REVIEW OF LITERATURE
CHAPTER II

REVIEW OF LITERATURE

Health insurance in India is dependent upon various stakeholders like health care, pharmaceutical industry, regulators, and hospital industry etc. Hence review of literature was done covering various aspects of health insurance, hospital industry etc.

In a book on 'Risk and Insurance', Mark.R.Greene (1973)¹ points out the major problems in health insurance. He opines that of all the types of insurance, health insurance is more complex, more prone to controversy and criticism. He identifies four major problems in health insurance viz., rising cost of medicines and inflated medical bills, over utilisation - wherein the tendency of the insured to over utilise hospital and medical services, inadequacy - as health insurance cannot serve as perfect indemnity policy, health insurance coverage often prove to be inadequate for the insured to cover hospitalisation expenses, over insurance - people sometimes take insurance policies from more than one company in order to benefit from sickness.

SP Dixit, CS Modi, RV Joshi, (1973)² in their book on ‘Mathematical Basis of Life Assurance’ have stated that rates of premium for the various classes should be consistent with benefits offered. The authors points out that on theoretical ground it is advisable to use different rates of mortality for different classes of assurance depending on their experience. But this is not practicable, as the method would involve preparation of many mortality tables.

Robert et. Al (1975)³ in their book on ‘Health Insurance Plans Promise’ and performance provides a new concept on ‘doctor care index’ based on the United
States of America (US) health insurance sector. They opine that use of medical care is usually reported as doctor visits or hospital days. The authors criticise that such measure hide lot of variation in the amount of work done. Hence based on 'California relative value studies', it is suggested to convert the work done into "dummy dollars" by multiplying the units by the average conversion factors reported by the physicians. It can be inferred that the conversion factors are equivalent from one type of care to another and each is unique by nature and not additive by nature.

Robin E Mastrivic, (1978) in his book ‘Determining Health Needs’, opines that the planning of health programs and resources must begin with a determination of the extent of need for health services in the population to be served. The types of services needed fall into three categories, basic health maintenance services - the need for which is generated by normal physical development, acute health services - the need for which is generated by incidence of specific episodes of disease or trauma and chronic health services, the need for which is generated by the prevalence of chronic disease and disability.

Kenneth Lee and Anne Mills (1982) in their book on ‘Policy and Decision Making in the Health Sector’ have surveyed and analysed, individual and collective decision-making in the health sector by making use of the market analogy and have opined that there are many players in the sector and conflict of interests among them hurdles the growth.

Aviva Ron, et.al (1990) in their book on ‘Health Insurance in Developing Countries’, identifies that the health insurance organisation may take one of a number of forms like a separate administration under an existing government ministry, part of a national social security administration, a separate autonomous government or quasi-
government body, a non-government organisation (as for example, when the health insurance scheme is sponsored by a trade union) or a number of non-government organisations, affiliated with different voluntary bodies, and with or without an umbrella organisation to manage all or part of their functions. This helps the reader to understand the various possible forms.

Trevor Hancock, (1993) in an article on the healthy city from concept to application implications for research, states the healthy cities concept is both an old and a new one, old in as much as people have been striving to make cities healthier since the dawn of urban civilisation, new in its manifestation as a major vehicle for health promotion-the new public health – in the pursuit of achieving health for all.

Reider K.Lie in his paper (1993) titled ‘Moral basis for the World Bank’s investing in Health’ has stated that on inequities in health care systems and interest of world bank in investments towards health points out that public money is spent on interventions of low-cost effectiveness for wealthy people in urban areas, at the same time as cost-effective interventions are not available for the rural poor.

These days various insurers discuss Risk Based Capital (RBC) Methodology and this has relevance for health insurance industry also. ND Hooker, et.al (1995) in their paper on ‘Risk Based Capital in General Insurance’ have stated that the RBC formula comprises of asset risk, credit risk, underwriting loss and loss adjustment expense reserve risk, underwriting premium risk and off balance sheet risk. It should ideally contain the asset risk, premium risk, reserve risk, credit risk, growth risk, catastrophe risk, currency mismatch risk and expense risk. The authors also suggest that RBC should be tested across various extreme conditions.
Charu C. Garg (1998) in the study 'Equity of Health Sector Financing and Delivery in India' has tried to analyse on the financing and delivery of health care in India from viewpoint of equity and concludes that although there is progressivity in public sources of finance, but in terms of government expenditures there is a bias in terms of allocation against the poor, the rural areas, and urban organised sector.

Prof. H. Helen, et.al. (1998) in an attempt to analyse the status of primary health care in the country observe that though general inter-ministerial coordinating body for primary health care has been set up at the national level, unless such bodies have the authority to institute concerted, comprehensive inter-sectoral programmes in support of primary health care, their influence is likely to be quite limited and also observes that their experiences are unrecorded.

Harriett.E.Jones, Dani.L.Long, (1999) in their book on 'Principles of Insurance: Life, Health and Annuities', have defined the differences between life insurance and health insurance that where the amount payable for a life insurance claim is definitely defined by the policy, the amount payable for a health insurance claim is often much less definite. Inflation, changes in the economy and changes in medical practice affect the amount of benefits paid for health insurance claims much more dramatically than such factors affect life insurance claims.

Renbao Chen, Kie Ann Wong, Hong Chew Lee (March 1999) in a note on 'Underwriting Cycles in Asia' based on their analysis paper with respect to select countries viz. Japan, Malaysia, Singapore, South Korea, and Taiwan opine that this study examines the presence and causes of the underwriting cycles in Asia. They observe that underwriting cycle is created by external factors and market characteristics that are outside the control of insurers. These factors include data
collection, regulatory policy renewal and accounting lags, interest rates, stock markets, and the general business cycle.

Randall P Ellis, Moneer Alam, Indrani Gupta (January 2000) in their analysis on the health insurance sector in India, based on reference from many studies have pointed out that the total health spending indicates that in a break-up of this 6%, as much as 4.7% of the expenditure is accounted for by the private sector. Moreover, of the 4.7% around 4.5% comprise out-of-pocket expenditures of the households. Remaining 0.2% includes contributions from the private employers and other non-government organisations.

Vijay Srinivas, (July-2000) in his article on ‘How Returns Linked Insurance Products can be Popularised’ states the reason for emergence of investment linked products, according to that he states that under normal general insurance policies, only one premium i.e. risk premium is collected. But keeping in view the Indian psyche, he suggests that return based insurance would be immensely popular.

Anil Gumber and Veena Kulkarni (September 2000) in their pilot study on ‘Health insurance for Informal Sector’, point out that a survey on 1200 households in Ahmedabad district in Gujarat shows that poor prefer public sector management of health care facilities and 30 percent are uninsured. Over 92 per cent of the non-insured households in both rural and urban areas have no awareness about the existing health insurance schemes, but when they were informed about the various plans, almost all of them showed interest in joining it.

Mahesh Bhatt and Dileep Mavalankar (November 2000) in their paper on ‘Health Insurance in India - Opportunities, Challenges and Concerns’ have analysed the opportunities for health insurance in India and found that, India has limited
experience of health insurance given that government has liberalised the insurance industry, health insurance is going to develop rapidly in future. They point out that 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 leaving out the poor and making them more vulnerable.

Hanson and Berman (2000)\(^{18}\) made an early attempt to analyse preliminary on the healthcare provisioning across the countries in Middle East, Africa, Latin American countries and Asia to identify the determinants of the size of the private provision sector. Their findings are that while there are existing models of total health expenditure, and, by tautology, the aggregate supply of health services, these models do not explain the differential growth of public and private providers, and thus the structure of the provision sector.

J.Francois Outreville (January, 2001)\(^{19}\) in his paper, ‘The Ageing Population and the Future of Healthcare Plans’ has examined the relationship between health care expenditure and age using individual expenditure records rather than cross-sectional data and conclude that as people are living longer, the hope is that they will also live healthier.

Indrani Gupta and Purnima Das Gupta, (February 2001)\(^{20}\) made a pioneering attempt of an exploratory study to understand the health seeking behaviour in urban Delhi, they concluded that Delhi seems to be segregated along economic status, with the health seeking behaviour of low-income households being quite different from that of middle and high-income households. A greater percentage of high and middle-income households use government facilities, and a greater percentage of lower income households use private facilities.
Soumya Vishwanathan states in her article on ‘Banking Industry finds new Market for Medical Professionals’ (March 2001) \(^{21}\), that management consultants have found that providing loans to medical professionals are considered as safe advances in current days.

It seems that there are certain schemes floated by corporate hospital groups, Nadhamuni Sridhar, (March 2001) \(^{22}\) in his article on ‘Health Insurance Scheme by Apollo Group’ states that Apollo Group has launched a package christened ‘Aashirwad’ (or Blessings) for the elderly-aged 45 to 75 years. The scheme involves a Rs 10,000 per annum payment and has an in-built Mediclaim health insurance worth Rs 3 lakhs just in case the elders need hospitalisation.

Nair KS (April to June 2001) \(^{23}\) in his paper Cost of health care, a study of unorganised labour in Delhi has found that the demand for health care on introduction of health insurance or risk sharing scheme mainly depends on quality of care provided under the scheme. The question of willingness and ability to pay for the health care services also depends on effectiveness of the curatives services provided under the health insurance schemes.

Herbert Meister (August 2001) \(^{24}\), in his article on Legal Rule of Health Actuaries in Germany states that the quoted premium has to arithmetically grant permanent fulfilment of the insurance policy which means that India has long way to go forward in this direction.

In an article on Police Sanjeevani Nidhi Yojana for police personnel in Maharashtra, Usha Holla (October 2001) \(^{25}\) has presented that the scheme today covers 90,000 personnel out of the total strength of 1,44,000. The scheme, which is
voluntary, covers 'hospitalisation' expenses of a number of ailments including cardiac operations, dialysis, kidney stone removal, cancer surgery, brain tumor etc. Till last year the coverage was only for the employee and his spouse.

Peter C Smith and Sophie N Witter (November 2001) 26 in their paper on 'Risk Pooling in Health Care' finance suggests three redistributive functions, from the rich to the poor, from the healthy to the sick and from the productive to the unproductive stage of life cycle

Eric and Francis (2001) 27 in their book on 'Insurance from Underwriting to Derivatives' suggest a stochastic simulation approach to analyse various scenarios. Factors suggested by the author for such simulation are capital market assumptions, liability modeling, investment simulations, cash flow simulations, and fair valuation and risk assessment. This has relevance to health insurance, which is very seldom practiced among health insurers.

Rob Kass, et.al (2001) 28 in their book on 'Modern Actuarial Risk Theory' have stated that there is a psychological reason why experience rating is broadly accepted with car insurance and not for instance with health insurance. Bonuses are seen as rewards for careful driving, premium increases as an additional and well-deserved fine for the accident-prone. Many think that traffic offences cannot be punished harshly and often enough. But someone who is ill is generally not to blame, and does not deserve to suffer in his pocket as well.

Ajay Mahal (February 2002) 29 in his attempt to assess the 'Private Health Insurance in India and Potential Impact on Regulatory Issues' has stated that the entry of private health insurance companies in India is likely to have an impact on the costs of healthcare, equity in the financing of care and the quality and cost-effectiveness of
such care. The author points out some practical difficulties of IRDA in implementing health related standards as many of the laws and their implementation are in the hands of individual states as a constitutional requirement.

Ramgopal Agarwala and Zafar Dad Khan (March 2002) \(^{30}\) in their attempt of classification of labour market in India and insurance state the presence of three segments of the labour market. At the top are the elite white-collar workers consisting of the senior public sector officials and the managerial class in the private sector, for about 1 percent roughly 3 million workers. At the other end are the unorganised sector including the self-employed, informal sector workers, and casual labourers accounting for 92 percent of the labour forces about 300 million workers. In the middle are the regular wage employees in the public sector and in the organised private sector, who account for about 7 percent of the labour forces about 22 million people.

Soumya Vishwanathan (April 2002) \(^{31}\) in an article on pricing methodology of hospitals has stated that prices are revised on a percentage basis every year, without doing actual profit and loss analysis on each item or procedure.

Prof (Dr) Gopinath N Shenoy (April 2002) \(^{32}\) in his article on Doctor’s fees has pointed out that The National Commission has observed that the charges made by health care service providers need not have any rationale.

EHM News Bureau (May 2002) \(^{33}\) in its observation on rise in consultation fee based on ORG-MARG survey has stated that the average doctor consultation fee across six metropolitan cities of Delhi, Kolkata, Mumbai, Chennai, Bangalore and Vadodara has gone up by 16-21 per cent. The survey also reveals that there is no uniformity in such increases among cities and doctors’.
Soumya Viswanathan (May 2002) in her analysis on the Insurer-Hospital model of health insurance states that many corporate hospitals like Apollo, KMCH are trying out new plans but it is feared in this article that hospitals coming up with insurance plans may leave enough room for the hospital to manipulate coverage and increase claims.

Soumya Viswanathan, (August 2002) in her article on ISO standards in hospitals observes that when a hospital gets ISO certified, the processes are supposedly under control, which yields 15-20 per cent benefit.

Abhijeet Nagrendranath and Pallavi Chari (September 2002) in their paper on Health Insurance in India, emerging paradigms, have stated that there is great potential for health insurance in India but public and private sector companies should work together to ensure healthy growth and development of the sector.

Devendra B Gupta and Anil Gumber (November 2002) in their paper on external assistance to health sector and its contributions, problems and paradigms, have stated that in the past thirty years India has received considerable external assistance for the health sector, including for family welfare. But various pitfalls have been observed like time lags in the sanction, start-up, and disbursement of donor funds, the implementation is reported to be tardy. This has resulted in both time and cost overruns.

In a study on Health Insurance in India, McKinsey (December 2002) stated that universal health care in India is a fond dream but a study report by the CII-McKinsey combine says it is possible by the year 2020. The study has recommended that the Government should stimulate the growth of private, social and community insurance to improve health care affordability in the country.
Anil Gumber (2002) in his paper titled health insurance for the informal sector, problems has stated that it is a well-recognised fact that the contribution of the informal sector to the Indian economy is enormous. He suggests that the Panchayat Raj Institutions (PRI) can play pivotal role in administering, co-coordinating and managing new health insurance schemes and especially community based health insurance schemes.

Ajay Mahal (2002), in his paper on Health Policy challenges for India, private health insurance and lessons from the international experience has tried to draw lessons for Indian health insurance by comparing with the existing system of various countries like UK, USA, Netherlands, Germany, Chile, Singapore and concludes that three important lessons needs to be learnt by India which has poor quality of health care, potentially high costs of care and increased burden of health spending on the poor. The first set of messages has to do with patient satisfaction and quality of care, secondly the choice of providers and third is reconciliation of consumer choice with equity. Private provision and private health insurance are one extreme, with high levels of consumer choice but low levels of equity.

Preker, A. S., Dror, D. M (2002) in their book on ‘Social Reinsurance’ stresses Reinsurance as a tool for enlarging the risk pool and spreading risks across larger population groups, which no single micro-insurance scheme can do on its own.

Pierre et.al (2002) in their book on Actuarial practice in social security (quantitative methods in social protection series) states that, there is increasing pressure in some countries to cover the services of health professionals involved in alternative medicine or para medical practices, such as chiropractors, acupuncturists, homeopaths, naturopaths and so on. The authors support such views and state that
there is still little empirical evidence to support the actuarial work in such circumstances.

John.A.Nyman (January 2003) in his revolutionising concept presents a health insurance theory, the case of vanishing welfare games, that an important source of value is missing from conventional theory of the demand for health insurance, namely the effect of the transfer of income (from those who purchase insurance and remain healthy to those who purchase insurance and become ill) on purchases of medical care. Because the portion of moral hazard that is attributable to income is welfare increasing and would replace some of moral hazard that is spuriously deemed to be welfare decreasing, the new theory suggests that the value of health insurance has been dramatically undervalued. This theory suggests that once a consumer becomes ill, it makes little sense to impose co-payments to limit consumption. This theory also suggests the current ‘managed care backlash’ is due to managed care’s denying coverage for procedures that the consumer would gladly be willing to pay for with the income transfer from insurance.

IRDA (March 2003) quoting the industry sources on the scope of revenue of TPAs reports that TPAs render services like issuing identity cards, running 24 hour call center services for emergency, cashless hospitalisation and claims processing to health policyholders on behalf of insurance companies. Since all these at the current rates of service charges of between 5.40 per cent and 5.50 per cent of the health policy premiums, and with an estimated Rs. 760 crores of health insurance premium incomes of insurance companies, the TPA industry could earn about Rs.42 crores if all health policyholders opt for their services on their policies.
Arpan N Thanawala, an eminent actuary in India, in his article a Long way to go, has stated (April 2003) that not many actuaries in India are trained in the area of general insurance, the regulator should make it mandatory for the appointed actuary to spend stipulated time in various departments of general insurance, till he acquires adequate expertise in order to appreciate the intricacies between various lines of business.

In a paper titled under ‘Health Insurance and TPAs, Issues and Challenges’, Ramesh Bhatt and Sumesh K Babu (April 2003) state that though IRDA has defined the role of TPAs to manage claims and reimbursements. Their role in controlling costs of health care and ensuring appropriate quality of care remains less defined.

Sheenu Jawahar (April 2003) in her article on ‘Moral Hazard in Health Insurance in India’ based on the sample analysis of claims points out that a study analysing 621 claims and reimbursements pertaining to policy initiation years 1997-1998, and 1998-1999 of the Ahmedabad branch of General Insurance Corporation (GIC) by Prof Ramesh Bhat et al points out that hospitals inflate the hospital charges for patients with insurance coverages.

GP Surekha in her analysis (May 2003) on the increase of Mediclaim premium rates has pointed out that insurance companies used to spend about 18 to 30 per cent of the premium as overhead expenses for providing service to the policyholders in the health sector, premiums on the mediclaim policy have gone up by about 30 per cent since January this year with 6 percent loading towards TPA service charges. The author questions that loading of service charges is a reward for their inefficiency and even then the customer should have option to choose the TPA based on their service standards.
Dr. Sudha Seth (June 2003)\textsuperscript{49} in her article on the rationale behind ordering investigations by Doctors' states that sometimes, certain investigations are ordered because of the apprehension of being sued in a consumer court. Doctors with good clinical acumen and willingness to spend enough time for physical examination some time have to strike a balance between ordering expensive investigations with limited benefit in assisting him in clinching the diagnosis, especially when patients are poor and without a company paying or having a health insurance to pay for the investigations.

EHM News Bureau (June 2003)\textsuperscript{50} in an article on 'Poor response by hospitals force GIPSA to extend deadline for enrollment' cites some practical difficulties in TPA administration a patient suffering from renal colic is denied authorisation by TPAs before clinical diagnosis establishing the illness that is covered is undertaken. At the same time, Doctors' point out that sonography, for instance, is not covered in the first two years and very few patients know about this.

IRDA (July 2003)\textsuperscript{51} has notified that it is planning initiatives to rectify the near total lack of data and real time information in two critical areas of insurance and, in fact, in the Indian society, namely health and road accidents. The need for a health insurance data warehouse stems from the fact that no reliable data or information is available in India on this subject. Whether individual health history or morbidity patterns across the populace, very little information is collected, analysed and made public. The plan is to pool data related to incidence of diseases geographically and in terms of socio-economic classes. Also required is a mapping of diagnostic, treatment and drug regimens and their availability and pricing across the country. Using this information, the patterns of morbidity and mortality can be traced, and the market, in
terms of insurance pricing and medical facilities, will then adjust itself to the needs as revealed by the analysed data.

EHM News Bureau, based on the survey done in Mumbai reports (August 2003) that non-availability of a public hospital is forcing about 44 per cent of the households to seek inpatient care services from the private sector, even if they were interested in seeking care from the public sector. Even the outpatient care services that are currently available in the area seemed to be inadequate, as 67 per cent of the households' needs for outpatient care are unmet.

GP Surekha (August 2003) in her article titled Unhealthy competition has observed unhealthy practices in health insurance sector in India with respect to Group health insurance. The author has observed that one of the private insurance companies quoted to a company at one third lower premium for the floater health cover for their 1,000 plus employees against the quote of a public sector insurance company without actuarial calculation and also with increase of benefits, without finding the past claims ratio. If the company referred to the above accepted low premium and has gone for the policy with the private insurer the result after three months, might be refunding of balance premium as per rules leaving period insured at crossroads where no other underwriter could have insured them. This infers the unethical practices prevailing in the industry.

Dr. Noel Coutinho points in his paper titled, National Health Data – Riding on IT Pathway, (September 2003) that IT related to health has primarily supported applications of high performance computing and telemedicine to the delivery of medical care to individuals. Relatively little attention has been paid, by either the private or the public sector, to applications that could improve the capacity of
communities to carry out the non-clinical or population-based functions of health (i.e., services that identify local health problems, prevent epidemics and the spread of disease, protect against environmental hazards, and assure the quality and accessibility of health services).

Bunty Pasricha (September 2003) in his paper about Avoiding being tripped by TRIPS has suggested that the drug companies can take some lessons from the music industry and find out how they convinced Michael Jackson to release his music on the same day in India at one-fourth the price of west because he must have accepted one-fourth the royalty.

Ravi Duggal (October 2003) in his paper on Operationalising rights to health care in India has stated that more than half a century’s experience of waiting for the policy route to assure respect, protection and fulfillment for healthcare is now behind us. He suggests that establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law specifically ICESCR, the Alma Ata Declaration among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific. Specific features of this historical baggage are, a very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximising their interests, a complete absence of professional ethics and absolute disinterest in organising around issues of self-regulation improvement of quality and accountability, and need for an organised health care system. A declining public health care system which provides selective care through a multiplicity of schemes and programs and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare.
Jayashree Padmini (November 2003) in her article titled ‘Unclear Government Regulations Mar Health Informatics’ while pointing out the unhealthy regulations with respect to health informatics states that despite phenomenal growth in health care delivery systems in the government and private sector; health informatics segment in the country has remained non-dynamic and stagnant. The author points out that the non-starter health insurance is the result of such a weak informatics base.

Dr. Arun Bal (November 2003) in his article on medical profession and pharmaceutical companies has made a note on generic drugs that The Hathi Committee in 1974 had suggested promotion of generic drugs, which would have curtailed the unhealthy marketing practices. Though the government accepted the report and decided to have only generic names for few drugs, the decision could not be effectively implemented, probably due to the lobbying by the pharmaceutical sector.

L. P. Mehta (December 2003) in his article on ‘Time for Reforms’, points out that health insurance with a base of over Rs. 1,000 crores is virtually non-existent today. Only 2.5 per cent of the population is covered by health insurance policies and the premium rates have remained high and customer service and healthcare infrastructure continues to be extremely poor.

Aloke Gupta while analysing the status of health insurance industry in India (December 2003) states that health insurance premium written in 2002-03 was Rs. 1,144 crores as against Rs. 519 crores in 2000-01 representing a growth of over 120 per cent in the three years of a liberalised insurance regime. He points out that premium generated from Overseas Medical Policies (OMP) is also included in the
more generic term of gross health insurance premium that projects an erroneous picture since by no stretch of imagination can this policy be seen to be increasing health insurance penetration in the country.

Referring the history of emergence of TPAs in India and revision of health insurance premium rates in the pre-liberalisation era, Nimish R. Parekh (December 2003)\(^6\) states that in 1996, the first TPA organisation was launched, offering services such as cashless hospitalisation, 24-hour call centre support, enrolment and claims administration. The model was successful and within a short span of three years, over 75 major employers had availed of these services. The average claim value per inpatient claim in metros and semi-metros has risen from Rs. 8,500 in 1995 to over Rs. 30,000 in 2002. But mediclaim premium has been revised only in 1996 and then in 2002. The result of this inherent under pricing is that health insurance portfolios will demonstrate inferior performance in a year just prior to an increase in premium. The impact is further amplified when taking the pure risk premium (which today is just 58 per cent of total premium, the rest being marketing and administrative overheads) into account. Even when a gross premium increase of 30 per cent is factored in between year 2000 and 2001, the loss ratio continues to increase alarmingly.

Craig.F.Churchill, et.al (2003)\(^6\) in their book on ‘Making Insurance work for Micro Finance Institutions’ (MFI), have proposed a due diligence checklist for micro insurance institutions to identify insurance parameters. The checklist suggests to verify the reputation of the insurance provider, the finance position of the insurer, the claims experience of the insurer and history of claims payouts, the interest of insurer in serving the low-income market, the adjustment of the insurer’s products to suit the preferences of the poor, willingness to make a medium or long-term commitment to the MFI, willingness of the insurer to pay the commission to MFI for performing the
agent role, issues related to regulatory compliance by the insurer, insurer’s willingness to give responsibility to MFI for verifying claims, insurer’s capability of minimising the number of exclusions without jeopardising the sustainability of the plan.

April Harding and Alexander S Preker (2003), in their book on ‘Private Participation in Health Services’, state that developing countries must include enhanced interaction with private providers. Although recognition of this fact is widespread, most attempts to operationalise such interactions are random. These efforts are often undermined by the lack of information about the private sector, and hence are undertaken in a relative vacuum.

Marcus Radetzki, et.al, (2003) in their book ‘Genes and Insurance’, mention that freedom of access for insurance companies to genetic information for the purpose of premium differentiation or determining the extent of insurance cover, infringes the insurance clients’ autonomy and privacy, and more importantly threatens to leave the groups representing high genetic risks entirely or partially without private insurance cover. Many rich market economics have chosen to avoid this problem by constraining the insurance industry’s access to genetic information.

Peters H David and Yazbeck S. Abdo (2003) have attempted to collate various health research in South Asia. In their paper on ‘A Framework for health Policy Research in South Asia’ points out that only a limited number of local agencies are capable of doing such work, and partly because of the time constraints imposed on the research project by both policymakers and funding agencies. However, they foresee that in the long term, as more institutions become capable of undertaking research and as the type of research methods change to more experimental and longitudinal
approaches, they foresee greater tension between the desirability of competitive means for soliciting research and the need to encourage greater collaboration among researchers. This infers that health related researches have more scope in future but it requires more funding.

Based on House hold survey done by National Sample Survey (NSS) in 1995-96 on 121,000 households wherein 71,300 in rural areas and 49,700 in urban areas on Health Care subsidies, Ajay Mahal (2003) in his paper ‘The Distribution of Public Health Subsidies in India’ point out that the health care subsidies are not well targeted to the poor, especially rural poor people and poor living in poorly states.

In India, it is well known fact that Government is not having enough infrastructures for meeting the health care needs of the whole population. In this context, VR Muraleedharan, and Sunil Nandraj (2003) in their paper titled ‘Private Health Care in India – Policy Challenges and Options for Partnership’ points out that government has limited capacity to regulate private health providers and to monitor contracts. Hence they suggest more intervention by the government for collaborative opportunities. The authors suggest the following areas for such collaboration viz. cooperating disease surveillance reporting, contracting for environmental activities in cities, contracting for non clinical services in large hospitals, collaborating on disseminating public health information, sharing resources for managing drug supplies, establishing patient referral mechanisms etc. They also points out that rise in cost of health care in government hospitals is comparatively lesser than private sector.

Though private health care delivery in India is widely acknowledged, little empirical evidence exists on how it functions. Chakraborty.S (2003) has made an attempt to study about the same with special reference to Uttar Pradesh State in India.
In his paper on 'Private Health Provision in Uttar Pradesh, India, an attempt has been made by him to understand the functioning of private health sector in Uttar Pradesh with reference to three districts in the state. It has been observed that less than 5 percent of the private hospitals are funded by government and many are financed by financial institutions. Some of the highlights of the findings are the rate of bed occupancy in private sector is only 40 percent, many private hospitals participate only in polio campaigns and family planning programs and do not participate in any other national health programs, there are many infrastructural problems like electricity and telecommunication break downs, poor drainage and inadequate waste disposal and water supplies. It can be inferred from the above that there are more areas for government to enhance its active role for better collaborative opportunities with private sector.

In India, though Consumer Protection Act of 1986 is said to play a vital role in consumer redressal, Bejon, Misra (2003) did a survey of 81 hospitals and interviewed participants of 86 cases brought before consumer courts in Delhi, Lucknow and Hyderabad to find out the effectiveness of the mechanism. The author finds that still the mechanism has lot of room to improve, as dissatisfaction exists among both claimants and defendants because of prolonged litigation involved. It is observed that 90 percent of cases went beyond the stipulated period of 90 days, with most lasting between one and five years. The author has recommended various suggestions to improve the same like increasing communication process between the stakeholders and improving the awareness of consumer redressal mechanisms.

Mahapatra, Prasanta (2003) made an attempt to analyse the quality of care in public and private sector in his paper on ‘Quality Health Care in Private and Public Health Care Institutions’. In this paper, he points out that India has yet to develop any
national program for development practice guidelines, medical review criteria, and so on. Research capacity for measurement of medical outcomes and risk rating of patients is also lacking. His findings based on the survey conducted in Health Sector in the state of Andhra Pradesh concludes that public sector betters private sector with respect to land and floor space, maintenance of medical protocols and therapeutic guidelines. Private sector bettered in terms of access, availability, convenience, communication, and general comfort. But on a whole, he concludes that the level of patient satisfaction is generally low in both private and public sector.

Joy Roy Choudhury and Rita Dutta in their article on rating standards for hospitals informs that (January 2004) leading private hospitals across the country are planning to set up a national-level body on the lines of National Association of Software and Service Companies (NASSCOM), the apex body of software companies in the country.

Ravi Duggal (February 2004) made analysis of 2004-2005 budget with respect to Pharma and medical devises and states that Pharma industry is no longer responsive to the local consumer in terms of adjusting prices lower with the effective duty cuts that have been given to them, he also observes that universal health insurance scheme in the 2003 budget has not really taken off except where NGOs have taken it up as a part of their health programmes.

Satyapal Menon (February 2004) in his article on Health Standards maintenance initiative in India in the lines of HIPAA in USA informs that The Union Government has tied up with the Apollo Hospital Group subsidiary Apollo Health Street Limited to standardise the capture, storage and dissemination of health information as well as to network all healthcare facilities in the country in an
ambitious project called 'Health Unite' inspired by a US legislation. The broad goal of 'Health Unite' is to deliver information to individuals, providers and planners, so that they could use this to make informed healthcare decisions. It also offers a way to connect distributed health data in the framework of a secure network.

Based on a survey, Sapna Dogra (March 2004) in her investigative article on Delhi houses 1600 unregistered nursing homes reveals that when India is promoted as a hub for medical tourism. She also points out that a recent survey carried out by a private company at the behest of the government, found that many unregistered small hospitals and nursing homes were operating in the garb of medical centers and polyclinics.

Dr Gopinath N Shenoy (March 2004) in his article on advertising norms of health care institutions points out that Medical Council of India, which prohibits not only registered medical practitioners but also healthcare institutions from advertising. Interestingly, the laws governing such institutions do not forbid them from advertising i.e. the Company Law does not consider advertisement as unethical but on the contrary permits the companies to spend huge amounts on advertisements.

SASHD, SASFP (May 2004) in an article on “India-Private Health services for Poor a policy note”, have stated that although India has made great strides since independence, fertility, mortality and morbidity remain unacceptably high both compared to countries in the region and those at similar income levels. Almost a third of the Indian population lives in poverty. The impact of poverty on health care and vice-versa is significant. A significant number of private health care providers in India (especially in the rural areas) are untrained practitioners. Although reliable data on their numbers are difficult to compile, it has been estimated that they number well
over 1.25 million. The vast majority of these providers are not registered, qualified or regulated. This portrays our poor infrastructure.

Saji Salam (May 2004) in his article titled Healthcare informatics in the next five years explains Health Level Seven (HL7) standards on health informatics pointing that is one of several ANSI-accredited Standards Developing Organisations (SDOs) operating in the healthcare arena. The HL7 Organisation was founded at the University of Pennsylvania in 1987 to design a consensus-based standard for the electronic exchange of healthcare related information. Most SDOs produce standards (sometimes called specifications or protocols) for a particular healthcare domain such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. Health Level Seven’s domain is clinical and administrative data. Several years of effort has gone into the making of standards. The advantage for India is that by leveraging these standards, the industry could leap to a higher level.

IRDA in their concept paper on Micro insurance (August 2004) have stated that micro insurance is the most underdeveloped part of micro finance. Yet various schemes exist that are viable, benefiting both the institutions and their clients. Such schemes have generally served two major purposes, they have contributed to loan security; and they have served as instruments of resource mobilisation. The functions that need to be focused must include providing guidance to members, collecting premium installments from members, insurance services to members, communication and exchange of experience, providing linkages with banks, Non-Government Organisations (NGOs) or donors, supporting the proposals of individual members to insurance companies through recommendations.
Rajiv Ahuja (October 2004) 79 in his article on Micro Insurance concepts, NGOs’ and health insurance for poor in India points out that a recent study of micro-insurance schemes in India by the International Labour Organisation (ILO) documents 51 operational micro-insurance schemes in India. Of these, 25 came up during the past four years alone. Most are linked with micro-finance services provided by specialised institutions (16 schemes) or non-specialised organisations (15 schemes). Healthcare providers implement only 12 per cent of the schemes. Of all micro-insurance schemes, 57 per cent provide for health insurance (it may be noted that many MFIs and NGOs are in the process of introducing health insurance). The author also points out that although health insurance only provides for the cost of hospitalisation, the poor also have to incur many indirect costs, such as wage loss, transportation costs, and opportunity cost of time of those who accompany the sick and special meal costs. These costs can be prohibitively high, discouraging a sick person from visiting a hospital and seeking treatment even when he or she has health insurance. For this reason, some health insurance schemes (for example, the two UNDP sponsored pilots in Karnataka) have also provided wage loss benefit that is used creatively by a nodal agency. For example, any unpaid instalment of premium is deducted from the wage loss amount that a sick person is entitled to. In some cases, it is also used to pay the renewal premium for the following year. The flip side of providing wage loss benefit is that it can induce hospitalisation when it is not required.

Nareen.N.Joshi (October 2004) 80 in his paper titled Rural Insurance Scenario has attempted to find the rural insurance scenario and has stated that there are a total of 124 million rural households. Nearly 20% of all farmers in rural India own a Kissan Credit Cards. He points out that the 23 million credit cards issued till date
offer a huge data base and opportunity for insurance. The agent plays a major role in creating awareness, motivating purchase and rendering other insurance services.

P.C. James in his article titled ‘Covering the Poorest’ (October 2004) has referred lots of surveys conducted by World Bank and National Sample Survey Organisation (NSSO). According to a NSSO study, the poor spend a much higher percentage of their income on healthcare vis-à-vis the rich, more than three quarters of the spending is on minor ailments.

Majumdhar (October 2004) in his article on regulations for health insurance criticises the lack of definition of responsibility on actuaries for health insurance. He states that it would appear that in Germany it is compulsory to have a Responsible Actuary overseeing an insurer’s health insurance business and it is perhaps the right time now for the authority to consider placing similar responsibility on the shoulders of the Appointed Actuary (AA) of the insurer.

Michael P. Keane, (November 2004) in his paper on modelling health insurance states that new econometric advances have not yet been widely used in the health economics literature. This suggests that more inter-disciplinary studies and research are required.

Express Pharma Pulse Journal in an article on Yashaswini Scheme, (December 2004) has published that Corporate India has joined hands for a worthy cause again this time, Bangalore-based biotech company Biocon Ltd has joined hands with ICICI Lombard General Insurance Company Ltd and the Bangalore’s Narayan Hrudayalaya to launch a first of its kind medical insurance scheme for the rural poor. The initiative, christened ‘Arogya Raksha Yojana’ has been introduced in Anekal Taluk
near Bangalore, which has a population of six lakh people. A scheme 'Yashawini', which offers similar healthcare insurance for farmers for a daily premium of five rupees.

David E. Bell and Arthur Schleifer Jr. (2004) in their book on Risk Management have studied the Claim Patterns and Actuarial rate setting, and points out that the industry suffers from the difficulty of establishing its prices before it knows its costs. With each policy the company undertakes three risks, viz, the likelihood of a claim against policy, the size of the claim, the timing of the claim. The whole idea of an insurance company is that claims will average out over a large number of policyholders. This is true as long as actuarial data continues to predict future claim patterns. Anything that systematically distorts the frequency or size of claims is a threat to the profitability of an insurance line.

Alan C Monheit and Joel C Cantor (2004) have in their book titled State Health Insurance Market reform, opined that while researchers strive to identify causality and obtain a set of plausible and unbiased estimates, policy makers and non-specialists are generally unfamiliar with the estimation methodologies and primarily concerned with whether the research yields a reliable set of empirical estimates that can inform public policy.

In a search about the potential for small employer groups, Thomas C. Buchmuller (2004), in his article, What can we learn from the research on small-group insurance reform, in the book titled State Health Insurance Market reform, states that in early 1990s nearly every state in the United States enacted new regulations governing the sale of insurance to small-employer groups. The author based on US experience points out that universal or near-universal coverage can be achieved only with a combination of public subsidies and some kind of requirement
that people obtain health insurance. It is not reasonable to expect supply-side policies, like that state-level small group reforms, to have had a major effect on coverage.

Suri Seeta Ram (January 2005) \(^{88}\) in his article Life as a Life Insurance Agent, refers to a survey done in 2001 regarding the awareness and points out that, it was found that 58 per cent of the urban educated did not know about health insurance. As much as 25 per cent of the people who suffered illnesses covered by health insurance did not bother to make a claim, with reasons ranging from “Anyway the insurance company may delay or avoid the payment” to “Who bothers to go over the rigmaroles of making a claim?”

Anil K Maini (January 2005) \(^{89}\) in his article on Medical Tourism states that the Indian healthcare market is Rs 15 billion and growing at over 30 per cent every year. Indian private hospitals are increasingly finding a mention in the travel itineraries of foreigners, with the trend of medical tourism catching up in the country. If industry estimates are to be believed, the size of the medical tourism industry stands at Rs 1,200 - Rs 1,500 crore (Rs 12-15 billion). A recent CII-McKinsey study on healthcare says medical tourism alone can contribute Rs 5,000- Rs 10,000 crore (Rs 50-100 billion) additional revenue for upmarket tertiary hospitals by 2012, and will account for 3-5 per cent of the total healthcare delivery market.

IRDA (February 2005) \(^{90}\) in a circular has stated that it has prescribed a mortality table LIC (1994-96) Ultimate Table to be used as base table for pricing the Life Assurance Products and LIC (1996-98) Annuities’ Table for pricing the annuity or pension business and for calculating the liabilities under these products. But there was no benchmark table prescribed for pricing or valuing the liabilities of the Health
products as regards the critical illnesses under Regulation 5 sub regulation 3 of IRDA (Assets, Liabilities and Solvency margin of Insurers) Regulations 2000. With no prescribed benchmark morbidity table, the life insurers are using the critical illness rates provided by their Reinsurers based on experience of another country/region with adjustments as may be necessary. In this process consistency was lacking with attendant issues like rationale for adjustments made and linkage to underwriting standards not being clear. IRDA referred the issue to the professional body- Actuarial Society of India (ASI) to examine and recommend reference table which can serve as a Standard reference table until Indian lives morbidity table based on experience of Insurers becomes a possibility. ASI after the process of examination by a committee of actuaries has suggested CIBT 93 to be used as the Standard reference Critical Illness rates table to be used under sub regulation 3 of regulation 5 of IRDA (Assets, Liabilities and Solvency margin of Insurers) Regulations 2000 for pricing and valuing the liabilities of Critical Illness Standalone products or Critical Illness Riders-Accelerated or Lump Sum.

A Health Insurance Working Group (February 2005) that had been constituted by IRDA a few months ago has representatives from Ministry of Health, Finance, ESIS, CGHS, Corporate Hospitals, Insurers, TPAs, Actuaries, and NGOs to popularise health insurance and to address the roadblocks hindering its growth. The working group consists of three committees. One of the committees is working towards developing a database for health insurance. The second committee will work towards making the environment conducive for entry of stand-alone health insurance companies while the third committee will address issues related to pre-existing disease and innovate health insurance policies. One of the main constraints lie in terms of access to quality data on mortality and morbidity trends on the basis of which
insurers can price health insurance products and innovate by offering tailor made solutions. One of the steps taken is to rationalise the interpretation of the term ‘pre-existing’ disease so that genuine claims are not repudiated thereby causing undue pecuniary hardship to the policyholders. Another aspect being considered concomitantly is to devise a mechanism to enable portability of insurance so that policyholders have the freedom to switch their policies from one insurer to another. Other issues, which the group will look into, include designing innovative health insurance products and feasibility of having standalone health insurers.

Falaknaaz Syed (April 2005) in his article Innovative Managed Care model to be launched on a pilot scale foresees that by the year 2025, the importance of HMO approach with emphasis on prevention for the entire Indian community will get appreciated. He also points out that a survey of 100,000 middle class families in Mumbai revealed that on an average each family spends Rs. 10,000 per year for medical expenses.

Jessica Feldman (2005) in her article A roaring rural market, kick starting health insurance for the rural poor narrates her experience she had on behalf of an NGO called Swayam Shikshan Prayog (SSP). Most of the people surveyed were farmers or labourers and family incomes were mostly in the range of Rs. 15,000-20,000 a year. The most frequent treatments were for gastroenterological conditions arising from poor sanitation and waterborne diseases, malaria and complications resulting from pregnancy. Families often sought treatment at public health centers or used home grown methods to alleviate the symptoms. The average expenditure for a hospital visit was Rs. 2,000, but the cost of caring for a serious injury or illness often went above Rs. 5,000. The most significant fact was that a data repository tracking the ailments and treatment of such ailments faced by the rural segment did not already
exist. But the researcher was able to collect data and designed schemes in consultation with Insurers based on the data collected.

TK Sundari Ravindran (2005) in a paper on “Health sector reform and public-private partnerships for health in Asia: Implications for sexual and reproductive health services cautions that such partnerships may have the insidious effect of shifting priority setting more in line with the interests of the private partner, with efficiency and cost-effectiveness dominating all else. This is because the private sector has less to lose from not entering into a partnership, or walking out of it.

Aloke Gupta (2005) in his article titled Initiatives to develop health sector has stated that from 0.104 percent in 1992-93, health insurance penetration (percentage of total population covered under private health insurance) in India has grown to 0.948 percent in 2002-03. It is projected to reach the level of 1.65 percent in 2005-06. During the corresponding period, health insurance premium have grown from Rs. 48.91 crores in 1992-93 Rs. 104.5 crore in 2002-03 and projected to touch Rs. 1800 crore in 2005-06. The penetration levels do not convey a very encouraging picture. Health insurance has been single product (Mediclaim) driven and loss making to insurers and hence not aggressively marketed. It has mainly been bought in metros and large cities with tax incentive being one of the important motivator. The present health insurance market differs from high utilisations by health providers and policyholders. There is no incentive for the policyholder to demand efficiency and cost from the health provider.

Kenneth A Cahill, Susan Matthies (2005) in their paper in Health insurance: global lessons and barriers to development in India opine that in practice, only a small percentage of health facilities offer consumers a systematic process for gaining
information and or registering complaints, most of which are about billings and claims. Only the most educated appear to take advantage of these information resources.

Howard J Bolnick (2005) in his paper on ‘A shock to the system’ alarms about the increasing complexities in health insurance ratings. He points out that insurance companies may not be keeping their risk classification systems up-to-date. For example, prescription drugs are increasingly effective at treating previous untreated health risks such as high blood pressure and high blood cholesterol.

Derek King, and Elias Mossialos, in their paper on The Determinants of Private Medical Insurance Prevalence in England 1997-2000, (February 2005) have stated that the paper is to identify the factors that determine the prevalence of private medical insurance (PMI) in England. The study finds that individual PMI is more prevalent among the well educated and healthy. Income, age, sex and political preference are key determinants of PMI prevalence for both individual and employer-paid PMI.
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