

Employee Benefit Trends in India – challenges and opportunities

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India – a much-watched, analysed and observed country – is standing expectantly on the brink of economic supremacy and leadership. Before it can realize its vast, latent economic potential, however, it has to improve its rapidly expanding but equally challenge-ridden health-care system. While the impediments in this area are complex and unique, the opportunities are also myriad and exciting. On the one hand, we have the multi-faceted demands and expectations of the mushrooming middle class coupled with an ageing population, a larger share of the global disease burden and a severely tested, not-so-strong health-care delivery mechanism. On the other hand, India has the fantastic opportunity to learn from (and, in fact, pre-empt) the challenges that health-care systems of other developed countries are dealing with – primarily by incentivizing private-sector participation in financing and delivery, improving access and quality and propelling the health insurance sector.

Amidst all these anticipated metamorphoses, we have Corporate India – with its own set of aspirations and responsibilities to cater to employees' concerns. As with their peers in any other economy, Indian employers are faced with an increasingly competitive search for skilled employees, with their diverse expectations and demographic profile, which has brought about dramatic changes to human resource management. The growing complexities in products, ever-changing government legislation and expanding administrative burdens are also posing new questions. Added to these challenges is the spiralling benefits cost resulting in the excessive financial burden of health care for employers. In short, organizations in India are being challenged in all aspects of benefit programmes. No wonder all this decision-making is proving not to be an easy job for an Indian employer.

This article explores the employee benefits market in India and the emerging trends. It details the existing health-care market and how it has evolved since the 1950s, elaborating on the present drivers of growth. Finally, it describes the trends associated with the market (read Corporate India) and how they are expected to evolve and have an impact over the next few years.

THE EXISTING HEALTH-CARE MARKET

An analysis of the prevailing demographic profile of India will provide us with a common-sense check of the existing potential, changing shape and future growth of the health-care market in India.

The Population and its Health-Care Potential

The current primary driver of growth in the health-care sector is India's enormous population. Estimated at 1.15 billion, it is currently the second largest in the world. It is growing at a rate of 2.2% annually and is expected to overtake that of China by 2030. By 2050, the population is projected to reach 1.6 billion. Importantly, this population includes a middle-income group of around 385 million people¹. However, only 15 million are covered by private health insurance, indicating the massive potential for growth.

In terms of revenues, in 2008 health insurance premiums amounted to approximately US\$450 million* as against the estimated potential of US\$8 billion. If we look at the overall health-care market[†], it is growing at a brisk 16%, with an estimated market potential of US\$30 billion. However, even at present levels, the market works out as US\$30 per capita and is the equivalent of only 6% of India's gross domestic product (GDP). This further indicates the enormous potential of the market.

Public-Private Partnership in Health Care

India spends around just 1.5% of its GDP on health-care funding – and less than a quarter of that sum on the actual delivery of health-care programmes. It is therefore of little surprise that in urban health care nearly 80% of funding comes from the private sector

* £1 = US\$1.67; €1 = US\$1.49 as at 13 November 2009

† The health-care market includes retail pharmaceutical, health-care services, and medical and diagnostic equipment and supplies.

and only 20% from the public sector. While the role of central government is limited to family welfare and disease control programmes, the state governments are responsible for primary and secondary medical care, with a limited role in specialty care. Conversely, private health-care providers consist of private practitioners, for-profit hospitals and nursing homes, and charitable hospitals. Unless there is a decline in the combined federal and state government deficit, currently standing at around 8%, the possibility for significantly enhanced public health spending will be remote².

In addition, as much as 84% of health-care expenses are funded out of pocket by individuals and around 16% come from private insurance, which is predominantly employer funded (see FIGURE 1 below)³. These facts and concerns have been acknowledged in the National Health Policy. It is indeed unfortunate that, even today, people in India have to borrow money or sell assets to fund in-patient care and, as a result, often defer – or even deny themselves – treatment. As a result, the expectation of an Indian employee that his/her employer will provide adequate health-care coverage is both understandable and justifiable.

Evolution of India's Benefits System

The evolution of India's benefits system can be divided into three distinct phases, as follows:

Phase I (1950s-1970s). This was when policy was based on two principles, namely that employer–employee participation for long-term funding is important and that it is the State's responsibility to provide health care and other benefits for the people (especially government employees and the rural population).

Phase II (1980s-2000). This was when the first National Health Policy was introduced to encourage

private initiatives in health-care service delivery, while at the same time widening access to publicly funded primary health care. This mainly benefited the urban employee.

Phase III (post 2000). We are now witnessing a further shift in two important respects, namely the liberalization of the insurance sector in order to provide new avenues for health financing and a redefinition of the role of the State from being only a provider to being a financier of health services as well (to cover the entire urban population).

Such a change in focus over the years has been largely in line with the overall policy framework of moving from a mass-based approach to a class-based approach, from monopolistic market conditions to a *laissez-faire* regime and from a philosophy of support to a belief in personal responsibility (see FIGURE 2 opposite).

Other Health-Care Benefit Highlights

Higher Per Capita Demand

India is perhaps the youngest of all nations as it is home to 20% of the world's people under 24 years of age. However, it is ageing. By 2025, an estimated 200 million Indians will be at least 60 years old. This is triple the number in 2004. Thanks to both greater affluence and better hygiene, there will be a continuous improvement in life expectancy (at present 65.4 years) leading to a further increase in the old-age population. This large chunk of the growing elderly population will obviously place an enormous burden on India's health-care infrastructure and costs. At the same time, the decline in the birth-rate (currently standing at 25.4 per 1,000) has led to a decline in the population below 14 years of age. Thus, all these factors have led to higher per capita demand, especially for old-age health services.

From a corporate standpoint, there is still no central health-care programme for senior citizens, which remains a huge concern for employers.

Lifestyle-Related Diseases

In 2007-08, while the Indian pharmaceutical industry grew by 8%, the cardiovascular segment recorded a growth of 15-17% and the diabetes segment, 10-12%.

Communicable diseases have declined while high severity diseases linked to lifestyle, such as diabetes, cardiovascular conditions and diseases of the central nervous system, are on the increase.

Corporatization of Medical Care

Recently, a number of large Indian companies (for example, Max India, Ranbaxy Laboratories, Escorts, Wockhardt, Birla, Nicholas Piramal and Dr. Lal's) have ventured into health-care delivery and diagnostic services. However, there is a debate as to whether this has led to increased professionalism in medical practices and/or efficiency in the use of hospital management tools.

Household Expenditure on Private Health Services

The demand for good-quality health care has increased, with patients preferring to use private health-care facilities. The growth in affluence of the Indian middle class is adding to this demand. In the period 1993/94

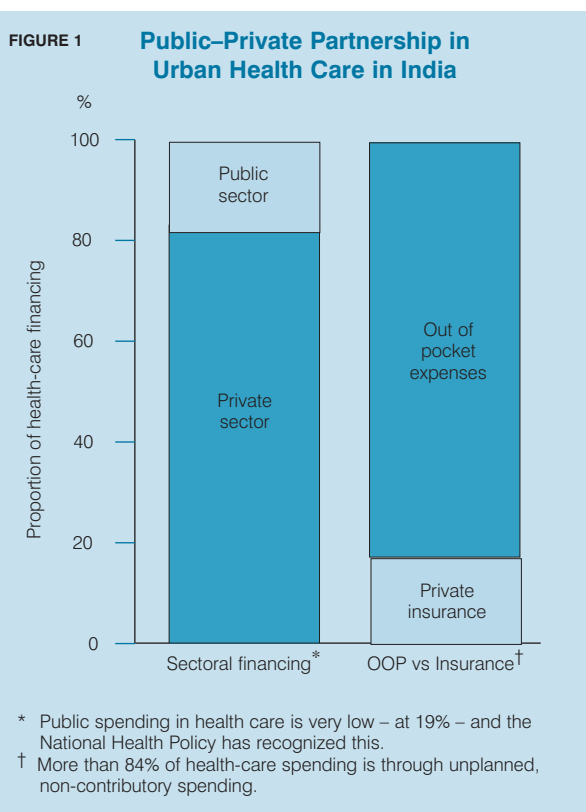
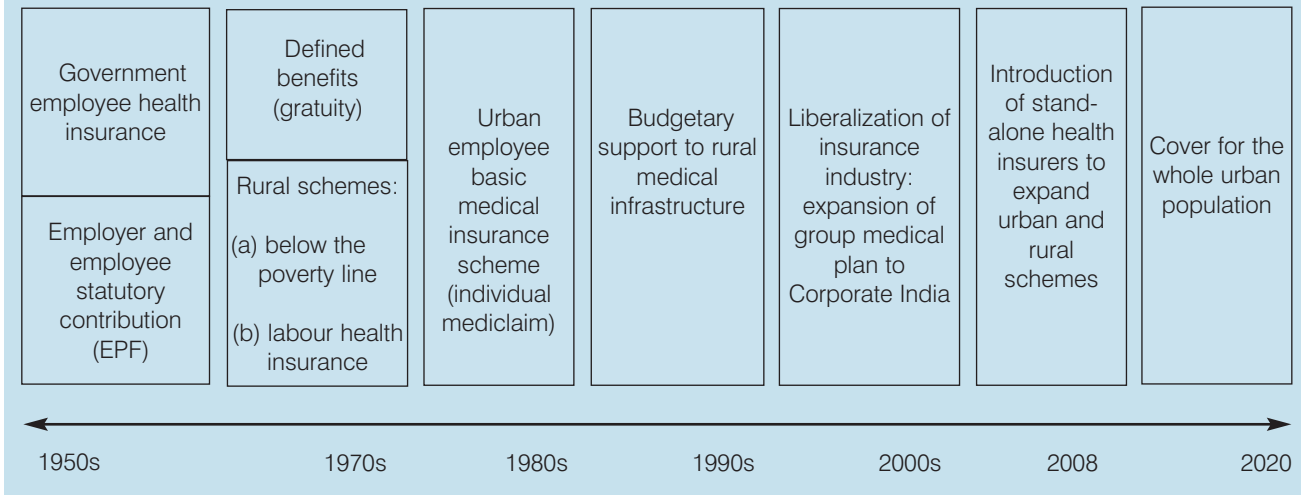


FIGURE 2

Evolution of India's Benefits System



to 2004/05, aggregate household expenditure on private health services has increased at an annual rate of 9.5%⁴.

Employers' New Focus on Productivity and Wellness

Benefit costs have outpaced both revenue growth and inflation, making employers more prudent and insisting on employees sharing the cost. Competition for talent is putting pressure on companies to squeeze the maximum financial savings out of plan design without diluting the benefits. Thus, employers have begun to focus more on productivity and attraction, retention and engagement through offering greater involvement and decision-making to employees. Furthermore, some employers are now showing an increased interest in wellness – a move from illness management to wellness management.

Medical Tourism as a Major External Driver

If you do a Google search for "India medical tourism", it throws up more than two-and-a-half million results. The emergence of India as a 'choice-destination' for medical tourism derives from the existence of the country's English-speaking and literate medical personnel, state-of-the-art private hospitals and sophisticated diagnostic facilities, together with relatively low costs compared with the spiralling health-care costs of the developed world or even India's neighbouring economies. India's private hospitals excel in fields such as transplants, cardiology, joint replacements, orthopaedic surgery, gastro-enterology and urology. For a comparative view of surgical costs between Thailand and India see TABLE 1.

Supply-Side Issues

On the supply front, the quality of administration and patient safety is still a grave issue. Error rates continue to be at a high level and the outcomes inconsistent. While there is greater impetus towards transparency – both from the consumer and the legislation – the insurers are still in a bind as they face resistance in data disclosure and are in need of protection against provider-network malpractice. This is further compounded by the limited purchasing power and somewhat weak decision-making skills of the consumer.

In summary, when it comes to health care, we find two Indias: one India is a country that provides high-quality medical care for upper- and middle-class Indians as well as medical tourists; and then there is the other India in which the majority of the population lives – a country whose inhabitants have limited or no access to health care.

All this points to an interesting scenario where complex problems and terrific opportunities co-exist. To iron out the challenges, no single solution would work; rather, a variety of tools and solutions will be needed. From an employer standpoint, although it is possible to score quickly through cost shifting, vendor selection management and the jugglery of financing; longer-term solutions lie in increasing consumerism, wellness, disease management, new design models and provider re-engineering. The involvement of both employer and employee is imperative.

THE CORPORATE BENEFIT LANDSCAPE

At present, India lacks a unified social security framework and whatever social security is available is overwhelmingly welfare-orientated without any planned financial discipline. Furthermore, one of the other great challenges is that, as each component of India's social security system has developed separately, there is no agency responsible for a system-wide perspective. Thus, most of the statutory and optional

TABLE 1 A Comparative View of Surgical Costs between Thailand and India

Surgery	Thailand US\$	India US\$
Bone-marrow transplant	62,500	30,000
Liver transplant	75,000	40,000
Open heart surgery	14,250	4,400
Hip replacement	6,900	4,500
Knee surgery	7,000	4,500
Hysterectomy	2,012	511
Gall-bladder removal	1,755	555

Source: India Brand Equity Foundation (IBEF)

TABLE 2

Statutory and Optional Corporate Benefits

Statutory	Optional / Employer Sponsored
Basic level of social security (including compulsory pension, medical insurance for government employees and work-related injury compensation)	Supplementary pension plan (known as superannuation) Medical plan Life assurance Leave encashment
Public holidays (eight days)	Accidental death and disability insurance Critical illness insurance
Other types of legal leave (casual leave, privilege leave, earned leave, maternity leave, etc.)	Supplementary housing plan Training and education assistance Stock plan
Severance and termination benefits, e.g. provident fund and gratuity	Perquisites

corporate benefits (see TABLE 2 above) have evolved independently.

Interestingly, roughly 15% of the current working population participates in the compulsory, formal programmes designed to provide income security during old age. Moreover, these participants (salaried employees in the formal private sector and in government jobs) are among the highest income earners in India.

In a bid to capture and understand changing employee benefits design in India, various surveys conducted by organizations like Watson Wyatt and MetLife have identified the following recent trends:

- The insured benefit components of the reward structure (viz. insurable with the insurer) are on the increase. Specifically, components like hospitalization cover, personal accident cover and group term life assurance are increasing while the non-insurable items like housing loans, car programmes and personal loans are becoming diluted. The gratuity (viz. a compulsory retirement benefit) has remained constant while superannuation has decreased because of the Fringe Benefit Tax (FBT) which made it financially unattractive.
- In the industries like IT* and pharmaceuticals (which are deemed to provide superior benefits for employees), a trend towards a greater emphasis on insured components has been reinforced. However, old-economy industries like consumer goods and cars are still somewhat heavier on the non-insured benefits side.
- Flexible benefits as a concept is still in its infancy in India... at least from what the analytics have depicted. Only 33% of the companies in industries like consumer products and cars have continued to offer any significant form of flexi-benefits (which is, in fact, a combination of cash and benefit elements). This further decreases to 30% in the IT sector. In addition, flexible benefits are most commonly provided at middle-management level and above (extended to junior-management employees in certain cases) while some benefit options, e.g. company accommodation, a car programme and related benefits, are restricted to certain levels.

From a qualitative perspective, in a corporate employee benefit programme, compensation is now being viewed from a Total Remuneration or Cost to Company (CTC) basis, where CTC equals:

Base pay
plus statutory and non-statutory benefits
plus perquisites
plus short-term and long-term incentives

Quality of leadership, challenging work, career advancement and brand are the new elements in the definition of 'reward'. 'Critical few' is gaining importance over 'broad based' amidst the changing expectations of employees, who want more cash compensation.

The Fringe Benefit Tax

The Fringe Benefit Tax was introduced in India in the year 2005/06. By definition, the FBT is a tax levied on perquisites – or fringe benefits – provided by an employer for his employees, in addition to the cash salary or wages paid. Such prescribed benefits included entertainment, festival celebrations, gifts, concessionary tickets, the use of club facilities, employee welfare, board and lodging in a hotel, running of cars and Employee Stock Options (ESOPs) incurred by the employer to reward the employees.

The rationale for levying a fringe benefit tax on the employer lies in the built-in complexity of isolating the 'personal element' in a benefit where there is collective enjoyment and attributing this directly to the employee. This is especially so where the expenditure incurred by the employer is supposedly for the purpose of the business but includes, in partial measure, a benefit of a personal nature – the value of which may be difficult to truly capture.

To counter this challenge, the perquisites that can be directly attributed to the employees are taxed in their hands in accordance with the existing provisions of §17(2) of the Income-tax Act and subject to the method of valuation outlined in Rule 3 of the Income-tax rules. In cases where attribution of the personal benefit poses a problem or where for some reason it is not feasible to tax the benefits in the hands of the employee, the FBT is levied

* information technology

on the employer on the value of such benefits provided or deemed to have been provided for the employees.

To update readers on the current status of the FBT, the Finance Bill (02) 2009 proposes to abolish it from Assessment Year 2010/11(Financial Year 2009/10) and subsequent assessment years.

While the abolition of the FBT has been greeted by employers as a welcome move, it may not be an unmixed blessing altogether. Implications for employers are as follows:

- The employer would not have to pick up the administrative burden of the taxation procedures prevalent in the area of the FBT.
- The abolition would provide employers with the scope to restructure employee remuneration, e.g. the reintroduction of stock options that serve as effective long-term retention and wealth creation instruments.
- Employers would be encouraged to strengthen superannuation plans as the third retirement benefit for their staff.

As the removal of the FBT means that perquisites will be taxed in the hands of employees, they are likely to pay more taxes (at the valuation rules that apply to perquisites).

Since there is scope for restructuring employee remuneration, taking into account the tax proposals, there is the possibility that employees may be looking at higher salaries (depending on the company's remuneration philosophy).

Health-Care Cost Components

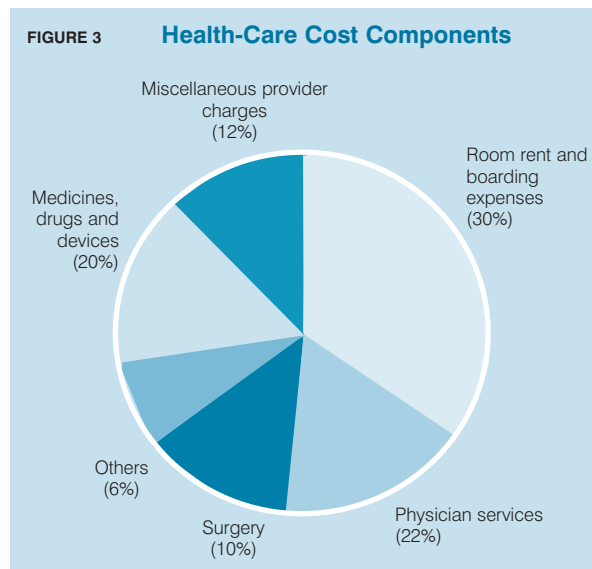
Against the changing nature of the corporate health-care landscape, it is imperative to analyse ballooning health-care costs in India – a sore point for corporate decision-makers and now a heated topic of discussion on many an HR forum (see FIGURE 3 above).

As can be observed, while 52% of the private insurance rupee goes towards medicines, drugs and devices, physician services and surgery, the administrative costs are as high as 48% of the total cost. Thus, there is palpable pressure on companies to rationalize these costs and find smarter ways of reducing them. These could provide economic incentives to select less costly forms of care, a programme for review or contracting with specific health-care providers.

Even though, at present, India is one of the world's lowest cost health-care markets, the recent rise in health-care costs has been exponential. Medical expenditure in India is experiencing an 18-24% increase in health insurance costs, which is four times economic inflation. In 2008 alone, health-care costs jumped by 20%, this being largely attributed to inflation (5%), demographic changes (5%) and new lifestyles (10%).

On further analysis, the following factors are the primary reasons for rising health-care costs in 2008:

- The technological changes and the adverse movement of the exchange rate have led to an



increase in the price of equipment. As a result, some treatment costs have increased by 28%.

- The increase in population as discussed earlier and, in particular, the growth in the richer segment of the population from 28% to 43% has also increased the treatment rate by 8%. In addition, there has been a 30% increase in average prices. To cite an example, thanks to rising incomes, today at least 50 million Indians can afford to buy Western medicines – a market only 20% smaller than that of the UK. If the Indian economy continues to grow faster than the economies of the developed world, and the literacy rate keeps rising, much of western and southern India will be middle class by 2020⁵.
- Another factor driving India's health-care costs is the interesting change in both infectious and lifestyle diseases. While certain illnesses, such as leprosy, tuberculosis, malaria and pneumonia, which are considered to be low-cost communicable diseases, are set to decline or even face eradication, the emergence of high-cost lifestyle diseases like hypertension, diabetes, cancer, cardiovascular disease (due to more affluent lifestyles but poor eating habits, obesity etc.) are on the increase. For example, the rise in chronic lifestyle-related diseases like diabetes (see TABLE 3 below) and

TABLE 3 Diabetes Rates

Country	Cases in 2000*	Cases in 2030*	Increase 2000-30	Annual growth
	<i>m</i>	<i>m</i>	%	%
Brazil	4.5	11.3	151	3
Canada	2.0	3.5	75	2
China	20.8	42.3	103	2
India†	31.7	79.4	150	3
Mexico	2.2	6.1	177	3
UK	1.8	2.7	50	1
USA	17.7	30.3	71	2

* all data rounded to the nearest 100,000

† The number of diabetes cases in India is expected to increase dramatically.

Source: WHO and UNICEF

TABLE 4

Tuberculosis Rates

Country	Cases per 1,000 people	Cases cured under DOTS*
		%
Brazil	91	75
Canada	4	81
China	245	93
India	287	87
Mexico	45	84
UK	12	–
USA	3	70

* Directly Observed Treatment, Short-course – the name given to the WHO-recommended tuberculosis control strategy combining five components (government commitment; case detection by sputum smear microscopy; a standardized treatment regime with directly observed treatment for at least the first two months; a regular drug supply; and a standardized recording and reporting system that allows assessment of treatment results).

NOTE: Tuberculosis remains prevalent in India but is expected to decline.

tuberculosis (see TABLE 4 above) has led to a 12% increase in treatment rates and a 17% increase in prices. Over the next five to 10 years, lifestyle diseases are expected to grow at a faster rate than infectious diseases in India, resulting in an increase in cost per treatment.

- The present scenario of a paucity of supply is expected to further increase the cost to the consumer. For instance, India has about a tenth of the number of physicians (51) compared with the USA (549) for every 100,000 people.

These are the most important reasons behind the recent health-care cost inflation.

CHANGING INSURANCE DYNAMICS

The Indian insurance market is undergoing an extremely sensitive and remarkable transformation – viz. detariffing – that is fast reshaping the way in which medical insurance as a benefit is both perceived and sold in India.

As we all know, the standard categories of insurance bought by any employer are property insurance, liability insurance and employee benefits. I will now look at each of these in turn:

Property insurance. This includes material damage, crime and breakdown insurance. Importantly, in India, this category of insurance used to be totally regulated, i.e. tariffed, the premium prices were determined by the regulator and insurers could not charge below the prescribed rates. Compared with global standards, such tariff premium rates were relatively high (and the profit margin for the insurers was as high as between 30% and 40%), making it the most popular line of insurance among carriers.

Liability insurance. The premium under this line of business has been driven by the rates prevailing in global reinsurance markets. Thus, locally admitted Indian insurers do not have much control on the risk pricing. Low capacity in India for liability insurance means lower net retentions by the local insurers and, consequently, lower margins.

Employee benefits. As employee benefits was a non-tariffed line of business (in pricing as well as policy design), 100% of the risk was retained by local insurers. A unique feature here was the common demand for dependent parents' inclusion under the medical plan. Under rising medical costs, this meant increasing severity of claims. Thus, historically, the average loss ratio under employee benefit insurance (specifically group medical insurance) was well in excess of 100%. The placement of volatile employee benefits insurance on a stand-alone basis was therefore naturally an expensive proposition.

As a result, companies were forced to innovate. They did so with the extensive use of cross-subsidization, whereby the placement of the entire portfolio across all categories of insurance is done with a single insurer and the expensive medical portfolio (as part of employee benefits) is therefore mitigated by the relatively profitable property premium.

TABLE 5

The Top Five Benefit Priorities

Employees	Employers
Include dependent parents' coverage in the health insurance programme	Insured benefits primarily to attract, retain and motivate talent (especially in IT, ITES and finance)
Adequacy of sum insured (family floater, corporate floater or even company sponsorship) with comprehensive benefits design (pre-existing conditions, maternity, child cover, dental, etc.)	The majority are cost conscious and seek the most price-competitive deal; willing to transition from incumbent if the latter's bid is above market median
Learn about personal health risks and how to control them	Especially concerned about the medical loss / claims experience and the need for strategic assistance in reining in without diluting the benefits design too much
Support at the time of incurring, making and settling claim(s)	Extremely keen on knowing what the peer group is doing (benchmarking)
Assistance in obtaining adequate retirement solutions	Need support in benefits administration (enrolment, endorsement and claims settlement)

Naturally, this system of having tariffs for some risks and free rates for others leads to distortions in pricing.

On 1 January 2007, the detariffing of property insurance was announced. This paved the way to allowing a complete negotiation of pricing between the insured and the insurer across all segments. No wonder the property insurance premium fell straight away (for some portfolios by as much as 80-90%).

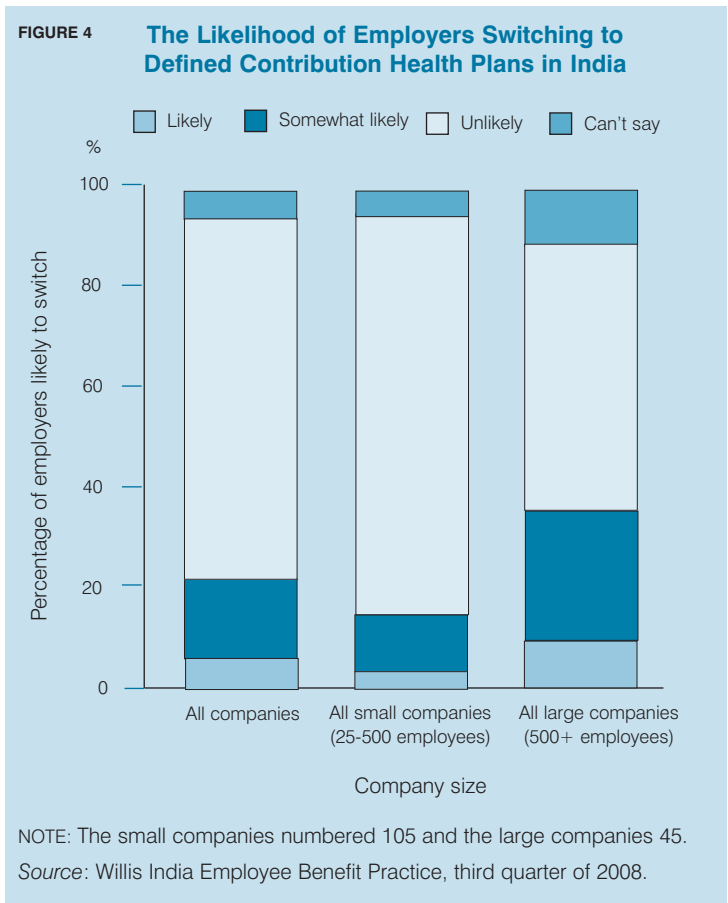
Simultaneously, it also had the following implications:

- Cross-subsidization as a concept began to disappear. Strategy relying solely on insurance negotiation has now become potentially more expensive.
- The viability of a group health insurance plan on a stand-alone basis is being severely tested. A rate break in medical policies is allowed only if stringent measures (the curtailment of high-usage benefits, a restriction on dependent parents' coverage, the imposition of a claims excess, etc.) are adopted.
- The average claims ratio in health insurance was approximately 140% in 2008. The medical premium rates are therefore likely to go up to a minimum of 30-40% in 2009/10 (on an as-is basis in benefits design).
- Carriers are becoming increasingly vocal and employers, mindful of the need to introduce cost controls in health insurance, are scaling back 'Cadillac plans'.
- Niche-marketing from carriers is now taking place. Stand-alone health insurance companies (two are already active in India) are also becoming commercially viable.
- There is an increased clamour for action against rogue hospitals, e.g. the blacklisting by benefits administrators, in networks that are known to overcharge and indulge in fraudulent practices.

In a nutshell, it is now widely expected that each line of insurance (including medical insurance) will have to run independently and under its own steam and that HR will also have to carry out thorough due-diligence on the benefits programme in order to maintain the quality of benefits with an eye to reducing loss ratios.

EMPLOYER/EMPLOYEE BENEFIT PRIORITIES

Each country has its own set of priorities when it comes to benefits. As I observed earlier, India already has a fairly mature corporate benefits structure in place, especially in the retirement space where the majority of the benefits are mandated by the Government. With the recent liberalization of the Indian insurance industry, private enterprise will be far more enthusiastic in product and servicing innovation in line with benefit priorities. From the feedback of 150 employers in IT, ITES*, FMCG†, finance, manufacturing and diversified sectors collated by my firm in the third quarter of 2008, we can see the benefit priorities of employers and employees in India, as shown in TABLE 5 opposite.



The other important, closely related, question hinges on the "likelihood of employers switching to defined contribution health plans in India" (see FIGURE 4). The overall findings of the survey are shown in BOX 1 overleaf.

FINAL THOUGHTS

Yes, the challenges faced by the Indian health-care segment are daunting. The physical infrastructure is problematic, public spending in health is below that of more advanced economies, insurance spread is token and the private-sector bandwidth has yet to reach out to the underprivileged. On the bright side, there is a growing awareness of health risks that is driving consumerism in health care. The Indian market has the appetite to:

- develop robust health-care delivery mechanisms, new medical technologies and treatment and equipment;
- support trained personnel; and
- foster productive public-private partnerships.

Specific to Corporate India, to rein in health-care costs the employer has an array of options, ranging from traditional cost-containment strategies (which are hard policy measures) to newer, intriguing strategies

* information technology enabled services
† fast-moving consumer goods

BOX 1**Findings**

- The majority of employers are keen to know about the implications of this new concept but are not willing to experiment with it... as yet.
- A possible solution is to ensure higher employee accountability/awareness while witnessing escalating health-care costs and loss ratios.
- The key to the success of a flexi-plan is the administration.

that revolve around the role of consumers of health care (viz. education, empowerment, incentivization and the motivation to influence behaviour to combat illness and live healthier lifestyles). The Indian employee, armed with improved disposable income, increased awareness of health risks and wellness initiatives and with a lower tolerance for inefficiencies in health-care delivery and claims processes, is less willing to be short-changed on the provision of the benefits portfolio from his/her employer.

Against the backdrop of changing insurance dynamics, all this has resulted in the re-examination of design and implementation strategies and the development of new paradigms that are likely to act as a catalyst on health-care changes.

In summary, the following actions should be taken by employers in India:

- Traditional cost-containment measures may provide temporary respite but real solutions cannot be short-term cost-shifting tactics.
- Post detariffing, health costs are set to rise dramatically over the next two to five years. However, the level of preparedness on the part of consumers and insurers seems inadequate.
- The risk of doing nothing may be greater.
- There is a need to communicate early and often with employees on impending changes in benefit design/delivery.
- An employer needs to provide the tools to ensure the successful understanding and adoption of new approaches.
- An effective programme must target consumerism and be holistic in order to change behaviour.

Emerging plans are a work in progress, but can still achieve better economic and affordable models, greater consumer accountability, improved administrative and communication technology, more self-reliance and self-service, coupled with a better sense of benefit value. All this will reduce the escalating health-care cost trend in India. Ω

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