Chapter-II

REVIEW OF LITERATURE

2.1 INTRODUCTION

An attempt is made in this chapter to review the earlier studies. The secondary data was collected from books, journals, e-journals and e-books by searching different web sites for relevant information, which may lend direction to the present study.

2.2 REVIEW OF THE STUDIES

Shreedevi (2014) conducted a study on ‘Evaluation of Rajiv Aarogyasri Scheme in Andhra Pradesh and survey of patients’ opinion’. This study captures the objective, functioning, achievements and impact of Aarogyasri. The study was conducted for the period April 2007 to December 2013 based on patient data. Simple tools such as frequency counts, percentages, ratios, averages, and so on were used to understand efficiency of insurance mode, and measure the performance of the scheme. A brief analysis of the scheme based on officially available data and media reports from a public health perspective revealed that 87 per cent of population of Andhra Pradesh was covered under the scheme. From the sample study, it was found that males had 40 per cent higher utilisation than females under the scheme. The cost benefit ratio of insurance mode was 81 per cent when compared to 91 per cent for Trust mode. Implementation of the scheme through the insurance mode is highly inefficient in terms of cost. Patients’ opinion regarding the scheme revealed that majority of them was happy with the scheme, none of them had a poor opinion about the flagship project of Government of Andhra Pradesh. The scheme has already contributed to its successful replication throughout the state. It aims to support, the replication of such a scheme elsewhere in order to achieve ‘Health for All’, ensuring that the most
underprivileged sections of society are able to claim their ‘right to live’. She concluded that the Rajiv *Aarogyasri* Community Health Insurance in Andhra Pradesh has been very popular social insurance scheme with a private public partnership model to deal with the problems of catastrophic medical expenditures at tertiary level care for the poor households.

Mallikarjuna, K. (2014) ii studied on ‘Health Care Policy and Administration: A Case Study of Rajiv *Aarogyasri* Health Insurance Scheme in Andhra Pradesh’. He mentioned that *Aarogyasri* model is a holistic approach to Healthcare, ensuring that people are given free health checkups by the network Hospitals and 24 hour Helpline, manned by 100 Doctors and 1,600 paramedics that handle about 53,000 calls a day. 108 and 104 Ambulance services will always available to the patients at their doorsteps with a simple phone call by the people. He cruised that since the coverage of diseases under *Aarogyasri* was limited, a large number of patients continued to seek assistance from Chief Minister’s Relief Fund for treatment of other ailments. The *Aarogyasri* Health, Scheme testifies to the State Governments skewed priorities. It helps only 500 out of the 20,000 odd patients who admitted to the Network Hospitals, both in the private and public sectors in the state every day. The rest of the patients have to incur out of pocket expenditure. The opposition political parties alleged that *Aarogyasri* with its focus on super specialty care has only helped corporate Hospitals paying step motherly treatment to the Government Hospitals. In order to rectify the shortcomings in this scheme, the efforts would be made to set up 40 per cent of the *Aarogyasri* operations back to the Government Hospitals. It would help Government Hospitals to get more sophisticated equipment and Doctors better equipped and enable them to earn incentives under this scheme. Recently, the Andhra Pradesh Government has stopped payments to the Corporate
Hospitals and launched punitive action against 66 Hospitals in the state for committing irregularities while offering treatment to the patients under Arogyasri Health Insurance Scheme.

Suman Goel (2014), iii in his article ‘Health Insurance: An Empirical Study of Consumer Behaviour in Rohtak District of Haryana’, summarised that health insurance is rapid rising as an important mechanism to funding health care needs of the people. The study has conducted in Rohtak district of Haryana and based on primary data collected from a sample size of 150 respondents via questionnaire method. The results have been analysed with the help of various statistical tools. The results have shown low level of awareness and willingness to join in subscription of health insurance. Health insurance companies should come out with clear cut policy details, as many of the respondents had indistinct ideas about the various benefits and risks involved in a policy. The middle and low socio-economic groups are a potential market to be tapped as they are ready to spend a reasonable amount as premium payable per annum rather than huge medical expenses in case of any adversities. If the private insurance players want to venture in the market, they should try to absorb trust in the people as most of the respondents preferred government health insurance schemes, the reason being guarantee for their capital. To develop a viable health insurance scheme, it is important to understand people's perceptions and develop a package that is accessible, available, affordable and acceptable to all sections of the society. To conclude, most of the respondents were of the opinion that government should come out with a clear cut policy, where the public can be made to contribute compulsorily to a health insurance scheme to ensure unnecessary out of pocket expenditures and also better utilisation of their health care facilities.
Hebbar, C.K. et al. (2014) found that ‘Health insurers in India currently facing many challenges including poor awareness, low product acceptance and uncertain business profitability’. So with this research, the insurers will be able to innovate in their product offerings and tighten their existing processes and cost structures. Private health insurance cannot grow if reasonable consumer expectations relating to access, cost and quality of healthcare remain promises rather than realities.

Rajesh K. Yadav and Sarvesh Mohania (2014) viewed that ‘Health Insurance Portability is a regulation set by IRDA where an individual is allowed to switch between insurers at their own choice without having to worry about their no claim bonus and pre-existing diseases cover’. The study aims to highlight the purpose of portability, a system that allows the policyholder to move the policy from one insurance company to another. In case of dissatisfaction with respect to the existing policy or the services or to switch over to an innovative/another product, which could be available elsewhere in health insurance services. The Indian health insurance market share is a mix of mandatory Social Health Insurance (SHI), voluntary private health insurance, and Community Based Health Insurance (CBHI). Health insurance is really a small player in the Indian health ecosystem. The study is based on the secondary data collected from IRDA and research papers from various journals. The study concluded that it has been more than 2 years since health insurance portability came into force but due to its complex nature, lack of interest of insurance agents, improper communication and lack of customer's awareness, it is not that much popular in health insurance services.

Santosh Kumar and Sriram Divi (2013) summarily concluded that ‘Public-private partnerships in the domain of public service delivery have
become hallmark ever since India opened its economy to the global market’. This has been the case particularly with health services, both in urban and rural areas. India’s southern state of Andhra Pradesh is implementing the *Aarogyasri* (health services) programme which is very popular with the masses. In this mode of health services delivery, corporate hospitals handle the biggest share of the cases. Unfortunately, there is no provision for day-to-day services (outpatient) which in fact could have made this programme all encompassing. The focus on tertiary healthcare to the exclusion of all other forms of medical assistance leads to an inefficient medical care model with lesser impact on meeting the needs of majority of the people. There is need for a debate on the healthcare and techno-commercial performance of the programme, especially, if it is going to be copied by other states and even by the centre in introducing some form of universal healthcare under the National Rural Health Mission. The scheme aims to provide medical care for BPL families up to a value of 0.2 million (Indian National Rupees) per annum for tertiary surgical and medical treatment of serious ailments, which, in turn, will help them from excessive private borrowing. The scheme is run by a public-private partnership called the *Aarogyasri* Health Care Trust between Star Health and Allied Insurance, the corporate hospitals and state agencies. This partnership has, however, come to an end in early March 2013. Medical and health services in the private sector are unregulated and where obstetrics is the single largest specialisation. The present study is of exploratory in nature and will try to assess the dimensions of PPPs in the health sector where public funding is mostly poor. It will also explain the impact of collaborations on the general reach of health services in the state of Andhra Pradesh where the government’s role has virtually become defunct.
Shankar Reddy Dudala et al. (2013) took a study on ‘Utilisation pattern of Aarogyasri Health Insurance Scheme by Cancer Patients in Khammam District, Andhra Pradesh’. They concluded that convergence for health can be evoked by providing comprehensive quality public health services inclusive of primary health care, screening services, tertiary care services and rehabilitative care, complimented with community health insurance schemes like RACHIS. The long term sustainability of such large scale public sector programs for the needy and poor can only be ensured sustainable, if the premium of insurance, which is currently borne solely by State Government, is shared or contributory in nature. RACHIS is able to extend medicare for those who need it most (vulnerable and marginalized groups). People’s participation to be encouraged both in terms of utilisation and service delivery. District Cancer Control Programme needs to be augmented with a fresh impetus and commitment. Cancer registries to be developed both field based and institutional based to identify the first probable point for a definitive intervention. To encourage evidence based practice in the management of cancer so that economical and relevant treatment can be given. Finally, they recommended that in addition, in the era of Globalisation, Privatisation or say Corporatisation there are many districts in India, blessed with Private Medical institutions or have corporate health sector penetration, can further contribute towards sustainability of schemes like RACHIS through development or delivering quality oncology care. There is a need to continue Health Insurance Scheme for those who are below poverty. Cervical cancer (26.2%) can be identified at an earlier stage with PAP smear and hence universal screening of women above the age of 40 years with multiparity to be considered. There should be an organised Breast Cancer Control Programme so as to reduce the morbidity and mortality by early detection.
Amandeep Kaur Shahi and Harinder Singh Gill (2013)\textsuperscript{viii} reviewed ‘Performance and progress of health insurance business that has evolved over the past 25 years in India’. The objectives of the study are to find origin of health insurance in India and abroad and to examine the growth pattern and trends of public and private health insurers in post-liberalisation period. The study analyses the performance of health insurance sector on the basis of contribution to GDP, health insurance portfolio share percentage in total non-life insurance business, sector and company wise analysis of public and private health insurers. The study found that the market trend and penetration level of health insurance business are changing over a period of time. The premium level and index of aware about the benefits of health insurance has been steadily increasing. The growth rate and market share of private health insurance has been increasing and public health insurers has been decreasing, due to number of increasing private health insurers, competition compulsions and coverage of rural areas with new and innovative products.

Nilay Panchal (2013)\textsuperscript{ix} conducted a case study on ‘Customer’s Perception Towards Health Insurance: An Empirical Study in Bardoli & Mandvi Region’. He observed that Respondents’ knowledge and confidence about health insurance is good. Further research indicates that awareness about the existence of health insurance is fine but preference is average. Most respondents’ know about health insurance but some of them don’t have any policy because of low awareness or lack of information regarding health insurance. Research indicates that there are clear possibilities for health insurance market in India; there are also possibilities for the public and private health insurance companies. It can be said that income of respondents plays a vital role for purchasing health insurance.
Rohit Kumar, Rangarajan and Nagarajan Ranganathan (2013) study examines ‘The Indian health insurance market by empirically observing the provider’s perceptions and its relationship with the insured, the insurer and the Third Party Administrators (TPAs)’. The study tries to find out the awareness level among the insured population and their attitude towards treatment cost. It then examines the role of TPAs and the impact of cashless services on the cost of treatment by studying a few cost drivers. Apart from studying the provider’s perceptions, it also tries to look at some of the evidence of moral hazards and that of fraudulent activity. The findings suggest that the awareness level regarding policy terms and condition is low among the insured population and most of them do not care for the cost of treatment. The providers increase their rates quite frequently and prefer the middle income group for extending cashless benefits. The TPA model has not been successful in bringing down the claim cost but has helped in providing unbiased services including cashless benefits. The price structure of healthcare services are linked to the room rent category and most of the insured patients, who are more demanding, prefer staying in higher category rooms. The concept of cost-sharing by the insured will help tackle this issue to some degree. The Indian health insurance market is not immune from supply-side moral hazards and fraudulent activities and there is a need to craft different strategies to tackle them. There exists an opportunity for the insurance companies to build long-term relationships with the preferred healthcare providers by using technology and by understanding each other’s roles in serving the common client.

Priyadarsini, M. (2013) made empirical study on ‘Investment pattern towards health insurance at Salem district, Tamilnadu.’ This research paper had made an attempt to explore the investment behaviour of
investors towards health insurance in Salem district, Tamil Nadu state. The primary data collection made through structured questionnaire. The opinions of 200 respondents were considered for the analysis. Through this analysis, it was found that consciousness’s of health insurance are lacking among the public of Salem district, as well as their income level do not support for high premium policy.

Sunita Reddy (2013) discussed on ‘Aarogyasri Scheme in Andhra Pradesh, India: Some Critical Reflections’. This article critically analyses the procedures and the cost incurred in private and public hospitals and finds that Aarogyasri is skewed towards curative tertiary care and is a big drain on the state exchequer with questions of sustainability. Further, this kind of partnership undermines the existence of large public sector, which is under utilised. The way forward for sustainable and comprehensive health care for people of Andhra Pradesh to ensure Arogyadhara is to promote and strengthen public sector.

Pooja Kansraa and Gaurav Pathania (2012) conducted ‘A study on factor affecting the demand for health insurance in Punjab’. They found that the economic status of a country is directly related to the health status of its people. Good health is one of the most important pre-requisite to human productivity which in turn leads to overall development of a society. Health is understood as the indispensable basis for defining a person’s sense of well-being. It is an important resource for a nation to pursue national development goals. It raises the productivity of the labor force and enhances economic growth. It plays a critical role in supplementing government effort in ensuring the availability and accessibility of health care services to the population. The objective of the present paper is to know the awareness of health insurance and the factors
affecting the demand for health insurance in Punjab. For the analysis of data descriptive statistics and factor analysis have been applied. The sample size is 200 residents of Jalandhar chosen according to convenience approach. The study highlighted that majority of the people aware of the health insurance. Only 11.5 per cent of the total sample has subscribed for health insurance scheme and five factors i.e. formalities bottlenecks, agent related problems, coverage issues, awareness, negative feedback are main barriers in the success of health insurance in Punjab.

Sanjiv Kumar, G.S. and Preetha (2012) analysed that ‘Health promotion is very relevant today’. There is a global acceptance that health and social wellbeing are determined by many factors outside the health system which include socio-economic conditions, patterns of consumption associated with food and communication, demographic patterns, learning environments, family patterns. The cultural and social fabric of societies; sociopolitical and economic changes, including commercialisation and trade and global environmental change. In such a situation, health issues can be effectively addressed by adopting a holistic approach by empowering individuals and communities to take action for their health, fostering leadership for public health, promoting inter-sectoral action to build healthy public policies in all sectors and creating sustainable health systems. Although, not a new concept, health promotion received an impetus following Alma Ata declaration. Recently it has evolved through a series of international conferences, with the first conference in Canada producing the famous Ottawa charter. Efforts at promoting health encompassing actions at individual and community levels, health system strengthening and multi-sectoral partnership can be directed at specific health conditions. It should also include settings-based approach to promote health in specific settings such as schools, hospitals, workplaces,
residential areas etc. Health promotion needs to be built into all the policies and if utilised efficiently will lead to positive health outcomes.

Kasirajan, G. (2012) conducted a study on ‘Health insurance–An empirical study of consumer behaviour in Tuticorin district’. He mentioned that in abstract that health insurance is fast emerging as an important mechanism to finance health care needs of the people. The need for an insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalisation by charging premium from a wider population base of the same community. In the present scenario, the annual expenditure on health in India amounts to about $7.00 in rural areas and $10.00 in urban areas per person, majority of care being provided by the private sector.

Sumathi Kumaraswamy (2012) studied on ‘Service Quality in Health Care Centres: An Empirical Study’. The analysis revealed that the important service quality factors in health care centers are physician behaviour, supportive staff, atmospherics and operational performance. The corporate health care centre are highly rated them the non-corporate health centers regarding all service quality factors. The perception on service quality factors in health care centers has a significant and positive impact on the patients’ perception on the overall performance of the health care centre. The important discriminant service quality factors among the two type of health care centre are atmospherics and supportive staffs. The study suggests improvement across all service quality factors and formulation of suitable strategies for enhancing patients’ satisfaction.

Pati S et al. (2012) analyzed in their paper that ‘Health promotion is the process of enabling people to increase control over and to improve their health’. This stream of public health is emerging as a critical domain
within the realm of disease prevention. Over the last two decades, the curative model of health care has begun a subtle shift towards a participatory model of health promotion emphasising upon practice of healthy lifestyles and creating healthy communities. Health promotion encompasses five key strategies with health communication and education as its cornerstones. The study is an attempt to explore the current situation of health promotion education in India with an aim to provide a background for capacity building in health promotion. A systematic predefined method was adopted to collect and compile information on existing academic programs pertaining to health promotion and health education/communication. Results of the study reveal that currently health promotion education in India is fragmented and not uniform across institutes. It is yet to be recognised as a critical domain of public health education. Mostly teaching of health promotion is limited to health education and communication. There is a need for designing programmes for short-term and long-term capacity building, with focus on innovative methods and approaches. Public health institutes and associations could play a proactive role in designing and imparting academic programs on health promotion. Enhancing alliances with various institutes involved in health promotion activities and networking among public health and medical institutes as well as health services delivery systems would be more productive.

The study of Dhiraj Jain and Nikita Goyal (2012)\textsuperscript{xviii} tries to understand ‘The awareness of the people towards the rights and duties against life insurance products after the privatisation of the insurance sector’. To actually understand this, a primary research was conducted to find out the level of awareness towards the rights and duties of the policy holders across demographic profiles and about the level of awareness
towards life insurance policies prevailing in the market. Chi-square test was used to test the significance of the relationship. The analysis is based on a sample of 117 individuals from randomly selected general public. A significant association between the demographic determinants and the awareness towards the rights and duties regarding life insurance was found showing low level of awareness towards rights and duties among the policyholders of life insurance.

Bhagabat Barik (2012)\textsuperscript{xix} reviewed ‘Customer expectation about insurance product in Indian Life Insurance Industry and concluded that Life Insurance sector has a lot of potential both in terms of sales, revenue, employment generation and difficult to estimate the required customer expectation’. Customers realise two basic types of expectation such as desired and adequate service. Their personal as well as technical knowledge catalyses the acceptance of life insurance products.

Suresh, K. (2012)\textsuperscript{xx} studied on ‘Evidence based communication for health promotion: Indian lessons of last decade’. This article elucidates the vital role of Health Promotion, a research based communication process, in achieving developmental, particularly health goals. It underscores that communication is as much a science as an art, as much process as it is about outcomes. It advocates for increased linkages between epidemiological research and social science research in planning effective health promotion interventions with quality service delivery.

Ramana, T.V. (2011)\textsuperscript{xxi} has conducted two various studies on the Rajiv Aarogyasri and social health care and highlighted the salient features and its implementation in Kakinada area. The analysis finds out that the scheme has been benefited more and providing health security to the poor.
Meanwhile the patients were opined on some facilities like availability of doctors and other staff for more time. The study also suggested that there should be a need of cleanliness of hospital establishment of waiting hall etc. Obviously, the study found that the scheme has been benefited immensely to the rural poor.

Devadasan et al. (2011) conducted a study on ‘Community health insurance schemes and patient satisfaction, evidence from India’. The results show that there was no significant difference in the levels of satisfaction between the insured and uninsured patients. The main reasons for satisfaction were the availability of doctors and medicines and the recovery by the patient. **Interpretation and Conclusions:** Our study showed that insured hospitalised patients did not have significantly higher levels of satisfaction compared to uninsured hospitalised patients. If CHI schemes want to improve the quality of care for their clients, so that they adhere to the scheme, the scheme managers need to negotiate actively for better quality of care with empanelled providers.

Bawa and Ruchita (2011) examined that there was ‘Low level of awareness and willingness to join and there were seven key factors acting as a barrier in way of opting for health insurance’. This present study very closely relates to what we are trying to achieve in our research i.e., to ascertain the level of willingness and awareness among general population of Rohtak district of Haryana. Srinath Reddy. K, (2011), the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010. The committee submitted its report along with a few recommendations in November 2011. The HLEG recommendations were considered by the Planning Commission and also approved by the National Development Council (NDC) for formulating the 12th Five Year Plan which has to be
developing a framework for providing accessible and affordable health care to all Indians. Most important recommendations of HLEG are, increase in public expenditure on health to at least 2.5 per cent of GDP. By the end of the 12th Plan, at least 3 per cent of GDP by 2022 and establishment of National Health Regulatory and Development Authority (NHRDA) to monitor universal health coverage.

Suminder Kaur Bawa (2011)xxv published a paper on ‘Awareness and Willingness to Pay for Health Insurance: An Empirical Study with Reference to Punjab India’. The present study is an effort in the area of health insurance and the peculiar feature of it lies in multi-dimensions. As firstly, it examines the respondents who are aware or not aware about health insurance as well as various sources of awareness; secondly, those who are aware have subscribed it or not; thirdly, those who have not subscribed what are the reasons behind the same; and last but not least are they willing to join and pay for it? The study was conducted in Punjab and 600 questionnaires were got filled from randomly selected general public, out of which 563 found to be suitable for analysis. The results shown low level of awareness and willingness to join and seven key factors are barrier in subscription of health insurance. Moreover, significant association exist between the gender; age; education; occupation; income of respondents with their willingness to pay for health insurance. On the other hand, no significant association exists between the marital statuses of the respondents with their willingness to pay for health insurance.

Desai (2009)xxvi found that large majority of Indian population depend on the private sector, mostly in the form of out of pocket spending that accounts for more than 70 per cent of all health spending in India. Two recent government initiatives National Rural Health Mission (NRHM) and
Rashtriya Swasthya Bima Yojna (RSBY) seek to shift this Burden from households.

Sakharkar, B.M, (2009)xxvii made an attempt to bring together ‘The knowledge pertaining to hospitals in a compact form’. He says that the problems of Government Hospitals are no more different from those of corporate hospitals. To deal with challenges, the author suggested that the chief executive of the hospital need to have proper outlook, expertise and experience. The book covered many issues like outpatient care, nursing services etc. The author also said that “sociologists considered hospitals as the social system based on bureaucracy, hierarchy, super-ordination, subordination and the hospitals manifest the characteristic of bureaucratic organisation with dual life of authority viz., administration and profession.

Garg and Karan (2009)xxviii assessed ‘The differential impact of out-of-pocket (OOP) expenditure and its components between developed and less developed regions in India’. The results showed that OOP expenditure is about 5 per cent of total households’ expenditure (ranging from about 2 per cent in Assam to 7 per cent in Kerala) with higher proportion in rural areas. Further in order to reduce OOP expenditure targeted policies are needed which in turn could help to prevent almost 60 per cent of poverty.

Ravi M, Hanna and Sofi (2009)xxix presented report ‘On the health sector reforms in Andhra Pradesh and explain how international organisations like the World Bank, European Commission and the Department For International Development (DFID) have involved with the health sector in Andhra Pradesh, initiated in 1995’. According to the report, in India the health sector reforms gained focus in the mid-eighties and took momentum in early nineties, along side economic reforms
initiated by the Government of India. Governance, service delivery and health finance are the major areas of the reforms. The study felt that the reform process could help government to build trust in the communities. It also felt that innovative steps have been taken to shape the future health status of population in Andhra Pradesh. The health care initiatives reflect positive changes in the mindset of both government officials and private health care providers, yet these reforms need sustained commitment to succeed and reach its target.

Lofgren et al. (2008), this study conducted in ‘Vietnam it was found that willingness to pay for health care services was directly proportional to the level of income, education, size of family and the number of lingering diseases in a household’. They observed that the groups of people who are most likely to face health related issues are the lower income level group.

Masood H Siddiqui, Tripti Ghosh Sharma (2008) developed a valid and reliable instrument to measure customer perceived service quality in the life-insurance sector. The resulting validated instrument comprised of six dimensions: assurance, personalised financial planning, competence, corporate image, tangibles and technology. Further, the results of analytical hierarchy process highlighted the priority areas of service instrument with assurance as the best predictor, followed by competence and personalised financial planning.

Venkat Changavalli (2008), ‘Chief Executive Officer of Emergency Management Research Institute (EMRI) of Andhra Pradesh announced that EMRI will spend more than 15 lakhs on a single emergency room at different rural hospitals’. 108 Ambulance will carry the patients from their residence or place of accident to the nearest
hospital. 108 ambulance services will work on public/private partnership mode. The CEO said that the State Government of Andhra Pradesh is all set to tighten the norms and regulate private/corporate and nursing homes. He also said that all private hospitals management should display medical charges such as bed charges, surgical procedure, emergency visits, lab investigation and consultation.

Malhotra Khamish, Gardner Stephen (2008)xxxiii concluded that ‘The recent advances in Internet enabled mobile devices had paved the way for remote patient monitoring applications.’ The aim of the study was to evaluate the scope and nature of mobile technologies in the healthcare sector on one of the largest countries by population and the fastest growing economy, India. The motivation for the research came from an analysis of the potential benefits of mobile information.

Himanshy Sekhar Rout and Prasant Kumar Panda (2007)xxxiv edited ‘a volume and has emerged from the research papers contributed by research scientists and academicians from different parts of the country, selecting specific health problem and health issues from different states in the country’. The main themes covered by this volume are health status, development, tribals and determinants of health, health care services and financing reforms. Many papers in this edition focused on Government control and regulation over private/corporate hospitals.

Dror et al. (2007)xxxv provides evidence on Willingness To Pay (WTP), gathered through a unidirectional (descending) bidding game among 3,024 households (HH) in seven locations where MHI units were in operation in India. Insured persons reported slightly higher WTP values than uninsured. About two-thirds of the sample agreed to pay at least 1
per cent; about half the sample was willing to pay at least 1.35 per cent; 30 per cent was willing to pay about 2.0 per cent of annual HH income as HI premium. Nominal WTP correlates positively with income but relative WTP (expressed as percent of HH income) correlates negatively. The correlation between WTP and education is secondary to that of WTP with HH Income. Household composition did not affect WTP. However, HHs that experienced a high-cost health event and male respondents reported slightly higher WTP. The observed nominal levels of WTP are higher than has been estimated hitherto.

Ashokan A.J. (2007), xxxvi in his research paper discussed ‘The nature and pattern of health care expenditure based on a cross-sectional household survey in rural Kerala, India’. According to the study, the average expenditure on health is estimated at Rs.244 crore and it consistently increases as we move up the socio-economic groups. The private sector provides about 4/5th of health care services. Private health expenditure is more than 4 times to the public health expenditure. The study pointed out that the health expenditure of people will reflect on the socio-economic conditions. It is an issue of serious concern. The government should set up regulatory mechanisms to fix specific norms for hospital infrastructure, cost of care and access to medical records. This study identified the rational and space for strengthening the efficiency of real public health system and the need for regulating private health care sector through appropriate legislation, identifying appropriate space for public / private collaboration. It felt that the decentralised health care system through democratic empowerment can act as a powerful strategy and instrument to improve health inequality by reducing the gap between “Health of haves and have-nots”.

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Pramod Singh.K, (2007) xxxvii, in his paper discussed ‘The governance issues involved in health care delivery of rural India’. It proposed Spatial Health Management Information System (SHMIS) for India and ways and means for its creation. The author felt that health care delivery system in India is highly selective institutionalised, centralised and top-down. It has failed to address the needs of majority of rural poor. It found inadequate planning, management and monitoring of services at the local level.

Jawahar K.F. (2007) xxxviii study was conducted by ‘The author to know the satisfaction levels of the patients and also to get feedback about the services provided in outpatient department in Sri Chitratirunal Institute for Medical Sciences and Technology at Tiruvananthapuram, Kerala’. The study found out that 95 per cent of patients were satisfied with the services offered by the hospital, but some of them complained about the waiting time and behaviour of nursing staff.

Gopinath Reddy, N. (2006) xxxix observed in his study that ‘The patterns of health facilities in India are shaped in party and political concerns, some health facilities identified as a resource for particular support groups to the exclusion of others’. The health sector reforms policy is profoundly influenced by the professional doctors association in the state with the overall effect of leaving the private medical market under-regulated and the work of public sector doctors are under-monitored.

Ahuja and Narang (2005) xl provided ‘An overview of existing forms and emerging trends in health insurance for low income segment in India’ and concluded that health insurance schemes have considerable scope of improvement for a country like India by providing appropriate incentives and bringing these under the regulatory ambit.
Krishna Reddy, B. and G.V.R.K. (2005) commented in their article that ‘Health care by its nature is an industry composed of numerous and complex processes’. The study felt that in a competitive business environment, it is not enough for an organisation to be doing well. The performance has to be seen in comparison with its best competitors. It is necessary to have reference to know how well one is performing. Keeping a constant watch on the competition is necessary to use benchmark, which is an approach to identifying quality by comparing a Service or Organisation with other Organisations. Benchmarking firms must assess the strength and weaknesses of their current work process.

Benchmark is a continual and collaborative discipline Asgary, Willis, Taghvari and Refeian (2004) estimated the demand and willingness to pay for health insurance by rural households in Iran. And concluded that a significant percentage of population (more than 38%) live in rural areas, but the health care insurance currently operating in urban areas.

Ahuja and De (2004) confirmed that ‘The demand for health insurance is limited where supplies of health services is weak and explained interstate variation in demand for health insurance by poor in relation to variation in healthcare infrastructure’. Beside this, the study also provided 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. In order to build demand for health insurance, it is necessary to address the demand side and at the same time, design the insurance schemes by taking into consideration the paying capacity of the poor.

World Bank Report (2004) reviewed ‘The existing community based and self-financing health insurance schemes in India that cater to the
general population and addressed the needs of the poor and vulnerable sections of the society’. It also dealt with critical issues of accessibility and use of health care services out of pocket expenditure on treatment and the need for health insurance for the rural poor and urban households pursuing varied occupations. It investigated how much health insurance mitigates the household burden of health care expenditure. The study suggested that the community plan fairly addresses equity in enrolment, in terms of providing financial protection and social insurance coverage was much more successful.

Park, K, (2002) furnished ‘The statistical data on primary health care of India from the census 2001, National family health Survey-2 and National health Policy 2002’. He also focused on bio-medical waste, which generates during the diagnosis and treatment. This book says that appropriate management of health care waste is a crucial component of environmental health protection and it should become an integral feature of health care services. It also explained the primary health care administration of India.

Sodani, P.R. (2001) investigates ‘The community's preferences on various aspects of health insurance’. According to the study quality of care and cost are the two important factors identified by the community as the factors affecting their decision to subscribe to any new health insurance plan. An integrated provider and insurer system is preferred irrespective of public or private-based management. Hospitalisation and maternity sentences are preferred among the given choices for benefits to be included under the plan. The results also suggest that there is high level of willingness to join a health insurance plan in future if designed carefully for the informal sector.
Kopparthy, S.N. (2001) explained ‘The relationship between social stratification and health care in the rural community of Andhra Pradesh, from a sociological perspective’. The study found that minor illness among females was slightly more than males and minor illness was more in low class groups than high class groups. Moderate illness was prevalent in high-class groups. They also found that higher class consulted private practitioners whereas low class availed local folk healing and Registered Medical Practitioners (RMPs) services.

Ellis, Alam, Gupta (2000) provided ‘An overview of existing pattern of healthcare financing in India’. The study also developed elements of a prospectus of strategy for increasing the coverage and extent of health insurance for the formal sector in India. They highlighted the need for alternative finances, including provision for medical insurance at a much wider level.

Mavalankar et al. (2000) examined that ‘India has limited experience of health insurance’. Given that government has liberalised the insurance industry, health insurance is going to develop rapidly in future. The study found that, if health insurance is left to the private market, it would only cover those which have substantial ability to pay.

Another study by Gumber and Kulkarni (2000) conducted in ‘Gujarat State of India explored the availability of health insurance coverage for the poor especially women their needs and expectations from a health insurance system and likely constraints in extending current health insurance benefits to workers in the informal sector’. The study made a comparative analysis of different forms of health insurance i.e., the ESIS, Mediclaim policy and SEWA, in the informal sector of Gujarat State. They analysed the comparative advantage of different forms of health insurance.
in meeting the health care burden of the people in the informal sector and also estimated the demand for and willingness to pay for the health insurance. The households subscribing to Mediclaim generally belonged to the higher income strata and their average annual income was twice that of the households enrolled with SEWA and ESIS as well as that in the non-insured category. The literacy rate is very close to 100 per cent for both male and female Mediclaim households. They further pointed out that over 92 per cent of the non-insured households in both rural and urban areas had no awareness about the existing health insurance schemes. Further, only a miniscule number of households were aware of other insurance plans available in the market.

Bhatt (2000) by studying ‘The Mediclaim policies of GIC's at the Ahmedabad City’ revealed that 64 per cent of the claimant suffered from non-communicable diseases where communicable diseases still account for 50 per cent of the mortality in India. And also the average age of the claimant was 29.45 per cent and 43.08 per cent for both the communicable and non-communicable diseases respectively. The study points out that there is an increase in both the enrolment and claims and a third of the increases in claims are due to the problem of adverse selection and supplier induced demand.

James A. Rodger, Parag C. Pendharkar and David J. Paper (1999) investigated ‘The moderating effect of Information Technology (IT) infrastructure on the relationship between health care information management and quality performance within health care departments’. The study conceptualised and developed measures for quality, MOHCI, and IT infrastructure variables. A significant relationship was observed between the management of health care information and quality performance. IT infrastructure exhibited a direct, rather than a moderating, effect on quality
performance. The research also found that significant differences existed between customer and manager perceptions of quality.

A study by K. Mathiyazhagan (1998)iii ‘About the willingness to pay for a rural HI scheme through people's participation in rural Karnataka suggests that most of the people are willing to join and pay’. However, the probability of willingness to join was found to be greater than the probability of willingness to pay. Further, the study reveals that socio-economic factors and physical accessibility to quality health services are significant determinants of willingness to join and pay for such a scheme.

The various studies related directly or indirectly with the objectives of the present study were reviewed. Gumber and Kulkarni (2000)iii undertaken a case study in ‘Gujarat and provided that SEWA a type of health insurance scheme is strongly preferred by those who can’t afford and also not access the services of various other schemes’.

Donald W. Lombardi (1998)iv provided ‘Practical guidelines to managers who are involved in the health care management’. He advocated the new managerial techniques, responsibilities and highlighted the necessity of communication between manager and his subordinate staff, managers and his superiors by exploring both virtues of good command and the pit falls of poor communication. This book focussed mainly on five factors like compassion, concern, communication, comfort and command, which are essential to build confidence and personal power of the administrator.

Sanyal (1996)iv examined that ‘the burden of health care expenditure in rural areas was twice in 1986-87 as compared to 1963-64’ and also provided that household is the main contributor to the financing of
health care in India, so the health planners would have to pay more consideration regarding this.

Anand, K.K, (1996) in his book, attempted to focus on ‘Management techniques relevant to health care institutions’. It included a number of reports based on the ground realities of health care institutions prepared by the health care management committee of Bombay Association. This book covered managerial issues. It says that Indian hospitals need more resources but they also need to make better use of their existing resources, equipment, funds, space and staff. They have adequate expertise in medical discipline but lack professional experts in other disciplines like finance, accounts and engineering personnel.

Rama V. Baru (1998) the author explained ‘The trends in privatization of health care and also the social conditions that transfer the future of public health services in India’. This book studied the empirical aspects of hospitals in the city of Hyderabad. The study explained, how the growth of private sector had a negative impact on the public sector, it raised questions on the quality of care and efficiency in Hospitals. The study also gave reasons for the growth of private hospitals in the city of Hyderabad and mentioned the social and economic background of the private hospital.

The IIMA study (1987) for an ‘ADB seminar based on Maharastra and West Bengal, reviewed various health insurance schemes namely the Sewagram experience in Maharastra’, the Seba Co-operative Health Society in West Bengal, the Government owned GIC schemes, the ESIS and CGHS. The moral hazard and adverse selection are the threat faced by the Sewagram and Seba as revealed by the study. The study highlighted the poor performance of the Mediclaim policy due to: 1) even those who can afford the premium are not typically insurance conscious;
and 2) the insurance companies have very low priority to the HI business since the HI premium forms a meagre portion of their total premium income and hence they would not have followed aggressive marketing strategies.

2.3 RESEARCH GAP IN EARLIER STUDIES

It is found from the above studies that many studies have concentrated on the level of health facilities in the country and various states. Majority of the studies is in the analytical manner. Few studies explained about the public private partnership in health sector. However, very limited studies focused on Rajiv Arogyasri Community Health Insurance Scheme basing on the secondary data. But none of the study has been explained about the management the impact of Rajiv Arogyasri health insurance scheme in East Godavari District. The present study tries to fill the gap.
Chapter-II : References


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