CHAPTER – II

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

There is adequate literature on health insurance and health care services in the form of journals, books and reports. Most of them are related to western countries but literature on Indian health insurance is limited.

2.2 VARIOUS STUDIES

Akerlof (1970) and Rothschild and Stiglitz (1976) reported that the extent of adverse selection or positive selection into insurance has important repercussions for an insurance provider’s ability to cover its costs. Standard insurance theory predicts that insurance markets will suffer from adverse selection, which occurs when less healthy people or people who are more risky with their health are more willing to purchase health insurance because they know that the amount they spend on healthcare will be larger than the premium they will pay. Voluntary health insurance cannot be financially sustainable if adverse selection is severe, since only the most costly patients would find it worthwhile to purchase insurance, and premium levels will not be able to cover the high costs of care. On the other hand, another group of people that may buy health insurance are those who are very risk averse with both their health and their finances. These people may buy insurance to protect themselves financially, but may also be very healthy because they take extra care with their health.

The RAND Health Insurance Experiment (1974-1982) in the United States is the only randomized experiment examining the effects of health
insurance on health to date. This experiment studied almost 4000 people in 2000 families. Some families were randomly assigned to a free care plan while others were assigned one of several plans that required varying co-payments.

Book et al. (1983) reported that for most health outcomes there were no general health benefits from having more complete insurance (i.e. full coverage). Health benefits were found, however, for individuals with poor vision and for persons with elevated blood pressure.

Lohr et al. (1986) and Manning et al. (1987) found that those assigned to a cost-sharing plan sought less treatment than those with full coverage.

Fihn and Wicher (1988) and Lurie et al. (1984, 1986) study insurance impact using the cancellation of some insurance benefits for former U.S. veterans in Seattle and some poor households in Los Angeles. In both cases, health status of the insured was not strongly correlated with the choice by the Seattle VA Medical Center and the state of California, respectively, to withdraw insurance coverage. The authors found that the cancellation of insurance for both groups of people was associated with reduced use of medical care and increases in blood pressure.

Several studies have examined the effects of the very large Medicare (for those over 65) and Medicaid (for the poor and near-poor) insurance programs in the United States.

Piper and Ray (1990) found no difference in the proportion of women receiving prenatal care in the first trimester immediately before and after Medicaid coverage was expanded in Tennessee. A follow-up study examining a longer period, however, finds a significant improvement in the adequacy of prenatal care.
Keeler (1992) concluded that the improvement in high blood pressure led to a statistically significant 10% reduction in mortality risk, apparently due to increased detection and treatment of high blood pressure among low-income households with free care. Forgone treatment for those with cost-sharing was primarily for preventive visits to doctors and “elective” care such as mental health treatment as opposed to emergency care.

Short and Lefkowitz (1992) modeled the probability that preschool children have at least one well-child visit per year. Relative to uninsured children, they find insignificant positive effect of full-year Medicaid and smaller, generally insignificant positive effects for private insurance and partial-year Medicaid coverage. They found that both Medicaid and private insurance are positively and significantly related to the probability of having at least 1 visit related to a specific medical condition during a 12-month period for children living at higher than, but not lower than, 200% FPL. This is similar to the pattern found by Marquis and Long (1995) for all visits. Similarly, Currie and Thomas (1995) found that both types of insurance increase the number of “visits for illness” for whites but have no significant effect for blacks. Currie and Thomas (1995) obtained similar results using data from a different source but similar time period. To control for unobserved heterogeneity, they also estimate fixed effect logic models. The fact that the results from these models are quite similar to their OLS results provides support for the validity of simpler econometric specifications in this context. Currie and Gruber (1996a) have done extensive research on the effects of the Medicaid eligibility expansions of the late 1980s and early 1990s, including a study that focuses on utilization by children. One important difference between
their work and most other studies in the literature is that the insurance variable they use is Medicaid eligibility instead of actual coverage. Thus, their “treatment” group includes individuals who were eligible but did not actually have Medicaid coverage, and the comparison group contains not only the uninsured but also people with private coverage. Using 1984-1992 NHTS data, they estimate the effect of Medicaid eligibility on the probability of having at least one physician visit during a 1-year period. Their preferred specification indicates an increase of 10%. Banthin and Selden (2003) also examined the effect of Medicaid eligibility on the probability of having at least 1 visit. Despite using different data and a different research design, they obtained a very similar result: a 9% effect on the probability of at least one visit.

Spillman (1992), Hahn (1994), Marquis and Long (1994-1995) and Long, Marquis and Rodgers (1998) conducted four studies using different data but a similar research design estimate an effect of private insurance on outpatient utilization ranging from 1 to 2 visits per year. Comparisons across these studies suggest that the effect is larger for women than for men and may have grown during the 1980s. Also, full-year measures of insurance tend to indicate a larger effect than point-in-time measures. Another study of low-income women (Almeida, Dubay and Ko, 2001) finds an effect of private insurance that is on the low end of this range-1.1 visits per year-and a larger effect for Medicaid-3 visits per year. This pattern may reflect the differences in cost sharing between Medicaid and the types of private insurance held by low-income women, although unmeasured differences in health status may also be a factor.
**Haas** (1993) studied the expansion of the Healthy Start program covering low-income pregnant women in Massachusetts and found that increasing program eligibility cut-off from 100-185% of poverty line had no effect on birth outcomes.

**Marquis** and **Long** (1994) seeks to understand how differences in data sources and econometric specifications affect estimates of the “uninsured access gap” — that is, the additional care that the uninsured would consume if provided with insurance. For children, they examine annual ambulatory contacts using the 1987 National Medical Expenditure Survey (NMES) and several National Health Interview Survey (NHIS) files spanning the years 1984 to 1989. The results from the two data sources are remarkably consistent, implying that privately insured children average one more physician visit per year than uninsured children. This is comparable to the result found by **Spillman** (1992) using earlier data.

**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 health care and concluded that there is no serious government initiative to encourage utilization of health services by means of devising health insurance.

**Stoddard, St. Peter** and **Newacheck** (1994) examined the relationship between insurance and the probability of any utilization for children who report chronic conditions indicating a need for care. Drawing the sample in this way reduces the potential bias from unobserved heterogeneity, since all children in their sample have a chronic condition, but makes it difficult to generalize to children without these conditions. Because of a small sample, they are unable to
distinguish between private and public insurance. Their results indicate that insurance increases utilization by between 21% and 36%.

Marquis and Long (1995) find that private insurance increases inpatient utilization by between 0.16 and 0.24 days per year, depending on the survey used. Hahn’s (1994) results based on the NMES and Long, Marquis and Rodgers (1998) estimates from the Survey of Income and Program Participation (SIPP) are quite comparable to Marquis and Long’s results using the same data sets. Marquis and Long found that the effect of insurance on hospital utilization is larger for adults in fair/poor health than for those reporting good/excellent health, which mirrors their findings for outpatient care. They consider the sensitivity of their results to the way insurance is measured as well as to other modifications in the econometric specifications. These tests provide some information on how insurance effects vary across the population and how their estimates are affected by the inclusion or exclusion of key variables. They find that insurance has a smaller effect for poor children compared to those in families with incomes higher.

Wolfe and Hill (1995) concluded that the empirical evidence indicates that workers who are in poorer health are less likely to obtain employer-sponsored coverage (Buchmueller 1995; Stroupe, Kinney and Kniesner 2000; Blumberg and Nichols 2001; Holahan 2001). In contrast, adults with Medicaid coverage tend to have poorer health than the uninsured or privately insured (Holahan 2001). This is presumably the case because of the historical link between Medicaid and cash welfare combined with the fact that poor health reduces labor supply and increases welfare participation.
Currie and Gruber (1996) estimated the effect of Medicaid eligibility on the probability that a child is hospitalized during a 1-year period. According to their preferred (IV) model, Medicaid eligibility raises the probability of being hospitalized by 4%, which is comparable to the effect that Spillman (1992) found for private insurance coverage (3%). Currie (2000) found a slightly smaller effect for native-born children and no significant effect for immigrant children.

Sanyal (1996) observed 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.

Currie and Gruber (1997) study how the variable timing of the expansion of Medicaid across states affected children and pregnant women. Both groups increased doctor and hospital usage in states where Medicaid was first to expand, as compared to states where the program was enacted later. The authors estimate that increased utilization of care led to a decline of 1.3 deaths per 10,000 children, relative to a baseline mortality rate of 3.1 deaths /10,000 children. They also found an 8.5% decline in the infant mortality rate.

Phelps (1997) expressed that according to standard economic theory, health insurance coverage induces greater medical care utilization by reducing the cost of care to patients. While the normative implications of this “moral hazard” effect are the subject of some debate (Pauly, 1994; Gaynor and Vogt, 1997), the positive prediction that insurance is likely to increase the use of care is well accepted. Obtaining policy-relevant empirical estimates of this effect can, however, be difficult. There are four important methodological considerations that
complicate using results from empirical studies to forecast the effect of insurance expansions on medical care utilization. Perhaps the most important is the possibility that estimates of the effect of insurance on utilization may be biased due to self-selection and unobserved heterogeneity, that is, the endogeneity of insurance coverage. Second, the effect of health insurance coverage on utilization may vary across the population. Third, insurance is not a single homogeneous good, and differences in the level and type of insurance will translate into differences in utilization. Fourth, while insurance-related differences in utilization are generally interpreted to represent demand-side responses by patients to the reduction in the cost of care brought about by insurance coverage, capacity constraints may cause physicians to modify their behavior in response to substantial increases in demand. Before reviewing the literature, we discuss each of these methodological concerns.

Ray, Mitchel and Piper (1997) gains were largest for demographic groups most likely to have obtained coverage through the expansion, while there was no significant change for women who were unlikely to have been affected. Other state-specific analyses suggest that the Medicaid expansions increased prenatal care use in South Carolina (Epstein and Newhouse, 1998) and Florida (Long and Marquis, 1998) where baseline eligibility was low and the safety net is relatively weak, but not in California (Epstein and Newhouse, 1998), where Medicaid eligibility limits were already high and there are more resources available to uninsured women.

Andaleeb (1998, 2001) proposed and tested a five- factor model that explains considerable variation in customer satisfaction with hospitals. These
factors include communication with patients, competence of the staff, their demeanor, quality of the facilities and perceived costs. An examination of the standardized beta values in the regression model used in the study suggests that perceived competence of the hospital staff and their demeanor have the greatest impact on customer satisfaction. These are followed closely in importance by perceived hospital costs. The quality of communication and the general condition of the facilities were also significant but less important in explaining customer satisfaction with hospital services.

Cutler and Zeckhaus (1998) find evidence that people with higher expected medical expenditures (measured in a variety of ways across studies) are more likely to buy insurance or pay for health insurance at higher premiums than those with lower expected medical expenditures. However, the extent of adverse selection in health and other insurance is often found to be minimal (Wolfe and Goddeeris, 1991; Finkelstein and Poterba, 2004) or non-existent (Cawley and Philipson, 1999; Cardon and Hendel, 2001; Finkelstein and McGarry, 2006). There is also some recent evidence of positive selection into health insurance (Fang et al., 2008).

Lave et al. (1998) examine the change in utilization for children enrolled in state-sponsored programs for low-income children in Pennsylvania and New York. Since the programs are similar to ones created by the State Children’s Health Insurance Program (SCHIP), these studies are relevant for understanding the impact of SCHIP programs and future incremental expansions. In their evaluation of two Pennsylvania programs, used a before-and-after research design that compares utilization for the 6 months prior to enrollment with utilization for
the first and second 6-month periods after enrollment. Comparing utilization in the first post enrollment period to that of the pre-enrollment period implies that insurance leads to an increase of 0.93 visits per year, which is quite similar to the effects found by Marquis and Long (1994-1995) and Spillman (1992). Results based on the second post enrollment period, however, imply smaller effects.

World Bank (1999), van Damme et al. (2004), Annear et al. (2006) reported that medical expenditures are consistently cited as a major economic burden for poor Cambodian families and health insurance is, at its core, a product meant to reduce the financial risk of health problems. In addition, descriptive evidence suggests that health insurance really may improve economic outcomes in poor countries. Most of the evidence on the relationship between economic outcomes and insurance status comes from developing countries. With the exception of evidence from China, there tends to be a positive relationship between access to health insurance and good economic outcomes (namely, lower out-of-pocket health expenditures and higher non-medical consumption). This leads us to be hopeful that having SKY insurance will improve economic outcomes for Cambodian families. However, as previously discussed, studies in developing countries to date are largely descriptive rather than causal. By including economic outcomes in the survey, this study will help to establish the firm causal link that is missing in other studies.

Dafny and Gruber (2000) examined the effect of the Medicaid expansions on avoidable hospitalizations. Their results imply that Medicaid eligibility reduces the rate of avoidable hospitalizations by 3.4% while increasing the overall hospitalization rate. One interpretation is that by improving access to preventive
and primary care for poor children, the Medicaid expansions led to a more efficient use of health care resources. They do several “back-of-the-envelope” calculations that suggest that the cost savings from reducing avoidable hospitalizations more than offset the cost of additional physician visits generated by expanding Medicaid. Work by Kaestner et al. (Kaestner, Racine and Joyce 2000; Kaestner, Joyce and Racine, 2001) provides mixed results on the question of whether expanding insurance coverage would reduce avoidable hospitalizations.

Gumber and Kulkarni (2000) 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.

Holl et al. (2000) analyses New York’s Child Health Plus program (CHPlus) finds larger effects than the cross-sectional studies, although this difference may be explained by the way the data were collected. Preprogram data came from retrospective chart review, whereas post enrollment utilization was measured sing parent interviews. To the extent that the chart review data are incomplete, preprogram utilization will be underestimated causing changes in utilization to be overstated. The difference in the completeness of the two data sources is a likely explanation for the finding that utilization was found to increase by between 0.6 and 1.6 visits per year for previously insured children. If we assume that these changes for continuously enrolled children can be entirely attributed to measurement error, the “true” effect of CHPlus for uninsured children is between 0.83 and 1.29 visits per year, which is consistent with the estimates mentioned above. This suggests that estimates based on cross-sectional differences
between children with and without insurance are good estimates of the effect of change in utilization associated with extending coverage to uninsured children.

Ambuj Bharadwaj et al. (2001) estimate that the private sector Hospitals have come up to provide the health care in a large way and this sector shares a major part of GDP 4.7% compared to 1.2% of public sector. 78.4% of total expenditure on health is shared by private sector, while 20% is accounted for by public sector.

McGee and Cegala (2001) face-to-face trained patients to ask questions for the physician to be clearer or more specific in the three phases of medical consultation: history taking, examination and conclusion. Patients were also told that they were there not only to provide information for their physician but also to seek information from their physician. It was found that trained patients showed a significant increase in overall participation, overall question asking and requests for clarification and information recall. This includes overall satisfaction, relationship satisfaction, communication satisfaction and expertise satisfaction. No consistent gender differences were found in patient satisfaction.

McKinley R.K. et al. (2001) have speculated that patient expectation of care they receive has an important impact on satisfaction of patients with inappropriately high expectations may be dissatisfied with optimal care and those with inappropriately low expectations may be satisfied with deficient care.

Narayanan Devadasan, Bart Criel, Wim Van Damme, Kent Ranson and Patrick Almeida, Dubay and Ko (2001) concluded that study of low-income women finds an effect of private insurance that is on the low end of this range 1.1 visits per year-and a larger effect for Medicaid 3 visits per year. This pattern may
reflect the differences in cost sharing between Medicaid and the types of private insurance held by low-income.

Prasanta Mahapatra et al. (2001) have identified in their work that, Corruption by all categories of staff was the greatest cause for dissatisfaction, followed by general cleanliness, poor utilities etc. Also significantly high level of dissatisfaction was noted regarding patient’s assessment of technical quality of doctor’s work and less time spent by the doctor with the patients, which are the main causes for people to go for private healthcare organizations, where majority of patients who come for treatment to public hospital are poor and illiterate.

Yip and Berman (2001) and Jutting (2004) in their studies they find a positive relationship between insurance coverage and health-care utilization and quality of care (Dong et al., 1999; Wagstaff et al., 2007). Results are more mixed regarding the relationship between insurance status and health expenditures.

Case et al. (2002), Currie et al. (2003) and Smith (2005) concluded recent theoretical work has focused on how the problem of adverse selection may be mitigated by factors such as wealth (which could both increase the probability of insurance purchase and improve health outcomes), risk aversion (which could increase the probability of insurance purchase and decrease the amount of risk one takes with one’s health) (Jullien et al., 2003; Chiappori et al., 2004) or optimism (where some people underestimate their accident probability, and thus don’t buy insurance, but are also less willing to take precautions, leading to a higher probability of a health shock) (Koufopoulus, 2005).

Gertler and Gruber (2002), Wagstaff and Doorslaer (2003) and Gertler, Levine and Moretti (2003) reported that when a person experiences a bad shock
to health, their medical expenses typically rise and their contribution to household income and home production (e.g. cooking or childcare) declines.

Lichtenberg (2002) and Card, Dobkin and Maestas (2007) studied the effect of Medicare by comparing health and health care outcomes of people just below 65 (many of whom lack health insurance) to outcomes of those just over 65 (all of whom are covered by Medicare). Both papers found that the group with more insurance received more care and had better health outcomes (although the reductions in mortality were often not statistically significant in the Card et al. study).

Michael Kent Ranson (2002) reported that in India, as in many other developing countries, spending related to hospitalization is often catastrophic for household finances. His study shows that community-based health insurance schemes can effectively protect poor households from the uncertain risk of medical expenses, and they can be implemented in areas where institutional capacity is too weak to organize mandatory, nationwide risk-pooling. The study identified various aspects of scheme design and management that can be tailored (depending on the priorities of scheme administrators) to achieve such goals as risk-sharing, cross-subsidization, financial protection of households and scheme financial viability. Firstly, this study suggests that community-based health insurance schemes can include poor people, including people and households below the poverty line. Factors that may facilitate inclusion of the poor include an affordable premium, external assistance and nesting the scheme within a larger organization that addresses other needs of the poor (for example, providing access to credit, education and bargaining power in the workplace). Secondly, the
financial risk borne by a scheme can be limited by placing a cap on the benefits provided. However, this also limits the extent of risk-pooling and cross-subsidization provided by the scheme. There will inevitably be cases where hospital expenditures far exceed this cap, with dire financial consequences for the insured. Thirdly, in order to relieve the financial burden of expenditures on households, reimbursement under a scheme should be fast and easy. This needs administration of the scheme, particularly processing of claims, to happen as close to claimants as possible. Fourthly, to fine-tune the design of a scheme needs information on who is enrolled and excluded, rates and causes of hospitalization, expenditure on hospitalization, and barriers that prevent enrolment in the scheme and use of the scheme by the insured. A system for monitoring and evaluating the scheme is vital. However, every change that administrators make to the fund - whether an increase in breadth or amount of the benefits package or interventions to improve rates and timeliness of insurance claim submission - will have to be weighed against impact on the fund’s affordability and ability to recover costs.

Reyaz Ahmed et al. (2002) have found that outpatient services in a Teaching Hospital in Jammu and Kashmir are being utilised by married adult males who are rural, illiterates and of poor socio economic status.

Asfaw (2003) concluded that rigorous evidence on the impact of insurance is scarce, and there are even fewer studies on the effects of insurance in developing countries. One reason for the lack of evidence is that it is difficult to find a valid control group for the insured. We cannot simply compare the outcomes of insured and uninsured households, since health insurance status is typically strongly correlated with other household characteristics. For example,
rich and well educated households typically have both better health and better health insurance coverage (Cameron and Trivedi, 1991; Jütting, 2004), but the positive correlation between health and insurance status tells us nothing about the impact of insurance. On the other hand, those in poor health may be more likely to pay for health insurance (Ellis, 1989; Cutler and Reber, 1998), but finding that the insured tend to be sicker would not imply that insurance causes illness.

Han et al. (2003) found on all four dimensions of patient satisfaction i.e. overall satisfaction, relationship satisfaction, communication satisfaction and expertise satisfaction, patients who received training, have scored significantly higher and were more satisfied than patients who received no training. No consistent gender differences were found in patient satisfaction in both experimental and control groups.

Jowett et al. (2003) and Jütting (2004) find a negative relationship between insurance coverage and health expenditures in Vietnam, and Yip and Berman (2001) in Egypt. But some find that out-of-pocket spending is the same or even higher for the insured when compared to the uninsured (Wagstaff et al., 2007a and Wagstaff et al., 2007b) in their studies of China. These authors explain this surprising finding as being a result of the institutional structure of health-care in China, which favors increased utilization and substitution toward more expensive services and treatments.

Kim et al. (2003) initiated a program called “smart patient coaching” in which a part of the training consisted of instructing patients to ask the provider for clarification when the patient did not understand something during the consultation. It was found that trained patients asked more overall questions,
expressed more concerns but did not ask more clarifying questions in comparison with the untrained group.

**Talluru Sreenivas et al.** (2003) evaluate patient satisfaction as a vital tool to measure efficiency of Government, Quasi Government and Corporate sector hospitals. One of the hospitals managed by corporate sector was found to be satisfying the needs of patients commendably. Patient’s satisfaction is one of the established yardsticks to measure success of the services.

**Wagstaff** and **Pradhan** (2003) overcome some of the selection bias plaguing most studies in their study of Vietnam’s health insurance (VHI) program. This program was much more likely to cover those enrolled in high school or college or those working for the government or state-owned employers. To reduce selection bias, the authors “match” insured households to uninsured households with similar characteristics, and compare outcomes of the insured to those of the uninsured with similar profiles. They also use a double-difference estimator, comparing the *change* in outcomes over time between the insured and uninsured. This technique reduces selection bias since it does not assume that insured and uninsured households are identical on unobservable characteristics. However, as the authors note, their study still must assume that in the absence of insurance, *changes* in outcomes over the study period would have been the same for the insured and the uninsured, an assumption which may not hold. With this possible bias in mind, the authors find positive impacts of insurance. In the insured group, children grew more rapidly and adults had improved BMI (body mass index) scores. The authors also find that the probability of contact with health care providers was higher, out-of-pocket health expenditures were lower, and non-
medical household consumption was higher among the insured group. Though a firm causal relationship between insurance status and outcomes has yet to be established, many studies do present interesting evidence on the correlation between insurance status and outcomes. In all of these studies the relationship tends to vary across income deciles.

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.

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.

Boshoff and Gray (2004) investigated the relationship between service quality, customer satisfaction, and loyalty (as measured by purchasing intentions) among patients in the private healthcare industry in South Africa, revealed that the service quality dimensions of nursing staff empathy, assurance and tangibles impact positively on patient’s loyalty.
Harrington et al. (2004) found that patients who received communication skill training, regardless of the type of training showed a consistent increase in requests for clarification. They argued that patients might feel more comfortable to ask questions for clarification than to initiate questions of their own. Clarifying questions are based on the content of the on-going conversation, thus perceived as appropriate for patients to ask.

Henry J. Kaiser (2004) stated that medicaid is the nation’s major public health program for low-income Americans, financing health and long-term care services for more than 50 million people – a source of health insurance for 38 million low-income children and parents and a critical source of acute and long-term care coverage for 12 million elderly and disabled individuals, including more than 6 million low-income Medicare beneficiaries. Medicaid accounts for 17 percent of all personal health care spending, finances 17 percent of hospital care, 12 percent of physician and other professional services, 17 percent of prescription drug spending, and nearly half of all nursing home care.

Philip Kotler (2004) has explained that customer’s expectations are the true standards for judging service quality understanding the nature and determinants are essential to ensure that service performance meets or exceeds expectations. If a hospital raises expectations too high, the patient is likely to be disappointed. However if the hospitals set expectations too low, it won’t attract enough patients.

Richard B. Saltman, Reinhard Busse and Josef Figueras (2004) elaborate information on social health insurance (SHI). In this book chapter I entitled concepts of social health insurance. The concept of social health insurance
(SHI) is deeply ingrained in the fabric of health care systems in Western Europe. It provides the organizing principle and a preponderance of the funding in seven countries - Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland. Since 1995, it has also become the legal basis for organizing health services in Israel. Previously, SHI models played an important role in a number of other countries that subsequently changed to predominantly tax-funded arrangements in the second half of the twentieth century – Denmark (1973), Italy (1978), Portugal (1979), Greece (1983) and Spain (1986). These multiple imperatives are captured in the SHI pyramid presented in the figure. In this conceptual approach, the lowest level serves as the essential foundation from which higher levels draw their character and legitimacy, and upon which these higher levels are thus integrally dependent. As his Figure suggests, the base of the four-part SHI pyramid incorporates the national culture and historically-tied values found in the broad society. The second level - dependent on society but functioning independently - is the nation state, which constructs the legislative, regulatory and judicial arrangements for SHI systems. Built on these two lower levels are, at the third level of the pyramid, the actual organizational and administrative arrangements of each studied country’s SHI system. Lastly and therefore most contingent upon and least independent of the lower three levels of the pyramid - one finds issues of funding. Thus, discussions and analyses that focus exclusively on the funding level alone implicitly assume the existing configuration and activities of the three lower levels.
van Damme et al. (2004); Annear et al. (2006); Factsheet N. (2007) reiterates that according to the WHO, “Each year, approximately 150 million people experience financial catastrophe, meaning they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs.” Low income and high medical expenses can also lead to debt, sale of assets, and removal of children from school, especially in poor nations. A short-term health shock can thus contribute to long-term poverty.

Zebiene et al. (2004) studied the relationship between meeting patient’s expectations and patient’s satisfaction with medical consultations in Lithuania. Analysis of 460 sets of questionnaires revealed that satisfaction with medical consultations was higher among patients who have a greater number of expectations met. The study found that physician’s success in meeting different types of patient expectations have different influences on patient satisfaction. The
most important expectations to be met were “understanding and explanation”
followed by expectations of “emotional support”.

Ahuja and Narang (2005) 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. 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.

Finkelstein and McKnight (2005) find that health care utilization
increased fastest in areas where Medicare caused the largest increase in health
insurance coverage. They do not find such areas experienced a faster decline in
mortality.

Hanratty (2005) compares health outcomes across Canadian provinces
that were early adopters of universal health insurance (1962) to outcomes in
provinces that were later adopters (up to 1972). Her results suggest that there was
a significant reduction of 4% in the infant mortality rate as a result of this
government health insurance program and a smaller reduction in low birth weight
of about 1.3%.

Jabnoun and Al-Rasasi (2005) investigated the relationship between
transformational leadership and service quality in the DAE hospitals. Data
collected from 242 patients and 201 hospital employees showed that UAE patients
were generally satisfied with the quality of service provided to them by hospitals.
The study found also that service quality is positively related to all dimensions of transformational leadership.

van der Reis and Xiao (2005) stated that the factor that is important in the changes that have taken place during the past half century and impact access to medical care is the changed gender ratio of physicians. Today most medical schools have a larger percentage of female than of male students. This changed ratio affects access to care in a negative manner. According to a survey study by van der Reis and Xiao (2005), 35 percent of USA female physicians work part time. This situation affects the supply shortage of physicians in a negative manner, and an ominous trend in terms of access.

World Health Assembly (2005) reported reveals that health spending through out-of-pocket payment (OOP) is not always easy to cope with. Households may encounter financial hardship and poverty as a result. In fact, over 150 million people face catastrophic health expenditure every year and 100 million fall into poverty worldwide after paying for health care. Thus, benefiting from health care remains difficult or impossible for many households because of financial barriers. Universal coverage and access to health insurance, with an important degree of prepayment, is an important policy objective that could improve financial protection for many. There are different strategies for increasing prepayment and reaching universal coverage. Tax-based systems, social health insurance systems or mixed systems commonly exist in most developed countries which have reached universal coverage. However, for developing countries, transition strategies are usually needed. These strategies include different prepayment mechanisms to reduce OOP and improve access to care, such
as mutual health insurance (MHI). However, MHI has often been small scale. Its sustainability and financial risk pooling capacities are considered limited when compared to nationwide schemes. Nonetheless, it can be a first step towards universal coverage for certain countries. In fact, a few countries such as Rwanda, have now managed to scale up MHI. This paper contributes to the evidence on MHI by examining and its effect on utilization and financial risk protection at the national level by analysing survey data from Rwanda.

Bellemare and Shearer (2006); Harrison et al. (2007); Anderson and Mellor (2008) reported that one cannot ask people directly the value of their risk aversion or discount rate, questions on risk aversion and discounting are particularly challenging. Risk aversion and discount rates are often measured using games and questions with real money prizes and consequences. However, a less costly alternative is to rely on hypothetical questions in the survey. It is important to learn from experimental work studying the predictive power of these types of hypothetical questions. Often-used measures of risk aversion include hypothetical lotteries and questions asking whether people engage in behavior that is risky for one’s physical or financial well-being. Shostack views service as fulfilling certain wants and needs, Services are those separately identifiable, essentially intangible activities, which provide want satisfaction and are not necessarily tied to the sale of a product or another service. To produce a service mayor may not require the use of tangible goods. However when such use is required there is no transfer of title (permanent ownership) to these tangible goods.

Dror (2006) laid seven myths regarding health insurance and examined the realities behind these myths. The evidence shown that most people are willing to
pay 1.35% of income or more for health insurance and the solvent market for health insurance business exist in India; however tapping of it is contingent upon understanding the customer’s needs and wants.

**IRDA Journal** (2006) and **IRDA Annual Report** (2006-2007) reported the insurance industry in India registered real growth (measured by first-year premiums) of 94.96 percent, exceeding the growth of 47.94 percent achieved in 2005-2006. The impressive growth has also resulted in greater insurance penetration: insurance penetration, or premium volume, as a ratio of GDP for 2006 was at 4.1 percent for life insurance and 0.6 percent for non-life insurance. The total premium for life and non-life insurance market in India was Rs. 181971.61 crore, or $41.74 billion.

**Salgo** (2006) conducting health care strictly as a business deteriorates doctor-patient relationship by treating patients like “customers”. The unique relationship between patient and physician, fundamental for the practice of good medicine, cannot be equated with the purchase of material goods. The deterioration of the doctor-patient relationship, primarily the result of economic demands from fiscal intermediaries, has clearly had a negative impact on access. Hospitals have made inroads in the practice of medicine through contractual agreements with individual and groups of physicians. For all practical purposes these agreements are commercial contracts subject to the conditions contained in the contract. When financial concern becomes one of major objects of hospitals, there is a shift in attitude within the profession.

**Sumninder Kaur Bawa** (2006) in his study Health Insurance: An Empirical Study with Reference to Punjab India concluded that the health
insurance is not a new concept and the people are also getting aware about it, which mainly comes from TV followed by newspaper, agents, friends, etc., but this awareness has not yet reached the level of subscription. As the results shown that just 19.4% are being covered by some form of health insurance and large chunk of the population is still financing health care expenditure without health insurance. Moreover it was observed that there are 7 key factors by clubbing the related variables under it which are acting as barrier in the subscription of health insurance. These are Lack of Funds to Meet Costly Affair; Lack of Awareness and Willingness to join; Lack of Intermediaries’ Outreach and Capabilities; Lack of Reliability and Comprehensive Coverage; Lack of Availability and Accessibility of Services; Narrow Policy Options; and Prefer Other Mode to Invest (followed by friends, relatives, etc.). Alternatively, the analysis of willingness to join and pay for health insurance has been made to know whether non health insurance policyholders are ready to buy it or not and the results provided that very few percentage i.e. 11.9% are ready to buy health insurance without any conditions and 19.8% are willing to buy only if certain conditions will fulfill. Remaining is not ready to buy, still need some time or not provided with any response. As far as the ranking of conditions of buying are concerned, 1 rank is assigned to “if comprehensive coverage provided with least cost” as its weighted average score is 3.36 is more as compared with all other conditions. Whereas 2 rank is assigned to “if some contribution will employer made”, followed by “If available with least formalities”, “If friends and relatives buy”, “If someone suggest about it”. Besides this the association between the various variables linked with the respondents has been determined with their willingness to pay for health insurance and the results
provided that on the one hand 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 status of the respondents with their willingness to pay for health insurance.

Cegala et al. (2007) administered a 14-page booklet instructing patients to provide, seek and verify information in the medical consultation. The information verifying section was designed to train patients to check understanding by asking the physician to repeat or clarify what the physician had just said. To facilitate the learning process, patients were also offered examples. It was found that trained patients asked more questions to verify what was said and their questions were more sophisticated in comparison with untrained patients.

Dror (2007) examined why the “one-size-fits-all” health insurance products are not suitable to low income people in India and provided that there is presence of considerable variability to pay for health insurance which is because of multiple reasons like variability in income, frequency of illness among households, quality and proximity of providers (private, public) in different locations.

van der Stuyft (2007) concluded that CHE (Catastrophic Health Expenditure) is a major cause of impoverishment and patients need to be protected from it. Some of the documented determinants of CHE are poverty. Household size, high medical costs, incidence of illness, payment mechanisms, low benefit packages and presence of ‘smokers or drinkers’ in the household. They showed that the incidence of CRE is also related to the type of provider; private-for-profit
providers considerably increase the probability of CHE. We have documented some of the illnesses that can lead to CHE, namely surgical ailments and admissions for non-communicable diseases. Indian CHI (Community Health Insurance) schemes are able to protect their members against CHE, but only to a limited level. However, this protection can be further enhanced if some design changes are incorporated. To begin with, the upper limit of the benefit package needs to be raised. To keep the premiums affordable, donors or the government would need to directly subsidies the premium, especially for the poorer sections of society. Exclusions need to be minimized to protect vulnerable populations. And finally, scheme managers need to negotiate costs with providers from the start to ensure that costs are contained. Such measures could considerably reduce the incidence and magnitude of CHE and protect households from iatrogenic poverty.

**Wagstaff et al.** (2007) concluded that non-experimental studies from developing countries sometimes find enrollment to be more common in households with chronically sick members, evidence of adverse selection and commonly find higher enrollment rates in wealthier households, potentially leading to positive selection if wealthier people also tend to be healthier.

**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 examine such impact. It showed that in India, OOP health expenditure by households account for around 70% of total expenditure on health and thereby pushes households in to poverty.

**Garg** and **Karan** (2009) 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% of total households’ expenditure (ranging from about 2% in Assam to 7% 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% of poverty.

Sona Bedi et al. (2009) identify that if any hospital fulfils patient’s expectations, patients are more likely to stay with that particular service provider for a longer time. Patient satisfaction is also the desired outcome of any hospital.

Priyanka Saksena, Adelio Fernandes Antunes, Ke XuLaurent Musango and Guy Carrin (2010) in their results find that many households in Rwanda did not seek care when needed and while others were pushed into financial hardship as a result of seeking care. These effects are particularly accentuated for the poor and the uninsured. Indeed, MHI coverage was strongly associated with a reduction in unmet need and risk of catastrophic expenditure. Nonetheless, the MHT benefit package may require some further enhancement. Longer-term financial sustainability of the scheme also needs to be considered in light of this and innovative ways to raise further resources may be needed. Continued expansion of MHI, as supported by these results, may also require further organizational strengthening to ensure that gains from it are maximized.