The review of literature is one of the prime and significant part of the research project ab-initia in any kind of research. Its primacy and importance is manifested in its better feature such as delivering intellectual and practical answers to the problem through the application of scientific methods and understanding of the work done so far. With the growing complexity of the problems of changing face of health insurance sector, research becomes more complicated than it looks in the beginning. Therefore, a social scientist should be familiar with and aware of the work done in the related areas to get the right comprehension of the issues and problems. A brief resume of the work done in this area of study is discussed below:-

K. MATHIYAZAGHAN (1998), in his article “Willingness to pay for Rural Health Insurance through Community Participation in India” examined the willingness to pay for a viable rural health insurance scheme through community participation in India, and the policy concerns it engenders. The willingness to pay for rural health insurance scheme through community participation is estimated through a contingent valuation approach by using rural household survey on health from Karnataka state in India. The results show that insurance schemes are popular in rural areas. Infact, people have relatively good knowledge of insurance schemes. Most of the people are willing to join the rural health insurance scheme. The justification for willingness to pay is attributed to: (A) Existing Govt. Health care provider’s services are not quality oriented. (B) Are not easily accessible. (C) Are not cost effective.

LILANI KUMARNAYAKE (1998), states that the increasing privatization of health care provision has been a central element of health sector reform in many countries. Regulation is often seen as a potential response to address the many problems, which arise in the private production, financing and delivery of health services. It is seen as having a crucial and balancing role in the push towards privatization. Despite the existence of basic regulatory legislation in most developing countries, the degree to which regulations are enforced and effective is low. The review of experience suggests that the ability of regulatory mechanisms to influence private sector activity is limited. Regulation is not costless. It requires both staff
and monetary resources in order to design, implement, monitor and enforce them. Thus privatization, partially in response to the government's poor performance and lack of resources, has led to greater demands for regulation, but regulation itself needs additional resources in order to be successfully implemented. The author looks at the appropriate role for regulation within this context. It is suggested that for poorer LMC, that there be minimal standards of health service provision laid out by legislation. However, beyond this non-regulatory interventions may be more appropriate for affecting private sector activity. In contrast, for wealthier LMC, it is suggested that incentive-based regulatory schemes may be feasible, although this requires more policy-action research.

DAVID M. DROR & CHRISTIAN JACQUIER (1999), proposed a way to improve health provision for populations that are usually excluded from access to health services. It starts out from a short description of who the excluded are, and what they are excluded from. The paper then looks at the major policy statements elaborated at the international level, and proceeds to propose the missing dimension. Next, based on field testing and analysis of several tens of pilot cases, the paper proposes a concept for group-based health insurance, or "micro-insurance", and explains its rationale and its components. Lastly, the paper proposes a strategy to implement this concept.

DEVENDER B. GUPTA, ANIL GUMBER (1999), said that here have been two major kinds of reforms affecting the rural health service. One is the introduction or expansion of user fees and the other is the devolution of central responsibilities to lower levels of govt. This paper reviews the various initiatives towards decentralization in the formulation of the several World Bank assisted projects in population, health and nutrition with a focus on the problems which may arise in the effective implementation of the policy.

SUMON KUMAR BHAUMIK (1999), examined the experience of the US insurance industry during 1970s and 1980s in order to facilitate debate about the future of insurance industry in India. It traces the evolution of the life insurance companies in the US from firms underwriting plain vanilla insurance contracts to those selling sophisticated investment contracts bundled with insurance products. In this context, it brings into focus the importance of portfolio management in the insurance business, and the nature and impact of portfolio related regulations on the asset quality of the insurance companies. The paper also highlights the experience of the US insurance companies with respect to the other important determinant of profitability, namely, cost management. In the process, it provides a rationale for the
increased automatisation of insurance companies, and the increased emphasis on agent-independent marketing strategies for their products. Further, while acknowledging the need for regulations, the paper draws our attention to the fact that regulations can be influenced by political agendas. If politicised, regulations have potential to adversely affect the pricing of risks, especially in the non-life industry, and hence the viability of the insurance companies. Finally, the paper uses the backdrop of US experience to provide some pointers for Indian policymakers.

**L.P. Singh (1999),** focused on privatizing insurance business. Firstly paper lays down that the objection to privatization came from public sector employees and their supporters in political parties on three counts: 1. Performance of LIC and GIC has been quite impressive; 2. Privatization will expose public sector to competition which would encourage unhealthy practices and are detrimental to national economy, 3. The very nature of insurance business tends to put it under the category of Natural state Monopoly. Paper appraises that nationalized companies have considerably expanded their business but simultaneously it says that lack of competition has engendered complacency in the insurance industry. It studies how privatisation of insurance sector is likely to affect our national economy. For this example from different areas of our economy has been taken like UTI mutual funds, public sector banks etc. These instances favoured privatisation. In conclusion, it says, privatisation would result in better customer service and help improve the range, quality and prices of insurance products.

**Randall P. Ellis, Moneer Alam, Indrani Gupta (2000),** said that there is growing evidence that the level of healthcare spending in India – currently at over 6% of its total GDP – is currently higher than in many other developing countries. The evidence also suggests that more than three-quarters of this spending includes private ‘out of pocket expenses’. Despite such a high share of expenditure by individuals, the provision of healthcare, that is adequate in terms of quality and access, is becoming more and more problematic. Particularly, public delivery of healthcare is poor in quality, presumably for reasons of inadequate financing. This highlights the need for alternative financing, including provision for medical insurance at a much wider level. The paper attempts to review a variety of health insurance systems in India (defined here as any mechanism which covers the risk of payment for healthcare at the time of its requirement), their limitations and the role of the General Insurance Corporation as an important insurance agency. It also attempts to develop a prospectus of strategy for greater regulation and increased health insurance coverage by
making suitable changes – particularly in claim settlements and the exclusion clause. Also highlighted is the need for a competitive environment (which is at present completely missing), and an opening up of the insurance sector.

D. TRIPATI RAO (2000), said that the macroeconomic implications of privatisation and foreign participation in the insurance sector, especially the life insurance sector, are far-reaching as the life insurance industry, coterminous with the Life Insurance Corporation (LIC) of India, is dominant in two aspects: pooling and redistributing risk across millions of policyholders and performing financial intermediation. The issue of privatisation and foreign participation must be approached cautiously with a ‘step-by-step approach’, and should be preceded by microeconomic institutional and legal reforms.

ANIL GUMBER, VEENA KULKARNI (2000) in their pilot study explores the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system and the likely constraints in extending current health insurance benefits to workers in the informal sector. The ESIS has substantial scope for improvement of its services, particularly better utilization of its facilities. The survey shows that the poor prefer the public sector management of healthcare facilities.

RAMESH BHAT (2000), proposed that Public-private partnerships in the health sector can bring needed resources while also taking care that the vulnerable groups – the poor and the rural populations have access to health facilities. The govt must clarify its policies towards the private sector and ensure that public spending on health does not decline. It must also determine a structure of subsidy and incentives for such partnerships.

PREMILLA D’CRUZ, SHALINI BHARAT (2001), said that the public, private and voluntary health sectors together contribute towards the provision of health care in India. All these play significant roles in influencing the health status of the Indian population. But their contribution is not without shortcomings. Indeed, it is largely their inadequacies that account for the limited improvements in the health status of the Indian people. Unfortunately, the chances that the recognition of these pitfalls and their implications will be translated into action and change are very few, given the present influence of the structural adjustment programme on the social sector. On the contrary, the situation is expected to worsen. This paper provides a perspective on India's health care system in the post-independence period in describing India's public, private and voluntary health sectors; it highlights some of the reasons behind the marginal improvements in health status in the country.
P.R. SODANI (2001), in his article investigates the community's preferences on various aspects of health insurance. The data has been collected from a sample of 300 households in Jaipur, Rajasthan. The study reveals a low level of awareness (15 per cent) about health insurance. 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. Hospitalization and maternity services 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. Some policy implications have been suggested in this study for the setting up of health insurance schemes.

CHARU C. GARG (2001), said that India spends a high proportion of its gross domestic product (GDP) on health care but is still poor in terms of health outcomes as compared to countries at a similar level of development. It is, therefore, extremely important to understand the financial dimensions of the health sector to enable policy makers to take wise decisions in this sector. Taking the case of Karnataka, a state in India, this article seeks to estimate the total health expenditure as a proportion of the state domestic product (SDP); examine the role of private and public sectors as financiers and providers of health services; and estimate health expenditure by different income classes of beneficiaries, and functions like preventive and curative care. Using National Health Accounts (NHA) as a tool of analysis, this article presents the results for 1993-94. It indicates that 76 per cent of health sector revenues come from private sources, of which almost 50 per cent go to private providers and 21 per cent are spent on drugs. Further, 7 per cent of household out-of-pocket expenditure is used as non-drug expenditure for using government facilities for outpatient and in-patient treatment. This has important policy implications for the government. The role of financial intermediaries, especially the insurance sector, is also highlighted in the analysis. A further analysis by income categories and functional classifications is expected to highlight important results.

BRIJESH C PUROHIT (2001), said that in the recent past the impact of structural adjustment in the Indian health care sector has been felt in the reduction in central grants to States for public health and disease control programmes. This falling share of central grants has had a more pronounced impact on the poorer states, which have found it more difficult to raise local resources to compensate for this loss of revenue. With the continued pace of reforms, the likelihood of increasing State expenditure on the health care sector is limited in the future. As a result, a number of notable trends are appearing in the Indian health care sector. These include an increasing investment by non-resident Indians (NRIs) in the hospital industry, leading to a spurt in corporatization in the States of their original domicile and an increasing participation by multinational companies in diagnostics aiming to capture the
potential of the Indian health insurance market. The policy responses to these private initiatives are reflected in measures comprising strategies to attract private sector participation and management inputs into primary health care centers (PHCs), privatization or semi-privatization of public health facilities such as non-clinical services in public hospitals, innovating ways to finance public health facilities through non-budgetary measures, and tax incentives by the State governments to encourage private sector investment in the health sector. Bearing in mind the vital importance of such market forces and policy responses in shaping the future health care scenario in India, this paper examines in detail both of these aspects and their implications for the Indian health care sector. The analysis indicates that despite the promising newly emerging atmosphere, there are limits to market forces; appropriate refinement in the role of government should be attempted to avoid undesirable consequences of rising costs, increasing inequity and consumer exploitation. This may require opening the health insurance market to multinational companies, the proper channeling of tax incentives to set up medical institutions in backward areas, and reinforcing appropriate regulatory mechanisms.

BHAT RAMESH & REUBEN ELAN (2001), said that Mediclaim insurance run by government owned insurance company General Insurance Corporation of India (GIC) is the only private voluntary health insurance scheme available in India currently. This scheme has been in operation since 1986 and from time to time a number of revisions have been carried out to address the needs of their clients. The documentation on claims and reimbursement of this scheme is scanty. This paper analyses 621 claims and reimbursements data pertaining to policy initiation years 1997-98 and 1998-99 of Ahmadabad branch of one of the subsidiary companies of the General Insurance Corporation of India. The analysis suggests that the number of policies and premiums collected have grown at significant rates, more than 30 per cent during 1998-99 and 50 per cent during the year 1999-00. The growth had implications for the management of scheme in terms of problems of adverse selection or provider induced demand and falling premiums per insured person. It was found that the number of claims increased by about 93 per cent during the year 1998-99 when polices sold grew at 32 per cent. The study estimates that about 1/3rd of claim amount increase is because of the problems of adverse selection or provider induced demand. The analysis of break-up of reimbursements suggests that about 40 per cent of reimbursements are made towards doctor's fees.
PREMILLA D'CRUZ, SHALINI BHARAT (2001), proposed that the public, private and voluntary health sectors together contribute towards the provision of health care in India. All these play significant roles in influencing the health status of the Indian population. But their contribution is not without shortcoming. Indeed, it is largely their inadequacies that account for the limited improvements in the health status of the Indian people. Unfortunately, the chances that the recognition of these pitfalls and their implications will be translated into action and change are very few, given the present influence of the structural adjustment programme on the social sector. On the contrary, the situation is expected to worsen. This paper provides a perspective on India's health care system in the post-independence period in describing India's public, private and voluntary health sectors; it highlights some of the reasons behind the marginal improvements in health status in the country.

DEBRA J. LIPSON (2001), in her paper provides background on the treatment of health insurance services by the General Agreement on Trade in Services (GATS) of the World Trade Organization, and explains the relevance of current GATS negotiations for health insurance trade. It begins with a general description of GATS, indicates how health insurance is classified in GATS-defined service sectors, and outlines options countries have when making insurance-related market access commitments. It then explains why GATS commitments made to date have not yet had any measurable effect on changes in insurance markets. It reviews some of the issues addressed in current GATS negotiations and their potential implications for market access commitments covering health insurance. It concludes by reviewing the opportunities, risks and challenges presented by GATS for national policies and regulations affecting health insurance.

PRITHVIRAJ DASGUPTA AND KASTURI SENGUPTA (2002), said, with the advent of the Internet, online processes are replacing conventional models in our society. The greatest impact in online technology has been achieved by e-commerce. E-commerce is attractive both to buyers and sellers as it reduces search costs for buyers and inventory costs for sellers. This paper investigates the impact of e-commerce on the insurance industry in India. The recent growth of Internet infrastructure and introduction of economic reforms in the insurance sector have opened up the monopolistic Indian insurance market to competition from foreign alliances. It studies the evolving scenario in the insurance industry in India and identifies the features of online insurance that improve the conventional insurance model and thus, makes it more attractive for the Indian insurance industry to go online.
PAUL, ASHOK VIKHE; SOMASUNDARAM, K. V; GOYAL, R. C. (2002), said that India is the second most populous country of the world and has changing socio-political-demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growth-orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical manpower and other health resources are concentrated in urban areas where 27% of the population lives. Contagious, infectious and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births); however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in a holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'socio-cultural model', which should bridge the gaps and improve quality of rural life, is the current need. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative.

K B S KUMAR (2002), In his paper states that the present scenario of and major challenges faced by health insurance in India. The growth in the health insurance sector has been negligible despite the aspiring and optimistic vision of Bhore committee in 1946. This paper tries to find out the reasons behind performance in the field of health insurance and the changes to be brought about to improve the functioning of the health care sector.

AJAY MAHAL(2002), states that the entry of private health insurance companies in India is likely to have an impact on the cost of healthcare, equity in the financing affair, and the quality and cost effectiveness of such care. However, an informed consumer and well defined and implemented insurance regulation regime will ameliorate some of the bad outcomes. Regulations relating to benefit packages, restrictions on risk selections and consumer
protection would be clearly useful; also required are improved enforcements of regulatory regimes, creating large insurance buyer groups, and better coordination between IRDA and other regulatory bodies. New legislation in improving standards in healthcare provisions may also be needed.

**INDRANI GUPTA (2002),** examined the IRDA bill and the consequent opening up of the health insurance sector to foreign and private investors that raised several questions like ‘Are Indian ready for private health insurance?’, ‘Will there be demand from all sections of society?’, ‘What would consumer look for when they purchase insurance to cover future health risks, a concept hitherto non-existent in India?’. These are some of the questions this paper attempts to answer, based on data collected in Delhi from about 500 households. The study found a wide disparity across sections on willingness to participate. The challenges for the new system would be to pool individuals across risk and economic categories; set up a multi-tier system to meet objectives of equity and efficiency in health care delivery and for planners and regulators to keep health insurance separate from other non health insurance.

**JANE LETHBRIDGE (2002),** her paper outlined some of the trends in the privatization of health services by region and how they are affecting access to services by poor people. It will also demonstrate that in the context of continuing challenges to public services, commitment to a public funded health care system remains remarkably strong in many countries. However, the paper also outline changes in the relationship between public and private health care sectors that may lead to the weakening of the power of the public sector to influence the direction and delivery of public health care services in future.

**MEENA GUPTA (2002),** The paper examined the state of the health sector in Orissa, a state with approximately half of its population living below the poverty line, high disease burden, and weak economy. After providing an overview of public health services and their performance in Orissa, the paper examines the various initiatives taken by the state government for reforming the health sector and for mobilizing resources. The role of the private sector in health outcomes is also discussed and an evaluation of the public health systems in Orissa is made in the paper. This paper by Meena Gupta provides important insights into the working of the health sector in a chronically poor state of India. Useful lessons can be learnt from this experience to improve the health status of the people of Orissa and other poor states in India.
SHELLEY SAHA  T.K. SUNDARI RAVINDRAN (2002), This paper covered a review of studies on health services conducted in India in the last decade through a gender lens. Here, we have tried to see the interplay of gender and social position in accessibility, acceptability, cost and effectiveness of health services for reproductive health concerns of women and men. It can be seen that since the mid-1980s health research has undergone a major shift as it went beyond the conventional framework to understand linkages between the health care service system, and the socio-economic and cultural factors vis-à-vis access and utilization, and in turn the health status of people. This was an important paradigm shift from understanding people’s health status in terms of medical determinants alone to understanding it in terms of socio-cultural determinants. The paper brings into light that in general health services research has not been sensitive to the specific health services need of women. It concludes with a series of unexplored issues in this regard, which could help undertake meaningful research that is informed by a gender and social perspective.

ANIL GUMBER 2002, This paper by Dr Anil Gumber, Senior Fellow, Warwick Business School, University of Warwick, UK and Senior Economist, National Council of Applied Economic Research, New Delhi, addresses some critical issues with regard to extending health insurance coverage to poor households in general and those working in the informal sector in particular. A review of the existing health insurance schemes in India and select Asian and Latin American countries, such as China, Thailand, Sri Lanka, Chile, Uruguay, Colombia, Brazil, and Argentina, is undertaken with a view to drawing lessons for India. On the basis of a pilot study undertaken in Gujarat during 1999, the paper examines the feasibility of providing health insurance to poor people in terms of both willingness and capacity to pay for such services. The paper also suggests various options available to introduce an affordable health insurance plan for workers in the informal sector. The issues discussed in this paper have assumed great importance in the current context of liberalization of the insurance sector in India. Health insurance will continue to remain a high priority area in the years to come.

DEEPANJAN BANERJEE (2003), In this article focus is on finding out Indian stand against the new disease management practice in health insurance in developing countries. According to the author, healthcare with global revenue of over Rs. 2.75 trillion is the largest industry in the world. The primary healthcare system in India is managed mainly by the shallow structure of government’s healthcare facilities and other public healthcare systems.
which follow a traditional model of health funding and provision. The healthcare policy in India is nothing but a burden because of the inefficiency of a government run system.

RAJEEV AHUJA, JOHANNES JÜTTING (2003), said that Community based health insurance is an emerging and promising concept that has attracted the attention of policy makers as it addresses health care challenges faced by the poor. This paper discusses solutions to important incentive problems in micro-health insurance schemes, which threaten their sustainability. In particular, three issues explored are: (i) if defining household as unit of insurance always mitigates adverse selection problem; (ii) how ex ante moral hazard problem can be circumvented through group insurance contract; and (iii) how to set incentives for scheme managers. Various public policies are discussed that help to set appropriate incentives to better manage health insurance schemes in low-income country environments.

V. B. ANNIGERI (2003), said that Economic reforms combined with a resource crunch have compelled planners and policy makers alike to constantly and frequently take stock of resources available to the vital health sector. Estimations of health sector resources and financial flows accruing to this sector were for a long while limited mainly to the public sector alone. This paper attempts a micro level estimation of health accounts at a district level in the hope of evolving, in due course, a more comprehensive methodology applicable to wider areas such as the state and the country.

ALOKE GUPTA (2003), Increase in penetration of health insurance was one of the express objectives of the opening up of the insurance sector to private players. This paper takes stock of how health insurance has fared during 2000-03. Here the focus is on: (1) Growth of health premiums crossing Rs. 1000 crores in 2002-03 as against 519 crores on 2000-01. (2) TPA experiment (3) The path ahead.

RAJEEV AHUJA, JOHANNES JÜTTING (2004), Community based micro insurance has aroused much interest and hope in meeting health care challenges facing the poor. In this paper it is explored how institutional rigidities such as credit constraint impinge on demand for health insurance and how insurance could potentially prevent poor households from falling into poverty trap. In this setting, it is argued that the appropriate public intervention in generating demand for insurance is not to subsidize premium but to remove these rigidities (easing credit constraint in the present context). Thus from insurance perspective as well, the analysis highlights the importance of having appropriate savings and borrowing instruments for the poor.

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INDRANI GUPTA, MAYUR TRIVEDI (2004), This paper says that despite a government policy on health, the health sector is currently changing shape mostly due to market forces. In this set up, change for greater health coverage takes on a more urgent tone, and policymakers need to act now, rather than later, to prevent the high costs of inaction and letting the objective of “Health for All” even more difficult to attain. The health system in India is ripe for moving towards “Coverage for All” system, which would take care of the “Health for All” objective to a great extent. First of all, it has to be understood that mere lip service is not going to make “Health for All” happen. There has been a tendency to not think beyond the current set up, which admittedly is a good one for a minority of our population. The need of the hour is for the same minority, who are often in the helms of policymaking, to understand that serious changes need to be made to the system if one wants to fulfil the basic objectives outlined in the health policy. While any change is difficult, the one that involves more than one department and organization is admittedly more so. It is, however, entirely possible to bring about these changes over the next several years, if a beginning is made now.

BHAT RAMESH & JAIN NISHANT (2004), This paper analyses the time-series behaviour of private health expenditure and GDP to understand whether there is long-term equilibrium relationship between these two variables and estimate income elasticity of private health expenditure. The study uses co integration analysis with structural breaks and estimates these relationships using FM OLS (fully modified ordinary least squares) method. The findings suggest that income elasticity of private health expenditures is 1.95 indicating that for every one per cent increase in per capita income the private health expenditure has gone up by 1.95 per cent. The private health expenditure was 2.4 per cent of GDP in 1960 and this has risen to 5.8 per cent in 2003. In nominal terms it has grown at the rate of 11.3 per cent since 1960 and during 1990’s the growth rate is 18 per cent per annum. The study discusses four reasons for this high growth experience. These are: (i) financing mechanisms including provider payment system, (ii) demographic trends and epidemiological transition, (iii) production function of private health services delivery system, and (iv) dwindling financing support to public health system. In developing countries where per se the need for spending on health is high, high levels of private health expenditures pose serious challenge to policy makers. The sheer size of these expenditures once it has risen to high levels can impede control of heal.

SARA BENNETT (2004), There is increasing advocacy for community-based health insurance (CBHI) schemes as part of a broader solution to health care financing problems in
low-income countries, but to date there is very limited understanding of how CBHI schemes interact with other elements of a health care financing system. This paper aims to set out a preliminary conceptual framework for understanding such interactions, and highlights the kind of research questions raised by such a framework. A basic conceptual map of a CBHI scheme is developed, and extensions added to this map that incorporate (1) effects upon non-members of schemes, (2) government subsidies to providers, (3) government subsidies to schemes, and (4) issues raised by the existence of multiple risk-pooling schemes in a particular context. The utility of a broader approach to analyzing/assessing CBHI schemes is illustrated through examination of two policy issues, namely (1) coordination of CBHI risk pools and government risk pools, and (2) equity implications of CBHI schemes and the role of government subsidies in such schemes. It is concluded that there is a strong need for empirical work to explore how CBHI schemes and the broader health care financing system interact, and that even if individual schemes achieve their own objectives (in terms of equity, efficiency etc.), this does not necessarily imply that such objectives will be achieved at the system level.

NEELAM SEKHRI, WILLIAM SAVEDOFF (2004), Private health insurance plays a large and increasing role around the world. This paper reviews international experiences and shows that private health insurance is significant in countries with widely different income levels and health system structures. It contrasts private health insurance across regions and highlights countries with particularly high rates of private expenditures. It argues that policymakers need to confront the role that private health insurance will play in their health systems and regulate the sector appropriately so that it serves public goals of universal coverage and equity.

RAJEEV AHUJA (2005), Micro insurance that deals with insurance for the poor is emerging in India. This is partly the result of policy intervention and partly due to the development of micro-finance activity in the country. In extending the reach of insurance to the poor, the role of nodal agency is deemed crucial. In this paper while bringing out the role of nodal agency in extending health insurance, it is discussed how health insurance for the poor is different from health insurance in general. Depending on the functions that a nodal agency performs, all micro insurance arrangements taking roots in the country can be categorized into three distinct types: intermediate type, manager type and provider type. Each type has its own strengths and weaknesses. All these types may be appropriate for a large and diverse country like India. Selected conceptual issues are analyzed that are generic.
to all types of health insurance initiatives as well as those that are specific to a particular type. A good understanding of these issues is important to remove some of the weakness in the design of these schemes. More empirical studies are needed to further our understanding of these schemes so that these schemes can be shaped better.

**RAJEEV AHUJA, BASUDEB GUHA-KHASNOBIS (2005),** Policy-induced and institutional innovations are promoting insurance among the low-income people who form a sizable sector of the population and who are mostly without any social security cover. Although the current reach of ‘micro-insurance’ is limited, the early trend in this respect suggests that the insurance companies, both public and private, operating with commercial considerations, can insure a significant percentage of the poor. Serving low-income people who can pay the premium certainly makes a sound commercial sense to insurance providers. To that extent imposing social and rural obligations by insurance regulator (IRDA) is helping all insurance companies appreciate the vast untapped potential in serving the lower end of the market. However, it is becoming increasingly clear that micro-insurance needs a further push and guidance from the regulator as well as the government. IRDA has already come up with the concept note on micro-insurance, which suggests the regulator’s bias towards insurer-agent model. Even so, two areas in which having explicit provisions would aid the development of micro-insurance are: one, flexibility in premium collection, and two, encouraging micro-insurance among micro-finance institutions (MFIs).

Given irregular and uncertain income stream of the poor, flexibility in premium collection is needed to extend the micro-insurance net far and wide. Moreover, MFIs are playing a significant role in improving the lives of poor households. Quite apart from this, linking micro-insurance with micro-finance makes better sense as it helps in bringing down the cost of lending. Given this, there is a case for strengthening the link between micro-insurance and micro-credit. At present micro finance business in the country is unregulated. Regulation of MFIs is needed not only to promote micro-finance activity in the country but also to promote the linking of micro-insurance with micro-finance, which as demonstrated in the paper makes a good sense.

**INDRANI GUPTA, MAYUR TRIVEDI (2005),** In this paper it is argued that since there are practical constraints in scaling up social health insurance as well as stand-alone community health insurance schemes, one way of achieving greater coverage is to use the asset-unfapped potential that exists in the voluntary (commercial) health insurance sector. In particular, it may be necessary to build and promote productive partnerships among different
stakeholders involved in the health insurance sector, who are currently by and large working on their own. Specifically, insurance companies in both the private and public sectors should be involved in productive partnerships with the government, community based organizations and providers in the endeavour to extend health coverage to the population. The paper looks at the role that insurance companies, that offer voluntary insurance, can play in helping the country achieve greater health coverage. The analysis involves a closer look at the data of one public sector insurance company – National Insurance Company Ltd. – as a prototype of commercial voluntary insurance, to better understand their role in the health insurance scenario, and examine whether and how they can make a positive difference in the health insurance scenario in India.

RAMESH BHAT, SUNIL KUMAR MAHESHWARI (2005) Given the growing complexities and challenges it faces, reforms in the health sector are inevitable. They generally focus on making the health systems responsive through strengthening financial systems, ensuring local participation and public–private partnerships, and autonomy of health facilities. It is only through these reforms that deficiencies in the health sector can be addressed. The process is also likely to help in developing strategies that ensure effectiveness and efficiency of resource use. However, the reform process makes some fundamental assumptions about the intrinsic organizational and professional commitment and availability of skilled and competent health care professionals. This paper examines the commitment of district-level health officials in the new state of Chhattisgarh in India. Since development-oriented human resource practices are powerful tools that commit health professionals to enhance the quality of care, we believe that health sector reforms should concentrate on human resource issues and practices more than ever. This paper attempts to examine the following issues: (a) the status of professional and organizational commitment and the technical competencies of health officials managing the sector; (b) the characteristics of human resource management practices in the health sector in Chhattisgarh; and (c) the linkage of these management practices with professional and organizational commitment. Finally, the paper discusses the implications of these issues in the health sector reform process.

BHAT RAMESH & RAJAGOPAL SRIKANTH (2005), this paper provided preliminary analysis of claims data of Mediclaim insurance scheme to understand the relationship between disease pattern and the quality of health care. Length of stay (LOS) and average length of stay (ALS) as one of the indicators of quality of care are used. Diagnostic Related Grouping (DRG) based ALS as the benchmarks are used to make the evaluation and
comparison. It is observed that the reimbursements in insurance system are tied to hospital inputs and resource use and not to diagnostic related groups or outputs. Therefore the current system of reimbursements and provider payment system influences the length of stay and there is significant variation in ALS observed across disease groups and its sub-groups. There is no consistency observed in ALS as the severity of diseases under each group increases. This reflects lack of standards/protocols and unintended consequences of current practice of provider payment system. Implementing systems like Diagnosis Related Grouping would be an attempt to link it with outcomes. The paper provides insights into whether there is a significant mismatch in the premium that insurance companies charge in comparison to the risk insurer undertake while issuing policies. It was also found that after adjusting for the purchasing power parity, the claims data suggest that healthcare costs reimbursed for medical insurance to private providers in India.

BHAT RAMESH & MAHESHWARI SUNIL KUMAR & SAHA SOMEN (2005), the advent of Third Party Administrators (TPAs) is expected to play an important role in health insurance market in ensuring better services to policyholders. In addition, their presence is expected to address the cost and quality issues of the vast private healthcare providers in India. However, the insurance sector still faces challenge of effectively institutionalizing the services of the TPA. A lot needs to be done in this direction. Towards this the present paper describes the findings of a survey study, which was carried out with the objective to ascertain the experiences and challenges perceived by hospitals and policyholders in availing services of TPA in Ahmadabad, Gujarat. The major findings from the study are: (i) low awareness among policyholders about the existence of TPA; policyholders mostly rely on their insurance agents; (ii) policyholders have very little knowledge about the empanelled hospitals for cashless hospitalisation services; (iii) TPAs insist on standardisation of fee structure of medical services/procedures across providers; (iv) healthcare providers do experience substantial delays in settling of their claims by the TPAs; (v) hospital administrators perceive significant burden in terms of effort and expenditure after introduction of TPA and (vi) no substantial increase in patient turnover after empanelling with TPAs.

K.V. RAMANI, DILEEP MAVALANKAR (2006), The paper seeks to show that health and socio-economic developments are so closely intertwined that is impossible to achieve one without the other. This paper sees that building health system that is responsive to community needs, particularly for the poor, requires politically difficult and administratively demanding choices. Health is a priority goal in its own right, as well as a central input into economic
development and poverty reduction. The paper finds that, while the economic development in India has been gaining momentum over the last decade, the health system is at a crossroads today. Even though Government initiatives in public health have recorded some noteworthy successes over time, the Indian health system is ranked 118 among 191 WHO member countries on overall health performance. This working paper describes the status of the health system, discusses critical areas of management concerns, suggests a few health sector reform measures, and concludes by identifying the roles and responsibilities of various stakeholders for building health systems that are responsive to the community needs, particularly for the poor.

BHAV RAMESH & JAIN NISHANT (2006), Health insurance schemes are increasingly recognized as preferable mechanisms to finance health care provision. In this direction micro health insurance schemes and community based health insurance schemes are assuming significant importance in reaching large number of people. However, at the community level despite low premiums the penetration of health insurance is small. The objective of this paper is to analyze factors determining the demand for private health insurance in a micro insurance scheme setting. The study uses two-stage model to examine this issue. First, we determine the factors, which affect the insurance purchase decisions, and at second level we focus on studying factors, which affect the amount of insurance purchase using Heckman two-stage estimation procedure. The data of this study is based on survey and collection of primary data from the Anand district of Gujarat where Charotar Arogya Mandal is offering a health insurance scheme. The results indicate that income and healthcare expenditure are significant determinants of health insurance purchase. Age, coverage of illnesses and knowledge about insurance were also found to be affecting health insurance purchase decision positively. For the decision regarding amount of health insurance purchase, income was found to be having significant but non-linear relationship. In addition, number of children in the family, age, and perception regarding.

ARMAN OZA (2006), According to the study Health insurance is still in nascent stage in India and will probably take some time to settle down. The dissonance generated amongst the customers, insurers and healthcare providers, despite its limited penetration, is not at all a healthy sign and needs to be redressed. Initiatives like actuarial rating, IT driven service network, regulation for healthcare providers and above all, conscious efforts by stakeholders to instil congruence between them will be required to make health insurance more acceptable to the dithering customers and make it a top priority for everyone after life insurance.
K PRAVEEN KUMAR (2006), The paper concludes that the health insurance in India provides a great opportunity as a business proposition for the insurer, a boon to the customer and a reward to the healthcare facility, provided the systems are well laid out. The bottlenecks of fraudulent claims result in an average claims rate of 130-150 against a premium of 100. Therefore, the need of the hour is to streamline the systems, bring in the claim adjudication system well in place either manually or mechanically to ensure that the deserving get the best benefit of health insurance.

SAMPA BHASIN (2006), Rapidly changing healthcare is a big challenge. In this article the author discusses health insurance in various scenarios. The study lists the main issues being faced as quality of service, reimbursement delays, limitation of services, inadequate information, provider malpractices, High cost and low penetration levels. Study suggests various solutions in which role of regulator plays an important part. According to the author health needs to be given a special status and not just combined with other insurance options.

GEETANJALI MEHLWAL (2006), Insurance in India has become a phenomenon that is worth reckoning. In the short span post liberalization, the market has evolved manifold. India’s enormous population and the ever-growing middle class continue to offer positive figures to the insurers. Life insurance remains the primary focus of the state as well as non-state players. The government is playing an active role by removing investment barriers and maintaining market checks through IRDA. There however remain several impediments such as sluggish health insurance market, which leaves about 80% of the country without any cover. This article describes the market, as it exists today, its growth potential and the incentive to private insurers from the world over.

U. JAWAHARLAL (2006), According to the paper, potential in health insurance is tremendous. It is going a begging because of the reservations we have moral hazards and associated problems on one side and a perceived lack of need for health insurance on the other. Insurers can certainly show the way in setting right the imbalance. The administration is doing its part by allowing life insurers to venture into the domain and also proposing to reduce capital requirement for stand-alone health insurers. The study predicts the bubbling health insurance market in the country in near future.

JAGENDRA KUMAR (2006), This paper attempts to present a fair picture of Health Care System of India. At the start it says that morbidity is going up one side, on the other side treatment is shifting from government to private sources. There is a serious cramp on
infrastructure. It also says that getting health care organized is not something that can be ignored or tackled merely by raising budgetary outlay. Major institutional reform is called for. Further this study says that health tourism market has great scope in India. Author then draws our attention to health care statistics. At the end it talks about the issue of spreading of health insurance.

GARIMA MALIK (2006), this paper attempts to examine the relationship between health and economic growth. The rate of growth is measured using gross national income (GNI) and health status is measured using infant mortality rate and life expectancy rate. A theoretical framework has been developed to model this linkage between health and growth and this is further tested using a regression model, which tests the causality between these variables of interest. It has also been assumed in this analysis that state-specific unobservable fixed effects affect these variables, since there are other cultural, political and social factors at work.

T.S. RAMA KRISHNA RAO (2007), The paper throws light on various opportunities ahead of insurance companies. De-tarrification from January 1, 2007 will totally change the complexion of the non-life insurance industry. The insurance industry will have a vital role to play by providing health insurance and other insurance products for the poor. The rural segment offers tremendous scope for expanding the insurance business, especially life insurance. According to the study, an area of concern is the high rate of lapse of policies and frequent churning of advisors. Further the imposition of service tax is a major blow for the industry. The recent cap on the pension limit at Rs. 10000 and its merger with the section 80C limit has also come as a setback to the industry. One of the biggest challenges the industry will face is training the intermediaries and the entire gamut of distribution force on de-tariffing.

SABERA (2007), The entry of private players helps in spreading and deepening the operations in the Indian insurance sector, which in turn results in restructuring and revitalising of public sector companies. The paper looks at the strategies of private insurance companies and the future expectations of the insurance industry.

U. JAWAHARLAL (2007), This study talks about healthcare scenario, opportunities and challenges ahead of heath insurance. Providing proper healthcare to the entire population is a monumental task in a country like India, with its massive population. The state should take lead in putting in place the measures to achieve this. However, there should be strong support
in the form of coverage for a large chunk of the population as also viable health insurance, if India were to achieve “health for all”.

B. V. RAMANA (2007), Author says that Globalisation is the process of interaction and integration among people, companies and governments of the different nations, driven by pulls and pressures from developed economies and aided by the pace of information technology. Insurance being an integral part of financial services could not claim immunity to the impact of globalization process and thus followed suit and opened up to private and global players, world over including India. The paper studies the globalization of insurance markets especially Indian and its impact on insurance sector in India like overall increase in awareness of the insuring public, wider range and choices of insurance products and their price etc.

PRADIP BANERJEE AND C. K. PARHI (2007), The study intends to explore the entire gamut of issues affecting Health Insurance in India. Comparative pricing has however been the major thrust area. This study is limited to the Individual Mediclaim alone. The problem of multiplicity of health insurance products is further exacerbated by the variable pricing models followed by insurers. The overall affects of all these have made insurance sector almost a financial jungle. The study intends to capture the interplay of these variables and its financial implications on health insurance pricing. The article attempts a comparative analysis of the products of different players from the viewpoint of premium they charge and the benefits they offer to find out the extent of perfectly competitive market conditions existent in health insurance pricing.

KAUR, JASPREET G, HARI SUNDAR VAIDYA, DEEPTI BHARGAVA, SHEELA (2007), People from many advanced countries, including the United States and Europe, see a benefit in travelling to developing third world countries, like India, Thailand, Philippines, South Africa, etc. while combining medical treatments with inexpensive vacation. This trend is now known as medical tourism. Medical tourism has greatly developed overtime and it is likely to further expand more as people find it more and more advantageous. This article focuses at the emergence of the medical tourism as a booming industry and the key management aspects that will help India establish India as a Health Care Destination.
BHAT RAMESH & JAIN NISHANT (2007), Health insurance policies are generally one-year policies and to remain part of the insurance pool, policyholders are required to renew their policies each year. Understanding the factors that affect the demand and renewal decisions to continue in health insurance programme is imperative for future growth and development of the insurance sector. We extend our previous work on factors affecting the decision to purchase health insurance to understand the factors affecting the renewal of insurance policy. We find the factors affecting health insurance renewal are not the same as factors affecting health insurance purchase decision. This has implications for insurance providers. The study also suggests customer satisfaction as an important factor influencing the renewal decision of policyholder.

From above discussion we can see that although much literature is available in the books regarding insurance sector and health insurance, yet nothing much has been discussed about the factors having impact on the demand of health insurance. Various researchers did job in various field of insurance but much work is not done in the area of health insurance. Though the effects of economic reforms are studied but their specific impact on health insurance is not touched. So through this study researcher tries to understand and analyze the impact of opening up of insurance sector, especially health insurance, due to economic reforms.
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