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बीमा विनियामक और विकास प्राधिकरण

Journal

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Editor:
K. Nitya Kalyani

Hindi Correspondent:
Sanjeev Kumar Jain

Design concept & Production:
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Editor: K. Nitya Kalyani

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Parisrama Bhavanam, III Floor
5-9-58/B, Basheer Bagh
Hyderabad 500 004
Phone: 5582 0964, 5578 9768
Fax: 91-040-5582 3334
e-mail: irdajournal@irdaonline.org

From the Publisher

The fairness and efficiency of any institution is judged by the speed with which it responds to grievances. While it makes commercial sense to respond to grievances when goods are sold, the benefits arising out of quick response to the grievances of customers in the "Services Sector" are somewhat intangible. Hence there is scope for neglect of this area of business. The insurance industry is traditionally known to respond slowly to consumer complaints. It is often said that in the case of insurance there is a gulf between sales talk and post-sales service.

The Government, as the sole provider of insurance through its life and non-life companies was deeply concerned about the need for providing relief to the policyholders and instituted the mechanism of Ombudsman in 1998. The uniqueness of this Institution is that the orders of the Ombudsman are binding on the insurer while the policyholders have the option to challenge them.

In this issue of **IRDA Journal** we take an analytical look at the structure and working of the institution of Insurance Ombudsman. You will read the experiences of and suggestions from those within the insurance industry and the grievances redressal system. The Law Commission has made recommendations on the grievance redressal system which is also covered in this issue.

What emerges is interesting in terms of suggestions on the working of the system, its legalities and logistics, and the lessons that can be learnt by the industry from past 'mistakes' that reveal certain erroneous assumptions and point to acts of omission and commission that can be rectified.

This month we at IRDA bid goodbye to Mr. P. A. Balasubramanian, our first Member (Actuary), who has served the Authority admirably for over three years. We are, however, glad that we continue to benefit from his presence and expertise as a Consulting Actuary of the Authority.

We are happy to welcome to the Authority Mr. C. R. Muralidharan as Member in charge of investments, accounts of insurers and intermediaries and off-site monitoring of insurance companies. He comes in from the Reserve Bank of India bringing considerable expertise in regulatory matters.

The next issue of the Journal will explore some ideas on micro insurance. Being a topic important to the mission of IRDA, of the development of insurance and its spread among the weaker sections of society, we hope the articles will help generate interest in an area which the insurers have looked at so far more as an obligation than as an opportunity.

C.S.RAO

Inside

ISSUE FOCUS

Changes...

The solution is always within, it is said. And that was the concept behind the Insurance Ombudsman as an institution. Its strength has been that it is an accessible and user-friendly system for the consumer without the costs and delays that the overburdened judicial system involves.

As the industry grows, so does the need for consumer access to remedies. So in this issue of **IRDA Journal** we reflect on the institution of the Insurance Ombudsman. Mr. Gnanasundaram Krishnamurthy, retired Chairman, LIC who was the Insurance Ombudsman at Mumbai writes from his experience on both sides of the table about the advantages and shortcomings of the system and its functioning.

Mr. G. V. Rao's article touches upon the effectiveness of the ombudsmen and suggestions on where they can enhance their working within the current framework and with a little more empowerment from without.

Ms. Yegnapriya Bharath, drawing on her experience handling IRDA's Public Grievances Cell, talks about lessons that could be learnt from the nature of complaints and the state of mind of the complainants. Mr. G. Gopalakrishna, retired from LIC, gives us an idea of the various grievance redressal methods and their relative place in the scheme of things. We also bring you the Law Commission's final recommendations on the grievance redressal machinery and some comments and observations on their direction

The next issue of the Journal will be about microinsurance – a vital tool to introducing and expanding insurance coverage among the weaker sections of society. That makes it important to the mission of IRDA and of interest to insurers and intermediaries who need to fulfil the social sector norms required by the Regulations today and who, it is being increasingly noticed, will sooner or later covet business from these sectors once initial barriers, both of the mental and material variety, are transcended.

We join the office of the Authority in bidding farewell to Mr. P. A. Balasubramanian who, as Member (Actuary), shaped this discipline in the Regulator's office and learnt a lot – in his own words – and stood his ground through three years here. He will, we are sure, continue to fight the good fight to strike a balance for the policyholders' interest by ensuring soundness and sustainability of insurance products, this time as Consulting Actuary to the Authority.

We also happily welcome new Member in charge of Investments, company accounts and off-site supervision, Mr. C. R. Muralidharan, who will implant into IRDA his regulatory experience with the Reserve Bank of India.

According to his Need....

K. Nitya Kalyani

"The objective of this section is to build a framework for poverty alleviation. We start with a simple proposition. If we stop thinking of the poor as victims or as a burden and start recognizing them as resilient and creative entrepreneurs and value-conscious consumers, a whole new world of opportunity will open up. Four billion poor can be the engine of the next round of global trade and prosperity."

The Fortune at the Bottom of the Pyramid:
Eradicating Poverty Through Profits
by *C. K. Prahalad*

The social objectives of the Government have been embodied in the Laws and subordinate legislations in different fields. The rural and social sector obligations of insurance companies, which are part of licensing conditions, is the insurance sector's version of the vehicle to fulfil these objectives.

Forget that this is the Government's objective. Is there an enlightened self-interest in reaching out to the markets inhabited by the poor? Yes, is the resounding answer from management guru C. K. Prahalad. An equally strong affirmative response, born of experience, comes from the Indian banking sector.

For long – the decades between nationalisation in the 1970s and liberalisation in the mid-nineties – the main metric of the banking industry was deposit base and priority sector lending.

Priority sector lending was the problem that bank chiefs liked to point to. It was mandated at 40 per cent, carried low rates and softer terms, and took away from commercial lending opportunities.

But came the competitive era, when banks recast their balance sheets according to prudential norms stipulated by the Reserve Bank of India (RBI), and they discovered an entirely unexpected pot of gold – the priority sector portfolio!

The RoI of this portfolio was better not the least because the non-performing assets were lower, and the activity had led to rural awareness of banking services, entrepreneurship and buying power – something that benefits the banking industry again indirectly by creating demand for goods.

Is there an enlightened self-interest in reaching out to the markets inhabited by the poor? Yes, is the resounding answer.

It is this market – termed the world's most exciting, fastest-growing new market – that we want to take a look at in the next issue of **IRDA Journal.**

IRDA, in its focus on spreading insurance, especially to the weaker sections of society, has imparted momentum to the process of selling insurance to them by drafting regulations for enabling microinsurance.

Given the spread and success of microfinance institutions and their interest in selling insurance to both add value to their constituents and to protect their assets in the form of loans, they are evolving into suitable insurance intermediaries. Considering the technical and legal requirements of an insurance contract, the draft regulations suggest a framework in which the business needs to be done to ensure healthy growth.

Specialised markets require not only specialised channels but products tailored to specific needs. They could be simpler products with a lower ticket value, and are usually group oriented in coverage and mode of purchase, the customers being aggregated through groups like self-help groups and cooperatives.

This said, the idea of microinsurance needs to be a positive one. As in the case of microfinancing, the target market needs to be treated not as poor needing charity but as those who can, with a little help, contribute to the economy.

This is a path that many insurance companies are treading already, perhaps a bit quietly and with a view to explore in the beginning. But it is a path that none can ignore except at their own risk – that of missing out on what could be the most sustainable and rewarding of markets.

'A Hectic but Satisfying Time'

K. Nitya Kalyani

He came in to look after the actuarial side of work at IRDA when it had its full complement of members. He wound up taking on investments and accounts also, as a consequence of all the other members, and the Chairman too, retiring in course of time.

Over the past three years, Mr. P. A. Balasubramanian, Member (Actuary), IRDA, who retired on May 31, 2005, has shouldered a colossal burden, investment portfolios of companies and their financial statements being the core of what a regulator needs to track. The actuarial aspects of the industry form its very foundation, more so with the Appointed Actuary being accorded a central role in the scheme of things as the eyes and ears of the regulator in the company.

Within days of his taking over on March 15, 2002, the Member in charge of investments retired. Since Mr. Balasubramanian had handled investments in Life Insurance Corporation of India (LIC) for eight years as Secretary, Chief, and then as Executive Director, it seemed natural that he take on the responsibility. Later on, company accounts too fell to his lot, since it was integrated with the actuary's role.

"It was an attractive basket of portfolios for me since all areas were interconnected, but it was also a very hectic time," he says, looking back on his days as Member, IRDA.

Going into details, he says that initially they were not able to go into sufficient depths on the actuarial side since the regulatory mechanism was still in startup mode. But his LIC background pointed out the gaps and grey areas, and he tried to bring in corrective action from the regulatory side. It became apparent that the Member (Actuary) should be involved in the final decision on regulations even if separate members are in charge of investments and companies' financial statements, he says out of experience in dealing with the intertwining of the disciplines.

He learnt a lot, he says refreshingly. "With my background working in a protected environment in a public sector unit, I had limited exposure to global actuarial practices and valuations. Later, when exposed to new practices, I had to become open to the learning process and got more insight into actuarial practices, which were reflected in actuarial valuations and reports submitted by different Appointed Actuaries."

Many aspects of a changing market were reflected in the work he encountered in these interesting times. And they have led to lessons he has distilled from them. One of them is that the Regulator needs to deal differently with old and new players due to the legacy practices of the former. "We need to keep a balance," he says reflectively.

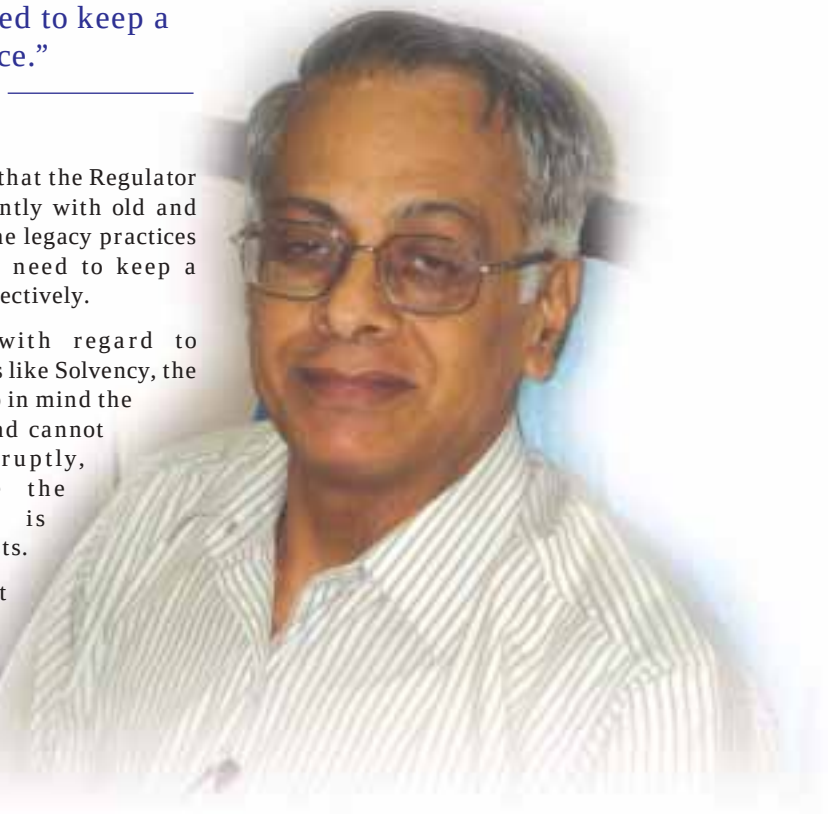
> "...the Regulator needs to deal differently with old and new players due to the legacy practices of the former. We need to keep a balance."

For example, with regard to compliance on aspects like Solvency, the Regulator has to keep in mind the existing practices and cannot change things abruptly, particularly since the ultimate goal is policyholders' interests.

This matter, as it has been discussed, decided upon and reopened for discussion, has raised some actuarial issues, he concludes. Namely, the liability of Solvency margin has to be borne by the shareholders but a company will charge for the same to premiums. But in the case of the large player this has been added to policy liabilities. "This will affect the Surplus," he points out.

Normally solvency capital on a risk is expected to be on the books till the pertinent policy is on the books, and then rolled over. In the case of LIC it actually belongs to the policyholder so it has to be returned to him when the policy exits the books, he says in what is his take on the complications of the issue.

These are features that a company has developed for a number of years. So their financials and need for solvency margin have to be approached differently – we have to look at it holistically and see what various hidden reserves the company may have created and their implications for solvency requirements.



Speaking of an actuarial knot-typical of a new-born industry - that he helped loosen as a Regulator, Mr. Balasubramanian says: "When new companies were registered and some launched participating policies, some wanted to declare bonuses early on due to competitive pressures even where they had not yet gathered actuarial surpluses, the reason being expense overruns and new business strain."

"I could take the initiative for addressing issues by working with senior colleagues in the actuarial profession," he says.

They took the view that the Regulator could not ask the shareholders to meet the deficit that arose in the policyholders' funds but could insist that, according to section 49 of the Insurance Act, bonuses could be declared only out of actuarial surpluses in policyholders' funds. Therefore IRDA could imply that they could build up the inadequate policyholders' funds through an irreversible transfer of funds by shareholders to enable compliance to section 49.

"Thus we ensured that actuarial best practices were followed. The profession and the Regulator could come to a reasonable, acceptable solution."

The second intervention was with regard to the review of actuarial returns of insurance companies. The review panel involving senior actuaries gave greater insight into actuarial principles and the management of insurance companies. "Thanks to the participation of Mr. K. P. Narasimhan and Mr. N. K. Shinkar, to whom we are deeply indebted, we could strengthen actuarial practices specially with regard to reserving," he says.

"Such aspects as provisions for the rider benefits and for policies lapsed but likely to be revived, presentation of actuarial returns and certain modifications ensuring consistency have helped improve the quality of actuarial reports. We have found that more reports are now meeting the expected standards."

The third incident Mr. Balasubramanian recalls is the streamlining of provisions for IBNR (incurred but not reported) and IBNER (incurred but not enough reported). "This is an area of challenge because it has to be supported by adequate data," he says, adding that thanks to the initiatives of Mr. C. N. S. Sastry, Advisor to IRDA, there is a new initiative to standardise the approach to data collection and estimation.

Many initiatives were taken in the areas of investment and accounting. With a view to bringing in wholeness in regulations and plugging gaps, especially in the regulations relating to investments and preparation of financial statements, "thanks to support by internal staff and feedback from insurers, we could issue quite a lot of clarifying circulars to companies. It was a pleasure and an education working with Mr. T. S. Viswanath and Dr. A. K. Bhattacharya," recalls Mr. Balasubramanian.

'Some critical areas are on-site supervision and market conduct, and these are getting attention.'

He is not without regrets though. When, in 2002-03, the Regulator wanted to give an impetus to the development of pension products, a committee of actuaries led by Mr. Shinkar created a very good model of a standard pension product that should have been given a lot of thrust by the industry to introduce. "I feel sad it was not taken to its logical end, specially since the variety of products in pension is confusing. This would have been a good standard."

A word about the current debate with regard to unit linked insurance products? Of late they have really become popular, he says, but as an investment product it is a risky one for the insured, as he has to assume the risk and needs to make an informed decision.

"It is not clear whether proper advice is being given and I fear misselling," he says, adding that the responsibility is on insurance companies to tender and document proper advice. Given the nature of this product, continued disclosures to the policyholder related to investments under the product should become part of best practices in this industry.

On the ongoing work of the Regulator, Mr. Balasubramanian says that with robust regulations in place the task of the Regulator now is to ensure it is followed. Some critical areas are on-site supervision and market conduct, and these are getting attention. "But the Regulator needs resources and the insurers need to provide comfort to the Regulator in these areas and the sooner it is done the better."

And back to his native topic – actuarial expertise development – this, he says is a special responsibility of the Regulator, since the Authority has to supervise and monitor the performance of the Appointed Actuary system.

And for that the Regulator itself needs a strong actuarial team, he says. At present, it is facing constraints of actuarial personnel and other limitations – something that needs urgent handling.

Looking back he says, "I enjoyed freedom in my area of work under both Chairmen, Mr. N. Rangachary and Mr. C. S. Rao, and benefited from the depth of their experience which guided me to a gentler management style!"

Post-retirement, Mr. Balasubramanian would be associated as Consulting Actuary advising the Authority on all actuarial matters.

Welcome...

K. Nitya Kalyani

From one regulator to another, it has been a lateral shift for Mr. C. R. Muralidharan who joined IRDA from Reserve Bank of India (RBI) in early May as Whole-time Member in charge of investments, accounts of insurers and intermediaries and off-site monitoring of insurance companies.

IRDA already has members from the insurance industry overseeing life, non-life and actuarial matters, and a new member with financial sector regulation as core domain expertise brings a new dimension into the composition of the Authority. It underscores the contemporary direction of the Regulator in implementing regulations and monitoring companies through on-site inspections and by building a robust offsite monitoring system.

Coming from the Reserve Bank of India where he was in the Department of Banking Operations and Development (DBOD) for 10 years, the last four of them heading it as Chief General Manager, the 57 year old Mr. Muralidharan can lay claim to the experience of creating and implementing successfully the new regulatory framework for banks in a rapidly changing environment.

It was in this period that new private banks were being licensed after decades and on the cards were an entire gamut of reform measures aimed at moving the banking system to an era of transparent balance sheets as per new prudential norms.

The regulatory phases that the insurance industry is going through and that the IRDA is both initiating and supervising, is similar in ways to what happened in the banking industry a decade ago.

A closed industry was broadbased in both cases, the difference being that private sector and foreign ownership was never alien to the banking systems unlike in the insurance industry. Regulation was made explicit and transparent once the industry welcomed new players.

New rules of the game according to Basle Core Principles for Bank Supervision pointed to the new directions in one case while IRDA's regulations based on best practices among world regulators, distilled to fit Indian conditions do the same in the other. In both cases the existing public sector units were a major factor in the market and, as Mr. Muralidharan puts it, "sequencing of reforms had to be done very carefully."

That the RBI did it without retracing its steps is something he recalls with satisfaction. The DBOD steered the industry through the entire process of cleaning up the balance sheets, the turnaround of the public sector and the old private sector banks including three public sector giants that turned sick and also herding them through a couple of mergers involving the old and the new, the public sector and the private sector.

This specialised experience in the supervisory framework is what the new member will bring into his work in the insurance sector. "When the industry is growing is the time to put a robust offsite monitoring systems in place," Mr. Muralidharan says, following the supervisory principles laid out by the International Association of Insurance Supervisors (IAIS).

In the last few months of his work there, the RBI ushered in the second phase of reforms with the release of the discussion paper on ownership and governance issues. "The entire initial reforms moves dealt with balance sheet items," he explains, "now in the second stage are those issues that transcend it."

Just as in the banking industry, the pattern seems to be falling in place in the insurance industry also. Accounting standards – a uniformity for which is being felt in international supervisory circles increasingly – is another area that Mr. Muralidharan will be looking after, contributing and participating in debates as they evolve for the insurance industry.

And what does he do for a hobby? "I read non-fiction," he says. And a recent read of his – The Tipping Point by Malcolm Gladwell – absorbed his interest. The sociological bestseller on what really brings about change may just have a very practical bearing on what Mr. Muralidharan is going to handle in the next few years!

Counter point to that is his interest in music – 'the very tradition bound, older, schools within Carnatic music." With that combination of affinity to the old and the new, his work at IRDA is bound to be interesting to all concerned!

Actuaries Review Committee Reconstituted

IRDA has reconstituted the committee consisting of senior actuaries to oversee if the the work of the Appointed Actuaries of insurance companies is as per Regulations. The circular issued by IRDA dated 17th May, 2005 reads as follows:

Re : Reconstitution of the Actuarial Review Committee

The Authority reconstitutes the committee consisting of senior actuaries to go through statements, documents etc. relied by the Appointed Actuaries in the course of their work to satisfy the Authority whether the appointed actuaries have carried out the requirements of the regulations made by it. This committee will, in addition to the formats prescribed by the Appointed Actuary Regulations made by the Authority, design, formulate its own method of satisfying itself about the quality of work of Appointed Actuaries. In pursuance of this, the Authority hereby appoints the committee which will consist of the following persons:

1. Shri P. A. Balasubramanian, Member (Actuary), IRDA
2. Shri K. P. Narasimhan
3. Shri N. M. Govardhan

The Committee, in consultation with the Authority, is authorised to engage such other consultants and actuaries in the course of its work as it considers necessary from time to time.

Mr. K. Subrahmanyam, Executive Director (Life Insurance and Actuarial), IRDA will act as the convener of the committee.

This circular supercedes our earlier circular dated 29th May, 2002.

sd/- C.S. Rao - Chairman

IRDA RECASTS GUIDELINES FOR ONLINE TRAINING INSTITUTES

IRDA had issued a notice dated March 9, 2005 with draft guidelines and instructions applicable for approval/renewal of online agents training institutes including in-house training institutes of insurers. In consideration of the comments and suggestions received by the Authority in response to this notice, final instructions and guidelines have been issued by

Mr. T. K. Banerjee, Member (Life) under the duties, powers and functions of the Authority and are to be complied in conjunction with Section 42 of the Insurance Act and Insurance Agents Regulations made by the Authority.

The text of the instructions and guidelines, placed on the website of the authority (http://irdaindia.org/ati/ati_final_guideline.pdf) reads as follows:

May 24, 2005

STANDARD INSTRUCTIONS AND GUIDELINES APPLICABLE FOR APPROVAL/RENEWAL OF ON-LINE AGENTS TRAINING INSTITUTES (PORTALS) APPROVED/ TO BE APPROVED BY THE AUTHORITY

These instructions/guidelines are applicable to all the on-line training institutes. These guidelines will be effective May 25, 2005. Any violation, non-adherence and breach of these instructions shall be treated as violation of provisions of IRDA Act, Insurance Act and regulations made thereunder requiring practical training for the grant of licence to an insurance agent and renewal thereof and met with penal provisions including fine, suspension, and cancellation of the approval granted by the Authority from time to time.

1. The applicant shall have to undergo atleast 100 hours' training in life or general insurance business and the time allotted for composite training shall atleast 150 hours', where such applicant is seeking licence for the first time to act as an insurance agent. However, time for revision test at the end of each chapter or at the end of training shall not be counted in 100 or 150 hours. The approved on-line training institutes (portal) will cover the syllabus prescribed by the Authority during this period.
2. The training duration should be minimum 18 days for 100 hours' training and 27 days for 150 hours training with maximum 6 hrs per day. Similarly, the training duration should be minimum 9 days for 50 hours training and 5 days for 25 hours training at the time of renewal with maximum 6 hours per day. The maximum time permissible for completion of training will be 30 days for 100 hours, 45 days for 150 hours, 15 days for 50 hours and 8 days for 25 hours. The total hours per chapter may be decided by the

Institute according to the length of the chapter.

3. No product training/market survey should be included into this 150/100/50 hours' training. However, revision examination may form part of the training. The product training, if any, to be given by the insurance company should be over and above the minimum training hours prescribed by the Authority.

4. The attendance record (login and logout time) of the trainees should be maintained by the software (system) itself. After the training, the attendance record should be available in hard copy as well as softcopy at the Institute for inspection purpose.

5. Every Institute should have atleast one qualified permanent/ Part time faculty who is an Associate or Fellow from the Insurance Institute of India for each stream to solve the on-line queries of the students.

6. The Training Institute should have adequate arrangement in place to incorporate changes in the portal at short notice.

7. The employment details of the faculty/Web administrator whether full-time or part-time with payment made should be available at the Institute.

8. The sponsorship letter must be available with the training institute at the time of commencement of training session and thereafter kept for the record and inspection purposes. The sponsorship letter should contain the photograph of the applicant, his/her complete address and signature and the seal and signature of the sponsoring insurance company.

9. Database should be maintained by the Web administrator at the training institute giving details of candidates who have completed their training, name of the faculty/ administrator who solved the online user's problem during the tenure of the training. The record of test at the end of each chapter or at the end of the training on the basis of question bank of the training provided must be recorded in the database.

10. The fresh accreditation will be given on need basis and depending upon the availability of good infrastructure in the Institute for the purpose of hosting on-line training portal.

11. The initial approval will be for a period of one year and consideration of further renewal depends on the satisfactory compliance of requirements of accreditation and the training conducted during the period of approval.

12. The training institute must display the certificate of accreditation to impart training issued by the Authority at the training institute and also IRDA Registration number should be made available in the home page of the portal.

13. No marketing fee/consultancy fee payment is permitted for getting the trainees.

14. It will be the responsibility of the Insurance Company to check the status of the institute before sponsoring any candidates for training. If name of the training institute is not displayed on IRDA web-site, no insurer should sponsor the candidate for training to such an institute.

15. (i) The existing Institutes may convey their willingness to abide by these instructions on a simple form. The information may include: Name & Address of the Institute, Date of Accreditation of the Institute, Expiry date of validity of the Accreditation, Accreditation granted for Life/ General or both, Name of the In-charge of the Institute.

    (ii) The above information must reach the Authority within 15 days from the date of issuance of these guidelines. The consolidated list of approved training institutes will then be placed and updated from time to time on our web-site so that Insurance Companies can approach them for conduct of training.

16. Prior approval of the Authority must be obtained if the Training Institute intends to change any of the particulars, details or provisions already approved by the Authority. All such changes would be simultaneously incorporated on IRDA web-site.

17. There must be an exclusive portal for the on-line agents training and on the portal no advertisement should be displayed.

18. It is necessary to provide separate user name/password to the IRDA as a user (candidate) as well as administrator to monitor the web site

(on line portal).

19. All the training institute who wish to apply the on-line training accreditation, may be required to make a live demonstration of the portal at the Authorities headquarters at Hyderabad.

20. The training completion certificate must be issued by the In-charge of the On-line training institute under his seal and signature and user applicant should not be allowed to print the certificate from the system itself.

21. A set of technical points (Annexure I) must be incorporated for new/ renewal of the license for on-line training institutes (portals).

CHAIRMAN

Report Card:LIFE

Year starts with 44% growth for life companies

The life insurance industry underwrote a premium of Rs.1,26,029.86 lakh in the first month of the financial year 2005-06.

The total Individual premium and Group premium underwritten were Rs.94,493.37 lakh (74.98 per cent) and Rs.31,536.49 lakh (25.02 per cent) respectively as against Rs.54,090.88 lakh (61.59 per cent) and Rs.33,732.67 lakh (38.41 per cent) underwritten in the corresponding period of the previous year. The premium underwritten towards individual single and non-single policies stood at Rs.6,149.30 lakh and Rs.47,941.58 lakh respectively accounting for 16,771 and 6,55,002 policies. The group single and non-single premium accounted for Rs.30,883.99 lakh and Rs.2,848.68 lakh.

LIC underwrote a premium of Rs.1,02,297.47 lakh during the period i.e., a market share of 81.17 per cent, followed by ICICI Prudential and HDFC Standard with premium underwritten (market share) of Rs.7,168.37 lakh (5.69 per cent) and Rs.3,036.56 lakh (2.41 per cent) respectively. The number of lives covered under various group schemes was 3,13,923 during April, 2005. The private players covered 52 per cent of lives under group schemes while LIC covered 48 per cent of lives. Tata AIG covered 25.53 per cent of lives. The new players underwrote first year premium of Rs.23,732.39 lakh. In terms of policies underwritten, the market share of the new players and LIC was 16.01 per cent and 83.99 per cent as against 13.38 per cent and 86.62 per cent respectively in 2004-05.

First Year Premium Underwritten by Life Insurers for April, 2005

(Rs. in lakhs)

Sl No.	Insurer	Premium		% of Premium	Growth (Per Cent)	No. of Policies / Schemes		% of No. of Policies	Growth (Per cent)	No. of lives covered under Group Schemes		% of lives covered under group schemes	Growth (Per cent)
		April, 04	April, 05	April, 05	April, 05	April, 04	April, 05	April, 05	April, 05	April, 04	April, 05	April, 05	April, 05
1	**Bajaj Allianz**	**1,378.97**	**2,917.36**	**2.31**	**111.56**	**6,073**	**14,445**	**1.76**	**137.86**	**458**	**4,319**	**1.38**	**843.01**
	Individual Single Premium	283.80	1,198.86			363	2,132						
	Individual Non-Single Premium	1,089.82	1,571.41			5,706	12,305						
	Group Single Premium												
	Group Non-Single Premium	5.35	147.09			4	8			458	4,319		
2	**ING Vysya**	**221.32**	**198.08**	**0.16**	**-10.50**	**5,587**	**718**	**0.09**	**-87.15**		**309**	**0.10**	
	Individual Single Premium	27.32	0.31			4,022	46						
	Individual Non-Single Premium	194.00	186.96			1,565	669						
	Group Single Premium		7.15								45		
	Group Non-Single Premium		3.66				3				264		
3	**AMP Sanmar**	**230.25**	**847.65**	**0.67**	**268.15**	**2,215**	**3,995**	**0.49**	**80.36**	**1,045**	**16,121**	**5.14**	**1442.68**
	Individual Single Premium		545.58				896						
	Individual Non-Single Premium	229.05	209.44			2,213	3,093						
	Group Single Premium		21.69										
	Group Non-Single Premium	1.20	70.95			2	6			1,045	16,121		
4	**SBI Life**	**1,118.96**	**1,315.74**	**1.04**	**17.59**	**4,413**	**2,547**	**0.31**	**-42.28**	**18,186**	**16,528**	**5.26**	**-9.12**
	Individual Single Premium	371.69	101.26			150	80						
	Individual Non-Single Premium	228.52	289.82			4,260	2,423						
	Group Single Premium	408.25	906.20							4,963	8,016		
	Group Non-Single Premium	110.50	18.46			3	44			13,223	8,512		

5	**Tata AIG**	**1,751.72**	**2,745.75**	**2.18**	**56.75**	**16,752**	**23,485**	**2.86**	**40.19**	**19,318**	**80,131**	**25.53**	**314.80**
	Individual Single Premium												
	Individual Non-Single Premium	1,195.94	2,572.41			16,747	23,458						
	Group Single Premium	50.07	62.79							6,772	7,541		
	Group Non-Single Premium	505.72	110.56			5	27			12,546	72,590		
6	**HDFC Standard**	**1,378.82**	**3,036.56**	**2.41**	**120.23**	**7,401**	**12,481**	**1.52**	**68.64**	**11,210**	**11,087**	**3.53**	**-1.10**
	Individual Single Premium	540.88	552.63			779	2,434						
	Individual Non-Single Premium	766.60	1,884.78			6,600	10,029						
	Group Single Premium	71.33	33.86			22	13			11,210	5,488		
	Group Non-Single Premium		565.30				5				5,599		
7	**ICICI Prudential**	**5,401.22**	**7,168.37**	**5.69**	**32.72**	**32,589**	**37,483**	**4.57**	**15.02**	**1,919**	**5,642**	**1.80**	**194.01**
	Individual Single Premium	859.93	394.99			693	274						
	Individual Non-Single Premium	3,492.72	6,170.10			31,882	37,194						
	Group Single Premium	1.07	15.48			1	9			214	4,679		
	Group Non-Single Premium	1,047.50	587.80			13	6			1,705	963		
8	**Birla Sunlife**	**2,239.91**	**1,815.42**	**1.44**	**-18.95**	**6,985**	**7,412**	**0.90**	**6.11**	**953**	**904**	**0.29**	**-5.14**
	Individual Single Premium	86.40	122.23			1,775	1,976						
	Individual Non-Single Premium	1,413.61	1,577.75			5,208	5,426						
	Group Single Premium	31.90	50.92							268	357		
	Group Non-Single Premium	708.00	64.53			2	10			685	547		
9	**Aviva**	**721.92**	**1,089.05**	**0.86**	**50.86**	**3,540**	**3,974**	**0.48**	**12.26**	**10,176**	**6,045**	**1.93**	**-40.60**
	Individual Single Premium	30.96	12.42			28	168						
	Individual Non-Single Premium	671.05	1,048.33			3,507	3,806						
	Group Single Premium		9.61								90		
	Group Non-Single Premium	19.91	18.69			5				10,176	5,955		
10	**Kotak Mahindra Old Mutual**	**507.03**	**642.42**	**0.51**	**26.70**	**1,253**	**3,131**	**0.38**	**149.88**	**21,325**	**5,353**	**1.71**	**-74.90**
	Individual Single Premium	0.70	45.96			2	92						
	Individual Non-Single Premium	124.00	545.95			1,248	3,034						
	Group Single Premium												
	Group Non-Single Premium	382.32	50.51			3	5			21,325	5,353		
11	**Max New York**	**394.20**	**1,601.82**	**1.27**	**306.34**	**2,506**	**19,360**	**2.36**	**672.55**	**4,655**	**4,128**	**1.31**	**-11.32**
	Individual Single Premium	27.28	13.92			3	16						
	Individual Non-Single Premium	354.64	1,538.69			2,487	19,336						
	Group Single Premium												
	Group Non-Single Premium	12.29	49.20			16	8			4,655	4,128		
12	**Met Life**	**174.61**	**347.11**	**0.28**	**98.79**	**688**	**2,029**	**0.25**	**194.91**	**12,147**	**12,659**	**4.03**	**4.22**
	Individual Single Premium	1.09	16.84			4	23						
	Individual Non-Single Premium	117.63	229.12			676	1,990						
	Group Single Premium												
	Group Non-Single Premium	55.89	101.15			8	16			12,147	12,659		
13	**Sahara Life**		**7.06**	**0.01**			**317**	**0.04**					
	Individual Single Premium												
	Individual Non-Single Premium		7.06				317						
	Group Single Premium												
	Group Non-Single Premium												
14	**LIC**	**72,304.62**	**1,02,297.47**	**81.17**	**41.48**	**5,82,443**	**6,89,055**	**83.99**	**18.30**	**2,64,535**	**1,50,697**	**48.00**	**-43.03**
	Individual Single Premium	3,919.25	34,079.96			8,952	1,10,101						
	Individual Non-Single Premium	38,064.00	39,576.59			5,72,903	5,78,338						
	Group Single Premium	30,321.37	28,640.92			588	616			264,535	150,697		
	Group Non-Single Premium												
	Total	**87,823.55**	**1,26,029.86**	**100.00**	**43.50**	**6,72,445**	**8,20,432**	**100.00**	**22.01**	**3,65,927**	**3,13,923**	**100.00**	**-14.21**

Note: 2004-05 provisional data — In the case of LIC, the number of policies under ISP may be read as 16,25,292.

Fitness For All

—How the four main stakeholders can benefit from health insurance

Insurers, the insured, hospitals and TPAs are unhappy with the current health insurance scenario, points out *G. V. Rao*, while also proposing a framework to improve the situation.

Of the lot, it's the healthiest. Health insurance is the fastest growing portfolio in the nation's non-life insurance sector, logging in a growth rate of 27 per cent in 2003-04. With a premium volume of over Rs. 1,200 crore, out of the overall non-life premium of Rs, 16,000 crore, it contributes over seven per cent of the total.

It was only in 1988 that health insurance covers were first introduced in India. In about 16 years, the level of popularity it has achieved is high; it has surpassed other types of traditional insurances, such as Engineering and marine insurances, that began to be transacted over several decades ago. Health premium in volume today ranks third, next only to the Motor (40 per cent) and Fire insurance (19 per cent) portfolios.

If there is some disappointment expressed in some quarters, that Health insurance is not rapidly progressing in India, the criticism appears to be misplaced; it probably shows an unconcealed impatience that it could have developed even faster. It is not that the insurers or their distribution channels have done anything spectacular to push their sales or create a special awareness for them in the buyers.

It is simply because the customers themselves are pressing the purchase button, hard and extensively. Health self-care consciousness has reached a high level among the population that can afford to pay the premiums. The public health system having broken down, all those who can afford to pay the premium would want to buy health insurance; and then begin to hope that their insurers would pay up, if and when they are put to test.

Types of cover

Health insurance covers include annual covers bought by individuals for themselves and their families, by the corporations for their employees and occasionally for their dependents, and the overseas medical insurance for those going abroad on short visits. Overseas medical insurance has gained rapid popularity on account of the high medical costs in the countries to be visited, the tendency of hospitals there not to entertain patients without proof of insurance cover or, in some cases, the situation that visas cannot be obtained unless one produces proof of an overseas medical insurance policy.

But the tales of unsettled claims and the technicalities involved in getting them settled are rising like a tide, though not yet of the tsunami type.

> There has to be a minimum amount of sentiment, idealism and concern on the part of all those involved in this business – what is desirable is less commercialism and more humane consideration.

Insurers are unhappy that they are losing their financial health due to the health covers. Hospitals grumble that their claim invoices are unpaid, and that they are unfairly questioned. The TPAs, the special agents set up as expert intermediaries, are indignant that neither the hospitals nor the insurers would listen to them. The claimant customers are bewildered, and often furious, as large chunks of claim amounts are either chopped off their claims altogether repudiated. No wonder the offices of ombudsmen, the adjudicators of personal lines' grievances, are flooded with health claims that constitute more than 80 per cent of the total.

IRDA, which organises the market environment and ensures fair play, is perplexed that all the stakeholders, without exception, seem discontented with the system that has been created to ensure fairness, equity and satisfaction. Why have things gone wrong for everyone?

Insurers' arguments

Insurers claim that what they sell is insurance – for diseases and accidents that may be contracted or happen in future – and that they are not in the business of paying for the treatment of chronic diseases and for those diseases known to the client before buying insurance. Hospitals indulge in overcharging and subjecting patients to unnecessary tests to keep the meter running. What irks the insurers is that hospitals often have dual rates: one for the insured and the other for the uninsured direct payers.

Customers' arguments

Claimant customers complain that no questions were asked of them before they parted with their premiums; at least they were not educated enough by insurers on the limitations of the cover at that point of time. The high medical costs incurred should be tackled by insurers with the hospitals directly and not negotiated through them. Hospitals, they agree, not only overcharge but are also unresponsive and often uncaring. Having received the premium, claims should be paid by insurers without questions and hassles. Is that not the sole purpose for which insurance is taken?

TPAs' arguments

The TPAs feel that they have been

rendered irrelevant, both by the hospitals and the insurers, and occasionally by even the claimants, who all resent their involvement in the entire process designed to render fair and prompt service to all the three stakeholders. They cannot pay the hospitals unless insurers provide them with funds, which they delay. They are always in deficit. Hospitals do not bother to reply to their queries for justifications of charges and medical tests. Hence claims do not get paid in time. It is indifference all the way.

Hospitals' arguments

Hospitals claim they ought to collect payments directly from patients; they have no time either for TPAs or the insurers. There is not enough business flowing from insurers to justify hospitals having to answer queries that touch a raw nerve in them. Hospitals would, therefore, not admit new patients till their old dues are liquidated. They see no need to provide supportive argument for every diagnostic tests already performed or the costs thereof, though they do admit charging higher for insured customers because of time delays in receiving monies. They say that the insurers, the patients and the TPAs need the hospitals more than vice-versa.

Whither the solution

This merry-go-round has thus gone on long enough. Most of the affected parties ultimately try and find a way out to beat the system, as it happens in every other industry, to get their share of benefits. The second time around it is definitely not as bad as the first experience was; one now knows where the boundary ropes are located. But can't the industry devise a better system that causes less dissatisfaction and friction among all the stakeholders?

To prescribe a system that substantially serves that objective requires more foolhardy courage rather than downright wisdom. But it is perhaps worth an effort to attempt doing it to reduce the inequities and the unfairness of it all for the rapid promotion of this cover among many more uninsured millions. One cannot give up hope; nor should the stakeholders attempt to make the situation a greedy financial opportunity out of the necessity of those inflicted with pain, suffering and fear of survival. There has to be a minimum amount of sentiment, idealism and concern on the part of all those involved in this business. What is desirable is less commercialism and more humane consideration.

The ideal system would have the primary objective of giving consumers more responsibility and control to manage their healthcare costs in terms of the premiums they pay and the claims they receive. Increasing premiums will lower the demand for health cover by making it less affordable. Consumers must make insurers aim at reducing premiums to make health insurance more affordable for many. What can consumers do to help insurers reduce premiums and how?

> Reduction in medical costs and in the resultant premiums, and giving the insured partial control or participation in management of the system, have a number of advantages.

Hospitals must endeavour to reduce medical costs without sacrificing the quality of care. They appear unconcerned about both these aspects. They do not inform the incoming patients about how their systems work, and neither do they bother to get feedback from the patients when they are discharged. They are, in the perception of most patients, medical mercenaries whose patient-to-doctor relationship is unsatisfactory.

The insured community must realise that it is insurance they are buying, for the fear of contracting future illnesses, and not for regular medical treatment of existing illnesses for which either the government hospitals or their pockets have to be searched. But for the large number of people who regard health insurance as a form of insurance, the system must be made less cumbersome and more equitable. What is wrong with the present disposition? How can it made be more equitable?

Equitable proposal

Medical costs for treatment vary from place to place, and also from hospital to hospital in each place. The costs for diagnostic tests, surgeries, treatments, medicines, consultations etc. do vary depending on the place where they are incurred and the category of the hospital employed. Yet, the level of premiums asked for from the insured are the same, irrespective of the place and the hospital employed, and the medical costs are only defined as the total limit chosen. In effect this would mean that the insured persons living in semi-urban and rural areas, whose costs are comparatively less, are subsidising the increased costs incurred for similar treatments by the urban and city dwellers. This is unfair.

The more equitable proposal would be for insurers to define the maximum amounts for each of the several items of common treatment at the same levels, irrespective of the residence of the insured in India and irrespective of the category of the hospital chosen. If the insured chooses to go to a higher category of hospital, he can do so but then he would meet the difference in costs.

This single measure would involve him in negotiating the hospital costs, and put the hospitals and insured in deciding on the costs and the necessity of taking the test itself. Such defined tables of benefits or costs should be priced ensuring that they are reasonable for a majority of the insured in a semi-urban setting or even slightly lower. The total limit as the sum insured can still remain at present levels.

Another measure for insurers to consider is the involvement of the

insured as a co-insurer. Insurers should reimburse only 80 per cent of the costs payable under the policy, giving an incentive to the insured to reduce medical costs through his personal involvement. Most of the insured do not want a full service provider, but one who will reimburse them substantially and make the burden less onerous.

The cost-benefit analysis should be self-evident. This will ensure active participation of the insured in claims management, as they are given an incentive of lower premiums.

The point made is that those that really need insurance and are genuine in their approach should not be penalised just because a few claimants highjack the system. Reduction in medical costs and in the resultant premiums, and giving the insured partial control or participation in management of the system, have a number of advantages.

Insurers to shape outcome

Insurers should encourage value creation – this means making the consumer experience more positive and less unpleasant, the outcomes less uncertain, the premium prices more affordable – as the benefits payable are jointly negotiated. The table of maximum benefits will provide a level field to all the insured irrespective of their residential addresses. But insurers need to reduce premiums downwards substantially to make the proposition fair to both. Reducing premiums will increase demand for health insurance. Joint control on medical costs will breed improved trust in each other.

The target group for insurers should be those individuals in the lower middle class, and in the lower crust of the upper middle class that do need affordable health insurance. The rich and those employed in corporates are well-placed on this count, for they are getting lower and subsidised premiums and as well as hefty reimbursements. For this situation, making health insurance less than profitable, the insurers themselves are responsible. They should provide statistics of premiums and claims for individual customers, corporate employees and overseas travellers in the interest of transparency of disclosure. That is the starting point.

The leadership role to shape a healthy market lies with the insurers. Their basic objective should be to increase the number of insured, and not just to raise the premium volume.

The leadership role to shape a healthy market lies with the insurers. Their basic objective should be to increase the number of insured under medical insurance and not just to raise the premium volume. For this desirable outcome, out-of-box thinking and new ideas should be tried out.

The framework suggested above has more merits than demerits. It can be modified. In addition to the present schemes, it can be offered as an alternative – as an experimental measure – and tested. But not doing anything at all, with each stakeholder pointing a finger at the other, has gone on long enough. There is no one speaking for the consumer. As an informed consumer and a concerned ex-insurer, this is my proposal. What is your reaction?

The author is retired CMD, The Oriental Insurance Company.

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The Small Man's Best Friend

– What the Insurance Ombudsman means to the lay policyholder

For insurance policyholders, the Ombudsman route to redress grievances is cost free and perhaps the speediest remedy available in the present day scenario, writes *G. Gopalakrishna* while recapitulating the background against which the Ombudsman operates.

Life insurance intrinsically provides an alternate source of income when the first source, viz., the insured's working capacity, ceases due to old age, death or disability.

As a welfare dispensing scheme, insurance must not only provide social security measures to the needy, but also ensure that the enforcement mechanism is effective, and that the incumbents have easy access to such mechanisms, either judicial or quasi-judicial. The dispute settlement mechanism and the redressal machinery ought to preserve and bring in the fruitful and beneficial results in the matter of social security of life insurance to the insured – customers and the beneficiaries.

As social security is based on the principle of *social justice,* which is the mandate of the Indian Constitution, it is the duty of the courts to take care of the interests of those people who are the beneficiaries of such concept, by providing an "easy access to justice," to ventilate their grievances.

Several factors have put the present day customer in the limelight – the phenomenal growth of the services industry, the encouragement of competition by the Government in various sectors that were nationalised after Independence (such as banking and insurance), the rapid growth of consumerism and the influence of consumer welfare legislation. The insurance industry is therefore forced to do a rethink on the customer, his needs, his preferences and the solutions necessary to serve him and satisfy him.

An insurance company typically has three classes of customers: the external customers viz., the policyholders, the internal customers, namely, the field force or agents, and the employees. Even without the compulsions of competition the public sector LIC has taken several initiatives to take care of its external customers over the past years. For instance, a massive reorganisation was undertaken in the 1980s, whereby the entire servicing of policies, right from the issue of policies to the settlement of claims, was decentralised to the branch office. With a network of over 2,000 branches, this could take insurance sales and service to nearly the doorsteps of the customer. A thorough HRD initiative and training for all classes of employees was brought about, which resulted in appreciable improvement in the knowledge, skills and attitude of the employees and instilled in them a greater degree of customer orientation.

> Though the concept is new to India, the institution of Ombudsman as a redressal authority is gradually gaining popularity. With the entry of new players, both in Life and Non-Life, the awareness is bound to grow.

The LIC has set up several mechanisms, such as the Customers Affairs Committee, Zonal Advisory Boards and Divisional Policyholder Councils, which are meant to act as the customer's mouthpiece. Customers' meets are organised for greater interaction. All these measures have greatly helped to build the image of LIC as a customer friendly organisation.

Despite all these improvements, there are bound to be instances of perceived deficiency of service and dissatisfaction in the degree of service rendered. The insurance policy is a long-term contract and involves many legal issues, which in turn sprouts customer grievances. Continuous monitoring is hence required to maintain high standards of efficiency and service.

LIC has complaints handling cells that receive the complaints, register them with a unique number, follow up the matter with the operating units and try to give a satisfactory reply and compliance to the complainant.

Besides these arrangements, the public is free to take recourse to Government's highest grievances redressal mechanism, at the Directorate of Public Grievances (DPG), and the DPG refers such complaints to the insurer. There are other informal mechanisms, such as helpline programmes in the electronic media, public complaints appearing in the print media, customer meets addressed by senior officers, etc.

The Malhotra Committee, 1994 was set up to frame insurance sector reforms. While recommending privatisation of the insurance sector, the Committee also acknowledged the need to protect consumers' interests, with the establishment of Ombudsman. The notification of the Draft of Redressal of Public Grievances Rules, 1998 was one of the concrete steps taken to implement

these recommendations and, more importantly, create a framework capable of tackling the hazards of a liberalised insurance sector.

The insurance Ombudsman

The Ombudsman can act as counsellor and mediator for matters within the terms of reference, if requested to do so by the insurer and the insured. The word 'Ombudsman' is Swedish, meaning the right of individuals to complain against public authority/establishments/ administration.

In exercise of the powers conferred by the Insurance Act, 1938, the Government has framed the Redressal of Public Grievances Rules, 1998, which apply to life and general insurance. These rules provide for the appointment of an Ombudsman who may be selected from those who have experience in the judicial, civil and administrative service, insurance industry etc.

The Ombudsman is empowered to receive and consider complaints under (a) any partial or total repudiation of claims by an insurer, (b) any dispute in regard to premium paid or payable in terms of the policy, (c) any dispute of the legal construction of policies in so far as such disputes relate to claims, (d) delay in settlement of claims, (e) non-issue of any insurance document to customers after receipt of premium.[1] The Ombudsman has quasi-judicial authority and his decision is binding on the insurer and the complainant. It can be contested only through a court of law.

Though the concept is new to India, the institution of Ombudsman as a redressal authority is gradually gaining popularity. With the entry of new players, both in Life and Non-Life, the awareness is bound to grow. The unique feature of the Insurance Ombudsman Scheme is that the awards and orders of the Ombudsman are binding on the insurance companies while the insured, if not satisfied with the award or order, can go to other redressal fora. However, a particular complaint that is already before a court/consumer forum/ arbitrator, or was decided upon by any such a forum, cannot approach the Ombudsman.

Other Legal Remedies

The policyholders have an option to approach civil courts or a high court under writ jurisdiction in certain circumstances. Some of the legal remedies available to the policyholders are:

It has been felt that the MRTP Act has become obsolete in certain respects, and that there is a need to shift the focus from curbing monopolies to promoting competition. So, the Parliament has recently taken steps to enact an Act called the Competition Act, 2002.

(a) Civil Courts

Before the setting up of the Consumer Dispute Redressal Authority (CDRA), under the Consumer Protection Act, 1986, the only legal remedy available to the consumers of insurance service was to file a suit in the civil courts. If we take into account the unequal strength of the parties, all the odds are against the consumer. Therefore, only cases that involved the interpretation of complex legal provisions would be filed. The civil courts seem to have leaned in favour of the insurer on the basis of the principle that a contract of business is a contract of utmost good faith.

Most of the litigation with regard to deficiency of service now takes place in CDRA. These Agencies, however, do not have the power to decide on the validity of terms and conditions of the insurance policy or validity of the rules framed by the Corporation. For disputes of this kind, the civil court will continue to be the proper forum.

(b) Monopolies Restrictive Trade Practices (MRTP) Commission

Economic liberalisation necessitated sweeping amendments of the MRTP Act in 1991. The Commission is now an appropriate forum to ensure that healthy forces of competition prevail in the market place.

A recent significant development in this direction has been the Parliament's move to overhaul many of its legislations and introduce new bills to bring its legal regime on par with that of the other countries.

It has been felt that the MRTP Act has become obsolete in certain respects, and that there is a need to shift the focus from curbing monopolies to promoting competition. With the above objective, the Parliament has recently taken steps to enact an Act called the Competition Act, 2002.

The new law seeks to establish a Competition Commission of India with the mandate to eliminate practices that adversely affect competition, promote and sustain competition and protect the interests of consumers. The Commission is expected to take suitable measures for the promotion of competition advocacy, creating awareness and imparting training about competition issues which are relevant to today's opened up insurance sector.

(c) The Legal Services Authorities Act, 1987 also provides for referring the

pending disputes before any court or tribunal on a joint application to the Lok Adalats for compromise or settlement. The District Authority may refer such disputes to the Lok Adalats for determination.

The award of the Lok Adalats thereafter will be binding like a decree of the civil court and no appeal will lie to a higher court against the award. This award therefore differs from that of the Ombudsman, as it is binding on both the disputing parties. The Lok Adalats further have all the powers of the civil court in the matter of summoning and enforcing of the attendance of any witness and discovery and production of any document. However, no court fee is payable as in the case of proceedings before the Ombudsman.

These factors reflect that for insurance policyholders, the Ombudsman route to redress grievances is cost free and perhaps the speediest remedy available in the present day scenario. The ombudsmen all over the country has been doing a commendable job. By making the insured public more aware about the existence of this entity, by enlarging the jurisdiction of the Ombudsman by including all types of disputes relating to policies in Rule 12, by providing an appellate body to whom insurers can approach in case of their non-acceptance of recommendations/ award of Ombudsman and by providing an enforcement agency for recommendation/award of Ombudsman in the Rules itself, the Office of the Ombudsman can perhaps be more effective and inspire more confidence in the general public as well as with the insurers.

Protection through IRDA

The protection of consumers' interest received a tremendous boost with the enactment of the Consumer Protection Act, 1986. It is not that the consumers had no opportunity to receive redress for their genuine grievances earlier. They could always appeal to the higher authorities of the company or department against which they had a grievance. They could also indicate their options for having their grievances arbitrated. And there were always the courts as a last resort. All these fora have their merits and limitations.

Under the Consumer Protection Act, about 600 District Forums, more than 30 State Commissions and the National Commission have been functioning with the sole objective of resolution of Consumers grievances. Consumers nationwide have immensely benefited from these services for the past two decades.

The Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002 is of particular interest to the small, isolated and defenseless individual policyholders against the big, powerful and monolithic insurance companies.

For bank customers and insurance policyholders, specific grievance redressal machineries were created in the form of the Banking Ombudsman in 1995 and the Insurance Ombudsman in 1998. There are 15 Banking Ombudsmen and 12 Insurance Ombudsmen in the country. There is no cost involved in taking the grievances to the Ombudsman and generally the decisions are very quick, unlike the district forum where, due to heavy backlog of cases and certain unavoidable court formalities, petitions are difficult to be disposed of in quick time.

Pertinent in this context is the Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002. This new piece of law is of particular interest to the small, isolated and defenseless individual policyholders against the big, powerful and monolithic insurance companies. These regulations also bring in improved and useful measures ushered in by the new law for protecting the interests of insurance policyholders.

Insurance companies have been instructed to inform policyholders about the Office of the Insurance Ombudsman along with the policy bond. The Insurance Ombudsman has a mandate to redress grievances within three months.

The Insurance Ombudsman Scheme applies to all insurance companies, whether private or public, and operating in Life or General Insurance. As both the sectors face vigorous competition in the post Liberalisation Era, and may overlook customer grievances in the race to the top, effective legal mechanisms and easy access to justice are a must to preserve consumer interests.

As our learned forefathers said so eloquently, *Sarvejana Sukhinobhavanthu* ('May all people live in Happiness').

The author is retired Senior Officer, LIC of India.

The 'Guard' Father

— The multi-faceted role of the Insurance Ombudsman

Disputes are a way of life, and the Insurance Ombudsman has a critical role to play in settling issues between the companies and customers, writes *Gnanasundaram Krishnamurthy*.

Public administration is often seen as a necessary evil. While it is needed to keep the machinery rolling, it is often rampant with abuse of power, arbitrariness, misadministration, unfair decisions, errors and negligence. A neutral figure – the Ombudsman – is therefore deemed essential to strike a balance between the frayed administration at one end, and disgruntled citizens at the other.

The Indian Government has rightly decided that sectoral Ombudsmen are required to cater to the needs of specific industries, and the banking and insurance Ombudsmen came into being in 1995 and 1998, respectively. This writer had the privilege of working as Insurance Ombudsman in Mumbai for Maharashtra and Goa, and also was placed in additional charge in Chennai for Tamil Nadu and Pondicherry for a while. The experience was rewarding, as it surely must be for the industry as well as customers.

The system confers certain benefits on the customers – such as cost effective and speedy resolution of disputes, scope for mediation and absence of cumbersome procedural formalities. What makes it even more popular is that the awards of the Ombudsman give finality to the decisions, and companies normally implement them. Little wonder then that the grievance redressal mechanism – a kind of Agony Aunt – has found favour with the customers, albeit with a slow start initially.

The institution is set up in such a way that it enjoys the confidence of the companies as well, as it is their own institution, within the industry but outside the organisation. Industry officials assist the Ombudsman in organising the work with their technical knowledge, such as sorting out disputes, and contribute to the system in their own way. In the process, the learning experience shared by both fine-tunes justice delivery to the satisfaction of the companies and the customers alike.

Theory and practice

But a gap between theory and practice is not uncommon in any system. It is so, here also, as elsewhere. It starts right at the head of the institution, viz., the Ombudsman. Though the selectors largely ensure that a round peg fits a round hole, credibility of dispensation of justice can be ensured only by maintaining integrity, transparency consistency, and legal validity of decisions. Particularly in a system where appeal provisions are absent for the respondents, these acquire greater importance, lest the companies are pushed to an unenviable position of unfair disadvantage.

The system confers certain benefits on the customers – such as cost effective and speedy resolution of disputes, scope for mediation and absence of cumbersome procedural formalities. Little wonder then that the grievance redressal mechanism – has found favour with the customers.

While, either on the established principles of law or on the veracity of the documentary evidence produced, the verdict of the Ombudsman going against the companies or complainants cannot be grudged, instances are not wanting where the Awards have been found pronounced in direct contravention of the principles which already stood decided by the judicial forums. It has also happened that on identical issues, verdicts have differed from centre to centre. The companies suffer comparatively more in this process, as they have little or no alternative but to implement the Awards, despite remaining unconvinced.

A blank commitment to accept the Awards may not be in the interest of the companies themselves, particularly those in the public sector, dealing with public money and entrusted with the responsibility of holding it in trust. On the other hand, any attempt by the companies to thwart the process of justice delivery, by going to judicial forums on appeal in every case, cannot also be allowed, as it will defeat the very purpose of the establishment of the institution of Ombudsman.

The Law Commission has recommended the introduction of provisions to establish a full-fledged grievance redressal mechanism, including the constitution of a Grievance Redressal Authority (GRA) to replace the system of Ombudsman.

The provisions would also pave the way for appeals to the Insurance Appellate Tribunal and the Supreme Court.

However, it is not known when this recommendation will see the light of day. Even if it does, the interest of individual small policyholders cannot be speedily taken care of by such a mechanism, which the institution of Ombudsman seeks to achieve. As a via media, therefore, it is worthwhile continuing the system of Ombudsman for protecting the interests of individual small policyholders, leaving the other

disputes to the GRA.

Need for Chief Ombudsman

Corresponding to the Insurance Appellate Tribunal, a post of Chief Ombudsman can be created, with whom appeals of companies and complainants can lie, solely on matters involving law and not facts of the case. The decision of the Chief Ombudsman should be made final.

The Chief Ombudsman should also look into contradictory verdicts on identical, settled legal issues, emanating from different Ombudsman centres and take *suo motu* cognizance of the same to set things right. The appointment of Chief Ombudsman is suggested because the Ombudsmen are not infallible and any alternative dispute resolution machinery should not go without an appellate body in our country.

More is also needed from the Governing Body of Insurance Council, where the companies are represented by Board level officers, to strengthen the institution of Ombudsman. The system has passed its nascent stage and has caught up with the imagination of the public as a result of beneficiary reaction and the awareness campaign conducted by the GBIC and the IRDA. The number of outstanding disputes has been increasing every year, with more than 64 per cent crossing the time limit of three months provided for in the notification. It is not, therefore, out of place to examine the appointment of additional Ombudsmen at major centres such as Ahmedabad, Delhi, Bhopal, Kolkata and Mumbai, where it is difficult for one Ombudsman to cope with the work load. Delays in the appointment of ombudsmen is also often responsible for this state of affairs, which should be avoided.

> Instead of using the opportunity to garner a learning experience, the Ombudsman is, more often than not, seen as a convenient tool for passing the buck, haunted perhaps by the fear of the three 'C's – the CBI, the CVC and the CAG. 'Let the Ombudsman decide' is the philosophy.

The GBIC ought to ensure the adequacy of support staff, both in terms of number and quality. So far, the public sector companies have taken upon themselves the responsibility of providing staff at the Ombudsman centres and, true to their functioning, first-rate staff are rarely provided. Moreover, hassles arising from staff rules impede effective placements. It is high time the private sector insurance companies, having come of age, stepped in to resolve the staffing problems. Laxity in ensuring proper infrastructure at the Ombudsman centres will sooner or later make them go the consumer disputes redressal forums way – it may be recalled that in Maharashtra, the High Court once had direct the State Government to provide adequate staff to the Forum, following a public interest litigation.

The right perspective

The companies themselves can play a very useful role in ensuring the success of this mechanism. For this, they need to develop a sound understanding of the role of the Ombudsman. Right from the initial stages, the Ombudsman has been viewed as an unwanted intruder in their functioning and as an outsider rejoicing in their downfall. That he is their own man and an appellate authority within the industry has failed to catch their imagination. That he is a counsellor and mediator has failed to click with them, with the result that disputes are mostly resolved only through Awards.

Not much has changed even now.

POINT BLANK

Aborted Claims

When GIC decided to allow expenses for abortion under its Mediclaim policy, Exclusion clause 4.12 of the policy was amended to exclude 'Treatment arising from or traceable to pregnancy, child birth including caesarean section' and 'voluntary medical termination of pregnancy within 12 weeks.'

In the case of missed abortion, when company 'X' repudiated the claim, treating it as arising from and traceable to pregnancy, this writer passed an award allowing the claim on the ground that the clause disallowed only maternity benefits, as 'pregnancy' relates to 'living foetus' and in view of the fact that the clause itself was framed only with an intention to allow expenses for abortion.

The Chairman of the company lodged a protest stating that, as per the company's panel doctor, abortion cannot occur unless there was pregnancy and therefore the claim was not payable, as abortion was traceable to pregnancy. The Chairman was put wise about GIC's decision to allow expenses for abortion under its Mediclaim policy and, the import of the wording of Exclusion clause 4.12.

Later, the clause was further amended, dropping the exclusion, 'voluntary medical termination of pregnancy within 12 weeks.'

On Tipplers and Tippers

In a particular case, life insurer 'X' repudiated a claim for accident benefit on the strength of the report of a police sub-inspector to the magistrate that the rider of the vehicle (policyholder) was under the influence of alcohol. Ombudsman 'Y' concurred with the life insurer, relying only on the report of the sub-inspector, although the claimant alleged solicitation of bribe by the police.

According to section 185 of the Motor Vehicles Act, a person is considered to be under the influence of alcohol only if the percentage of alcohol in his/her blood exceeds 30 mg per 100 ml. While this is the legal intoxication level so far as motor vehicle riding/driving is concerned, a mere police report that a person is under the influence of alcohol carries no evidentiary value unless supported by a blood analysis report specifying the percentage of alcohol in blood. This was absent in the above case, and the police charge is particularly suspect since there was an allegation of solicitation of bribe.

A Question of Ratios

Clause 5.9 of the Mediclaim policy of public sector unit (PSU) insurers stipulates that the policy may be renewed

This writer recalls an instance where a company lodged a protest over the signature of no less a person than its chairman, against an Award pronounced on him. Though the company was put wise that the protest was misplaced and that the Award was in tune with the decision of the industry, it was indicative of the fact that even at the chairman's level, there was non-acceptance of the role of Ombudsman. In yet another instance, the same company again lodged a protest against an Award allowing ex-gratia payment on the grounds that, as per the rules, the claim was not payable, oblivious to the fact that ex-gratia arises only when a claim is not lawfully payable and that the Ombudsman had full authority to grant ex-gratia payment, of course, under explainable circumstances.

The lower rungs at the operational level are no exception. Instead of using the opportunity to garner a learning experience, the Ombudsman is, more often than not, seen as a convenient tool for passing the buck, haunted perhaps by the fear of the three 'C's – the CBI, the CVC and the CAG. 'Let the Ombudsman decide' is the philosophy.

Despite previous Awards being in place under similar facts and circumstances of the case, same arbitrary and wrong decisions by the same office are not uncommon. The practice of referring cases, particularly in mediclaim, to the panel doctor, panel lawyer or panel doctor-cum-lawyer, has scuttled the initiative and capacity to take independent decisions, even at fairly senior levels, and a plethora of previous pronouncements by ombudsmen and quasi-judicial and judicial fora has failed to make any perceptible impact due to the deliberate unwillingness to differ from the opinions of the panel doctors / lawyers.

Some of the companies even authorise their panel doctors (for an avoidable fee) to represent them before the Ombudsman in the hearings, losing thereby an opportunity to interact with and benefit from the mediation process.

In all these areas the GBIC can contribute by educating their people to develop the right perspective. Of late, the GBIC has been bringing out a compendium of Awards of all the Ombudsmen, which is indeed commendable. This can be carried forward further towards truly building up a cadre of officers in the companies who are more sensitive to customer interests.

The IRDA and the Central Government also have their respective roles to play in making the system more customer friendly. The notification is six-and-a-half years old and needs a relook, especially the wordings. Several suggestions made in the past in this regard are still under consideration. An early amendment to the clauses to remove any ambiguity is necessary to prevent company stalwarts from spotting loopholes and scuttling or delaying the process of justice delivery. This writer was rather amused once, at an argument put forth by the Senior Manager of a company, relying on a clause's wording, that if the company does not give consent for mediation by the Ombudsman, that seals the fate of the complaint and that the Ombudsman cannot move an inch forward thereafter. Why give scope for such funny interpretations?

The Insurance Ombudsman was put in place after due deliberations, taking a cue from the report of the Malhotra Committee. Six-and-a-half years of operations have proved to be worthwhile, despite the shortcomings. The Ombudsman needs to be nurtured in the interests of customers and the companies alike.

The author is retired Chairman, Life Insurance Corporation of India and former Insurance Ombudsman, Mumbai.

by mutual consent. Thanks to this clause, insurers often refuse to renew policies where the cases throw up adverse claim ratios.

This writer once expressed the view that while the clause does not confer a right on the insured for automatic renewal, consent for renewal also cannot be withheld except for good and sufficient reasons, and that adverse claim ratio cannot be a reason for refusing renewal and, on renewal, no loading or excess can be imposed nor diseases excluded.

However, Ombudsman 'X' took the view that an insurer was justified in not renewing a policy due to adverse claim ratio, on commercial consideration. Ombudsman 'Y' held that, on renewal, the insurer could either load the premium or restrict the liability for the particular disease. Ombudsman 'Z' held that as the disease was to result in unending liability in future, it could be excluded on renewal.

It is interesting to note that the Supreme Court had, in the case of Biman Krishna Bose Vs United India Insurance Co. Ltd., held that denying renewal cannot be arbitrary (CA No. 2296 of 2000) and renewal should be on the same terms and conditions. Further, the Delhi High Court recently held in the case of Mukul Lal Duggal Vs United India Ins. Co. Ltd. that a high claim ratio cannot be the ground to turn down renewal (vide the writer's article 'God proposes, Ombudsman disposes', in *The New Indian Express* dated April 11, 2005).

Birth Pangs

Under the Group Mediclaim policies for GIC and LIC employees, maternity benefits are payable. Pursuant to this, the PSU insurance companies took a decision that though as per scheme rules the newborn child will be covered only after a three-month period, the mother and child will be treated as one unit in the event of hospitalisation for childbirth. This was even incorporated in their Manual.

However, in a particular case, the insurer allowed expenses for the mother but disallowed expenses for treatment of the child for jaundice on delivery. Ombudsman 'Z' agreed with the company's decision in view of the scheme rules.

This is a classic example of a company not only not following its own rules, but also failing to bring to the notice of the Ombudsman the said relaxed rule, despite the contention of the insured that the mother and the child should be treated as one unit up to three months after birth.

A Stitch in Time...

— Insurers must allay customer anxieties at first go

Educating the customer about the terms of the policy and conveying the right attitude during claims settlement will help insurers keep off the Ombudsman and the courts, observes *Yegnapriya Bharath.*

If the proof of a pudding is in its eating, that of an insurer's reputation is at the point of claim. It is at this time that a harried customer expects the insurance firm to leap up in support – as was promised by the friendly agent and the attractive brochures during the purchase – and feels cheated if the response is either not quick or is plain inadequate. The customer has paid money, and expects value for it.

Having received and examined nearly 2,000 written complaints including e-mails and more than 1,500 phone calls relating to non-life insurance over the past year, we at the IRDA's Public Grievances Cell have a feel of what the average policyholder seeks of his insurer when it comes to a claim. In general, it would appear that claims handling takes a beating as resources are diverted to selling and marketing. Every customer with a complaint invariably has this charge to make – that the insurer marketed the product with an enthusiasm that somehow flagged when the claim was made.

What I write here is based purely on my experience as a complaints handling officer at the grievances cell. It must be remembered that the number of complaints I have dealt with is just a fraction of the claims that the insurance industry disposes of. But it is definitely representative of the pattern or nature of complaints relating to claims that arise from policyholders whatever be the channel a complainant has approached – an insurer's complaints redressal cell, the Grievance Cell of the Regulator, the Ombudsman, the consumer court or other judicial channel.

When a complainant seeks redressal from a source external to the insurer, it is almost always because he or she has either no confidence in the insurer's redressal system, or has failed to evoke a response from there, leave alone getting the complaint resolved. A customer's dissatisfaction should be contained within the company as far as possible.

However, sometimes, the insurers' staff just fails to recognise or acknowledge that a customer is complaining until the complaint is made to an external source. When the complaint is examined by the external source, it is very clear that there is a very unhappy customer whose grievance has not been addressed. It is important for insurers to not only have an effective complaint redressal system with levels of internal reviews but also make known this procedure to their policyholders.

Every customer with a complaint invariably has this charge to make – that the insurer marketed the product with an enthusiasm that somehow flagged when the claim was made.

Logical explanations

What we have been able to gather from most complainants is that they want an explanation as to why a particular decision has been taken regarding their claim, be it a case of avoidance of claim or a reduction in the quantum. Many people do not understand how insurance practice works, such as what warranties are, or conditions and exclusions. It is important for the insurer to communicate the reasons for denying liability under a policy or reducing the claim amount.

Complainants are generally not unreasonable – they need to be explained to clearly about why a particular decision has been taken by the insurer. It is interesting to note that the most aggressive, vocal and persistent complainants are the ones that are most receptive to a logical and clear explanation of how and why the insurer took a particular decision. Such complaints could have been nipped in the bud by the insurers through transparency and clear communication.

We have come across hundreds of complaints relating to claims where the insurers are not liable under the terms and conditions of the policy. The letter of repudiation to the policyholder, simply says – '*…we regret that your claim is not payable as per the terms and conditions of the policy and is hereby being repudiated or closed as No Claim.*' Even the most reasonable customer would want to know under what terms and conditions the claim is being repudiated or closed. Such communications go out to small and large customers.

Sometimes, insurers make arbitrary deductions in claims. Many customers do not have the energy or time to argue with the insurers and forego the amount unless it is substantial. But I came across a customer who fought to be reimbursed Rs. 49 deducted from his Mediclaim policy without any stated basis. He was not so upset about the fact that the insurer denied him the amount, as he was about the attitude of the staffer who said that he ought to be

glad he got the rest of the amount. The gentleman stood his ground on principle. He spent a lot of his time and energy as well as mine. It was all well spent, as he did win the battle. The customer had half a mind to claim for interest for the delay but I talked him out of it successfully!

We receive quite a few complaints relating to deduction of short-charged premium from claim amounts. Insurers sometimes try to rectify rating errors when a claim is made under the policy.

There was a complaint where a claim under a Group Personal Accident policy was kept pending for three years because the insured (a corporate group) refused to pay the premium after the expiry of the policy. The insuring office demanded additional premium because the insurer's auditors had made a remark that the premium charged under the policy was not in line with the company guidelines.

The sufferer was the family of the deceased employee consisting of his aged mother, young unemployed wife and two little children. It required the intervention of an external source for the insurer to discharge its liability.

Underwriting to blame

There are quite a few complaints relating to claims arising out of defective underwriting. Not acknowledging the defect in underwriting, those handling the claims process them strictly as per the wordings of the policy. There was this complaint from a policyholder whose claim for hospitalisation due to high fever was denied because he had disclosed in the proposal form that he had once been admitted for a week in hospital for fever and dehydration. Under the head 'Diseases excluded' was mentioned 'fever and dehydration.' This complaint could have been contained within the company! Such errors give wrong signals to prospects who may end up not disclosing facts which could be material.

Also, many customers are not aware that their policy may not give them the coverage they expected because of information they had not disclosed, especially when they would not consider that information to be critical to their being insured. When their claim is denied for innocent non-disclosure of a material fact, they get agitated. Educating a customer regarding a policy, its terms, conditions and exclusions at the point of sale is crucial. Half the complaints relating to claims would not arise if insurers go through the process of educating their customers about the importance of a proposal form, the details of the products and the claims procedure diligently rather than just leaving it to them to go through the documents.

> The most aggressive, vocal and persistent complainants are the ones that are most receptive to a logical and clear explanation of how and why the insurer took a particular decision and could have been nipped in the bud by the insurers through transparency and clear communication.

Probably, the most often heard complaint is that of not being heard or guided properly when a customer approaches the insurer's office with a complaint. Several complainants send us mails or call up to say that no one in the office is willing to lend them their ears or give them their time. Quite often, once a claim is disposed of one way or the other, the servicing office considers the matter closed and is unwilling to deliberate on it or re-examine it. The claimant is also not apprised sufficiently about the company's redressal system for complaints.

Insurers ought to ensure that their complaints redressal system is *visible*, so that customers know where and how to complain, and *accessible*, so that the customer is allowed to complain with ease at any point in the process.

The various grievance redressal mechanisms like insurers' own grievances cells – which is mandated by IRDA Regulations – the Insurance Ombudsman, consumer fora and IRDA's Public Grievances Cell, provide a window not only for customers to get their problems solved, but also give the companies an opportunity to see what in their product or process gave rise to problems and continue to do so.

With the anatomy of the problem readily available to examine and learn from, experiences at these grievance fora should be used as lessons to avoid such problems in the future.

The author is Deputy Director, IRDA. The views expressed here are her own.

Little Heard, Little Seen

— Why the institution of the Insurance Ombudsman languishes for recognition

G. V. Rao discusses the effectiveness of the institution of the insurance Ombudsman, and suggests steps to make it more purposeful and productive for the benefit of all the stakeholders.

The pressure is mounting on insurers. The competition is fierce and their bottom lines are getting squeezed. To survive, therefore, they need to take vigorous measures.

As a result, the insurers – sharp as ever – are tending to be even more contractual minded with their customers than before. The inadequate informational exchange at the point of sale and the perceptual gaps between what a cover provides and what it does not are ever widening. The dissatisfaction in the insured community against the claims' behaviour of insurers is growing. This power imbalance in the bargaining positions of each other in enforcing contractual obligations, is sought to be reduced not only by insurers themselves through adoption of best practices but by the intervention of the State through a variety of assisting channels.

Since getting justice in courts is a long drawn out process, both the insurers and the Government, one in self-interest and the other in public interest, have devised alternate dispute mechanisms that are less expensive and less time consuming. But whatever machineries are set up, it is ultimately the earnestness and the sense of fairness that insurers bring to making the systems work that will ensure their success.

Alternate dispute resolution

The insured public now has a variety of channels to have their complaints redressed when insurers refuse to honour their contractual obligations to pay claims, or cause delays in giving their decisions, or agree only to partially settle their claims' obligations. Disputes between them could also arise on policy issues of ratings, refunds, etc. The numerous dispute resolution channels now available to dissatisfied customers include:

1. Insurers have set up internal grievance redressal machineries, as a matter of best business practice and in self-interest to guard their reputation for fair dealings. The Directorate of Public Grievances is another agency set up by the Government deal with public grievances of all hues including delays in claims settlements and other insurance related matters. IRDA also intervenes to speed up or facilitate claims' issues, though it does not instruct insurers or deliver decisions on claims. Where the quantum of claims is in dispute, liability having been admitted, arbitration is an option.

> The Ombudsmen must realise that their decisions are required to be pragmatic and consistent with the legal provisions of the policy. If the awards they pronounce are to be obeyed by insurers, they must give opportunities to insurers to be engaged in a consultative process at the higher level.

2. Consumer protection forums deal at a judicial level with claims that are delayed, as 'deficiency in service.' The Civil courts serve as the arbiters of last resort for disappointed claimants to seek decisions both on liability and on quantum. MACT Tribunals, Lok Adalat forums and other bodies that are exclusive judicially intervene to determine compensation amounts payable in respect of Motor Third Party injuries and deaths.

With such a plethora of institutions to deal with claimants' disputes quite active, it was yet felt that these were insufficient to render speedy justice to individual claimants. This was mainly because of the inadequate bargaining power they possessed, quite unlike the corporate firms, which had both money and premium clout to deal with insurers.

Functions and powers of ombudsmen

It was this particular concern of wanting to protect individual customers that led the Government to enact a set of rules in 1998, under the Insurance Act 1938, to create the institution of Insurance Ombudsman, for life and non-life insurance related disputes.

The governing body of the Insurance Council selects ombudsmen. They can act only if both the disputing parties seek their services to mediate in a dispute, in writing. They are empowered to deal with claims up to Rs. 20 lakh, and are bound to give their decisions within three months of reference of a dispute. They can consider references only if there have been any undue delays or they have been turned down by insurers.

Ombudsmen, under the rules, act as counselors and mediators in matters referred to them that fall within the terms of their reference. They have powers under their mediation process to bring about a settlement through mutual agreement; where it is not settled thus, they can pass awards, which the insurers should comply within

two weeks. They also have powers to award ex-gratia payments.

The complainant is at liberty either to accept or reject the award. Insurers bear moral responsibility, but not legal responsibility, to comply with the 'awards' made by their appointees, the Ombudsmen, when mutually acceptable solutions have not been reached between the disputing parties.

Performance record

The appointed ombudsmen are currently functioning from 12 centres, three located in each of the four zones. Out of 4,311 references made on non-life insurance matters in 2003-04, 1,227 emanated from the Western zone, 1,099 from the Northern zone, 1,087 from the Southern zone and 988 from the Eastern zone. The data is a broad indication of the premium distribution in each zone, as well. Metro city wise, Mumbai has the largest number at 764, followed by Kolkatta with 714, New Delhi with 691 and Chennai with 480 complaints.

The number of recommendations made for settlement (mutually acceptable) for non-life insurance complaints was 242 and that by way of awards, 938. Five hundred and seventy claims were found not justified; 1,175 claims were beyond the terms of reference. It can be seen from the analysis that the number of awards is quite significant, showing either the obduracy of insurers or the inability of ombudsmen to persuade insurers to accept their legal point of view.

In the case of life insurance, the number of references to ombudsmen was 3,404 in 2003-04, with the West witnessing at 511 complaints, the North 1,075, the South 993 and the East 825. Metro city wise, Kolkata had the largest number with 622, followed by Chennai with 378, New Delhi with 298 and Mumbai with 280. The number of life insurance recommendations made was 94 (mutually acceptable); 392 awards; 339 dismissed; 1,735 as beyond the terms of reference. Here again making an award has been found the easier way to decide on issues.

Considering that there are 12 centres with full infrastructure and elaborate offices set up with the sole purpose of settling disputed claims, the number of complaints received in both the sectors of insurance is 7,715, a very small number indeed. Out of this number, settlements amount to 4.5 per cent, awards 17 per cent, not entertainable 38 per cent and the rest, withdrawals. Thirty per cent of all complaints are still outstanding. Fifteen per cent of the total complaints outstanding are beyond three months, the time given to settle disputes.

The performance of the Ombudsmen, as seen from the relevant statistics, falls far short of expectations in terms of their public utility and governance standards. One of the possible reasons could be that many customers may not be aware of the existence of the very institution.

The performance of the ombudsmen, as seen from the above numbers, falls far short of expectations in terms of their public utility and governance standards. One of the possible reasons could be that many customers may not be aware of the existence of the very institution. The other could be that many ombudsmen turn out to be poor persuaders of both the parties and can be categorised more as power-wielders than mediators. They are untrained for the job and do not bring the skills of negotiation to bear on their primary tasks so very necessary.

Insurers too need to extend full cooperation to the ombudsmen, their own appointees, even when decisions go against them. However, there are certain operational problems to be addressed.

Operational problems

- In order to assist them in their functions, the ombudsmen are entitled to engage the services of professional experts. It would, however, seem that till now no Ombudsman has availed of this facility for some curious reason. In view of this provision not having been invoked, the ombudsmen have missed out on a consultative process of having their decisions questioned internally by other professional experts before passing awards.
- It is also unclear if there is any legal backing for the awards passed for their implementation. Such awards cannot be characterised as 'awards' made under arbitration, as neither of the parties has agreed to appoint the Ombudsman as their sole arbitrator. Both can challenge the so-called award.
- The rules made thus are defective in respect of enforcing the awards; and this has led to the institution of Ombudsman being denigrated by insurers themselves, whenever they decline to accept the award. Failure to enforce their awards has belittled their prestige in the estimation of complainants. As it is the Insurance Council that selects the ombudsmen, it is expected that decisions made by their own appointee will not be faulted with as based on bias or misguided or perverse.
- It should be inferred as a solemn commitment by the insurers that the decisions of the ombudsmen will be honoured, unquestioned. The failure of communication between the insurers and the ombudsmen is so obvious that the very purpose of

setting up this machinery is hardly realised. There are mutual recriminations between the two of exhibiting unfair attitudes towards each other.

- This challenge of awards of ombudsmen by insurers poses a particular threat to their mediatory intervention. They have, however, chosen not to confront this issue with the Insurance Council till now for specific guidance. The rules are clear enough; but what is lacking is the insurers' cooperation. Insurers should demand the appointment of a panel of experts to guide the ombudsmen, so that the process of conciliation and mediation is implemented in good faith.

What reforms are needed?

- The ombudsmen must realise that their decisions are required to be pragmatic and consistent with the legal provisions of the policy. Further, there is no appellate body to review their decisions, short of insurers going to courts. If the awards they pronounce are to be obeyed by insurers, they must give opportunities to insurers to be engaged in a consultative process at the higher level.

  Often, claims are represented by lower formations of insurers, which lack the skill and knowledge to put across the insurers' point of view. In such an event, the Ombudsman must inform the insurers in writing of his provisional draft award and ask the insurers to explain their legal stand on it. It is, after all, a mediatory mechanism and there is no legal disability in their doing so. After the receipt of insurers' comments, the Ombudsman can either review his earlier provisional decision or confirm it. This will demonstrate a flexibility of mind and a judicious approach to resolution of disputes.

- Where the ombudsmen's award is required to be reviewed for any reason, insurers must seek permission from IRDA to challenge it, based on the likely wrong legal precedents such awards may cause for future. No challenge to the awards otherwise should be entertained as a matter of routine. Insurers must be barred from challenging ombudsmen's awards at their own discretion. Such a practice exists in the banking industry.

> In order to assist them in their functions, the Ombudsmen are entitled to engage the services of professional experts. It would, however, seem that till now no Ombudsman has availed of this facility for some curious reason.

- Ombudsmen must have a panel of professional experts to choose from to guide and advise them as permitted under the rules. It must be made compulsory.

- Meetings should be organised for interactive sessions between insurers and ombudsmen to discuss their mutual concerns at least twice a year. Such a communication process will bring about a better understanding and appreciation of mutual concerns.

- Insurers should comply with the regulation to publicise the role of the machinery of the Insurance Ombudsman machinery in personal lines policy as a policy condition. There is little publicity to what ombudsmen can do for the individual customers.

The Government proposal to abolish the institution of ombudsmen in favour of an exclusive Insurance Tribunal is yet to take shape. Is the proposal made out of the Government's frustration that the consumer forums and ombudsmen have failed to make customers realise their due? It is no doubt true that the affluent section of the insured misuses consumer forums meant for weaker sections. Withdrawing insurance disputes from its ambit is to be welcomed.

But it is important that the institution of ombudsmen be encouraged even by bringing in small firms with a capital of Rs. 1 crore or less and individual customers to have their grievances redressed, by making the setup a panel-based one, instead of a single member.

As yet, ombudsmen are languishing with no recognition of their worth in solving the insurance problems of the small man. Egos have to be unplugged and realism and humility must mark the process and decision making to carry conviction that the system is beneficial to the disputing parties. It is too much to hope that this will happen any time soon. But efforts to achieve it must never be given up.

The author is retired CMD, The Oriental Insurance Company Limited.

Courting Change

—The proposed new face of the Insurance Ombudsman

The future of the Insurance Ombudsman seems to be to be replaced by or be morphed into a Grievances Redressal Authority (GRA) as recommended by the Law Commission says *K. Nitya Kalyani*, outlining other recommendations and tracing the history of this initiative.

The Insurance Ombudsman system, set up to help the individual insured sort out his dispute with an insurance company, has been functioning from 12 centres for a few years now. In spite of all its drawbacks and constraints it represents an accessible and user friendly forum with the advantages of no fees for filing a complaint and time bound decisions which are binding on the insurer while allowing the insured the option of taking the matter to consumer or other courts.

If the final recommendations of the Law Commission – given in October 2004 –were to be realised, then these advantages, envisaged to right the balance of power against the insured battling the mighty corporation, are all set to go. In fact, the basic objection of the Commission to the present system of Insurance Ombudsman is that it is not satisfactory to consumers, and to insurers since the latter "is not – contrary to the principles of equality to access to justice – permitted to question the decision of the Ombudsman."

Instead, it has recommended, the Insurance Ombudsman should be replaced by a Grievances Redressal Authority (GRA) constituted under the Insurance Act, 1938. The jurisdiction of the GRA, according to these final recommendations, would include all the powers and functions of the civil court and would involve adjudication of issues of fact and law, its decision, or the final decision on appeal, will be enforceable by the GRA.

If the final recommendations of the Law Commission were to be realised, the advantages of the Ombudsman system, envisioned to right the balance of power against the insured battling the mighty corporation, are all set to go.

The GRA will be geographically widely present, will hear disputes between the insured and the insurer that pertain to personal lines of insurance, disputes between an insurer and intermediaries, disputes between insurer and insurer and disputes between the assignees of a policy as to priority of assignment.

The IRDA will appoint Adjudicating Officers/Investigating officers to adjudicate/investigate violations of the Act, Rules and Regulations by insurers, insurance intermediaries and insurance agents and levy penalties as provided in the Act. Any person aggrieved by the decision of the Adjudicating/ Investigating Officers can appeal to the Insurance Appellate Tribunal (IAT).

The Commission has recommended that each insurer will have an in-house mechanism for grievance redressal under the overall supervision of the IRDA and that this will be the first resort of the aggrieved.

It is not only the Insurance Ombudsman that will be replaced by the

HOW IT ALL BEGAN

In April 2002 IRDA requested the Law Commission to examine the Insurance Act (1938) and make recommendations for revision of the Act.

The reasoning was that the multiple legislations governing the industry needed to be unified and anomalies and redundancies rectified.

The principal legislation regulating the insurance business in India is the Insurance Act, 1938. In addition are other legislations like the Life insurance Corporation of India (LIC) act, 1956, the Marine Insurance Act, 1963, the General Insurance Business (Nationalisation) Act, 1972 and the Insurance Regulatory and Development Authority (IRDA) Act, 1999. The provisions of the Indian Contract Act, 1872 are applicable to the contracts of insurance and the provisions of the Companies Act, 1956 are applicable to the companies carrying on insurance business.

Subordinate legislation includes Insurance Rules, 1939 and the Ombudsman Rules, 1998 framed by the Central Government under s. 114 of the Insurance Act, 1938 and the Regulations made by the IRDA under s. 114 of the Insurance Act, 1938 and s. 26 of the IRDA Act, 1999.

Thirteen grounds of revision were identified by the Consultation Paper including revamping the grievance redressal machinery. For this it had suggested the setting up of an independent grievance redressal mechanism with an appeal to an Insurance Appellate Tribunal and further appeal to the Supreme Court of India.

GRA. The consumer court system too, to the extent that it handles insurance related complaints, will be replaced by it because the Commission has recommended that all pending disputes arising under Insurance Act, 1938 before the consumer fora be transferred to the GRAs by amending the Consumer Protection Act, 1986 to provide that disputes arising under the Insurance Act, 1938 will not be entertained under it.

Civil courts' jurisdiction is also to be excluded in such matters that come under the jurisdiction of the GRA. However, alternate dispute resolution (ADR) by way of mediation or conciliation would be encouraged.

An Insurance Appellate Tribunal (IAT) is envisaged, which will hear appeals from the GRA, appeals against the orders passed by the Adjudicating/ Investigating Officers appointed by the IRDA and appeals against any order passed by the IRDA. There will be further statutory appeal to the Supreme Court from the decision of the IAT.

The expenditure of GRA and IAT, the Commission has recommended, must be borne by the Central Government since they are to adjudicate disputes arising under a central statute.

IRDA has referred the recommendations to the newly formed K.P. Narasimhan Committee for its comments, but here are a few initial thoughts on the complexion of the new system.

The problem with the suggested new system is that it appears to be a parallel to the court system, inaccessible and intimidating to the consumer who is already in distress. It also makes it inconclusive for the insured in the sense that the company could appeal the decision.

The problem with the suggested new system is that it appears to be a parallel to the court system.

Instead, it would be more effective to strengthen the existing Ombudsman scheme in terms of infrastructure and technical and legal support, and let it continue to deal with consumer related grievances.

This is because the system is simple and easy to use for the complainant and the time bound nature of its decisions and its conciliatory nature is better suited to the nature of complaints and complainants. Moreover the system has just begun to become familiar to consumers and it replacing it with a more complicated system would be counterproductive at this point.

The non-consumer related disputes on the other hand – as those between insurers and those between insurer and intermediaries and appeals against IRDA decisions could well be handled by an existing appellate tribunal like the Securities Appellate Tribunal of the Securities and Exchange Board of India (SEBI) with a broad basing of its powers and technical strengthening. This will avoid replication of infrastructure and institutions while providing the required mechanisms for dealing with these kinds of disputes which do not carry the pressure of personal distress.

In making these changes to a system created to help the consumer, his ease of use and promptness of the system in resolving disputes should be the main consideration. If the existing system is performing below par on these metrics then that is what should be rectified rather than throwing the baby out with the bath water.

The document called attention to the need for "an effective grievance redressal machinery to deal with the numerous complaints of policyholders, which had hitherto not been satisfactorily dealt with." The remedy under the Consumer Protection Act, 1986 did also not prove to be effective given the large number of cases pending decision.

It was therefore suggested that there should be a composite, effective and independent grievance redressal mechanism modelled on the one set up under the Securities and Exchange Board of India (SEBI) Act, 1992. (Interestingly, SEBI, it has been reported very recently, is going to appoint ombudsmen for consumer grievances!)

The Consultation Paper proposed that the present system of Ombudsman under the 1998 Rules be replaced by Grievance Redressal Authorities constituted by appropriate amendments to the Insurance Act, 1938 itself. These would then be statutory authorities exercising statutory functions and other suggestions relating to the constitution and jurisdiction of the GRA.

Following the circulation of its Consultation Paper in June 2003 and subsequent discussions and suggestions from various segments, the Law Commission awaited the response of the Government of India as well as the IRDA. In March 2004 it received a brief letter from the Insurance Division indicating that they are in total agreement with the proposals in the Consultation Paper following which it finalised its recommendations based on both oral and written responses received to the Consultation paper.

प्रकाशक का संदेश

किसी भी संस्थान की न्याय संगति तथा कार्यकुशलता इस बात से जानी जाती है कि वह किस गति से शिकायतों का निपटान करता है। इस बात की व्यवसायिक रूप से बुद्धिमत्ता है कि जब माल बेचा जाए तो विशेष रूप से सेवा क्षेत्र में ग्राहक की शिकायतों की जल्द प्रतिक्रिया ऐसा प्रतिलाभ है जिसे छुआ नहीं जा सकता अत: व्यवसाय के इस क्षेत्र को नजरअंदाज करने कि संभावनाएँ बहुत कम हैं। प्राय: बीमा के क्षेत्र में ऐसा कहा जाता है कि इसमें विक्रय के समय की बातचीत तथा विक्रय के बाद की बातचीत में बड़ा अंतर होता है।

सरकार जो जीवन तथा गैर जीवन बीमा के क्षेत्र में बीमा एकाधिकारिक उपलब्धकर्त्ता थी वह पालसीधारको को राहत दिलवाने के लिए गंभीर रूप से चिंतित थी इसी लिए वर्ष 1998 में बीमा लोकपाल तंत्र की स्थापना की गई। इस संस्था की अभिनवता यह थी कि बीमालोक पाल के निष्कर्ष बीमाकर्त्ता पर बाध्यकारी है जबकि पालसीधारक इन पर आपत्ति दर्ज कर सकता है।

आईआरडीए के इस अंक में हम बीमालोक बीमालोकपाल के संगठन तथा प्रक्रिया पर समालोचनात्मक दृष्टिपात करेंगें । आप उद्योग के भीतर तथा शिकायत निपटान प्रणाली से सम्बद्ध लोगों के अनुभव तथा सुझाव पढ़ेगें। विधि आयोग ने भी शिकायत निपटान प्रणाली के संबन्ध में संस्तुति प्रस्तुत की हैं जिन्हें इस अंक में स्थान दिया गया है।

इस प्रणाली के सम्बध में दिये गये सुझावों से जो निकल कर आया है वह रूचिकर है इसकी व्यवस्था तथा सामग्री तथा वह पाठ जो उद्योग अपनी पुरानी गलतियों से सीख सकता है तथा जिससे निकलकर भूलयुक्त पूर्वानुमान तथा ऐसे बिन्दू आये हैं जिन पर कार्यवाई करने से भूलचूक दूर की जा सकती है।

इस माह हम हमारे पहले बीमांकक सदस्य श्री पी.ए. बालासुब्राहमण्यम को अलविदा कह रहे हैं जिन्होंने प्राधिकरण में तीन वर्ष से ऊपर समय तक कार्य किया हमें इस बात की प्रसन्नता है कि वह अपनी उपस्थिति तथा अनुभव से प्राधिकरण को एक परामर्शदाता बीमांकक के रूप में लाभ प्रदान करते रहेगें।

हमें श्री सी.के. मुरलीधरन का सदस्य के रूप में स्वागत करते हुए प्रसन्नता हो रही है जो बीमा कर्त्ताओं तथा मध्यवर्तीयों के निवेश, लेखा, स्थानापन्न अनुवीक्षण करेगें। आप भारतीय रिजर्व बैंक से आयें हैं तथा अपने साथ विनियामक मामलों का बड़ा अनुभव लाये हैं।

जर्नल का अगला अंक माइक्रो बीमा के कुछ नये पहलूओं को खोजेगा। आईआरडीए के मिशन वाक्य के महत्वपूर्ण विषय के रूप में जिसमें बीमा का प्रसार समाज के कमजोर वर्ग तक करने की बात की गई है। हमें उम्मीद है कि यह लेख बीमाकत्ताओं में उस क्षेत्र के लिए रूचि पेश कर सकेगें जिन्हें अब तक एक अवसर की अपेक्षा एक बाध्यता के रूप में देखा जाता था ।

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

..... पीढ़ी में एकल अवसर

श्री एन्ड्रीयू कीनिशी, अध्यक्ष, यूके एसोसियेशन आफ इंशुरेन्स एण्ड रिस्क मैनेजमैट, उद्योग में हाल ही में आये परिवर्तन जिन्हें न्यूयार्क के एटोर्नी जर्नल इलियट स्पिंस्टजर कि जाँच-पड़ताल द्धारा लाया गया।

सम्पूर्ण रूप से वित्तिय सेवा उद्योग पहले से ही उपभोगता, विनियामक, तथा टिप्पणी करने वालों के मस्तिष्क में खंडित छवि के रूप में छोड़ दिया गया है

लार्ड पीटर लीवेन वर्ल्ड ट्रेड सेन्टर के दावे के मुकदमे के समय यह चर्चा करते हुए की पालसी शर्तो के अनुसार वह एक घटना थी अथवा दो घटनाएँ थी।

यह प्रस्ताव बीमा उद्योग को उनकी व्यवसाय प्रथाओं के बढ़े हुए उत्तरदायित्व की तरफ ले जायेगें । स्वीकृत बीमांकक के लिए एक नई आवश्यकता वार्षिक वित्तिय हालत रिपोर्ट बनाना है जो जीवन बीमा क्षेत्र में पिछले काफी समय से परिपाटी रही है।

श्री स्टीव सोमाजी, सदस्य, आस्ट्रेलिया प्रूडेशल विनियामक प्राधिकरण (एपीआरए) अपना नया प्रूडेंशल मानक ड्राफट प्रूडेशल जोखिम तथा प्रबन्ध के साधारण बीमा पर्यवेक्षण को मजबूत करने के लिए प्रस्तुत करते हुए।

इसमें कोई चतुराई नहीं है कि हवा में नरकट की तरह मुडा जाए तथा अपनी निति को उस अनुक्रिया के अनुसार बदल दिया जाए जिसकी माँग किसी एक वर्ग से उठी हो। इससे कोई अंतर नहीं पड़ता की हमारी आवाज कितनी उँची हो। बाजार प्रकटन की आचरण संहिता की सहमति के लिए इसका उपयोग करेगा।

श्री जान टीनर, मुख्य कार्यपालक, वित्तिय सेवा प्राधिकरण, यूके। ब्रोकर द्धारा अधिक प्रकटन के लिए।

(एआईजी) एक काला बाक्स है जो सीईओ के लौहमुठ से चलता है जिसने जनता को सत्य नहीं बताया।

श्री इलियट स्पिंस्टजर न्यूयार्क के एर्टोनी जरनल एक टीवी कार्यक्रम “इस सप्ताह जार्ज स्टीफनपोलुस” में।

कुछ चर्चा हुई हैं जो उच्च सैद्धांतिक हैं। लोग हमेशा हमसे बात करते हैं लेकिन ..... हम बेचने के लिए ठीक परिस्थिति में नहीं हैं।

श्री वाणी ट्रीवेन्स, अध्यक्ष, इक्केटेबल लाईफ

स्वविनियमन

उदाहरणों से सीख

-इंडियन सीए बुक से एक अध्याय

भारतीय बीमा उद्योग एवं बीमा विनियामक भारतीय सीए पेशेवरों से काफी कुछ सीख सकते हैं और उनमें महत्वपूर्ण है स्व-विनियमन। मान्यता *पी. एस. प्रभाकर*

भारतीयों ने ब्रिटिश साम्राज्य से लोहा लिया और आजादी प्राप्त की। आजादी प्राप्त करने के पीछे एक प्रमुख कारण यह था कि हम समझते थे कि हम अपना देश खुद संभाल सकते हैं और इसके लिए हमें किसी बाहरी तत्व की आवश्यकता नहीं है। प्रमुख तमिल कवि सुब्रहमनिया भारती ने लिखा है, "हमारे मध्य हजारों बातों में असमानताएं हो सकती है, पर क्या इन असमानताओं को दूर करने के लिए हमें किसी बाहरी शक्ति की आवश्यकता है?" स्वतंत्र अस्तित्व को कायम रख हम बेहतरीन प्रदर्शन कर सकते हैं और इसके लिए हमें किसी ऐसे तत्व की आवश्यकता नहीं जिसका हमारी कार्यविधियों के ऊपर नियंत्रण हो। हम अपना स्व-विनियमन कर सकते हैं।

इंडियन एकाउंटिंग प्रोफेशन शायद पहला ऐसा संस्थान है जिसने स्व-विनियमन के वातावरण को बढ़ावा दिया है। भारत की स्वतंत्रता प्राप्ति के बाद एवं इसके गणतंत्र बनने के पहले चार्टर्ड एकाउंटेंट एक्ट, 1949 पारित किया गया। सन् 1950 में देश भर में चार्टर्ड एकाउंटेंट्स की संख्या मात्र 1,689 थी जो आज 70 गुणा बढ़कर 1,20,000 के आँकड़े पर पहुँच गई है। यह एक ऐसा समाज है जो स्व-विनियमन का पूरी तरह पालन करता है। और इसलिए अनुशासन, गुणवत्ता, स्वच्छता एवं स्व-विनियमन के उदाहरण के रुप में इसे अन्य उद्योगों के समक्ष रखा जा सकता है।

विभिन्न गुण जैसे एकता, योग्यता, उद्देश्य, प्रतिबद्धता, स्वतंत्रता, सर्वश्रेष्ठ पेशेवर व्यवहार इत्यादि किसी भी एकाउंटिंग प्रोफेशनल में आवश्यक रुप से होने चाहिए तथा ये सभी गुण इंस्टीट्यूट ऑफ चार्टर्ड एकाउंटेंट्स ऑफ इंडिया (आईसीएआई) में देखे जा सकते हैं।

आईसीएआई की कार्यप्रणाली

> इंडियन एकाउंटिंग प्रोफेशन शायद पहला ऐसा संस्थान है जिसने स्व-विनियमन के वातावरण को बढ़ावा दिया है। भारत की स्वतंत्रता प्राप्ति के बाद एवं इसके गणतंत्र बनने के पहले चार्टर्ड एकाउंटेंट एक्ट, 1949 पारित किया गया।

आईसीएआई एक विनियामक बॉडी है जिसकी काउंसिल में 30 व्यक्ति हैं। इनमें से 24 व्यक्तियों का चयन सदस्यों द्वारा किया जाता है तथा शेष 6 व्यक्तियों को सरकार नामित करती है। इन ६ नामित व्यक्तियों में से तीन क्रमश: सीएजी, डीसीए तथा सीबीडीटी से आते हैं तथा शेष तीन एकाउंटेंट प्रोफेशनल्स होते हैं। काउंसिल का संचालन तीन स्टैंडिंग कमेटी तथा 16 गैर-स्टैंडिंग कमेटी के माध्यम से किया जाता है। यह संस्थान एकाउंटिंग स्टैण्डर्डस् को तय करता है तथा साथ ही सदस्यों को यह भी बताता है कि क्या करना चाहिए और क्या नहीं।

सीए के लिए विनियमन एवं मौलिक संचालन केवल चार्टर्ड एकाउंटेंट एक्ट में ही नहीं तय किए गए हैं, बल्कि ये कंपनी एक्ट, 1956 में भी देखे जा सकते हैं। सीए के लिए कुछ प्रमुख मौलिक संचालन निम्न है:

1. इंडियन कंपनी एक्ट, 1956 के सेक्शन 11(2) के अनुसार किसी भी साझेदारी फर्म में साझेदारों की संख्या 20 से अधिक नहीं हो सकती है।
2. कंपनी एक्ट के अनुसार यदि एक सीए किसी कंपनी में शेयर रखता है तो वह उस कंपनी का लेखा-परीक्षण नहीं कर सकता है।
3. कंपनी एक्ट के अनुसार किसी सीए के लिए कुल लेखा-परीक्षणों की संख्या भी सीमित है।
4. कंपनी एक्ट के अनुसार कोई भी फर्म किसी कंपनी में शेयरहोल्डर नहीं हो सकती है।

भारतीय चार्टर्ड एकाउंटेंट्स भारत में या बाहर विज्ञापन नहीं दे सकते हैं। सीधे या परोक्ष रुप से वे कैनवासिंग नहीं कर सकते हैं। उनका कोई लोगो भी नहीं हो सकता है। यदि किसी चार्टर्ड एकाउंटेंट फर्म को आईएसओ प्रमाण पत्र मिलता है तो वो अपने बिजनेस कार्ड या कार्यालय के दस्तावेजों

पर इसका उल्लेख नहीं कर सकता है। संभावित ग्राहकों के लिए फर्म कोई भी प्रजेन्टेशन तैयार नहीं कर सकता है। यदि वह अपना वेबपेज भी डिजाईन करना चाहे तो इसके लिए भी कई पाबंदियाँ हैं। कार्यालय के बाहर लगाए गए हॉर्डिंग बोर्ड के आकार एवं स्टाईल के लिए भी कोड तैयार किए गए हैं।

एक सीए टेलीफोन डायरेक्टरी में अपना नाम या फोन नम्बर बोल्ड नहीं करवा सकता है। किसी अन्य सीए द्वारा किए गए कार्य को पहले वाले सीए की अनुमति के बगैर वह हाथ में नहीं ले सकता है। यहाँ तक की यदि सीए कोई नया लेखा परीक्षण हाथ में लेता है तो उसे उस सीए से पूर्व लेखापरीक्षणों की जानकारी लेनी होगी, जिसने पहले लेखा परीक्षण किया है।

भारतीय सीए फर्म में गैर-सीए को साझेदार नहीं बनाया जा सकता है, और न ही किसी गैर-सीए के साथ लाभ-बँटवारा एग्रीमेंट तैयार किया जा सकता है। चार्टर्ड एकाउंटेंट एक्ट इस प्रकार के मल्टी-डिससीपलनरी कार्यों को रोकता है।

ये कोड ऑफ एथिक्स कुछ अधिक कड़े दिख सकते हैं, परन्तु आईसीएआई साफ कहता है कि ये कोड प्रोफेशन एवं बिजनेस, आइडिया एवं उत्पाद, पेशेवर एवं व्यापारी इत्यादि के मध्य एक सीमा तय करते हैं। चार्टर्ड एकाउंटेंट्स एक्ट के पूर्णत: पालन के लिए एक विशेष कोष्ठ का निर्माण किया गया है जहाँ से सभी सीए की गतिविधियों पर नजर रखी जाती है तथा शिकायतों को सुना जाता है।

विकास के पर्याप्त अवसर नहीं

इन कोड ऑफ एथिक्स की वजह से सीए व्यवसाय में अपेक्षित वृद्धि देखने को नहीं मिल रही है। जहाँ अन्य व्यवसाय अपना संरचनात्मक विकास कर रहे हैं, सीए इस मामले में पिछड़े हुए हैं। पेशे के स्तर को उठाया नहीं जा सका है। साझेदारों की सीमित संख्या एवं लेखापरीक्षणों की सीमित संख्या की वजह से अधिक कार्य को हाथ में नहीं लिया जा सकता है, भले ही सीए के पास इसे पुरा करने के लिए पर्याप्त क्षमता हो। इससे कई बार कार्य उन सीए के हाथों में चला जाता है जो इसके लिए पूर्णत: सक्षम नहीं हो। इससे ग्राहक अपनी पसंद के सीए से सेवाएँ प्राप्त करने से वंचित रह जाता है।

लेखक जो साधारण बीमा उध्योग में कार्य करते थे एक सनदी लेखाकार हैं।

भ्रष्टाचार के विरूद्ध बीमा

हाल ही में कॉमन वैल्थ डिजास्टर मैनेजमेट ऐजेन्सी (सीडीएमए) ने विश्व बैंक की बीमा ईकाई (एमआईजीए) से भ्रष्टाचार विरोधी बीमा पालसी की संभावनाओं को ढूँढने को कहा है इसकी आवश्यकता विकासशील देशों विशेषकर अफ्रिका महाद्वीप के देशों में विदेशी पूँजी निवेश के लिए की जा रही है।

दिनांक 9-10 दिसंबर को संयुक्त राष्ट्र संघ के भ्रष्टाचार विरोधी दिवस के अवसर पर सीडीएमए द्वारा मैलर्बोन हाऊस लंदन में एक बैठक का आयोजन किया गया जो बिटिश सरकार का कॉमन वैल्थ का सचिवालय भी हैद्य बैठक में बिटिश सरकार के प्रतिनिधियों, बीमा विशेषज्ञों, निजि व्यवसाय तथा बैक निवेशकों, जोखिम सलाहकार समूह,अफ्रीका ट्रेड इंशुरेन्स तथा क्राऊन ऐजेन्ट ने इसमें भाग लिया।

इनका निष्कर्ष यह था कि जिस इंस्टूमेंट के बारे में सोचा जा रहा है वह प्रोजेक्ट के सभी संभावित भ्रष्टाचार के विरूध प्रत्याभूत प्रदान नहीं कर सकेगा। यह सरकार किसी कदम विशेष के लिए सुरक्षा प्रदान करेगा जो अन्यथा सलाह अथवा रिश्वत के वाहक बनते। एक प्रकार से यह समझौते को रद्द करने के लिए सुरक्षा प्रदान करना है इसलिए यह पूर्णरूप से नये प्रकार का इंस्टूमेंट नहीं कहा जा सकता।

संग्रहकर्त्ता - संजीव कुमार जैन

हमने काफी लंबा रास्ता तय किया है...

उदारवादिता के पश्चात से ही भारतीय बीमा उद्योग में काफी प्रगति हुई है और इसे सतत रखने के लिए प्रमुख मुद्दों को कायम रखने की जरुरत है तथा साथ ही सभी संभव टैंड्स, संभावनाओं एवं चुनैतियों को आउटलाइन करना है जो बाजार एवं ग्राहक संतुष्टि को पूरा करता हो ताकि अंतर्राष्टीय मापदंड तैयार किए जा सकें। मान्यता ***संदीप कौंदल***

उद्योग के लिए आज सबसे बड़ी चुनौती वेधन का निम्न स्तर है। अन्य निवेश अवसरों के कारण भी चुनौतियों का सामना करना पड़ रहा है। आज की युवा पीढ़ी खर्च करने में अधिक विश्वास रखती है न कि पैसे को बचाकर रखने में। भारतीय बाजार में उदारवादिता आने के बाद से निजी बीमा कंपनियों को पर्याप्त अवसर मिले हैं तथा इससे रोजगार के अवसरों में भी वृद्दि हुई है।

ऐसा अनुमान किया जा सकता है कि आने वाले १० वर्षों में भारत में एक टिलियन यूएस डॉलर के निवेश की आवश्यकता होगी। बीमा क्षेत्र इसमें से कुछ पूँजी को संरचनात्मक विकास तथा साथ ही देश के आर्थिक विकास में उपयोग में ले सकता है। भारत में जीवन बीमा के व्यापार की प्रक्रिया सन् 1818 में प्रारंभ हुई जब कोलकाता में ओरियोन्टल लाइफ इंश्योरेंस की स्थापना की गई। 1850 में टिटोन इंश्योरेंस कंपनी लिमिटेड की स्थापना के साथ जनरल बीमा व्यापार की शुरुआत हुई। इस कंपनी में ब्रिटिश भागीदारी थी। किसी भारतीय द्वारा प्रारंभ की गई पहली जनरल बीमा कंपनी इंडियन मर्चेन्टाईल इंश्योरेंस कंपनी है जिसकी स्थापना 1907 में की गई थी। आगे आने वाले 50 वर्षों में कंपनी ने काफी उन्नति की।

1956 में भारत सरकार द्वारा भारतीय जीवन बीमा निगम की स्थापना की गई। जनरल इंश्योरेंस बिजनेस एक्ट सन् 1972 में पारित किया गया और इसके पश्चात जनरल इंश्योरेंस कोरपोरेशन ऑफ इंडिया तथा इसकी चार अन्य सहयोगी कंपनियों ओरियन्टल इंश्योरेंस कंपनी लिमिटेड, न्यू इंडिया एश्योरेंस कंपनी लिमिटेड, नेशनल इंश्योरेंस कंपनी लिमिटेड तथा यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड की स्थापना की गई। वर्ष 2000 के अंत तक इन कंपनियों को जनरल इंश्योरेंस कोरपोरेशन ऑफ इंडिया से स्वतंत्र कर दिया गया तथा आज ये कंपनियाँ स्वतंत्र कंपनी के रुप में संचालित हो रही है।

1990 के दशक में किए गए परिवर्तन तथा आईआरडीए

भारतीय बाजार में आज भी बीमा भेदन काफी कम है, परन्तु साथ ही इसमें बढोतरी भी देखी जा रही है। ग्राहक आज अपनी बीमा जरुरतों को समझने लगा है तथा उसे लगने लगा है कि बीमा उत्पाद किस प्रकार उसकी वित्तीय सहायता कर सकते हैं। हाँलाकि आज भी बीमा का प्रचार-प्रसार की काफी आवश्यकता है ताकि इस व्यापार को लोगों तक पहुँचाया जा सके।

भूतपूर्व वित्त सचिव तथा रिजर्व बैंक ऑफ इंडिया के गवर्नर की अध्यक्षता में वर्ष 1993 में मल्होत्रा कमेटी की स्थापना की गई जिसका कार्य भारतीय बीमा उद्योग का अध्ययन करना था तथा भविष्य में इसके विकास के लिए आवश्यक परिवर्तन सुझाना था। कमेटी ने 1994 में अपनी रिपोर्ट प्रस्तुत की जिसके मुख्य बिंदू निम्न थे:

1. बीमा कंपनियों में सरकारी हिस्सा 50 प्रतिशत तक कम कर दिया जाए।
2. सरकार जीआईसी एवं इसकी अन्य सहयोगी कंपनियों के शेयर ले ले ताकि ये अन्य कंपनियाँ अपना स्वतंत्र अस्तित्व कायम कर सके।
3. सभी बीमा कंपनियों को संचालन हेतु स्वतंत्रता प्रदान की जाए।
4. न्यूनतम पेड-अप पूँजी के साथ निजी कंपनियों को बाजार में आने दिया जाए।
5. कोई भी कंपनी जीवनबीमा एवं जनरल बीमा साथ-साथ नहीं कर सकती है।
6. घरेलु कंपनियों के साथ मिलकर विदेशी कंपनियों को बाजार में आने की अनुमति प्रदान की जाए।
7. एक बीमा विनियामक का गठन किया जाए।
8. बीमा नियंत्रक को स्वतंत्रता प्रदान की जाए।
9. भुगतान में 30 दिनों से अधिक की देरी होने पर एलआईसी ब्याज का भुगतान करे।
10. बीमा कंपनियों को यूनिट लिंक्ड पेंशन प्लान जारी करने के लिए प्रेरित किया जाए।

इस रिफॉर्म प्रोसेस को लागु करने के लिए वर्ष 1999 में आईआरडीए एक्ट 1999 पारित किया गया। 1938 में लागु किए गए बीमा एक्ट के पश्चात बीमा क्षेत्र में यह दूसरा महत्वपूर्ण परिवर्तन था। पहली बार आईआरडीए को एक स्वतंत्र विनियामक के रुप में स्थापित किया गया। इससे निजी बीमा कंपनियों का बाजार में प्रवेश आसान हो गया। आईआरडीए बीमा उद्योग के नियंत्रण के साथ-साथ इसके विकास हेतु कार्य करने के लिए भी प्रतिबद्ध है। इस भूमिका में इसका उद्देश्य आर्थिक विकास हेतु अनुकूल माहौल तैयार करना है। बीमा आर्थिक क्षेत्र में विकास का एक महत्वपूर्ण साधन है। आईआरडीए भारतीय बीमा बाजार का लगातार अध्ययन करता है तथा इसके भविष्य के दिशा-निर्देशों को तय करता है।

बीमा उद्योग विश्व भर में ही सदैव विकास की ओर अग्रसर है। भारत में भी अन्य उद्योगों के मुकाबले बीमा उद्योग में वृद्धि सराहनीय है। अगस्त 2000 में जब आईआरडीए ने बीमा कंपनियों के नामांकन के लिए आवेदन पत्र जारी किया, यह बीमा उद्योग के लिए एक माइलस्टोन था। उदारवादी अर्थव्यवस्था तथा निजी कंपनियों के बीमा क्षेत्र में प्रवेश के पश्चात इसके विकास को एक नई दिशा मिली तथा भविष्य में इसके विकास की संभावनाएँ काफी प्रबल हो गई।

दिसम्बर 2000 में जीआईसी की सहयोगी कंपनियों को स्वतंत्र अस्तित्व प्रदान किया गया। इसी समय जीआईसी राष्ट्रीय पुन: बीमाकर्ता के रुप में सामने आया। जूलाई 2002 में संसद ने अन्य

चार कंपनियों को जीआईसी से स्वतंत्र करने के लिए बिल पारित कर दिया।

एक नए युग का जन्म

जीवन बीमा बाजार: निजी बीमा कंपनियों के आने से पूर्व भारतीय जीवन बीमा बाजार काफी पिछड़ा हुआ था तथा सिर्फ भारतीय जीवन बीमा निगम का ही बाजार पर एकाधिकार था। बीमा उत्पादों का बाजार में भेदन सिर्फ 19 प्रतिशत था। एलआईसी टैक्स प्लानिंग साधन के रुप में बीमा उत्पादों को बेचा करता था ना कि एक ऐसे उत्पाद के रुप में जो भविष्य में सुरक्षा प्रदान करेगा। उत्पादों में कोई लचीलापन या पारदर्शिता नहीं थी। निजी बीमा कंपनियों के आने के पश्चात सारा गेम परिवर्तित हो गया। आज भारतीय बाजार में निजी क्षेत्र की 13 बीमा कंपनियाँ है तथा बाजार में इनकी भागीदारी 13 प्रतिशत है। तथा साथ ही इनके प्रीमियम में लगातार वृद्धि देखने को मिल रही है।

आईआरडीए के आँकड़ों से पता चलता है कि निजी बीमा कंपनियों की बाजार में भागीदारी प्रीमियम के आधार पर देखा जाए तो 21.90 प्रतिशत तथा पॉलिसी संख्या के आधार पर देखा जाए तो 9.60 प्रतिशत है। (जनवरी 2005 के आँकड़े)

बेहतरीन उत्पाद, बेहतरीन मार्केटिंग तथा प्रतिबद्धता ये ऐसे तत्व हैं जो निजी बीमा कंपनियों में खासकर देखने को मिलता है तथा बीमा क्षेत्र के विकास के लिए यह एक महत्वपूर्ण बिन्दू है। भारतीय अभी तक बीमा उत्पादों को टैक्स बचाने के उपाय के रुप में ही देखते थे, परन्तु आज उनका नजरिया बदल रहा है तथा भविष्य की सुरक्षा को ध्यान में रखकर इसे खरीदा जा रहा है। हाँलाकि निजी कंपनियों ने एलआईसी से कुछ बाजार भागीदारी ले ली है, परन्तु प्रमुख विकास बाजार के विस्तार की वजह से ही हो रहा है।

गैर-जीवन बीमा बाजार: आज बाजार में कुल 13 गैर-जीवन बीमा कंपनियाँ हैं। इनमें से 9 निजी क्षेत्र तथा 4 पब्लिक क्षेत्र से है। हांलाकि पब्लिक क्षेत्र की कंपनियाँ आज भी बाजार भागीदारी का काफी बड़ा हिस्सा रखती है, निजी कंपनियाँ तेजी से अपना विकास कर रही है। वर्ष 2003 में निजी कंपनियों की बाजार भागीदारी 9 प्रतिशत थी जो 2004 में बढ़कर 13 प्रतिशत हो गई। वर्ष 2002 की प्रथम छमाही में निजी बीमा कंपनियों ने 6.34 अरब रुपये का प्रीमियम इकट्ठा किया। ग्रामीण इलाकों में अपनी पहुँच बनाने के लिए नए मार्केटिंग चैनल्स एवं वितरण व्यवस्था की तलाश की जा रही है।

हांलाकि पब्लिक सेक्टर की कंपनियाँ आज भी बाजार में अपनी भागीदारी मजबूत किए हुए है, नई कंपनियों के लिए भी बाजार में काफी संभावनाएँ व्याप्त है।

बेहतरीन उत्पाद, बेहतरीन मार्केटिंग तथा प्रतिबद्धता ये ऐसे तत्व हैं जो निजी बीमा कंपनियों में खासकर देखने को मिलता है तथा बीमा क्षेत्र के विकास के लिए यह एक महत्वपूर्ण बिन्दू है। भारतीय अभी तक बीमा उत्पादों को टैक्स बचाने के उपाय के रुप में ही देखते थे

प्रतियोगी बाजार तथा ग्राहक सेवा में सुधार: उदारवादिता ने बीमा कंपनियों को काफी अधिकार प्रदान किए हैं ताकि ये कंपनियाँ अपने प्रदर्शन को बेहतरीन कर सके, स्वतंत्र रुप से काम कर सके तथा वित्तीय आवश्यकताओं को पूरा कर सके। आज पुरा संचालन कम्प्यूटरों के माध्यम से हो रहा है, तकनीकी का सतत विकास हो रहा है, नए उत्पाद बाजार में आ रहे हैं तथा ग्राहकों का विशेष रुप से ध्यान रखा जा रहा है। बहुराष्टीय बीमाकर्ता बीमा के इस बढ़ते बाजार में विशेष रुप से काफी उत्सुकता दिखा रहे हैं, क्योंकि उनका घरेलु बाजार इसमें काफी विकास कर चुका है और अब उन्हें नए बाजार की तलाश है। वे देश जहाँ बीमा भेदन काफी कम है, जैसे भारत, उनके लिए अच्छा बाजार सिद्द हो रहा है। इसलिए वे सभी अंतर्राष्टीय मानदंडों को यहाँ लागु कर रहे हैं, ताकि प्रतियोगिता में ठहर सकें।

पब्लिक क्षेत्र के बीमाकर्ता अपने संचालन की लंबी प्रक्रिया, नौकरशाही इत्यादि के कारण ग्राहकों के लिए आज भी अनुकूल वातावरण तैयार नहीं कर सके हैं। इसलिए निजी क्षेत्र के बीमाकर्ता ग्राहक सेवा, गति तथा लचीलेपन के कारण तेजी से विकास कर रहे हैं। ग्राहकों को बेहतरीन उत्पाद मिल रहे हैं तथा उनके पास कई सारे विकल्प भी मौजूद हैं।

बीमा, बैंकिंग से कहीं अधिक वोल्यूम का गेम है। पॉलिसी की संख्या एवं प्रीमियम यहाँ काफी बड़ा स्थान रखता है। अत: निजी क्षेत्र की कंपनियों का उद्देश्य उन ग्राहकों तक अपनी पहुँच बनाना है जो अभी तक बीमा क्षेत्र से अछूते रहे हैं। कई नए बीमाकर्ता इस उद्देश्य को पुरा करने के लिए कार्य कर रहे हैं तथा एक विशाल ग्राहक आधार तैयार कर रहे हैं। प्रतियोगिता को देखते हुए हम उम्मीद कर सकते हैं कि पब्लिक क्षेत्र की कंपनियाँ भी अपनी पॉलिसीज में बदलाव लाएगी तथा ग्राहकों को बेहतरीन सेवाएँ मुहैया करवाने की दिशा में कार्य करेंगी। इससे ग्राहकों को फायदा होगा तथा साथ ही कंपनी को भी लाभ मिलेगा।

रोजगार के नए अवसर: भारतीय बीमा क्षेत्र में उदारवादिता आ जाने के बाद से निजी प्रतियोगिता में काफी बढ़ोतरी हुई है तथा आज बीमा क्षेत्र में रोजगार के विभिन्न अवसर देखने को मिल रहे हैं। भारत में 5 लाख लोग बीमा क्षेत्र से जुड़े हैं जबकि ब्रिटेन में यह संख्या 6 लाख है। बहुराष्टीय कंपनियों के बाजार में आने से बीमा क्षेत्र में काफी सुधार आ रहा है।

क्योंकि आज कई कंपनियाँ बाजार में आ गई है और साथ ही उन्हें अनुभवी कर्मचारयों की भी तलाश है। मार्केटिंग विशेषज्ञ, वित्तीय विशेषज्ञ, इंजीनियर्स इत्यादि की माँग बढ़ रही है। अंडरराइटर्स तथा बीमांककों के लिए सुनहरा अवसर है। अनुभवी

विशेषज्ञों की मदद से उत्पाद कीमतों तथा निर्णय लेना इत्यादि कार्य संभव हो सकेगा। सेल्स प्रोमोशन तथा विज्ञापन के लिए अच्छे कर्मचारियों की तलाश है।

सेल्स एजेंट के रुप में भी लोगों की भर्ती की जा रही है। इससे एक अन्य विकल्प के रुप में भी रोजगार की संभावना नजर आ रही है तथा लोग काफी संख्या में बीमा उद्योग से जुड़ रहे हैं।

कैरियर निर्माण: बीमा क्षेत्र में कैरियर बनाने के लिए कई सारे विकल्प मौजूद हैं। विपणन, बीमांकन, अंडरराइटिंग, सेल्स प्रोमोशन, विज्ञापन, सेल्स एजेंट इत्यादि के रुप में बीमा कंपनी में कैरियर बनाया जा सकता है। इनमें से कई विकल्प तो दूसरे क्षेत्रों में भी मौजूद हैं, परंतु बीमांकन एवं अंडरराइटिंग ऐसे विकल्प हैं जो सिर्फ बीमा क्षेत्र में ही देखने को मिलते हैं तथा लोग तेजी से इनकी तरफ आकर्षित हो रहे हैं।

बीमा क्षेत्र में कैरियर बनाने के लिए उम्मीदवार की शैक्षणिक योग्यता के साथ साथ क्षेत्र पर उसकी पकड़ भी मजबूत होनी चाहिए। बीमा क्षेत्र में कैरियर बनाने के लिए भारतीय बीमा संस्थान, राष्टीय बीमा अकादमी तथा भारतीय बीमांकक समाज प्रशिक्षण प्रदान करता है।

नया बाजार एवं संरचनात्मक विकास: भारतीय बाजार में आज 20 से अधिक बीमा कंपनियाँ है (जीवन एवं गैर जीवन बीमा क्षेत्र में)। भारतीय बाजार में इसका व्यवसाय 400 मिलियन रुपये का है तथा बैंकिंग सेक्यर के साथ यह देश की जीडीपी का कुल 7 प्रतिशत प्रदान करता है। बीमा प्रीमियम में प्रतिवर्ष 15 से 20 प्रतिशत की वृद्धि देखी जा रही है। फिर भी भारत की तीन-चौथाई आबादी अभी भी बीमित नहीं हो पाई है। इससे यह पता चलता है कि इस सेक्टर के विकास के लिए काफी संभावनाएँ भारतीय बाजार में मौजूद है।

बीमा क्षेत्र देश को लंबे समय के लिए धन उपलब्ध करवाता है तथा इस प्रकार देश की आर्थिक व्यवस्था को बेहतर बनाने में इसका काफी महत्वपूर्ण योगदान है। ऐसा अनुमान लगाया जाता है कि आने वाले 10 वर्षों में देश को एक टिलियन यूएस डॉलर के निवेश की आवश्यकता होगी। इस धन से बीमा क्षेत्र अपना संरचनात्मक विकास कर सकता है तथा साथ ही देश की अर्थव्यवस्था को मजबूती भी प्रदान कर सकता है। आईआरडीए के निर्देशों के अनुसार कोई भी बीमा कंपनी अपने

बीमा क्षेत्र में कैरियर बनाने के लिए उम्मीदवार की शैक्षणिक योग्यता के साथ साथ क्षेत्र पर उसकी पकड़ भी मजबूत होनी चाहिए। बीमा क्षेत्र में कैरियर बनाने के लिए भारतीय बीमा संस्थान, राष्ट्रीय बीमा अकादमी तथा भारतीय बीमांकक समाज प्रशिक्षण प्रदान करता है।

कुल फंड का 15 प्रतिशत से अधिक संरचनात्मक या सामाजिक क्षेत्र में उपयोग नहीं कर सकती है।

चुनौतियाँ: बीमा उद्योग के समक्ष सबसे बड़ी चुनौती देश में कम बीमा वेधन है। अन्य निवेश विकल्पों की मौजूदगी इसका सबसे बड़ा कारण है तथा साथ ही आज के नवयुवकों में खर्च करने की प्रवृति भी बढ़ रही है जिसके कारण बीमा की तरफ झुकाव कम है। इससे निपटने के लिए बीमा कंपनियों को अपनी मार्केटिंग प्रक्रिया में काफी सुधार करना होगा। भारत में अन्य उत्पादों के साथ साथ पेंशन उत्पाद के लिए काफी संभावनाएँ मौजूद है, जरुरत है ग्राहकों तक अपनी पहुँच बनाने की ताकि वे लोग जो अभी तक बीमित नहीं हो पाए हैं, उन्हें बीमा उत्पाद बेचे जा सकें।

यूनिट लिंक्ड पेंशन पॉलिसीज आज काफी तेजी से बाजार में अपना स्थआन बना रही है, परन्तु यह बीमा को एक निवेश के रुप में अधिक प्रदर्शित करती है ना कि सुरक्षा के लिए आवश्यकता के रुप में। बीमा का मुख्य उद्देश्य भविष्य में सुरक्षा प्रदान करने का होना चाहिए न कि इसे केवल एक निवेश या टैक्स बचाने के साधन के रुप में देखा जाना चाहिए। आज के बदलते परिपेक्ष्य में भी इसे कायम रखना होगा।

गैर जीवन क्षेत्र में डिटैरिफिंग एक प्रमुख मुद्दा बना हुआ है। उत्पादों की कीमतों का निर्धारण करना किसी एक कंपनी के लिए आसान नही है तथा डिटैरिफिंग के पश्चात प्रतियोगिता में काफी इजाफा होगा और इस पुरे घटनाक्रम में यदि किसी को भुलाया जाएगा तो वह है, ग्राहक।

निर्णय: भारतीय बीमा बाजार ने काफी उतार-चढ़ाव देखे हैं तथा काफी परिवर्तनों का सामना किया है। इसके सतत विकास के लिए इसके प्रमुख मुद्दों का बारीकी से अध्ययन करना होगा तथा संभावित टेंड्स, अवसर एवं चुनोतियों को रेखांकित करना होगा ताकि अंतर्राष्ट्रीय मानदंडों पर इसे खड़ा किया जा सके तथा ग्राहकों को बेहतरीन सेवाएँ एवं उत्पाद प्रदान किए जा सकें।

लेखक कन्फेडेरेशन ऑफ इंडियन इंडस्टी (सीआईआई) में कार्यकारी अधिकारी के रुप में कार्यरत हैं तथा यहाँ उल्लिखित विचार उनके स्वयं के हैं।

धन शोधन, हवाला, तथा कर-अपवंचन

संजीव कुमार जैन

अमेरिका में सितंबर 11 की घटना से पहले कहा जाता था आर्थिक विकास के लिए शांति तथा शांति के लिए आर्थिक विकास की आवश्यकता है लेकिन इस घटना के बाद दुनिया की सोच बदल गई और अब कहा जाता है कि यह सुरक्षा विकास को बढ़ावा देती है तथा विकास सुरक्षा को।

वर्तमान शताब्दी में अंतर्राष्ट्रीय सीमाओं को लक्ष्य बना कर अपराध करना एक बडा उद्योग बन गया है। कुछ लोगों के लिए वैश्वीकरण का अर्थ ही नशीले पदार्थो की तस्करी, महिलाओं तथा बच्चों का बंधक मजदूरी व वैश्यावृति में उपयोग, निषिद्ध हथियारों का प्रर्वतन, ऐसे व्यवसायो का प्रचालन जिनमे बडे पैमाने पर रिश्वत दी जाती है तथा धन शोधन (मनी लांडरिग) शामिल हैं। यह सभी गतिविधियॉ उग्रवाद तथा संगठित अपराध से जुडी हैं। ऐसे अपराधों से लड़ने के लिए प्रत्यक्ष रूप से अंतर्राष्ट्रीय संस्थाओं, राष्ट्रीय सरकारों, उद्योगों तथा स्वयं सेवी संस्थाओं को एक समन्वयकारी ष्टिकोण बना कर आगे बढ़ना होगा। दूसरी तरफ संभावित जोखिमों को आर्थिक सुरक्षा प्रदान करने के लिए बीमा उद्योग की भूमिका अधिक महत्वपूर्ण हो गई है।

21 वीं शताब्दी में सरकारों को शासन तन्त्र चलाने के लिए सीमापार के खतरों पर नजर रखना, न्याय प्रणाली को सशक्त करना तथा कानून को सख्ती से लागु करना ही काफी नहीं होगा इन खतरों की जड़ अर्थात इन गतिविधियों से जुटाई जाने वाली धनराशि के स्त्रोत पर ध्यान देकर ही इन अपराधों की मेरूदण्ड को तोड़ा जा सकता है। और इन गतिविधियों से संचालन के लिए धनराशि का प्रबन्ध धन शोधन द्वारा किया जाता है इसलिए आर्थिक लेनदेन के लिए अंतर्राष्ट्रीय मानकों पर आधरित एक अच्छी रिपोर्ट पद्वति सभी राष्ट्रों के स्वयं के हित के लिए लागु करना आवश्यक हो जाता है।

कई लोग धन शोधन परिकल्पना की उत्पति वर्ष 1930 में शिकागों मोब के साथ मानते है जब एक संदिग्ध व्यक्ति बगसी सीगल ने अपराधो से कमाये गये 10 लाख डालर शेयर बाजार में लगाये थे लेकिन इस अवधारण को प्रसिद्ध बनाया वर्ष 1973 में अमेंरिका में हुए वाटर गेट कांड ने। धन शोधन या मनी लांडरिग के बारे में हम लंबे समय से स्वीट्जरलैंड के बैंक खातों के रूप में सुनते रहे हैं जब स्वीट्जरलैंड देश ने अपने गोपनियता कानून के चलते किसी भी खाता धारक के बारे में कोई भी जानकारी देने से इंकार कर दिया। आज स्वीट्जरलैंड से अलग इंटरनेट दुनिया में धन शोधन के क्षेत्र में नाईजिरिया ने अपना स्थान बना लिया है। इसकी पुष्टि सार्वजनिक ई-मेल का प्रयोग करने वाला कोई भी व्यक्ति कर सकता है जा सप्ताह में औसत रूप से दो बार से अधिक धन शोधन का प्रस्ताव प्राप्त करता है विश्व में ड्रग करोबार मे लिप्त नाईजिरिया के नागरिकों की संख्या को देखते हुए यह संदेह होना स्वभाविक हो जाता है कि इसकी कड़ी कहीं ड्रग व्यवसाय से भी जुडी हुई है। पिछले वर्षो में पाकिस्तान के कराची शहर में पुलिस ने कुल 42 विदेशी नागरिकों को नशीले पदार्थो की तस्करी में गिरफतार किया जिसमें से 35 नाईजिरिया के नागरिक थे।

धन शोधन या मनी लांडरिग की कई परिभाषाएँ वैसे तो अलग अलग पुस्तकों में दी गई है लेकिन प्राय: वह या तो ड्रग ट्रेफिग से जुड़ी है अथवा करअपवंचन (टैक्स इवेजन) तक सीमित होकर रह जाती हैं। सामान्यत: किसी ऐसे स्त्रोत से कमाया गया धन जिसकी सूचना व्यक्ति के लिए कानूनी रूप से देना संभव नहीं है तथा वह इसे बडे मक्कडजाल द्वारा इसे ऐसी व्यवस्था में बदल ले जहाँ उसके लिए इस घन राशि के स्त्रोत की घोषणा करना संभव हो इसे धन शोधन कहा जा रहा है। वास्तव में आम व्यक्ति के लिए यह इससे भी कुछ अधिक है इस मक्कडजाल में एक से अधिक देशों का शामिल होना, बडी धनराशि का शामिल होना तथा किसी संगठित उद्देश्य के लिए इस राशि का उपयोग किया जाना ऐसे तत्व है जिनके अभाव में धन शोधन तथा कर-अपवंचन में भेद नहीं किया जा सकता भारत में हवाला, पाकिस्तान में हुंडी, चीन में चोप नाम से प्रचलित प्राचीन अर्धबैंकिग प्रणाली जो विश्वास पर संचालित होती है इसमें घन के सम्बन्ध में किसी भी प्रकार का दस्तावेज नहीं रखा जाता इस पद्वति को धन शोधन के एक भाग के रूप मं देखा जाता है लेकिन वास्तव में यह भी प्रत्यक्ष रूप से आपराधिक गतिविधि ही कही जा सकती है लेकिन इसमें व्यक्ति के द्वारा धनराशि का अंकेक्षण करवा कर उसे कानून सम्मत करवाने का प्रयत्न शामिल नहीं है।

यद्यपि वर्ष 2002 में भारतीय संसद ने धन शोधन निरोधक कानून को पारित कर दिया था लेकिन अभी भी अधिकांश लोगों का मानना है कि भारत में धन शोधन के नियम विनियम अभी नये है तथा तकनीक को विकसित करते हुए ऐसी गतिविधियों पर नजर रखने कि आवश्यकता है । भारत में केपीएमजी द्वारा 100 बैंको वित्तिय संस्थाओं बीमा कंपनियों के सर्वेक्षण में यह बात सामने आयी कि राजनेता धन शोधन जोखिम में सबसे ऊपर हैं। भारत ने अभी फाईनेंशल एक्शन टास्क फोर्स की अंतर्राष्ट्रीय पहल पर अभी हस्ताक्षर करने हैं जिसका गठन विभिन्न देशो में आर्थिक सुधारों तथा धन शोधन के नियम विनियम में कमियों को दूर करने के लिए किया गया है। ऐसे भारतीय बैंक जो अंतर्राष्ट्रीय बैंक व्यवसाय करना चाहते है वे स्वयं भी धन शोधन को रोकने के लिए सामने आये है।

लेखक आईआरडीए में उप निदेशक पद पर कार्यरत हैं।

Recap

—A listing of some articles from past issues of IRDA Journal for quick reference.

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"विम्याच्या हक्कासाठीची सर्व कागदपत्रं मी पाठवली त्याला आता तीन आठवडे झाले ... ते पैसे लवकर पाठवतील अशी आशा आहे."

"होय, पाठवतीलच. सर्व कागदपत्रं व्यवस्थित असतील तर त्यांना ३० दिवसांच्या आत दाव्याची रक्कम द्यायची असते. तसा नियमच आहे ! "

विमा नियामक आणि विकास प्राधिकरण (आय आर डी ए), ही भारतातील विमा उद्योगाचे पर्यवेक्षण करणारी संस्था विमाधारकांच्या हिताचे रक्षण करते. आयआरडीएने घालून दिलेले काही नियम खालीलप्रमाणे आहे :

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- प्रस्ताव स्वीकारल्यापासून ३० दिवसांच्या आत विमा कंपनीने संभवता विमाधारकाना प्रस्ताव पत्राची प्रत मोफत देणे आवश्यक असते.
- प्रस्ताव मिळाल्याची पावती दिल्यानंतर १५ दिवसांच्या आंत त्यावर विचार होऊन तसे विमा कंपनीने कळवणे भाग असते.
- आवश्यक ती सर्व कागदपत्रे दिल्यानंतर पैसे चुकते होण्यास विलंब झाला तर विमा कंपनीला तेवढ्या काळासाठीचे व्याज देणे गरजेचे असते.
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- विमाधारकाने कोणत्याही कारणास्तव संपर्क केल्यास १० दिवसांच्या आंत विमा कंपनीने प्रतिसाद देणे आवश्यक असते.

विमा नियामक आणि विकास प्राधिकरण द्वारा जनहितार्थ प्रकाशित :
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बशीरबाग, हैदराबाद- ५०० ००४.
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Report Card:GENERAL

April trends

G. V. Rao

The new financial year 2005-06 has started off with three new players showing larger premium accretions in the month of April 2005 than any of the established players, setting a new trend for the year. National Insurance that was the front runner on the premium growth front, for the entire non-life industry, for the first time, has recorded a drop in its monthly premium, indicating another change in trend. The private players have raised their market share to 27.34 per cent from 20 per cent for the last year, a big jump indeed.

Considering that April is the month in which a majority of the corporate accounts are normally renewed, the growth rate of the industry is just 12.17 per cent, which is less than the growth rate of 12.7 per cent of the preceding year 2004-05.

ICICI with an accretion of Rs. 87 crore has marched ahead of all others with the next player, Bajaj showing Rs. 49 crore and IFFCO showing Rs. 33 crore. For the established players New India with an accretion of Rs. 31 crore ranks fourth among the 13 players, including ECGC.

For those in the game of grabbing market shares, 2005-06 is likely to prove a difficult year after April. Growth in Fire and Marine business will have to come from business diversions from the current players, as the market growth is likely to be driven by Motor and Health segments, for which even the established players are showing less appetite.

Performance in April 2005

The industry has recorded a premium of Rs. 2,330 crore with an accretion of Rs. 253 crore (12.17 per cent growth) with the new players contributing Rs. 209 crore (49 per cent) and the established players Rs. 44 crore (2.7 per cent).

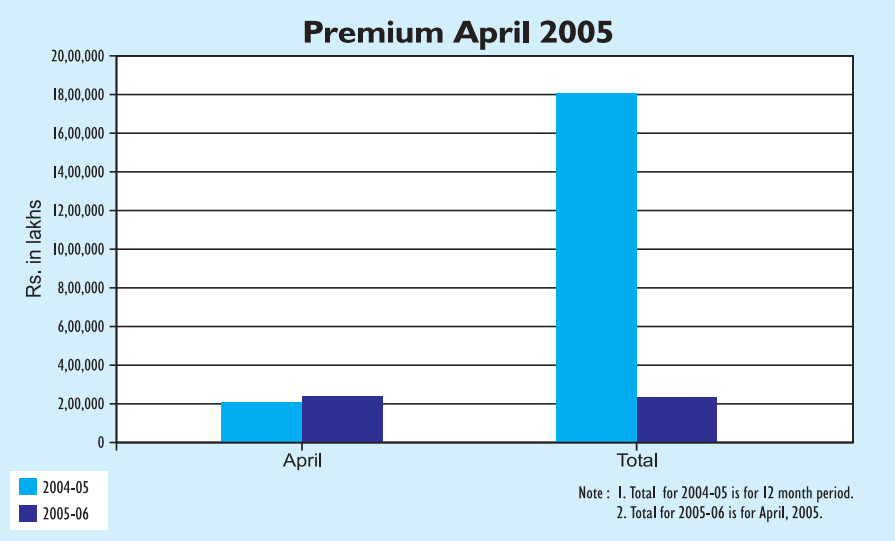
Among the new players ICICI with Rs. 87 crore, Bajaj with Rs. 49 crore, IFFCO with Rs. 33 crore are prominent. Royal Sundaram with Rs. 14 crore, Chola with Rs. 13 crore , Reliance with Rs. nine crore come in the next category. Tata and HDFC have shown Rs. three crore and Rs. 1.5 crore – a slow down from their past better trends.

The four established players seem to have hit a bad patch in April with an accretion of only Rs. 46 crore and a growth rate of 2.8 per cent. With National Insurance recording a drop of

GROSS DIRECT PREMIUM (within India) APRIL, 2005

(Rs.in lakhs)

INSURER	PREMIUM		MARKET SHARE IN APRIL, 2005	GROWTH % YEAR ON YEAR
	APRIL '05	APRIL '04		
Royal Sundaram	5,074.37	3,701.00	2.18	37.11
Tata AIG	7,723.22	7,432.89	3.32	3.91
Reliance General	3,048.00	2,197.26	1.31	38.72
IFFCO-Tokio	9,660.00	6,372.07	4.15	51.60
ICICI Lombard	20,217.64	11,451.76	8.68	76.55
Bajaj Allianz	12,992.12	8,086.97	5.58	60.65
HDFC Chubb	1,396.29	1,253.18	0.60	11.42
Cholamandalam	3,571.10	2,294.25	1.53	55.65
New India	51,107.00	48,075.00	21.94	6.31
National	37,238.00	38,772.00	15.99	-3.96
United India	38,032.00	37,771.00	16.33	0.69
Oriental	39,959.00	37,111.00	17.15	7.67
ECGC	2,935.04	3,158.55	1.26	-7.08
TOTAL	**2,32,953.78**	**2,07,676.93**	**100.00**	**12.17**



Rs. 16 crore, it is obvious that the current year has set new trends for it, and possibly for the entire group of four. With United India showing Rs. two crore accretion on its Rs. 380 crore renewals—an improvement over its previous consistent drop in premium—it is yet another sign that consolidation is on.

With Oriental showing a growth of 7.8 per cent, and New India 6.4 per cent over its massive renewal of Rs. 511 crore, the signs are obvious that defending renewals is the major concern, as inevitably Motor (other than private cars and two-wheelers) and Health segments lean towards the established players.

ECGC too has shown a fall in premium with a couple of new players competing on its turf. ICICI is breathing down their necks.

The new players have been relentless in waging their competition against the established players and must have made fresh inroads into the renewals of the profitable corporate accounts in April, hitherto held by the established players. Has it been an easy surrender by the established players?

The growth strategies of the two sectors seem altogether different: one for widening the market by acquisition of new business in Motor and Health, the other prising the existing profitable accounts from the established players. With Marine Hull going out of tariff regime, one more weapon to compete on subsidised rating of profitable segments has been placed in the hands of players. Growth in Hull premium will surely be slow-paced from now on.

Future trends

With underwriting losses mounting, and with a struggle on hand to retain a majority of profitable corporate renewals, and with staff looking to wage revisions and promotional opportunities, and with the middle management looking for directions and instructions from above, with skills developed more towards managing insurance business than marketing insurance, the established players have huge challenges to overcome.

As yet, there is no clear sign of how they propose to arrest the trends of a faster slide down in their market share and in profitability. Growth has to be matched with profitability; and the present market strategy of growth alone is just not conducive to it. The internal systems of monitoring growth on a monthly basis and measuring profitability at half yearly or annual intervals are costing them dear.

With price controls continuing to remain, they have the biggest problem of meeting competition in profitable segments to overcome other than those pointed above. The new players have taken full advantage of the current situation and have exploited the competitors' weaknesses to the full. Their success will enthuse them to go after more of the same.

The author is retired CMD, The Oriental Insurance Company.

RRBS ALLOWED TO DO INSURANCE BIZ ON REFERRAL BASIS

After permitting Urban Co-operative Banks to conduct insurance business on a referral basis, the Reserve Bank of India has now extended this facility to Regional Rural Banks (RRBs) as well.

According to a press release from RBI, RRBs will now be permitted to perform insurance business on a referral basis, without any risk participation.

Under the referral arrangement, RRBs can provide physical infrastructure within some select branch premises to insurance companies for selling their products to the bank's customers. In return the banks earn fees on the basis of the premia collected.

The release said that RRBs wishing to do referral insurance business should comply with the Insurance Regulatory and Development Authority regulations and not force customers to opt for the product of a particular insurance company.

The period of agreement between the bank and the insurance company should initially be only for a period of three years. After that the bank can sign a longer-term contract, if it wishes, with the approval of its board.

All publicity material distributed by the bank should be displayed and there should be no connection between the banking services and use of the products, the release added.

INSURANCE-BACKED HEALTHCARE FOR BPL POPULATION SOON

The Kerala State Planning Board will introduce an insurance-linked healthcare scheme for those below poverty line (BPL) in the State. As much as 37 per cent of the population could count itself under the BPL category, by the State Government's own admission.

Speaking to newspersons here, Mr C.V. Padmarajan, Vice Chairman of the Planning Board, is quoted saying the proposal would be given a final shape by September this year before it could be forwarded to the State Government for its consideration.

Traditionally, education and health accounted for the greatest shares of the State Government's expenditure. Health sector spending continued to grow even after 1980 during a time when its fiscal deficit was growing and the Government has had to look for ways to control expenditure.

But growth in the number of beds and institutions in the public sector had slowed down by the mid-1980s. During 1986-1996, growth in the private sector surpassed that in the public sector by a wide margin.

Answering a specific question, he said the scheme would not in any manner compromise the services being offered by Government-run hospitals. In fact, it would only go to complement these services and help strengthen the overall healthcare system.

Non-life insurers want cap on Motor Third Party liabilities

Non-Life insurers have sought Government intervention for capping third party liabilities in a bid to make the underwriting business viable, it is reported.

Reports say that the capping of third party liability was sought as an alternative to hiking premiums. to limit claims ratios to manageable levels or below 100 per cent.

Currently claims ratios in Motor Third Party risk covers are about 200 per cent. Insurers said that the Government and the insurance regulator had remained non-committal about allowing increase in premium. In fact premium hikes or loading is capped at 100 per cent.

Reports quote sources that the current structure of premia for Third Party did not allow underwriting business to become profitable. Besides, since the liabilities could not be accurately estimated, none of the non-life insurers, both in the public and private sectors, is in a position to make provisions for unexpired risks. In fact, some of the insurers have in the past observed that the actual liabilities on Motor Third Party losses were far in excess of their provisions for unexpired risks.

Mortgage insurer waits in the wings

Plans to set up India Mortgage Insurance Company (IMIC) has hit a roadblock with the government yet to frame guidelines and decide on a regulator for such companies in India.

P K Gupta, chairman, National Housing Bank, has quoted saying, the government needs to decide who will regulate the mortgage insurance companies - the Insurance Regulatory Development Authority or the Reserve Bank of India or yet another independent body.

The National Housing Bank (NHB) had taken up the task of floating IMIC along with the International Finance Corporation (IFC), the World Bank's investment arm.

Later, the Canadian Mortgage Housing Corporation (CMHC) was roped in as a third equity partner for IMIC, which would have been the first outfit to provide such cover for housing finance activities in the country.

NHB was also looking at the option of roping in other equity partners for the company and had appointed IFC to act as a facilitator and play the lead role in attracting equity investors for the mortgage insurance company that would provide mortgage credit guarantee on housing loans, it is reported.

The proposed company would provide guarantee to housing finance companies that would cover the risk of default by mortgage borrowers. To induce housing finance companies to expand the size and scope of their lending operations.

FOREIGN BANKS A BOON TO PRIVATE INSURERS

The aggressive marketing culture of retail-focused foreign banks such as Citibank, Standard Chartered Bank, ABN Amro and HSBC has come as a big blessing for private insurers. So much so, the risk firms say this bancassurance route has given their sales the biggest boost of all, it is reported. Standard Chartered Bank mopped up Rs 170 crore in premium income, accounting for 75 per cent of total premium (Rs 225 crore) collected through the bancassurance channel. Bajaj Allianz Life's total premium income amounted to Rs 1,001 crore in 2004-05, of which 25 per cent came through its tie ups with 5 banks.

The volume of life insurance policies sold by Standard Chartered through its branches has become a benchmark for bancassurance. Similarly, Citibank's contribution accounted for 50 per cent of the total premium income generated through the bancassurance channel for Birla Sunlife Insurance Company.

Forty per cent of total premium collections, which amounts to Rs 240 crore, was through tie ups with 10 banks. Birla Sun Life pointed out that foreign banks bring the same kind of aggressive zeal in all their business segments and is not something unique in the sale of life insurance products. Foreign banks in India on account of their having a limited branch presence in the country, have invested in sales people and have an existing culture of sales orientation embedded. Sale of risk products through bank branches, popularly known as bancassurance, today accounts for an average of 30 per cent. In the case of Aviva Life Insurance and SBI Life Insurance, about 70 per cent of sales come through bancassurance.

At the same time, insurance companies are not underestimating public sector banks. State Bank of India for instance has contributed about 67 per cent of the Rs 601 crore premium income of SBI Life in 2004-05. The private insurer is extensively using the massive reach of its parent SBI to ramp up business volumes. SBI Life Insurance Company's chief sales officer said the bancassurance channel is also a cost effective way of enhancing reach.

Huge opportunity for insurance sector

Rural India is hugely under-insured and this is a tremendous opportunity for the insurance sector. The information technology revolution has made sure that the rural areas are now better connected to the rest of the world and this provides an incentive for the insurance sector to jump in, according to Pradeep Kashyap, Managing Director MART and a rural marketing consultant.

Indian banks have already made headway in rural areas, he said. While the traditional method of saving in villages was real estate and gold, there is now a demand for financial instruments such as fixed deposits, mutual funds and even stocks and shares. According to a recent survey, the number of households investing in such financial instruments was exactly the same in rural and urban areas i.e. 6.2 million.

Kashyap was the keynote speaker at 'Rural Asia 2005,' the two-day summit on rural marketing in Asian countries.

Highlighting the various aspects of rural marketing and key issues that need to be addressed, he said, it was important to bridge the gap between India and Bharat, culturally, physically and emotionally.

The critical missing input was knowledge on the subject. In India for example, not even a dozen business schools offer rural marketing as a core subject and a majority do not offer it as an option at all. Most governmental marketing agencies that handle marketing of rural products do not employ professionals. There is also a general lack of understanding of the rural customer. Most research agencies are using western techniques to map rural consumers in South Asia.

He also pointed out the headway made by several prominent Indian companies in reaching rural consumers. The now-famous e-chaupal initiative by ITC and the nascent project Shakti by Hindustan Levers has reached the villages in many parts of India. Most villages are now connected through STD facilities. Large format stores started by companies such as ITC and Godrej are empowering the rural consumer.

Haats or village mandis are another way popular way that large companies are trying to reach rural consumers.

He said that though large conglomerates are making headway with the rural consumer, the penetration leaves much to be desired. Unless the governmental agencies and banking and insurance sectors jump in, rural markets will remain largely untapped.

Prudential marches into eighth Chinese city

British insurer Prudential Plc has received an operating licence for Zhongshan, in China's Guangdong province, it has been reported. This mark's the UK's second largest insurer's eighth licence in China, and provides Prudential with access to a population of 2.5 million people.

As the Chinese Government reduces social welfare benefits and the nation's 1.3 billion population is increasingly turning to commercial insurers for protection, insurers are making a beeline for the exploding market. Prudential, which expects to secure regulatory approval for 10 cities in China by the end of the year, now has the same number of city licences as American International Group Inc. (AIG) in the country.

Prudential's expansion in the region has not gone entirely as per plan, however. The company replaced its Beijing head, Mr. Choo Sin Fook, on May 11 and closed two sales offices in the city after China's insurance regulator said they were illegal. The company was also fined 200,000 yuan ($24,165) for the breaches.

Prudential operates in the country through CITIC Prudential Life Insurance Co., a joint venture with China International Trust & Investment Corp. AIG owns 100 per cent of its Chinese life insurance unit.

HSBC expands interest in China

HSBC bank is set to double its stake to 19.9 per cent in leading Chinese life insurance firm Ping An for HK$8.1 billion, it has been reported. The maximum allowable for a single foreign investor is 20 per cent.

The move is part of HSBC's plan to expand its presence in China 'wherever possible'. Ping An has 20 million policyholders and 250,000 sales agents.

HSBC is already China's largest foreign bank, with 16 branches and sub-branches in its own name and a 62 per cent share in Hang Seng Bank, the Hong Kong-based group. The UK bank also owns 8 per cent of the Bank of Shanghai, 27 per cent of Fujian Asia Bank, with Ping An holding the rest of the bank's shares, and 19.9 per cent of China's Bank of Communications.

HSBC already owned 10 per cent of Ping An, which it bought for £318.7 million in October 2002. The further 9.9 per cent that the bank bought recently was made up of shares held by Goldman Sachs and Morgan Stanley, the investment banks.

AON BAGS CHINESE AGRICULTURAL REINSURANCE CONTRACT

Aon Re China Ltd., a unit of Aon Corp., has secured 100 per cent placement of the first agricultural reinsurance contract in China, it has been reported. The contract was awarded by the Shanghai Anxin Agricultural Insurance Co. Ltd. (AAIC), the first specialised agricultural insurance company in the country approved by the China Insurance Regulatory Commission (CIRC) to serve the agriculture and farming industries.

Under the agreement, Aon Re China, supported by its global network spanning over 40 countries around the world, will provide AAIC with advisory services such as catastrophe information forecasting and financial analysis to protect its crop insurance portfolio. Reinsurance arrangements will also reportedly maximise the economic benefit of its risk transfer programme.

The founding of AAIC in September 2004 is reportedly regarded as an important milestone in the development of China's burgeoning insurance industry. Given the full backing of the CIRC, the company was established to revive the agricultural insurance business and better protect the agriculture and farming sector from risks.

Aon's current global reinsurance projects include crop schemes for Consorcio in Spain; Mauritian Sugar Fund; Kiwi fruit production in New Zealand; course, cotton, broad acre and horticulture in Australia; and an agriculture insurance pool in Chile.

BRAINSTORMING OVER HURRICANES

Before the onset of yet another tough season, the Lloyd's Chairman, Lord Levene, had three important lessons for insurance professionals, taken from the 2004 hurricane season.

Although the insurance industry has made a number of improvements in responding to policyholders compared with Hurricane Andrew, there is much work to be done, Lord Levene has been quoted as saying. He called for further improvements in disaster modelling, disaster planning and claims handling.

Lloyd's, the world's leading specialist insurance market, incurred the second largest loss from the hurricanes of any carrier with a net loss of $2.3 billion from the four storms.

Lord Levene's first lesson was that hurricane forecasting must be improved by investing in new technology and research to improve our understanding of risks and their impact.

Secondly, he suggested insurers and regulators must work more closely for better disaster planning. "Part of the process must involve insurance markets and their regulators working together more closely on an ongoing basis, sharing their respective knowledge and expertise," he said.

Lord Levene said the third key lesson is better handling of claims. Pointing to the shortage of adjusters on the ground during the 2004 season, he said that the relationship between the adjuster and the insurer is critical.

UNEASE OVER JAPAN HEALTH INSURANCE REFORMS

A political controversy is raging in Japan over a proposal to revamp the government-managed health insurance programme for employees of small and medium-sized companies and their families by putting it under prefectural supervision, say Japanese media reports.

About 36 million people are covered by the state-run programme. Employees of participating companies pay 4.1 per cent of their annual income for the plan, while management puts up an equal share. In addition, the central government covers 13 per cent of overall medical costs. Two years ago, the government decided to reorganise the health insurance system into a prefectural-managed regime as a way to curb ballooning medical bills.

The reform blueprint envisions a new health insurance system for people aged 75 or older to be established in each prefecture. The national health insurance programme, which is targeted mostly at the self-employed and currently operated by municipalities, would be integrated into prefectural units. The state-managed programme for employees of small businesses, meanwhile, would be handed over to prefectural governments.

However, there is concern that reorganisation would lead to significant regional differences in insurance premiums as the degree of utilising medical institutions differs from one prefecture to another. That may not be offset totally by adjustments for regional differences in factors like age and income.

According to an estimate by the health ministry, the premium for the programme would be 8.7 per cent (to be split between employees and employers) in Hokkaido, where the number of hospital beds per head of population is higher than elsewhere.

The reform could prove painful for prefectures like Fukuoka, as well as Hokkaido. Gaps in premiums among prefectures could make both employees of small firms and their employers more sensitive to wasteful medical spending. That could result in slowing the rapid growth of medical expenditures.

The Japan Medical Association has taken issue with the government's reform plan, arguing the premiums should remain uniform nationwide. The association says the central government should bear the responsibility of financing the programme under the long-established principle of universal care.

Online dictionary of insurance terms

The UK's Chartered Insurance Institute (CII) has come out with an in-depth online dictionary of insurance terms. Just two weeks ago, it launched a similar dictionary of finance and investment terms.

From 'abandonment of events' to 'zillmerisation', 'accidental bodily injury' to 'zero-beta asset', the dictionary provides detailed definitions of over 3,500 terms. The CII has described the new dictionary as "covering all branches of insurance and related subjects like pensions, financial services regulation and risk management." It also includes many legal and financial expressions commonly employed in the industry as well as many troublesome phrases that can appear in policies - expressions like "left unattended and pay on behalf of." It explains as well as defines and is effectively a concise online technical encyclopaedia for insurance practitioners, claims CII.

"Terminology is central to insurance," says Mr. Robert Cunnew, CII head of information services, "and no practitioner can be expected to understand every term they come across in the course of their business. This online dictionary ensures they will always have the facts at their fingertips - the latest offering in an ever-expanding package of support services offered by CII Information Services."

The new service is available to all CII members and to corporate subscribers to CII Information Services. Further information on the dictionaries is available at www.cii.co.uk/is/dictionaries. For further information on corporate subscriptions go to www.cii.co.uk/is/subs.

Retired...

Mr. P. A. Balasubramanian retired as Member (Actuary), IRDA on May 31, 2005.

Mr. C. S. Rao, Chairman, IRDA gives a memento to Mr. Balasubramanian during a formal sendoff function at the offices of IRDA on May 31.

...once in a generation opportunity

Mr. Andrew Cornish, Chairman, UK's Association of Insurance and Risk Managers about the recent changes in the industry brought about by the New York Attorney General Elliot Spitzer's investigation.

The financial services industry as a whole has already been left with a tarnished image in the minds of consumers, regulators and commentators.

Lord Peter Levene while discussing the trial over the World Trade Center claim dispute concerning whether its destruction by terrorists constituted one or two covered incidents under the policies that were issued.

These proposals will move the insurance industry toward increased accountability for their business practices. One of the new requirements for approved actuaries to produce an annual financial condition report, as has been the practice in the life insurance industry for many years.

Mr. Steve Somogyi, Member, Australian Prudential Regulation Authority (APRA) announcing its new draft prudential standards on a proposed strengthening of the prudential supervision of general insurance for risk and financial management.

It wouldn't make sense to bend like a reed in the wind and change our policy in response to calls from some quarters for us to do so, no matter how loud or authoritative the voices. The market is welcome to use this opportunity and collaborate to agree on a code of conduct on disclosure.

Mr. John Tiner, Chief Executive, Financial Services Authority, UK on more disclosures by brokers placing in context that the FSA had consulted extensively before deciding its disclosure policy.

(AIG is) a black box run with an iron fist by a CEO who did not tell the public the truth.

Mr. Elliot Spitzer, New York Attorney General on the TV show "This Week with George Stephanopoulos"

There are discussions but they are highly theoretical. People talk to us all the time. But ... we are not yet in a fit condition for sale.

Mr. Vanni Treves, Chairman, Equitable Life

RNI No: APBIL/2002/9589

Events

12 - 14 June, 2005
Venue: Singapore
LOMA/LIMRA Strategic Issues Conference

27 - 28 June, 2005
Venue: Manila
Catastrophe Insurance in Asia
Philippines 4th Conference on Catastrophe Insurance in Asia
Theme: Managing CAT Risks in the Post-Tsunami Era

27 - 29 June, 2005
Venue: Pune
Management of Motor Insurance (OD) (Non-Life)
by National Insurance Academy (NIA)

30 June - 02 July, 2005
Venue: Pune
Actuarial Appreciation Prog. (Non-Life)
by NIA

30 June - 02 July, 2005
Venue: Pune
Programme on Networking (Life)
by NIA

04 - 06 July, 2005
Venue: Pune
Actuarial Practices in Life Insurance
by NIA

07 - 09 July, 2005
Venue: Pune
Multiple Distribution Channel Management (Life)
by NIA

07 - 09 July, 2005
Venue: Pune
Advanced Prog. on Claims Management (Non-Life)
by NIA

07 - 09 July, 2005
Venue: Pune
Latest Trend in IT Hardware & Software
by NIA

10 - 13 July, 2005
Venue: Hong Kong
Annual Seminar of the International Insurance Society

18 - 27 July, 2005
Venue: Pune
Programme on Advanced IT Security (Life)
by NIA

25 July, 2005
Venue: Sydney
Australia & New Zealand Insurance Industry Awards

26 - 27 July, 2005
Venue: Sydney
The New World of Liability Insurance

28 - 30 July, 2005
Venue: Pune
Management of Executive Stress (Non-Life)
by NIA