CHAPTER - I

AIM, OBJECTIVES AND METHODOLOGY OF THE STUDY

1.1 INTRODUCTION

1.1.1 Significance of Health in Economic Development

The health of a nation refers to the physical & mental wellbeing of the population. The constitution of WHO defines health as a "state of complete physical, mental & social well being & not merely the absence of disease or infirmity".¹

Since the last five decades the importance of health as a crucial component for the socio-economic development of a nation has been realized by one and all. The economic development of the country depends not only on the physical resources but also on human resources. The significance of 'investment in man' or development of human resource in economic development has been highlighted by the economists since 1960's. "Health facilities & services are broadly concerned to include all expenditures that affect the life expectancy, strength, stamina, the vigour and vitality of the people".² It is one among the five ways of developing human resources according to T.W.Schultz (1961). He along with Dennison (1962) has brought about a revolution in human resource

Preamble of WHO constitution 1948

development thinking and therefore today, there is great recognition of the fact that physical capital in the absence of devoted and dedicated human resources cannot bring about balanced development of the economy. Thus, in the process of economic development both physical resources and human resources play equally important roles.

The accumulation of human capital does not stop with education and training in developing countries; it includes health promotion equally. It is obvious that among the different methods of improving human resources, is the provision and promotion of health facilities and services. The multiplier effect of investment in health sector is more widespread and far reaching than investment in other sectors. Gunnar Myrdal says "the quality of population can be increased through various public health & medical care measures of the entire population". Health is an important component of human capital in the sense that investment in health has direct effect on productivity per unit of time and thus on economic growth. Healthier individuals are productive when measured in terms of per unit of time with given complementary inputs of land & capital. Good health contributes to economic growth in four ways. It decreases production loss due to illness. (2). Permits use of natural resources that had been inaccessible because of disease. (3). Increases enrolment of children in schools and makes them better able to learn. (4). And it frees for alternative uses the resources that would otherwise have to be spent on treating illness. The economic gains are relatively greater for poor people, who are typically most handicapped by ill health and also gain the most from development of underutilized natural resources. Apart from the economic

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argument, the availability of health services incorporates humanitarian approach for the betterment of the living conditions of the people.

1.1.2 Health of the Individuals – Nature of Health Care delivery System

Health is a basic need of every individual. It is important both as an end in itself and a means to achieve other ends. Health of an individual is a multi-dimensional state which varies over the his/her lifetime. Hence, health is a dynamic entity. Health is a state of the human body which results from variety of inputs, some of which are of a permanent nature, while others change over time. Though it is a "state of complete physical, mental & social well being" it is practically impossible to find persons in a state of "complete" physical & mental well being. For any individual, his/her state of health at any particular point of time is a combined result of the following factors.

(1) State of health prevailing immediately before the point of time, and at that point of time.

(2) Depreciation in health that has occurred due to aging in the time interval.

(3) The operation of 3 broad inputs namely
   a) Inputs that cannot be controlled (genetic factor)
   b) Inputs controllable by the society & Government
   c) Inputs controllable by individuals themselves

(4) The health care the individual can avail of.

Among all the inputs mentioned above health care is rather a special type of input because of a number of features on both demand side & supply side.
On the demand side it may be noted that at the individual level, health care is specifically related to the health status of a person. Hence, its composition varies according to each individual's circumstances. Thus it is a tailor made thing and cannot be traded as standardised consumer goods. Secondly, people lack information about nature of illness. Infact it is the medical practitioner (supplier) who decides the type of health care that is to be demanded - a case of supply induced demand. In other words, no option is given to the demander. The peculiar characteristics possessed by the health care from the demand side prevent the rational utility - maximising consumer from operating appropriately in the market. The consumer choice is decided by the supplier on account of the unpredictability of demand which is due to the uncertainty of the incidence of illness.\(^5\) Thus the unpredictable and uneven incidence of illness limits the extent to which he can shop around to find the best buy. In other words he has no command over the price factor. Thirdly, diagnosis can be a probabilistic one in many cases, calling for the services of specialists. This may give room for unethical methods to be followed by the medical practitioners and the specialists many a time, escalating the costs of health care.

On the supply side, health care can be supplied at the following three stages (1) prevention (2) cure (3) life long disease management where cure is not possible. At the first stage, namely prevention health care can be delivered in the following forms (1) Clinical - vaccinations and innoculation against

specific diseases, and through early detection of the diseases and taking appropriate steps (2) Health education (3) Environmental - by methods to prevent health damage due to environment. In the absence of proper preventive measures, and sometimes even despite such measures the health problem moves on to the remaining two stages namely cure & life long diseases management, where cure is not possible requiring the service of properly qualified persons to deliver the particular type of care needed.

On account of inadequate basic infrastructure and paucity of resources developing countries like India are unable to provide preventive health care to their people in required amounts. As a result there is high morbidity and mortality imposing heavy healthcare burden at the next two stages on the people. Nevertheless, efforts are being made on a war footing to provide preventive health care, in the process of economic progress. This effort has had positive effects in the community in terms of increase in life expectancy, increasing proportion of aging population and a significant shift from communicable to non - communicable diseases in the health scenario. However, today on account of this shift, developing countries, like the developed countries, are increasingly facing a different and a serious type of health problem namely morbidity. Morbidity (or state of illhealth) is being increasingly used as an indicator of the well being of the population in the place of conventional indices like death and infant mortality rates that were used to measure social development and personal well being. Hence, the attention is gradually being shifted to tackle the problem of morbidity more than mortality.
At the remaining two stages, health care can be delivered on both non-commercial (Government and Charitable Organisations) & (commercial basis) (Private sector). In the first category - namely non-commercial, Public hospitals provide free health care (except the cost of medicines and other incidental charges) both in urban and rural areas. Health care services rendered by the private sector is purely on the basis of payment causing heavy financial burden for the people. Even if the people seek non-commercial type of health care services still there is a financial commitment to them, since “user charges” are demanded.

1.1.3 Health Care Expenditure Patterns

Expenditure data as are available, show that compared to the developed countries, the total of public and private expenditure on health as a percentage of gross domestic product are low in the developing countries. Thus, according to the WHO study “National Health Expenditure - A Global Analysis”\textsuperscript{6} total health expenditure as percentage of GDP in Established Market economies ranged between 12.71 for the USA to 5.39 for Greece in 1990. Of this, the share of Public Sector ranged between 7.85 for Sweden & 4.10 for Greece, and for the USA the share was 5.6 \% and for Canada 6.70. A recent estimate states that health care costs both Public & Private are 14\% of GDP for USA & 10\% for Canada. For the developing countries the figures for 1990 have been much smaller. It has been 5.9\% for India. Public health expenditure was quite low amounting to only 1.2\% of the G.D.P. With external assistance the figure amounted to 6\%.

1.1.4 Indian Plan Outlays for the Health Sector

Realising that human capital is as important as physical capital for the building up of the economy and for augmenting the welfare of the community, the Government of India has been paying attention to the provision of health services since the inauguration of the planning era in 1950-51. This effort has been intensified since the IV Plan period onwards. The Government had further adopted a comprehensive & intensive approach to health care system since early 1980's.

However, inspite of its significant role in the process of economic development & growth, health sector's share in the Indian plan outlay has been very meagre as evidenced from the percentage distribution of resources in the plan outlays by Heads of Development of the Centre, State and Union Territories.

Table 1.1 : Percentage distribution of resources to health sector - Plan wise

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<tr>
<th>S.No.</th>
<th>Plan Period</th>
<th>% Distribution to Health Sector</th>
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<tbody>
<tr>
<td>1.</td>
<td>3rd Plan</td>
<td>2.6</td>
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<tr>
<td>2.</td>
<td>4th Plan</td>
<td>2.1</td>
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<td>3.</td>
<td>5th Plan</td>
<td>1.9</td>
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<tr>
<td>4.</td>
<td>6th Plan</td>
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<td>5.</td>
<td>7th Plan</td>
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<tr>
<td>6.</td>
<td>8th Plan</td>
<td>1.7</td>
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<td>7.</td>
<td>9th Plan (for the year 2000 -2001) (B.E)</td>
<td>1.2</td>
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It is obvious from the table 1.1, that there is a steady decline in the percentage allocation to the health sector. From 2.6% in the 3rd plan period it has come down to 1.7% in the 7th & 8th plan periods. The budget estimate (B.E) for 2000-2001 shows that the percentage has further declined to 1.2%. The exception in the 6th plan period (3.1%) has been due to a combined figure given for health and family welfare. The eighth plan has commented that “it is time that the concept of free medical care is reviewed and people are required to pay even if partially for the services”.

It is obvious that for a country where 38% of the population is under 14 years of age & 6.2% over 60 years of age, the average life expectancy being 62.41 years [(2000) - (as against 47 yrs. in 1960)]; 15% of the population has no access to health services & 52.5% of population below the poverty line, earning less than 1 dollar per day, health sector has been getting a shrinking share of plan outlay by the government over the decades.\(^7\) Out of the meagre percentage of resources allocated to the health sector, salaries & establishment cost constitute a major component (40% - 59%) between 1974-1991 leaving a minor component for actual health care services.\(^8\)

1.2 THEME FOR THE STUDY

1.2.1 Peoples attitude towards health and health expenditure

It has been observed in recent times in India that the population's tendency is to demand the highest level of treatment due to their initial


\(^8\) P.Berman (1996): "Health Care Expenditure in India" in Monica Desgupta et.al., (eds.) Health, Poverty & Development in India, Oxford University Press, Delhi, pp.331-358.
lukewarm response to prevention of diseases. Rather than taking primary care for maintaining their health, they often assume that medical system will cure any health care problem that may arise. It is felt that no expenses would be spared to remedy the problem. This attitude has had its reflections on increased level of health expenditure in general. The health care activity today has assumed the proportions of an industry.

The stress and strain created by the complexities of modern life have led to a wide variety of health care problems, especially curative type. An average Indian is working, thinking and traveling more today, and thus exposing himself to a whole variety of diseases and ailments. Much illness is natural and inevitable, although some health problems can be prevented, delayed or minimised. Good medical care is often essential to survive and always necessary to live relatively pain free. To lead a disease free healthy life, individuals are facing enormous financial burdens. The escalating cost of medical treatment today is beyond the reach of common man. The increasing life span is also magnifying this problem further.

1.2.2 Delivery of Health care services – Predominance of Private sector

Today more than 70% of the health care needs of the people in India is taken care of by the private sector. "Government are having great difficulty in running health care industry since, it has today, become as sophisticated as software industry". The government is not able to fulfill its obligation due to

resource constraint. Of late, there is very little money left for upgrading the facilities or creating a comparative environment. Thus, the government is finding it increasingly difficult to provide requisite health care facilities through its machinery. Moreover, the demand for health care is growing due to population increase, greater urban population migration, increase in per capita income and increased expectations from health providers. It is no wonder that under the circumstances, the profit oriented private sector (market sector) has stepped in to bridge the growing health care demand and supply gap. It is slowly and steadily increasing its dominance in curative health care delivery with majority of household expenditures being channeled to it. Moreover, a status symbol is attached to private sector treatment today by the people. And most of the household expenses are being met out of savings, and wherever possible through the prepaid insurance schemes.

Health surveys conducted by NCAER(1993) reveal that a majority of the people seek health care from private rather than health providers from outpatient care and a very thin majority of sick people seek care from public providers for in patient care, and high income families avoid public health care services.

By and large the reasons for people's preference for private sector for health care services is an account of complex problems confronted in the public sector hospitals. The symptoms of this underlying problems include:¹⁰

1. Patient over crowding in the wards
2. Long waiting queues in out - patient clinics.
3. Questionable quality of care
4. Shortages of basic pharmaceutical and medical supplies
5. Lack of/or inoperable diagnostic and treatment equipment
6. Low staff morale
7. Dirty and decaying sanitation facilities

The above difficulties are caused by a combination of problems including lack of a clearly defined role and relationship to other parts of the health system, organisational weaknesses, lack of responsiveness to service the population and communities; and management deficiencies including poor planning and monitoring. All these problems relate directly or indirectly to the availability and use of resources by hospitals. On account of all these reasons it must be mentioned that though the services are officially expected to be rendered freely "user charges" are demanded.

1.2.3 High Cost of Health Care – the problem

Cost is the single most important problem facing health care today in India as its escalation has now reached a crisis level. How to reduce the cost of health and make it more accessible and acceptable is the crucial issue facing the health care organisations. Obviously, the greater the economic ability, the better the health services and the higher the level of health of the people.

Two basic forces drive the cost of health care upward. The first is the aging of the population - as the elderly need more care than younger people.
Societal stress and strain are causative factor for health problems among the younger generation. In addition, medical specialisation and super specialisation continue to drive up cost of health care. At the same time, capital costs have been rising, as diagnostic and therapeutic equipment have become complex and costly.

Again the nature of illness has shifted in recent times from communicable disease to degenerative diseases. With improvement in living conditions and advances in the medical science the communicable diseases are now largely controlled and life expectancy has risen accordingly.

The great paradox in health care is that the tremendous advances in diagnosis and treatment coupled with the increased expectations of the people to have high quality care have steeply increased the cost of medical care.

Even though physicians have more influence on costs than any other participants in health care, they are trained to focus attention on the quality of care and what is best for the patient almost without regard for the cost. As physicians make extensive use of diagnostic and laboratory tests, especially in big hospitals, the cost of care goes up appreciably. Though these investigations help in pinpointing diseases, it is incumbent on physicians to utilise these diagnostic tests only to clinch the diagnosis and not as a routine to satisfy other requirements.

It is obvious that Public sector today is no longer the lead player in the delivery of health care services in India. Whatever services that are rendered suffer from poor quality and accessibility presumably for reasons of inadequate
financing forcing the people to go in for expensive private treatment in times of sickness. Moreover, public health care is also not absolutely free, since user charges are collected by way of incidental expenses. Naturally, individuals are facing enormous financial burden in the form of out of pocket expenses for curative health care.

1.2.4 Health Insurance – The Solution

Among the different funding sources, health insurance is the best method to reduce and minimise the financial burden for the people. It is, in simple terms, a mechanism which covers the risks of payment for health care at the time of its requirement. It is one of the best ways of financing health care especially hospital (medical) care. “it is a way of realising social justice, since it is based on solidarity and cooperation between the well and the ill, the rich and the poor and the employers and employees.”

Health insurance, like any other risk-sharing arrangement, is useful when the illness or injury to be insured is unpredictable and the cost of its occurrence is high. In effect, this scheme implies that those fortunate enough to be healthy pay those who are sick, with the clear understanding that should those well fall sick later on, their costs in turn will be covered.

As Klarman puts it "Health Insurance is a financial mechanism for spreading the costs of medical care over as large a proportion of the group at

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risk as possible. It is one method for removing all, or part of the economic barrier to health and medical care services.\textsuperscript{12}

The case of health insurance rests on three grounds; first illness cannot be predicted, second, hospitalisation costs are lumpy cannot be planned and three, the proportion of falling ill requiring hospitalisation in any large population is small and therefore permits risk pooling. These three factors enable a person to cover the risk of illness at a very small cost, provided an appropriate insurance scheme is in position.

According to Sorkin\textsuperscript{13} "The justification for health insurance is the uneven and unpredictable incidence of illness that leads to wide fluctuations in medical care expenditures at a point in time. One purpose of health insurance is to equalize the distribution of the burden of medical care costs among individuals and families. Because health insurance entails a transfer of purchasing power from the well to the sick, it increases the total demand for services. It also assures that the producer will be paid for services rendered".

1.2.5 Health Insurance schemes in India\textsuperscript{14}

In addition to the two old insurance schemes (Employees State Insurance ((ESI)) & Central Government Health Scheme (CGHS)) there are other several insurance corporations namely General Insurance Corporation (GIC), Life

\textsuperscript{12} Op.cit. p.33
\textsuperscript{14} The various schemes are discussed in detail in chapter III section 3.8.
Insurance Corporation (LIC), United Trust of India (UTI), Voluntary and Charitable Organisation, operating in the field of insurance.

The GIC was set up by the Government in 1973 as a public sector organisation to market a range of insurance services including hospitalization cover. Before the GIC came into existence, a number of private insurance companies were engaged in offering group health insurance cover to the corporate bodies. With the formation of the GIC these companies were merged into four of its subsidiaries. All the four companies operate nationally, although each has a regional concentration reflective of the location of its home office. They offer a full range of insurance types, with health accounting for a small share of their total business.

One purpose of the merger of all the insurance companies was to standardize the coverage and various medical benefits. GIC introduced the standard ‘Mediclaim’ health insurance scheme in 1986 which became operational in 1987. This policy was modified in 1996 and in 2000 to operate on a wider range.

1.3 AIM OF THE STUDY

Health care is an important area to become sensitive about. One of the basic components needed for the maintenance of good health is finance. In the scenario of rising medical costs, health insurance schemes provide support to prevent the erosion of the already low income of majority of population of a developing country like India. The traditional covers which the Government is implementing have not been accepted well by the population at large. In this
second largest country – population wise – only a small percentage of people are covered by the health insurance schemes. And almost all of them belong to the organized sectors only. Thus, health insurance market in India is in an infant stage. For the existing schemes to penetrate into larger sections of uncovered population to help them financially in times of medical exigencies, they should be administered efficiently and effectively in their current areas of operations. This is all the more so since the private insurance sector is still to make a mark (it has made its appearance only in the recent past) and the non governmental organisations are not a force to reckon with.

This research work focuses exclusively on the working of the most popular health insurance cover - The Mediclaim insurance scheme in Chennai city. The aim is to find out how effectively the policy holders have utilized this insurance service to overcome the financial constraints in times of medical emergencies.

1.4 OBJECTIVES OF THE STUDY

1. To study the general working of the mediclaim scheme.

2. To study how effectively the claims are settled by the insurance companies and identify any hurdles in the process of settlement.

3. To articulate the attitude and opinions of the policy holders regarding the working mechanism of the mediclaim policy.

4. To suggest policy measures on the basis of inferences drawn from the study.
1.5 METHODOLOGY

A panoptic review of health insurance schemes in India is made by studying the material available. This method has been used as the secondary source of information on the topic. However, the study relies basically on primary data. A well structured questionnaire has been used to collect this data. A cross section analysis of the data is attempted by utilizing statistical tools like $\chi^2$ test (chi-square test), ANOVA tables and multiple regression analysis in this context, to arrive at meaningful conclusions.

Purposive sampling has been used in the choice of the study area.

One percentage of Chennai city’s mediclaim policy holders have been interviewed for the study purpose. They have been identified on the basis of cluster random sampling technique. Logical reasoning is adopted wherever necessary. Discussions with different cadres of insurance personnel were also conducted to widen the scope of the analysis.

1.6 HYPOTHESES

The thesis seeks to test the validity of the following hypotheses

1. Holding the mediclaim policy helps the individuals/ families/ groups to overcome financial hurdles in times of medical emergencies. However, different policy holders receive different amounts of reimbursements based on different factors to overcome these hurdles.
2. Non-adherence to the terms and conditions laid down in the mediclaim health insurance scheme leads to total or partial rejection of the financial claims made by the policy holders.

1.7 CHOICE OF THE STUDY AREA

Out of the 8 lakh Mediclaim policy holders in Tamil Nadu at the time when the survey was conducted between December 2000 and February 2001, around 2 lakhs (i.e. 25%) mediclaim policy holders were residing in Chennai city, which was the highest figure for the whole of Tamilnadu. Hence, the choice of Chennai city emerged as the study area.

1.8 DATA BASE

The source material for the study is both primary and secondary. The secondary data has been gathered from the published materials and records of the insurance companies, Census department, Statistics and Evaluation and Research.

Besides WHO chronicles, World Bank Reports and other published Journal articles, books concerning Economics of health insurance have been used. A comprehensive usage of the internet facility was also undertaken to download the necessary information on health insurance in India and abroad. A well structured questionnaire has been used for the collection of the primary data.
1.9 CHAPTER SCHEME

In the first chapter, the aim, objectives and methodology of the study are presented. In this chapter attention is given to health of the individuals and the problems faced by them with respect to high cost of treatment due to the predominance of private sector. The solution to this problem of health care is health insurance which is the best method to reduce and minimize the financial burden.

Chapter two, deals with the literature on health insurance in India and abroad. The review of literature itself is a major area of research. A survey of prior work of research in different areas to the extent that such an enquiry would seem to be germane to the task on hand is undertaken.

Chapter three, is devoted to the study of curative health care expenditure in India and people’s preference for private sector which involves heavy expenditure, thereby emphasizing the role of health insurance in this context. The structure of health insurance in India is studied with special emphasis on mediclaim policy.

Chapter IV which is the focal point of the study traces the socio-economic backgrounds and the behavioural attitudes of the policy holders towards the mediclaim insurance services. It also discusses at length the variables that influence the levels of utilization of the insurance services by the policy holders in terms of reimbursements they receive on claims made in times of medical emergencies to ward off the funding problems. The reliance