CHAPTER – I

INTRODUCTION

1.1 INTRODUCTION

From the ancient times, human beings have been interested in trying to cure disease. The magician, priests, medicine man and the herbalist have all formulated various ways to cure man’s disease and/or to bring relief to the sick. Though there was an almost complete absence of scientific medical knowledge, it would not be fair to say that the early practitioners of medicine contributed nothing to the alleviation of man’s suffering from disease.

Medical knowledge in fact has been derived, to a very great degree, from the experimental and observational propositions and cumulative experiences gleaned from others. A history of medicine thus contributes a review of accomplishments and errors, false theories and misinformation and mistaken interpretations. It is also a study of the evolution of man and of human knowledge down the ages; of the biographies of eminent individuals who developed medicine; of the discoveries and inventions in different historical periods; and of the ever-changing concepts, goals and objectives of medicine. In the course of its evolution, which proceeded by stages, with advances and halts, medicine has drawn richly from the traditional cultures of which it is a part, and later from biological and natural sciences and more recently from social and behavioral sciences. Medicine is thus built on the best of the past. In the crucible of time, medicine has evolved itself into a social system heavily bureaucratized and politicized. The “explosion” of knowledge’ during the 20th century has made
medicine more complex, and treatment more expensive, but the benefits of modern medicine have not yet penetrated the social periphery in many countries. The glaring contrasts in the state of health between the developed and developing countries, between the rural and urban areas, and between the rich and poor have attracted worldwide criticism as “social injustice”. The commitment of all countries, under the aegis of World Health Organization, is to wipe out the inequalities in the distribution of health resources and services, and attain the Millennium Development Goals. The goal of modern medicine is no longer merely treatment of sickness. The other and more important goals which have emerged are prevention of disease, promotion of health and improvement of the quality of life of individuals and groups or communities. In other words, the scope of medicine has considerably broadened during recent years. It is also regarded as an essential component of socio-economic development.

1.2 PUBLIC HEALTH

The public health concept was born in England around 1840. Earlier, Johanna Peter Frank (1745-1821) a health philosopher of his time, conceived public health as good health laws enforced by the police and enunciated the principle that the State is responsible for the health of its people. The Public Health Act of 1848 was a fulfillment of his dream about the State’s responsibility for the health of its people.

Cholera which is often called the “father of public health” appeared time and again in the western world during the 19th century. An English epidemiologist, John Snow, studied the epidemiology of cholera in London from 1848 to 1854 and established the role of polluted drinking water in the spread of cholera. In 1856, William Budd, another pioneer, by careful observations of an outbreak of typhoid
fever in the rural north of England concluded that the spread was by drinking water, not by miasma arid sewer gas. These two discoveries were all the more remarkable when one considers that the causative agents of cholera and typhoid fever were not identified. Then came the demand from people for clean water. At that time the Thames was both a source of drinking water and the depository for sewage. A comprehensive piece of legislation was brought into force in England, the Public Health Act of 1875 for the control of man’s physical environment. The torch was already lit by Chadwick, but the man who was actually responsible more than any other for sanitary reforms was Sir John Simon (1816-1904), the first medical officer of health of London. He built up a system of public health in England which became the admiration of the rest of the world.¹ This early phase of public health (1880-1920) is often called the “disease control phase”. Efforts were directed entirely towards general cleanliness, garbage and refuse disposal. Quarantine conventions were held to contain disease.

The development of the public health movement in America follows closely the English pattern. In 1850, Lemuel Shattuck (1793-1859), a bookseller and publisher, published his report on the health conditions in Massachusetts. Like. Chadwick’s report it stirred the conscience of the American people to the improvement of public health. France, Spain, Australia, Germany, Italy, Belgium and the Scandinavian countries all developed their public health. By the beginning of the 20th century, the broad foundations of public health clean water, clean surroundings, wholesome condition of houses, control of offensive trades, etc were laid in all the countries of the western world. After the First World War,

there were three particular newcomers to the public health scene Yugoslavia, Turkey and Russia.\(^2\) These three countries in 1920 presented the typical picture of the underdeveloped world. Today they are quite advanced in public health.

While public health made rapid strides in the western world, its progress has been slow in the developing countries such as India where the main health problems continue to be those faced by the western world 100 years ago. The establishment of the WHO providing a Health Charter for all people provided a great fillip to the public health movement in these countries (1819-1901) who first mooted the concept of multifactorial causation of disease but his ideas were lost in the bacteriological era. The concept of multifactorial causation was revived by epidemiologists who have contributed significantly to our present-day understanding of multifactorial causation of disease and “risk-factors” in the etiology of disease.

1.3 CONCEPT OF HEALTH

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the “absence of disease”. In some cultures, health and harmony are considered equivalent, harmony being defined as “being at peace with the self, the community, god and cosmos”. The ancient Indians and Greeks shared this concept and attributed disease to disturbances in bodily equilibrium of what they called “humors”.

Modern medicine is often accused for its preoccupation with the study of disease, and neglect of the study of health. Consequently, our ignorance about

health continues to be profound, as for example, the determinants of health are not yet clear; the current definitions of health are elusive; and there is no single yardstick for measuring health. There is thus a great scope for the study of the “epidemiology” of health.

Health continues to be a neglected entity despite lip service. At the individual level, it cannot be said that health occupies an important place; it is usually subjugated to other needs defined as more important, e.g., wealth, power, prestige, knowledge, security. Health is often taken for granted, and its value is not fully understood until it is lost. At the international level, health was “forgotten” when the covenant of the League of Nations was drafted after the First World War. Only at the last moment, was world health brought in. Health was again “forgotten” when the charter of the United Nations was drafted at the end of the Second World War. The matter of health had to be introduced ad hoc at the United Nations Conference at San Francisco in 1945.3

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a worldwide social goal; that it is essential to the satisfaction of basic human needs and to an improved quality of life; and, that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that the main social target of governments and WHO in the coming decades should be “the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, for brevity, called “Health for All”.4 With the adoption of health

4 WHO (1979). Health for All, SLNo.2.
as an integral part of socio-economic development by the United Nations in 1979,\(^5\) health, while being an end in itself, has also become a major instrument of overall socio-economic development and the creation of a new social order.

1.4 DEFINITIONS OF HEALTH

“Health” is one of those terms which most people find it difficult to define although they are confident of its meaning. Therefore, many definitions of health have been offered from time to time, including the following:

a. “the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain” (Webster);

b. “soundness of body or mind; that condition in which its functions are duly and efficiently discharged” (Oxford English Dictionary);

c. “a condition or quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic and environmental”;\(^6\)

d. “a modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world”;\(^7\)

e. “a state of relative equilibrium of body form and function which results from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response of body forces working toward readjustment” (Perkins).

Health Economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care.

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\(^5\) WHO (1980). *WHO Chr.*, 34 (2) 80.


Health economics seeks to identify problem areas in a health care system and propose solutions for pressing issues by evaluating all possible causes and solutions.

1.5 HEALTH INSURANCE

Health insurance is an insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Health insurance in a narrow sense would be ‘an individual or group purchasing health care coverage in advance by paying a fee called premium.’ In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt.

Most developed countries have some kind of collective financing for health services, either through tax (e.g., the Health Service of the United Kingdom) or through their contributions to “social” health and the demand for Social Health Insurance. This type of insurance is usually characterized by mandatory membership, at least for the vast majority of the population, open enrollment, and community rating, i.e., a prohibition to charge premiums related to individual risk.
From a normative point of view, the institution of Social Health Insurance (SHI) can be defended on both Efficiency and equity grounds, whereas positive economics seeks to explain its existence in democracies on the basis of public choice models.

Historically the first political step toward Health insurance happened in Germany, in 1883 and followed in other European countries in twentieth century. The payment method in Germany was per capital and monthly some amount paid to physician according to the insured patient list.

From 1930 the conception of social insurance gradually was widespread and each country established its social insurance system based on traditional values, financial condition and ideological primaries.

The history of social insurance in developing countries is sketchy and not well known. The information about Asia, Middle East and North Africa is not clear but good information is available for Latin America.

In the third millennium the first concern for future of health insurance institutes is costs, while other elements including supplying services have second importance in institution charts. Increasing pressure on existing financial resources, it is inevitable to achieve strategic economical analyzes from different points. The governments are responsible to supply the most amount of financial resources in health care section.8

In supplying financial resources there are three absolute problems:

A. The costs of health care boosting constantly
B. Science and technology are boosting nonstop
C. World population trends indicate boosting

One of the criteria of developments in different countries is the scale of population fruition from social insurance.  

The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes
(2) Employer-based schemes
(3) Insurance offered by NGOs/community based health insurance, and
(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS)

1.6 HEALTH ECONOMICS

Health economics has been defined by various authors in different terms. Analysis of some of the definitions suggest that health economics is the discipline that determines the quantity and price of scarce resources devoted for the care of the sick and promotion of health. It encompasses the medical 'industry as a whole and extends to such fields as the economic analysis of the cost of diseases, benefit of health programmes, returns from investments in medical education, training and research.

The definition laid down by the WHO inter-regional seminar seems to be more comprehensive. It defined health economics as that which seeks inter alia to

9 Ahmad Pour Mohammad Hassan. A Study about using health care insurance systems in supplying financial resources for Firooz Gar Hospital, The dissertation of Master of science in Management of health care and remedy services. Islamic Azad University. 1998.
quantify over times, the resources used in health service delivery, their organization functioning and the efficiency with which the resources allocated and used for health purposes and the effect of preventive curative and rehabilitative health services on individual and national productivity.

The health economy is essentially an application branch in economics which briefly can be divided into four sub branches; supplying financial recourses and insurance, hospital economy, labor force and general financial supply.

In developed countries health care cost covers 6 to 13 per cent of GNP while in developing countries it is less than 5 per cent. The World Health Organization ascertains the limit to 5 percent. Although “Health for all” is acceptable for all countries as a strategy but the necessary financial resources has not been foresighted.

For supplying financial recourses there are several solutions such as “Compulsory Insurance”, “Supplying financial resources by tax revenue” and “Benefiting financial resources from non-government systems”.10

Anne Mills the professor of London Health and Medical Colleague for tropical areas express a summery of progress in health economy for medium countries in three stages (decades 1970, 1980, and 1990) as following.

A. The health economical views before decades of 1970

Attention to economical activates in healthcare and welfare was started from the historical article by Gerry Rosenthal regarding Health & Society with emphasizing on historical trend in United States of America.

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10 Poor Kar Salmani, Bahareh, A study about the equality criteria in insurance of selected countries, Monthly review. Education of whole population insurance. No 10. 2001.
The root of economical health can be found in eighteen century in writing of Sir William Petty who was an economist and statistic expert and founder of political economy. Petty evaluated the worth of each person based on the services he or she offers to society. He says “It is not in benefit of government to leave sick and physician to themselves and avoid any help” (Petty, 1676).

In nineteenth century E. Chadwick could influence the law making about heath. He expressed, “Such as an artist who imagines a human being as beautified personalized statues and philologists according to his profession imagine human being merely as living statue, the economist also for boosting and development of his science can imagine human as a capitalist in productive forces.

He demonstrated that “building a bath is a good investment and prevention of diseases could be more useful than building a hospital”.

In autumn of 1908 an infectious disease were prevailed in Punjab of India, the effects firstly appeared between railroad staffs by outbreak of fever and influenced the services! In all cities nearly all population were paralyzed, normal business deranged in all cities nearly, and the workers were sick for several weeks and even sellers were hindered from daily work.

B. The view about Health economy in decades of 1970

In this decade the difficulties and shortcomings of government for allocating of financial resources and using them efficiently sparked the technique of cost-revenue which helped the economists to discuss in this field. This technique in decades of 1950 to 1960 in decision about investments in health care then in investigation of disease influences on production was used. In 1970 also the same as previous decades the influences of health improvement on growing of
economy was emphasized with this difference that more emphasize was on investments in health care. The progress in techniques of economical evaluation for health section resulted in appearance of cost –effectiveness. This technique predominantly were used in measurable area.

Brian Able Smith says “Now the Cost –Effectiveness analysis is the main tool of improvement in health car system”.

In latest years of 1970 a lot of research about evaluation were carried out which we here indicate two of them that reveal the usefulness of research about Cost –Effectiveness in politicizing and management of special fields.

Good Ferry, Walker and Oscar Gish investigated about the affects of using air plane in health care aid for far reaching areas of Botswana.

At that time using air planes were privileged in some African countries. Walker using some infectious information which were collected from remedied ills by physicians and other health care staffs.

C. The Health Economy Views in 1980

1980 can be named the period of supplying financial resources for health care. In this decade the economists after confirmation of economical conception relations in health care systems tried to estimate the demand functions and using them for determining the cost disease policies.

The private sector was in center of observation so it boosted the using of standard tools usage in economical analyzing in health care so gradually the relation between economy and health were accepted.

In first years of this decade economists gradually discussed the important case of diseased peoples and proposed appropriate structures for franchise and pricing levels.
Gertler et al in 1987 used a model of demand anticipation which was able to provide the guessed demand anticipation through imperfectness between price and revenue from data collected in Peru. They found out that there is a relation between demands of health care watch and low incomes so the high prices decrease the demand. This survey indicates that increasing diseased share in health costs may decrease the accessibility to health care services in compare to wealthy accessibility to these services.

Because the pricing based on final cost price of health care services without prepayment or diseased partnership is impossible and impropriate, so the health insurance is observed as new revenue resources. In addition the advocates of health care insurance is reasoning that through this system the load of health care costs for staffs who use health care insurance system off take from tax system and the new financial resources can be allocated to poor people (World Bank, 1987).

**D. Health Economy Views in 1990**

In this decade the quality of health care services was the first priority, the researches about economical condition were widespread which included the priorities of public sector and financial resources allocation, supplying the financial resources, the habits of private sector and habits of consumers.

In this decade the documents of development report of World Bank was recommended the priorities for all private and public sectors.

The first priority of Cost-Effectiveness analyses on politicians, programs and health care systems. It seems that the main content of 1990 researches is about market and competition. And the health institution, habits and change of motivation in organization is scrutinized and emphasized.
Also using some market mechanisms in public sector will boost while the trends of health research and policies may be determined by developed countries which emphasize the importance of essential separation of customers and service providers the competition to attract customers and their satisfaction.

1.7 NEED FOR STUDY

Importance of Insurance

Having health insurance is important because coverage helps people to get timely medical care and improves their lives and health. Some may believe that people always have access to medical care because they can always go to an emergency room. But even areas with well supported safetynet care do not remove barriers to access to the same extent as does having health insurance. “Coverage matters,” concluded the Institute of Medicine (IOM) during a recent multiyear appraisal. Indeed, the prestigious IOM estimated that lack of coverage was associated with about 18,000 extra deaths per year among uninsured adults. Several points deserve emphasis.

1. Uninsured people receive less medical care and less timely care

Overall, uninsured people get about half as much care as the privately insured, as measured in dollars spent on their care—even taking into account free care received from providers. This discrepancy holds true even when spending is adjusted for age, income, health status, and other factors. (This finding and most information presented here do not come directly from District sources, for which

12 IOM. 2002. Care without Coverage: Too Little, Too Late.
data are often lacking. But most patterns are believed to generally true of all locations.) Uninsured adults get fewer preventive and screening services and on a less timely basis. Shortfalls are documented for many types of illness or condition, including screening for cervical and breast cancer as well as testing for high blood pressure cholesterol. Cancers, for example, are more likely to be diagnosed at a later stage of illness, when treatment is less successful. Uninsured pregnant women use fewer prenatal services, and uninsured children and adults are less likely than their uninsured counterparts to report having a regular source of care, to see medical providers, or to receive all recommended treatment. Shortfalls are particularly notable for chronic conditions. For instance, uninsured adults with heart conditions are less likely to stay on drug therapy for high blood pressure. Some uninsured people may decide not to obtain insurance precisely because they expect not to need medical care, so simple comparisons of the insured and uninsured can be misleading. However, many studies adjust for factors like age and health status that affect need for care. One recent study examined people who experienced an unintentional injury or a new chronic condition—times when care is more clearly needed. Uninsured individuals were less likely to obtain any medical care, and if they did receive some initial care, they were more likely to get none of the recommended follow-up care.

2. **Uninsured people have worse health outcomes**

The “bottom line” for uninsured people is that they are sicker and more apt to die prematurely than their insured counterparts. Conversely, having health coverage is associated with better health-related outcomes. Evidence comes from many studies using a variety of data sources and different methods of analysis. Death risk appears to be 25 percent or higher for people with certain chronic conditions, which led to the IOM estimate of some 18,000 extra deaths per year.

Some complain that low health status may be a cause of uninsured status, rather than the other way around. (Note that this objection is the opposite of the complaint noted above that good health may promote uninsurance.) Again, however, as the IOM noted, several studies use statistical methods to adjust for this “reverse causation,” and still find that lack of health insurance results in poorer health outcomes. The study of unexpected accidents and new chronic conditions also addressed this issue; its short-term follow-up showed that uninsured accident victims were more likely to have ended treatment without being fully recovered, and that those with chronic conditions still reported worse health status.  

3. **Lack of insurance is a fiscal burden for uninsured people and their families**

Uninsured people do not benefit from the discounted medical prices that are routinely negotiated by private health plans or imposed by public programs. Until recently, those without coverage were billed full hospital charges, for example. The low incomes of some patients qualify them for charity care, but others have often been dunned for unpaid bills. Uninsured families report medical

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17 See sources cited in note 3 and the literature that they review.
bill problems at double or triple the rate of insured families, and medical bills have been found a contributing factor in a sixth or more of bankruptcies, according to various surveys.¹⁹

A recent movement to reduce charges for the uninsured has gained strength among public officials and from hospitals, and it may have alleviated this problem. On the other hand, affordability problems have increased along with rapid growth in the costs of care. The IOM noted that low levels of insurance in an area can also burden medical providers because of higher demand for free or reduced-cost care.

4. The benefits of expanding coverage outweigh the costs for added services

Expanding coverage would improve health, lengthen lives, reduce disability, help control communicable diseases, and raise productivity. Newly insured people would get more services, above what they currently pay out of pocket or receive from medical providers in the form of uncompensated care. This can be expected to raise medical spending, but by less than the value of longevity and other benefits achieved.²⁰ Such estimates are complex to make and do not address political issues concerning the sources for financing increases in spending, especially the likelihood that expansions would shift some spending from the private to the public sector.

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5. Safety-net care from hospitals and clinics improves access to care but does not fully substitute for health insurance

Proximity to safety-net hospitals or clinics increases access to care, according to studies using various methodologies.\textsuperscript{21} Better access presumably improves health outcomes, although this effect appears less well documented, and safety-net access may provide less continuity of care than insurance. Comparison across states shows that access to care is better where governments and private payers better support the safety net, but that the improvement is less than that insurance achieves.\textsuperscript{22} Similarly, communities that have high capacity of community health clinics have better access to care than communities with low capacity, but the effect on access of higher insurance coverage rates is even greater.\textsuperscript{23} Insurance likely costs more as well, however, and it can be argued that public budgeting can control public safety-net subsidies, whereas an insurance entitlement like Medicaid is a more open-ended commitment of public resources. Support for safety-net care can be seen as complementary to insurance expansion. Some people will always remain uninsured, and community clinics add capacity to otherwise underserved geographic areas. Clinics may also be better for addressing access problems attributable to cultural and language barriers.

Most benefits of insurance coverage are estimated for coverage in general, not for every type of insurance. Medicaid has sometimes been separately analyzed


and achieves less on some measures than do private coverage. One possible reason is that enrollees more often go on and off coverage; another is that Medicaid programs often pay lower rates to participating providers. Private insurance coverage that differs from traditional patterns—for instance, limited-benefit coverages or plans with very high deductibles—might also achieve lesser health improvements. Conversely, adding additional benefits to existing conventional coverage will not necessarily achieve improvements of proportionate magnitude. Insurance and access to safety-net services are far from the only influences on health and longevity.

Environmental and public health measures can have major impacts as well, including promotion of vaccinations, smoking cessation, and maintenance of healthy weight.

### 1.8 SCOPE OF THE STUDY

The topic is titled “Impact of Health Insurance on Health Care Services in India-A Case Study of Mysore City”. This is confined to be a study on the impact on the health insurance on health care service scenario; however, the area of study chosen is that of Mysore City, in Karnataka State. The reason behind this is the fact that Mysore is one of the fast growing Tier II cities in India and has several organisations belonging to the Public and Private Sectors; research Institutes of repute and enjoys the sobriquet as the cultural capital of Karnataka.

Further it was observed that it had all the major types of Hospitals, i.e., Government and Semi Government Hospitals, Corporate Hospitals, Private

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Hospitals and Super Specialty Hospitals; which facilitated the study very well. Hence, the researcher selected Mysore city and surrounding areas for his Collection of Data.

This City enjoys a heterogeneous population as the employees of the aforementioned organizations are from all parts of India and are residents here. As a heritage city absorbing all modern amenities particularly health facilities. Though many studies conducted on health, the study related to health insurance is a new attempt which is the need of present context.

1.9 LIMITATIONS OF THE STUDY

As all aspects of health care and wellness cannot be brought under a single study, the limitations are as following:

1. This study has taken the voluntarily insured under the scope and has not taken those who belong to the Government sector or those covered by the employer such as the Railways, etc.

2. This study is mainly aimed at the satisfaction levels of the health insured and is not to suggest which of the insured respondents are better than the others.

3. The study is limited to Mysore City of Karnataka State in India.

4. Due to time constraints and as a foreigner only limited respondents are choosen for collecting opinions.

1.10 RESEARCH OBJECTIVES

1. To study the nature and functioning of health insurance in Indian context

2. To study the influence of various demographic factors of insured on health insurance related issues.
3. To study the opinion of health insured towards health insurance and related aspects.

4. To study the hurdles faced by insured in claiming health insurance.

5. To study the attitude of insured and non insured towards health insurance.

6. To suggest proper measures to improve effective functioning in health insurance sector

1.11 RESEARCH HYPOTHESES

With respect to the objective, following hypotheses were formulated.

H1: Insured respondents vary significantly in their opinion on the health economics regarding health insurance for the following

a. Income

b. Expenditure

c. Amount invested on health insurance

H2: Demographic variables of insured respondents have significant influence over health insurance issues.

H3: Insured respondents vary in their opinion on claiming health insurance and other aspects.

H4: Insured respondents face several hurdles in claiming, documentation related issues.

H5: Insured and non-insured respondents differ significantly in their attitude towards health insurance with special reference to

a. Accessibility

b. Time spent

c. Cost of health care services
1.12 ORGANISATION OF THE STUDY

This study consists of seven chapters with various sections and subsections. Chapter I presents the Introduction of the Study. Chapter II presents a Review of Related Literature. Chapter III describes the Methodology of the Study. Chapter IV deals with the Profile of the Study Area. Chapter V deals with the Existing Health Services System. Chapter VI gives the details of Analysis and Interpretation of the Data. Chapter VII contains Findings, Suggestions and Conclusions of the Study.

1.13 SUMMARY

This chapter highlights the importance and conceptual background of health insurance. The chapter also discusses need of the study, research objectives and hypotheses of the study.

The next chapter presents the relevant literature related to the topic of the study and its important variables.