MEDICAL LIFE UNDERWRITING IN A NATIONALISED ORGANIZATION FOR LIFE INSURANCE THE INDIAN SCENE

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India became independent in 1947. At this point of time, there were a large number of insurance companies operating mainly in the metropolitan urban centers and a very tiny fraction of the population was covered by life insurance. Having opted for a socialistic pattern of society, the developmental model encouraged the growth of the public sector as well as the private sector. As a matter of national policy, the basic industries like steel, heavy electricals, and the petroleum industry have been in the public sector. In 1956, the life insurance industry was nationalised and brought under governmental control but with a significant degree of autonomy. The main objective of nationalisation of life insurance was to invest the money to the best advantage of policyholders as well as the community as a whole, in projects involving large financial outlays for improving the basic living conditions of a large population, i.e., irrigation, housing, etc.

Since the formation of the Life Insurance Corporation of India in 1956, the growth of the Corporation has been remarkable by any standards, both in terms of horizontal and vertical growth, as shown in the Table.

TABLE

New Business
Life Insurance Corporation of India

1970-71 — Rs. 1224.14 crores on 16.16 lakh lives.
1975-76 — Rs. 2116.30 crores on 20.12 lakh lives.
1981-82 — Rs. 3492.89 crores on 21.06 lakh lives.
1982-83 — Rs. 3994.77 crores on 22.35 lakh lives.
1983-84 — Rs. 4415.28 crores on 23.71 lakh lives.
1984-85 — Rs. 5398.57 crores on 27.05 lakh lives.
1985-86 — Rs. 7088.45 crores on 32.94 lakh lives.

Crores = 10,000,000
Lakh = 100,000

Till recently, underwriting of substandard lives as well as standard lives with higher sums has been centralised at the Central Office of the Corporation in Bombay, with three senior physicians (internists) doing most of the underwriting of substandard lives. Relatively, less substandard lives have been underwritten at the Divisional and Zonal offices. Right now, we are actively decentralising the medical underwriting as well as the financial underwriting in a phased manner. A growth rate of 5 to 10 million new policies per year is expected in the nineties. As of today, only 5% of the entire population is covered by life insurance. Life insurance is still voluntary.

Health Insurance is not a part of the activity of the Life Insurance Corporation of India but is the activity of the General Insurance Corporation and its subsidiaries, again in the public sector. Medical underwriting standards are high and follow mostly the Western model in the absence of availability of accurate medical statistics for such a heterogeneous population of this sub-continent. The medical underwriting, however, does lay emphasis on adopting the Western model to Indian conditions based on the medical underwriter's clinical expertise, as they are practicing clinicians and members of the teaching faculty in medicine in this country.

One of the arguments against a monopolistic body like Life Insurance Corporation of India is that a person cannot get insurance coverage if he is considered uninsurable by the monolith, while in the West he may be able to shop around with competing insurance companies. To take care of this aspect, we have reinsurance arrangements with Swiss Re and Munich Re for highly substandard lives under what we call "Decline Life Treaty" and this arrangement has worked well over the years. With this arrangement, such a case is referred to reinsurance underwriters for assessment and opinion.

Since our underwriting standards can be considered reasonably good, opinion of the reinsurers' more often is similar to ours. Customers' interest in a monopoly is thus well taken care of.

One of the main problems we face in our country is the quality of the medical reporting by the initial medical examiner. In any insurance underwriting, quality of the medical reporting decides the soundness or otherwise of the business. In India, insurance is still sold rather than bought voluntarily by a well-informed insurance minded clientel as in the West. The insurance agent and the person to be examined decide which doctor from the panel of the Corporation he will go to for the medical examination. This system in my experience leads to a lot of anti-selection and suppression of material information if the honesty of the doctor and agent are suspect. I suppose this is a universal problem and each insurance company has its own ways of tackling this problem.

Standards of medical training in this country vary from mediocre to very good and world class, but what bothers the medical underwriter here is the validity of information provided.

I am told that the quality of medical reporting is under proper scrutiny with provisions for appropriate punitive action

against the doctor by a proper collaboration between the association of Life Insurance Companies and the medical associations in some countries, e.g., Switzerland, where the choice of choosing the doctor for the medical examination is left to the insured. Some companies in Japan have ensured better quality of medical reports by employing full-time doctors to do this work and getting the person examined at his residence by the appointed doctor.

Time and again, we hold meetings with our panel doctors to emphasize the need for accurate reporting.

Amounts calling for special requirements like an electrocardiogram, chest X-ray and other laboratory reports are almost on par with foreign insurance companies. AIDS, fortunately for us so far, has not been a big underwriting problem. However, we are fully aware that this situation may not last long and we are constantly monitoring the spread of the disease in our country.

Being a large Corporation, we are also able to take a more rational and liberal approach for persons with static and non-progressive disabilities, locally prevalent diseases like leprosy and tuberculosis, as well as the handicapped as a part of the social objective of a government controlled organisation.

My organisation has been laying considerable stress on interaction and dialogue with the actuaries and financial underwriters so that a concensus decision is arrived at to safeguard the interest of both the insurer and the insured and to arrive at a just decision.

The area one personally considers as yet neglected is the growth of Insurance Medicine as a specialty in this country. The total number of underwriters being rather small, an attempt is now being made to involve the medical underwriters who are all doing work on a part-time basis to hold regional conferences to discuss mutual problems.

There is no official body yet of Life Insurance Medical Underwriters in India. Only when this comes into being, we can think of a closer collaboration with the larger medical associations of this country like the Indian Medical Association, Association of Physicians of India, Cardiological Society of India and other specialty organisations. We already have a Society of Actuaries which is a fairly active academic body undertaking training in actuarial science, holding examinations, as well as compiling the ongoing mortality statistics.

A lot, however, needs to be done for the furtherance of Insurance Medicine in this country and my organisation is fully aware of this lacuna.

As a member of the Association of Life Insurance Directors of America, we certainly benefit from the academic publications of ALIMDA like the Journal of Insurance Medicine and the Transactions published yearly after the annual meeting in America and we are looking forward to more academic collaboration between ALIMDA and our organisation.

I hope this account of our functioning will give the readers of JIM a bird's eye view of the problems of medical underwriting in a developing country with a gigantic population.