Chapter II

A number of studies both conceptual and empirical have been conducted regarding various aspects of health insurance in India and abroad. The review of these studies has been done to explore the concept, framework, and state of health insurance. Hence, for the purpose of the present study, the review of literature has been divided broadly into four sections. Section I deals with the review of studies in relation to performance evaluation. Section II covers the review of studies in relation to Community Health Insurance (CHI). Section III includes the review of studies in relation to Third Party Administrators (TPAs). Section IV covers the review of studies in relation to customers’ perception.

Section I: Review of Studies in Relation to Performance Evaluation

Houston and Simon (1970) conducted a cross-sectional study of the relation between the average costs and premium receipts of life insurance companies, as a means of investigating economies of scale. Further, average cost functions for the life insurance industry, all of which show increasing and then constant returns, are estimated from cross-section data for 237 companies of U.S. The special problems of measuring output, controlling for product mix, and accounting for the effect of rate of growth in output are examined and dealt with. The study concluded that average costs are constant beyond $100 million of premiums.

Charnes, Cooper and Rhodes (1978) provided a nonlinear programming model, which has given a new definition to the measurement of efficiency. In other words, it has provided with a scalar measure of efficiency, which can objectively determine the weights with reference to observational data for multi-input as well as for multi-output. The dual aspects of this programming model pave the new way for estimating external relations from the observational data. Connections between engineering and economic approaches to efficiency are delineated along with the new interpretations and ways of using them in evaluating and controlling managerial behavior in public programs.
Praetz (1980) examined the average cost relationship between life insurers and each of ten main insurer characteristics. The data used was mainly drawn from 90 insurers with more than half of the life insurance in force in U.S. The study revealed that the following independent variables were significant in producing economies of scale in life insurance business: premium income; new business ratio; proportion of whole life business; and size of insurer (i.e., giant mutual insurers).

Doherty (1981) analyzed the conceptual and econometric problems arising from the use of premium income as a proxy for output, while making estimation of various efficiencies. The study suggested that output measure is not independent of the firm's pricing policy and its use implies potentially serious problems of simultaneous equation bias and errors in variables. Moreover, the study concluded that a delivery-based output measure is theoretically more superior and will encounter less severe econometric problems.

Weiss (1986) examined that productivity improvement is critical factor for all the firms facing increasing competition such as life insurers, because the output consists of services that are not directly observable. The purpose of this study was to develop and illustrate a method for measuring productivity for life insurers, with the main emphasis on developing new techniques for measuring output and used in computing divisia and exact indexes of total factor productivity for two sample insurers—one stock and one mutual insurer—over five year intervals. The study concluded that applicability of the output and productivity measurement methodologies developed is not limited to the specific insurers studied, but rather can be used as a guide in measuring the productivity of any life insurer or the life insurance industry in general.

Grace and Timme (1992) analyzed the U.S. life insurance industry with the sample of 423 life insurers and estimated that the overall and product specific scale economies as well as pair-wise costs are complementarities for a wide variety of products. Estimates of these costs characteristics are provided for numerous output vectors, since theory suggests that the magnitude of scale economies and costs complementarities may vary with the scale and mix of outputs. In contrast, previous studies provided that only a single point estimate of industry cost characteristics using the sample mean output vector. Therefore, the study provided with a more complete
representation of the industry's cost characteristic and, in turn, new insights into decisions related to the optimal scale and mix of outputs.

**Cummins, Turchetti and Weiss (1996)** provided benchmark statistics to facilitate the comparisons of efficiency and productivity under the new European regulatory regime, when data on more recent periods become available. In addition, the production frontier results were used to test hypotheses about two major issues in industrial organization: the coexistence of alternative product distribution systems and organizational form in an industry. The results indicated that technical efficiency in the Italian insurance industry ranged from 70 to 78 percent during the sample period. There was almost no efficiency change over the sample period, i.e., on average Italian insurers operated at about the same distance from the production frontier throughout the sample period. However, productivity declined significantly over the sample period, with a cumulative decline of about 25 percent. The decline was attributable almost exclusively to technological regress, implying that insurers needed more inputs to produce their outputs at the end of the sample period than at the beginning. Although improvements in both technical efficiency and technical change appear to be needed, the main problem at present appears to be the adverse shift in the production frontier.

**Cummins and Zi (1996)** conducted a comparative analysis of frontier cost efficiency methodologies with the application of wide range of econometric and mathematical programming techniques to a data set consisting of 445 life insurers over the period 1988-1992. The study provided that alternative methodologies give significantly different estimates of efficiency for the insurers. Moreover, the efficiency rankings are quite well-preserved among the econometric methodologies; but the rank correlations are lower between the econometric and mathematical programming categories and between alternative mathematical programming methodologies. Therefore the results provided with the fact that the choice of methodology have significant effect on the measurement of efficiency.

**Korhonen (1997)** conducted a study in order to deal with the problem of searching the efficient frontier in Data Envelopment Analysis (DEA). The basic aim was to show that the free search approach developed to make a search on the efficient frontier in multiple objective programming can also be used in DEA. The study recommended the
use of Pareto Race (Korhonen and Wallenius [1988]) for purpose to make a free search on the efficient frontier due to following reasons: as in Pareto Race, the Decision Maker (DM) may simply control the search with some function keys; the information is displayed to the DM as bar graphs and in numeric form; the search can be terminated at any time, the DM wishes.

**Fukuyama (1997)** investigated the productive efficiency and productive changes of Japanese life insurance companies with primarily focus upon the ownership structure and economic conditions. The results of the study revealed that mutual and stock companies possess identical technologies, but the productive efficiency and productive performance changes from time to time across the stock and mutual under different economic conditions.

**Brockett et al. (1998)** examined the efficiency effects of different forms of ownership (stock versus mutual) and types of marketing system (agency versus direct) for the property-liability insurance industry of US. Data envelopment analysis (DEA) results are obtained from the recently developed RAM (Range Adjusted Measure) model and then extended for comparison with studies by others. Using agency theory (and like approaches) the study assumed that the operations all occur only on the efficient frontier. The need for that assumption is obviated by using operations provided by DEA to project all observations on their efficient frontiers. A use of (non-parametric) rank-order statistics then produced and provided with results which differ from these other studies. Therefore the results provided that application of different measures provided with the different estimate of efficiency.

**Cummins and Misas (2001)** examined and provided new information on the effects of deregulation and consolidation in financial service market with the analysis of Spanish insurance industry. The sample period 1989-1998 spans the introduction of the European Union’s (EU) Third Generation Insurance Directives, which deregulated the EU insurance market. The study provided that deregulation has led to dramatic change in the Spanish insurance market; the number of firms declined by 35 percent; and average firm size increased by 275 percent. The study also analyzed the causes and effects of consolidation using modern frontier efficiency analysis to estimate cost, technical, and allocative efficiency, as well as using Malmquist analysis to measure total factor
productivity change. The results shown that many small, inefficient, and financially under-performing firms were eliminated from the market due to insolvency or liquidation and those who acquired during merger and acquisition prefer relatively efficient target firms. As a result, the market experienced significant growth in total factor productivity over the sample period. Consolidation reduced the number of firms operating with increasing returns to scale but also increased the number operating with decreasing returns to scale. Further the study suggested that large firms should focus on improving efficiency rather than on further growth.

Boonyasai, Grace and Skipper (2002) examined that liberalization and deregulation lead to greater competition for the insurer, therefore insurers should become more efficient. They analyzed the impact of liberalization and deregulation of four life insurance markets: Korea, Philippines, Taiwan, and Thailand. Using Data Envelopment Analysis (DEA) to measure cost efficiency, the study found that liberalization and deregulation of the Korean and Philippine life insurance industries seem to have stimulated increase and improvement in productivity whereas liberalization of the Taiwanese and Thai life insurance industries seems to have had little effect on increase and improvement in productivity. Finally, the study concluded that liberalization and deregulation together can promote competition and thereby results in more efficiency on the part of insurer. Moreover, the results of the study are in consonance with the view that, in a restrictive regulatory environment, welfare gains will be minimal if deregulation does not closely follow liberalization.

Cummins, Weiss and Zi (2003) investigated the economies of scope in the insurance industry of US, over the period 1993-1997 by using two primary hypotheses – the conglomeration hypothesis, which holds that operating with diversity of business can add value by exploiting cost and revenue scope economies; the strategic focus hypothesis, which holds that firms can best add value by focusing on core businesses and core competencies. The study also attempted to analyze, whether it is advantageous for firms to offer both life-health and property-liability insurance or to specialize in one of the major industry segments. The Data Envelopment Analysis (DEA) applied because of an innovative feature of the estimation of cross-frontier efficiency, where each group of firms (diversified firms and specialists) were compared to a reference set consisting of
the other type of firm, enabling us to determine whether the specialization or conglomeration was the dominant strategy for each firm in the sample. The results provided only weak evidence for the existence of economies of scope in the U.S. insurance industry. Although diversified firms dominate specialists in the production of diversified firm output vectors in terms of revenue efficiency for both life-health and property-liability insurance, specialist firms dominate diversified firms for the production of specialist output vectors in revenue efficiency and also dominate diversified firms in cost efficiency for property-liability output vectors. The study concluded that in general, strategic focus appears to be a better strategy than conglomeration.

**Martin (2003)** evaluated the performance of Zaragoza University’s Departments (Spain) including the existence of differences in the strength and weakness between departments of various areas. The study uses the Data Envelopment Analysis (DEA) to obtain an overall performance measure through the comparison of a group of decisions units. The result of the study revealed those departments in comparison to other who carry out their activities efficiently and effectively.

**Chang (2006)** conducted a study on solvency and continuous growth of insurance companies and provided that both depend on their performance. For this a data set consisted of 20 insurance companies in Taiwan were used. Beside this, an effort was made to calculate separately 19 items of financial ratio into five operation indicators, which can be used as performance evaluation variables of insurance companies. These five indicators are: Capital Structure; Profitability; Solvency; Management Efficiency; and Capital Operational Capability. The results of the study indicated that overall performance of insurance companies were significant in the short run during the period 2000-2002 and concluded that both return on assets and sign of profitability influence a heavier financial ratio as well as operating index on performance.

**Bikker and Leuvensteijn (2008)** examined the competitive nature of Dutch life insurance industry by investigating the several factors, which affect the competitive nature of the market. Beside this, the study attempted to analyze the relationship between the scale economies and X-inefficiencies, because the severe competition forces the firms to exploit scale economies and to reduce X-inefficiencies. The results of the study provided that limited competition exist in Dutch life insurance industry as compared to
life insurance industry of Netherlands and thereby results in availability of less scale economies for the firms of Dutch life insurance industry.

Eling and Luhnen (2008) analyzed and provided new empirical evidence on frontier efficiency measurement in the insurance industry. The first part of the study consist of review of 87 studies and put them into a joint evaluation of efficiency measurement in the field of insurance, whereas second part of the study involve, a broad efficiency comparison of 3,555 insurers from 34 countries. Different methodologies, countries, organizational forms, and company sizes were compared, considering life and non-life insurers. The study found a steady technical and cost efficiency growth in international insurance markets from 2002 to 2006, with large differences across countries. Denmark and Japan have the highest average efficiency, whereas the Philippines were the least efficient. Furthermore, the analysis provided that mutual were more efficient than stock companies. Only minor variations were found that too when comparing different frontier efficiency methodologies (data envelopment analysis, stochastic frontier analysis). Moreover, the results of the analysis gave us valuable insights into the international competitiveness of insurers in various countries.

Yuan and Phillips (2008) examined the efficiency effect from the possible economies of scope across two formally separate sectors by estimating multi-product costs, revenue, and profit functions. To achieve the above stated objective of the study, a unique dataset that links the U.S. banking and insurance regulatory was constructed. The motive behind such construction was to identify newly formed domestic “assurbanks” (insurers owning banks), “bancassurers” (banks owning insurers), and all the unique subsidiaries licensed either as commercial banks, thrifts, or insurance companies. The empirical evidence of the study suggested that a significant number of cost scope diseconomies; revenue scope economies; and weak profit scope economies exist in the post-GLB U.S. integrated banking and insurance sectors. The scope economies were variant among firms, and certain firm characteristics were the determinants of scope economies.

Eling and Luhnen (2010) conducted a study to provide an overview on frontier efficiency measurement in the insurance industry. The study conducted was mainly review based and involves a comprehensive survey of 95 studies with a special emphasis
on innovations and recent developments. Beside this, the study also involves the review of different econometric and mathematical programming approaches to efficiency measurement in insurance and discusses the choice of input and output factors. Furthermore, it categorized the 95 studies into 10 different areas of application and discusses selected results. The results of the study provided that there was a broad consensus with regard to the choice of methodology and input factors, the difference lies in case of output measurement. The study concluded that there is significant need for future research with regard to analysis of organizational forms, market structure and risk management, especially in the international context.

Ansah et al. (2010) evaluated the performance or efficiency of Ghanaian general insurance companies from the year 2002 to 2007 and also tested the hypotheses relating to the roles played by dimension and market share in the efficiency of the Ghanaian general insurance companies. The study provided with the result that Ghanaian general insurers operated at an average overall efficiency of 68%, technical efficiency of 87% and scale efficiency of 78%. Besides this, result also provided with the fact that Ghanaian general insurers with higher dimension and market shares tend to have higher efficiencies; implying that general insurers could increase their efficiencies by trying to increase among other things their dimension and market shares.

Section II: Review of Studies in Relation to Community Health Insurance (CHI)

Rama and Baru (1994) examined the structure of health care provision existed in public; private; and voluntary sectors and utilization patterns for both inpatient and outpatients care across states. For this data obtain from the World Bank’s Country Report on India, “India: health sector financing-coping with adjustment; opportunities for reforms” and World Development Report 1993. The study showed the presence of much variation in the availability of non-government health services across states. In most of the states, public sector was the main source of provider of curative services and private and voluntary sector marked by uneven spread and regional variations. However, there were some states in which private and voluntary sector was achieving the significant growth and supplementing the public services. However, the suggested that the private and voluntary sector should move only into those areas, where they can show better
results and get profit. Moreover, majority of socio economic groups depend on public provisions. Therefore the cut back of public services will results in disparities of access between rural-urban, advanced-backward areas and across classes.

**Sanyal (1996)** ascertained the intensity of use of the government and private source of treatment by the households and expenditure incurred by them; changes in the utilization pattern; expenditure; and the differentials across the rich and poor. The study used the results of three surveys [(conducted by National Sample Survey Organization (NSSO), National Council of Applied Economic Research (NCAER) and National Institute of Public Finance and Policy (NIPFP)] on health care expenditure and utilization in order to elicit information. The results shown that the burden of health care expenditure in rural areas was twice in 1986-87 as compared to 1963-64 and support the view that avenues for additional revenue earning lie more in the secondary and tertiary hospitals. Moreover, the study suggested that some introspection is needed particularly when abnormal increase in prices of medical care took place, so the Indian health planners would have to pay more consideration at the data sources resulting in to the interstate differences in household financing.

**Gumber and kulkarni (2000)** undertaken a case study in Gujarat with the objective of determination of :- burden of health care expenditure; the extent to which health insurance has helped in mitigating the burden; demand for health insurance; willingness to pay for it; and to suggest an affordable health insurance plan for workers in informal sector. To achieve this objective, a primary survey of 1200 households was undertaken in Ahmedabad district of Gujarat. The study concluded that private sector has played a dominant role in providing services to the both urban and rural areas and also there is strong need for health insurance especially for low income people because of heavy burden of out-of-pocket expenditure on them. Thereby the study suggested that while seeking health care, SEWA a type of health insurance scheme having strong preference by those who cannot afford to pay and also not access the services of various other schemes.

**Sodani P.R (2001)** investigated the community’s preference on the various aspect of health insurance. For this data has been collected from a sample of 300 households of Jaipur, Rajasthan. The study revealed a low level of awareness about health insurance.
Quality of care and cost are two important factors affecting the community’s decision to subscribe any new health insurance plan. An integrated provider and insurer system is preferred as compared to public or private-based management. Hospitalization and Maternity services are preferred among the given choices for benefits to be included under the plan. The study also suggested that there is high level of willingness to join a health insurance plan in future, if designed carefully for the informal sector i.e. an innovative and feasible health insurance scheme at low cost for providing quality services to the informal sector of the community.

Ekman (2004) assessed the evidence of the extent to which a Community-Based Health Insurance (CBHI) is a viable option for health care financing; for mobilization of resources; and for the extension of financial protection in low income countries. The approaches taken for this includes: review of 36 separate studies, of these 15 are published articles in peer reviewed journals and 21 are unpublished papers and reports. The review contributed the strong evidence that CBHI provides some financial protection by reducing out-of-pocket spending and improves cost of recovery. On the other hand there is weak or no evidence that schemes have no effect on quality of care. The study found that the effect is small and schemes serve only a limited section of population. But the CBHI are, at best, complementary to other more effective system of heath financing. Moreover, suggested that for improvement of reliability; and validity of evidence, the analysts should agree on a more coherent set of outcome indicator; and policymakers need to be better informed as to both cost and benefits associated with implementing various financing options.

Ahuja (2004) examined the more suited arrangement for providing health insurance to poor people in India and also explored how the reforms in insurance sector alter health insurance prospects facing the poor in developing countries and what changes have happened or likely to happen as a result of insurance sector reforms. In developing countries, community based arrangement is more suited for providing health insurance to low income people. Insurance sector reforms lead to development of private health insurance, at the same time reforms can affect the low income people through its effect on the provision and financing of health care services. The study concluded in India, CBHI will play an important role, but there is need to be encouraged by government’s
interventions in order to guide and direct health insurance market, so as to minimize the cost escalation of health care provision.

Nayar, Kyobutungi and Razum (2004) attempted to discuss the historical background, scope as well as limitation of Self Help Movement in the Europe, where it was originated and analyzed its experience in Bangladesh and India and draw conclusion regarding the relevance of Self Help Groups for improving health of population. The study shown in Europe SHGs originated because of dissatisfaction with depersonalized health care, where as in South Asia it provided by NGOs and government. SHGs can help to achieve some degree of synergy between health care providers and users but can’t prescribe to replace the government health services in low income countries. Moreover, SHGs are suitable for individualistic societies with developed health care system and less suitable for hierarchical societies with unmet demand for regulated health care.

Devadasan et al. (2004) conducted study on Indian community health insurance schemes; context in which they are operational; their design and management; administrative challenges faced by them; and their impact. Earliest scheme started in Kolkata in 1952. Currently, in India more than 20 CBI schemes are operating, but the study based on 12 such schemes. The study reflected that there are three basic designs of CBI schemes depending upon the insurer, in most of schemes enrollment is individual and membership is voluntary. The main barrier in development of CBI schemes is to find an appropriate provider and financial sustainability. So the government should come forward to subsidies this equitable health financing mechanism. Therefore, CBHI in India offer valuable lesson for the policy makers and practitioners in the field of health care.

Bennett (2004) conducted a study with a view to set out preliminary conceptual framework for examining interaction between Community-Based Health Insurance (CBHI) schemes and other aspects of health care financing system. In order to explore implication of interaction, this paper; (1) set out a series of conceptual maps that illustrate how CBHI schemes may relate to the broader health care financing system. (2) Uses the maps to explore how CBHI schemes may (or may not) contribute to national policy objectives, and how different feature of CBHI schemes and government policy may interact to affect achievement of policy objectives. The utility of broader approach to analyze CBHI schemes is illustrated through examination of two policy issues, namely
(1) coordination of CBHI risk pools and government risk pools, and (2) equity implications of CBHI schemes and the role of government subsidies in such schemes. The study concluded that there is a strong need for empirical work to explore how CBHI schemes and broader health care financing system interact, and that even if individual schemes achieve their own objectives (in terms of equity, efficiency etc), this does not necessarily imply that such objectives will be achieved at the system level.

Jajoo and Bhan (2004) described the social upliftment of villagers in the Sevagram region of Maharashtra, where Jowar micro health insurance scheme was first introduced to ensure uniform health care to the poor and needy people in the Nagpur village. The study initiated by Medico Friend Circle Student Group that Jajoo started in Sevagram, when he joined as faculty in Medical College Nagpur. The scheme began in 1979, with focus on curative care, later on included preventive and promotive care. Its wide acceptance in the Nagpur village leads the team to extend it to other villages. Because of increasing acceptance among more villages, the scheme extended to cover Income Generation Programme and Women’s Self Help Groups. Thereafter, it extended to action-oriented individuals. The intention behind the introduction of Jowar Health insurance scheme at sevagram was to identify revered individuals, to empower them by bringing together, cultivate a sense of decision making by consensus and initiate act of common faith.

Ahuja and Narang (2005) provided an overview of existing forms and emerging trends in health insurance for low income segment in India with focus on both the demand and supply side factors promoting this development, and provided that three conditions essential for extending health insurance to low income segment. Further based on the efforts of the central government by way of its Universal Health Insurance (UHI) schemes as well as on the three insurance pilots of United Nation Development Programme (UNDP), some designs of health insurance for low income groups were drawn. The study concluded that these schemes have considerable scope of improvement for a country like India by providing appropriate incentives and bringing these under the regulatory ambit. Currently public health services are weak and inefficient, private and voluntary health care is unregulated and scattered. The study suggested that in order to develop health insurance for poor in a big way, health care provisions need to be
strengthened and streamlined as well as coordination among multiple agencies is needed.

Acharya and Ranson (2005) conducted a study to determine the burden of health care expenditure on poor; working of CBHI; how CBHI differ from standard health insurance; and role of state, market and NGOs in health sector of Gujarat. The study was based on four NGOs that are running health insurance schemes in Gujarat. For this data obtained from focus group discussion with schemes managers, researchers, and representative of funding agencies, executives of public and private companies and members of targeted communities. The study showed that although the schemes were diverse in respect of their design and management, yet similar in terms of “prepayment” mechanism. Moreover, these are so far reached to very small segment of poor and government of Gujarat have very limited interaction with CBHI schemes operating in state. The study suggested that in order to improve coverage and to bring better results it is necessary to link these schemes with other structures like Self Help Group (SHGs), Panchayati Raj Institutions (PRIs), Gram Sabhas (GSs), large NGOs etc.

Gupta and Trivedi (2005) examined the concept of social health insurance; the form in which it currently exists in India; the issues and constraints in development of social health insurance; and innovations in existing social health insurance in context of other forms of health insurance. In India, there is only one scheme that qualifies as social health insurance- Employee State Insurance Scheme (ESIS). The study concluded that in spite of government efforts on health policy, the health sector is currently changing shape mostly due to market forces and in such a situation the policy makers need to act immediately in order to provide greater health coverage. The health system in India is gradually ripe for moving towards “coverage for all” which meets the main objective to great extent “health for all”. The study recommended that the followings steps will scale up SHI over next two-three years: - setting up of separate social health insurance organizations, which have at least three divisions one each for the organized sector, unorganized sector and for the remaining population etc. and government will have to these organizations.

Sinha et al. (2006) examined the various barriers faced in accessing scheme benefits by the members of Community-Based Health Insurance Schemes (CBHIs) run by Self-Employed Women’s Association (SEWA) in Gujarat, India. To satisfy the
objective, the qualitative researches carried out that include four village-level Focus Group Discussions (FGDs) with members of VIMO SEWA and two district level FGDs with grassroots level workers (aagewans). The study found that members face a variety of different barriers, particularly in seeking hospitalization and in submitting insurance claims. Some of the barriers were outside the scheme’s control, such as illiteracy and financial poverty amongst members, and inadequacies of the transportation and health care infrastructure. But the other barriers relate to scheme’s design and management such as, lack of clarity among scheme staff regarding the scheme’s rules, processes, and requirements that claimants submit document to prove the validity of their claims. In order to overcome these barriers the study strongly recommended for: - institutional linkage with providers; intensified contact with scheme members; capacity-building; and supportive supervision of aagewans.

Kharva (2008) observed the purposefulness of cashless hospitalization and initial hardship associated with its implementation. For this, analysis of VIMO Self Employed Women’s Association, the insurance unit of SEWA was done. Initially the scheme provides reimbursement after hospitalization but later on provide reimbursement while they were still in the hospital. The scheme incorporates health insurance as a crucial programme. Based on the positive experience of scheme in Gujarat in Jan 2006, the scheme extended in Ahmedabad city and renamed as “cashless” (CL) hospitalization. In Ahmedabad, this method of reimbursement was optional for members for the first year. However in 2007, it was made mandatory and members were required to go only to one of selected hospital to use cashless reimbursement system. It showed that cashless system has reduced the claim processing period as it takes only the number of days the members is hospitalized while in the normal system, it takes more than that. Thus CL system has been successful in making is members access low cost quality care a reasonable rates.

Agarwal et al. (2008) examined that there is no strong linkage between health providers and slum communities in Indore city of Madhya Pradesh. For this 539 slum community were identified and categorized as extremely, moderately and less vulnerable. By considering the situation of urban poverty in Indore and the available opportunities, two approaches were suggested: - Demand Supply Linkage Approach (based on the premise that building social capital, i.e. norms and networks within a community
facilitating collective action, helps improve the demand and supply of health services for the urban poor) and Ward Coordination Approach (based on encouraging local stakeholders to function in a coordinated manner to ensure better health service coverage in underserved slum areas. The findings shown that programme has enhanced utilization of health services among slum communities of Indore and helped improve immunization coverage and other maternal and child health indicators. The study concluded that when adopting similar mechanism in other developing countries, the key is to select mechanism that will involve and strengthen the capacities of existing local slums level, groups or network during planning and implementation.

Section III: Review of Studies in Relation to Third Party Administrators (TPAs)

Mahal (2002) analyzed whether the regulatory steps in the IRDA bill will influence the progress towards achieving health policy goals of India or not; and also described the regulatory structure currently existing in India in relation to health care provisions, private health insurance and its ability to promote national health policy goals. The study concluded that private health insurance is likely to have an impact on equity in the financing of health care, cost and quality of health care. The private health insurance may turn out to be more inequitable than social insurance of comparable coverage. However an informed and well defined, regulated and implemented insurance regime will ameliorate the bad outcomes of private health insurance. Not only the insurance regulations, but the regulation relating to benefit packages, restriction on risk selection and consumer’s protection would be equally useful. At the same time there is need for improved enforcement of regulatory regimes and better coordination between the IRDA and other Regulatory Bodies. New legislation may also be required in improving standards in health care provision.

Parekh (2003) examined the training aspects of the Third Party Administrators (TPAs) and concluded that there is a dearth of knowledge and training in the TPA community and training for the leadership team alone is inadequate. The lack of training at most insurance companies is also woefully insufficient and alarming. So the study suggested that IRDA should arrange for adequate training facilities for TPAs which will enhance their knowledge and the ultimate benefit will be reap by the community.
Sureka (2003) conducted a study on the TPAs and its regulator and concluded that TPAs are forced to provide service to the policyholder for an obsolete product – the Mediclaim policy which was introduced at least almost two decades ago. Beside this, if the policyholder is made to pay for the services he is availing, then why is the insurer imposing a TPA on the policyholder? The policyholder should have the right to accept or refuse the services of a TPA for such absolute products.

Gupta, Roy and Trivedi (2004) examined the role of TPAs and the issues that required to be taken into consideration while evaluating their usefulness and functioning in India. The study based on a series of meetings, discussions and interviews with various TPAs, insurance companies and providers. No doubt, the TPAs face different barriers in terms of capital, capacity and connections but still they are providing cashless transaction at the time of service delivery to the customers. The IRDA and Health Ministry should come together so as to ensure TPAs which in turn will ensure active role of the TPAs in Community and Universal Health Insurance Schemes. Moreover, the study concluded that TPAs can play an important role in making insured health care availability smoother, but neither can it be seen as a panacea for all the problems, nor it can be blamed for these problems of health sector. The TPAs system should be regulated and checked in order to take care off consumers’ interest.

Bhat and Babu (2004) discussed the role, importance, functioning of TPAs in health insurance market; analyzed the existing TPA system; IRDA regulation on TPAs and its implications; examined the issues and challenges TPAs face in an unregulated health sector; and analyzed the prospects of intermediaries in insurance sector. The study concluded that introduction of IRDA has paved the way for (TPAs) Third Party Administrators who are playing the role of insurance intermediaries in setting up of managed health care systems. The objective behind setting up of TPAs was to ensure better services to policy holders and to mitigate the negative consequences of private health insurance. However the TPAs face immense challenges in the health sector because of demand and supply side complexities of private health insurance and health care market. IRDA has defined the role of TPAs as insurance intermediary in the management of claims and reimbursement, but at the same time their role is not well defined in controlling the cost of health care and ensuring appropriate quality of care.
Mohapatra (2005) provided that TPAs form a vital link between insurers, healthcare service providers and policyholders. Beside this, also provided that for a smooth functioning of the system, the TPAs should be judiciously governed and meticulously regulated. Under the present dispensation, the issues of standardization/governance between the TPA and the providers is left to the vagaries of market forces, the respective parties flexing their muscles to browbeat one another, forcing the TPAs to negotiate local agreement. Further, it is recommended that IRDA constitute a consultative mechanism consisting of representative from providers, insurers, TPAs and consumer bodies to attack the various issues affecting smoother governance. If need be, necessary changes can be brought about in the regulatory compliances.

Bhat, Maheshwari and Saha (2005) ascertained the experiences and challenges faced by hospitals and policyholders in availing the services of TPA in Ahmadabad, Gujarat. For this 110 hospitals and policyholders were selected by random sampling method, out of which 72 hospitals and 85 policyholders were found suitable for analysis. The study shown that only a small percentages of respondents have knowledge about existence of TPA, there was substantial delay in settlement of claims between TPAs and health care providers, administrators of hospital perceive burden in terms of efforts and expenditure after the introduction of TPA. The study concluded there was no mechanism to appraise the performance of TPAs and regulatory body need to focus attention on developing mechanism, in order to strengthen the TPAs so as to ensure smooth delivery of TPAs services in the emerging health insurance market.

Ruchismita, Ahmed and Rai (2007) highlighted the challenges in financing health in India and examined the role of health insurance in addressing these challenges. For promoting health and confronting disease require action across a range of challenges in the health system, these include improvements in the policy making and stewardship role of government; better access to human resources, drugs, medical equipments and consumable; and a greater engagement of both public and private providers of services. The study concluded that insurance has limited but important role to play in solving some of the health financing challenges. The study provided with an operational framework for development of sustainable health insurance model under national rural health mission which will respond to the contextual need of different states. Moreover, innovative pilots
of partner agent model led micro insurance could give useful insights for designing a national level programme, led by an apex body could systematically impact the health system in the country.

Jaswal (2010) examined the cashless hospitalization which was evolved during the last decade, as an integral part of health insurance claim offering, making claim under health insurance policy indeed a customer friendly process. The practice to pay claims through physical cheques is quite outdated and inefficient; it would benefit all, if newer methods of payment like electronic fund transfer were to be implemented. Indian medical industry being unregulated, there are no standard treatment guidelines or uniform Medical protocols which are followed by medical professionals all over the country, in all hospitals.

Section IV: Review of Studies in Relation to Customers’ Perception

Purohit and Siddiqui (1994) examined the utilization of health services in India by making the comparison of Indian states in terms of low, medium and high household expenditure on the health care, public and private facilities across the state. For this, data obtained from NSSO 1992 (extends over 8346 villages in rural areas and 4568 blocks in urban areas) and NCAER 1992 (extends over 1061 villages in rural areas and 1873 blocks in urban areas). The study concluded that there is growing popularity of indigenous non allopathic system, increasing involvement of private sector in expensive tertiary care, existence of regional disparities in health service utilization among different expenditure groups of states and these disparities in urban and rural areas tends to continue. Moreover, there is no serious government initiative to encourage utilization of health services by means of devising health insurance and other cost recovery mechanism. Therefore, the study suggested the dire need to consider carefully in to some of aspects most important of which is that policy guideline should be implemented in a satisfactory manner.

Long and Marquis (1999) examined the trends in job based health insurance during 1993-1997. For this, they compared estimates of National Employers Health Insurance survey and Robert Wood Johnson Foundation (RWJF) employer’s health insurance survey. The study shown that the share of workers enrolled in employer’s
health plan remained constant, prices also remained stable, whereas share of premium contributed by employer showed little change over a period and there was no difference in contribution for health plan between small and large firms. Moreover, the study also found the existence of overall stability in coverage and concluded that Insurance Market Reforms and Health Insurance Portability and Accountability Act of 1996 will certainly affect the participation in job based health insurance.

**Bonet (2000)** analyzed the effect of waiting time in Spanish public health system on the demand for private health insurance. For this data was gathered from the National Health Survey (1993) of Spain, which contain results of 21,120 adults and Spanish Family Budget survey (1990-91). The study assumed that velocity of delivery is a qualitative attribute of health care system that is considered while selecting health coverage plan. Moreover, the Expected Utility Maximization determine whether or not individual buy a private health insurance and also the waiting time in doctors’ offices and waiting list for surgical procedure, income and education level have positive effects on the probability of buying private health insurance. The study concluded that the worsening quality of public health care has the effect of shifting consumer towards the private sector and at the same time with the improvement in public health care has adverse effect on the private sector.

**Sodani P.R (2001)** investigated the community’s preference on the various aspect of health insurance. For this data has been collected from a sample of 300 households of Jaipur, Rajasthan. The study provided with the fact that low level of awareness exist about health insurance. Beside this, quality of care and cost are two important factors affecting the community’s decision to subscribe any new health insurance plan. An integrated provider and insurer system is much preferred as compared to public or private-based management. Alternatively, hospitalization and maternity services are preferred among the given choices for benefits to be included under the plan. The study concluded that there is high level of willingness to join a health insurance plan in future, if designed carefully for the informal sector i.e. an innovative and feasible health insurance scheme at low cost for providing quality services to the informal sector of the community.
**Fronstin (2002)** examined the state of employment based health benefits among workers in U.S and how it has changed since 1993. For this purpose, the data was obtained from Current Population Survey (CPS) and workers were asked questions about health benefits in the workplace. The study findings provided that the percentage of workers offered health benefits has been rising, percentage of workers with health benefits through their own employer has also increased, but the fewer workers were taking health benefits when they were offered because they were getting health insurance through other sources. This expansion in employer coverage (health benefits) began in Mid-1990 and continued into early 2001. No doubt, during this period cost of providing health benefits to the workers has been rising, but we may continue to see more workers with these benefits, if the economy strengthens.

**Gupta (2002)** conducted a study in Delhi, which is different from other because it has looked at a kind of formal insurance that is likely to come to India with privatization. The main objective was to analyze whether individuals and households would be willing to participate in private health insurance schemes. For this purpose, a survey of 504 households of Delhi was conducted. The study showed high level of willingness to participate in insurance programme was mainly from low income individuals because the middle and high income households have already some form of insurance. The biggest deterrent would be prior coverage and most of the households willing to opt for standalone health insurance schemes. The study concluded that majority of population is either uninsured or underinsured and the introduction of private health insurance would definitely be a welcome change, if it could bring the uninsured and underinsured under its fold.

**Mahal (2003)** accessed the potential impact of the entry of private players in the health insurance market on the size of insurance market and on the distribution of public health subsidies on health care provision in India. For this, data was obtained from number of previous published studies as well as information on medical care and expenditure from survey undertaken by India’s National Sample Survey Organization (NSSO 1995-96), (NSSO1998) was used. For the purpose of analysis, a simple analytical model as well as simulation model was used to assess the impact of such entry. Simulation results presented in the paper suggested that redistributive effect is small,
when richer group have privileged access to public facilities. Further, the analysis suggested that with the relaxing entry conditions the health insurance market will likely to be much larger than the existing business of General Insurance Corporation of India and this increased size have many equity-enhancing effects that include reduced use of public sector hospitalization facilities by the upper income group.

**Watts et al. (2003)** investigated how public employers make health benefit decisions for their employees and how they altered their decision in response to rising premiums in U.S. The study explored the changes in contribution strategies of state and local government employers, the extent of premium cost shifting to employees and other means used to reduce the impact of rising premiums on public budgets and compare these changes with those of private employers. The study was based on Community Tracking Study (CTS), conducted in 12 US communities during 2000-01 and survey conducted by Robert Wood Johnson Foundation (RWJF) in 1997. The results of the study provided that public employers were providing health insurance coverage to nearly 16% of all workers of U.S. Their reaction to rapidly rising premiums can have important effect on local market for health insurance, because of their size, visibility and reflection of public policy. The study concluded that public employers were bound by the tight budget set by elected officials and statues regarding due process, public input and public accountability. Moreover, the public employer faces tough choice regarding employee benefits due to consolidation in insurance market as well as continuous increase in premiums.

**Matthies and Cahill (2004)** observed how India can break barriers to expand health insurance, as several developed and developing nation have already done. It state health insurance involving a mix of health insurance company management and risk taking, state government, industrial contributions and local NGOs administration, would gradually encompasses most of the rural poor. The study shown a level playing field with adequate consumer protection created through the legal regulatory framework is necessary, but not sufficient to promote the development of health insurance market. Alternatively, health insurance claim tends to be more frequent, smoother and predictable, so that the insurance companies could reflect this. Moreover, the absences of a substantial and accurate data base addressing morbidity, mortality, beneficiary and claim related information is especially handicapping the development of health insurance.
But the India can develop and expand its health insurance market through the right policies and stringent regulations and this would bring quality care for teeming millions of people at a reasonable cost.

**Asgary et al. (2004)** estimated the Demand and Willingness to Pay (WTP) for health insurance by rural households in Iran and, to understand the factors that contribute to households WTP for health insurance. A Contingent Valuation Model (CVM) was applied and data has been collected from a sample of 2,139 households. The finding of the study provided that a significant percentage of population (more than 38%) live in rural areas, but the health care insurance currently operating in urban areas. The WTP is less than average premium currently set in urban areas, only if the price of insurance is set a minimum level, would most of the households be willing to buy it. In order to provide rural areas with same level of protection as urban areas, the difference would have to be subsidized and the policymakers would need to consider this difference in WTP in different region of the country in policy formulation. The will result in rural development which in turn leads to increase in rural households WTP for health insurance.

**Sekhri and Savedoff (2004)** examined the private health insurance coverage around the world and how its wide spread has become and intended to encourage policymakers to pay attention to private coverage and the role it can and does, play in health care system. For this purpose, the data was obtained from National Health Accounts (NHAs) regarding private health insurance. The study shown that private health insurance is significant in countries with widely different income levels and health system infrastructure. The main challenge is to choose how to use it wisely. Further the study suggested that policymakers should regulate the private health insurance sector appropriately so that it could serve the objective of coverage in universe and equity.

**Ahuja and De (2004)** confirmed that the demand for insurance is limited where supplies of health services is weak and also explained the interstate variation in demand for health insurance by poor in relation to variation in healthcare infrastructure. For this purpose, data was collected from General Insurance Public Sector Association (GIPSA) and National Sample Survey Organization (NSSO) 55th round. The data analysis was done by using Regression analysis and shown that healthcare infrastructure is positively
related to demand for health insurance by poor, whereas the proportion of Below Poverty Line (BPL) population is negatively related. Further, the study suggested that, in order to build demand for health insurance it is necessary to address demand side more seriously and at the same time, the design insurance schemes by taking into consideration the paying capacity of the poor.

**Mudgal, Sarkar, and Sharma (2005)** examined whether consumption expenditure of households in rural India is insured against medical ailments. For this purpose, data was obtained from the 52nd round of National Sample Survey (NSS) as well as primary survey was conducted, which involved 70725 households from 7253 villages in 77 regions. The study shown that with the exception of few regions and certain section of scheduled tribes’ households, villagers in India are able insures their consumption against medical ailment shocks. But the villagers are not perfectly able to share the risk of all shocks. So, the study was unable to conclude whether they perfectly share health risk or not and also it does not mean that the possibility of health insurance existing in the rural India is indeed high. Further, careful village level studies could be conducted to test for the robustness of this possibility.

**Marquis et al. (2006)** conducted a study on consumers’ decision making in an individual health insurance market in California. The study based upon data obtained from Current Population Survey (CPS1996-2002). Beside this, the primary survey with a sample of 3964 subscribers in individual and family health plans enrolled during 1996-2003 was conducted. The study shown that the tax credits and subsidies have modest effect on number of uninsured people and consumers’ choice modestly affected by changes in benefits design, non price barriers etc. The cost of obtaining information plays an important role in the low rate of participation. Further, it was also found that there was substantial pooling in the individuals health insurance market, which increases over a time because who become sick can continue coverage without new underwriting. Moreover, it will be easier to attract healthy subscriber than high risk subscribers to high-deductible policies.

**Dror (2006)** laid seven myths regarding health insurance and examined the realities behind each of these myths. For this purpose, data was obtained from survey conducted in seven locations and sample of 4931 households was selected. The evidence
shown that most people are willing to pay 1.35% of income or more for health insurance, each consultation to doctor is not very costly, larger households have fewer illness, higher income associated with more reported illness episodes, a decision tool called Choosing Health Plan All Together (CHAT) was used in selection of health insurance benefit package, because the health care needs of the poor are not uniform and the premium that the poor are willing and able to pay represent significant part of cost of insurance; but they can’t afford reinsurance premium. No, doubt that there is a solvent market for health insurance among India’s poor. However tapping of market is contingent upon understanding the customer’s needs and wants.

Ramani and Mavalankar (2006) examined the health system in India and shown that health and socio economic development are so closely related that it is impossible to achieve one without other. Beside this, an effort was maintained to examine health system that should be responsive to community needs, especially for the poor. The study found that no doubt the economic development in India has been gaining momentum over the last decade, but the health system is a cross roads today. In India, public health system has recorded some success over time because of government initiative, but still India health system is ranked 118 among 191 WHO members’ countries on overall health performance. The study concluded by identifying the role and responsibilities of various stakeholders for building efficient and effective health system and also state that health is priority goal in its own right, as well as a central input in to economic development and poverty reduction.

Dror (2007) examined why the “one-size-fits-all” health insurance products are not suitable to low income persons in India. The study hypothesized that attractive health insurance must represent an optimum match between clients’ needs for health care, demand for health insurance and available supply of health care. To satisfy this objective, a survey was conducted in 7 locations, include a total of 4931 households, representing a total of 24042 individuals. The results provided with the evidence of presence of considerable variability to pay for health insurance, which was because of multiple reasons like variability in income; frequency of illness among households; quality and proximity of providers (private, public) in different locations. Alternatively, the results also shown that aggregated expense of consultations and drugs exceed those of
hospitalization in all the locations. Further, the study concluded that because of multiple variations in clients’ needs, the cost of health care, demand and supply of health insurance across locations, there is dire need to combine a different optimal benefit package for each location, based upon the context specific parameters relevant in each location.

**Danis et al. (2007)** conducted a study aims at determination of a plan that allows people who are inexperienced with health insurance to pick health benefits and accordingly, they developed a modified version of Choosing Health Plan All Together [CHAT] decision tool. For this, the experiment was conducted in 17 locations with 302 participants. The study showed that it was possible to create decision tool that allow rural and poor communities to participate in insurance benefits packages. Moreover, the findings has also shown that even within a limited premium there is choice of different packages and the level of premium determines the expectation of coverage by health insurance. CHAT tool has important influence on group dynamics in selecting health insurance benefits package and at the same time retaining balance between individual priorities and collective responsibilities.

**Kipp and Snook (2008)** analyzed the key factors that insurer will need to consider when developing pricing policies for health insurance products, because they need some type of data to formulate an approach to pricing new coverage, where no claim experience exists. This co-pay encourages the policyholders to shop for most cost effective treatment. The following are the consideration for expanded health benefits which include:- the diagnoses covered; the procedure covered; the service area of policyholders; providers fees for services rendered; cost sharing with policyholders; underwriting and risk assessment process used; and the place where services rendered. The study concluded that in order to be more successful in the area of health insurance, insurers have to classify the risk in accordance with the individual’s profile and price them accordingly.

**Zhou et al. (2008)** conducted the study in order to assess the differences in drug spending among cancer inpatients in China according to social health insurance status and to explore the factors that affect drugs costs. For this purpose, a sample of 1977 cancer inpatients that were discharged between 1 Oct 2005 and 31 Sep 2006 collected out
of which 1631 were found usable for analysis. The sample divided into two groups according to Social Health Insurance (SHI) status: - with SHI and without SHI. The study found that majority of respondents did not have social health insurance and it appears to affect drug spending by cancer inpatients in China. SHI inpatients had higher drug costs than non SHI in patients had. The study provided with the fact that SHI coverage was positively associated with higher drug cost and drug spending, whereas differences were attributable only to differences in insurance coverage.

Joglekar (2008) examined the impact of health insurance on catastrophic out-of-pocket (OOP) health expenditure in India and taken zero percent as threshold level to define and examined such impact. For this purpose, data was obtain from World Health Survey (WHS) 2003 conducted in six states of India, which cover 10750 households and further information on environmental risk factor was also obtained with the help of individual questionnaire. The results showed that in India, OOP health expenditure by households account for around 70% of total expenditure on health and resultant reduced consumption expenditure on other goods and services and push households in to poverty. Literature defines OOP expenditure as catastrophic if its share in the household budget is more than some arbitrary threshold limit. But the study argued that any expenditure on health is catastrophic for household below poverty line as they are unable to attain sustainable level of consumption. Moreover, the study found that poorer households are more vulnerable than richer; the extent of OOP health expenditure is lower for households where they has completed either primary or secondary level of education and health insurance has been considered as one of the possible instrument to reduce the effect of large OOP health expenditure.

Vellakkal (2009) examined the determinants behind the process of health insurance by analyzing the behavior of an insurance agents and various preconditions affecting the rational behavior of an insurance agents, who are facing a tradeoff between selling ‘health Insurance’ and ‘other forms of insurance’ and the implications of such behavior on adverse selection and equity. The study also discussed the two new concepts- ‘insurance habit’ and ‘asymmetric information’ on health insurance schemes’ and various strategies followed by insurance agents for maximizing their incomes. The study based on the survey conducted with 400 households selected from districts of Kasargod (less
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developed) and Trivandrum (developed) in Kerala, India. It was observed health insurance schemes are a less profit but high risk oriented business and the income and education have limited positive impact on demand for health insurance. The study concluded that in India, incentive system for promoting various form of insurance; low level of awareness among the general public; rational and dominant role of insurance agents in market results in low level of health insurance coverage. Therefore, the study concluded that IRDA should provide more incentives to insurance agents for selling health insurance.

Garg and Karan (2009) investigated the differential impact of out-of-pocket (OOP) expenditure and its components between developed and less developed regions in India. Further, an attempt was also made to measure poverty at disaggregated rural-urban and state levels. For this purpose, data on households’ consumption expenditure which was collected from 17 major states of India by National Sample Survey Organization (NSSO) 1999-2000 and which include a sample of more than 120000 households (71000 rural and 49000 urban) was used. The results showed that OOP expenditure is about 5% of total households’ expenditure (ranging from about 2% in Assam to 7% in Kerala) with higher proportion in rural areas. Purchase of drug constitutes 70% of total OOP expenditure. Approximately 32.5 million persons fell below poverty line in 1999-2000 through OOP payment, showing that overall poverty increases after accounting for OOP payment is 3.2% as earlier rise of 2.2%. Poverty increases much higher in poorer states and rural areas as compared with affluent states and urban areas, except in case of Maharashtra. The study suggested that, for better method of capturing drug expenditure in household surveys special attention to be paid towards expenditure on drugs, especially for the poor and to reduce OOP expenditure targeted policies could helps to prevent almost 60% of poverty.