CHAPTER – II

REVIEW OF LITERATURE AND METHODOLOGY

ADOPTED

2.1 Literature Review

The researcher has not come across any study specifically dealing with the factors determined by the urban insured and their preference for various types of health insurance providers and policies. There is a gap in the field of investigation specifically in the urban population of Chennai District of Tamil Nadu. Several recent papers and reports have critically reviewed by the researcher to fulfill the research gap. The literature on Health Insurance in India includes books, compendia, theses, study reports, and articles published by academicians and researchers in different periodicals. The review of this literature gives an idea and to make the present study more distinct from other studies. The literature available is presented below:

Randall P. Ellis, et al., (2000) noted that there are two important limitations of the present healthcare system and its financing in India. The first limitation is exceptionally high healthcare expenditure over three-fourths of which is a private out-of-pocket expenditure. The other one relates to unsatisfactory outcomes of these expenses. Most of the out-of-pocket expenses are borne by households engaged in low income informal economic activities. Those in the organized sector are covered by health plans. But the majority of the low-income people are left to suffer either from poor healthcare delivery or to incur high out-of-pocket expenses, or both. Even though covered by health plans, low-income people experience growing inefficiencies and low quality of services. A revamp of the health system with expanded and improved health insurance facilities, is therefore essential.¹

Mutual benefit society, (2000) Health Insurance focuses on how the needs for health protection among micro-entrepreneurs can be rightly addressed by mutual health organizations. Indeed, micro-entrepreneurs fulfill the principal requirements for the establishment of such an organization. The need for protection against the risk of illness is real, where it is related to the individual’s state of health and the family’s source of income. Health needs are important, but the establishment of a system of protection is limited by its members’ capacity to contribute. In such conditions, a mutual health organization must pay particular attention to its choice of benefits. It must seek to strike a balance between the best possible health coverage in areas that cause the greatest difficulties to its members, and a contribution they can afford financially. The trade-off between affordable contributions and valued benefits is an issue on which a mutual health organization typically needs expert advice.²

Dileep Mavalankar and Ramesh Bhat, (2000) study concluded that government has liberalized the insurance industry and health insurance is going to develop rapidly in future. The challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without the negative aspects of cost increase and over use of procedures and technology in the provision of healthcare. The experience from other places suggests that if health insurance is left to the private market it will only cover those which have substantial ability to pay to leave out the poor and making them more vulnerable. Hence India should proactively make efforts to develop social health insurance patterned after the German model where there is universal coverage, equal access to all and cost controlling measures such as prospective per capita payment to providers. The existing health insurance programmes such as ESIS and Mediclaim also need substantial reforms to make them more efficient and socially useful. The Government should catalyze and guide the development of such social health insurance in India.³

Reeta Dhingra, (2001) revealed that there were only a few examples of Non-Government Organizations operating in India and providing a wide range of health services. In fact, India’s NGO sector was one of the most developed in the region, though they were more active in the areas of preventive and promoting health care, their contribution to curative health care was also more substantial. The fact that several of these health insurance sectors run dispensaries, clinics and hospitals which indicated that there is a lot of scopes to encourage and expand the role of NGOs in the provision of curative health care. The Government has realized early that NGOs could be complementary to provide healthcare services. One of the encouraging facts of this movement has been the cooperation and helps extended to many health insurance schemes by the government.  

Prithviraj Dasgupta and Kasturi Sengupta, (2002) study the evolving scenario in the insurance industry in India and identify the features of online insurance that improves the conventional insurance model and thus, makes it more attractive for the Indian Insurance Industry to go online 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. The recent growth of internet infrastructure and the introduction of economic reforms in the insurance sector have opened up the monopolistic Indian insurance market to competition from foreign alliances.  

Ashok Vikhe Patil, et al., (2002) discusses that the selective health intervention during the colonial period resulted in the so-called ‘Modern Medicine’ in India. After independence, the state has chosen to follow the ‘western models’. The system, which is highly selective, institutionalised, centralised and top down – not by oversight but by design – and which treats people as objects rather than subjects, has failed to address the needs of the majority, that is to say, the rural poor and indigenous

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people. While the urban middle class in India have ready access to health services that compare with the best in the world, even minimum health facilities are not available to the rural and tribal people, and wherever services are provided, they are inferior. While the health care of the urban population is provided by a variety of hospitals and dispensaries run by corporate, private, voluntary and public sector organisations, rural healthcare services, mainly immunisation and family planning, are organised by rural hospitals, primary health centers and sub-centers. It is unfortunate to note that due to regional imbalances, the type and quality of services being offered, adequacy and motivation of the staff, and a shortage of supplies in the centers have attributed to gross underutilization of the infrastructure. It is obvious that there is a marked concentration of health personnel to maintain the heavy structures, in the urban areas.\(^6\)

Anil Gumber, (2002) suggest that there is much potential and scope to enhance the coverage of health insurance in general and, more specifically, to the general public. In view of the recent development in the insurance sector, by opening it to the private player have come up with a health insurance plan and it is our assertion that only the upper and middle-income people are most likely to be benefited by the new plans. Therefore, the main thrust of the state should be in initiating schemes for the individuals. For this purpose looking towards options that could be explored through using the existing infrastructure, institutional arrangements and networks in the public sector welfare programmes. It is presumed that the following options could be more suitable under the existing circumstances, that is, without putting much strain on both physical and financial resources of the state. It is of utmost importance that such options should be more cost-effective and the services are more responsive to people in the future. These viable options which encircle and involve the existing system pertain to: Employee State Insurance Schemes, crop insurance schemes, poverty alleviation programmes, safety nets, and Panchayat Raj institutions.\(^7\)


Neelam Sekhri and William Savedoff, (2004) shows private health insurance is more widespread than public debates may lead us to believe. Many developing countries have private health insurance markets which are serving their middle class, and may also afford some degree of financial protection for the poor. Many developed countries use supplementary private insurance to fill gaps in their publicly funded systems and pay for increasing health services demand. As developing country policymakers consider whether they will allow private insurance to emerge or, if it already exists, how they can better manage the market, a few lessons are important from the experiences of developed countries. Whether a country considers private health insurance to be a transitional measure on the road to a comprehensive publicly funded system; a predominant form of insurance coverage in the future; or an unwelcome but irrepressible guest; private health insurance will be a factor in health financing. The challenge is to choose how to use the policy wisely.8

Rajeev Ahuja (2004) concludes the study, health insurance is emerging to be an important financing tool in meeting healthcare needs of the person. Appropriate regulatory changes can minimize the risks and turn potential benefits into concrete gains for the insured. However, currently, even the private health insurance market lacks development for want of proper regulatory decisions both on the supply of health services and on the demand for health insurance. The liberalization of insurance market has made this less likely, as competition in the marketplace will turn the focus of companies in most profitable lines of business. However, a regulatory requirement to this effect may then be a possible way out. The proposed scheme being a group insurance scheme is not meant to cover the entire population, also, it excludes outpatient care. As experience accumulates, the scheme can be fine-tuned and expanded to cover all low-income people. But increased public health spending and reforming of public health facilities is a must for the success of the community based health initiatives.9

Devadasan. N, (2004) concluded that the poor in India need to be protected from high out-of-pocket expenditures on health. A well-managed pre-payment system with risk pooling is effective in removing financial barriers at the time of illness. This can increase access to care, an important step towards improving the health status of households. Community health insurance is an innovative method to extend social protection to excluded groups. However, for this to happen, community health insurance needs to start on the foundation of solidarity, to have an affordable premium, an appropriate benefits package, and a minimal administrative burden.\textsuperscript{10}

Kent Ranson et al., (2004) suggest that community health insurance could be an interim strategy to finance the health care of the people; till a more formal social health insurance is in place. Also, suggest that this is a feasible alternative given that community based organisations and movements exist in India. What is required is to regulate the providers and to legislate so that the community health insurance programmes find a space within the Indian insurance context.\textsuperscript{11}

Ramesh Bhat and Nishant Jain, (2006) indicate that micro-insurance schemes may be vulnerable and significant adverse selection has been found to be a serious problem with health insurance in general as reflected by high claim ratios. In case of micro health insurance, it is all the more important because this problem will make these schemes further vulnerable. The micro insurance schemes would have lesser option to reduce this vulnerability as a number of members and communities willing to buy the insurance are limited in number. This makes risk pool small and adverse selection problem will get manifested in a major way. Micro-insurance schemes need to work in this area to reduce these risks. Some methods which have been used in other countries to tackle the problem of adverse selection are segmenting customers using risk categories, increasing the risk pool and/or ensure the whole family instead of an individual. Since these methods have been developed elsewhere, there is need to pilot some method(s) keeping in mind the unique issues associated with Indian Micro Insurance Schemes. \textsuperscript{12}

Olive Shisana, et al., (2006) study reveals that the outcome of inequity in access to care is that there are many missed opportunities for early prevention and care. Hence, there is a policy imperative to design a health care financing system that offers social protection in health and ensures that no one should suffer financial burden because of illness. National health insurance allows contribution-based financing to be combined with tax-financed subsidies or tax-financed partial population coverage, e.g. for covering specific sub-groups within the population. A mix of financing methods would share the burden of health care expenditures between employers, employees and the population working in the informal sector, and with government possibly subsidising insurance for the poor. A critical issue raised by the study is the incorporation of informed public opinion into the design and implementation of a national or social health insurance system. Achieving universal coverage is a long-term process. A number of factors determine the speed and form of transition political will and effectiveness of government stewardship; the institutional and legal framework; the relative acceptance of the values and concepts of equity and solidarity in society; the population’s confidence in government and its institutions; health care infrastructure; and the availability of skilled administrative, medical and nursing personnel to facilitate the effective implementation of a universal system. 13

Reshmi. B, et al., (2007) their study consents that the awareness of Health Insurance in South India. The determinants of awareness were based on socio demographic features. A large number of professionals were aware of Health Insurance than others. The study concludes that the middle and low socio-economic groups are a potential market to be tapped as they are ready to spend a reasonable amount as premium payable per annum rather than huge medical expenses in case of any adversities. The middle and low socio-economic groups favored government health insurance compared to private health insurance. The study suggests that government should come out with a policy, where the public can be made to a health insurance scheme to ensure unnecessary out-of-pocket expenditures and also better utilization of healthcare facilities. 14

Murali R.K. Iyer, (2007) study opined that, the healthcare industry in India is undergoing a tremendous transformation, both from the demand and supply side. With the Governments in many countries are withdrawing the subsidies and support to the healthcare sector ‘Healthcare Financing’ will need the support of Health Insurance. Now an economy on wings with the teeming Indian population being looked at as a potential market and a huge opportunity awaits the insurance industry. People are also facing the twin burden of communicable diseases of the developing world as well as the non-communicable diseases of the developed world e.g. lifestyle diseases. India is also a signatory country to the United Nations Millennium Declaration – widely referred to as ‘Millennium Development Goals’. There is a growing disparity between the availability of healthcare and its affordability. Healthcare financing is a becoming a key factor in the accessibility of healthcare where Health Insurance will play a crucial role. However health insurance covers only less percent of our population, but to achieve the ideal of ‘Health for All’, have to increase the insurance coverage for population by introducing innovative health insurance to target the vast segment of our country’s population. The partners in this industry the customers, service providers, the Third Party Administrators and the insurance companies, which presently perceive each other as adversaries, can take collective as well as individual steps in developing trust amongst themselves and also in popularizing the concept of health insurance.  

Jonathan Kolstad and Michael Chernew, (2007) discussed as more pressure is exerted on consumers to engage more fully in their health care experiences, policymakers will want to craft quality reporting interventions that have the greatest positive impact on consumer health. Though researchers have made great strides in this arena, future studies that build on this knowledge base will be essential to pinpoint mechanisms that facilitate informed consumer decision making in the healthcare sector.

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Randall. R, et al., (2007) Private insurance coverage that differs from traditional patterns—for instance, limited-benefit coverage or plans with very high deductibles—might also achieve lesser health improvements. Conversely, adding additional benefits to existing conventional coverage will not necessarily achieve improvements of proportionate magnitude. Insurance and access to safety-net services are far from the only influences on health and longevity. Environmental and public health measures can have major impacts as well, including promotion of vaccinations, smoking cessation and maintenance of healthy weight.\footnote{Randall. R, et al., “Why Health Insurance Is Important”, The Urban Institute, DC-SPG, Number 1, November 2007, pp.1-3.}

Chirag Gosalia, (2008) suggests that there is a tremendous potential for the insurance sector to attain a high growth level. The insurance penetration in a country depends on its level of economic activity, risk awareness among the people and the deepening of the financial system. With a large population and an untapped market, the insurance industry has a huge growth potential in India. The largely underserved rural sector holds great opportunity of growth for non-life insurers. To realise this potential, insurance companies must show a long-term commitment to the sector. Insurers will have to design products that are suitable for the rural population and utilise appropriate distribution mechanisms. Insurers will also have to pay special attention to the characteristics of the labour force, like the prevalence of irregular income streams and preference for simple products before they can successfully penetrate this sector.\footnote{Chirag Gosalia, “A Study on Financial Performance of Indian Non – Life Insurance Industry”, Presented to TASMAC & University of Wales, July 2008, pp.1-105.}

Robert W. Fairlie and Kanika Kapur, (2008) found that the potential loss or disruption in health insurance coverage due to pre-existing condition limitations, waiting periods for coverage, changes in health plans and providers, high premiums in the individual health insurance market, and risk of high health costs while uninsured may dissuade many employees from starting a business when it would otherwise be optimal. The clearest evidence comes from the regression discontinuity results which create the most comparability in experimental and controls groups. The finding of "entrepreneurship lock" is important as it suggests that the bundling of health
insurance and employment may create an inefficient allocation of which or when workers start businesses.\textsuperscript{19}

Arunachalam and Mini P.P., (2008) concludes that the liberalization of insurance sector has provided vast opportunities, with a variety of challenges to both public and private players, to prove themselves with their innovative strategies in covering a wider market with different segments. A direct positive result of the entry of private sector into the insurance business is the rise in awareness level about the need for insurance among the general public. The private players triggered off with massive advertising campaigns highlighting the need of insurance and product suitability. They are using print and electronic media to popularize their products in the market. They have made the premium payments easier and they have call centre services that attend to the queries of the policy holders or future customers, leading to easy accessibility of information to the customers. This can led to increased awareness among the customers regarding the various options available in the market.\textsuperscript{20}

Ghuman B.S. and Akshat Mehta, (2009) recommended that the level of public expenditure on health in India should be enhanced considerably, to reduce regional disparities in the provision of health services and to reduce rural-urban division in the provision of health services. The government of India has launched a programme known as National Rural Health Mission (NRHM). The implementation of this mission should be speeded up so that gets improved. For improving the quality of health services the government on priority basis should fill all the vacant posts of medical personnel particularly doctors and nurses, improve the quality of infrastructure and availability of medicines. The private sector has emerged as the major provider of health services in India. With a view to controlling private sector on account of price, quality of services, unethical practices, it is recommended to evolve an effective regulatory mechanism.\textsuperscript{21}

Sukumar Vellakkal, (2009) found that the ‘insurance habit’ of the people results in a kind of intrinsic insurance education in the form of familiarity with various forms of insurance which in turn has a positive externality on the probability to going in for health insurance. This also implies that the people should be given an opportunity to experience various forms of insurance so that they understand what insurance is all about. Free or subsidized health insurance to low and middle income households should be given to make them familiar with health insurance; after a point, the subsidy can be withdrawn gradually. Further, education about insurance in the school curriculum and insurance awareness campaigns for the public is highly recommended.\textsuperscript{22}

Sudha Meghan, (2010) in his study stated that there are various issues that have either hindered the growth of micro-insurance’s client base, the efficiency of the health care received, as well as the types of health services that can be covered. The primary focus moving forward would be to increase the population reach; this would facilitate a greater number of people being provided with some level of financial health protection, and thereby also enlarge the risk pool. The penetration of micro-insurance is very low currently in India. An empirically calculated demand for health insurance among disadvantaged population segments could implicate a need for government and private insurers to enter the market. In addition, this would provide greater support for government subsidy in the form of a rural or social sector mandate for private insurers through the Insurance Regulation and Development Authority (IRDA). The emergence of state-sponsored health schemes, micro-insurance could serve as an extension of this arm, to reach the bottom income quintiles in an efficient manner. The fit with government schemes would also include complementary benefits to ensure that health care services coverage is not duplicated and is offered most efficiently.\textsuperscript{23}

Utkarsh Shah and Ragini Mohanty, (2010) viewed that the professional management of healthcare institutions, to generate profits or surplus also gained considerable momentum over the past two decades. Recent innovations include a focus on ambulatory and retail healthcare, designed to focus on non-communicable diseases. Inherent factors like improved efficiency, better quality, greater reliability and transparency has also aided in the growth of private sector in healthcare. With the incorporation of medical professionals under the Consumer Protection Act, 1986, there was an increased realization of the importance of quality in the provision of medical care services. With various initiatives of the Quality Council of India, efforts are underway to promote standardization of medical care services and enhance quality of medical care provided by the private sector.24

Dilpreet Singh, (2010) pointed out that the main reason, as to why there has been restraint in the growth of health insurance, during the last decade is inadequate healthcare infrastructure, limited reach, significant underwriting losses for health insurance business in India, lack of standardization and accreditations norms in healthcare insurance industry in India, insufficient data on Indian consumers and disease patterns resulting in difficulty in product development and pricing. There has been some resistance from the health insurance companies, which is adding to the suspicion of customers before making any decision to enroll in a health insurance policy.25

Anushree Sinha, et al., (2011) study has noted that improving insurance awareness requires both structuring and enhancing the penetration of an appropriate awareness creation campaign with a regional and spatial focus. Such a campaign needs to be supported by stronger information infrastructure for the efficient functioning of the insurance markets. As argued in this report, fostering insurance awareness among rural households is more vital in this effort as there is a large gap between rural and urban awareness levels. Also, the insurance packages need to be different and made attractive to the rural poor, keeping their needs in perspective. This is because rural poor households are more in need of social protection but at the

same time are less capable of paying premia. However, it needs to be acknowledged that a potential insurance market exists for the poor as they have substantial requirements, and a proper package would make insurance a viable option for both the companies and poor households.  

Srinath Reddy. K, et al., (2011) analyses as, health insurance covering outpatient care, especially drugs, ideally, it is desirable to include medicine for reimbursement under the Indian conditions in principle. The prime reason for the denial of coverage of drugs and outpatient coverage is that all the stakeholders, physicians, pharmacists, patient, etc can easily influence the outcome. The study argues that in principle while this is desirable but practical implementation and the associated problems of enforcing medicine reimbursement to patients would be a stupendous task and could fiscally strain the coffers of the government. Outpatient care and drug reimbursement must be kept out of the health insurance programme while strengthening of public health institutions and sprucing up of medicine procurement and distribution is called for.

Devadasan. N, et al., (2011) study showed a high level of satisfaction regarding the care received both among the insured and uninsured patients. Meeting patients’ expectations is an important step towards providing continuous high-quality healthcare. It has the potential to make patients adhere to the care provided and return for follow up. This is more important in a Health Insurance Scheme, where dissatisfied patients may refuse to renew their membership in the next year. They may dissuade others from joining the scheme, thereby affecting the overall viability of the scheme. Hence it is imperative that Health Insurance Scheme managers ensure that the insured receive a high quality of care and are satisfied with the services. This, along with other measures, like affordable premium, acceptable benefit package, easy administrative procedures and trust in the organization would go a long way in ensuring the success of health insurance schemes.

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Balarajan, Y, et al., (2011) discusses that, despite improvements in access to health care, inequalities are related to socio-economic status compounded by high out-of-pocket expenditures, with more than three-quarters of the increasing financial burden of health care being met by households in India. Healthcare expenditure is an additional expenditure people falling into poverty every year as a result of such expenditures. The researcher identifies the key challenges for the achievement of equity in service provision, and equity in financing and financial risk protection in India. These challenges include an imbalance in resource allocation, inadequate physical access to high-quality health services and human resources for health, high out-of-pocket health expenditures, inflation in health spending, and behavioral factors that affect the demand for appropriate healthcare. Use of equity metrics in monitoring, assessment, and strategic planning; investment in development of a rigorous knowledge base of health-systems research; development of a refined equity-focused process of deliberative decision making in health reform; and redefinition of the specific responsibilities and accountabilities of key factors are needed to try to achieve equity in healthcare in India. The implementation of these principles with strengthened public health and primary-care services will help to ensure a more equitable healthcare for India’s population.29

Mita Choudhury and Srinivasan, R, (2011) revealed that the coverage of beneficiaries under most of the insurance schemes appears to be low. In a number of schemes, the share of beneficiaries covered in the targeted population is less percent only. This points at the low reach of these insurance schemes in the targeted population. The performance of the schemes is affected by a number of factors. The bulk of the targeted population is not affiliated to any organized group through which these insurance schemes are operated, this adversely affects the coverage. Also, illiteracy and lack of basic schooling leads to problems in carrying out the operational modalities of the schemes in terms of premium requirements and submission of claims with the relevant documents. At the State-level, the staff assigned with the task of increasing coverage and implementing the scheme is also burdened with other work. Notably, these officials act as crucial links between the beneficiary groups and

the insurance company and the active involvement of these officials are indispensable for improving the performance of the schemes.\textsuperscript{30}

Dash. U and Muraleedharan. V.R., (2011) suggested that the government could improve access by constructing or adding more private facilities to the panel of recognized hospitals where the insured patients can get treatment. This is particularly important as the current perception of quality of care among beneficiaries is poor. Private providers are spread throughout rural and urban areas and are available wherever there is a demand for services. They are also more easily accessible to people than public facilities and have flexible opening hours and short waiting times. The basic infrastructure of the existing facilities could be improved to provide a higher quality of service to the beneficiaries; this includes making basic diagnostic equipment available, providing nursing personnel, laboratory services and making conditions more sanitary. Finally, policymakers suggest that there has been little continuity in the highest policy making system, thereby considerably weakening the efforts taken to bring about major changes and to improve the overall performance of the scheme.\textsuperscript{31}

Ahmer Akhtar, (2011) opined with lower institutional capacity, insurance companies often require support from development partners to develop regulatory frameworks. There is a growing interest and promotion of market-based approaches to the scaling up of healthcare and products for the poor, with international organisations such as the International Finance Corporation, World Bank, USAID, Non-Government Organisations and donors all seeking ways of harnessing the commercial health sector in Low and Middle-Income Countries (LMICs). However, efforts to assist country partners in the development of regulatory frameworks and techniques are lagging. The reasons for this are not well documented but may be due to the limited evidence of effective approaches. As well, there is a lack of investment in institutional capacity and seeking different ways of achieving regulatory outcomes. Consequently, international actors actively promoting commercialisation of the health


sector should also provide investment for improved regulatory systems. The consequences of unregulated healthcare markets in LMICs are potentially serious, including increasing inequities, further weakening of public sectors, opportunistic behaviour and poor quality care. Such circumstances undermine health objectives and can harm the weakest and most vulnerable members of society. Regulation of health care in LMICs should always maintain a culture of public interest and protection.32

Ranajit Chakraborty and Anirban Majumdar, (2011) concluded that healthcare is one of India’s largest sectors, in terms of revenue and employment, and one can well witness the sector to expand rapidly. With the fast growing purchasing power, Indian patients are willing to pay more to avail healthcare services of international standard. In the era of globalization and heightened competition, it has been observed that delivery of quality service is imperative for Indian healthcare providers to satisfy their indoor as well as outdoor patients. Hence, it is essential to be aware of how the patients and patient parties evaluate the quality of healthcare service. Such an understanding facilitates hospital administration to enhance the quality of service and satisfy patients to a great extent as well. Researchers have suggested different models and methods of measuring patient satisfaction considering service quality as one of the antecedents. Service Quality instrument among several tools for measuring service quality and patient satisfaction is the most widely used tool.33

Chitirai Selvan, et al., (2012) puts forward, it is imperative to find out the varieties that determine the policyholder satisfaction on service quality of public general insurers. Customer satisfaction is the prime yardstick used to measure the quality of services provided by any luxuries establishment. The results of the study reveal that public sector general insurers have to concentrate more on spreading awareness as a high level of satisfaction is associated with awareness on mediclaim insurance. A vast majority of the people is still not covered by any health insurance coverage. The study also indicates that the government, as well as those involved in

32Ahmer Akhtar, “Health Care Regulation in Low and Middle Income Countries: A Review of the Literature”, Health Policy and Health Finance Knowledge Hub, Number 14, October 2011, pp.1-17.
offering health care policies has to devise strategies to educate people on the need to be covered under a health insurance plan as well as to motivate them to come under the umbrella of protection.  

Harshal Tukaram Pandve, (2012) viewed that, the strength of any nation is its health. There is empirical evidence that the health of a nation significantly enhances its economic development and vice versa. India is a second populous country in the world and also the largest democracy in the world. Since its independence, India has made considerable progress in terms of the health indicators and health infrastructure. Indian health system is characterized by a vast public health infrastructure which lies underutilized, and a largely unregulated private market which caters to the greater need for curative treatment. The mixture of various health insurance service providers must be used effectively to ensure the health of citizens.  

Kasirajan. G, (2012) opined that the need for an insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging a premium from a wider population base of the same community. With improved literacy, modest rise in incomes and rapid spread of print and electronic media, there is greater awareness and increasing demand for better health services. The middle and low socio-economic groups are a potential market to be tapped as they are ready to spend a reasonable amount of premium payable per annum rather than huge medical expenses in case of any adversities. If the private insurance players want to venture in the market, they should try to imbibe trust in the people as most of the respondents preferred government health insurance schemes, the reason being a guarantee for their capital. To develop a viable health insurance scheme, it is important to understand people's perceptions and develop a package that is accessible, available, affordable and acceptable to all sections of the society. 

Jangati Yellaiah, (2012) discusses, the need to shift from the current predominance of out-of-pocket payments to a health insurance programme to the reasons are an insured patient can walk into a burden, push families into indebtedness or poverty, its risk pooling mechanism is better quality care. The study was carried out to identify the determinants – of awareness of Health Insurance in Andhra Pradesh. From the variables an effective information, education and communication activities are the major factors to improve the understanding of the people about insurance.

Arnab Acharya, et al., (2012) found that the measure of out of pocket expenditure and the welfare implications. A measure of income as catastrophic OOP expenditure does not have the same welfare implications for different income earners. One suggestion that is appealing is that insurance should protect people from high levels of expenditure, especially those who are insured. Simply examining the higher end of the expenditure distribution for the insured and non-insured can be an interesting measure. How such distribution can be incorporated when selection into insurance is present is not clear. Protection from risk using some kind of decline in risk aversion can take income into account. Such measures may hold great promise, as this can serve as the dependent variable for each individual and be used in regression formulations as well as in propensity score matching exercise.

Yellaiah. J and Ramakrishna. G, (2012) states that the health insurance minimizes the burden of health expenditure significantly for a poor household and increases his productivity. Government should come forward in introducing and widening the schemes along with the coverage of health insurance. And the study suggested that there are only some selected hospitals which provide the insurance benefits to the insurer. This reduces the availability of choice to the people insured. To avoid this problem a provision should be made so that all hospitals irrespective of private or public, can provide health insurance benefits to the insurers. This would also encourage people to go for health insurance.

Shankar Prinja and Manmeet Kaur, (2012) concede that universalizing the health insurance is not the sole answer to India's health system problems. It entails major revamping of governance and management capacity, infrastructure, management information system, and regulatory frameworks. Special efforts are needed to upgrade the MIS system, which will be critical to success of monitoring of insurance claims, setting premiums, and establishing risk pools. Unregulated private sector market with lack of quality accreditation requires attention. Inclusion of private providers for provision of care through insurance system would provide an opportunity for regulating their quality.  

Swati Dattatray Kedare, (2012) analyses that there is demand for the cashless health insurance scheme but the customers want a reduction in a number of exclusions and inclusion of pre-existing diseases. They want the TPAs to be efficient and perform up to the expectation of the policyholders and insurers. The population of elderly people, in India, is rising and they would require institutional care, which is totally missing. The plans need to include pregnancy related expenses, the inclusion of chronic and debilitating diseases, HIV and AIDS, TPAs need to be more efficient in claims processing and providing better networking for the policyholders. These challenges can be overcome by setting up and stand-alone health insurance companies that are run non-profit objective. In India, life insurers should be allowed to underwrite health insurance. The tax benefits available at present should be hiked and continued with. To create the awareness of health insurance is very important, the Government and all the associated bodies should all offer their support in spreading health insurance awareness so that Indian citizens are aware of the right to seek quality healthcare without any financial thought.  

Pooja Kansra and Gaurav Pathania, (2012) opined that the health insurance is not a new concept and the people are also getting aware about it, which mainly comes from newspaper followed by radio, television, agents etc, but this awareness has not yet reached the level of subscription. As the results show that just a few

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percents are being covered by some form of health insurance and a large chunk of the population is still financing healthcare expenditure without health insurance. Moreover, it was observed that there are five key factors such as formalities bottleneck, agent-related problem, coverage issues, awareness, negative feedback by clubbing the related variables under it which are acting as a barrier in the subscription of health insurance.  

Amit Mookim, (2013) reviewed that, the major factors driving the growth in the sector are increasing population, growing lifestyle-related health issues, easier accessibility to healthcare, thrust in medical tourism, improving health insurance penetration, rise in middle income group population, increased disposable income, government social sector initiatives on penetration of health insurance and focus on Public Private Partnership (PPP) models. As the Indian healthcare industry has been displaying strong growth prospects and in view of the prevalent optimistic atmosphere, many foreign companies have been displaying an eagerness for investment/setting up their base in India and looking to have an access to the untapped market in Tier-II and Tier-III cities.  

Aanchal Aggarwal, et al., (2013) their study revealed that the Indian health insurance scenario today is a mix of Government Insurance Schemes, Social Health Insurance (SHI), Voluntary Private Health Insurance and Community-Based Health Insurance (CBHI). As per the recommendations of High Level Expert Group on Universal Health Coverage on institutional reforms, to make quality health care affordable, insurance penetration should increase to at least fifty percent of the population by 2020. The mixture of various health insurance service providers must be used effectively to ensure the health of citizens. For the Indians the health insurance is the need of the hour. Product innovation would be one of the key drivers to reach this penetration target. The rebuilding of India’s healthcare infrastructure, combined with the emergence of medical tourism and telemedicine, will drive strong demand within the sector and its allied industries. Many international companies have expanded their operations in the Indian market in recent years and established local
operations. The government is actively encouraging growth in the sector, creating a high number of compelling opportunities, such as developing new infrastructure, expanding the reach of healthcare to remote areas via ICT and providing novel medical equipment solutions.44

Preeti, et al., (2013) opined that the winds of liberalization and privatization, which have brought in dramatic and phenomenal changes in the economic and financial sector, across the developing world particularly in the last decade and a half are perceivable in the impact of globalization. Insurance sector found a new dimension to increase its business. Insurance product packaged savings feature with risk management feature. Insurance cell promises to pay on a future date for a predefined contingency. The essence of insurance is sharing of losses and substitution of certainty for uncertainty. In an increasingly competitive economy the need for insuring against risk is well recognized. The insurance business has been protected by investors. And the ripple effects of the same can be observed in the domestic markets as well. The rising per capita income increased demand for insurance to cover risks of old age and death. The insurance sector is a major contributor to the financial savings of the household sector in the country, which are further channelized into various investment avenues. Growth in the insurance sector during the post liberalized period caused because of a considerable shift in the percentage of savings from financial assets (like a deposit in banks, non- banking company, co-operatives, mutual funds, small savings etc.). In this growing competition, the investors are truly the kings. Products are being designed, redesigned, and customized to suit the changing preference of investors, taking into account different factors like age, gender, family status, employment and income levels. All these efforts would give fruitful results only when there is high public awareness.45

Manish Menda, (2013) discusses that making healthcare affordable and accessible to all its citizens is one of the key focus areas of a country today. In India where healthcare services still do not reach many pockets of the country, it becomes

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an even bigger challenge. Many patients even today delay their treatment plans due to lack of funds thereby weaning themselves from a better quality of life. The Indian healthcare sector is here to evolve to a state where it will reach out to patients across varied income groups. People will have multiple options to access healthcare from a variety of different insurance schemes, government schemes or patient financing programmes. Insurance plans are already starting to evolve and the government is working on various healthcare programmes all over India. The key will be consumer choice in the future where the end user will have access to a plethora of options.46

Nilay Panchal, (2013) states that Health Insurance is increasing day by day, which most people payout their pockets. In the current scenario of consistency increase medical expenses, some people also sell their personal assets. The researcher would like to know that which factors affect the health insurance and reasons for not having one in rural areas. From the analysis, the study said that level of income of respondents plays a vital role in purchasing health insurance. The study found that because of low awareness people do not have health policy and some time because of lack of financial tools people do not purchase health insurance because of high premium by the view of them.47

Senthil Kumar. S. A., et al., (2013) the study is carried out with the objectives of health insurance market and health finance in India, to study various health insurance products available in India and to study the growth of health insurance market the way of forward. The government to provide universal access to free / low-cost health care insurance can be an important means of mobilizing resources, providing risk protection and perhaps, improved health outcomes. This scenario, the challenge, then for Indian policy makers to find a way to improve upon the existing situation in the health sector and to make equitable, affordable and quality health care accessible to the people, especially the poor and the vulnerable sections of the society. In the way inevitable that the state reforms its public health delivery system and explores other social security option like health insurance.48
Pranav. S, (2013) concluded his study as, everyone should be covered by some form of health insurance. People are always vulnerable to injury and illnesses from their everyday activities. Whether it is an individual plan or employer or government-sponsored coverage, having health insurance is better than not having it at all. Millions of Americans are uninsured in part due to high premium costs. Many are forced to pay these high health costs out of pocket, which can create more problems medically and financially. Indian health insurance or medical insurance sector has been growing, since the country’s economic reforms. The reason why mediclaim insurance has grown is that it ensures good medical care from reliable healthcare institutions.49

Elizabeth Schultz, et al., (2013) examined that the ongoing barriers that prevent people from enrolling in health insurance, given that knowledge about the program and its benefits appear to be high. Findings suggest that although most people consider the cost of the program to be reasonable, it is a challenge to have the cash to pay for the programme on hand when payment is due and when it is convenient to go to make the payment. The liquidity challenge might also be eased through use of Micro Finance Institutions credit or savings products that would allow individuals to borrow to pay for premiums or save ahead towards making premium payments for themselves and their households. Installment payment options and timing enrollment campaigns during times when those eligible are likely to have more cash on hand may also mitigate these barriers to paying premiums. 50

Akila. M, (2013) expressed, while India has the highest potential for Health Insurance, the penetration is lowest compared to western countries. The opportunities to acquire and the challenges ahead are identified in this explorative study. The ways and means to overcome those challenges also discussed. Mass marketing strategies like the promotion of Group Insurance, Micro-insurance for BPL families will be greatly helpful for enhancing the growth of this industry. Insurance agents also have to be equipped enough to enroll more policies and to serve better for the customers as

and when a need arises. The Other stakeholders like healthcare providers and TPAs also should work together to enhance the penetration of Health Insurance sector in India.\textsuperscript{51}

Manish Pandey, et al., (2015) recommend free or cheap public healthcare for the lower income groups and better customer-focused insurance products for the middle and higher income groups. With improving infrastructure, macroeconomic conditions, raising awareness about benefits of health insurance products, better accessibility, easier product description with no fine prints, trust on insurance as an investment through TPA, convenience of enrollment & claim process, the health insurance penetration should improve.\textsuperscript{52}

Ramesh Bhat, et al., (2015) study discusses the perception of hospital administrators and health insurance policyholders about the TPA services. Only small percentage of the policyholders in the sample has knowledge about the existence of TPAs. General awareness about the TPAs existence and services they provide is low. Policyholders rely more on their insurance agents than on the insurance companies or third-party administrators. TPAs are the interface between the insurer and the insured and they are in a position to educate the policyholders about health insurance. However, their role in consumer education does not infuse much confidence in their intention or ability to do so. Hospital administrators do not perceive, introduction of TPAs has increased their patient turnover and at the same time, they perceive that this has increased the burden on their expenditure as effort level to manage relationship has gone up. However, there is an indication that hospital administrators foresee clear business potential in their association with the TPA system. The TPA services, on the other hand, need to focus on developing their competencies and capacities and take care of various operational issues in the provision of services. This will need a significant amount of investment in developing their human capital. TPAs have a role in containing the cost of healthcare and standardizing the quality of care. However,

\textsuperscript{52}Manish Pandey, et al., “Improving Penetration of Health Insurance In India”, IIMB, 2015, pp. 3-22.
the current level of services raises doubts about their ability to take this task seriously and effectively in near future.\textsuperscript{53}

\textbf{Ramaiah Itumalla. G, et al., (2016)} concludes that there is no doubt the health insurance in India is going to develop rapidly in future. The task of the government, private providers and the civil society is to solve the issues and challenges and to see that the health insurance benefits consumer most importantly the poor and the weak in terms of better coverage and health services at lower costs with quality without the negative aspects of cost increase and over use of procedures and delay in provision of health care. The experience from other places suggest that if health insurance is left only to the private market it will only cover those which have substantial ability to pay leaving out the poor and making them more vulnerable. Hence, the existing central and state health insurance schemes also need substantial reforms to make them more efficient and socially useful. There is a need to create the awareness on rights and responsibilities, standardization of cost, increased tax benefit and pool for senior citizen.\textsuperscript{54}

\textbf{James. P.C., (2017)} states that despite all regulations and oversight health insurance is a service that is prone to generate pain points to those who a valid and face claims. This was foreseen by the regulator almost as soon as the sector was opened up, and the Third-Party Administration concept was introduced. TPAs were licensed to ensure that every insured is guided by the TPA in obtaining seamless care. More importantly, by ensuring TPA service the regulator ensured that cashless claim settlement, which is critical in catastrophic health claims, becomes the standard practice in health insurance. However, because of the rapid growth of health insurance and the evolving nature of treatments and policy coverage, there are issues that trouble consumers in the care-receiving value chain.\textsuperscript{55}

\textsuperscript{55}\textit{James. P.C, “Removing the Pain Points in Health Insurance”, IRDA Journal, March 2017, pp.45-50.}
Tarun Chauhan, (2017) the study is to find out the awareness level about health insurance schemes among the urban unorganized sectors and make awareness can be created in such sector in Urban areas and make them secure to get health insured. It has been found that three main reasons i.e. low income, not heard about it and financial constrains or problems more influencing for taking health insurance schemes among the public. The study suggested that the government through its health department should make a policy and thereby should ensure that every unorganized worker should be a member of health insurance sector.  

2.2 Important Definitions

2.2.1 Insurance

Insurance is a social device whereby uncertain risks of individuals may be combined in a group and thus made more certain, small periodic contributions by the individuals providing a fund out of which those who suffer losses may be reimbursed. —Riegel R. and Miller J.S.

2.2.2 Section 114A of the Insurance Act-1938 and Section 14 read with section 24 of the IRDA Act 199 and in consultation with the Insurance Advisory Committee, the Authority hereby makes the regulations, In these Regulations, unless the context otherwise requires:-


b) "Agreement" means an agreement entered into between a Third Party Administrator and an insurance company prescribing the terms and conditions of services, which may be rendered to Insurance Company; or an agreement entered into between a Hospital/Health care provider and an Insurance Company, and may include TPA as a tri-party, prescribing the terms and


conditions, which may be rendered to insured persons of the Insurance Company.

c) “Authority” means Insurance Regulatory and Development Authority of India established under sub-section 1 of section 3 of the IRDA Act 1999.

d) “Break in policy” A break in policy occurs when the premium due on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

e) “Cashless facility” means a facility provided to the insured by an insurer, to make payments of treatment costs directly to the hospital in respect of treatment undergone in a network provider, to the extent of approval given in the pre-authorization where such treatment is in accordance with the policy terms and conditions.

f) “Health insurance business” means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, travel health insurance and personal accident cover.

g) "Health Services" means all the services to be rendered by a TPA under an agreement with an insurance company in connection with "health insurance business" or “health cover” as defined in regulation 2(f) of the IRDA (Registration of Indian Insurance Companies) Regulations, 2000, but does not include the business of an insurance company or the soliciting, directly or through an insurance intermediary including an insurance agent, of insurance business.

h) “Health plus Life Combi Products” shall mean the combination of Pure Term Life Insurance cover offered by life insurance companies and Health Insurance cover offered by non life insurance companies.

i) “Network Provider” means hospitals or health care providers which have an agreement with the insurer to settle claims through a cashless facility.
j) “Portability” means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

k) “Senior citizen” means any person who is sixty or more years of age as on the date of commencement of insurance policy.

l) “Third Party Administrators or TPAs” means any person who is licensed by the Authority and is engaged, for a fee or remuneration by an insurance company, for the provision of health services.\(^{58}\)

2.3 Scope of the Study

The present study is mainly concerned with the awareness of health insurance and its impact among the policyholders. The intention is to analyze the level of awareness of Health Insurance companies and their policies among the urban population and specifically the relationship between insured and health insurance providers. The study also examines the perception of policyholders from various health insurance companies. The collection, analysis, interpretation and presentation of the primary and secondary data are the main process to obtain the findings of the study. The important aspect of the analysis is to examine the perception of policyholders, benefited through private sector or public sector health insurance policies in Chennai District.

2.4 Need for the Study

Buying health insurance protects us from the sudden, unexpected costs of hospitalization which would otherwise even lead to in debtedness. Each of us is meeting with various health hazards and a medical emergency can strike anyone of us without any prior warning. Healthcare is increasingly expensive, with technological

\(^{58}\) IRDA-Section 114A of the Insurance Act 1938 and Section 14.
advances, new procedures and more effective medicines that have also driven up the costs of healthcare. While these high treatment expenses may be beyond the reach of many, taking the security of health insurance is much more affordable. There is a contractual agreement between the insurers and the providers in case of cashless hospitalization benefits and reimbursement benefits. The understanding of the insurers and the health insurance services is very critical. The lack of understanding about the relationship between the hospitalization costs paid, components of hospitalization cost and the risk covered by the insurers. The study is important because it is aiming to give valuable suggestion to the insured about the health insurance policies and procedures.

2.5 Significance of the Study

There are disparities in health insurance services in public and private health insurance sector. The public and private disparities in health outcomes in India are often attributed to urban bias in allocation of resources. In urban areas, many needy and deserving people do avail health insurance services of public or private services but not get any benefits due to time and procedure to avail the benefit. Against this background, the present study contrasts the standard of health insurance services provided by a public sector and private sector health insurance companies in the district of Chennai.

2.6 Statement of the Problem

The Health Insurance Companies provides various measures for the welfare of the public. The benefits such as reimbursement benefit and cashless hospitalization benefit are offered by Health Insurance companies to protect the public. In availing any kind of benefits the policyholders have to undergo a lot of procedural formalities. The procedure designed for benefit is somewhat complicated for the policyholders, who are not able to understand such procedural aspects. This is the main hurdle in availing such benefits from their health insurance provider on time. In this study, an attempt to study the preferred health insurance providers, the awareness level of Health Insurance products and the providers, utilization of policy benefits, level of
satisfaction, procedural concerns and problem faced by the policyholders in availing benefits from their health insurance providers was made by the researcher.

2.7 Objectives of the Study

The objectives of the proposed study with respect to awareness of Health Insurance and its impact are-

1) To analyze the socio-economic determinants of Health Insurance buyers in Chennai District.
2) To study the trends in Health Insurance and to identify the preferred Health Insurance providers.
3) To evaluate the awareness level of Health Insurance policies and the providers in Chennai District.
4) To elicit the opinion of Health Insurance policyholders in connection with the policy benefits.
5) To examine the problems faced by the policyholders in accessing health care services.
6) To analyze the satisfaction level of health insurance buyers towards the Health Insurance Companies’ services and their policies.
7) To give valuable guidelines and suggestions for the development of Health Insurance.

2.8 Hypothesis

To achieve the objectives of the present study, a number of null hypotheses were constructed. To identify the preferred health insurance company and health insurance policy of the respondents, the demographic features such as gender, age, community, religion, marital status, educational qualifications, occupation, monthly income, type of family and earning members of the family of the respondents and association between the selection of health insurance company and health insurance policies are taken into account.

To elicit the opinion of respondents based on the selection of health insurance companies and
the problem faced by the policyholders at the time of making claim,
reasons for rejection of a claim,
problems at the time of renewal,
level of satisfaction are considered.

To elicit the opinion of respondents based on the selection of health insurance policies and
the pattern of health insurance coverage,
benefits of the policy,
the problem faced by the policyholders at the time of making claim,
reason for rejection of claims,
problems at the time of renewal,
level of satisfaction are considered.

Finally, the study examines the impact on health insurance, as-

An association between the impact on study domains and selection of health insurance policies from different health insurance companies.

2.9 Profile of Chennai District

Chennai formally known as Madras is the capital of Tamil Nadu, India. Located on the Coromandel Coast off the Bay of Bengal, it is one of the cultural, economic and educational centers in South India. According to the 2011 Indian Census, it is the sixth-largest city and fourth-most-populous urban agglomeration in India. The city together with the adjoining regions constitutes the Chennai Metropolitan Area, which is the 36th largest urban area by population in the world. Chennai attracts 45 percent of the health tourists visiting India and 30 to 40 percent of domestic health tourists. As such, it is termed “India’s Health Capital”.

According to 2011 census the city had population of 4,646,732 within the area administrated by the Municipal Corporation. The city limits were expanded later in 2011 and its population reached 7,088,000 with Chennai, Municipal Corporation is being renamed as Greater Chennai Corporation.
Chennai District, formally known as Madras District or "Madarasapattinam" is a district in the state of Tamil Nadu in India. It is the smallest of the entire district in the state, but has the highest human density. It is a city district which means it does not have a district headquarters. Most of the Greater Chennai City comes under this district, erstwhile under Kancheepuram and Thiruvallur district. As of 2011, the district had a population of 4,646,732 with a sex-ratio of 989 females for every 1000 males.

The average literacy of the district was 81.27 percent, compared to the national average of 72.99 percent. In December 2013, the five erstwhile taluks of the district were divided into the current taluks of Aminjikarai, Ayanavaram, Egmore, Guindy, Mylapore, Mampalam, Purasawakam, Perambur, Tondiarpet and Velachery.59

2.10 Methodology Adopted

The present study is descriptive in nature. This section consists of sources of data, a pre-test for the study, sampling techniques and sample size used, statistical tools used and period of the study.

2.10.1 Sources of the Data

The study makes an attempt to understand the determinants of awareness about the Health Insurance policies, procedures and its benefits mainly from the urban population. Thus the study uses primary and secondary data.

The primary data have been collected using pre-tested structured questionnaire from the beneficiaries of Health Insurance in Chennai District. The source of primary data that has been collected from 530 policyholders randomly selected. An opinion survey was also conducted. The opinion of the beneficiaries over the health insurance and suggestion were collected.

The secondary data was collected from various reports, journals, books and booklets published by central and state government. Annual reports published by

59 http://en.wikipedia.org/
IRDA and Insurance Information Bureau in India were also referred to and used. Health Insurance Companies reports, various Health Insurance policies of State and Central Government, Annual budget and valuable literature from difference libraries and websites were used in this study.

### 2.10.2 Pre-test for the Study

Reliability analysis was carried out after taking 50 samples in the Pilot study. Reliability coefficients were computed using both Alpha and Split-half methods. The number of items included was 80 and the sample size was 50. The reliability coefficient, the Cronbach’s alpha was found to be 0.873 in the Alpha method.

#### Table 2.1 Reliability – ALPHA Method

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<th>%</th>
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<tr>
<td>Valid</td>
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<td>100.0</td>
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<tr>
<td>Excluded(^a)</td>
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<td>.0</td>
</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
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\(^a\) Listwise deletion based on all variables in the procedure.

<table>
<thead>
<tr>
<th>Reliability Statistics</th>
<th>N of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach's Alpha</td>
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<tr>
<td>.873</td>
<td></td>
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</tbody>
</table>

In the split-half method, the reliability coefficient, Cronbach’s alpha for part 1 was found to be 0.877 and for part 2, it was 0.803.
Table 2.2 Reliability – SPLIT-HALF Method

<table>
<thead>
<tr>
<th>Case Processing Summary</th>
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<tr>
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<tr>
<td>Total</td>
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<td>100.0</td>
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a. Listwise deletion based on all variables in the procedure.

<table>
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<th>Reliability Statistics</th>
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<tbody>
<tr>
<td>Cronbach's Alpha</td>
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<tr>
<td>Part 1 Value</td>
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<tr>
<td>N of Items</td>
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<tr>
<td>Part 2 Value</td>
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<td>N of Items</td>
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<td></td>
</tr>
<tr>
<td>Total N of Items</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Correlation Between Forms | .823

Spearman-Brown Coefficient |   |   |
| Equal Length             | .787 |
| Unequal Length           | .769 |

Guttman Split-Half Coefficient | .782

The reliability coefficients in the two methods were found to be more than 0.800 and hence it was concluded that the questionnaire was highly reliable and could be used to collect information from all sample respondents included in the present research.

2.10.3 Sampling Technique and Sample Size

The simple random sampling method is used purposively to select the policyholders of various Health Insurance Companies in Chennai District. The total size of the sample taken for the study is 530, from the health insurance policyholders of various companies.
2.10.4 Statistical Tools Used

The primary data collected were analyzed using SPSS package. The information so collected has been classified, tabulated and analyzed as per the objectives of the study. Mean, Standard Deviation, Cross tabulation, Chi-square test, F-test and Post Hoc Test have been used for conducting analysis at different parts of the research to achieve the objective of the study. One-way ANOVA, Factor analysis, Cluster analysis and Discriminant analysis are done to find the reliability of the study.

2.10.5 Study Period

The study covers the period from 2012 to 2018. During this period the IRDA Annual Reports, IIBI Annual Reports, Five Year Plans of India, Reports from Insurance Companies and Government Amendments are confined in the contexts of Health Insurance. The primary data were collected from 2015-2017, during the period opinion of policyholders were also collected.

2.11 Limitations of the Study

The study is not deprived of any limitations which are noted as-

1. The study area is restricted to Chennai District only.
2. The study concentrates only the opinion of Health Insurance policyholders from Chennai District.
3. The study is restricted to selected public and private sector Health Insurance Companies.
4. Lack of time, availability of data and unwillingness of the policyholders to answer the question etc., are normally faced by the researcher.
5. The findings of the present study are based on the opinion given by sample respondents.

Despite all the constraints and limitations, the recommendation and suggestion given at the end of the study would go a long way in improving health insurance service in Tamil Nadu as well as other states in the country.
2.12 Chapter Scheme

The present study is presented in seven chapters-

Chapter 1: Introduction

The first chapter provides an introduction to the subject matter and its importance. A detailed picture of insurance, general insurance and health insurance are also presented.

Chapter 2: Review of Literature and Methodology Adopted

The chapter contains a comprehensive review of various studies conducted connected to health insurance in India. The objectives of the study, hypothesis, scope, need, significance, the methodology adopted and also associated limitations are presented.

Chapter 3: Role of Health Insurance Market in India

This chapter deals with forms of health insurance, health insurance market in India and profitable portfolio, key players of health insurance, issues and challenges, benefits of health insurance, emerging trends and macro indicators of health insurance.

Chapter 4: Health Insurance Companies and Policies in India- An Overview

Various health insurance policies and its services related to both public sector and private sector health insurance companies are placed. It also highlights the benefit of policies provided by various health insurance companies.

Chapter 5: Insurance Regulatory and Development Authority and Grievance Redressal - Customer Service Function

The fifth chapter provides information relating to the Insurance Regulatory and Development Authority and grievance redressal mechanism in India.
Chapter 6: Data Analysis and Interpretation

Awareness of health insurance and its impact on the urban population are examined in this chapter. The analysis is carried out according to the collected data from the policyholders of various health insurance companies.

Chapter 7: Summary of Findings, Suggestions and Conclusion

The chapter intended to conclude the study with suggestions, and recommendations way forward.

2.13 Summary

The Chapter deals with the review of the literature. It provides information about various researches undertaken by the academicians and institutions in India, which are relevant to the present study. This chapter provides a scope of the study, need for the study, the significance of the study, statement of the problem, objectives of the study, the hypothesis tested, the methodology adopted, a pre-test for the study, limitations of the study and chapter scheme for a plan of the study. The succeeding chapter three explains a brief outline of health insurance market in India and its implications.