntary Retirement Schemes due to Government interventions. Hence, Voluntary Retirement Schemes with various packages are announced from time to time by PSUs as well as industrial Organizations.

In most of these organizations, employees/workers are covered against medical insurance/medical reimbursement/ESIS whilst in service. In many cases even their spouse and dependent children are covered against the medical benefits. While designing a VRS package if this medical benefit also can be granted till the employees attain superannuation age) it would definitely be very attractive for those employees/workers who wish to opt for VRS.

However, it is not feasible from management point of view as well as not practicable for employees opting for VRS to continue in the medical reimbursement scheme along with the serving employees. It is, therefore, felt that if an insurance policy to take care of this need is handed over to the employee at the time of opting for VRS (by making one time payment) the VRS

plan will become attractive.

To take care of this requirement, a VRS Superannuation Plan may be specially designed which can be availed by organizations who are planning to declare VRS. Employees opting for VRS above the age of 40 can be covered in the Scheme. The policy is for a sum insured ranging from Rs.25,000 to 5 lakh. The sum insured opted is available for an annual limit. The policy period will be from the date of VRS till the date one would attain superannuation. Either the limit can be single limit for individual or the insured or spouse can enjoy the sum insured limit jointly. Claims are settled directly with the insured employee. In short, this is a need-based attractive policy to take care of the requirements of various Public Sector and Commercial Organizations who are contemplating to declare VRS.

### **8. Health Quarters Plan**

There are over ten million NRIs (Non-Resident Indians) settled abroad. Due to distance and other constraints) they are separated from their near and dear ones in India. The problem is accentuated in case of aged parents staying alone while the young NRI is settled abroad.

The Health Quarters Plan builds on an emotional appeal of the NRI in assuring the NRI that somebody is looking after his/her loved ones while they are away.

The Health Quarters Plan combines a health insurance package along with personal accident.

The Health Quarters Plan provides Indemnity Plan to the NRIs for the benefit of their loved ones in India.

### **Target Group**

NRIs all over the world, particularly in the USA, UK, Canada and the Gulf for the benefit of their parents/relatives in India.

The cover operates long-term for a period of five and ten years.

### **Section I**

Long-term hospitalization/domiciliary hospitalization insurance policy.

### **Section II**

Personal accident.

Insured can opt for sum insured ranging from Rs.1 lakh to Rs.10 lakh. The criteria for fixing sum insured depend on the annual income of the insured as per Tariff. Policy covers death, permanent total and partial disability and temporary total disability as per the standard scheme.

## **9. Gram Arogya Yojna**

In our country 70% of the population lives in villages. The literacy among the villages is at a low rate. They are poorly informed about worldly activities. Their main occupation is agriculture and allied activities.

It is needless to highlight that this section of population in our country needs maximum insurance protection. Also it is this group which is least availing Insurance.

The existing urban-oriented health insurance policies are beyond the reach of a villager. Added to this grief the existing medicare offered by various agencies are inadequate.

"Group Surgical Operation Insurance Policy" desires to fulfil its obligation to the society.

### **Salient Features**

**a)** The policy is to be taken in the name of Gram Panchayat. The Gram Panchayat should provide the list of persons to be covered.

**b)** The entire population of the village should be compulsorily insured without any exception.

**c)** There is no age limit and all eligible families of the village irrespective of age are covered.

**d)** Under this policy the premium to be paid by the villager is very low hence policy covers expenses incurred by surgical operations only.

By payment of additional premium policy can be extended to cover hospitalization and domiciliary hospitalization expenses incurred because of other illness/injury, etc. This can be an appropriate substitute for Universal Health Insurance, which is so tentative in the market place.

Policy can also be offered for a higher sum insured by collecting proportionate additional premium.

**e)** A family is considered to cover minimum four members. The sum insured per family is fixed at Rs.10,000 for inclusion of each additional member; the sum insured will be increased by adding Rs.1,000 by collecting additional premium.

Insurers have introduced a new concept called "FLOATER" sum insured. It means the amount of total sum insured can be availed by anyone member or all the members of a family within the policy period.

**f)** The head of the family named in the Schedule is covered against death due

to accident for a capital sum insured of Rs.10,000. This benefit is in-built and there is no additional premium.

**g)** A smaller family with less than four members too have to be covered for the same sum insured of Rs.10,000 by paying appropriate premium.

**h)** Pre-existing conditions: Any disease/illness with which insured was suffering at the time of commencement of policy is not covered.

**i)** The policy may be designed with an attractive bonus (low claim) and malus (high claim) clause.

### ***Care and Caution***

This unique perspective will fuel profound change in the healthcare marketplace. It's been observed that in most societies, death is considered inevitable but for Managed Care Society, it's optional. Like the auto, defence, and banking industries in the yesteryears and like today's telecommunications and energy providers healthcare system bears the brunt of massive transformation. Insurers face growing price pressure from purchasers combined with quantum changes in technological capabilities and rising consumer expectations.

Seemingly overnight, the definition of "value" has shifted focus: From high-cost, inpatient, procedure-oriented care to an increasingly patient-cantered system of wellness, prevention, and improved health outcomes. The revolution is complicated by the lack of a national, ethical consensus about the appropriate level of healthcare spending in both the public and private sectors.

Faced with a volatile marketplace, insurers have to carefully evaluate their market positions. Many have reorganized to leverage core strengths, achieve greater economies of scale, and promote continuous quality improvement. Others re-engineer their operations to improve efficiency. Still others acquire their competitors and/or physician practices. Each of these decisions is a local one, based on how the insurer believes it can most effectively provide its existing and future customers with high-quality, affordable healthcare services.

This healthcare revolution fascinates those who are part of it; world is witnessing a turning point in social history. For patients, however, the revolution is confusing, often frightening. Cartoons, editorials, and news articles portray the phrase "managed care" as an epithet. The very words conjure up visions of faceless bureaucrats denying needed services, imposing long waits for treatment and putting profits ahead of patients. These concerns are sometimes well founded:

Massive change frequently is accompanied by a period of chaos. Moreover, on the path toward effective competition, the Indians have done a good job of managing costs, but not done an equally effective job of managing quality.

### ***Guide to Better Health***

As the healthcare marketplace changes, Managed Care continually works to discover new and better ways to serve members. The emergence of new technology, including the Internet, means that members can be

empowered, more than ever before, to learn about the healthcare issues that touch each of their lives. Good health means good living and the more you know the easier it is to stay healthy.

Until recently, we identified health as merely the absence of disease. Doctors concentrated on fighting acute illnesses such as tuberculosis, polio and smallpox that threatened entire communities. Biomedical researchers focused their efforts on identifying the viruses and bacteria that cause disease and then developing "silver bullets" such as antibiotics and vaccines to fight them. Our definition of health now includes a marriage of body, mind and environment.

General Insurance companies can be leaders in this new healthcare paradigm. Such companies build partnerships among doctors and other health professionals who provide patients with the full spectrum of coordinated care services from preventive efforts and primary care to speciality treatment and follow-up. These seamless systems help patients control their symptoms everyday at home, work or school, rather than waiting to visit the doctor when they are seriously ill. Instead of managing the cost of healthcare, member establishments or plan procuring companies focus on managing the care itself. At each point along the continuum of care, such companies use information-driven programs to improve their care-receiver's health and quality of life.

The major components of the care management approach include: disease prevention and wellness; early

detection; the management of chronic illness; and partnerships to improve healthcare quality.

Today's Health Plans are partners in keeping patients healthy. Healthcare companies often called Third-Party Administrators (TPAs) if they only mediate between the insurer and healthcare providing hospital on behalf of their members or Managed Service Organisation (MSO) if they undertake both care service and member administration use sophisticated management information systems to provide their physicians with valuable data about which patients have received important screening tests like mammograms and Pap smears and which patients have not. Healthcare companies also mail reminders to their patients encouraging them "to undergo these important tests. Encouraging patients to take responsibility for living healthy lives is another important component of disease prevention. Plans supply their members with self-care books, health promotion materials and other resources to help them educate themselves about their personal health and learn to practice good health habits.

Despite years of media attention to the importance of early detection, analyses of patient data reveal that many still do not receive such widely recognized preventive tests as mammograms, Pap smears, skin examinations, and other important cancer screenings. Studies have shown that use of the Pap test for early detection can reduce cervical cancer mortality by 75 percent. Similarly, a mammogram can sometimes detect breast cancer two

years before a woman or her doctor can feel a lump.

Elsewhere in the world, Healthcare companies are launching aggressive and multi-faceted education campaigns to ensure patients receive these tests. Along with detecting cancer and other acute conditions, such companies conduct sophisticated health assessments that may also reveal chronic illnesses like asthma, diabetes or cardiovascular disease. They then develop innovative programs for these "at-risk" patients to receive appropriate treatment or better information on managing their chronic ailments to avoid further complications.

Emerging weapons in combating chronic diseases include advanced information systems and computer technology and such companies are leading the way in gathering data that helps doctors treat patients at risk for chronic ailments. By collecting and analyzing health information on their enrolled populations, such companies can develop educational programs and clinical interventions that assist physicians and patients in managing chronic diseases.

By studying patterns of care and

treatment outcomes for specific diseases, such companies and their affiliated physicians are developing clinical practice guidelines. Such companies are also participating in clinical studies and working with community physicians to better understand the evolution and symptomatic patterns of chronic conditions.

Diseases like Alzheimers, Cancer, Diabetes, Heart Attacks, Arthritis, Allergy, Asthma, AIDS, Rheumatism, Kidney Failure or other renal disorders have now created an environment of uncertainty in the life of people. Even the trivials like dental care and preventive maintenance of highly stressed human visceral elements require meticulous planning of finances. Here is a demand, which has to be matched with a supply side economical engineering. Managed Healthcare seems to be the only viable model in near terms.

If the nation is determined to recognize health as a proxy for usable wealth, then we have to scout the investments for protection of such wealth. The following elements of the matrix may indicate the location of the wealth:

	<b>Communicable</b>	<b>Lifestyle</b>	<b>Accidental</b>	<b>Preventive Wellness</b>	<b>Promotive R&amp;D</b>
<b>Natal range</b>					
<b>Poliotic age range</b>					
<b>Reproductive age range</b>					
<b>Gerentological age range</b>					
<b>Challenged life</b>					

The nation has to decide what should be the size of this health box and how much should be put in which shelf of the box. The dilemma is who should

fill up the maintenance box when the hidden wealth may have unconnected ownership in time and space.■