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Ensuring care for the golden years – Way forward for India

FICCI 7th Annual Health Insurance Conference



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Contents

Message from Chairman, IRDA	3
Foreword by FICCI	4
Message from Deloitte	5
Introduction	6
The Indian Landscape	9
Healthcare for elderly - the global context	15
Implications for the Indian context	29
The way forward	32
Acknowledgements	35
About FICCI	36
About Deloitte	37
Contacts	38

Message from Chairman, IRDA



T.S.Vijayan
Chairman, Insurance Regulatory and Development Authority (IRDA)

FICCI's thought paper on healthcare for the elderly has indeed arrived at the right moment, at a time when the elderly population in the world is increasing and needs better attention. Given the increase in life expectancy not only across the globe but also in India, a welcome positive indicator, it is necessary to streamline our thoughts towards providing better financial protection to the elderly in the context of healthcare.

The shift to non-communicable diseases is profound and impacts the elderly more than the average person, particularly in India. In this context, FICCI's paper on covering elderly and chronic care gives a lot of food for thought to various stakeholders. *What can be the Government's role? What can insurers do? How can they innovate? How can the Regulator facilitate from the angle of the framework?* These are questions that we should get thinking about. FICCI's paper sets the ball rolling on these and more. I congratulate FICCI for this effort and look forward to some positive developments it will trigger.

Foreword by FICCI



Mr Antony Jacob
Co-Chair, FICCI Health Insurance Advisory Group & CEO, Apollo Munich Health Insurance Co. Ltd.



Dr Nandakumar Jairam
Chairman, FICCI Health Insurance Advisory Group & Chairman & Group Medical Director, Columbia Asia Hospitals



Mr Girish Rao
Co-Chair, FICCI Health Insurance Advisory Group & Chairman, Vidal Healthcare Services Pvt. Ltd.

Significant socio-economic trends along with emergent healthcare needs, underline the need of innovation in insurance products and mechanisms as an imperative to address the rising burden of healthcare costs of the elderly population in any country. India, the world's second most populous country, has experienced a dramatic demographic transition since independence, entailing almost a tripling of the population over the age of 60 years (i.e., the elderly). The Nation, today, is confronted with the enormous challenge of preparing to meet the demands of an aging population.

We are standing at a stage, where the present scenario demands development of innovative financing models to support the elderly care, thus reducing out of pocket expenditure, schemes with contributory funding from government and tax breaks to incentivize the people to save for old age. Both subsidized and private health insurance are key players in this role.

Given this view, The Chairman IRDA, advised FICCI Health Insurance Advisory Board to study and analyse the Indian scenario, look at global best practices and suggest a way forward for elderly care financing mechanisms in the country. FICCI supported by IRDA firmly believes that there is a need to spur the ecosystem of innovation around elderly care financing, create a framework of insurability and service scope with the intent of protecting the elderly and their families from financial catastrophe.

The FICCI-Deloitte paper that is being released during the 7th FICCI Health Insurance Conference aims to act as a catalyst of change to encourage policy makers and stakeholders for working towards the much needed transformation in the area of elderly care financing.

Message from Deloitte



Charu Sehgal
Senior Director and Lead - Healthcare Consulting
Deloitte India

The burgeoning elderly population is driving the need for elderly care globally. In India, the situation is paradoxical – on the one hand we are reaping the benefits of a large working age population and on the other we are staring at a significant portion of it being above 60 years by the year 2050, translating into ~300 million elderly people. This calls for a serious focus on elderly care, and we need to start now.

The ramifications of ageing, from a healthcare perspective, are significant and diverse. The elderly are faced with a combination of increased disease incidence, shifting disease burden to those that require longer term care, and a whole host of non-medical implications – social, psychological, and physical. Despite the growing need for healthcare of this segment, India does not have very strong mechanisms in place to effectively address elderly care. There are few dedicated avenues for delivery of elderly care, in the form of both facilities and service offerings. Health financing, a particularly important factor in the case of the elderly, too lacks focus on the specific needs of the elderly, with only a few insurance offerings covering elderly care with the flexibility and comprehensiveness that is required. As a result, a high component of elderly care is being financed out of pocket. Additionally, both delivery and financing mechanisms predominantly ignore the non-medical aspect of care.

In the context of this critical need for elderly care, we turn to global models of developed as well as developing economies to understand the nuances of designing and implementing public and private models of elderly care. These experiences can provide us important insight into critical success factors as well as challenges in managing elderly care, which can be very useful as India designs its own policy framework and mechanisms of elderly care provision. What emerges from these global lessons is the critical need for collaboration amongst various stakeholders, especially health insurers and healthcare delivery players. Additionally, the government needs to a play a critical role in facilitating policy making and strengthening its own mechanisms of care provision and financing. It is to be noted that the Indian Government is already cognizant of elderly care requirements and the need for addressing them.

A collaborative, multi-stakeholder approach has the potential to transform India's elderly care landscape, and bring it to a level that is comparable with global standards.

The Federation of Indian Chambers of Commerce and Industry (FICCI) is hosting the 7th Annual Health Insurance Conference, titled 'Health Insurance 2.0: Leapfrogging beyond Hospitalization' and Deloitte is privileged to collaborate as the knowledge partner for the conference.

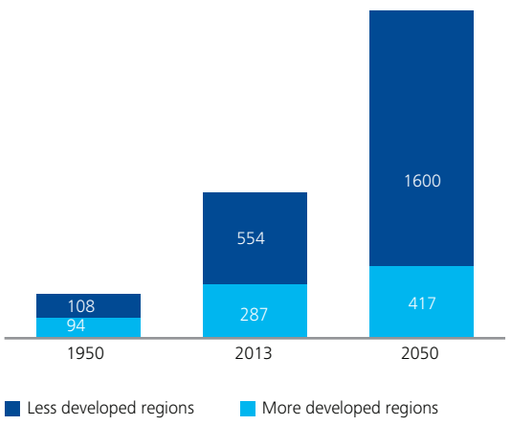
Introduction

Population ageing

With increasing mortality and declining fertility the number of elderly people worldwide is increasing at a rapid rate. While the number of elderly persons (aged 60 years or over), currently comprises ~11.5% of the world's population, it is expected that the elderly population will more than double to reach over 2 billion in 2050 from 841 million people in 2013[1].

In terms of proportion of total population, the elderly comprise 22.7% of the population in developed regions vis-à-vis 9.2% of population in less developed regions[2]. However, in absolute terms, the population of the elderly is increasingly gaining relevance for developing regions. These regions currently house 66% of the total global elderly population, and are expected to witness a faster growth in the number of older persons as compared to more developed regions.

Exhibit 1: Size of elderly population in developed and developing regions (in million)



Source: World Population Ageing 2013, United Nations Department of Economic and Social Affairs Population Division

Implications of an ageing population

A growing elderly population has a wide gamut of implications for both the individual and the society-health linked, social and economic. These could be age-related ailments, social implications such as loneliness, or economic consequences arising from a lack of stable income and inability to bear the cost of healthcare. Additionally, an increase in number of older persons necessitates higher public expenditure on benefits and social services such as pension and public health.

Exhibit 2: Implications of an increasing ageing population



A growing elderly population has significant ramifications both at a micro and macro level, especially for less developed settings. Developing regions, such as India, already face constraints on capacity and capability of their healthcare system to effectively cater to the current needs of its population. The projected increase in the number of people requiring elderly care will therefore put greater strain on an already stretched health system. In this context it is imperative to understand and strengthen the mechanisms for both provision and financing of care for the elderly, to ensure that their unique needs are effectively recognised and addressed through appropriate delivery and financing mechanisms.

1 World Population Ageing 2013, United Nations Department of Economic and Social Affairs Population Division

2 The UN has grouped countries into two general groups on the basis of demographic and socio-economic characteristics: less developed regions include all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean, and Oceania (excluding Australia and New Zealand). The more developed regions include all other regions plus the three countries excluded from the less developed regions

Understanding elderly care

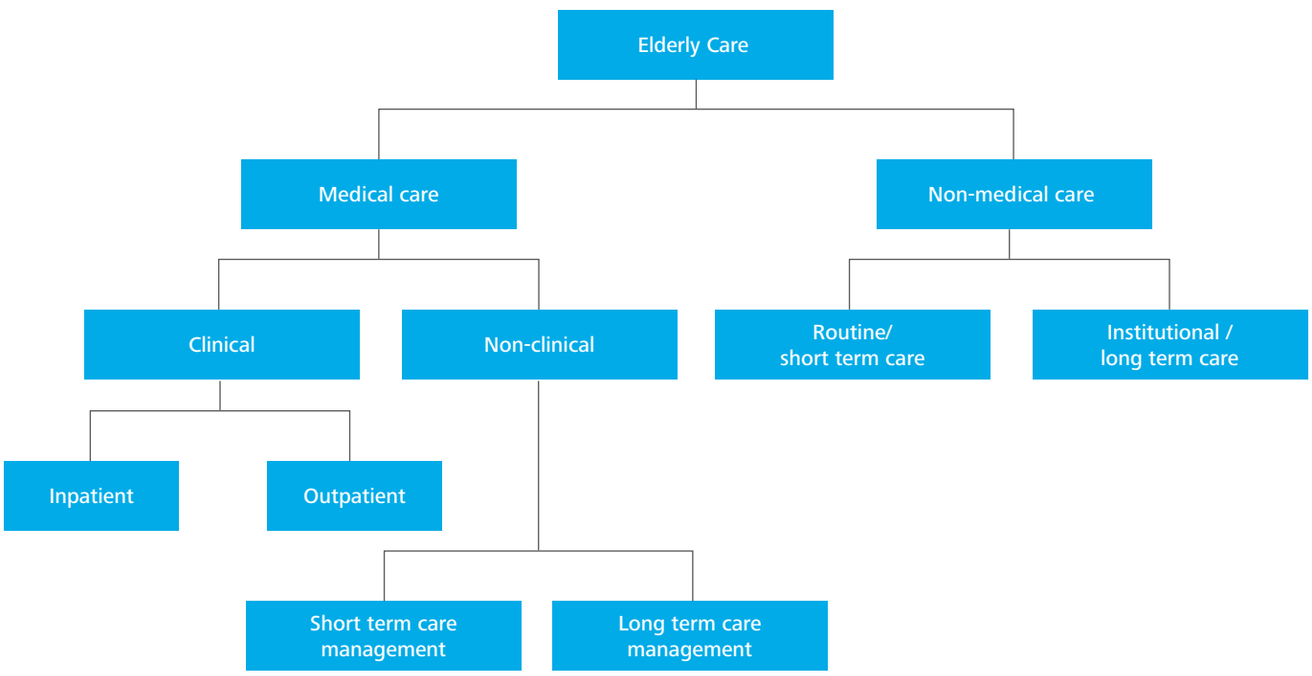
Keeping in mind the growing elderly segment and its ramifications, this paper attempts to provide an understanding of elderly care, an overview of elderly care in India and the current landscape of delivery and financing of elederly care. Additionally, it analyses the global context of care from the perspective of both developing and developed countries, draws the learnings and implications from these countries for India, and puts forth a roadmap for the way forward for India.

Elderly care comprises of the provision of both medical and non-medical services to older persons.

Medical services cater typically to point ailments, some of which are age-related, (such as hearing impairment, vision loss, arthritis, diabetes, hypertension, cardiac disorders and dementia in various forms, etc.); and their co-morbid complexities. These services have been classified into clinical and non-clinical care. While clinical administration of routine, episodic or chronic requirements can be addressed only via the inpatient and outpatient medical services route at healthcare delivery facilities, a large part of non-clinical care, such as short-term care management, is increasingly getting addressed through avenues such as home-care services as well as palliative care services for long term requirements.

Non-medical services, on the other hand, largely cater to other physical and emotional repercussions of ageing that do not require medical interventions. These services too can be classified on the basis of short-term and long-term care requirements. The former comprises of services provided at home or through day care facilities, including companionship, personal care, rehabilitation services etc., while the latter is provided through facilities for the elderly such as continuing care retirement communities (CCRC) comprising of independent living, assisted living and skilled nursing facilities.

Exhibit 3: Components of elderly care



Note: The exhibit illustrates types of care provided to the elderly, which can be catered to through a variety of avenues ranging from home-care and adult day care to institutional care delivery

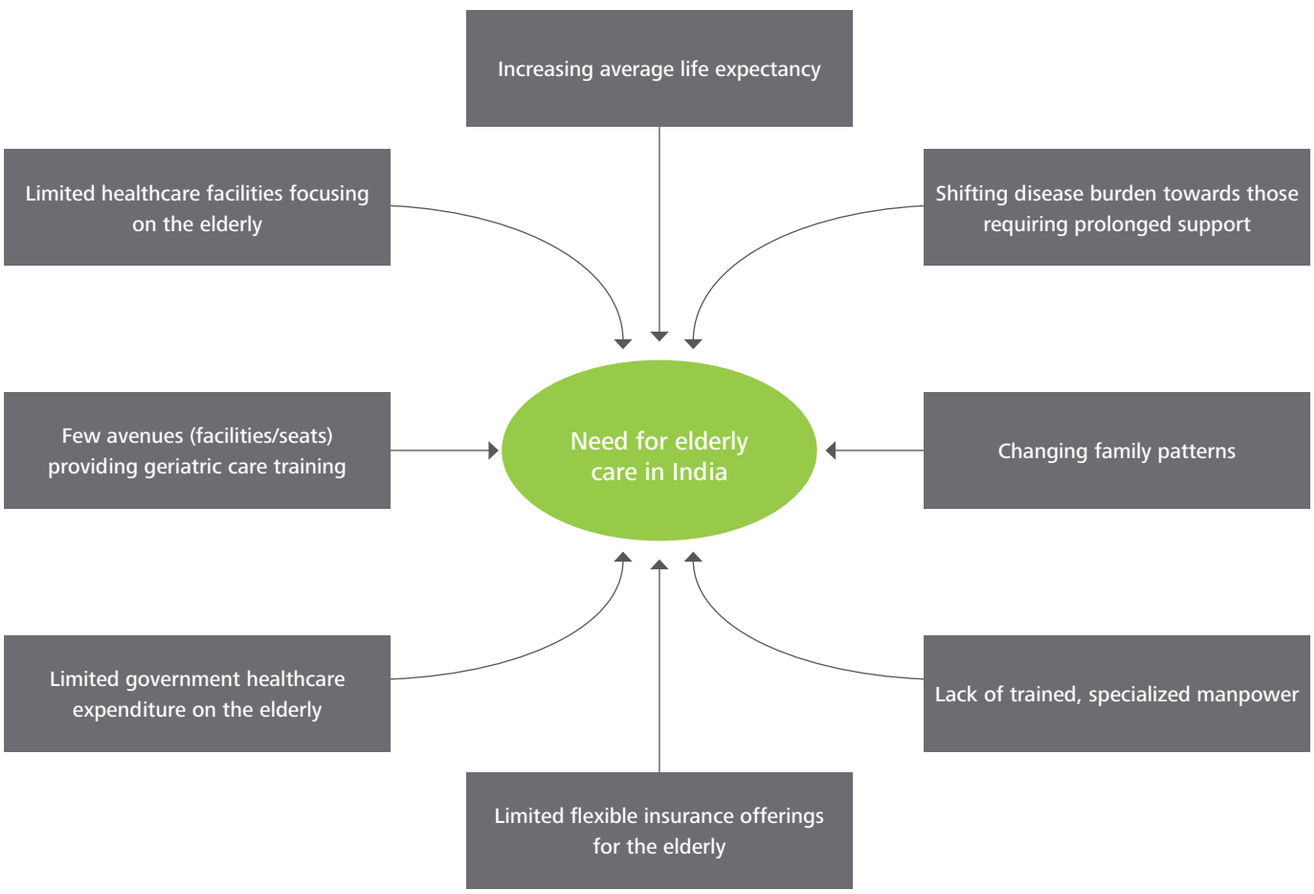
The context of elderly care in India

The need for elderly care in India is analogous to the global scenario, with India likely to witness a similar increase in the proportion of elderly population over the next few decades. Additionally, there are several factors at play, some pertinent especially to India, that underscore the importance of addressing the emergent need for elderly care in the country.

A combination of demand side and supply side factors are driving the need for elderly care in the country. From a demand side perspective, there is an increase in the need for elderly care due to factors such as a growth in the sheer numbers of older persons, shifting disease profile to those that require longer term care, and changing lifestyles that reduce family support that has traditionally existed for the elderly in India. On the supply side, a lack of emphasis on the elderly, perhaps stemming from their limited influence, has translated into lack of a supporting infrastructure. This manifests in the form of limited healthcare facilities, trained manpower foreriatric care , insurance products, and supporting government expenditure.

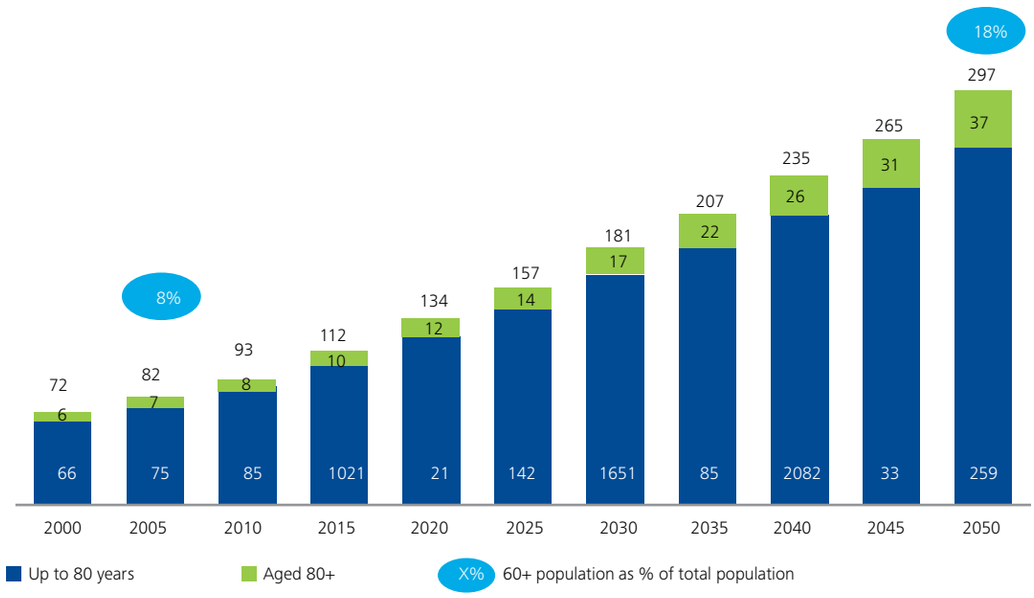
All these factors combine to make elderly care a neglected component of the health system and one that requires immediate attention in light of its complexity and growing burden.

Exhibit 4: The need for elderly care in India



The Indian landscape

Exhibit 5: Indian population aged 60+ (in million)



Source: World Population Prospects: The 2012 Revision, United Nations

Population demographics

India's growing elderly population (both in terms of absolute numbers and as a proportion of the total population) is expected to change the demographic profile of the country.

According to UN population projections, the elderly population is estimated to constitute 18.3% of the total population in 2050, up significantly from 7.7% in 2010. Similar to the overall population distribution in the country, the distribution of the elderly is skewed towards rural areas, with approximately two-thirds living in villages[3]. In addition, as a result of a lack of steady income and savings during old age, a large proportion of the elderly are of poor socio-economic status and economically dependent on others. Approximately one-third of the elderly population is classified as belonging to below poverty line[4] vis-à-vis 22% for the total population of the country[5].

From a geographic standpoint too, the distribution of the elderly is not uniform across the country. As per Census 2011, the elderly as a proportion of the total population of a state ranges from as little as 4-5% in states such as Nagaland and Meghalaya to 13% in Kerala. The southern states, in addition to Punjab and Himachal Pradesh, have experienced a faster growth of the elderly population; this trend is expected to continue, with the southern states, West Bengal, Punjab and Himachal Pradesh estimated to have the largest proportion of elderly people over the next few years[6].

Owing to the difference in the relative proportion of the elderly people in different geographical regions it is clear that from a delivery standpoint a single strategy for elderly care delivery is unlikely to work through the country. Therefore, a demand driven model for the setup of an elderly care delivery network would be required to be put in place across regions.

Changing needs of elderly healthcare

The prevalence of diseases increases with age, resulting in the elderly segment bearing a higher burden of diseases as compared to other age segments. The elderly face a changing disease mix, most commonly suffering from ailments such as cardiovascular illness, circulatory diseases, and cancers, while younger population segments suffer more from infectious and parasitic diseases. The elderly thus tend to suffer from chronic, long-term diseases and acute ailments that cannot be quickly cured. In addition to medical issues, the elderly also suffer from the non-medical implications of ageing, ranging from social and psychological issues such as lack of companionship to physical limitations that come with old age.

3 Health of the Elderly in India: Challenges of Access and Affordability; Aging in Asia, National Research Council
4 Geriatric Health in India: Concerns and Solutions, Indian Journal of Community Medicine
5 Planning Commission Poverty Estimates, 2011-12
6 Demographics of Population Ageing in India: Trends and Differentials, United Nations Population Fund

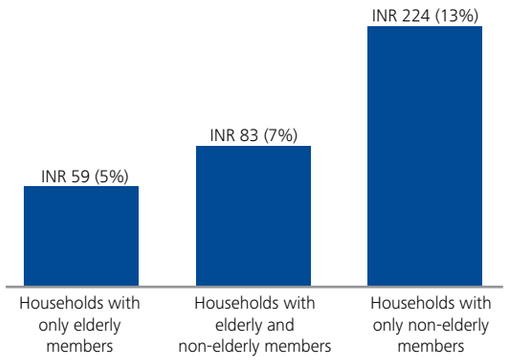
The leading cause of death among the elderly in India is cardiovascular disease; other common chronic diseases with high incidence include chronic bronchitis, anaemia, high blood pressure, chest pain, kidney problems, digestive disorders, vision problems, diabetes, rheumatism, and depression[7].

The combination of increased prevalence and a changing disease mix (towards those that require long term care) translates to a significantly higher spend on healthcare by the elderly as compared to the overall population, both in terms of absolute expenditure on healthcare as well as percentage of total consumption expenditure.

Financial burden of elderly healthcare

It is estimated that households with only elderly members incur a monthly per capita health expense that is 3.8 times that of households with no elderly members[8]. Elderly households hence spend a disproportionate amount of their total monthly consumption on healthcare needs when compared to other households.

Exhibit 6: Health spending by households with elderly and non-elderly people.



Source: Out-of-pocket Expenditure on Health Care Among Elderly and Non-elderly Households in India, Social Indicators Research

This when juxtaposed with the lack of a stable income and resultant economic dependence of the elderly underlines the need for immediate action. According to NSSO 2006, only 33.5% of the elderly were economically independent, while 13.3% were partially dependent, and 51.8% were fully dependent on their children.

Other issues in India such as limited mechanisms of social security; lack of access to benefits such as provident fund, pension schemes, and gratuity to a majority of the elderly, further compound the financing issue.

Additionally, insurance penetration remains low, and comprises predominantly of government funded schemes that have limited coverage. Even for the insured elderly, expenses remain a burden, with almost non-existent coverage for outpatient care or pharmaceutical needs.

This results in a very high out–of–pocket expenditure on healthcare by elderly people.

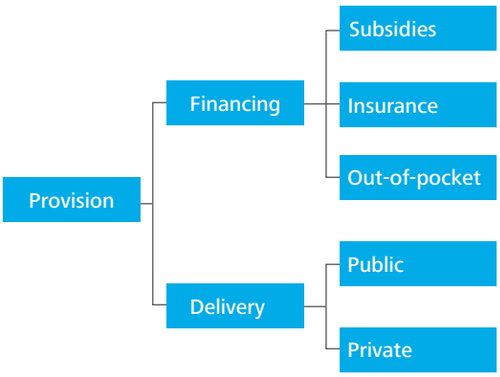
7 Health of the Elderly in India: Challenges of Access and Affordability; Aging in Asia, National Research Council

8 Out-of-pocket Expenditure on Health Care Among Elderly and Non-elderly Households in India, Social Indicators Research

Current model of elderly healthcare provision in India

Provision of elderly care takes place through both financing and delivery of healthcare. For each, the mechanisms in place are illustrated in the exhibit below.

Exhibit 7: Provision of elderly care in India



Source: Out-of-pocket Expenditure on Health Care Among Elderly and Non-elderly Households in India, Social Indicators Research

Healthcare financing

The current financing mechanisms in India only cater to medical care, while non-medical care has limited focus.

Financing through Government subsidies

Currently, central and state governments provide subsidies for healthcare through various schemes that target elderly care. The delivery is through free or subsidised healthcare services in public health facilities. While this subsidised care model targets the low-income elderly population that would otherwise be unable to access care, issues around quality of care are of concern. Additionally, the fiscal burden of this mechanism renders it un-scalable and difficult to sustain.

Insurance

Overall health insurance penetration in the country is estimated to be 26%. Insurance penetration among the elderly, however, is significantly lower (estimated to be 1.6%[9]) under public and private insurance schemes. This low insurance penetration amongst the elderly is further exacerbated by inadequate coverage provided to the insured, in terms of both amount and type of services covered.

While the government has not developed specific insurance schemes or financing policies for the elderly; social insurance schemes such as Rashtriya Swasthya Bima Yojana cover elderly care as they do not have an age limit for eligibility. Additionally, there are a few initiatives and schemes for the elderly that have insurance or financing components such as:- the National Policy on Senior Citizens. However, issues such as limited coverage and low reimbursement amounts restrict the effectiveness of these schemes in an elderly care context.

Private health insurance includes a combination of insurance products that target specifically only elderly people or general insurance plans that have a flexible entry age. e. While these products cover a wider range of medical care services including emergency care and long-term treatment, the issue of their affordability makes them unavailable to a majority of the elderly population. Most of these products in India do not offer coverage for non-medical services such as home-health or palliative care.

Also restrictive conditions further reduce the attractiveness of existing options. For example, several policies do not cover care for common age-related ailments such as cataract or asthma. Additionally, pre-existing conditions often serve as an eligibility restriction for insurance schemes, or result in the need for payment of an additional premium.

Corporate insurance companies with insurance offerings that have an entry age of above 65 years include Apollo Munich, Max Bupa, Bajaj Allianz, Cigna TTK, and ICICI Lombard, amongst others.

9 Deloitte Analysis

Out-of-pocket expenditure

In the context of the above, a large portion of medical expenses incurred by the elderly are financed out of pocket for the uninsured and under-insured population segments. Additionally, since non-medical needs are almost entirely financed out of pocket, this results in out of pocket spend serving as a major means of health financing for the elderly.

Healthcare delivery

In India, the family remains the primary caregiver for elderly people. The elderly population accesses care predominantly through the general healthcare system, which often have limited dedicated service offerings or facilities for the elderly. This delivery of elderly care takes place through both conventional forms of treatment such as allopathic medicine and alternative systems of medicine such as homeopathy and ayurveda. While some new channels of care targeting the geriatric population are observed across start-ups and NGOs , their impact and reach remain limited.

Public healthcare delivery

Emphasis on geriatrics in the public health system is limited, with the focus areas of public health expenditure being issues such as maternal and child health and communicable diseases. As a result, dedicated geriatric service offerings through the public system are few.

In addition the issues of the public health system, such as lack of infrastructure, limited manpower, poor quality of care, overcrowding of facilities, etc., are exacerbated for geriatrics due to insufficient focus on elderly care. For example, India has 7 physicians and 17.1 nurses per 10,000 people, vis-à-vis a global physician and nurse density of 14.1 and 29.2, respectively[10]. This lack of availability of health personnel is even more acute for geriatric people, as gerontology remains an ignored field in the Indian medical education system. Therefore, few doctors are qualified to assess and treat geriatric conditions in the country.

Private healthcare delivery

In the private health space, provision of medical care for the elderly predominantly takes place through tertiary care hospitals. Most of these hospitals do not have dedicated geriatric care specialists or departments. Holistic elderly care infrastructure or services are not common andthe elderly are usually catered to through the internal medicine or other relevant departments at medical care facilities. Additionally, a large part of healthcare delivery takes place through nursing homes, which similarly do not offer dedicated elderly care services. However, private players are beginning to express an interest in this space, as displayed through an increase in targeted offerings for geriatric care.

Both medical and non-medical facilities for the elderly are predominantly located in urban areas; this represents a major gap in geriatric care delivery as the bulk of the elderly reside in rural areas.

Provision of non-medical care in India takes place through home-care services, adult day care, and senior living facilities. As with medical services, these facilities are also predominantly clustered in urban areas and witness limited investment for service delivery and infrastructure augmentation. However, several start-ups and dedicated players are now beginning to show interest in this space[11].

Apollo Hospital, Chennai and Heritage Hospitals, Hyderabad have separate departments for geriatrics, and standalone geriatric hospitals such as Vindhya Geriatric Hospital, Bangalore and Aastha Hospital, Lucknow have recently come up

10 World Health Statistics 2014, World Health Organization

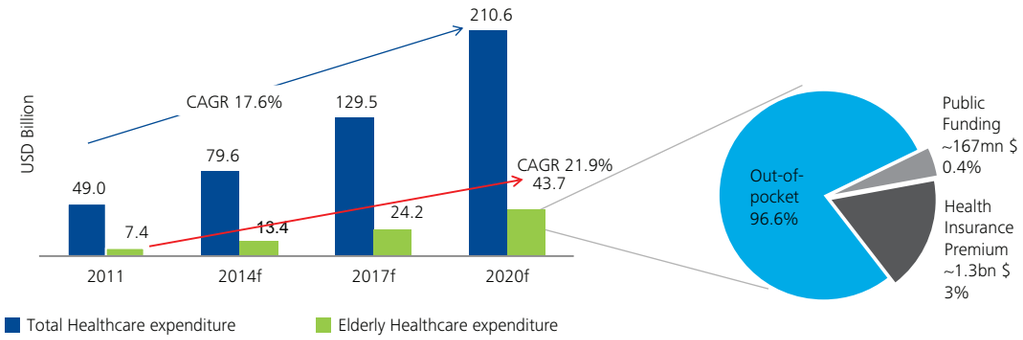
11 Examples of players in home care include Epoch Elder Care (assisted living homes), Tribeca Care (home care, assisted living, hospice care), Protea Medical, (home care, in-home doctor visits), and India Home Healthcare (home care, assisted living). Examples of players in senior living include Antara Senior Living (part of Max India), Age Ventures India, Ashiana Utsav, etc.

Existing and future demand for elderly care

As a result of the factors discussed in the previous sections, the average per capita healthcare expenditure on elderly is significantly higher than the population average.

While the total healthcare expenditure has been pegged to grow at a CAGR of 17.6% till 2020[12], elderly healthcare expenditure is estimated to grow at a CAGR of 21.9% over the same period[13]. Moreover, these expenditures cover only the medicine-related and various other clinical expenses. A considerable investment is needed for non-clinical care such as long-term care or assisted living in the case of elderly people. All these expenses further multiply the quantum of actual expenditure on elderly healthcare. Consequently, in future, the expenditure on elderly will increasingly take up a larger portion of the total healthcare expenditure pie.

Exhibit 8: Total Healthcare expenditure vs Elderly Healthcare expenditure in India, 2010-2020* (USD billion[14])

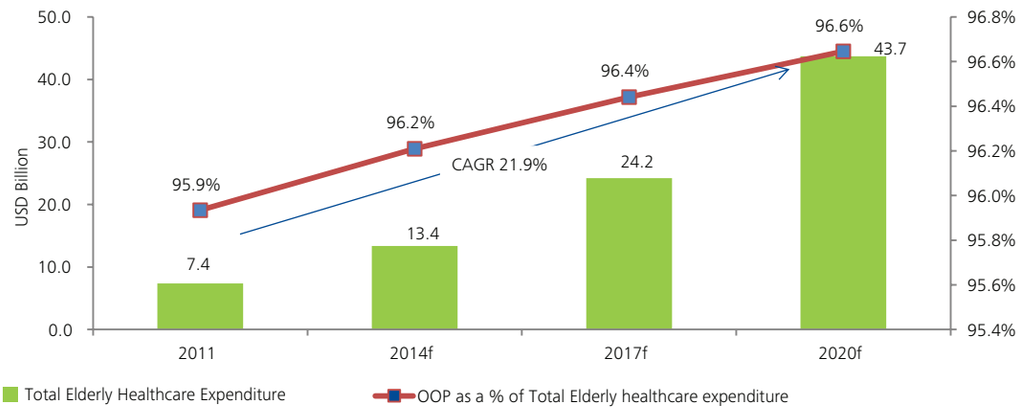


Source: Deloitte Analysis, NSSO 66th & 68th round MPCE report, IRDA Annual Reports, IIB Reports; f Forecast
*Factors accounted for growth in healthcare expenditure- change in population demographics, population growth, medical cost & general inflation.

12 IBEF Healthcare report Nov 2011
13 Deloitte Analysis
14 1 USD = 60 INR



Exhibit 9: Elderly Healthcare expenditure in India, 2010-2020 (USD billion)



Source: Deloitte Analysis, IRDA Annual Reports, IIB reports, NSSO 66th & 68th round MPCE report; f Forecast

While this expenditure can be financed through different routes; in India, historically the share of public funds and health insurance contribution out of total elderly healthcare expenditure has been abysmally low. In terms of dedicated government spending, an investment of USD 28 million under the National Programme for Health Care of the Elderly (NPHCE) was made by MoHFW in 2011. The total health insurance premium raised from elderly for the same year was close to USD 250 million[15]. As against these, the total elderly expenditure stood at approximately USD 7.4 billion[15]. These figures reflect that most of the expenditure was financed out-of-pocket.

Accounting for reasonable assumptions for growth in elderly insurance and public funding, the analysis shows that over time the out of pocket (OOP) expense would reach alarming proportions and become unsustainable for a majority of the elderly population in India.

While the insurance premium from elderly is estimated to grow at a CAGR of 20%, translating to ~USD 1.3 billion by 2020, this amount is only ~3% of the total expected expenditure on healthcare of the elderly[15].

Based on estimates, health insurance penetration among elderly is currently as low as ~1.6% of the total elderly population[15]. Clearly, all these estimates underscore the glaring need to expand the health insurance coverage among elderly and increase public spending on elderly care in order to bring down the massive OOP spend.

Need of the hour

As discussed in the previous section, while demand for elderly care represents a huge market in India, its unique challenges call for a differentiated strategy and mechanisms across financing as well as healthcare delivery.

In this context it is also important to understand the models of elderly care followed by other countries, to draw out lessons for effective interventions in India and the roles that various stakeholders need to play.

15 Deloitte Analysis

Healthcare for elderly
The global context

Overview

Providing sufficient and satisfactory elderly care remains a challenge globally, even for some of the most developed nations. Both government and private sector have continued to play a critical role in providing medical and non-medical coverage for the ageing population – however, there is no universal solution and countries have adopted different approaches to address the issue. The global context covered in this paper looks at the elderly care landscape in both developed and developing countries, is aimed at understanding current state of affairs, operating model of financing and delivery mechanisms, roles of key entities and insights that can be drawn from their experiences.

Elderly care in developed countries

Efforts to provide elderly care started very early in developed countries, with the models evolving and maturing over the years. Even though gaps in care and challenges in funding exist for these nations, they have been successful in providing care for a large part of the ageing population. The developed countries covered in this chapter include US, UK, Germany, Japan and Singapore, which represent some of the large economies in the world with the highest per capita spend on healthcare.

Comparing and contrasting the approach to elderly care in these countries reveals a spectrum of elderly care models based on funding mechanism. On one end there are countries like UK that rely heavily on government / public funding while on the other end, there is Germany, which has mandated funding through insurance. In between, there are arrangements with shared responsibilities like in the US, Singapore and Japan.

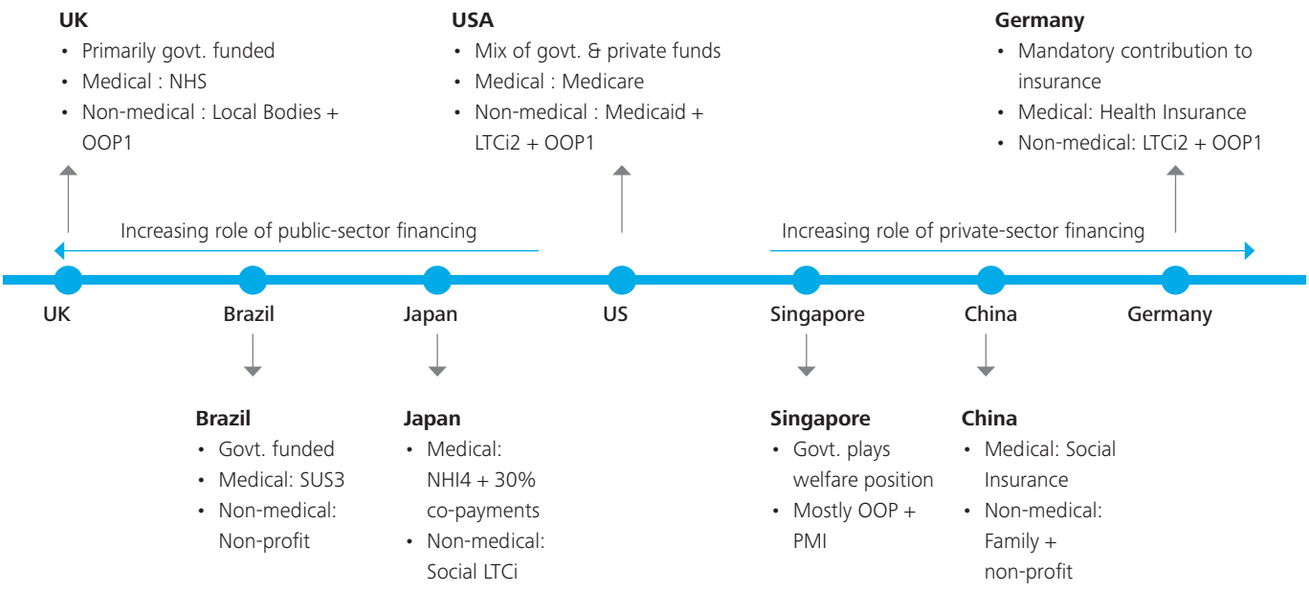
Delivery of elderly care in most developed nations is similar in nature, with medical care provided in large acute care hospitals while non-medical long term care is delivered through a multitude of channels such as nursing and residential homes, long term care institutes and home care. While the family plays a role as a caregiver, it is not the primary mode of care in these countries.

Elderly care in developing countries

Focus on elderly care in developing countries remains limited as they continue to grapple with the challenge of providing medical care to the larger population. Medical care for the elderly is largely a part of government insurance, with limited private insurance penetration, while non-medical care is supported by self, social or family care. However, as developing countries are now starting to emphasize elderly care, the chapter looks at Brazil and China, developing economies similar to India, to understand their approach to manage elderly care.

From a health financing perspective, elderly care in developing countries is largely self-funded. Additional support comes from limited government funded facilities providing basic medical coverage, philanthropic / not for profit / NGO driven long term care homes for severely ill patients and limited at-home support, and limited private insurance for those who can afford it.

Exhibit 10: Global models in elderly care



Key learning from the global context

Developed economies provide a few key experiences pertaining to the delivery of elderly care

- Governments play a key role in policy making as well as managing taxes and health care funds to finance elderly care
- Private insurance players are critical in managing funds and facilitating care for the elderly
- Risk of elderly care needs to be distributed across a range of entities such as governments, private insurers, delivery centres and patients to manage increasing costs
- Developing economies, meanwhile, offer the following lessons in providing elderly care
- Significant government involvement required initially to drive basic coverage
- Involvement and integration with multiple entities including health insurance players, hospitals, NGOs and other philanthropic organizations key to providing coverage

The following case studies of developed and developing countries further detail out the themes and lessons that have been drawn from these contexts.

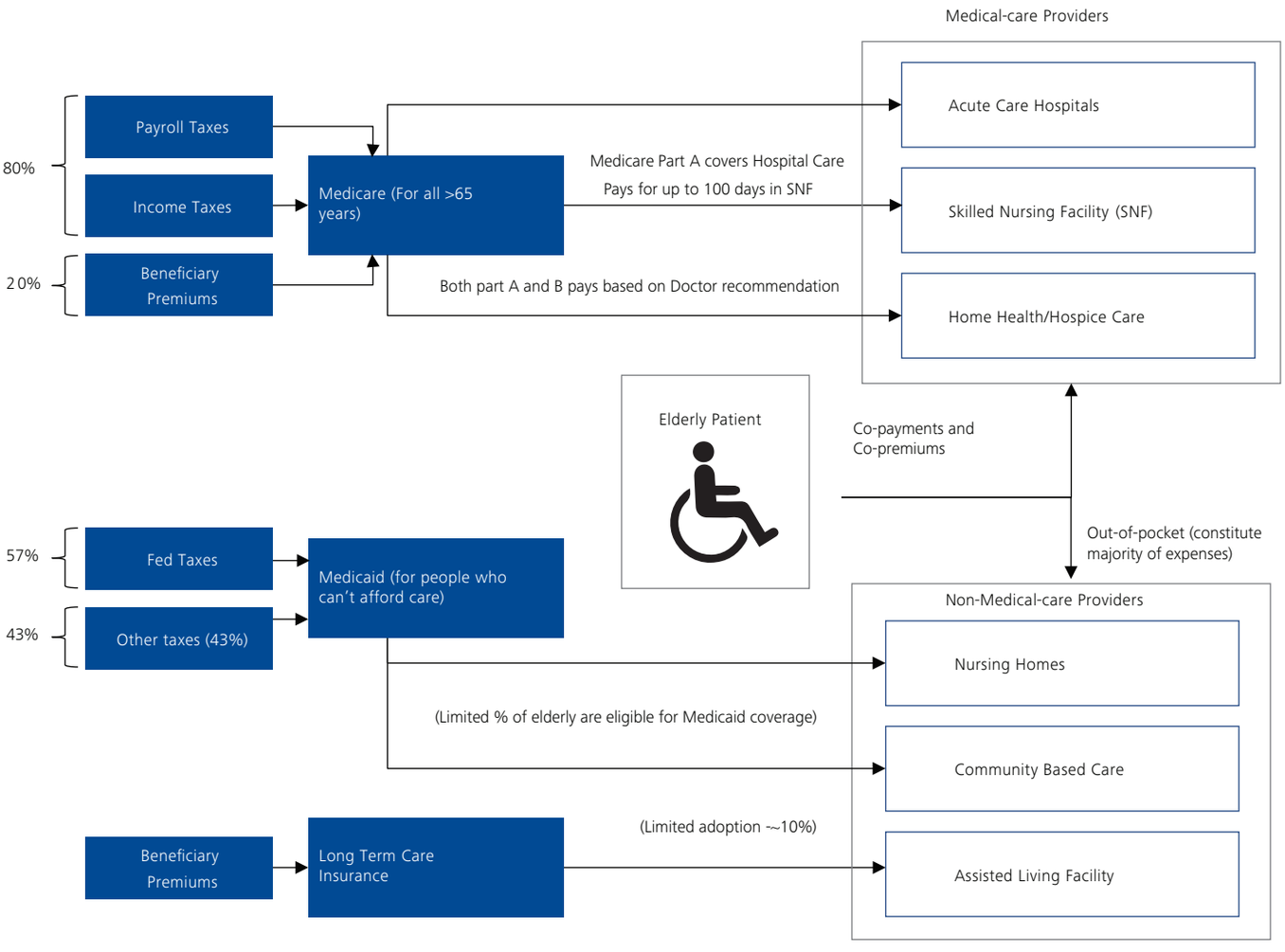
Case Study 1: United States of America

The US has a total population of 315 million, of which around 50 million is above 65. Its healthcare system is among the most expensive in the world; total per capita spending on healthcare is $8,608[16] (highest in the world) with 46.4% coming from public sector, 32.9% from private and 20.7% from out of pocket[17]. However, the spending on above 65 is close to $18,424 per person[17]. Elderly care accounts for ~20% of total healthcare spending for the government[16]. With the number of Americans over 65 years of age projected to increase from 50+ million currently to 88.5 million[18] by 2050, the need for long term care is expected to increase tremendously.

Medical care provision for the elderly is typically addressed by Medicare, with support from Medicaid, long term insurance, MediGap and family members for non-medical care. The following exhibit provides an overview of the US elderly care system:
Government finances a large portion of premium through payroll taxes; however, over the years, the proportion of out of pocket spend has continued to increase. Most non-medical care is paid for by the patients themselves, with Medicaid providing very limited coverage for low income people. Private long term care insurance exists but has limited penetration; adoption is limited to 10% among the elderly[19] . In order to control the increasing burden of elderly care

16 Health Expenditures, Centers for Disease Control and Prevention
17 National Health Expenditure Fact Sheet, Centers for Medicare & Medicaid Services
18 'Older Americans Month: May 2012', U.S. Census Bureau
19 The Market for Long-Term Care Insurance, National Bureau of Economic Research

Exhibit 11: Overview of elderly care system in United States





and curb expenses, the US is also experimenting with new models of care such as medical homes, accountable-care organizations and community health programs. Continuing care communities that provide a variety of care options are also prevalent in US. These communities provide primarily three categories of services, varying from the extensive or full life care contracts to continuing care and fee for service contracts. Each category has its own set of risk coverage and corresponding fee structures, though affordability of these is limited to only the affluent.

Experiences and learnings from the model can be highlighted below:

- Integration across providers to reduce healthcare expenditure: As the healthcare financing system is moving towards accountable care and value-based reimbursement rather than fee-for service, an increasing number of medical care providers are integrating with long-term care providers. This has been beneficial in reducing re-admission rates of the elderly and hence reducing overall costs
- Ownership of health risk across entities: Adoption of care delivery models that spread the risk not only among health insurance players / employers / government but also to care delivery entities like hospitals / physicians / pharmaceutical organizations, allowing for accountability and ownership
- Needs assessment of eligible patients to help contain costs: Patients eligible to use Medicare can access the full suite of Medicare benefits, which often leads to overutilization of services. An assessment of care-needs can help in cost containment
- Holistic focus on elder care at all spectrum of affordability: While public focus remains largely on mass products, the private sector has led development of long term care solutions combining both medical and non-medical care.

Case Study 2: United Kingdom

The UK's healthcare system is one of the most robust, offering 100% medical coverage to its citizens, which is funded by general taxation. Approximately 9.6% of UK's GDP is spent on healthcare[20]. In addition to public sector involvement, the private sector also plays a small role in the healthcare space. 85% of healthcare in UK is funded by the government, and the remaining 15% by private insurers[21]. National Health Service (NHS) is the primary financier for health expenses that all UK residents are entitled to.

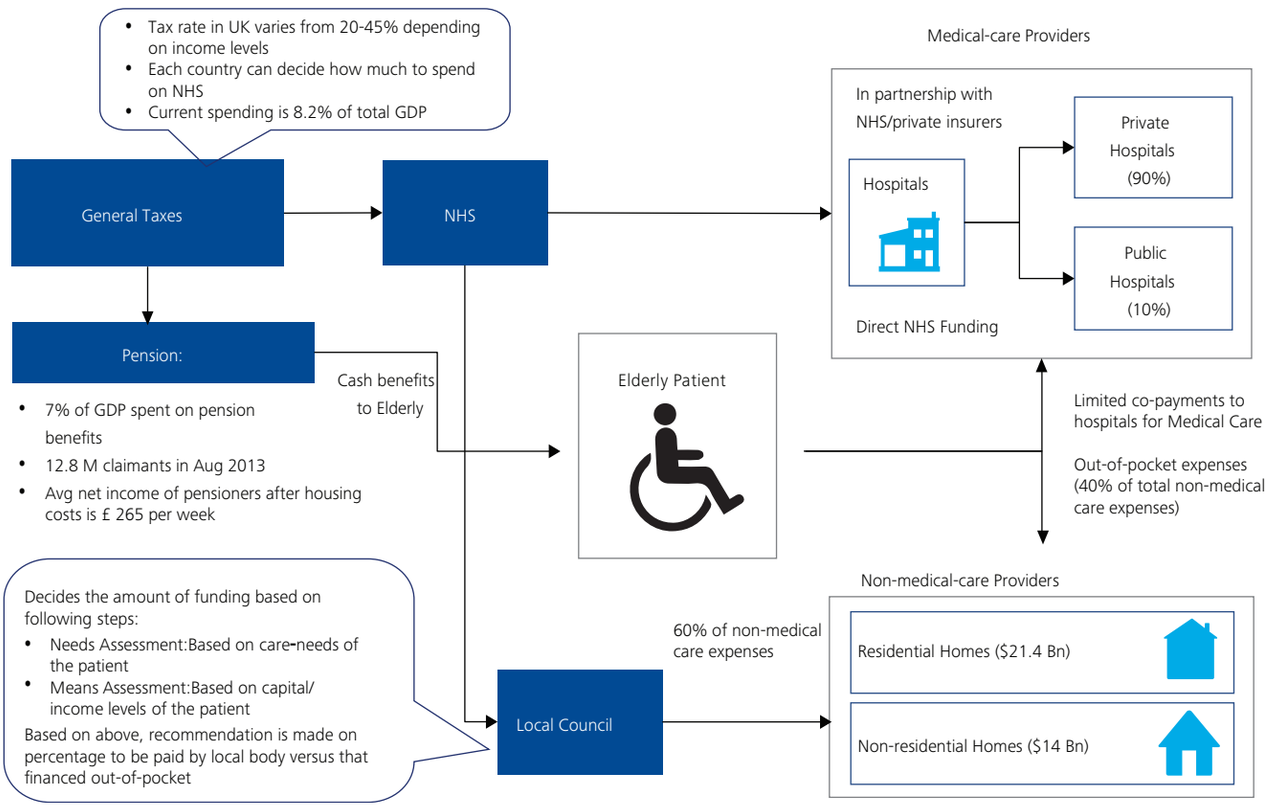
Currently totalling 11 million and comprising ~17.7% of the total population, the elderly population is expected to grow to 16 million, constituting ~23.5% of the total population by 2030[22]. The elderly (aged 65+) are major consumers of healthcare, which, coupled with changing demographics and rising per capita healthcare expenses is expected to result in increased pressure on the UK government.

Even though medical care is funded by NHS, the elderly end up paying for a part of care through out of pocket expenses due to the stringent eligibility criteria for NHS funding. In terms of non-medical care, 60% is financed by local bodies/NHS and 40% from out-of-pocket expenses. A process of needs and means assessment is adopted to identify percentage of coverage provided to an individual.

Despite limited private sector involvement at present, with growing pressure on healthcare and an increasingelderly population, there is potential for private health insurance to play a role in the provision of elderly care.

20 Expenditure on healthcare in the UK: 2011, Office for National Statistics
21 The UK Health Care System, Columbia University
22 Social statistics, December 2012, Eurostat, European Commission

Exhibit 12: Funding and delivery operating model for elderly care in UK





UK is on an extreme end of the spectrum, where healthcare is predominantly financed by the government and delivered through private facilities. There are experiences and learning that can be drawn from this model.

- Government's role in both medical and non-medical care: UK is one of the few countries with a structured financing mechanism by the government for both medical (through NHS) and non-medical care (through local bodies). However, the out-of-pocket component is higher for non-medical care and is based on need
- Income and need based approach to distribute funds: The means assessment ensures that tax funds go to those most in need, thereby ensuring effective allocation of resources and bringing parity in the treatment available across the population.
- Limited integration with private payers to drive elderly care: Lack of private payers specifically for elderly and long term care has resulted in limited opportunities for the government to share the burden of care

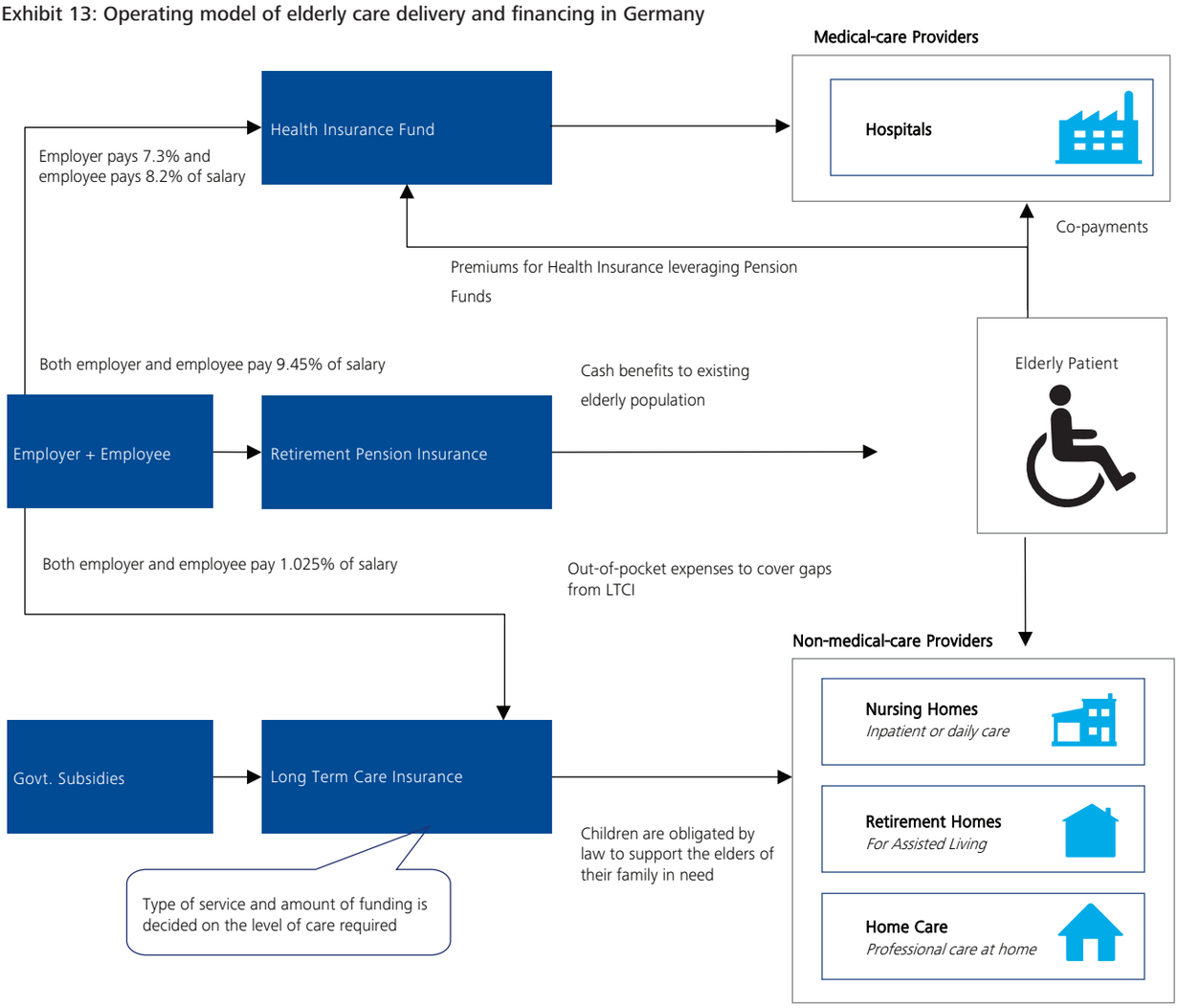
Case Study 2: Germany

Germany is an example of comprehensive healthcare coverage driven mostly by private insurance with the government playing a policy making role. It is compulsory for all salaried citizens to pay a certain percentage towards health insurance and long-term-care insurance, resulting in higher contribution for high-earners, but universal coverage of services for all. Approximately 85% of the population is covered by the compulsory public health scheme, and the remaining 15% have private insurance coverage. There are also limits on out-of-pocket expenses, over which cost is shared by the government. 11.6% of GDP is spent on healthcare[23], of which 3.32%[25] is for long-term care, a majority of which is utilized by senior citizens. The 65+ population, currently constituting 21% of the total, is expected to grow to 22.3% by 2018. While per capita expenditure on healthcare is $4,884 in PPP terms[24], long term care expenses are expected to rise to 3.32% of GDP[25] from current levels of 2.1%. Out-of-pocket expenditure usually is a considerable amount in Germany.

Salaried employees and their employers also make contributions towards a pension fund, which is used to provide cash benefits to the elderly. These are usually used to fund out of pocket expenses whenever required. Unlike other countries, Germany has a robust and structured healthcare financing system for non-medical needs as well.

23 International Profiles of Health Care Systems, 2011, The Commonwealth Fund
24 Health expenditure data, World Development Indicators, World Bank
25 Reforming Home Care Provision in Germany: Evidence from a Social Experiment, ZEW Discussion Papers

Exhibit 13: Operating model of elderly care delivery and financing in Germany



Being one of the better managed health care systems, Germany's model offers several learnings.

- Compulsory state social insurance to reduce burden on government funds: Mandatory contribution of salaried employees and employers towards health insurance programs facilitates sharing of healthcare costs between beneficiaries and the government
- National assessment aids accurate prediction of future care expenditure: Access to long-term care insurance depends on a standard national assessment. With accurate information about the current and anticipated future need for care, future expenditure on care insurance can be estimated with reasonable certainty and resources managed more efficiently
- Pay-as-you-go: As young people indirectly finance elderly care through taxes, it results in an excessive burden on the young without any guarantee of future coverage

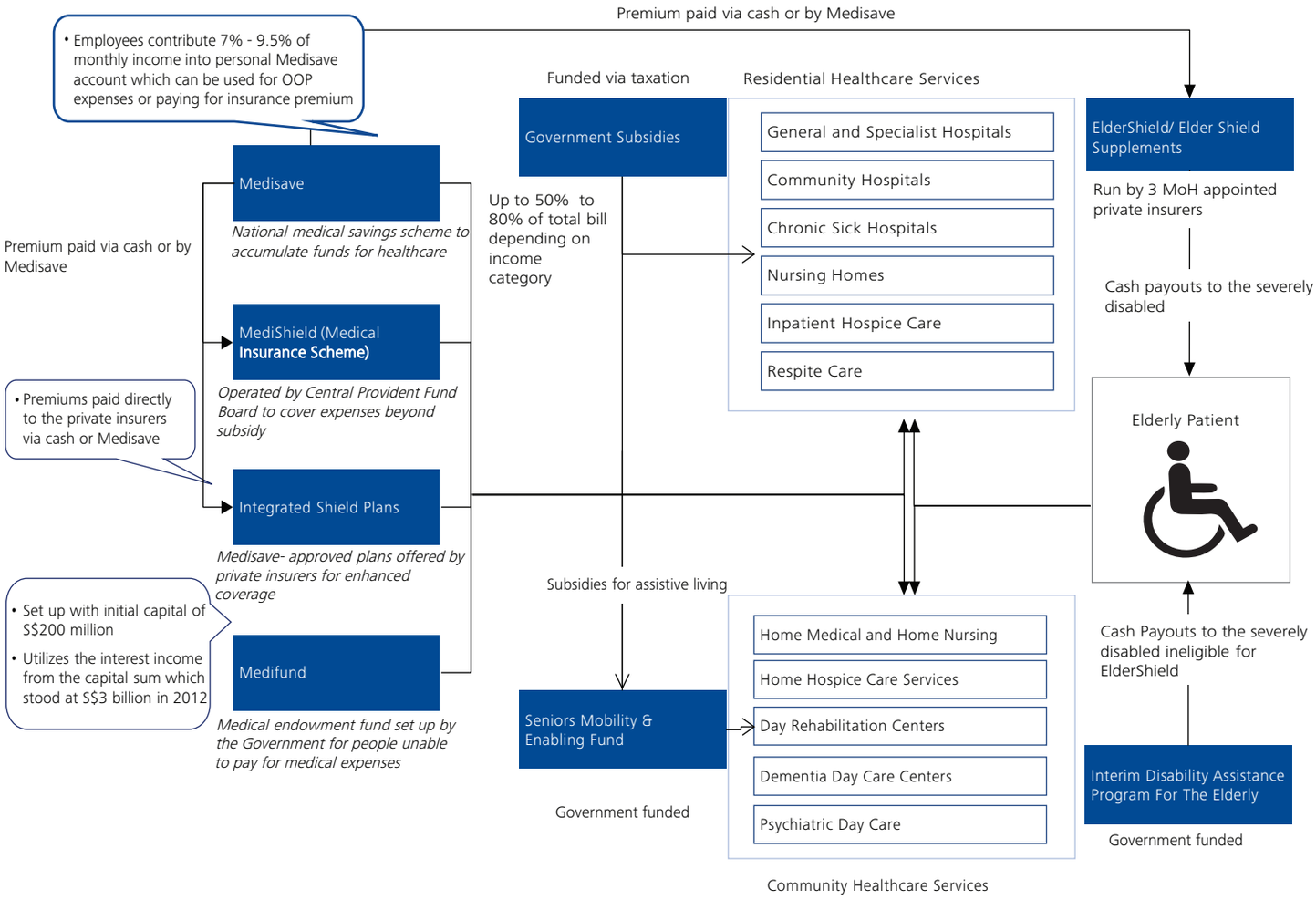
Case Study 4: Singapore

The Ministry of Health in Singapore plays a key role in designing and governing the healthcare eco-system to provide quality and affordable healthcare to all citizens. With the aging of its workforce and political pressure on the government to ease the burden on the country's poor, Singapore has increased its healthcare spend in the recent years. It currently ranks among the most efficient healthcare systems in the world, with an annual healthcare expenditure of 4.7% of GDP[26] and government health expenditure of 1.4% of GDP[27] in 2012.

Singapore's current population is ~5.4 million, of which 10.5% is the 65+ population. The majority of the elderly population (~85%) reside with their spouses and/or children, with a very small percentage (~3%) living in senior care facilities as of 2010[28]. Elderly receive medical care like any other patient, while non-medical services are broadly classified as either residential or community healthcare services. These services are provided by both voluntary welfare organisations (VWO) and private sector operators. The government subsidizes a part of the medical expenses (50%-80% financed by taxes/ government budget)[29]. The remaining costs are covered by patients using the mandatory savings set aside (Medisave) for health-care needs, with the government providing a safety net to cover expenses for which these personal savings are inadequate.

26 Health expenditure data, World Development Indicators, World Bank
27 Government Health Expenditure and Healthcare Financing, Ministry of Health, Singapore
28 Caring for the Elderly in Singapore: Are We Doing Enough?
29 Caring for the Elderly in Singapore: Are We Doing Enough?

Exhibit 14: The care delivery system in Singapore and the primary financiers.



The Singapore healthcare model offers some key insights:

- Saving for the Future: Singapore's health system is different from everywhere else as individuals pay for their own healthcare and save enough to cover care in the future, unlike other countries with a "pay as you go" approach. This boosts sustainability of the system
- Accountability for everyone: A key feature of the healthcare system in Singapore is that no service is provided free of cost, with patients required to pay a part of the cost themselves. This allows for accountability and rationalized use of services instead of over utilization.
- Regulated healthcare marketplace supported with advanced healthcare delivery system: The healthcare market is highly regulated in Singapore. Although public and private hospitals coexist, care is intentionally directed towards the public sector through the use of patient incentives and subsidies. The ability to set prices of services at public hospitals and regulate the number of public hospitals and beds allows the government to shape the marketplace and keep costs low. The system is effective since public hospitals offer high quality services, thus forcing private health providers to maintain prices at public levels to avoid pricing themselves out of the market.

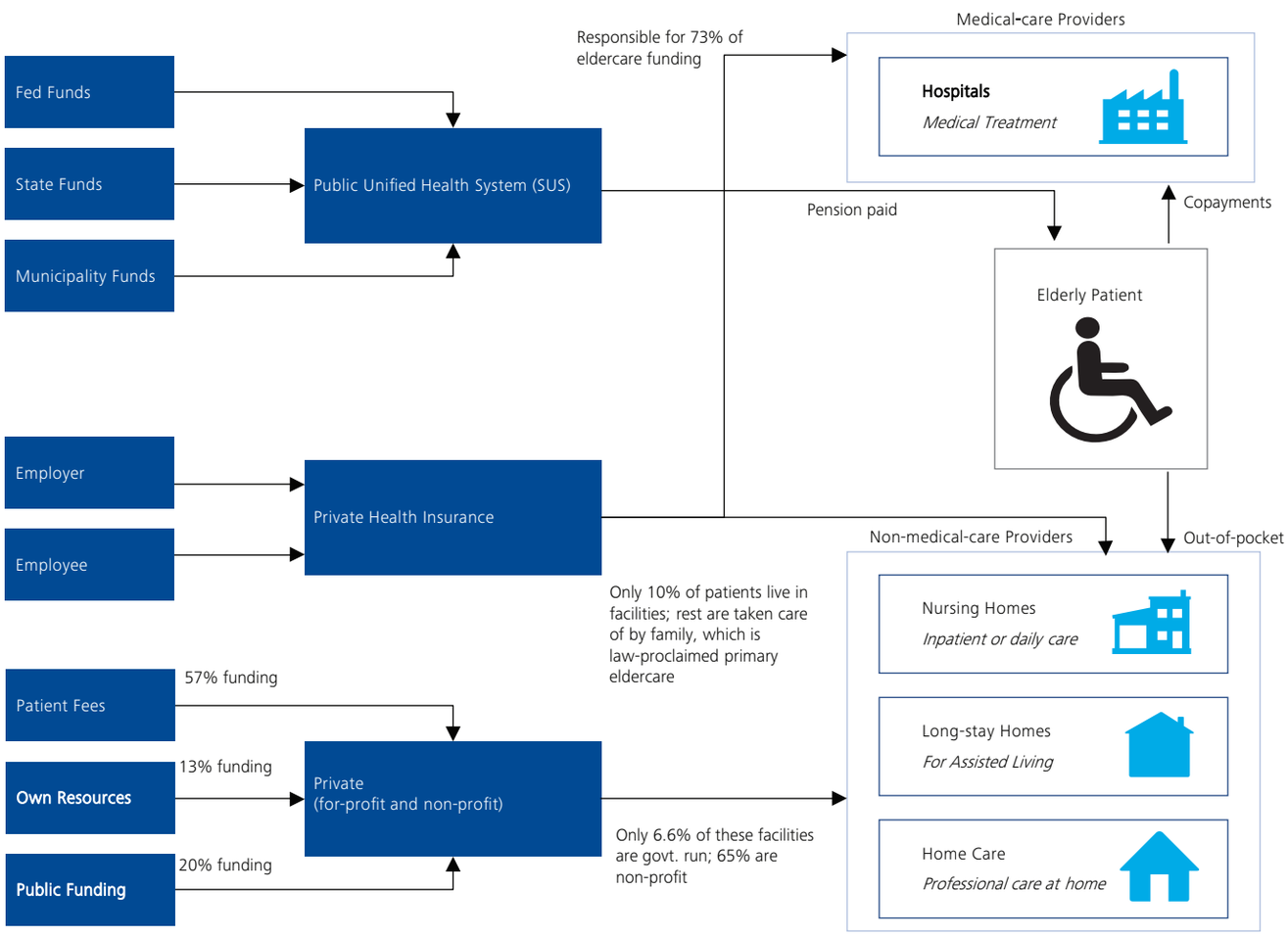
Case Study 5: Brazil

Healthcare in Brazil is mostly funded by the Brazilian Government, following a 1988 regulation ensuring access to free medical care for all citizens. The Ministry of Health is responsible for the various public health services, medical services and government hospitals. All legal citizens, including residents of foreign origin, are entitled to free healthcare at any public clinic or hospital by producing an RG (Brazilian ID card) and an SUS card (Cartão SUS). The annual budget of the Ministry of Health is approximately US$ 49 billion, of which approximately US$ 37.5 billion is earmarked for the financing of SUS[30]. Most Brazilian residents (around 70%) use public hospitals, while the rest opt for private hospitals. Those that use private facilities either pay out of pocket or are covered by private medical insurance plans.

The total population of Brazil is ~200 million, of which 7.5% is the 65+ population[31]. This number is expected to grow to 8.9% by 2018. Traditionally, the elderly are taken care of by their families, with about 10% staying in formal care-providing facilities. Non-medical care is mostly financed by non-profit organizations and a few private sector entities; public sector involvement is low. In terms of medical care, public entities fund 46% of health expenses for the elderly[32], while ~27% of 60+ have private health plans[33]. While the elderly comprise ~7.5% of the total population, they account for ~34% of hospitalization expenses of SUS. The per capita costs of the elderly is also three times that of the overall population[30].

30 Costs of elderly health care in Brazil: challenges and strategies, MedicalExpress
31 Health expenditure data, World Development Indicators, World Bank
32 OECD Health Statistics 2014: How does Brazil compare?
33 Lima Costa MF, Barreto SM, Giatti L. Health status, physical functioning, health services utilization, and expenditures on medicines among Brazilian elderly: Cad. Saúde Pública, Rio de Janeiro. 2003;19(3):735-743

Exhibit 15: Operating model of elderly care in Brazil.





The Brazil healthcare system offers some key insights:

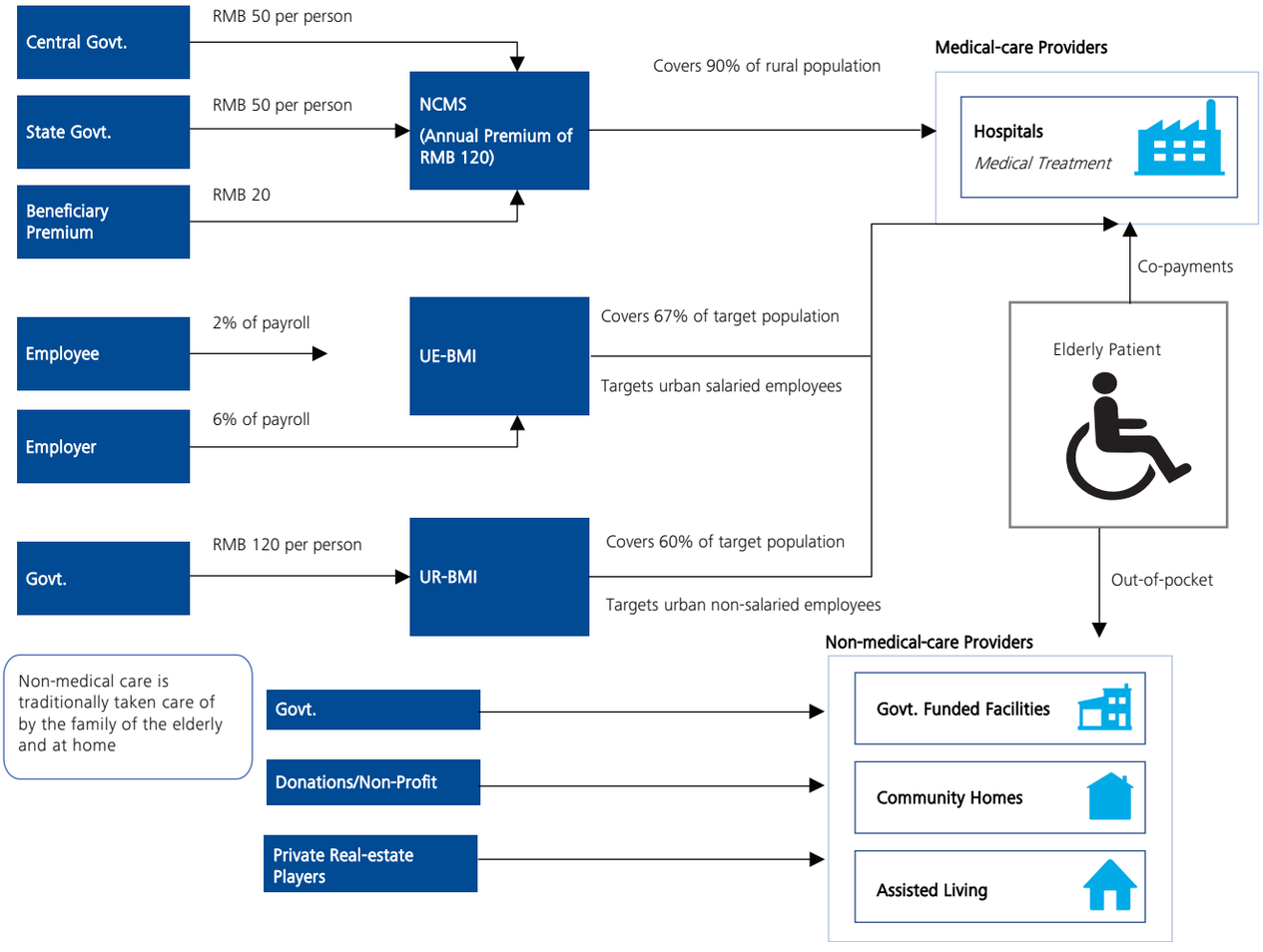
- Philanthropic non-medical care might not be sustainable: Majority of non-medical care is supported by philanthropist activities, which might not be sustainable in the long run. With a high percentage of population not being able to afford healthcare and a rapidly ageing population, there is a dire need for a structured and well-financed elderly care infrastructure
- Significant support from Government: Significant support for medical care comes from the government in terms of financing and empowering family members / care givers to support the elderly. This helps in covering the basic healthcare needs of the elderly and improves their quality of life
- Legal responsibility of children to take care of parents: Non-medical care delivery is largely unstructured, with the family serving as the primary care-giver. The legal framework surrounding this helps in dealing with capacity constraints in the country

Case Study 6: China

While China's government is aiming for a more comprehensive healthcare coverage, elderly care mostly takes place at home and by family members. There are separate insurance programs for rural and urban residents, but in addition to these the Chinese end up covering a large part of medical care out-of-pocket (~35% in 2011). Currently, healthcare expenses in the country constitute 5.4% of GDP , of which the government spending accounts for ~57% .

China's current healthcare expense is $516 B and is expected to rise to $940 by 2018, the primary reason being the decreasing number of earning members and increasing number of senior citizens due to the adoption of the one-child policy. In 2010, 65+ accounted for 8.2% of the population, which is expected to reach 23.3% by 2050. Very few of them actually stay in senior care facilities at the time of need. There are only about 3.2 million beds in residential senior care facilities in China, which means less than 2% of China's senior population live in senior care facilities, much lower than 5% or 6% in advanced economies .

Exhibit 16: Care-delivery system in China and the primary financiers.



NCMS: New Rural Cooperative Medical Scheme; UE-EMI: Urban Employees Basic Medical Insurance; UB-BMI: Urban Residents Basic Medical Insurance

Following are some of the key learnings from the China model, from an India perspective:

- Payroll taxes to fund medical care: It is mandatory for citizens and their employers to pay premiums for health insurance, which is used to fund medical care. This helps in reducing the burden on the government
- Separate insurance schemes for different target segments: This ensures that the government is paying according to the monetary needs of the target population.
- Encouragement of private investment: Most private assisted-living facilities are being developed as "senior living real-estate" as gated communities in the outskirts of big cities, primarily for the independently living elderly population. There are also policies in place to encourage private investment in nursing homes and other care facilities to build required infrastructure.

Global perspective

Global initiatives and experiences with elderly care provide good food for thought and ideas that can be adopted in the Indian context. However, there is no single model that fits perfectly given the current Indian scenario and the gaps / challenges that exist with the global elderly care models. As India embarks on the journey to provide elderly care, there are elements that can be incorporated to come up with an approach customized to the Indian context.

Implications for the Indian context

The mechanisms of care present in other countries, and their relative strengths and weaknesses, provide potential pointers for strategies that may need to be adopted in India across the value chain to adequately address the elderly care imperative.

Key tenets for Indian elderly care ecosystem

Government involvement is critical

As demonstrated in the previous chapter, governments play an essential role in the provision of elderly care across geographies. While the need for the government in this space is indisputable, the scope of involvement could range from playing only a policy role to active involvement in both delivery and financing of care., The government needs to serve as a policy making authority as well as support private sector initiatives and actively participate across the value chain.

Need for a collaborative approach

In addition to government intervention, the elderly care space also requires involvement on the part of other key stakeholders, including health insurers, care delivery players, infrastructure developers, NGOs, employers, family members and individuals. These interventions, across the range of stakeholders, must span policy, financing, and care delivery initiatives, which are interlinked.

Differentiated strategies for different segments

The nuances of the Indian context also warrant a differentiated approach in designing the mechanisms of elderly care. Since population groups and their healthcare needs across the country vary greatly, the need for elderly care cannot be addressed in a uniform manner across all types of end users. Overarching elements of care can be applied consistently; however, there is a need to introduce specific strategies and components within this overall framework to cater to specific sets of users. The exhibit below illustrates a few of the factors, and indicative classifications within these factors, that impose the need for a differentiated approach.

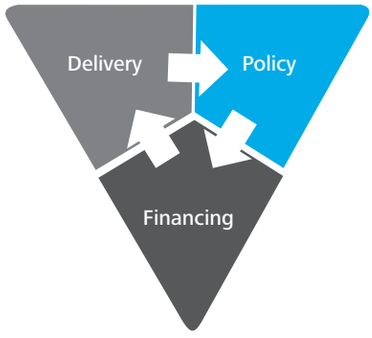
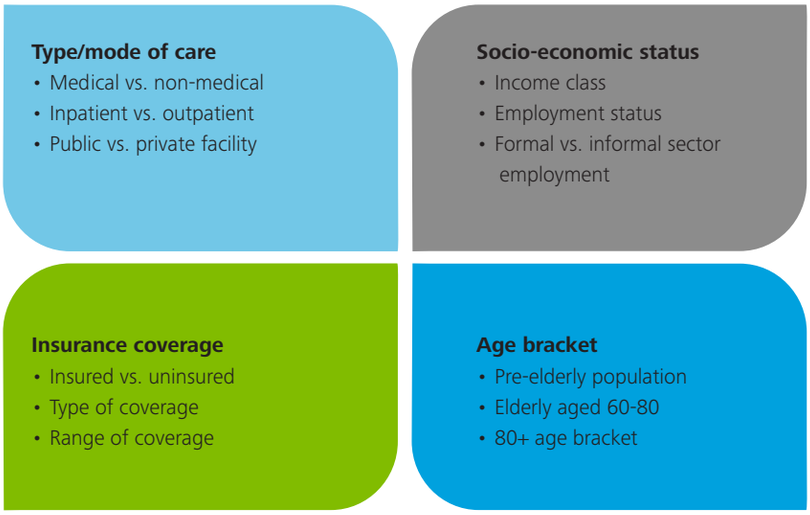


Exhibit 17: Factors necessitating a differentiated approach for elderly care



These factors and considerations impact health seeking behaviours and payment mechanisms, and result in the emergence of varying needs and issues for different population segments. This has implications for elderly care as it requires a differentiated approach across policy, financing, and delivery mechanisms to effectively account for these considerations.

Customized insurance offerings

Insurance products and offerings would need to be comprehensive yet flexible in order to incorporate a customized approach while providing effective coverage. As witnessed in the case of a few developed countries, this has been implemented in some form through multi-tiered universal coverage schemes. Under these schemes, low-income groups are covered under public programs while middle income groups have private coverage with government subsidies, thus effectively maximising coverage. A precursor to introducing a differentiated approach is identifying the various population segments that need to be targeted differently. This has been done from an income-level perspective through needs and means assessments in various countries that ascertain public healthcare coverage requirements for patients. For example, a country that relies heavily on public funding such as the UK uses needs and means assessments to determine the level of care that will be financed by the government for a patient, and thus effectively allocates public resources.

Financing and accountability of care

Optimum involvement of stakeholders to ensure financial coverage

Financing of care requires a collaborative approach among a range of stakeholders, which in the global context has panned out in different ways. For example, countries like the UK rely heavily on public funding, with the bulk of healthcare being financed by the government, whereas in Germany, healthcare coverage consists predominantly of private health insurance. While both the extremes have their strengths, they also have weaknesses that impact their applicability in the Indian context. A heavy emphasis on public healthcare in the UK and the resulting lack of private players in the market translates into limited opportunities to share the burden of care. Meanwhile, an overdependence on private insurance excludes the segment of the population that cannot afford it. As a result, neither extreme is feasible for a country like India, which requires the optimum involvement of the various stakeholders and use of financing mechanisms.

Sustainable healthcare financing mechanisms

The global context serves to provide examples of financing options available and the ways in which they can be implemented. A few of these examples include payroll taxes or similar pay-as-you-go mechanisms wherein the younger age groups pay taxes that fund elderly care (such as in the UK and US), employee contributions to fund medical care or insurance (as is the case in Germany), and innovative medical savings schemes to cover out-of-pocket expenses (such as Singapore's Medisave scheme) and save for the future. While the global context demonstrates the necessity of developing a corpus fund mechanism to finance elderly care, the characteristics and nuances of India must be kept in mind. As a result, the financing options used by other countries may not be applicable directly for India. For example, payroll tax would have limited revenue generating potential in India due to the low penetration of the formal sector employment (~3% of workforce) vis-à-vis the informal sector (~30% of work force). However, learning from them and ensuring that India comes up with a sustainable financing mechanism is critical in limiting "pay as you go" and emphasizing saving for the future.

Accountability of care to optimize utilization

Countries globally are now realizing the importance of ensuring accountability of care across entities and incentivizing stakeholders and individuals to optimize usage of services. For instance, the US is moving towards the concept of value based care where services are reimbursed by quality of outcomes rather than volume, thereby making physicians and hospitals accountable for their actions. Singapore, similarly, improves accountability among patients by requiring individuals to finance a part of care out of pocket rather than providing free care, thus motivating patients to remain healthy. It is imperative for elderly care financing to incorporate the concepts of accountability and ownership to avoid misuse and ensure optimization of care provision.



Healthcare delivery infrastructure to adopt innovations across care continuum

The Indian context warrants the strengthening of care delivery, both medical and non-medical, through means that are not currently being effectively leveraged.

Care beyond institutional delivery

The lack of elderly care services discussed previously, especially in delivery facilities, ties in to the need for medical care delivery means that do not require institutional support. A few such means include home-based services and remote healthcare delivery through mHealth or telemedicine initiatives. The effective use of these means, while providing medical care to the elderly through innovative means, will also reduce pressure on healthcare facilities.

Emphasis on non-medical care

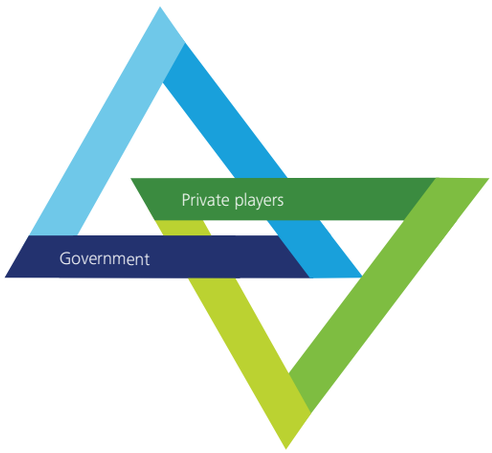
Another important implication for the Indian context relates to the under-penetrated state of the non-medical services space. The state of this space is not unique to India; most countries have prioritised medical care for the elderly at the cost of non-medical care. As a result, non-medical care such as development of senior living infrastructure has largely been ignored, and lacks a formal structure in most countries. However, few countries are taking early steps in this direction. A couple of such examples are Singapore, where non-medical services are provided through voluntary welfare organisations and private sector players, and China, where organisations that create infrastructure for elderly care are given tax benefits. There is scope to derive lessons from such countries in understanding how India can implement its own mechanism to strengthen non-medical based care from the very beginning

Strengthening care provision through family members

Another way to address low availability of elderly care services is through effectively leveraging family members in the provision of elderly care, especially for non-medical services. This is an inherent advantage in India as the family serves as the primary caregiver for the elderly and has the scope to play a big role in delivering care, as is the case in other developing countries discussed in the previous chapter. In this context as well, lessons can be derived from these countries in strengthening caregiving through family members, for examples through initiatives such as Brazil's mandate legally requiring children to take care of their parents. With the slow erosion of the joint family system in India, strengthening caregiving through family members is an especially pertinent need.

The implications arising from the global elderly care landscape provide a starting point, which can subsequently be built on to develop a recommendatory framework to effectively strengthen elderly care in India.

The way forward



There is a need to improve mechanisms of elderly care both in the short-term, by leveraging and strengthening existing facilities and services, and the long-term, by setting up additional care delivery and financing mechanisms and encouraging the entry of new players in this space. Additionally, in the short-term, there is a need to prioritise certain aspects of care by focusing on areas that pose a more immediate concern for the elderly. Short-term prioritisation of care will also result in ensuring that tangible changes take place in a short period of time.

Effectively addressing elderly care requires collaborative action between government and private sector stakeholders, across issues of policy, financing, and delivery. This is an imperative since no single stakeholder has the ability to address all the discrete elements of elderly healthcare provision that need to come together for a holistic solution.

Role of the government

The government's role spans policy, financing, and delivery mechanisms of elderly care, for which it can act on its own or through public private partnership (PPP) models.

Policy and regulatory initiatives

Policy and regulatory measures have the potential to set up an enabling environment that will encourage elderly healthcare provision from both a financing and delivery perspective. Additionally, the government will need to play an increasingly dominant role in educating and building awareness amongst the population on the need for preventive healthcare and health savings/ insurance for old age.

Few examples of policies and strategies that the government could implement in its bid to improve elderly care, include:

- Formulation of a policy on mandating monetary contribution from the working population towards elderly care, in an effort to build a future 'corpus fund' that can be leveraged to cover healthcare expenses beyond the age of 60
- On a similar note, mechanisms such as individual and employer contributions, payroll taxes, and government subsidies can be used to finance care and minimise the burden on a single stakeholder.
- Enhancement/ addition of incentives for adoption of health insurance products for the elderly, such as income tax exemptions or mandatory social health insurance for elderly
- Incentivisation for investments in infrastructure for provision of dedicated medical and non-medical elderly care through tax breaks and subsidies
- Formulation of guidelines and frameworks for alternate models of care for the elderly, such as home-based care, remote medical services as well as non-medical services such as assistive living etc. Clarity on medico-legal aspects or insurance coverage of telemedicine procedures would be some of the indicative action areas.
- Providing the elderly with a special status in the government's upcoming National Health Assurance Mission, to ensure coverage for the range of elderly care needs
- Bringing the stakeholders together in a time bound manner for formulation of a medical education curriculum for geriatric care as a specialty

Financing initiatives

- Financing initiatives aimed at elderly population segment that does not have the paying capacity to cover healthcare expenses or for buying private health insurance. A few such initiatives include:
- Providing deferred elderly coverage through financial instruments that encourage long-term saving; a few examples are health savings accounts, which are insurance products that combine a high deductible risk cover and a savings component, and health bonds, which can be structured like infrastructure bonds

- Incentivising health insurance covers from a younger age, so that insurance would be compounded with age to provide sufficient coverage at an older age, offering the dual benefit of affordability for the patient and sustainability for insurers through longer term contributions
- Design of social insurance schemes/ variants targeted for the needs of the elderly

Delivery initiatives

In addition to directly financing care, the government also has the scope to facilitate delivery of elderly care. Again, this is especially relevant for addressing the low-income elderly population that cannot afford private facilities, as also geographical areas where it is not financially viable for private players to set up facilities. Some of the areas for consideration could be:

- Introducing screening and disease-management programs to identify at-risk population groups and ensure effective care management
- Specifically, identifying patients with chronic ailments that have long-term healthcare needs, and ensuring effective healthcare delivery for these patients through the entire lifecycle of the disease
- Provision of services that cater to elderly care needs such as non-medical and home care, areas that have been almost ignored
- Setting up of dedicated infrastructure and facilities for the elderly, such as senior living facilities, and geriatric wards or departments in public health facilities
- Ensuring sufficient availability of geriatric specialists in public health facilities

Role of the private sector

The private sector can play a significant role in improving elderly care through targeted efforts in the fields of healthcare financing and delivery.

Private health insurers

Private health insurers have the potential to play a significant role in financing of elderly care through differentiated products for different age groups. Innovative insurance product development and pricing would need to be encouraged through mechanisms such as:

- Creating long-term, dedicated insurance products for the elderly that provide an appropriate balance of medical and non-medical coverage
- Innovative insurance offerings for the elderly, a few such examples of which are:
  - Products that cater to the differentiated needs of elderly care such as home-based care, senior living facilities, and long term care management
  - Micro insurance products catering to low-income groups, rural and semi-urban segments etc.
  - Products that include flexible payment and coverage components keeping in mind the various considerations discussed in the previous chapter, such as age, socio-economic status, mode of care delivery, etc.
- Innovative mechanisms to share risk and reduce expenses being incurred solely by health insurers. One such example is co-payment of costs between insurers and other entities such as individuals, governments or NGOsEvaluating means to cover certain pre-existing conditions for the elderly; for example, people who have undergone procedures such as angioplasties can be offered insurance coverage for related ailments subject to medical underwriting at the time of enrolment

Private healthcare delivery players

Healthcare delivery players have the potential to improve the availability, quality, and cost of healthcare services for the elderly. The following are a few examples of the nature in which delivery players can contribute to the strengthening of elderly care.

- Creating dedicated infrastructure to provide both medical and non-medical care for the elderly, which could include facilities such as senior living facilities, day care centres, assisted living facilities, and geriatric hospitals/ wards/ departments
- Undertaking training initiatives to develop human resource capacity to provide high-quality elderly care; this could be for geriatric medical personnel both in healthcare facilities and other contexts, such as at-home nursing care
- Collaborating and working closely with other stakeholders such as insurers and the government to share risks and undertake efficiency and cost containment measures, which could subsequently drive down costs for end users. These measures could include standardisation of treatment and the use of clinical protocols to streamline delivery, leveraging remote healthcare delivery models such as telemedicine, and the use of technology to increase efficiencies

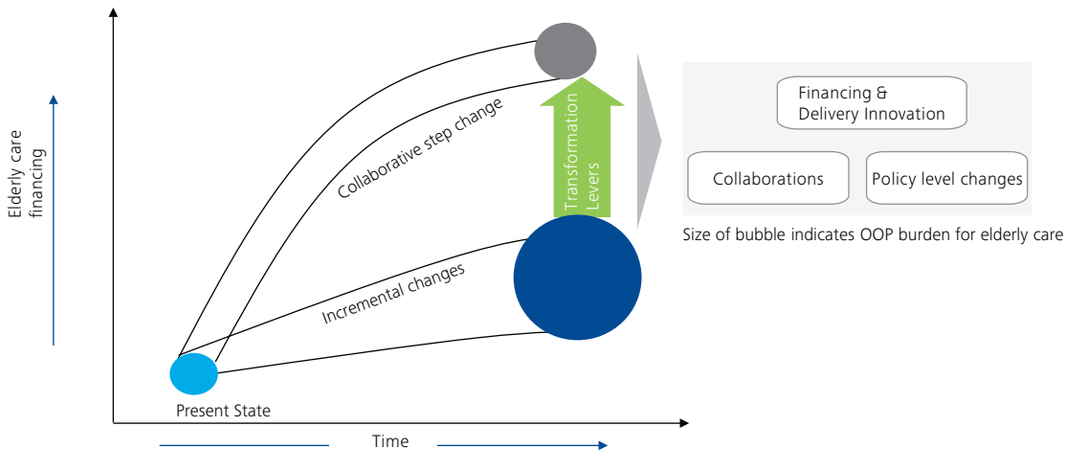
The future depends on pace and extent of changes undertaken

The initiatives currently in place will bring incremental change in terms of improving the state of elderly healthcare in India.

A significant transformation of the landscape of elderly healthcare in India requires a collaborative multi stakeholder approach to produce a 'step' change in the future provision of healthcare to the elderly.

- Innovation in insurance products is essential to ensure coverage and affordability of both medical and non-medical care
- A comprehensive policy framework is required to serve as an enabler and facilitator, and bring together all stakeholders
- Collaborations between the government, care providers, insurers and patients are a precursor to any significant change involving elderly care
- Effective use of these transformation levers would enable India to reach its targeted future state of elderly care provision, and bring it at par with global standards.

Exhibit 18: Present and potential future state(s) of elderly care



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- **Alexander Thomas** (Dr), Principal Advisor - AHPI
- **Aloke Gupta**, Consultant-Health Insurance
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About FICCI

Federation of Indian Chambers of Commerce and Industry (FICCI)

Established in 1927, FICCI is the largest and oldest apex business organisation in India. Its history is closely interwoven with India's struggle for independence, its industrialization, and its emergence as one of the most rapidly growing global economies. FICCI has contributed to this historical process by encouraging debate, articulating the private sector's views and influencing policy.

A non-government, not-for-profit organisation, FICCI is the voice of India's business and industry. FICCI draws its membership from the corporate sector, both private and public, including SMEs and MNCs; FICCI enjoys an indirect membership of over 2,50,000 companies from various regional chambers of commerce.

FICCI provides a platform for sector specific consensus building and networking and as the first port of call for Indian industry and the international business community.

Our Vision

To be the thought leader for industry, its voice for policy change and its guardian for effective implementation.

Our Mission

To carry forward our initiatives in support of rapid, inclusive and sustainable growth that encompass health, education, livelihood, governance and skill development. To enhance efficiency and global competitiveness of Indian industry and to expand business opportunities both in domestic and foreign markets through a range of specialised services and global linkages.

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