CHAPTER – I

INTRODUCTION

The level of health status of persons in a nation is a robust reflection of the state of development of the nation. It is, de facto, the quality of human health upon which the realization of life goals and objectives of a persona, the community or nation as whole depends. Health is a multi-dimensional phenomenon. It is both an end and means of development strategy.¹

The relationship between health and development is mutually reinforcing. A nation with good health tends to be productive and that productivity tends to uplift economic and societal developments. Economic and societal developments, in turn, tend to improve the indicators of health status and quality of life.²

If the quality of human capital is not good, physical capital and natural resources cannot be properly utilized and growth can neither be sustained nor be qualitative. Health is major segment of human capital.

Since ‘health’ is often overcast with too many intellectual and idealistic notions that are not testable under objective norms, it is essential to define health under a norm of minimum objective criteria. The World Health Organization defines

health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.³

1.1 INDIA AND HEALTH STATUS

With 16.5% of the global population, India contributes to a fifth of world share of diseases. There are only 59 doctors per 100000 populations compared to nearly 200 in most developed countries.⁴

The Report of the National Commission on Macroeconomics and Health (NCMH), Equitable Development Healthy Future, states that India’s performance is worse than Bangladesh and Sri Lanka. Against India’s infant mortality rate of 68 per 1000 live births, Sri Lanka has only 8. Also, Bangladesh’s under-5 mortality rate at 69 per 1000 live births is far below India’s 87, states the report.⁵

The future does not look any promising either. Estimates suggest that by 2015 the number of HIV/AIDS cases would increase three-fold and cardiovascular and diabetes incidence will double.⁶

McKinsey estimates that the health care spending in India will increase from Rs.86000 crore in 2000-2001 to over Rs.200000 crore by 2012. Private health care will form the largest chunk of this at Rs.156000 crore and this growth will be driven by the rise in lifestyle diseases, especially cancer, cardiovascular diseases, diabetes

⁵ ibid.,
⁶ ibid.,
and chronic respiratory diseases. World Health Organization attributes 60% of all deaths to chronic diseases like these.\textsuperscript{7}

McKinsey report also highlights the poor health infrastructure in India. It has only 1.5 beds per thousand people as against middle-income countries like China and Korea with an average of 4.3 beds. Although the per capita health expenditure has increased from Re.1 in 1950-51 to about Rs.215 in 2003-04, with a share of 4.8% of the GDP, more needs to be done especially on the human infrastructure front.\textsuperscript{8}

Estimates, irrespective of the definition, reveal that the per capita spending by the Government is far below the international aspiration of US$12 recommended for an essential health package by the World Development Report 1993 (World Bank) and, again by the Commission on Macroeconomics and Health (World Health Organization 2002) CMH (WHO) for low-income countries.\textsuperscript{9}

\textbf{1.2 HEALTH CARE}

Understanding of the working system of health insurance basically requires understanding of Healthcare as a system, which is two-dimensional in its perspective, which includes provisioning and financing of the health care services.

The provisioning of health care, especially in India, includes facilities for administering the health care services, such as clinics, hospitals, doctors, para-medical teams, availability of medical-equipment for diagnostic tests, medicines, etc.

\textsuperscript{7} ibid.,
\textsuperscript{8} ibid.,
\textsuperscript{9} http://www.mohfw.nic.in/reports/Report_on_NCMH/BackgroundPapersreport.pdf
On the other hand, the financing of health care services refers to the sources from which the individual pays for his/her medical and hospitalization expenses. This source can be either from out-of-pocket, past savings, by raising loans or mandatory health schemes like the ESIS and the CGHS schemes.

With inadequate management of public facilities, consumers are forced to visit private facilities and incur large out-of-pocket expenditure for care that could otherwise have been available at no or little cost at Government facilities. In such a scenario health insurance serves as a means of financial protection against the risk of unexpected and expensive health care.\(^\text{10}\)

Further, in India the poorer segments of population have less access to both public and private sector curative services than the better off sections. The out-of-pocket expense on both public and private facilities for the lowest quintile is about one-fifth that of the highest quintile population. The private health care expenditure is four times that of public health care and there is little preference for Government health delivery system vis-à-vis the private. This is because of the poor quality services in the Government managed facilities.\(^\text{11}\)


1.3 GOVERNMENT AND INVESTMENT ON HEALTH

Nevertheless, the government of India has been consistently increasing investment on the health and family welfare sector, showing its concern for the spread of health care services in different plan periods.

TABLE 1.1

INVESTMENT ON HEALTH DURING DIFFERENT PLAN PERIODS IN INDIA

<table>
<thead>
<tr>
<th>Plans</th>
<th>Period</th>
<th>Rs. in crores</th>
</tr>
</thead>
<tbody>
<tr>
<td>First plan</td>
<td>1951-56</td>
<td>65.2</td>
</tr>
<tr>
<td>Second plan</td>
<td>1956-61</td>
<td>140.8</td>
</tr>
<tr>
<td>Third plan</td>
<td>1961-66</td>
<td>225.9</td>
</tr>
<tr>
<td>Fourth plan</td>
<td>1969-74</td>
<td>335.5</td>
</tr>
<tr>
<td>Fifth plan</td>
<td>1974-79</td>
<td>760.8</td>
</tr>
<tr>
<td>Sixth plan</td>
<td>1980-85</td>
<td>2025.2</td>
</tr>
<tr>
<td>Seventh plan</td>
<td>1985-90</td>
<td>3688.6</td>
</tr>
<tr>
<td>Eighth plan</td>
<td>1992-97</td>
<td>7494.2</td>
</tr>
<tr>
<td>Ninth plan</td>
<td>1997-02</td>
<td>1981.4</td>
</tr>
<tr>
<td>Tenth plan</td>
<td>2002-07</td>
<td>31020.3</td>
</tr>
</tbody>
</table>

Source: Tenth-Five-Year plan Report, p.76.

The investment of Indian government in the health sector showed a significant increase over the plan periods, from a meager Rs.65.2 crore, in the first plan to
Rs.31020.3 Crore in the tenth plan showing the commitment of the government to the cause. However, in the ninth plan, it was decided that only essential primary health care, emergency life saving services, services under disease control programmes, and family welfare programmes would be provided free of cost.

The Tenth five-year plan report has given some deeper insight into the health care financing status in India. The report states that in India financing of health care is mostly from out-of-pocket in both the public and private –funded hospitals.

India’s health priorities need re-alignment. By 2005, only 0.9% of the GDP is allocated to health, a proportion far less than many less developed and poorer countries than India. To make the situation even starker, even of this grossly inadequate allocation, a large proportion is spent on urban tertiary care and only a minor share is allocated to health care for the rural areas. Of this latter proportion, the majority is dedicated to curative care leaving preventive and promotive interventions at the tail end of the budget allocation.12

1.4 PROFILE OF THE STUDY AREA

1.4.1 Population of Tamilnadu

The provisional population of India (2001 Census) is 1027015247 comprising of 531277078 males and 495738169 females. The population of Tamilnadu is 62405679 constituting 6.05% of the India’s population. It ranks 6th among the States / Union territories. The population of Tamilnadu which was 55858946 in 1991 has

12 http://www.mohfw.nic.in/reports/Report_on_NCMH/BackgroundPapersreport.pdf
gone up by 6251893 over the last 10 years representing an increase of 11.19%. The density of population per sq. km. is 478 in 2001 as against 429 in 1991.\textsuperscript{13}

\begin{table}[h]
\centering
\caption{POPULATION OF TAMIL NADU}
\begin{tabular}{|c|c|}
\hline
Census Year & Population (in Lakhs) \\
\hline
1941 & 262.7 \\
1951 & 301.2 \\
1961 & 336.9 \\
1971 & 412.0 \\
1981 & 558.6 \\
2001 & 624.1 \\
\hline
\end{tabular}
\end{table}

\textit{Source: Census of India 2001}

1.4.2 Population of Tamilnadu – Gender profile

The gender profile of the population of Tamilnadu indicates that there are 31400909 males (50.31\%) and 31004770 females (49.69\%).\textsuperscript{14}

\begin{table}[h]
\centering
\caption{POPULATION OF TAMIL NADU}
\begin{tabular}{|c|c|}
\hline
Census Year & Population (in Lakhs) \\
\hline
1941 & 262.7 \\
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\hline
\end{tabular}
\end{table}

\textsuperscript{13} http://www.thaibicindia.org.in/study/tamil_nadu/Demographic.pdf
\textsuperscript{14} http://www.census.tn.nic.in/pca2001.aspx
TABLE 1.3
POPULATION OF TAMILNADU – GENDER PROFILE

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. of persons (in Lakhs)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>314.0</td>
<td>50.31</td>
</tr>
<tr>
<td>Females</td>
<td>310.1</td>
<td>49.69</td>
</tr>
<tr>
<td>Total</td>
<td>624.1</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Census of India 2001

1.4.3 Population of Tamilnadu – Urban Vs Rural

The area profile of the population of Tamilnadu indicates that the urban population is 27483998 (44.05%) and the rural population is 34921681 (55.95%).

TABLE 1.4
POPULATION OF TAMILNADU – Urban Vs Rural

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of persons (in Lakhs)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>274.9</td>
<td>44.05</td>
</tr>
<tr>
<td>Rural</td>
<td>349.2</td>
<td>55.95</td>
</tr>
<tr>
<td>Total</td>
<td>624.1</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Census of India 2001

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15 http://www.census.tn.nic.in/framers.php?id=27
1.4.4 Literacy Rate

Close to 75 per cent of Tamilnadu’s population is literate which is higher than the national average of 65%. In 2001, 82.4% of males and 64.4% of females of Tamilnadu could read and write.¹⁶

1.4.5 Living standards¹⁷

Cemented flooring appears to be the norm (68% of homes). The average home size is small ranging between one room (37%) and two rooms (29%). Less than 5% have large homes with 5 or more rooms. Two – third have an attached bathroom.

While two-third receives drinking water by tap, 16% depend on wells and an almost similar proportion gets drinking water from a hand pump. Most homes are lit by electricity, the balance managing with kerosene lamps. LPG connection is restricted to a third or so of homes while a similar proportion is still using firewood and another fifth are using kerosene lamps.

Ceiling fans are found in a majority of homes while a third has a table fan. Air conditioners are hardly to be found. Two-fifths own an iron. Three-fifths own a bicycle while a little more than a third owns a motorized 2-wheeler, the preference being motorbikes. Car ownership is less than 3%.

A lot of homes have mixers, reflecting the greater grinding requirements in their cuisine, while only 22% have a refrigerator again reflecting their culture of not

¹⁷ http://www.thaibicindia.org.in/study/tamil_nadu/Demographic.pdf
storing stale food. About 14% have a kitchen sink. A little more than half of the homes have a color TV set while a third possesses a B&W set. High end systems are barely seen in Tamilnadu. Little below a tenth owns a washing machine. 28% have a landline connection, 4% have mobile connection and only 2% have a PC at home.

1.5 REVIEW OF LITERATURE

The theory of risk has been applied extensively to the literature related to health insurance decision (Arrow 1963, Feldstein\textsuperscript{18} 1973). Under conditions of consumer rationality and risk averseness, the decision to purchase insurance is made on the basis of expected utility gain.

The perception of individuals towards the risk is also an important factor. A consumer’s knowledge of being a risk by being a member of a particular group of people with high-risk characteristics (e.g., those who know they have high cholesterol) likely to influence their insurance decision. Hopkins and Kidd (1966) and Butler\textsuperscript{19} (1999) found that smokers are less likely to purchase insurance. Smoking behaviour is viewed in these studies as a proxy for risk-aversion.

The role of education in health decision-making has been well documented by Grossman (1972) and Muurinen\textsuperscript{20} (1982). The implication is that not only is a better educated person likely to be healthier which would lower the probability of insurance,

but also he/she is likely to be better informed about both the services available in the public hospital system and the benefits of joining a private health insurance fund. The indirect effect of education is its impact on income.

Feldstein\textsuperscript{21} (1973) has argued that as the price of health care increases, the demand for insurance should increase as well because this causes an increase in the risk of net worth depletion and thus an increase in the demand for insurance. Healthcare expenditure largely depends on healthcare costs.

Education and income are generally positively correlated. Higher income generally decreases the opportunity cost associated with the purchase of private health insurance. Overall, increases in both income and education would be expected to lead to an increase in the probability of buying the insurance. (Van De Ven and Van Praag\textsuperscript{22} 1981)

Gender also plays an important role in the insurance decision through its effect on expected medical consumption. Sindelar\textsuperscript{23} (1982) notes that most of the higher demand for medical services by women may be explained by increased need during the reproductive years.

The Mimeograph of Savage, E and D. Wright revealed that income is one of the important determinants of purchase of health insurance. Income has been found to be having a positive association with health insurance purchase decision consistently in different studies conducted in different countries. [Propper (1989) in UK; Cameron, Trivedi et al. (1988) in Australia and Hurd and McGarry (1997) in USA].

Married respondents are more likely to take out coverage, though family size apparently has been of little influence on the purchase decision (Cameron and Trivedi 1991).

The studies in Indian context on health insurance are scanty. Several recent papers and reports have critically reviewed the Indian health delivery and financing system (Bhat and Mavalankar 2000, Berman and Khan 1993, World Bank 1995, Planning Commission 1996, etc). These studies have documented issues and challenges the system faces in terms of accessibility, efficiency and quality of the health care delivery.

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Adverse selection is one of the major hurdles for insurance companies in selling their Health Insurance schemes to clients. It is a situation of high-risk people buying Health Insurance with the result that there is over-representation of such high-risk people in the risk pool. Studies by Van de Ven and Van Vlenit28 (1995) and Cardon and Hendel29 (1996) found evidence of the presence of adverse selection in Health Insurance markets.

The utility gains, expected from the purchase of private insurance are related to the expected medical need of the people in the first instance. Some individuals face greater risk vulnerability than others due to their age, pre-existing health status, job profile and marital status. For example, Hopkins and Kidd30 (1996) suggest that the probable distribution of future health states is based on present and past health states.

The health status of the family is another important factor which may influence the health insurance purchase decision. In literature, studies have used variables like hospitalization, doctor consultation, self health assessment to proxy for health status (Hopkins and Kidd 1996, Barrett and Conlon31 2003). Healthcare expenditure of the household may be another proxy of health status of the household.

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Health expenditure per se may not tell much about health burden on household and health expenditure as a percentage of total expenditure may provide a better idea about the health burden on a household.

Several recent papers examine the empirical evidence for adverse selection in health insurance markets in the United States. In these studies ‘adverse selection’ is defined as the situation where consumers have differential health risks but are not charged a premium equal to the expected marginal cost of their insurance. As a result, ‘high risk’ consumers find insurance most attractive and will tend to take out more generous and expensive policies relative to ‘low risk’ consumers (Cutler and Zeckhauser32 1998). Therefore, more health expenditure of family may give rise to higher probability of health insurance purchase.

Healthcare expenditure is another important variable affecting health insurance purchase (Kronick and Gilmer33 1999). Relation of health insurance purchase decision and health expenditure is based on the premise that families which have higher chances of requiring hospitalization will have higher probability of buying health insurance. Some other socio-economic factors like age, education etc. have also been found to be important factors affecting health insurance purchase.

One important reason for higher healthcare costs is the introduction of new technologies which may lead to higher demand for insurance in the face of rising costs (Nyman\textsuperscript{34} 1999).

However, people belonging to different income groups are likely to respond differently to these changes. Kronick and Gilmer\textsuperscript{35} (1999) argue persons with low incomes and few assets buy insurance primarily to protect their health. Most such persons could not possibly pay for the care they would need if they were uninsured. They might be forced to deplete their assets and the risk to health and future earnings for such persons can be substantial and therefore they may be willing to buy insurance.

Another set of factors which are found important in the literature of health insurance are demographic and economic variables. These variables are employment, age, marital status and gender. The available evidence suggests that socioeconomic variables act on choice in the expected ways. Those who are employed and those in executive positions are likely to purchase insurance (Butler 1999; Savage and Wright\textsuperscript{36} 1999).

Age has also been shown to have a significant influence on insurance choice. Age has also been found having positive and significant impact on the probability of

\textsuperscript{34} Nyman, J.A.: “The value of health insurance the access motive”, Journal of Health Economics, 18(2), 1999, pp.141-152.
having insurance cover (Cameron, Trivedi et al. 1988, Ngui, Burrows et al. 1989, Savage and Wright37 1999).

Also the studies point out the excessive financial burden on the Indian households. This excessive financial burden on households may arise for a variety of reasons. At one level, they can be blamed on India’s public health care system, which is under-funded and suffers from quality and access problems, forcing consumers to visit the private and relatively more expensive treatments. Ellis et al.38 (2000) contended that these financial burdens arise because the consumers are either not insured or are insured inadequately for their health care expenses.

Gumber and Kulkarni39 (2000) compared the Mediclaim, ESIS and SEWA health insurance policies to find the similarity and differences among them.

Health insurance choice essentially entailed a simple decision—whether or not to purchase private health insurance (Barrett and Conlon40 2003).

Rao (2004) discusses the issues and challenges for health insurance sector in India. She found financing to be one of the most important components to improve

37 ibid.,
health system in India and advocated that health insurance should be given very high priority by the government as a financing mechanism.  

Bundorf and Pauly\textsuperscript{42} (2004) also find evidence that individuals who have high-expected health costs are more likely to obtain health insurance in the group market and in the individual health insurance market.

Some studies have tried to analyse community based health insurance in India (Devadasan, Ranson et al. 2004, Ahuja\textsuperscript{43} 2005).

In another study, Acharya and Ranson (2005) compared four different CBHIs in Gujarat and tried to analyse their insurance schemes.\textsuperscript{44}

With reference to health care expenditure more than 80% of the total health care expenditure is out-of-pocket expenditure. Reliance on out of pocket payments is inefficient and it is also unfair for the poor on whom the burden of disease fall more than proportionately (Ahuja\textsuperscript{45} 2005). Channeling these high private expenditures through insurance system is real challenge in Indian context.

\textsuperscript{44} Acharya, A. and K. Ranson ;“Health Care Financing for the Poor: Community-based Health Insurance Schemes in Gujarat.” Economic and Political Weekly, VOL 40 No. 38 September 17 - September 23, 2005, pp. 4141-4150.
Bhat and Nishant (2006) study discusses factors affecting the decision to buy health insurance in a micro insurance setting.\(^{46}\)

Royalty and Abraham\(^{47}\) (2006) demonstrate that workers with access to spouse health insurance sort into jobs that do not offer health insurance, again suggesting that worker demand for health insurance may play an important role in job choice.

**1.6 STATEMENT OF THE PROBLEM**

The best documented and largest system of health care delivery in India is the diverse network of hospitals, primary health centres, community health centres, dispensaries and speciality facilities financed and managed by the central and state local governments. These facilities are officially available to the entire population either free or for nominal charges. Along with some other networks of village health workers, maternal and child health programmes and speciality disease prevention programmes these public facilities carry out a central role in India’s primary health care system.

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Numerous studies have indicated that these facilities are mostly under funded, understaffed and short of drugs and essential supplies and that they sometimes suffer from low morale and inadequate work motivation.\footnote{http://medind.nic.in/haa/t08/i1/haat08i1p92.pdf}

Excessive financial burdens on households arise for a variety of reasons. At one level, they can be blamed on India’s public health care system, which is under funded and suffers from quality and access problems, forcing consumers to visit the private and relatively more expensive treatments. These financial burdens arise because the consumers are either not insured or are insured inadequately for their health care expenses.

Health care has always been a problem area for India, a nation with a large population and larger percentage of this population living in urban slums and in rural area, below the poverty line. The government and people have started exploring various health financing options to manage problem arising out of increasing cost of care and changing epidemiological pattern of diseases.

Health care financing in India can be considered almost unique in several respects. The share of public financing in total health care financing in the country is considerably low--just around 1% of GDP compared to the average share of 2.8% in low and middle-income countries or even relative to India’s share in disease burden.

The beneficiaries of this limited public health financing are not only the poor as one would expect in a limited public spending to be, but also the well-off section
of the society. Over 80% of the total health financing is private financing, much of which takes the form of out-of-pocket payments (i.e., user charges) and not any prepayment schemes.\(^{49}\)

Health insurance is more complex than other segments of insurance business because of serious conflicts arising out of adverse selection, moral hazard, unavailability of data and information gap problems. Health sector policy formulation, assessment and implementation are an extremely complex task, especially, in changing epidemiological, institutional, technological and political scenario.

Health insurance is supposed to be a sector with a lot of potential. However, of India’s total population in urban and rural sector, less than 10% are insured. A huge base still remains to be covered by different kinds of innovative products.

For most general insurance companies, health is a loss-making portfolio and companies are facing claim ratios of over 100%.

Lack of awareness about various schemes has been one of the major challenges in spreading rural health insurance. The other challenges are selecting an appropriate distribution channel to meet the needs of the widely dispersed population and tying up financial support for premium funding in the economically weaker sections.

\(^{49}\) http://www.icrier.org/pdf/wp123.pdf
Third Party Administrators lacked the competence and necessary infrastructure to handle the huge number of claims successfully. One of the reasons behind this is the lack of proper underwriting norms and the product structure of the Mediclaim policy. Moreover, companies are cross-subsidizing health with more lucrative tariffed products.

In this scenario, a study on health care insurance business becomes inevitable. As revealed by the review of literature, many research studies in this respect have already been made at national and international level. However, research reports in respect of health care insurance business with reference to Tamil Nadu are scanty and hence the present research work is undertaken.

1.7 OBJECTIVES OF THE STUDY

The present research work entitled “A STUDY ON HEALTH CARE INSURANCE BUSINESS IN TAMIL NADU” has been done with the following objectives:

1. To provide an overview of health insurance in terms of its different forms and to present the status and challenges of Indian health insurance industry.

2. To give an account of health care insurance providers along with the distinct features of their product offerings.

3. To provide the demographic profile of health insurance policyholders and their health insurance coverage.
4. To study the behaviour of health insurance policyholders during the pre-
selection and the post-selection of health insurance plan.

5. To examine the conditions of and procedure for licensing of Third Party
Administrators (TPAs) and to study the awareness of health insurance
policyholders about TPAs and use of TPAs by them as mode of settlement of
claims.

1.8 RESEARCH METHODOLOGY

The present research work is with reference to Tamil Nadu, a State in India
which can very well match with any other State in India in terms of population, urban
and rural area, industrial progress, education, income pattern and culture. The study
period covered is between 2001-02 and 2005-06.

The present study is based on both primary and secondary data. The primary
data has been collected with the help of a sample survey of health insurance
policyholders in Tamil Nadu.

The sample respondents were selected from the health insurance policyholders
of the health insurance companies that have completed a track record of at least five
years in the year 2005-06.

At the end of 31st March 2006, there are four public sector health insurance
companies and eight private sector health insurance companies in India as given in
the following list.
**TABLE 1.5**

PUBLIC SECTOR HEALTH INSURANCE COMPANIES

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Year of Registration</th>
<th>Name of the Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1906</td>
<td>National Insurance Company Limited</td>
</tr>
<tr>
<td>2</td>
<td>1919</td>
<td>The New India Assurance Company Limited</td>
</tr>
<tr>
<td>3</td>
<td>1938</td>
<td>United India Insurance Company Limited</td>
</tr>
<tr>
<td>4</td>
<td>1947</td>
<td>The Oriental Insurance Company Limited</td>
</tr>
</tbody>
</table>

Source: [http://irdaindia.org/](http://irdaindia.org/)

**TABLE 1.6**

PRIVATE SECTOR HEALTH INSURANCE COMPANIES

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Date of Registration</th>
<th>Name of the Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>23.10.2000</td>
<td>Royal Sundaram Alliance Insurance Company Limited</td>
</tr>
<tr>
<td>2</td>
<td>23.10.2000</td>
<td>Reliance General Insurance Company Limited</td>
</tr>
<tr>
<td>4</td>
<td>22.01.2001</td>
<td>TATA AIG General Insurance Company Ltd.</td>
</tr>
<tr>
<td>5</td>
<td>02.05.2001</td>
<td>Bajaj Allianz General Insurance Company Limited</td>
</tr>
<tr>
<td>6</td>
<td>03.08.2001</td>
<td>ICICI Lombard General Insurance Company Limited</td>
</tr>
<tr>
<td>7</td>
<td>15.07.2002</td>
<td>Cholamandalam General Insurance Company Ltd.</td>
</tr>
<tr>
<td>8</td>
<td>27.08.2002</td>
<td>HDFC-Chubb General Insurance Co. Ltd.</td>
</tr>
</tbody>
</table>

Source: [http://irdaindia.org/](http://irdaindia.org/)
Thus, the survey covers the health insurance policyholders of all the four public sector health insurance companies and six private sector health insurance companies that meet the criteria of a track record of at least five years in the year 2005-06.

Having decided the health insurance policy providers, a sample of 500 health insurance policyholders from both the urban and rural region of Tamil Nadu have been considered for the study. Due representation has been given to the urban / rural respondents on the basis of the census 2001 for the population of Tamil Nadu. As per the census 2001, the urban population is 44.05% and the rural population is 55.95%. Hence, the sample of 500 health insurance policyholders have been taken in such a way that 220 respondents (44%) are from urban region and 280 respondents (56%) are from rural region. Again, the gender representation has also been on the basis of the census 2001 for the population of Tamil Nadu. As per the census 2001, there are 50.31% of males and 49.69% of females. Hence, 220 urban respondents have been taken in such a way that there are 115 males (52.27%) and 105 females (47.73%). Similarly, 280 rural respondents have been taken in such a way that there are 150 males (53.57%) and 130 females (46.43%).

Stratified non-random sampling is the method of sampling used for the present study.

First hand data are collected from the field through interview schedule and observation. A number of discussions have been made with knowledgeable persons
such as academicians, insurance experts, and the health care insurance takers for designing the interview schedule.

The interview schedule drafted at first instant was circulated among a few research scholars and field experts for a critical review with regard to wordings, format and sequence. It was redrafted in the light of their comments. The schedule has thus become an undisguised structured data gathering instrument suitable for a personal interview.

The study has also widely used the secondary data. The secondary data for the study has been collected from the documents of the public and private sector health insurance companies under study as available from their respective web sites. Besides, the data has been collated from standard text books of related topic, specialized websites on health insurance, business dailies and magazines as available on line.

The entire study is of descriptive in nature and is based on the responses obtained from the personal interview of the health insurance policyholders.

1.9 LIMITATIONS OF THE STUDY

The findings of the present study are subject to the competitive environment created by the health insurance providers and the extent of awareness on the part of health insurance policyholders during the study period 2001-02 to 2005-06. This is the period that has witnessed just the emergence of private health insurance.
1.10 CHAPTER CLASSIFICATION

The present thesis entitled “A STUDY ON HEALTH CARE INSURANCE BUSINESS IN TAMIL NADU” is inter-twined into seven Chapters.

This Chapter 1, “INTRODUCTION”, starts with the importance of health, health status in India, provisioning and financing of the health care services and the role of government in this respect. This chapter also gives an account of the profile of the study area. It presents the relevant review of literature, statement of the problem, objectives of the study, research methodology, limitation of the study, and the chapter classification.

Chapter 2, “HEALTH INSURANCE - AN OVERVIEW”, throws light on the status of total health expenditure in India. It presents a bird’s eye view of the various forms of health insurance. It also discusses the values in health insurance, and the elements of a health insurance programme. Besides, it presents the historical background of the Indian health insurance industry. It provides information on health premium collected, claims ratio, health segment market share, proportion of health business segment in total non-life business, and the challenges before health insurance sector.

Chapter 3, “HEALTH CARE INSURANCE PROVIDERS”, is devoted to present the origin and growth, health premium collected, market share, the features of various products offered in respect of the four Public sector health insurance
providers and the six Private sector health insurance providers taken for the present study.

Chapter 4, “PROFILE OF HEALTH INSURANCE POLICYHOLDERS” provides the profile of health insurance policyholders who are taken as sample respondents in the study area in terms of age, education, income, size of the family, household structure, electricity, source of drinking water, water treatment prior to drinking, sanitation facility, health problems, decision making regarding health insurance, and selection of health insurance policy providers.

Chapter 5 “BEHAVIOUR OF HEALTH INSURANCE POLICYHOLDERS” focuses on the preference of the health insurance policyholders regarding the sum insured, premium, health insurance provider, type of health insurance plan, and renewal of the health insurance policy. It also highlights the behaviour of health insurance policyholders in respect of their effort in knowing the terms of the policy before actually taking the policy. Besides, it examines the reimbursement mode of the claim process.

Chapter 6 “THIRD PARTY ADMINISTRATORS” concentrates on the concept, objectives, mechanism, licensing and benefits of TPAs. It also studies the awareness of health insurance policyholders about TPAs and use of TPAs by them as mode of settlement of claims.
Chapter 7, “CONCLUSION”, is a capsule summary of the findings of the study. It also provides viable suggestions for better performance of health care insurance business in Tamil Nadu.