CHAPTER NUMBER TWO
MARKETING OF HEALTH CARE, INSURANCE SERVICES, AND MEDICLAIM POLICIES IN INDIA
CHAPTER TWO AT A GLANCE

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EXECUTIVE CHAPTER SUMMARY:

An attempt has been made in chapter number two to provide the framework in the form of the marketing of services, review of marketing of health care services and insurance services. The objective underlining this chapter was to review on marketing of the health insurance services aimed to examine the chief issues in the marketing of the health insurance services and the health insurance sector of India. The researcher has offered outcome of an in-depth review of the marketing of the mediclaim policies and mechanism of the mediclaim policies. Concluding remarks have been also given by the researcher at the end of this chapter. Moreover, the detailed list of the selected references as well as 'Glossary' pertaining to important terms relating to health insurance have been given at the end.

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MARKETING OF HEALTH CARE, INSURANCE SERVICES, AND MEDICLAIM POLICIES IN INDIA

2.0: AN INTRODUCTION:

The concept of the marketing have been reviewed and evolved gradually by various marketing experts over the period of time. The marketing experts have commented on various controversial developments in marketing theory which has raised the need for the revaluation of the goals and direction in the theoretical developments of the discipline (W.T. Tucker, 1974)[1].

According to Hiram C. Barksdale and Bill Darden (1971)[2], the so-called marketing concept was first introduced to the U.S. business during 1950s in very simple form and with unarguable basic levels of its principle. The marketing concept had been considered as the part of all major business decisions, and was thus suggested to be introduced at the beginning of the production cycle rather than at the end to view the purported integrated and consumer-oriented concept of marketing as a fundamental business philosophy which guided and coordinated the operations of the entire organization.

William Lazer (1969)[3] had advocated that the concept of marketing as being stimulating massive consumption, and had recommended the adoption of the new consumption standards that could recognize the extravagant demands and hedonistic desires which were normal and often justified by an affluent society.

Philip Kotler and Sidney J. Levy (1969)[4] had predicted the role of marketing beyond business organizations, such as viz., Political Parties, Professional Associations, Charities, Universities Government Agencies-to Market the Persons, Organizations, and Ideas that these organizations might wish to promote. While, at the other extreme, Phillip Kotler and Gerald Zaltman (1971)[5] had insisted on the inclusion of the critical social issues and beneficial public services in the marketing concept in order to make it societal over the period of time. They had also appreciated the success of the marketing concept in selling the products of the firm and had urged the extension of the same expertise to other organizations, other than the firms for social marketing. Consequently, this had expanded and raised the stature of the concept of marketing with the marketing mix comprising of product, price, promotion, and place (physical distribution) have been evolved. As with the passage of time, the nature of consumption also had been altered from being what the producer wanted to sell to more nearly what the consumer needed to buy which had confused the role of the marketing, consequently had become an area of interest of the marketers (F. Kelly Shuptrine and Frank A. Osmnaski, 1975)[6].

2.1: MARKETING OF SERVICES:

A service refers to the doing activity of something for someone or something, which is mainly intangible, and immaterial, which is likely to be the consuming experience at the point of purchase, but still remaining un-owned due to its perishable nature (http://marketingteacher.com; Accessed on 24/04/11)[7]. According to the American Marketing Association, services refer to the offered activities, benefits or satisfaction for sale or are provided along with the sale of goods. Thus, the services are activities, benefits or satisfaction and marketers identifies it application in sale of intangible as well as tangible products (S.M. Jha, 2003)[8]. Services fall into three broad categories viz., the pure standalone services viz., Physiotherapy, Counseling and Consultancy, etc., the blend of the service and goods, such as, viz., Restaurants, Retailing, etc., and, the service as a part of goods in the total marketing mix, such as, viz., after-sales service, service and repair of home appliances, etc.

According to the Kotler, Armstrong, Saunders and Wong (1999), a service is any activity or benefit that one party can offer to another which is essentially intangible and does not result in the ownership of anything. Services are the production of essentially intangible benefits and experiences either alone or as part of a tangible product through some form of exchange with the intention of satisfying the needs, wants and desires of the consumers (C. Bhattacharjee, 2006)[9].

2.2: MARKETING OF THE HEALTH CARE SERVICES:

Marketing is not only preoccupied for the profit-making organizations, but it also makes important contribution to the other social sectors such as health care (Julian L. Simon, 1968)[10]. Philip Kotler and Gerald Zaltman (1971)[5] had defined social marketing as the design, implementation, and control of programs intended to influence the acceptability of social ideas and involves emphasis of product planning, pricing, communication, distribution, and marketing research. Much of the services literature has focused on want services, viz., Recreation, Entertainment, and Communications services, in comparison to that being given to the studies related to the services needed by the customers, but may not want, such as, the health care and some specific public services (Leonard L. Berry and Neeli Bendapudi, 2007)[11]. This has also affected the marketing of the health care services in terms of the frequent use of advertising with many health care professionals using marketing firms or internal marketing or advertising committees which has resulted into the critical marketing budget for most medical practices (Sahl, 2003)[12]. Various experts have discussed the relevance of marketing management and marketing strategy in health care organizations, and have also presented the perspectives of health care organization as the seller, the preventive intervention or services provided as the product and the consumer as an individual responding to the offer, viz, the health care seeker or the potential health care seeker (Lovelock, 1977; Tucker, 1977; Clarke, 1978; Fryzel, 1978; Garton, 1978)[13, 14, 15, 16, 17.]

John A. Quelch (1980)[18] had reviewed the fundamental marketing aspects and its budding role in the health care management as well as the wide broad collection of preventive interventions offered to policy makers and stated the variation in the applicability and role of the marketing. Research has also been conducted in various health sectors viz., Hospitals, Walk-In Clinics, and various specialty health care viz., Dentistry, Pediatrics and Surgery respectively (Brand, Richard . R., Cronin, Joseph J., and Routledge, Jeffrey B., 1997)[19].

The health care services reflect numerous characteristics normally related with other services. They are not tangible, but are performance based, and the health seekers incurs expenses for availing the same, for instance, the core benefits of medical diagnosis, treatment, and patient education. Often the health care service involves the mix of intangible services which are assisted by the tangible goods, viz., pharmaceuticals and pharmacy services. The healthcare services based on the intangibility are considered as a pure service which in combined with the dynamics of the prolonged service schedules complicated the evaluation of performance and the results due to uncertainty of the outcome for certain period of time. Moreover, the healthcare services being the professional service can be evaluated only by the professional with the specific training, and possess strong credence qualities such as the buyer do not find it possible to analyze the results neutrally even after the providing of the services (Darby and Karni, 1973)[20].

The health care services are labour and skill intensive, which not only contributes to significant performance variation but also in the technical skills of the one clinician to another. Victoria Bolanos-Carmona, Ricardo Ocana- Riola et al., (2002)[21] had offered the managerial framework for the application and measurement of the performance improvement to the health care organizations. Bridget M .Costello, Bernard J. Healey, Michele McGowan (2007)[22] had described the benefits of the six sigma approach from the context of variation in the offering of the medical services as well as has also stated the executive and political motivations for following the six sigma approach. Clinicians and medical care providers are conscious about the perishable nature of the services thereby resulting into overbooking of the appointments of escalated charges to compensate the missed appointments (Leonard L. Berry and Neeli Bendapudi, 2007)[11]. John Quelch (1980)[18] had regarded the marketing mix decisions as the most critical decisions. In spite of the customers being the emerging crucial point of the decision making in health care, vary scanty research studies have been undertaken from the context of the customers' decision making (Jay P. Carlson, John W. Huppertz and Presha E. Neidermeyer, 2008)[23]. Customers come across and overcome the dreadful challenges during the process of making judgments among competing healthcare alternatives (Robinson, 2001)[24].

Customers are often purchasing the health services without knowing the costs of the services as the customers do not have readily access of the pricing information about professional healthcare services (Berry, Mirabito, and Berwick 2004)[25], and many considering only the cost of the health care purchased by them with the introduction of the consumer-focused health plans (McNeill 2004)[26]. Zeithaml had suggested that service value, particularly health care service is directly and positively related to the purchase behaviour as well as existence of the strong relationship between the consumer satisfaction and future purchase intent (Anderson, E. and Sullivan, M. W., 1993)[27], apart from the service encounter which involves high degree of person-to-person interaction (Solomon, M. R., Surprenant, C.F., Czepiel, J.A., and Gutnam, E.G., 1985)[28].

However, very few researchers had undertaken the studies focusing on customers' interest in or attitudes in the direction of price negotiation with the healthcare providers (Berkowitz, 1992)[29]. The services are also evaluated on the basis of service-scape which includes range of physical aspects of the service encounter environment, viz., hygiene, noise level, aroma, temperature, furnishings, site, and parking associated with a physical facility that had been found to influence service customers' perceptions of the quality attributed to as specific service provider (Baker, J.1987; Harrel, G. D. Hutt, M.D. and Anderson, J.C. 1980)[30, 31]. With the emergence of the health care among the most emphasized concern for the value of life in the society, and with the World Health Organization's target of health for all, the expectations of the trouble-free availability and affordability of the efficient health-care services, in combination with the empathetic care, have been found rising among the target health care customers (Nidhi Shah and Upinder Dhar, 2007)[32]. Moreover, the approach to the health has been no-longer remained only techno-medically oriented, but has evolved as the integrated phenomenonal together of the Physical, Emotional, Social, Spiritual and Intellectual Health. The field of health care has 90 per cent of individual periphery, and only 10 per cent of the mechanical periphery, and the professional health care(O'Donnell, 2000)[33].Moreover, despite of the similarities with the other services, health care services possesses certain uncommon characteristics which has not only resulted into the variation in the marketing of the health care services but has even complicated the marketing of the health care services (Leonard L. Berry and Neeli Bendapudi, 2007)[11].

Hence, in spite of the applications of the marketing principles as applied for marketing of the health care services, there are various issues yet to be addressed by the marketers of the health care services. As the trend for the marketing of the health care services have been found increasing gradually, various experts have commented on the obstacles experienced in marketing health care services.

A brief review of literature on the issues in the marketing of the health care services is offered as follows.

Berkowitz (1996)[34] had identified there structuring in the health care industry and had suggested changes in the perspectives of the marketing challenges in the health care industry, viz., population based medicine and marketing of health education as the means of minimizing the increasing health care costs. Lynch and Somerville (1996)[35] had identified hospitals as the central players in consolidating the service units which has been traditionally fragmented among all the health care organizations. Kwangsoo Lee and Thomas T.H. Wan (2002)[36] had observed the problems of fragmentation in the process of providing the health care service and their associations the networked systems. They had suggested that the healthcare marketers inevitability to identify the health care seeker as a whole and consequently customization of the health care services, with the help of their active participation at the service-encounter fronts (Leonard L. Berry and Neeli Bendapudi, 2007)[11].The health care marketers deal with the health care customers, who are usually ill stressed with the uncertainty of their health risk, mixed with the feeling of fear sometimes.

According to Duhachek (2005)[37], individuals also involve in the avoidant coping strategies in case many medical services decision making which results into suboptimal decision making and behaviour. Moreover, the health care consumers are often reluctant which influences the evaluation of the perceived dreadful services differently. Also, the sense of awareness of the loss of control over the outcome makes the customers unwilling to perform the role of the co-producer.

Bloom and Reeve (1990)[38] had considered health care as the credence good, which refers to an offering that the health care customer with limited medical knowledge may find it difficult to evaluate and may rely on the search signals of quality treatment from the health care providers, which are proxy indicators simplifying the evaluation of the effectiveness of the health care providers. The original factual model for analyzing the health care has been developed by Avedis Donabedian, which focused on the structure, process and outcomes as the means to analyzed the efficaciousness of the health care (William R. Gombeski, Jr., Jason Britt, Jan Taylor, et. al., 2008)[39]. The rise in the consumerist movement has also amplified the necessity of customer satisfaction measurement pertaining to the health care services (Band, 1991 and Parasuraman et al., 1988)[40, 41].

Bryant et al. (1998)[42] had categorized variables influencing customer satisfaction viz., socio-economic, system and moderating factors. Hardip Chahal, R.D. Sharma and Mahesh Gupta (2004)[43] had conducted a study emphasizing the quality evaluations pertaining to the mechanical and practical services by the customers as offered by the health care centers with the aim to assess the health care seekers' satisfaction for the selected variables, viz., patients' attitude towards doctors, medical assistants, quality of administration, and quality of atmospherics.

They had identified the causes of lower satisfaction, and provided the recommendation of the patients for improving the public health care services apart from offering necessary tactical strategies in order to achieve health care needs of the customers of the public health sector in the developing countries. David Colton (2007)[44] had examined the underlying principles for defying the assessment of the performance and portrayed the initiatives to be undertaken by the health care organizations with the aim to form a systematic method for gathering and improving the organizational effectiveness as well as client services. Moreover, for developing and maintaining the satisfied customer, the importance of the customer has been widely accepted (Bowen D.E. and Hallowell R., 2002)[45]. Scott Melten, Daniel Eveleth and Jeffrey J. Bailey (2005)[46] had found that there exists the favourable effect of the internal managerial assistance of nursing personnel on the perceived customer satisfaction.

According to Davies A.R. and Ware J.E. Jr. (1981)[47], the health perceptions can be defined as the individuals' perception to their health, that is, whether they perceive that they are in a fit condition or an unfit and reflects the mind-set feelings, view-points and attitudes of the individuals on health which may or may not reflect the actual physical health. The health perceptions influence the individual's ability to participate in the wide range of physical, social and occupational activities.

Julia E. Connelly, John T. Philbrick, et. al. (1989)[48] had described the perceptions on health of the individuals seeking primary care, and determined its influence on utilization of medical care services as well as the influence of the perceived health on the use of the outpatient health care resources on the basis of the scores provided by the physicians on patient's perceptions about their health and their physical and psychological health.

C. Jeanne Hill and Kishwar Joonas (2005)[49] had investigated into the acceptable and unacceptable span of the waiting time considered by medical care patients and its influence of the rising unacceptable waiting time on the perceived quality of service, satisfaction, probability of recommending the provider and repeat visits by the patients, and the alternative means undertaken in the context to the unacceptable waiting time.

Grethe Fochsen, Kirti Deshpande and Anna Thorson (2006)[50] had studied the medical encounter as experienced by health care providers and not on what has actually happened or the experience of the patients. They had also explored the experiences and perceptions of the health care providers' encounters with male and female patients of the rural district imbalances in the doctor-patient relationship and found that the doctor's dominance, patient-centered approach, acknowledgement of the patients' own experiences and shared decision making of the control activities are influenced by gender factor. The concepts of quality in health care had been firmly rooted in the spirit of the Hippocratic Oath, and in the bylaws of the medical practices in India, China and Greece (Kols and Sherman, 1998)[51], and had been defined in the context of the personal responsibility.

In most of the health systems, the quality in health care has been explained as the aggregate of extremely skill-based training and selection of health care personnel and a self-regulation process by the individual and the professional body (Harvey, 1996)[52].

The significance in the quality of health care had been invigorated due to numerous factors, such as viz., emphasis on the distribution of the resources; affordability and efficiency; high social contribution and customer activism in health; transformation of the managerial attitudes and culture in the private health care sector; public health care sector reforms; health care professionalism; healthcare standards; determination of the quality limitations of the primary health care setups; widening role of the private health sector in the advanced and developing countries; and an insight pertaining to the methodical investigation and alternative solution of the critical problems (Blumenfeld, 1993; Shaw, 1993; Scrivens, 1995; Reerink and Sauerborn, 1996; Stern, 1997)[53, 54, 55, 56, 57].

Maxine Whittaker (1999)[58] had explored the evolution of the health care quality management principles, and had defined the doctrines evolved gradually in the health care quality management. The author had also investigated in to the structural and process quality improvement with the understanding of the illustrative application in the health care systems of the advanced economies, along with the outline of the challenges involved. Thus, the process of health care quality improvements has emerged as the proactive, methodical and persistent process which had complicated the role of the marketing the health care services.

Sandra S. Liu and Alan J. Dubinsky (2000)[59] had studied the evolution and development of the health care industry in Hong Kong by conducting the survey of the patients, and had suggested the essentials of Quality Health Care. Moreover, the conceptualization and measurement of customers' perception have increasingly attracted the marketing researchers focusing on the service quality literature (Brady and Cronin 2001)[60].

The emergence of the various concepts, viz., services marketing, relationship marketing, targeted marketing, integrative marketing, etc., have been embraced by the marketing practitioners and academicians along with significance of the service quality and customer satisfaction, delight and value (Niraj et al. 2001)[61].

Brand, Richard R., Cronin, Joseph J., and Routledge, Jeffrey B., (1997)[19] had examined the process by which older Americans analyzed the service quality of the personal health care provider, They had suggested that service quality perceptions are related with in particular to the factors, viz., the physician, the office staff, the medical office environment and processes, and the externalities, and directly influences service value and satisfaction attributed to the service provider, as well as the purchase and repeat purchase behavior. They had also suggested that sacrifice has a direct effect on the value attributed to the health care providers' services and the healthcare seeker.

McAlexander, Kaldenberg and Kocnigg (1994)[62] had suggested that various medical services are differentiated by the patients' on various quality factors, viz., convenience, service attentiveness, physical facilities, responsiveness, and the credentials of the staff.

Jaideep G. Motwani, Chung Hung Cheng and Manu S. Madan (1996)[63] had described, in the form of the case study, strategies and the process used by the organization in obtaining the ISO 9001 certification by the large health care manufacturing organizations.

Aanchal Kapur and Meenu Pande (2005)[64] had provided an empirical check of some assumptions used to define the quality of care in the health services literature in general, and had specifically tested the service intensity as the only determinant of the provider's quality, and that the high service intensity always causes higher quality. Berry, Mirabito, and Berwick (2004)[25] had observed that customers were not been accustomed for considering price or even knowing it for their health care decision making. Moreover, with price becoming more likely to enter the consideration set regarding health care purchases, it has become essential to understand the role it plays in the patients' decisions. In the health service costs to the patients are rarely limited to service alone and generally involve increased effort by the client, that is traveling long distances, psychological and physical discomfort, viz., impersonal treatment, uncomfortable diagnostic procedures, the fear of hearing bad news about illness and treatment of pain, and waiting limitations, viz., waiting hours, days, or weeks to get an appointment, for examinations, tests and operations. John Quelch (1980)[18] had identified the common tendency of the customers to associate price with quality of the services which further add to the dilemma of the health care marketers in designing the marketing mix as setting the lowest possible price would not necessarily constitute to the effectiveness of the pricing policy of the concerned health care services. Moreover, a service when offered free may be perceived as less valuable in comparison to the other which is not offered free.

Dilaver Tenilimoglu and Sophia F. Dziegielewski (2000)[65] had analyzed the determination of the pricing or the cost of actual services by the private and Governmental hospitals in Turkey, and had also made the comparisons between the health services expenditures and the customer price index. They had suggested to the managers of public and private hospital managers about the general cost of health services. Raman Kutty (1989)[66] had studied the health care utilization in Kerala and identified three components of price that determine people's health care choices, viz., money, travelling time, and waiting time.

Access to medical care is one of the key determinants of health status, along with environment, lifestyle, and heredity factors (Starfield, 1973 and Blum, 1981)[67, 68] which has been linked to quality of care and efficient use of the needed services with the growth of managed care and the ensuing integration of health care financing and delivery (Williams and Torrens, 2002)[69].

Some efforts have been made at developing systems for assessing performance and generating information to assist in the distribution of resources in the health sector (Isaac Adams, Daniel Darko and

Dr. Sandro Accorsi, 2004)[70]. Unlike other industries, it has been difficult to gain economies of scale by creating large facilities in the health care as the health care services cannot be stored which has been limiting the distribution of the health care services to some extent demanding tactful designing of the distribution policy by the health care marketers (Ramesh Bhatt and Nishant Jain, 2006)[71].

Sherman T. Folland (1997)[72] had provided an extensive review of literature pertaining to the spreading and sustaining of the innovations in health service delivery and organization from the perspectives of defining and measuring the diffusion of innovation in organizations, and reviewing the literature in a systematic and reproducible way. The author had discussed the prudent and evidence-based model for considering the diffusion of innovations in health service organizations, clarified knowledge gaps, a vigorous and transferable methodology for systematically reviewing health service policy and management. Designing the communication strategy by the health care service marketer for the target market has been among the most critical criteria of the marketing- mix strategy. The marketer has to develop an insight not only on the modes that are generally adopted and preferred by the target customers, but also that preferred by the potential and the present customers.

Moreover, in order to create unity and commonality among people, for changing knowledge, attitudes and behaviour, the communication of the health information is important by adapting and integrating the suitable communication methods, that has the potentials of many media in terms of effectiveness on the various criteria, viz, characteristics of the recipients; particular health problems; channels of communication; content of the message; timing; social context; community norms; cultural attitudes, and, behaviour of community (Vasuton Tanvatanakul, Joau Amado and Sastri Saowakontha, 2007)[73].

Mischa Willis Shattuck, Posy Bidwell, et. al., (2008)[74] had undertaken a systematic review to consolidate existing evidence on the impact of financial and nonfinancial incentives on motivation and retention, and had concluded that motivational factor were undoubtedly country specific, of which the financial incentives, career development and management issues were the core factors. The financial incentives are not enough to motivate health workers. International migration has been widely blamed for being resulting into the crises of the human resources in general (Hongoro C. and Normand C, 2006)[75] which has become their common practice for filling up the vacancies in richer countries (Stilwell B, Diallo K, et. al., 2003)[76] resulting into medical carousel. Medical Carousel refers to the movement of the health workers to the countries offering varied attractions, viz., better salaries and training opportunities, thereby leaving the poorest countries with all drain, and no gains. Furthermore, such loss of experienced personnel has serious impact on health system progression (Eastwood J.B. and Conroy R.E., et. al., 2005)[77]. Chikanda A. (2005)[78] had emphasized on the migration of the health worker from the rural to the urban areas or from public to private sector within India which had affected the rural areas at the worst from both the understaffed and under-qualified staff.

Chopra M., Munro S., Lavis J., Vist G., and Bennett S. (2008)[79] had suggested Government to summarize the various studies on the migration of health worker, the strategies to retain and motivate them in the designing the policies to overcome the human resources crisis in the health sector. C. Skinner and P. Spurgeon (2005)[80] had examined the association between health managers' self-assessed compassion, their leadership behaviour as ranked by the staff, and their individual rating on the staff's personal ratings on a variety of work satisfaction and its results. A. Laing; G. Hogg and D. Winkelman (2004)[81] had examined the role of the Internet as a source of patient information and support, and in particular the effect on the relationship between informed customers and professionals involved in the delivery of health care services. Thus, the Internet as an information resource can best be viewed as being facilitating the actualization of latent consumerist behaviour in health care rather than directly engendering customer patterns of behaviour. The basic classification of the resources and the types of healthcare information available to the consumers via internet has been stated in brief in the Table Number 2.1 as follows:

Table Number 2.1: Categorization of Internet Health Care Information Sources

Sr. No.	Generic Information	Product Information	Patient Information
01	Basic Education on Medical Conditions from Health Promotion Websites	Detailed Drug Information from Manufacturer Websites	Special Interest Groups
02	Basic Education on Treatment from Health Promotion Websites	Detailed Medical Device Information from Manufacturer Websites	Online Support Groups
03	Medical Therapeutic News	Consultation with Specialists	Success/Failure stories.
04	Medical Journals	Locating a Specialist	
05	Conference Highlights/Bulletins	Company Specific Medical News	

Source: A. Laing; G. Hogg and D. Winkelman, 2004[81].

However, the accuracy and quality of information available via Internet has been the central challenge for the Internet empowered customers (Impicciatore et al., 1997)[82] along with the validity of the information available in comparison to that accessed from the other formats (Falnigan and Metzger, 2000)[83].

Adrienne Curry and Gail Knowles (2005)[84] had demonstrated progress in terms of operational and strategic information management and had highlighted some of the problems experienced in the health-care environment in striving to comply with the Government policies relating to information sharing.

Teo and Ang (1999)[85] had argued that the current introduction of new IT in hospitals as deviation of the priorities and significance from the business processes, management problems and organizational culture to the procurement of the hardware and software.

David Greatbatch, Elizabeth Murphy and Robert Dingwall (2001)[86] had examined the contributions of the qualitative research to the evaluation of the medical information systems by comparing and contrasting an interactionist and an enthno-methodological perspective of using the medical computer systems as well as by assessing their strengths and weaknesses.

The health care system of India is the most highly privatized systems in the world which functions with the traditional tiered public health sector, with the conflicting perceptions about each other, having no empirical support (World Health Statistics, 2007)[87]. The uncooperative attitude between the public and private health care sectors has been nurtured by the conflicting perceptions about each other (Uplekar, Pathania and Raviglione, 2001)[88]. Ayesha De Costa, Eva Johansson and Vinod K. Diwan (2008)[89] had found that the barriers of the mistrust have been hindering the true dialogue, and are complex, with social, moral and economic bases. They had suggested structural changes that would foster the long-term effective Public-Private Partnership (PPP) in health care sector of India. Undoubtedly, the health care services provided by the public health sector have been used extensively by the upper as well as lower classes of the people in India (Hardip Chahal, R. D. Sharma and Mahesh Gupta, 2004)[43].

However, because of the inability of the states to fulfill the demands of the population, the entry of the private sector have been encouraged by the Government, and has become an important constituent of India's health care delivery system (Ramesh Bhatt 1993; Chatterjee 1993; Duggal 1998; Yesudian 1994)[90, 91,92,93].

In order to accomplish the customers need the private health care sector has initiated the customer-focused practices (McAlexander et al., 1993)[94] in advancing countries, while, the public health care sector has been lagging behind identifying and implementing the similar approach in the context of the health care centers (Hardeep Chahal 2002; Sharma and Chahal 1995; Srilatha and Artken 1991)[95, 96, 97]. Gradually, the private sector health care providers have been recognized by the community, as more receptive from the context of the availability, timings, and accessibility of services (Amit Patel, K.V. Ramani, Dileep Mavlankar et. al., 2007)[98].

In spite of this, the private sectors are also criticized for providing low quality health care by few experts. Nandraj and Duggal (1996)[99] had conducted a study in two districts of Maharashtra and found that large numbers of doctors practicing modern medicine were unqualified; several hospitals were not having even the basic infrastructure and personnel to carry out their functions, and were operating without any licenses or registration.

Nandraj, Khot and Menon (1999)[100] had studied private medical hospitals in Calcutta and Bombay and reported that the poor state of private sector facilities and frequently carrying of the medically unnecessary procedures on patients.

From the ethical perspective, conducting health care strictly as a business has been deteriorating the doctor-patient relationship by treating patients like customers specifically or the relationship between the service seeker and service provider in particular (Lee, 2001)[101].

P. Rameshan and Shailendra Singh (2005)[102] had examined the customer orientation of primary health centres of a district in the state of Uttar Pradesh in India, and had explored from the context of the health care customers, the input level facilities, availability of health care personnel, attitude and behaviour of doctors and other staff pertaining to the customers.

Ramesh Bhatt (1996)[103] had commented on the lack of evidence against the practitioners of traditional systems practicing modern, allopathic medicine without any sanctions, as well as absence or inadequate enforcement of the malpractice laws against misbehaving doctors on account of doctors' unwillingness to depose against their peers. In many of the private doctors' accounts, patients were perceived as customers rather than as individuals in need of health care accompanied by the doctors' effort to satisfy the patients at the expense of correct diagnosis and treatment. Investigations and treatment were performed and prescribed respectively on the basis of the patients' request and financial situations, and diagnoses were often based on symptoms and signs. It has been also pointed that the patients' ability to pay has been influencing the doctors' referral practices. However, in the view of the doctors, the social and financial dependent role of the women has been influencing the female patients' ability to pay (Grethe Fochsen, Kirti Deshpande and Anna Thorson, 2006)[50].

While, facing the challenges of improving health in India, the key five emerging concerns were, viz., encouraging equity by lowering household expenditure in total health spending and innovating the alternate health financing mechanism; vigorous public health infrastructure, and reformation of the existing primary health care system ensuring higher accountability; plummeting the disease burden and the level of covariate risk; setting up the institutional frameworks for advanced health governance quality; and investing in know-how and human resources for the added additional proficient and skilled workforce as well as superior examination, to be addressed by the resolved policy framework (Report of the National Commission on Macroeconomics and Health, 2005)[104].

The health care marketers face enormous pressure in demonstrating the effectiveness of their strategies, and their growing contribution to the accomplishment of the organizational goals. A tool for measuring, organizing and tracking the same had been discussed by William R. Gombeski, Jr., Jason Britt, et. al., (2008)[39]. The framework starts off at the bottom with the most simple measures, structure and process, and then follows with different levels of increasingly more valuable outcome measures to the management and marketer followed in increasing value by performance, benchmarking, financial and leading marketing measures.

Hence, successful marketing of the health care services demands the active involvement of the marketer at the program development stage that is the stage of product concept formulation as it is the set of benefits to be delivered to the target market on the implementation of the program.

But, the increasing health care costs led by the various innovations in order to cure the complex diseases or the newly technologically designed health care services have raised the issue of the healthcare financing. Moreover, due to the inadequate role of the central and state Government in financing the health care spends of the citizens has resulted into the reliance of the people on the private out-of-pocket expenditures. In such case the effective health care financing mechanism has to be identified and nurtured inevitably, that enables effective and efficient marketing of health care service. One of such mechanism identified is insurance or the insurance services, in general, and, the health insurance services in specific.

2.2.1: Insurance: An Introduction:

According to M.N. Mishra and S. B. Mishra (2007)[105] as per the functional definition, insurance is a co-operative device to spread the loss caused by a particular risk over the number of people who are exposed to it and who agree to insure themselves against the risk.

It is the co-operative device of distributing losses, falling on an individual or his family over the large number of persons, each bearing a nominal expenditure and feeling secure against heavy losses. As per the contractual definition, insurance is a sum of money as a premium paid in consideration of the insurer's incurring the risk of paying a large sum upon a given contingency. It consist of one party called as insurer, agrees to pay to the other party, called as the insured or his beneficiary, a certain sum upon a given contingency known as the risk against which insurance is sought. In financial terms, insurance is a social device in which a group of individuals called as insured transfer risk to another party called as an insurer in order to combine loss experience, which permits statistical prediction of losses and provides for payment of losses from funds contributed known as premiums by all members who transferred risk. In legal terms, insurance is contract by which one party in consideration of the price paid to him proportionate to the risk provides security to the other party that he shall not suffer loss, damage or prejudice by the happening of certain specified events. It is meant to protect the insured against the uncertain events, which may cause disadvantage to him (ibid).

2.2.1.1: Insurance Sector of India:

The insurance sector voyage in India has witnessed 360-degree turn over the period of about more than two centuries, thus, experienced the circular movement from being an open competitive market to nationalization and back to liberalized market. Insurance Companies are the establishments which provide insurance to the people. The framework for registration of the various insurers was provided by the Insurance Act, with its two major categories, viz., the Life Insurance and the General Insurance.

The life insurance business was started in India in the year 1818 with the establishment of the Oriental Life Insurance Company in Calcutta, followed by mainly, the establishment of the Bombay Mutual Life Assurance Society, the first Indian owned life insurer in the year 1870; enactment of the Indian Life Assurance Companies Act in the year 1912,the first statute to regulate the life insurance business; as well as the enactment of The Indian Insurance Companies Act in the year 1928 and the amendment in the same in the year 1938 for protecting the interest of the insuring public. The major turn in the insurance sector of the country came in the year 1956, with the nationalization of the 245 insurers from India and foreign countries as well as the provident societies by the central Government, forming Life Insurance Corporation (LIC) viz. LIC Act, 1956, by contributing Rs. 5 Crores from the Government of India. While, the General Insurance business in India commenced in the year 1850 with the establishment of the Triton Insurance Company Ltd., the first general insurance company in Calcutta by the British. The Indian Mercantile Insurance Ltd. was the first Indian company to transact in all classes of general insurance business which had been set up in the year 1907. While, the General Insurance Council, a wing of the Insurance Association of India was set up in the year 1957 and the amendment in the Insurance Act as well as setting up of the Tariff Advisory Committee was made in the year 1968.
The major transformation period in the General Insurance sector of India was brought by the nationalization of the general insurance business, by setting up the General Insurance Business (Nationalization) Act, 1972, which came in effect from the 1st January, 1973, by incorporation of the General Insurance Corporation (GIC) by amalgamating 107 insurers, categorized into four general insurance companies, viz., the National Insurance Company Ltd.; the New India Assurance Company Ltd.; the Oriental Insurance Company Ltd.; and the United India Insurance Company Ltd (www.indian-insurance.com; Accessed on 24/04/08)[106].

The share of India's services sector in the Indian economy, in terms of real GDP continued to rise consistently, which reached to about 66.8 per cent in the year 2011-2012 in comparison to 65.5 per cent in the year 2010-2011.The services sector of India registered the growth of about 8.2 and 7.1 per cent in the year 2011-2012 and 2012-2013, respectively. The growth rate of 8.6 per cent in the sectors, viz., financial, insurance, real estate and business services, among the varied sectors of the services sector was recorded in the year 2012-2013, in comparison to the 11.7per cent in the year 2011-2012 (IRDA Annual Report, 2012-2013)[107].

As on 30th September, 2013, there were about 27non-life insurance companies being operating in the non-life insurance business in the country, in addition to the General Insurance Corporation, as the sole re-insurer. Of which, six are in the public sector and the other in the private sector.

Among the public sector companies, there are two specialized insurance companies: one for credit insurance, that is., Export Credit Guarantee Corporation Ltd. (ECGC), and the other for crop insurance, Agriculture Insurance Company of India Ltd., (AIC). Of the private insurance sector companies, four have been granted license to carry on operations in the health segment as shown in the Table Number 2.2 (ibid).

Table Number 2.2:
List of the Non- Life Insurance Companies Operating in India

Sr. No.	PUBLIC SECTOR	Sr. No.	PRIVATE SECTOR
01.	New India Assurance Co. Ltd.	01.	Bajaj Allianz General Insurance Co. Ltd.
02.	National Insurance Co. Ltd.	02.	Bharti AXA General Insurance Co. Ltd.
03.	The Oriental Insurance Co. Ltd.	03.	Cholamandalam MS General Insurance Co. Ltd.
04.	United India Insurance Co. Ltd.	04.	Future Generali India Insurance Company Ltd.
	Specialized Insurers	05.	HDFC Ergo General Insurance Company Ltd.
05.	Export Credit Guarantee Corporation Ltd.	06.	ICICI Lombard General Insurance Co. Ltd.
06.	Agriculture Insurance Company of India Ltd.	07.	IFFCO Tokio General Insurance Co. Ltd.
		08.	Liberty Videocon General Insurance Co. Ltd.
		09.	L & T General Insurance Co. Ltd.
		10.	Magma HDI General Insurance Co. Ltd.
		11.	Raheja QBE General Insurance Co. Ltd.
		12.	Reliance General Insurance Co. Ltd.
		13.	Royal Sundaram Alliance Insurance Co. Ltd.
		14.	SBI General Insurance Co. Ltd.
		15.	Shriram General Insurance Co. Ltd.
		16.	Tata AIG General Insurance Co. Ltd.
		17.	Universal Sompo General Insurance Co. Ltd.
		Standalone Health Insurers	
		18.	Apollo Munich Health Insurance Co. Ltd.
		19.	Max Bupa Health Insurance Co. Ltd.
		20.	Religare Health Insurance Co. Ltd.
		21.	Star Health and Allied Insurance Co. Ltd.
RE-INSURER			
General Insurance Corporation of India			
*As on 30th September , 2013			

Source: IRDA Annual Report, 2012-2013[107]

The share of the Indian non-life insurance premium in global non-life insurance premium increased slightly from 0.62 per cent in the year 2011-2012 to 0.66 per cent in the year 2012-2013 and maintained its rank at 19th even in the year 2012-2013 (ibid).

While, the segment wise premium underwritten by the non-life insurance companies in India is summarized in the following table (IRDA Annual Report, 2011-2012) [108].

Table Number 2.3:
Premium (Within India) Underwritten By Non-Life Insurers-Segment Wise

Sr. No.	Non-Life Insurance Segment	2010-2011		2011-2012		2012-2013	
		(Rs. In Crores)	(In Per Cent)	(Rs. In Crores)	(In Per Cent)	(Rs. In Crores)	(In Per Cent)
01	Fire Insurance	4555	10.70	5430	10.27	6659	10.57
02	Marine Insurances	2519	5.92	2875	5.44	3029	4.81
03	Motor Insurance	18173	42.68	24239	45.84	29630	47.05
04	Health Insurance *	9943.93	23.35	11777	22.27	13975	22.19
05	Others	7386	17.35	8556	16.18	9680	15.37
	Total Premium	**42576**	**100.00**	**52876**	**100.00**	**62973**	**100.00**

Source: IRDA Annual Report, 2011-2012[107] and 2012-2013 [108] .
*Excluding Standalone Health Private.
Note: Figure (in per cent) indicate share of respective segment in total premium

2.3: MARKETING OF THE INSURANCE SERVICES:

An attempt has been made to present the review of literature on the marketing of this critical service in general which is the base for understanding, developing and implementing the marketing strategy for marketing of insurance services particularly, in health context in the form of review of literature on the same. Insurance Marketing is fundamentally knowledge marketing, in many respects. Moreover, the sales flow increases as seller knows more about the potential customers and their attitudes, goals and problems as well as the buyers knows more about the seller and his product, viz., why it is needed, and what solutions it offers the buyer for his problems (David L. Bickelhaupt, 1967)[109].

Robert Miner (1961)[110] had suggested the application of the five major principles of marketing set forth to the marketing of insurance. William S. Jewell (1974)[111] had surveyed, interpreted and presented the applications of operation research in the insurance industry.

John S. Bickley (1967)[112] had provided an overview of the insurance marketing in general, as well as Bernard L. Webb (1974)[113] had provided an overview of the changes in the insurance marketing. While according to Gary K. Stone (1973)[114], the marketing of term insurance is rare, unless, it is in combination with a base cash value policy, or is used for unsure return of premiums. Thus, buying insurance is accepting the relative small but definite financial loss in order to avoid a larger possible loss.

Arthur Meidan (1982)[115] had reviewed the various characteristics that make the marketing of insurance products different in comparison to the manufacturing ones, viz., perishability, inseparability, heterogeneous, fluctuations in demand, labour intensive, the impact of Government legislation, size and distribution of the population and national income, competition, and, inflation.

Rahman and Khondkar (2000)[116] had presented the significant differences between insurance service and other services, viz., the greater complexity of the insurance services; involvement of the substantial legal characteristics subject to the future contingent services, absence of scope for immediate utility for the customers; long waiting period to enjoy the benefit of the insurance purchase, and, the tedious function of informing, educating, motivating, persuading, advising and providing other services prior to, at the time of and after the issuance of the insurance documents. Marketers are involved in the marketing different types of entities, viz., goods, services, experiences, events, persons, places, properties, organizations, information and ideas (Philip Kotler and Keller, 2006)[117].

The marketing of insurance falls in the category of service marketing among these entities. Services can be referred to the deeds, processes and performances, in simple terms. Broadly, service include all economic activities whose output is not a physical product or construction, is generally consumed at the time it is produced and provides added value in various forms, such as, convenience, amusement, timeliness, comfort, or health, that are essentially intangible concerns of its first purchaser (Zeithaml and Bitner, 2000)[118]. Services can also be as any activity or benefit that one party can offer to another that is essentially intangible and does not result in the ownership of anything (Philip Kotler and Keller, 2006)[117]. In other words, insurance marketing can be described as the marketing processes and practices of organizations doing insurance business aiming to satisfy the specific needs of their target customers, which involves various marketing efforts in varied forms and issues.

The brief review of literature on the insurance marketing issues is presented as follows.

2.3.1: Issues in the Marketing of the Insurance Services:

The marketing of the insurance services involves the determination of the marketing strategy, identification of market segmentation, identifying the target markets, positioning the insurance product in the minds of the potential policyholders, as well as application of the elements of marketing.

However, insurance being the service entity of marketing, the application of marketing, starting from strategy determination to accessing the market needs, satisfying the target market, adds to the criticality in marketing insurance products.

These complex areas have even grabbed the attention of the researchers have been reviewed as follows:

2.3.1.1: Strategic Posture:

The word strategy has been derived from the ancient Greek word, strategos, which means the art of the general. However, the term strategy to the insurance people refers to the type of decision made by the top insurance managers concerning the relationship between the insurance organization and its environment. Thus, strategy describes those critical boundary-spanning judgments which explain the outline and trend for the marketing organization management as a whole.

An insurance firm strategy is a plan for action that determines how an insurer can best achieve its goals and objectives in the light of the existing pressures exerted by competition, on one hand, and its limited resources on the other hand. The strategic posture is recognized by the insurer partly on the basis of the competitive environment and partly on its allocation of marketing resources, which has to be determined in the light of the strengths, limitations and corporate objectives of the insurance firms.

The two broad categories of insurance marketing strategies are the growth strategies, viz., the geographical expansion; market penetration; new market strategy, and, cost cutting strategy, and, the competitive marketing strategies, viz., market-leader strategy; market challenger strategy; market follower strategy, and, market nicher strategy, whose characteristics are determined by the market objectives, target market, organizational structure (Arthur Meidan, 1982)[115].

2.3.1.2: Market Segmentation:

The insurance markets can be classified on the bases of various classification systems, viz., (1) System based on the role of the risk seller in the economy, viz., personal, agricultural, commercial and industrial; (2) System based on the intensity of the hazard involved, viz., high risk, standard risk and low risk; (3) System that separates the primary market from reinsurance market; (4) System based on the location, viz., local, state, regional, national and international; (5) System based on the population, viz., highly urbanized areas, large commercial and industrial towns, small secondary trading-center towns, and sparsely populated rural areas; (6) System based on the coverage, viz., how the coverage is acquired, where it is obtained, and the quantity and quality of service needed by the insured, (7) System based on form of coverage, viz., individual or group, with there being some shading of one type into the other through the use of franchise arrangements, and (8) System based on the degree of freedom association with the transaction, viz., free and captive markets (Robert I. Mehr, 1969)[119].

The marketing offer of the insurance companies varies on the basis of various aspects, viz., extensiveness of the markets to be covered, the intensiveness of the coverage of the market targeted, the current buying habits of insured, varied patterns of the behavioral changes (ibid).

2.3.1.3: Product Development:

Mark S. Dorfman (1971)[120] had explored the accelerated change in the insurance marketing and semantic aspects of the developments in the new products in the life insurance industry of India as the consequence of the completion explosion in the products and pricing of the life insurance sector. Michael L. Murray (1976)[121] had analyzed the performance of the private insurance innovation by distinguishing between two major types of innovations which were expected from the private systems and the public systems along with the effects of various models of industry organization and size of the firm.

Robert A. Peterson, William Rudelius, Glenn L. Wood (1972)[122] had investigated into issues of adoption and diffusion of demand-stimulating innovations by the life insurance companies' and differentiation of the offers from that of the other companies in the life insurance sector and thereby contributing to raise the market share of the company.

2.3.1.4: Process and Product Innovations:

Robin Pearson (1997)[123] had provided the distinction between the process innovation and product innovation for the insurance services. The changes in the process of producing the various lines of the insurance, such as viz., improvements in risk assessment in the form of the new policy conditions, new classifications of existing risks, in marketing, and in organization, are referred to as the process innovations. On the other side, the product innovations have been classified into two categories, such as, primary product innovation in the form of the new product and the secondary product innovations in the form of the new product for existing risks.

2.3.1.5: Pricing:

Pricing of the insurance products has been mystifying to most of the people as it is different from the pricing of the tangible and in other services, where figuring out of the cost of inputs is easier and the cost of providing them can be estimated with some judgment, respectively. In insurance transactions, the sale price, that is, the insurance premium is collected before stipulated services, such as, claim payments are provided duly. A fundamental principle of insurance pricing is that if insurers are to sell coverage willingly, they must receive premiums that are sufficient to subsidize their expected claim costs and administrative costs, and provide an expected profit to compensate for the cost of obtaining the capital necessary to support the sale of coverage. The insurance actuaries constantly face a trade off in determining the premium to charge for coverage, keeping in mind that the premium must be high enough to cover expected losses and expenses, and at the same time, low enough to remain competitive with premiums charged by other insurers (P.K. Gupta, 2006)[124].

The fair premium is that just sufficient amount to fund the insurers' expected cost and which provides the insurance company owners with a fair return on their invested capital (ibid).

In terms of the designing of the insurance prices, few markets can be developed with the designing of the sound products, with the prices within the financial capacity of the potential buyers, and the qualities of the product or service are understood and accepted (Harold H. Maynard, 1956)[125].

There are basically three recognized rate-making methods, namely, Judgment rating, Class rating and Merit rating methods. In non-life insurance, the insurers make estimates of the claims cost based on past experience, which are subject to review from time to time. The factors considered when pricing general insurance products are, viz., claims cost; business acquisition cost; management expenses; margin for fluctuations in claims experience and the reasonable profit (P.K. Gupta, 2006)[124].

Kiseok Oh and Han B. Kang (2004)[126] had attempted to develop a pricing model with which a premium can be assigned to an insurance contract with the implications in terms of the fairness or the individual premium of an insurance contract and had focused only on the net premium, not considering the expense load, and has regarded the insurance premium as the value of the payoff to an insurance contract.

2.3.1.6: Insurance Distribution Channels:

The pattern of insurance distribution has been changed and is also being changed with increasing speed on the basis of the careful studies of the insurance consumption patterns. Robert A. Rennie (1957)[127] had attempted to show the need of the new marketing patterns for policy guidance and has also suggested some directions likely to be taken by these distribution concepts, along with emphasizing various features peculiar to the insurance marketing derived inherently from the characteristics of the insurance contract. Moreover, because of the rising costs of various types of insurance coverage, coincided by the greater price conscious customers, the insurance companies are compelled to experiment with less costly distribution methods (David L. Bickelhaupt, 1967)[109].

John J. Burnett and Bruce A. Palmer (1983)[128] had highlighted the ability of the agent to effectively sell his or her products as the primary reason behind those customers having insurance agents and others do not. The system of using brokers, legally representing insured rather than the insurer, has been a part of the insurance marketing system since long, unlike the agency systems, wherein the agent technically is writing the insurance for the insurer. However, in practice, the differences often are not noticeable by the purchaser. Group Insurance Systems is one of the most revolutionary ideas in the marketing of the insurance services, which is hardly investigated by the property-liability insurance business.

Laureen Regan and Sharon Tennyson (1996)[129] had emphasized on the role played by the sales agents in obtaining the information about customers. The distribution of insurance services is also being changed dramatically by the Internet (Peter J. Aspinall and Bobbie Jacobson, 2005)[130].

The insurance malls are the growing resource for online insurance shoppers, offering one-stop shopping which have forced many insurance companies to establish partnerships with them. Many insurance companies are currently using their own web presence largely to make available company-specific information and to generate sales leads.

2.3.2: Information Technology (IT) in Insurance Marketing:

Richard L. Manning, Matilde K. Stephenson and Jerry D. Todd (1985)[131] had attempted to forecast the IT utilization and its impact in the insurance sector. Trevor Watkins (1988)[132] had presented the views and evidence on the use of various forms of Information Technology (IT) made by the various insurance companies in UK in their sales and marketing activities with the objective to audit the quantity and quality of IT usage in the sales and marketing activities of insurance companies.

2.3.3: Insurance Promotional Strategies:

According to Richard Baker (1961)[133], the insurance product or service is an intangible and it promises to fill the future need, or perhaps it may never fill a future need at all, depending upon how each buyer feels. Hence, the response eliciting from the clients has become the basic requirement in order to sell the insurance policy by the insurance marketer.

In the marketing of insurance the only promise of satisfaction to an insurance buyer in this case is peace of mind, along with the opportunity, or else to spend each penny at somewhere else for another good or services that promises more tangible or immediate satisfaction, instead of insurance. Thus, while marketing insurance services, insurance product has to compete firstly, with goods and services that promises greater economic utility as compared to the various types of insurances, viz., property, casualty, health or life insurance policy. Apart from this, there are various factors that cause an individual to respond to the appeals, directed emotionally as compared to the rational and logical appeal. Thus, the insurance marketer has to use the emotional language more to persuade the client and discover the action strategy on the basis of client's analysis. The author had suggested the approaches to produce an emotional experience, viz., happening of an event, a personal concern about the consequence of the event and the third is the feeling of bodily changes incurred inside an individual caused by the concern of the individual regarding the consequences of an event. Apart from this, the various abilities to be developed by the insurance marketer to assess and analyze the clients' wants, needs, desires, likes and dislikes were also suggested by the author.

Joseph M. Belth (1974)[134] had described variety of deceptive sales practices used in the life insurance business and suggested the ways in which such practices might be modified in order to eliminate the element of deception.

Gary K. Stone (1973)[114] had emphasized on the unsound sales practices of selected life insurance companies selling on the college campus by describing in depth the problems encountered. The author had suggested that in order to reduce the severity of the problems, the combined efforts shall be made by the campus administrators, the insurance industry and the insurance regulators.

Syed Maruf Reza and Mohammed Masum Iqbal (2007)[135] had critically examined the marketing of insurance in Bangladesh and depicted that the insurance companies are not marketing oriented apart from being void of marketing research. The authors had also identified the insurance marketing problems in Bangladesh, viz., low per capita income; poor knowledge of agents; illiteracy of prospects or target customers; religious superstition; low awareness of prospects; low savings of target market; lack of continuity; lack of reminder; negligence of policy holders; poor services to policy holders; low return to the customers, and, lack of reliability and so on.

They had suggested insurance marketing performance measures, viz., sales force training; building awareness of prospects; diversified policies; marketing research for improved strategies; improvement of the sales force commitment; new legislation; improvement in professional ethics; quick settlement of claims, and, expansion of coverage, respectively.

2.3.4: Ethical Issues in the Insurance Marketing:

Stephen R. Diacon and Christine T. Ennew (1996)[136] had examined the nature of the various ethical problems from the conceptual perspectives. They had reviewed the key ethical issues in marketing of the financial services by conducting a survey of the insurance company executives on the basis of the empirical evidence. Thus, undoubtedly, the face of the service mix has been changing due to the changing socio-economic requirements, the gap in the services promised and services-offered is found expanding, resulting into various other marketing problems to the insurance organizations. Moreover, by conceptualizing modern marketing principles, the insurance business can be improved, the profitability can be increased and the quality of services can be matched to the changing expectations of the users (S. M. Jha, 2003)[8].

2.4: HEALTH INSURANCE: AN INTRODUCTION:

The combination of physical, mental, and social well-being forms the overall health of any individual, commonly referred to as the Health Triangle. It forms the overall 'Health' of any individual (http://en.wikipedia.org; Accessed on 07/07/10)[137]. The health problems are the major cause of financial anxiety, as without adequate financial support, treatment, hospitalization often results in financial upheaval. More than 40 per cent of hospitalized Indians borrow money or sell assets to cover medical expenses (Reddy, 2007)[138].

Therefore, resorting to the creative uses of healthcare financing is the only powerful means to trim down the financial saddle and improve the accessibility of the healthcare delivery (N. Devadasan and Sunil Nandraj, 2006)[139].

Insurance theory has been extensively used in health care insurance (Arrow K. J., 1963)[140]. Moreover, the use of the health insurance-based services has been further enhanced with the reorganization of the health care sector in the mid-1980s, which has paved the way to the health care financing through the financial institutions, and reduction in the import duty on medical equipments and technology. Also, the various socio-economic transformations, such as, increase in the literacy rate, rise in awareness due to widespread infiltration of the media channels', has heightened the attention paid to health by the individuals, followed by the development of the charity hospitals by many family-run-businesses set up lending their name, thereby has also developed good market image, as well as the healthcare sector, generally, and the pharma sector, particulary (Nagendranath and Chari, 2002)[141].

Health insurance, one of the methods to finance healthcare and medical care offers the enrollees the financial reimbursement assurance on incidence of the specific incident in turn of the premium paid basically meet up the costs of the benefits (http://www.ehow.com; Accessed on 20/03/09)[142].

Ashoke S. Bhattacharyya and Puneet K. Sapra (2008)[143] had provided an overview of the trends in the health insurance as financing mechanism for health care in India by discussing various health insurance approaches which meets the unique needs of various populations, and have suggested a broad policy approach to aligned and mobilized forces that had allowed the segmented expansion of public and private health insurance. Thus, health insurance can play an important role in addressing the societal burden of financial catastrophe that is faced by individuals in obtaining health care in the countries of China and India.

According to Ali Asgary, Ken Willis, Ali Akbar Taghvaei, Mojtaba Rafeian (2004)[144] health insurance reduces the influence of high health care costs on the overall economic wellbeing of households. Hence, health insurance have been emerging as the most preferred form of health financing mechanism in the countries where private out-of-pocket expenditures on health are significantly high and cost recovery strategies affect the access to health care (Gilson, 1998; Sauerborn, Nougtara et. al., 1994; Ramesh Bhatt and Nishant Jain,2006)[145, 146, 147]. The insurance system assist the society to pool and transfer unexpected health care costs for the determined fixed premium, consequently, enables the individuals to avoid the shattering financial burden (Griffin, 1992)[148].

According to International Labour Organization(ILO), health insurance is the reduction or elimination of the uncertain risk of the loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in common fund that makes good the loss caused to any one member (N. Devadasan and Sunil Nandraj, 2006)[139]. It has been defined as the mechanism wherein the individual or group purchases health coverage in advance by paying a fee called ‘premium’, and, in broader sense includes all financing arrangements, whereby, the customers are able to defer, delay, avoid or reduce their expenditures at the time of use of services (Dileep Mavalankar and Ramesh Bhatt, 2000)[149]. Hence, it can be said that health insurance provides coverage for medicine, visits to doctor or emergency room, hospital stays and other medical expenses. It is an insurance against medical expenses, and loss of earnings due to accident or illness, which may either cover only individuals, or extended to their dependents, or may be purchased on group basis, that is, by a firm to cover its employees(http://www.encyclopedia.com; Accessed on 20/03/11)[150].

The health insurance is the type of insurance, whereby, the insurer pays the medical costs of the insured if the insured become sick due to covered caused, or due to the accidents. The insurer may be a private organization or a Government agency, or sometimes the non-Government organization.
As health insurance in India exists in its wider constellations, it can be said that health insurance includes covering of disability or long-term nursing or custodial care needs. But in each case, the covered groups or individuals pay premiums or taxes to enable themselves to protect from high or uncertain healthcare expenses(http://en.wikipedia.org; Accessed on 20/03/11)[151].Health insurance schemes may be compulsory or voluntary (http://www.encyclopedia.com; Accessed on 20/03/11)[150]. The policy of health insurance are basically the policy for a year and to continue the policy, the insured have to renew their policies (http://www.eksporttilindien.um.dk; Accessed on 28/08/09)[152].

According to Ramesh Bhatt and Nishant Jain (2007)[153], health insurance providers are normally averse in offering the health insurance policy for prolonged period due to numerous reasons, viz., the unexpected and uncertain health care costs on account of the advancements in the medical technology, medical research and medical procedures.

It also includes various other several reasons, viz., complexity in assessing the healthcare coverage costs; poor understanding of the issues pertaining to the health epidemiology of society and the complexities emerging thereby in determination of the price of the insurance products, and health insurance portability issues. In the mechanism of the health insurance, the insurance provider in connection with the third party administrator develops the network for offering the insurance services inspite of the unexpectedly high costs. Consequently, the inevitability of renewing the health insurance policy has been accelerated.

Peter Diamond (1992)[154] had pointed out the presence of risk categories due to which the possibility of extensive rise in the premiums and drop of the entire business line by the insurer is common threat being faced by the health insurance customers on renewal of the health insurance. On the other side, the health insurance buyers may also opt to shift to another insurance company offering the health insurance product, which further complicates the health insurance mechanism.

John H. Cochrane (1995)[155] had described health insurance as the insurance contracts that solve the problem of insuring the people with long-term illnesses that involve severance payment as the solution. The author suggested the time-consistent contracts along with its implementation outline to the insurance companies in order to provide long-term insurance without intrusive and distorting regulations, but with the policy route of deregulation to achieve it.

2.4.1: Evolution of Health Insurance:

The concept of health insurance for the first time was proposed in the year 1694 by Hugh the Elder Chamberlien from the Peter Chamberlien family. In the late 19th century, accident insurance began to be available which operated much like modern disability insurance.

Until the start of the 20th century, the payment model of this accident insurance/disability insurance continued in certain jurisdictions, like California, where majority of the laws regulating health insurance actually referred to the disability insurance. Accident insurance was first offered in the United States by the firm named Franklin Health Assurance Company of Massachusetts, which covered insurance against injuries arising from railroad and steamboat accidents. By the year 1866, about sixty organizations were offering accident insurance in the U.S., however, the industry was consolidated rapidly soon thereafter. In the year 1890, the sickness coverage was introduced in the U.S., and, in the year 1911, the first employer-sponsored group disability policy was issued (http://en.wikipedia.org; Accessed on 20/03/11)[151].

The fee-for-service business model was popular before the development of medical expense insurance under which the patients were expected to pay all other health care costs out of their own pockets.

Gradually, from the period of mid to late 20th century, traditional disability insurance was evolved into the modern health insurance programs and during the first half of the 20th century, hospital and medical insurance policies were introduced. Unlike, at present, the comprehensive private health insurance programs, does covers the cost of routine, preventive, and emergency health care procedures, and most of the prescribed drugs. By the year 1929, through the period of 1930s and World War II, services on the pre-paid basis to the individuals by the individual hospitals were started which gradually evolved into the present day' Health Maintenance Organization (HMOs) business model of health insurance (ibid).

It was only in the year 1912, with the establishment of the first Insurance Act, the health insurance in its present form was introduced in India (ibid).

The present form of the Insurance Act was introduced in the year 1938 in India and since then till the nationalization of the general insurance industry in the year 1972, which had brought about hundreds of the private insurance companies under the sunshade of the General Insurance Company, with very petite change in the act in the real terms. However, the winds of liberalization which blew across India do had affected the insurance industry of India during the period of 1990s. While, in the year 1999, with the passage of the Insurance Regulatory Development Authority (IRDA) bill the private and foreign entrepreneurs were allowed to enter the Indian insurance market (ibid).

2.4.2: Health Insurance Mechanisms in India:

The health insurance program generally performs two major functions, viz., to rise the availability of healthcare and to safeguarding the households from rising health care costs during illness. It operates involving the mechanisms y of pre-payment and risk pooling as its basic essentials.

Pre-payment emerges as one of the main advantage of the health insurance programme, as the individual or families makes the payment for the probable or uncertain illness, when they are in the health and able state of making such payments which is thereby used to finance their health care needs, resulting into the state of no financial burden at the time of illness. The risk-pooling operates in three types viz., between the sick and the healthy, the rich and the poor, and, between the active and inactive. There are also some important values of health insurance, viz., solidarity and equity. Solidarity refers to the practice of contributing to the health insurance funds by the people being completely aware of the limitation of the direct benefit of their contribution, as would be utilized to assist others who needs aid. In the absence of this value the health insurance programme would fail. Equity refers to the cross-subsidy which is promoting both the types of equity, horizontally as well as vertically (N. Devadasan and Sunil Nandraj, 2006)[139].

The purpose of health insurance is to minimize the risk of financial catastrophe often resulting from unexpectedly large losses or expenditures by pooling the experiences of a large number of people (John F. Sheils and Patrice R. Wolfe, 1992)[156]. The health insurance programmes involves the insurance company who bears the risk and organizes the health insurance programme. The basic elements of the health insurance programme, viz., Insurer; Community; Provider; Risk Management; Administration and Quality. There are also three subsidiary elements of the health insurance programme other than these 06 core elements, viz., administering the health insurance programme, managing the risk and finally ensuring the quality (N. Devadasan and Sunil Nandraj, 2006)[139].

However, there are comparatively more number of the stakeholders in the health insurance in comparison to the other types of insurance, viz., health providers; Government; the community; employers; distributors (Agents); insurance company; third party administrator, and, insurance products, apart from the varied health insurance schemes (Ramesh Bhatt and Nishant Jain, 2006)[71].

2.4.3: Health Insurance Sector of India:

The healthcare insurance sales can be classified under retail, corporate or Government categories. The retail category constitutes of about 40 per cent of the total healthcare insurance in India along with the increase in other categories. In India, initially, the health insurance was within the domain of non-life insurance. However, to make it more effective IRDA of India allowed establishing stand-alone health insurance companies to market the health insurance products exclusively, in addition to the non-life insurance companies. Government of India has also suggested to lower down the capital requirement of stand-alone health insurance companies from Rs. 100 Crores to Rs. 50 Crores and increase in foreign direct investment (FDI) from 26 per cent to 49 per cent, as per the proposed "Insurance Amendment Bill, 2008" (Nina Mehta, 2009)[157].

The health insurance sector is projected to grow by 38 per cent, with US $ 5.75 Billion, and US$ 10 Billion by the year 2010 and 2018 respectively (http://www.directories-today.com; Accessed on 24/04/09)[158]. The health insurance premium has increased by 6 times that is from Rs. 2221 Crores in the year 2005-2006 to Rs. 13,975 Crores in the year 2012-2013 (IRDA Annual Report, 2012-2013)[107].

The market share of the health insurance segment was recorded at 22.19 per cent in the year 2012-2013 as against 10.91 per cent in the year 2005-2006. Hence, the health insurance segment of India had recorded the highest CAGR of 30.05 per cent during the period 2005-2006 to 2012-2013which was substantially higher than CAGR of the Gross Domestic Premium growth during the period 2005-2006 to 2012-2013 of about 17.50 per cent. Accordingly, the infiltration of health insurance has observed the spiky growth, which is in contrast with the non-life sector excluding health which has a CAGR of 15.25 per cent, which in low even in comparison to the growth of Indian economy (ibid).

Various studies in India have analyzed the health insurance sector and its challenges in terms of the availability, efficaciousness and health care quality, and have thus offered the critical comments on Indian health delivery and financing mechanism (Berman and Khan 1993)[159]. Gupta (2007)[160] had also provided the critical review of published and grey literature on the health insurance in India. Rao (2004)[161] had also discussed the issues and challenges for health insurance sector in India. Although, competition has been considered as inevitable by the economists in the various economic sector of any country, the competition in the insurance market of the country has been regarded as somewhat problematic (David M. Culter and Sarah J. Reber, 1998)[162].

Moreover, the increased globalization has also posed the global challenges for health insurance and health provision which has been affected greatly by more people purchasing the health care products and services across the world, due to the improved communication and travel facilities (Hima Gupta, 2007)[163]. Few studies have tried to analyze causes for low health insurance penetration in India (Ellis et al., 2000)[164].

According to Ramesh Bhatt and Sunil Kumar Maheswari (2004)[165], the complexities in the health insurance industry has been much talked about but less understood, especially in Indian scenario. The health care sector has been witnessing the proliferation of the medical technology and new treatment protocols which has further resulted into the increase in the health care which stretch the justification of the inevitability of the health insurance. The slow growth in the health insurance can be attributed to the various factors and regulation in this sector in terms of the opening up of the sector and challenges posed by the entry of the corporate hospitals to be addressed by the insurance industry and its regulators.

These challenges are, viz., an estimated one-third increase in claim amount due to the moral hazard; the adverse selection problem and/or the provider-induced demand; rationalizing the cost structure of treatment in a private healthcare sector characterized by uncontrolled and unregulated expansion; about more than one-third of reimbursements made towards doctor's fees, followed by diagnostic charges accounting for about one-fourth; lack of actuarial data, lack of standardized billing and under reporting of information by private providers; high administrative cost of insurance companies; and slow claim processing.

Anil Gumber and Veena Kulkarni (2000)[166] had looked into issues related to the availability and the needs of health insurance coverage for the poor, especially women, and the likely constraints in extending current health insurance benefits to workers of the informal sector. The various other thriving aspects of the competitive insurance market, viz., the low rates of the insurance premiums and absolute cap on each of the specific areas of the services provided by the insurance provider instead of that on the total payout as a percentage of the total sum assured by the insurance provider, encourages the organized health care service providers to launch innovative business opportunities and models (Arvind Singhal, 2007)[167].

Kosali Simon (2008)[168] had emphasized the role played by the health care reforms by identifying some of the areas which has increased the need for better warehousing and maintenance of policy databases, and discussed this research agenda by the Agency for Healthcare Research and Quality in state health insurance policy. Thus, an initiative was made by the author to augment the market-level data available to researchers. The author had also highlighted the data needs for the study of state health insurance markets that enables the researchers to examine the other new issues.

2.4.3.1: Reviewing Performance of the Non-Life Insurance Companies:

The total health insurance premium in the year 2011-2012 was recorded at Rs.9, 47236 Lakhs which increased to Rs.11, 09,850 Lakhs in the year 2012-2013 in comparison to the total premium collected by the companies in the non-life insurance segment (IRDA Annual Report, 2012-2013)[107]. Moreover, the total health insurance premium collected by the public and the private sector companies in the year 2011-2012 was Rs. 8148.23 Crores and Rs. 3660.79 Crores, respectively, indicating the dominance of the public sector companies, which increased to Rs. 9592.15 Crores and Rs. 4382.52 Crores, respectively, in the year 2012-2013. The health insurance premium by the standalone companies in the year 2012-2013 was recorded at Rs. 1726.21 Crores against Rs. 1659.78 Crores in the year 2011-2012 as stated in the Table Number 2.4 (IRDA Annual Report, 2012-2013)[107].

Table Number 2.4:

Health Insurance Premium Underwritten (Premium in Rs. Crores and Growth Rate in Per cent)

Sr. No.	Insurer	2011-2012		2012-2013	
		Premium	Growth Rate	Premium	Growth Rate
01	Private	3660.79	20.76	4382.52	19.72
02	Public	8148.23	17.88	9592.15	17.72
03	Standalone Health Private	1659.78	8.07	1726.21	4.00
	Total	**13468.80**	**17.33**	**15700.88**	**16.57**

Source: IRDA Annual Report, 2012-2013[107]

The detail review of the net premium income earned by the players in the health insurance segment is provided in the Table Number 2.5.

Table Number 2.5:

Segment Wise Net Premium Income by Non-Life Insurers (Earned) (Rs. In Lakhs)

Sr. No.	Name of the Non-Life Insurance Company	2011-2012		2012-2013	
		Health Insurance Premium	Total Premium	Health Insurance Premium	Total Premium
01.	Bajaj Allianz	35626	247468	47264	292433
02.	Bharti AXA	9345	56463	18098	88638
03.	Cholamandalam MS	17297	86913	23740	116743
04.	Future Generali	10554	52133	13057	73910
05.	HDFC Ergo	19621	91447	24407	124257
06.	ICICI Lombard	109915	354900	111654	400925
07.	IFFCO Tokio	13302	133268	16560	162408
08.	L & T General	405	4889	1708	11962
09.	Liberty General	---	----	----	(46)
10.	Magma HDI	---	----	-----	1427
11.	Raheja QBE	---	794	----	1444
12.	Reliance	19437	116309	21829	135982
13.	Royal Sundaram	18515	110503	17583	124063
14.	SBI General	243	3461	449	22413
15.	Shriram	---	54286	----	100934
	TATA AIG	9839	108432	11471	138774
	Universal Sompo	2554	24654	3938	34131
	Sub Total (Private)	**266652**	**1445919**	**311759**	**1830399**
16	National	160843	607353	209311	746848
17.	New India	197465	787459	231762	945064
18.	Oriental	129914	489306	140179	538711
19.	United India	192361	**608724**	**216840**	**725094**
	Sub- Total (Public)	**680584**	**2492842**	**798091**	**2955717**
	Grand Total	**947236**	**3938761**	**1109850**	**4786116**

Source: Constructed from IRDA Annual Report, 2012-2013[107]

*Other that Standalone Health Insurers and Specialized Insurers.

Figures in brackets represent negative values.

Among the states of the country, the state of Maharashtra stood first not only in terms of the total non-life insurance premium collected, but also that for the health insurance premium as well as the overseas mediclaim premium collected in comparison to the other states in India (Table Number 2.6) (ibid).

Table Number 2.6: State-Wise Gross Direct Premium Income (Rs. in Lakhs)

Sr. No.	States/Union Territories	2011-2012			2012-2013		
		Health Insurance	Overseas Mediclaim	Total	Health Insurance	Overseas Mediclaim	Total
01.	Andhra Pradesh	10612193	2628.99	432714.97	69542.39	3110.57	479479.07
02.	Arunachal Pradesh	203783	20.81	12908.75	80.34	0.29	1931.99
03.	Assam	587334	31.06	48947.65	7505.92	37.06	68971.30
04.	Bihar	2604874	35.24	124224.63	31529.15	51.76	176851.23
05.	Chhattisgarh	165936	35.05	62467.97	8726.55	38.24	79667.24
06.	Goa	1127970	119.08	47661.69	10674.40	158.92	57602.61
07.	Gujarat	7976301	2012.65	406772.16	88601.95	2129.03	501674.33
08.	Haryana	6044705	534.15	215874.62	78917.92	779.36	266608.30
09.	Himachal Pradesh	193665	18.20	27903.78	2619.91	30.26	39914.03
10.	Jammu & Kashmir	606704	46.50	47805.21	1013.40	39.98	40205.93
11.	Jharkhand	387630	77.61	40502.82	7878.02	85.99	60619.30
12.	Karnataka	11778647	3728.66	409867.61	141552.93	4331.31	489726.97
13.	Kerala	4512838	835.23	220686.61	60902.38	892.21	272389.98
14.	Madhya Pradesh	1131968	215.27	162469.37	15658.47	232.38	199133.01
15.	Maharashtra	36820791	12047.43	1337149.60	437345.54	13848.54	1579409.59
16.	Manipur	36742	2.75	3892.86	916.97	1.02	2485.92
17.	Meghalaya	730950	55.34	25069.61	312.75	4.75	5674.08
18.	Mizoram	2509.10	7.91	12753.13	793.97	0.95	3716.68
19.	Nagaland	46777	0.31	2614.43	380.22	1.10	2824.85
20.	Orissa	517876	66.08	106014.03	11356.94	76.39	114949.80
21.	Punjab	2742521	875.98	163652.20	15865.24	689.94	162954.07
22.	Rajasthan	1102939	296.29	238872.65	16562.78	320.29	277105.97
23.	Sikkim	76.45	0.96	2451.54	112.75	1.41	3360.13
24.	Tamil Nadu	121017.49	2844.73	512605.88	178402.86	3149.17	671397.32
25.	Tripura	2658.44	1.00	6908.76	2430.48	1.74	8892.81
26.	Uttar Pradesh	4250472	503.42	292773.58	55390.01	710.20	364728.12
27.	Uttrakhand	241194	55.42	32966.76	3772.69	69.54	43521.32
28.	West Bengal	7855681	1032.98	266266.12	99306.96	1065.81	330511.02
29.	Andaman & Nicobar Island	137270	3.92	10071.46	13.64	0.25	1358.31
30.	Chandigarh	614979	425.94	34880.82	5791.80	433.87	46614.07
31.	Dadra & Nagara Island	551422	54.23	19216.01	208.49	0.77	2344.83
32.	Daman & Diu	20548	0.24	2272.61	295.38	1.03	2335.51
33.	Delhi	127147.15	3764.21	438022.41	145462.04	4135.49	501626.00
34.	Lakshadweep	8466	0.38	2273.10	1.18	0.01	129.77
35.	Pondicherry	674163	42.56	26009.52	1080.85	34.78	11180.70
	Total	**129628204**	**32420.56**	**5797534.67**	**1501007.27**	**36464.49**	**6871896.16**

Source: Constructed from IRDA Annual Report- 2011-2012[108] and 2012-2013[107].

Note: Figures in brackets indicate the Negative Values

2.4.3.2: Types of the Health Insurance Formats in India:

The health insurance is administratively very complex form of financing health care as there is the basic shift from providing services to purchasing health care. Moreover, diversity of the population is the essence of India demanding the stratification from the planners and the policy makers. The health care in India is guaranteed to improve for all under the constitution, wherein social health insurance; private health insurance, and community health insurance are operating. Amit Banerji and Vishnu Ramdeo (2007)[169] had categorized the health insurance schemes, viz., voluntary health insurance schemes or private-for-profit schemes; employer-based schemes; insurance offered by not for profit organizations NPOs/Community based health insurance, and mandatory health insurance schemes or Government run schemes, viz., Employees' State insurance scheme (ESIS) and Central Government Health Scheme (CGHS) are explained in brief as follows:

2.4.3.2.1: Social Health Insurance:

The social health insurance is a mandatory health insurance particularly for the formal sector under which certain amount is deducted from the employees payroll as the part of the contribution and the grant provided by the employers is used in health care financing of the employees as well as their dependents. There are two compulsory and contributory health insurance schemes in India under Social Health Insurance that is the CGHS for the Government of India's civil servants and the ESIS for the low-paid industrial workers. The CGHS was introduced in the year 1954 as a contributory health scheme, provides the comprehensive medical care to the former as well as current central Government employees, members of parliament, Supreme Court and High Court and High Court judges. The benefit package includes both outpatient care as well as hospitalization. The ESIS was introduced in the year 1948 which provides cash and medical benefits in the form of the compulsory social security benefits, including coverage, viz., cash compensation for illness; maternity benefits; disability benefits; survivorship and funeral expenses on the death of the worker, for workers in the formal sector.

The ESIS has its own clinics, hospitals and health care personnel, empanelled with the selected private health care practitioners to offer medical care. Patients in need of the health care treatment from specialists unavailable at the ESIS centers can avail it the specialty centers which would be reimbursed by ESIS. Generally, health insurance form the part of the benefit package of the employer to the employee (N. Devadasan and Sunil Nandraj, 2006)[139].Governments are increasingly turning to market forces as a way to limit the cost of social insurance as the increasing costs of the social insurance has brought the centralized model of social insurance under the strained (David M. Culter and Sarah J. Reber, 1998)[162].

2.4.3.2.2: Community Health Insurance:

In order to provide the health insurance to the low-income people residing in the advancing economies, the Community Based Health Insurance (CBHI) have been considered as more suitable alternative by the author, and neither Government provided nor market mediated arrangement are suitable. The valid benefit of CBHI is in maintaining the low transactions costs of the scheme planned to meet the needs of the people, in influencing health behaviour through health education and offering of the health care. These schemes are more appropriate in reducing the informational asymmetries, influencing provision of health services, and designed to meet the specific community health care needs. In order to make the insurance popular among the people with low-income the insurance providers may emphasis on the communicating and campaigning of the exact idea of the policy, along with the collection, verification and reimbursement of the premium and claims. However, there are also certain limitations of the CBHI schemes. When Non-Government Organization (NGO) itself provides insurance, limited diversified risk pool curtails the capacity of NGO to provide coverage for variety of risks encountered by the target segment. Moreover, CBHI schemes are vitally dependent on the funds from the external sources, which further limits the actual accessibility of these schemes (Rajeev Ahuja, 2004)[170].

2.4.3.2.3: Private Health Insurance:

Private health insurance is a voluntary form of health insurance under which people can enroll and avail the insurance product according to the personal likes and premium paying capacity. In other words, it is the type of insurance that is sold either by the profit-making firms or private organizations to individuals or to the groups. Such insurance is voluntary for the individual or group as a whole, though it may be compulsory for members of the group. The private health insurance, thus, take care of the upper and middle-income people, with effective and sound regulated health financing, which do not ambit the low-income people (ibid).

Harmon and Nolan (2001)[171] found that on enrolling under the voluntary health insurance, the likelihood of hospitalization increases by 3 per cent compared to those individuals who have not availed such insurance policy. Hence, as concluded by the authors, the health care cost load seemed to have been decreased on surface only in reality

The health insurance schemes have been reviewed as follows.

Dileep Mavalankar and Ramesh Bhatt (2000)[149] reviewed various types of health coverage in India, and based on the ownership, has broadly divided the health insurance schemes as, Government or state-based systems; market-based systems, viz., private and voluntary insurance; employer provide insurance schemes and member organization-based systems, viz, Non-Government of co-operative systems.

Ramesh Bhatt and Nishant Jain (2007)[153] had stated that in spite of the growth in the private and micro health insurance schemes, the health insurance sector is still in its nascent stage of development.

While, Anil Gumber (2002)[172] had categorized the diversed health care programmes operating in India as the State-run schemes for formal sector employees; Public sector health insurance schemes; Corporate sector health care programmes; Community and self-financing schemes, primarily for workers outside the formal sector, and, Micro-credit linked health insurance schemes.

The important feature of the various health insurance formats has been that the premium of the policy qualifies for the income tax benefits, covers fractional medical benefits by restricting to hospitalization coverage for chiefly communicable diseases and selected non-communicable diseases. None of the policy has provided the coverage for the outpatient care.

The Shariff (1994)[173] had undertaken a detailed patient surveys in Gujarat and found that more than half of those covered under the ESIS did not seek care from the ESIS facilities due to the unsatisfactory nature of ESI services, such as, low quality drugs and long waiting periods; the impudent behaviour of ESIS personnel, lack of interest on the part of employers and low awareness of ESI procedures; delay in informing the benefits; disallowing injury claims by changing the eligibility conditions with retrospective effect, and manipulation of the work schedules of part-time employees so as to make them ineligible for ESIS coverage. Thus, the author commented on the success of the ESIS in terms of coverage and quality of services, as the ESIS hospitals were perceived to be of poor quality, the hospital equipments were not in the state of order and shortage of the medicines and drugs.

Brigitte C. Madrian, Gary Burtless, Jonathan Gruber (1994)[174] reviewed the relationship between the health insurance and employment, specifically from the perspective of the decision to retire, as the employer -provide health insurance has been thought to deter job mobility, as well as has been likely to deter retirement, and has quantified the effect of the various issues of the policy.

Anil Gumber and Veena Kulkarni (2000)[166] had offered the comparative study of the Mediclaim, ESIS and SEWA health insurance policies with the objective to examine the similarities and distinguishable areas.

The other public sector health insurance schemes stated by Anil Gumber (2002)[172] includes the Senior Citizens Unit Plan, that is, SCUP, the scheme launched by the Unit Trust of India (UTI),a public-sector undertaking, in the year April 1993 that provided hospitalization coverage up to Rs. 500,000 for the investors after attaining the age of 58 years.

Apart from this, even the major corporate houses have also developed their own health care services systems for the benefit of their personnel which can be widely classified into the empanelment approach and the direct provision of the services approach referring to the mechanism in which an employer develops a network of private hospitals, clinics and group mediclaim coverage.

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The another type of health scheme is in the form of the Employer Managed Facilities and Reimbursable Schemes, whereby, the Government provides direct health services for employees of a large number of state-owned departments like Railways and Defense and Police services who have established their own system of clinics, hospitals, and personnel, to and provision of the healthcare services free of cost. Schools and Universities too have their panel of hospitals and clinics. Certain Micro-Credit Linked Health Insurance Schemes too have been started by various vulnerable groups to break the vicious circle of poverty, malnutrition, disease, low productivity, and low income which has been considered as not only an effective tool for poverty reduction but also is being used as instrument for empowerment of the poor, particularly the women.

The health insurance, whether social and private, whether formal or informal, has been extremely limited in India. The various schemes considered all together covers of about only 110 Million people or about 11 percent of the total population of India (Charu C. Garg, 2000)[175] which may be associated to be limited to the poor product design and lack of vigorous marketing of the products to sensitize the public of the need for health insurance.

Eugene M. Lewit, Courtney Bennett, Richard E. Behrman (2003)[176] addressed some of the most persistent questions in relation to the publicly funded health insurance for children, and synthesized the learning on making the programmes more responsive to the needs of low-income children. They had also discussed the promises of public health insurance programs as well as the steps to extend the programs and implement strategies virtually covering all low-income children.

Chuan-Fen Liu and Jon B. Christianson (1998)[177] had examined the decisions of small group employees to enroll in prepaid plans offered through Health Care Group of Arizona (HCGA), a state-sponsored and state-administered voluntary insurance program. They had found that the small group employees without prior insurance were more sensitive to the price of health insurance than those with prior insurance. HCGA health plans may have been viewed as inferior goods by high income employees possible because of their association with the Medicaid program. The health insurance has also been widespread in the various formats, accompanied by the health maintenance organization, fee-for-service, and managed care.

Ashoke S. Bhattacharyya and Puneet K. Sapra (2008)[143] had suggested that appropriately designed health insurance models in general and private health insurance models in particular can expand health care access and lower its costs. The health insurance models in general emphasizes the factors, viz., focus on the issues of pricing; benefit-design; information transparency; clarification of standards on coverage and service providers; encouraging the efficiency on both the supply and demand sides through prudent policies that address information asymmetries, and risk sharing.

While, in particular from the supply side, policies promoting greater transparency in tariffs and charges accessible of the quality information to beneficiaries can be applied to address the issues such as, fraudulent claims; abuses by the unethical providers; moral hazards of the overtreatment leading to the higher transaction costs and extraneous payments. While, from the demand side, the policies encouraging financial risk sharing by beneficiaries could discourage overuse of health care.

The varied health insurance formats operating the in the various countries of the world contributes to the comprehensiveness of the world health insurance products and thereby serve the basic objective of accessibility and availability that has been reviewed as follows.

The World Health Organization [WHO] established on 7th April 1948 headquartered in Geneva, Switzerland, is a specialized United Nations agency which acts as a coordinator and researcher for public health around the world. The agency has inherited the mandate and resources of its predecessor, the Health Organization, an agency of the League of Nations. Most of the developed countries and many developing countries provide health care to everyone regardless of their ability to pay. The world's first universal health care system has been the National Health Service, established in 1948, by Clement Atlee's Labour Government in the United Kingdom. Compulsory Government funded health insurance with nominal fees was another development in the world's health system, and according to the World Health Organization, Italy has the second best health system in the world (http://en.wikipedia.org; Accessed on 20/03/11)[151].

2.5: MARKETING OF HEALTH INSURANCE SERVICES:

Marketing can be examined from both a philosophical point of view as well as from the managerial process perspective, as presented in the beginning of the chapter which has been followed by the brief introduction of the service marketing. Service marketers perform the role of facilitator while marketing the service products (C. Bhattacharjee, 2006)[9]. But, this dynamic area has remained as mystery to many in the economy. Moreover, the competitive world has increased the probability of the risk to be faced and also intensified the complexity of the risk faced by an individual which has been further made more fearful as a result of the recent trends of the sky-rising health care costs led by the increased innovations and use of technology, complex illnesses and diseases with its expensive treatment, etc.

Health is an integral part of the human existence and insurance is the critical mechanism for the defense for the life of the individual in general and the health of the individual in particular. Hence, health insurance is the intricate mechanism of healthcare financing, with the vital shift from offering services to purchasing health care. Health insurance is in healthy state in number of countries, but, is still a not very popular concept in India.

Moreover, given the health financing and demand scenario in India, the health insurance has a wider scope in the present day situation in India, hence, market research, detailed planning and effective insurance marketing is likely to assume significant importance (Dileep Mavalankar and Ramesh Bhatt, 2000)[149].

2.5.1: Reviewing Issues in the Marketing of the Health Insurance Services:

With the growing health insurance market, the efforts for marketing health insurance products has been increasing both from context of the inquisitive nature of the experts as well as the marketers to understand the behaviour of the health insurance customers, and various health aspects accompanied by the various other factors.

Gerald Zaltman and Vertinsky I. (1971)[178] had suggested the psychosocial model of health-related behaviour emphasizing on the less developed countries, by assembling mosaic of relevant variables and processes from the social context view.

Further, the variation of approaches and issues have been discussed in brief as follows.

2.5.1.1: Health Insurance Market Segmentation and Health Insurance Products:

The insurance companies use the geo-demographic systems to locate and quantify the insurance demands of the pockets which exist in rural and urban micro-markets. Industry spokespeople see this as the key to future success (Russell J. Kirchner and Richard K. Thomas, 1990)[179]. The health insurance was first started in India by the Government insurance companies under the name Mediclaim in the year 1986, then after, it has been revised to be made as an attractive product (Paul J. Feldstein and Thomas M. Wickizer, 1995)[180]. Strategies should be framed to boost the health insurance sector of India as there exists the tremendous prospects in the health insurance sector, which are often curtailed due to pitiable healthcare services distribution, difficulty in accessing the health care services and the sky-reaching health care costs. Majority of the health insurance companies have been following the myopic strategy. Hence, the key thrust should be laid to activate the demands in the untapped healthcare segments. Moreover, the policy as existing in India are rigid which further heightens the urgency of launching the health insurance policies that offers the comparatively higher returns (Nagendranath and Chari, 2002)[141].

Helen H. Jensen and William E. Saupe (1987)[181] had described the distribution of health insurance coverage among households and health related fringe benefits of off-farm employment. On the basis of the analysis of health insurance coverage, the major factors associated with the lack of health insurance were identified by the authors, viz., lower total household income; larger household size, and being more conservative regarding risk in farming.

Barbara Greenberg and Robert A. Derzon (1981)[182] had examined the coverage process of Medicare and Blue Cross-Blue Shield and the policy changes. They had also discussed the strengths and drawbacks of four coverage policy options, viz., restricting insurance coverage of unproven procedures; introducing cost-effectiveness criteria; educating physicians and educating the customers.

Anil Gumber and Veena Kulkarni (2000)[166] had as found that the poor preferred public sector management of health care facilities. Alan C. Monheit and Peter J. Cunningham (1992)[183] had examined the changes in children's health insurance status and explored the consequences of disparities in children's health insurance status for their use of health services over the period of time. Eugene M. Lewit and Linda Schuurmann Baker (1995)[176] had provided the recent trends in health insurance coverage for children, and the growing importance of the Mediclaim program as both a current and a potential source of health insurance for children.

According to Ramesh Bhatt and Shrikant Rajagopal (2005)[184] had suggested that the application of sound, reliable and authentic diagnostic and treatment parameters for a particular disease both clinically and diagnostic test may enable the designing of innovative health insurance products for segments identified, which may further also promote standardization in healthcare benefits disbursement apart from the strategic decisions of entering into tie-ups with pharmaceutical companies and retail chains to provide medicines at lowest possible cost.

The various health insurance products approved by IRDA for the year 2012-2013 are as provided in the given as below (IRDA Annual Report: 2012-2013)[107].

Table Number 2.7: Channel Wise Gross Direct Premium Income for the Year 2012-2013 (Premium in Rupees Crores and Policies in '000)

Sr. No	Type of Channel	Health Insurance		Overseas Medical Insurance		Total	
		Policies	Premium	Policies	Premium	Policies	Premium
01	Individual Agents	9226	4976	482	96	64846	24558
02	Corporate Agents: Banks	1372	871	55	14	7826	4186
03	Corporate Agents: Others	227	314	95	13	2823	1789
04	Brokers	430	3203	338	49	9248	14699
05	Referral Arrangements	10	5	0	0	103	37
06	Direct Business	794	5306	1767	188	21651	19594
07	Micro Insurance Agent	2	24	--	---	55	33
07	Others	346	311	15	5	2997	3822
	TOTAL	**12408**	**15011**	**2752**	**365**	**109549**	**68719**

Source: Constructed from IRDA Annual Report, 2012-2013[107]

2.5.1.2: Health Insurance Pricing:

Insurance rating assesses the cost of the insurance product. On the basis of the rating type, viz., Judgment Rating, Class Rating and Merit Rating Methods, the price that paid by one buyer may be entirely different from that paid by another. In non-life insurance, the insurers make estimates of the claims cost; business acquisition cost; management expenses; margin for fluctuations in claims experience, and a reasonable profit, which are subject to review from time to time (P. K. Gupta, 2006)[124].

Experience rating is a method of computing premiums based on expenses incurred by the insurance company in settling claims involving a particular group of enrollees (Health Insurance Institute, 1981)[185], wherein the claims expenses depends on three factors, viz., enrollees' illness probabilities, their consumption of medical care services for a given illness, and policy coverage of incurred expenses. Tier rating and Experience rating have become the industry's standard operating procedure. Tier rating assigns the risk factor to different industries, resulting in a hierarchy of premiums. Experience rating set premiums based on the health history of a company's employees. Currently, the health insurance premiums are factors of two independent variables, sum insured and age profile (Russell J. Kirchner and Richard K. Thomas, 1990).

On the other side, the type of the system adopted for grouping the diseases, International Classification of Diseases (ICD-10), and Diagnosis Related Grouping (DRG) also has its implications on the premium charged from the health insurance policyholder. DRG is a three digit number, a system created by the Federal Government of the USA in the year 1983 as a way to assess payment requirements for Medicare patients. It describes the medical diagnosis wherein a hospital receives the same fee for all patients diagnosed under a particular DRG disease, irrespective of how sick the patient is how costly it is to treat the patient or how long the duration of stay of the patient is, thus providing an incentive to reduce the cost of treatment and length of stay (LOS) in the hospitals.

The DRG system has been adopted by many private insurance companies in the USA and Australia. The DRG system provides a standardized diagnosis nomenclature, an Average Length of Stay (ALS) and a standard average Cost Ceiling for each disease. ALS and LOS are considered as having significant influence on cost of care and is surrogate measure for cost, and rarely as the measure of quality. The hospital having long ALS may be relatively inefficient in the use of resources and those with low ALS may be considered to be efficient (Thomas, Guire and Horvat, Winter, 1997)[186]. The healthcare expenditure depends greatly on the health care costs consequently any change in the health insurance coverage can be attributed to the higher health care costs (Chernew, Cutler, 2002)[187].

According to Peter Diamond (1992)[154] costs can also be categorized into two categories, viz., static and dynamic. Static analyses emphasize on the factors determining the current level of total medical expenditures. Dynamic analyses identify the factors that are absent in the static posture. Hence, revamping of the medical services affects the dynamic analyses.

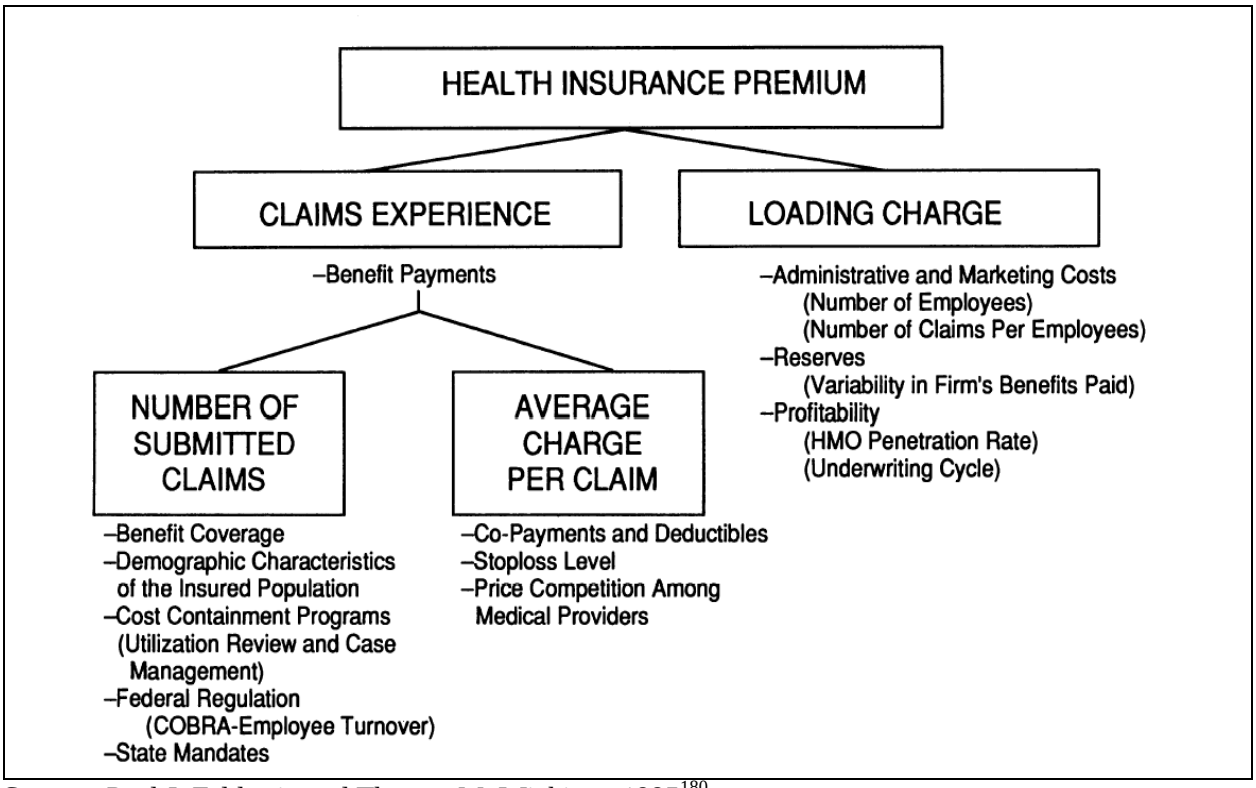
According to Paul J. Feldstein and Thomas M. Wickizer (1995)[180], the actuarial cost of health insurance is the claims experience. A lower rate of increase in claims experience generally results in a lower rate of increase in insurance premiums. However, the purchaser price sensitivity to insurance premiums is affected by the degree of competition in the health insurance market. Hence, health insurance premiums are determined by claims experience which represents 80 to 90 per cent of the premium, and the loading charges which represents the remaining portions of the premium. The claims experienced may be thought of as the pure premium or the actuarial cost of providing health insurance. Insurance however is never sold at its actuarial cost. There are administrative costs of handling the claims as well as the requirements for a minimum rate of profit if the insurance company is to remain in business. To understand the rise in health insurance premiums, it is therefore necessary to examine the costs of providing insurance as well as the loading charge factors. The claims experience of an insured group reflects the number of claims submitted multiplied by the average charge per claimless any deductibles and co-payments.

These two components are, in turn, related to factors over which the insured group has some control, viz., benefit coverage and use of cost containment program and other less controllable factors, viz., medical technology; federal and state regulations, and the state insurance mandates (ibid).

The components of the health insurance premium are presented in the Figure Number 2.1, as shown below, which provides an understanding of the components of the health insurance premiums and is useful in identifying the factors that should be considered in analyzing the rise in health insurance premium (Paul J. Feldstein and Thomas M. Wickizer, 1995)[180].

While, the second component of claims experience, that is, average charge per submitted claim, is influenced by factors, viz., deductibles; copayments and stop-loss level wherein higher the stop-levels, the greater is the employee's liability which not only affects the paid by the employers, but also the propensity to use service. In addition, the average charge per submitted claim less employee cost sharing tends to be influenced by the degree of competitiveness in the medical services market. Reserves, one of the components of loading charges refers to the amount provided to the insurer to cover underwriting risk, which is affected by the expected variability of claims. Insurance profit, another component of the loading charges, is influenced by the size of the company whose policy is underwritten.

Figure Number 2.1: Figure Showing Components of the Health Insurance Premium



Source: Paul J. Feldstein and Thomas M. Wickizer, 1995[180]

Mathew Jowett (2004)[188] had determined the factors that affects the efficient risk spreading, viz., the probability of insured individuals to get ill which enable the insurance company to predict the exact quantity of the claims at the particular point of time; risk autonomy and, the likeliness of a person in need of the health care being significantly less than one, which is reflected in the difficulty faced by the elderly persons in purchasing health insurance. Akerlof (1970)[189] had formalized the phenomenon of unraveling the health insurance market due to the asymmetrical information availed by the insurance company and policyholder pertaining to their health as the health care patient carries greater information as compared to the insurer. Consequently, the definite figure of claims and payouts tends to be greater as compared to that estimated. However, when the prejudiced favourable information is provided by the new customers to the insurer in the context of their health status, the insurer would be required to make upward adjustments in the premium, to maintain the safe profits. While, in case, when the insurance company had loaded the premiums before, they encourage the new customers to supply prejudiced information. Hence, in both the case those in the relatively fit health status compelled to withdraw, which further increases the standard risk of others in the same insured pool.

2.5.1.3: Channel Members:

Many experts have reviewed and commented on the role of various intermediaries in the health insurance mechanisms of India. Ramesh Bhatt and Babu (2004)[190]; Gupta, Roy and Trivedi (2004)[191]; Matthies and Cahill (2004)[192]; Kalyani (2004)[193]; Vishwanathan and Naranyanan (2003)[194] have contributed to the literature from the context of the role played by key stakeholders involved in the health insurance industry.

Vita Rees (2007)[195] had suggested strict steps to be undertaken by the insurance companies against the dropping of the insurance agents selling the plans incorrectly; and introduce the methods for improving training and certification for its brokers; to know the post-purchase experience of the policyholders by taking their feedback. The various channels of distribution are used by the health insurance companies to offer the health insurance products to their target market, viz., individual agents; corporate agents; brokers; referral arrangements; direct business, and others. The channel wise gross direct premium income for the health insurance companies for the year 2012-2013 is presented in Table Number 2.8 below which provides the overall review of the performance of the various channels in selling the health insurance policies in the country as well as overseas, wherein the competition between the Individual agents and direct business is appearing on the surface (IRDA Annual Report, 2012-2013)[107].

Table Number 2.8:
TPA Licenses Renewed during the year 2012-2013 by IRDA

Sr. No.	Name of the TPA
01	Vipul Med Corp TPA Private Ltd.
02	Dedicated Healthcare Services TPA (India) Pvt. Ltd.
03	Grand Health Care TPA Services Pvt. Ltd.

Source: IRDA Annual Report, 2012-2013[107]

Over the period of time, the increase in the number of the people enrolling in the health insurance policies has resulted into the increased complexities of managing the claims. IRDA has recognized the role of Third Party Administrators (TPAs) in order to facilitate the development and accelerate the move towards more mature insurance systems. Thus, the TPAs have joined to act as an intermediary to function in assisting the co-ordination between insurance company, healthcare provider and customer, necessitating the concept of cashless hospitalization on receiving a fixed per cent of about 5.6 per cent of insurance premium in the form of commission or fee. TPAs are presumed to infuse new management system, viz., benefit management, medical management, provider network management, claim administration and information and data management in order to enrich knowledge base of managing healthcare services, and costs ensuring higher efficiency, standardization and improving penetration of health insurance in the country, which has involved the concept of cashless hospitalization (Ramesh Bhatt and Shrikant Rajagopal, 2005)[184].

2.5.1.4: Promotional Strategy for the Health Insurance Products:

However, the communication strategy of the insurers with the target market or the stakeholders by the insurance companies has to be abided by the IRDA regulations in this context. Insurance regulation in the context of the consumer protection orbits around the marketing and its related aspects, such as viz., the language of the insurance contracts, the relationship between the insurers and providers, and other. To be more specific, it can be stated as that the language in the insurance contract shall be easy to understand, along with the terms used, like, benefits package, premium rate, deductibles, as well as, shall also include the regulations relating to the unfair trade practices, such as, misrepresentation; discrimination; inducements, and failure to maintain records. Also, the benefits packages of the insurance contract are subject to the various other legislations, in terms of the minimum package of services available to everyone and catastrophic insurance. Moreover qualifications of insurance agents and their mode of functioning may also fall in this category (Ajay Mahal, 2002)[196]. However, various specific interventions focusing on raising the customer awareness about the insurance products and various intricacies of the insurance plans have been developed with the effects of liberalization on the health insurance sector of the country. The minimum expected outcome of the deregulation process has been the provision of the complete information to the customer along with the reduction in the price of the schemes and dealing with the claims in a fair and prompt way. Moreover, lots of confusion and disputes has been created by the insurance companies, in the case of their not following the terms and conditions of the contract in certain cases (Shah M., 1999)[197]. Zeithaml and Bitner (2000)[198] had suggested that the marketing mix of the traditional four Ps which includes three more Ps, viz., people, physical evidence, and process, being the important avenues to the service firms by enhancing their attractiveness and appeal to a larger proportion of the target market. People are all those who performs a significant role in service delivery and thereby affects the perceptions of the policyholders. These individuals include all company personnel, the agents, the brokers, the TPAs of the insurance companies, the customer, and additionally other customers in the service environment. Process denotes the entire flow of activities, procedures, and mechanisms through which the service is distributed which thereby determines the efficiency and effectiveness of the health insurance providing companies.

The IRDA has re-designed the file & use formats with the aim to enhance the health products' processing at the time of filing of the health insurance products by the insurance companies which would also suffice the necessity of the health specific information from the health insurance companies. Moreover, the insurance companies were also instructed by IRDA to ensure that the policyholders were informed about the nearest possible alternative hospitals with the availability of the cashless facility, in case there is any change in the chosen network of the hospitals on account of such review (www.irda.gov.in; Accessed on 31/03/11)[199].

The physical evidence includes anything physical that represents the services, from business cards to forms to an entire facility. In the health insurance policy in particular, and the insurance policy in general, the brochure, stating the policy features, the policy documents provided by the insurers, the policy code, the premium receipt received by the insured, the visit to the insurance company office, and the records pertaining to the insured's insurance contract with the insurance company serves the mode of the physical evidence by the company serves the role of the physical evidence thereby overcoming the service limitation of the intangibility in this context. This marketing mix of the four Ps, Product, Price, Place and Promotion, along with the additional components may be manipulated and focused by the firm in various ways to influence and affect the prospective customers and the customers toward greater probability of purchase (Jeff Ritter, 2004)[200].

2.5.1.5: Social Issues:

There are also various social issues in relation to the health insurance products, viz., omission of sexually transmitted diseases, AIDS, delivery and maternal conditions, etc., which are unacceptable both socially and ethically (Dileep Mavalankar and Ramesh Bhatt, 2000)[149]. The marketing of the health insurance policies will be also affected by the portability of the health insurance policies. On one side, the portability of the health insurance policies take away customization of health insurance policies, it is not as large price in comparison to the freedom availed out of the portability and the breathe of relax from the pinch by the health insurance company during the critical times experienced by the policyholders. However, health insurance portability in India will be available for sum insured up to Rs. 1 lakh or above (Shankar P. Nath; http://EzineArticles.com; Accessed on 24/03/11)[201].

Thus, the health insurance companies hope that the health insurance probability would lead to increased transparency and innovativeness. The health insurance policyholders can choose between various tailored policy products and carry out price comparisons between different types of health insurance products which could render the cause of portability as service-oriented and also impact various profile groups differently. The new players in the health insurance sector views initiative of the health insurance portability as an opportunity to prove their service not only to the untapped health insurance market of India, but also to attract the current policyholders of the other public and private sector giants. Moreover, the health insurance companies may become sloppy in providing the services to their policyholders knowing about the fact of no other option available to the policyholders has to now pull up their socks and be ready to run on the demands of the services of their policyholders or may have to accept the reduction in their total policyholders' base. It will also ensure that health insurance companies may introduce more cost competitive and customer friendly health insurance schemes so that there is no switch over by its existing policyholders, thus leading to a reduction in premium (ibid).

Further, the initiative by IRDA will provide the health insurance companies an momentum to emphasize on customer value and rendezvous (www.financialexpress.com; Accessed on 01/04/11)[202].

2.5.2: Risks and its effects on Marketing of Health Insurance:

There are certain obvious risk involved in the marketing of the health insurance policies which are derived from the very nature and mechanism of the health insurance services. Some of the peculiar basic risks to the health insurance products are, viz., adverse selection, cream skimming and moral hazard. Adverse selection refers to the consequence of the outflows exceeding the inflow due to poorly designed health insurance programme which may led to the enrollment of the sick in large numbers as compared to the healthy against the desired enrollment of both the sick and the healthy. In other words, when the health care seekers select to avail the health insurance frequently, it results into adverse selection as the insurance suppliers do not possess the complete information regarding the personal health risk insured. It results from the probability of the healthcare seeker to renew the coverage to limits higher than that of the healthy person. Adverse selection affects the financial sustainability of the insurance programme, if not prevented. However, by making compulsive insurance or raising of the coverage limit, it can be limited to the particular extent. Cream Skimming results from the deliberate selection of the relatively healthy individuals by the insurer. Thus, it makes complex for the high-risk individuals to avail private insurance.

Moral Hazard in terms of the health insurance can be of two types, first, supply side moral hazard and second, demand side moral hazard. Supply side moral hazard is caused due to the likeliness of the irrelevant interference of the healthcare provider in terms of accelerated charges for the insured hospitalized individual. Demand side moral hazard refers to the tendency of the insured healthcare seeker to claim higher healthcare, or involve in dicey behaviour (N. Devadasan and Sunil Nandraj, 2006)[139].

A brief review on the risks in the health insurance, and its effects on the marketing of the health insurance services have been given as follows.

Due to lack of the adequate information, the markets of the health insurance does suffers from failures, as the operating efficiency of the health insurance owes to the existence of the certain conditions, viz., independent probabilities of ill health, less than one and known about, with no major problems with adverse selection, moral hazard and monopoly of the parties to the contracts. The issue of adverse selection is one of the relevant issues which has aroused because of the ability of the insurance seekers to conceal information about their risk of ill health from the insurers (Rotschild and Stiglitz, 1976)[203].

Cummins, et al., (1993)[204] had defined adverse selection as the probability of high risks to be more likely to buy insurance or to buy larger amounts than low risks. The term adverse selection has been used to describe the tendency for high-risk people to be more likely to buy health insurance which escalated the complications and variation in the health insurance markets (Ramesh Bhatt and Nishant Jain, 2006)[71].

According to Mark J. Browne (1992)[205], the quantity of insurance held by an individual is basically the function of two elements. Firstly, the design of the insurance policy, including the deductible, coinsurance rate, through which the amount of insurance can be increased or decreased, and, secondly, the risk characteristics of the insured. Thus, if an insurer sells identical policies to two individuals, believed to be of similar risks, the insured actually having greater risk will receive more insurance, because the insurer assumes more risk from the high risk individual than from the individual who is a low risk.

Rothschild and Stiglitz (1976)[203] had pointed out that the insurance market have been subject to the familiar adverse selection problems results into the failure of the existence of competitive equilibrium, and has also viewed the use of underwriting the problem as it have been increasing the differences across risk pools. Ramesh Bhatt and Nishant Jain (2007)[153] had also considered that the risk category of policyholder has the significant implications on the health care costs which can severely affect the pricing of the product in various ways as the insurance premium of the senior citizen would be comparatively greater than the younger person. Hence, demographic profile of the customer affects the costs and competition among various insurance providers which produces undesirable results.

Van de Ven and Van Vliet (1990)[206] had described range of alternatives by which insurance companies can attempt to attract the individuals with reasonable risk and to deject the poor risk individuals. Matthew Jowet (2004)[188] had questioned the relevance of the insurance theory particularly the vital ideas of adverse selection and moral hazard developed in wealthier economies. Peter Diamond (1992)[154] had elaborated the reasons for the variation in premiums' expensiveness among the individuals. In the view of the author the life time medical expenditure risk has to be related with the differentiation between the random yearly expenditures and their expected values, and the expectations considered in the beginning of the year.

The other issue in terms of the hazards in health insurance market is the moral hazard. The insurance mechanism enables the shift in the risk to the individuals who take the action when benefits exceed costs after weighing the costs and benefits of an action. While, on the other side, the insurance companies does try to lower the moral hazard risk by means of offering the policyholder with a the monetary benefits in order to evade him in making a claim by utilizing the options of deductibles, co-payments and co-insurance (Bridget M Costello, Bernard J. Healey and Michele McGowan, 2007)[22].

The health insurance is prone to moral hazard risk especially in an unregulated market with inadequate regulations on costs and quantity of care to be provided (Ramesh Bhatt and Nishant Jain, 2006)[71].

Thus, moral hazard implies high probability of collusion between healthcare providers and patients to increase service provisions and thereby affecting billing amounts with lack of any overseeing authority to prevent the same; absence of standardization of medical diagnosis and treatment implying that even in the absence of moral hazard due to a diverse array of diagnosis and treatment practices for the same disease across different healthcare providers all over India, verification of reimbursement claims took inordinately long periods of time, introducing inefficiency into the system, and, adverse selection implying that the system does not appear to have adequate screening for assessing the risk of contracting a particular disease (Ramesh Bhatt and Shrikant Rajagopal, 2005)[184].

The health insurance which varies from other segments of insurance business on account of the serious conflicts of the adverse selection, moral hazard, and information gap problem have heightened the complexity in formulation, assessment and implementation of the health insurance policy. Also, there have been very little conduciveness of implementation of the health sector reform strategies, evolved elsewhere, due to the structural limitations of the health sector programmes and the compounded nature of the healthcare providers (Dileep Mavalankar and Ramesh Bhatt, 2000)[149].

2.6: MARKETING OF THE MEDICLAIM POLICIES IN INDIA:

2.6.1: Mediclaim Policy: An Introduction:

The health insurance is the much broader concept which includes various formats of providing for the hospitalization and the treatment of the diseases or illness or related aspects varying from one health insurance product to another. It is also one type of the health insurance product.

It covers hospital care and domiciliary hospitalization benefits wherein the premiums, eligibility and benefit coverage are included within the specifications of rules and regulations framed by the regulatory authority. It is the type of private health insurance policy which can be purchased voluntarily by the individual providing the health cover to the policy holders in the form of individual mediclaim policy or in case when extended to the family member of the policyholder in the form of family floater mediclaim policy or the group mediclaim policy or the overseas mediclaim policy, as the case may be (Anil Gumber, 2002)[172]. There has been the consistency medical benefits and coverage offered under the mediclaim policy since the period of its inception in the year 1986 till the period of liberalization of the general insurance industry too, and the entry of the stand-alone health insurance companies. However, this policy also was not without any shortcomings. Particularly, in the context of the non-coverage of the routine outpatient care, with the coverage for only hospitalized expenses along with manifold exclusions, coverage and eligibility limits and restrictions, etc. Moreover, the higher claim amounts in comparison to its premium have been questioning its viability. Hence, the mediclaim policy as the product of the health insurance also comprises varied benefits features.

2.6.2: Features of the Mediclaim Policy:

An Individual Mediclaim Policy is also known as the hospitalization benefit policy. It provides reimbursement in Indian currency of medical expenses incurred towards hospitalization anywhere within India, in the cases of sudden illness or accident and extends to pre-hospitalization of 30 days and post-hospitalization of 60 days. This cover also includes domiciliary hospitalization which implies that a patient may get the medical treatment at home in case where s/he is unfit to be moved to the hospital or where there is no accommodation in the specialist hospital on the condition that the treatment was for a period not less than 3 days, and the sub-limits of sum insured towards domiciliary hospitalization are provided in the sum insured and premium schedules (Jyotsana Sethi and Nishwan Bhatia, 2007)[207].

In other words, the mediclaim policy takes care of the medical expenses of the insured against hospitalization and domiciliary hospitalization, due to the sudden illness, an accident, sudden illness or any surgery which is required in respect of any disease which has arisen during the policy period. The domiciliary hospitalization is applicable when the treatment is such for an Illness/Disease/Injury which in the normal course would require treatment and care in the hospital/nursing home but actually has taken treatment at home in the either of the circumstances such as the condition of the patient is such that he/she cannot be moved to the hospital/nursing home or the patient cannot be moved to Hospital/Nursing Home for lack of accommodation therein. The domiciliary hospitalization benefits cover the expenses on employment of qualified nurses who are employed on the recommendation of the attending medical practitioner and who holds a certificate of recognized Nursing Council. The mediclaim policy covers only allopathic and Ayurvedic treatment (http://www.fhpl.net; Accessed on 08/07/11)[208].

Moreover, when the treatment such as Dialysis, Chemotherapy, Radiotherapy, etc., are taken in the Hospital/Nursing Home, and the insured person is discharged on the same day, the treatment will be considered as to be taken under the hospitalization benefit scheme. Thus, the different benefits that can be taken under the hospitalization head of the mediclaim policy are the room boarding expenses by the Hospital/Nursing Home; Nursing Expenses; Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist's Fees; Anesthesia, Blood, Oxygen, Operation Charge, Surgical Appliances, Medicines and Drugs; Diagnostic Material and X-Rays, Dialysis And Chemotherapy, Radiotherapy, Pacemaker, Artificial limbs and cost of organs and similar expenses. These benefits are limited to the maximum sum insured (http://www.emediclaim.com; Accessed on 07/07/11)[209].

Mediclaim can be availed by the individuals aged between 5 to 80 years. Children between the age of 3 months and 5 years can also be covered by the mediclaim policy provided one or both parents are covered concurrently. The minimum period of hospitalization has to be for 24 hours (www.freelibrary.com; Accessed on 04/04/09)[210].

But, in case of the bundled charges levied by the hospital for specific treatments the application of these limits is excluded. Generally, the hospitals registered with a local authority with more than 15 beds can be identified as the providers (ibid).

Also, these conditions may vary from the individual mediclaim policy of one company to the other. These individual mediclaim policies can be provided by the non-life insurance companies and the stand-alone insurance companies. Moreover, as the individual mediclaim policy is the form of the health insurance policy, the insured person must renew the policy without break, in order to ensure that in the subsequent renewals, medical conditions, incepting since the policy was taken, do not get excluded(http://sify.com/finance; Accessed on 04/04/09)[211].

2.6.3: Mechanism of the Mediclaim Policy:

The standard mediclaim policy provides coverage only for hospital care and domiciliary hospitalization benefits, majority of which is reimbursed subject to the various important exclusions viz., Pre-Existing Diseases; Pregnancy; Child Birth; HIV-AIDS, etc. Moreover, conventionally, only compensation insurances were provided by the insurance companies, however, now the health insurance companies have started practicing with the Third Party Payment System involving the TPAs. Thus, the scheme may be administered by either an insurance company or the TPA, as the case may be, viz., whether reimbursement or the cashless hospitalization, respectively. When the scheme is in the indemnity format, an insurance company reimburses the policy holder, the patient, after the patient has paid the hospital charges and submitted the required documents to the insured. However, uncertainty also prevails in terms of the reimbursement on the grounds of partial submission of the insufficient documents (N. Devadasan and Sunil Nandraj, 2006)[139].

2.6.4: Marketing of the Mediclaim Policies in India:

The Mediclaim policy, a type of the health insurance product available in India can be widely categorized viz., Individual Mediclaim Policy, Group Mediclaim Policy/Family Mediclaim Policy, and Overseas Mediclaim Policy. Some of the Mediclaim Products approved by IRDA which were offered by the health insurance companies in India in the year 2012-2013 are given in the Table as follows (IRDA Annual Report: 2012-2013)[107].

Table Number 2.9:
Health Insurance Products Cleared during the Financial Year 2012-2013

Sr. No.	Name of the Insurer	Name of the Product
01	Apollo Munich	Optima Restore – Revision Easy Health Individual Insurance - Revision Optima Super Easy Travel Individual Travel Health Insurance
02	Bajaj Allianz	Travel Care Plus Tax Gain – Refiling
03	Bharti AXA	Smart Micro Insurance Policy Smart Tax Saver Insurance Policy Smart Health Insurance Policy – Revision
04	Cholamandalam MS	Chola Swastha Parivar Chola Loan Protector Chola Group Loan Protector Micro Insurance Personal Accident
05	Future Generali	Future Hospicash Health Suraksha - Revision Future Health Raksha Tax Optimizer Janata Personal Accident Policy
06	HDFC ERGO	Health Suraksha - Top Up Student Suraksha - Student Overseas Travel Policy
07	ICICI Lombard	International Travel Insurance Hospital Cash Plan Swaranjayanti Arogya Bima Yojana International Travel Insurance – Revision
08	IFFCO Tokio	Jan Kalyan Bima Yojna
09	L & T General	my: Health Medisure Classic Insurance my:Jeevika Micro Health Package Insurance my: Health Group Medisure Insurance Policy
10	Liberty Videocon	Group Personal Accident
11	Magma HDI	Individual Personal Accident Policy
12	Max Bupa	Health Assurance
13	Raheja QBE	Cancer Insurance Policy- REVISION Cancer Insurance Policy- REVISION
14	Reliance	Reliance Individual Mediclaim policy Reliance Health Protect Plus Policy Reliance Health Gain Policy
15	Religare Health	Care (Individual Health Insurance Product) Group Care (Group Health Insurance Product) Group Secure (Group Personal Accident Insurance Product) Assure (Critical Illness Health Insurance Product)
16	Royal Sundaram	Family Health Insurance Scheme (Group Health-Micro Health Shield) Group Personal Accident - Karnataka Government Master Product - Revision Master Product - new plan Family Health Protector - Revision Family Good Health - Revision Master Product - new plan
17	SBI General	Individual Personal Accident

18	Star Health and Allied Insurance	Star Hospital Cash Insurance Policy Family Delite Insurance Policy Micro Healthcare Insurance - Revision Comprehensive Insurance Policy Family Health Optima Insurance Policy - Revision Mediclassic Insurance Policy - Individual Cardiac Care Insurance Policy - Individual Accident Care Insurance (Individual)
19	Tata AIG General	Micro Health Guard Insurance Policy (Group) Travel Guard Home Guard Plus Accident Shield Policy Janata Personal Accident Policy
20	Oriental	Oriental MediPlus Policy
21	United India	Extensions to Personal Accident & Group Personal Accident Policy Tamil Nadu Chief Minister's Comprehensive Health Insurance Scheme
22	Universal Sompo	Critical Illness Policy Senior Citizen Health Insurance Policy Individual Health Insurance Policy Swarn Gramin Bima Policy Aapat Suraksha Bima Policy Hospital Cash Insurance Policy Top Up Health Insurance Policy

Source: IRDA Annual Report, 2012-2013[107]

The detail presentation of the Gross Premium and the Number of the Persons covered by the non-life insurers and standalone health insurers under Individual Insurance Excluding Family/Floater and the total premium under the health insurance segment has been provided in the table as follows.

Table Number 2.10:
Health Insurance (Other than Travel-Domestic/Overseas & Personal Accident): Gross Premium and Number of Persons Covered (2012-2013)

Sr. No.	Insurer	Individual Insurance Excluding Family/Floater Policies			Total		
		No. of Policies	No. of Persons Covered (in '000)	Premium (in Rs. Lakhs)	No. of Policies	No. of Persons Covered (in '000)	Premium (in Rs. Lakhs)
01	Bajaj Allianz	258625	471.20	12370.80	404406	1933.21	52249.59
02	Bharti AXA	16177	28.25	651.49	19262	829.16	21059.71
03	Cholamandalam MS	39796	59.97	1210.74	63117	21185.38	28130.39
04	Future Generali	12565	19.97	543.46	22885	554.68	12868.78
05	HDFC Ergo	326642	268.42	25230.38	467763	3181.76	49738.32
06	ICICI Lombard	321145	341.19	33385.49	427693	24832.51	167466.05
07	IFFCO Tokio	27274	51.00	1791.47	44687	3375.00	20839.14
08	Liberty Videocon	-----	----	----	----	----	----
09	L & T General	2295	2.86	155.07	3852	88.26	2622.62
10	Magma HDI	-----	-----	----	----	----	----
11	Raheja QBE	44	0.04	1.51	44	0.04	1.51
12	Reliance	32088	37.05	1192.47	104124	4831.21	25950.84
13	Royal Sundaram	210221	367.21	11687.07	261725	2026.65	21442.47
14	SBI General	1002	0.90	28.49	1228	23.97	674.11
15	Shriram General	----	----	----	----	-----	----
16	TATA AIG	51479	60.96	1833.20	77842	1735.48	11897
17	Universal Sompo	44283	66.11	514.02	120203	491.86	5563
	Sub Total (Private Sector)	**1343636**	**1775.13**	**90595.66**	**2018831**	**65089.16**	**420503.98**
18	National	1369444	4380.03	77317.79	1586751	21868.98	254096.43
19	New India	1496305	3564.00	105546.00	1594838	23003.00	276700.81
20	Oriental	57340	1389.00	34177.58	1193562	15923.00	163414.02
21	United India	977879	2901.00	49326.00	1277616	67734.00	263775.00
	Sub Total (Public Sector)	**4417058**	**12234.03**	**266367.37**	**5652587**	**128528.98**	**957986.26**
	STANDALONE HEALTH PRIVATE						
22	Apollo Munich Health	404	512.19	14969.80	2255	5682.16	59323.72
23	Max Bupa Health	55601	55.57	3902.96	142086	1238.55	20615.06
24	Religare	7850	8.25	480.25	16776	170.88	3839.14
25	Star Health	488147	602.64	21132.76	1152234	6572.72	83026.72
	Sub Total (Stand Alone)	**552002**	**1178.65**	**40485.77**	1313351	13664.32	166804.64
	Grand Total	**6312696**	**15187.81**	**397448.80**	**8984769**	**207282.46**	**1545294.88**

Source: IRDA Annual Report, 2012-2013[107]

The brief review of the various individual mediclaim policies of the insurance companies in India has been outlined in brief as follows.

2.6.4.1: The Bajaj Allianz:

The Bajaj Allianz is the pioneer company to offer a sum insured of Rs. 10 lakhs. The individual mediclaim policy of Bajaj Allianz is the Health Guard Policy. The company offers the coverage up the sum insured from Rs. 1 lakh to Rs. 10 lakhs from 3 months to 55 years age person, as well assume insured from Rs. 1 lakh to Rs. 5 lakh from 56 months to 65 years age person which can be renewed up to 80 years (http://www.bajajallianz.com; Accessed on 05/07/11)[212].

Under the Health Guard Policy the policy holder is provided with the cashless facility at over 2300 hospitals across India. In case the treatment is taken in the non-network hospitals, 10 per cent co-payment is applicable, while, for the members of age group 56-65 years, 20 per cent co-payment is applicable. However, waiver on 10 per cent co-payment is available on payment of additional premium. The pre and post- hospitalization expenses covers relevant medical expenses incurred 60 days prior to and 90 days after hospitalization. Moreover, no sub-limits are applicable on room rent and other expenses. The policy also covers the ambulance charges in an emergency subject to limit of Rs. 1000, and no tests are required up to 45 years up to the 10 lakhs sum insured. The Pre-existing diseases are covered after 4 years of the continuous renewal of the policy. The company also offers for the heath checkup for maximum amount of Rs. 1000 at the end of the four claim free years. Moreover, the company under the policy also offers in-built E-cover for the sum insured 5 lakhs and above. However, the company reserves the right to review the premium rates and revise them by an amount not exceeding 12 per cent (ibid).

2.6.4.2: Mediclaim policy of the Cholamandalam MS Health Insurance Company:

The individual mediclaim policy of the Cholamandalam MS Health Insurance Co., the Individual Health Line, is the comprehensive, policy for the individual, covering the policyholder, spouse, children, parents, and parents-in-law, with an individual sum insured for each person. It is the first company to offer the purchase of the policy to individual up to 65 years of age, with no medical check-ups till 55 years of age, allowing the renewal of the policy till life-time. The company offers three varied plans with varied benefits, Standard, Superior and Advances. The sum insured ranges from Rs. 1 lakh to Rs. 10 lakhs. The company also offers the cashless hospitalization over the network of 2,600 hospitals across India, as well as, the direct claims settlement through Chola MS HELP, which do not involve the third party administrators.

The pre-hospitalization expensed up to 60 days and post hospitalization expenses up to 90 days are covered by the policy. The company also offers the claim free bonus for every claim free years, as well as, coverage for 141 day care procedures not requiring hospitalization. Moreover, the company also offers the discount of the 10 per cent over the premium charged in the case if the policyholder agrees for 10 per cent co-payment on all claims under the policy. The company also over the period of time, and subject to IRDA approval, retains the right to revise the premium rates/terms and conditions based on experiences, which shall apply from the time of the renewal of the policy. The pre-existing diseases as defined in the policy are not covered until 48 consecutive months of continuous coverage have elapsed, since the inception of the first policy with the insurer. The benefits of the policy will not be covered for any illness diagnosed within 30 days of the effective date of the policy period, in the case, it is the first policy taken by the proposer. The company also offers another Individual Policy, that is, Chola Individual Health Policy (http://cholainsurance.com; Accessed on 06/07/11)[213].

2.6.4.3: Bharti AXA:

Bharti AXA offers the individual mediclaim policy, in the three different plans, that is, Smart Health Basic, Smart Health Premium and Smart Health Optimum respectively. The sum insured for the Smart Health Premium and Smart Health Optimum starts from Rs. 1 lakh to Rs. 5 lakhs, while the Smart Health Basic, offers the sum insured ranging from Rs. 50,000 to Rs. 5 lakhs, for an individual. An individual shall be the resident of India to purchase these individual mediclaim plans, with age limits of 5 years to 65 years, 5 years to 60 years and 5 years to 55 years, are applicable to the Smart Health Basic Plan, Smart Health Premium Plan and Smart Health Optimum Plan, respectively. However, the renewal limits for Smart Health Basic Plan, Smart Health Premium Plan and Smart Health Optimum Plan plans is 75 years, 70 years, and 65 years, respectively.

The maximum coverage provided by these plans comprise of the policyholder, spouse, and two dependent children who are over 90 days old and up to 23 years of age. While, any person aged 46 years and above or anyone with a history of pre-existing condition/disease must undergo medical tests.

The policy excludes the pre-existing diseases/illnesses/injuries including symptoms or conditions existing when the policy cover comes into force for the first time, which shall be covered after four continuous renewals of the policy of the company, along with the other specifications of the exclusions of coverage (www.bharti-axagi.co.in; Accessed on 06/07/11)[214].

2.6.4.4: The Future Generali:

The Future Generali provides individual mediclaim policy, through its Future Health Suraksha-Individual, basic, silver, gold and platinum, which are classified on the bases of the geographical zones which are based on the location of the hospital were the treatment can be received. The eligible age for an individual for this policy cover is from 90 days to 45 years.

The policy allows the entry of the child only if is over 90 days and the parents are concurrently insured with the Future Generali. The policy offers for the cashless hospitalization, with the common pre and post hospitalization benefits as offered by the Bajaj Allianz, Bharti AXA and Cholamandalam. The Future Generali offers the renewable discounts of 5 per cent on the renewal of the premium, which are applicable on the date of renewal, for each claim-free year by the insured, up to a period of the five years. At the end of the fifth year, subject to no claim, the cumulative bonus of 10 per cent on the basic sum insured, the policy provides the cumulative bonus of 10 per cent on the basic sum insured up to a maximum of 50 per cent of the sum insured (http://www.futuregenerali.in; Accessed on 06/07/11)[215].

2.6.4.5: HDFC ERGO General Insurance Company:

The individual mediclaim policy provided by the HDFC ERGO General Insurance Co., is Health Suraksha, with the sum insured for Rs. 2 lakhs, 3 lakhs and 4 lakhs. The policy has the similar features as compared to the other companies in terms of the pre-post hospitalization expenses and the day care procedures. The policy also covers the medical expenses for inpatient treatment under Ayurveda, Unani, Siddha or Homeopathy, up to20 per cent of the sum insured, i.e., maximum Rs. 20,000, for the sum insured for 2 lakhs and 3 lakhs, and Rs. 25,000, for the policy sum insured Rs. 4 lakhs. The policy also provides for the 5 per cent increase in the sum insured for every claim free year, up to maximum of 50 per cent, and pays the health checkup up to 1 per cent of sum insured, up to maximum of Rs. 5000 (http://www.hdfcergo.com; Accessed on 06/07/11)[216].

The policy exclusions include, 30 days waiting period, and 2 year waiting period for the specific illnesses and treatments, pre-existing conditions till the 48 months of continuous coverage, war or any act of war, any breach of nay law with criminal intent, self-destruction or self-inflicted injury, terrorism, war or radioactivity, or any claim arising out of the use of the intoxicating drugs and alcohols, AIDS/HIV, plastic surgery or cosmetic surgery with specifications, etc., as mentioned in the policy wording (ibid).

2.6.4.6: The Royal Sundaram General Insurance Company:

The Royal Sundaram General Insurance Co. Ltd. offers the Individual Health Insurance Online policy requiring no documentation, covering the individual, spouse, children above 90 days, and dependent parents of the maximum of 50 year of age, which can be renewable only up to the 70 years of the policyholder. The company also offers the cashless hospitalization policy, as well as the 24 hour helpline and ambulance referral facility at no additional cost. The company also offers under this mediclaim policy, the family discount of 10 per cent for covering 3 or more family members under a single personal health insurance policy (http://www.royalsundaram.in; Accessed on 06/07/11)[217].

The Company also offers the Royal Sundaram Individual Health Care Insurance Card, specially designed exclusively for all individual health insurance customers online, enabling the customers to provide for the cashless facility at over 3000 hospitals across 166 cities in India, following the procedure of intimating the TPAs, the policyholder can avail the treatment in the network hospital, as and when required, subject to the exclusion and conditions. In the case of the policyholder taking treatment in the hospital other than the network hospital, the reimbursement mechanism can be used by the policyholder.

The another Individual health insurance offered by the company, is the Health Shield Online, which insures self, spouse and dependent parents up to the age of 50 years, as well as, the dependent children, unmarried children, between 91 days to 18 years. The policy includes the renewal up to the age of 70 years. In this case, if the person has the pre-existing disease, the customer will have to contact the nearest branch office for buying the policy (ibid).

2.6.4.7: National Insurance Co. Ltd:

The Mediclaim Policy of the National Insurance Co. Ltd. has been designed under the guidance of the Government of India, which includes the sub-limits for the hospitalization expenses, which provides coverage to the policyholder, spouse, dependent children and dependent parents, which can be availed to a person between the age of 18 to 59 years and can be renewed up to the age of 80 years, subject to the stipulated premium. The policy covers children above the age of 3 months provided parents are covered at the same time and suitable premium is paid. If the child above 18 years is employed or if the girl child is married, he or she shall cease to be covered under the policy. However male child can be covered up to the age of 25 years if he is a bonafide regular student and fully dependent on primary insured.

Female child can be covered up to the time, she is married. In the case of the continuous Mediclaim insurance policy for at least 5 years prior to attaining the age of 80 years, the policy can be renewed beyond the age of 80 up to the age of 90 years as a special case with approval of regional in charge on case to case basis. The premium chargeable shall be 10 per cent of the premium for 75 to 80 years age slabs for proposers above 85 and 20 per cent of the premium for 75 to 80 age slabs for proposers above 90. The company also has certain specifications in terms of entry of the new family member to the policy. Minimum sum insured under the policy is Rs. 50,000, which can be increased in the multiples of the Rs. 25000, up to Rs. 5 Lakhs. The company offers cashless hospitalization facility, but if the policy holders opt for reimbursement option, than the company offers 6 per cent discount on premium to the policy holder. Pre-acceptance health check-up is mandatory in case the age of individual or member of the policy is above 50years. The policy covers pre-existing diseases after 4 continuous claim free policy years with the national insurance company (http://www.nationalinsuranceindia.com; Accessed on 06/07/11)[218].

2.6.4.8: New India Assurance Co. Ltd:

The Individual Mediclaim policy of the New India Assurance Co. Ltd. is available to the persons between the age of 18 years to 60 years. Children between the age of 3 months to 18 years can be covered provided parents are covered simultaneously, along with the either or facility of services of the third party administrators or on the basis of reimbursement directly with the company. The individuals beyond 60 years can continue their insurance provided they are insured under Mediclaim policy with the National Assurance Co. Ltd. Company without any break. The premium is based on the age of the proposer and geographical area of treatment. The special features of policy includes discount in premium for family cover; loyalty discount; good health discount; cumulative bonus; cost of health check-ups, income-tax benefit under section 80D of IT Act (http://www.newindia.co.in; Accessed on 06/07/11)[219].

2.6.4.9: The Star Health and Allied Insurance Company:

While, the standalone health insurance companies also offers the unique benefits in the coverage of the individual mediclaim policies. The individual mediclaim policy of the Star Health and Allied Insurance Co. Ltd., Star Unique Insurance Policy, provides coverage to any person between the age of 18 years and 65 years which can be renewable up to 70 years, for both the future ailments/diseases and for pre-existing diseases/conditions. Moreover, beyond 70 years, the renewals of the policy would be provided under any other health insurance policy of the company. Pre-Existing Disease/ Condition, except those specified under exclusions, is covered by the policy after the elapse of the continuous coverage of 11 months, since the inception of this policy with the Company. It is a two year policy, wherein the sum insured and sub limits are for each year of insurance which cannot be cumulated or carried forward.

Thus, the premiums under the policy can be paid under the two installments, one at the time of the commencement of the policy and the other at the beginning of the second year of the policy. In case a claim is made before the other installment becomes due, the same would be recovered from the eligible claim amount. Failure of the policyholder in payment of the installments on or before the due date will result into the cancellation of the policy. The policy do not requires the pre-acceptance medical screening. The conditions for the pre-hospitalization remains similar to that of the other insurance companies, but in the case of the post hospitalization charges a lump sum amount is calculated at 7 per cent of the hospitalization expenses, excluding the room charges, subject to the maximum of Rs. 5000 is considered for the coverage by the policy. This policy also covers the HIV positive persons except for the opportunistic infections and treatments for HIV/AIDS, if the minimum CD 4 count at the time of entry is 350. This policy also covers the non-allopathic treatment up to 25 per cent of the sum insured up to a maximum of Rs. 25000 per occurrence, per year of insurance. The company offers the network of more than 4,600 hospitals across India for the claim settlement on the reimbursement basis or on the cash less basis, being settled through direct in-house settlements (http://www.starhealth.in; Accessed on 08/07/11)[220].

The company provides for the 24 x 7 toll free help line, free general physician consultation over phone or with doctors on duty 24 x 7, by simply quoting the policy number for medical advices; as well as also free health magazines are issued to the policy holders at regular intervals. The other individual mediclaim policy of the Star Health and Allied Insurance Company Ltd., is the Mediclassic. The policy requires compulsory medical check-up for persons above 50 years of age at the cost of the company. The company covers the pre-existing diseases/illness after 48 months of continuous coverage with the company. The pre-post hospitalization expenses are similar that offered by the company in its Star Unique Insurance Policy. The policy provides discount in the range from 5 per cent to 25 per cent for every claim-free year.

Moreover, the policy can be renewable up to 65 years for the sum insured of Rs. 10 lakhs. The company also offers other optional benefits on payment of additional premium. The company also offers other polices such as the Super Surplus policy, offering much large coverage that that offered by the basic plans, to any person between the age 5 months and 60 years, such as maximum sum insured of Rs. 10 lakhs, renewable up to 75 years of age, coverage of the pre-existing diseases/illnesses after the 36 months of the continuous coverage, etc. (ibid).

The another individual health policy offered by the company is the Star Health Gain Insurance focusing on the maximum tax benefit to the policyholders, which is extended to both the outpatient and in-patient hospitalization expenses, offering coverage of the flat amount of Rs. 14725, irrespective of the sum insured or age of the persons or number of the persons, to both the in-patient and out-patient treatment, and other such benefits as well as also announced the specific policy for the senior citizens, being India's first health insurance policy, entitled as the Senior Health Insurance Policy Red Carpet Benefits. This policy provides for coverage to anyone above the age of 60 and permits eligibility up to the age of 69 years with guaranteed renewals for the people beyond 69 years, offering the hospitalization as well as post-hospitalization cover, not requiring any pre-insurance medical test. The policy also offers for the coverage of the pre-existing diseases from the first year, except for those for which the treatment or advice was recommended during the immediately preceding 12 months from the date of proposal. However, the policy covers the disease for which the treatment or advice have been recommended by or received during the immediately preceding 12 months from the date of proposal will be covered from second year onwards (ibid).

2.6.4.10: Apollo Munich Health Insurance Co. Ltd:

The another standalone health insurance company is the Apollo Munich Health Insurance Co. Ltd., which offers the individual mediclaim policy, entitled as the Apollo Munich Health Insurance-Easy Health Standard, providing the sum insured range as 1, 2, 3, 4 and 5 lakhs (http://www.emediclaim.com; Accessed on 12/07/11)[221].

The pre-post hospitalization conditions applicable here are the 30 and 60 days, prior and post hospitalization respectively are covered by the policy, with certain specifications in case the intimation is not done within/before hospitalization. The company also offers an additional cover for Critical Illness, subject to the specified range of the premium cover, which can be either 50 per cent or the 100 per cent of the policyholder's basis sum insured. The company offers various other value added services. The policy can be renewed till the life time of the policy holder, however, for the additional cover of Critical Illness, maximum cover ceasing age is 70 years. Moreover, the policy also offers for the reduction the waiting period by 1 year on every continuous renewal of the Easy Health Insurance Plan.

The other policy offered by the company is the Easy Health Premium Policy, with the sum insured for 4 lakhs, 5 lakhs, 7.5 lakhs, 10 lakhs per insured person per policy year, which also covers for critical illness and the sum insured for critical illness can be either 50 per cent or 100 per cent of the basic sum insured, with most the other conditions similar to its Easy Health Standard. The Easy Health Exclusive offers the coverage up to the sum insured as 3, 4, 5 and 7 lakhs (ibid).

2.6.4.11: Max Bupa Health Insurance:

Max Bupa Health Insurance, the another standalone health insurance company offers the individual health insurance, entitled as the Heartbeat Individual health insurance plan, in the three types, namely, Silver, Gold and Platinum, with the varied sum insured ranges, such as, Rs. 2 and 3 lakhs; Rs. 5, 7.5 and 10 lakhs, and, Rs. 15, 20, and 50 lakhs, offering coverage to every member of the individual's family, with no conditions on the minimum or maximum age for enrollment. All claims are processed directly by its customer services team (http://www.emediclaim.com; Accessed on 07/07/11)[209].

In case of the renewal of the policy with the company, the policy also provides eligibility to the policyholder for the company's Health Relationship Program for the health services and products with the market value of up to 10 per cent of the renewal premium, along with the other benefits similar to that provided by the other standalone health insurance companies (ibid).

Moreover, with the announcement of the IRDA for the portability of the health insurance policies, the companies have started including the specifications in relation to the same in their policy documents.

Few studies focusing on the marketing of mediclaim policies have been reviewed as follows.

Dileep Mavalankar and Ramesh Bhatt (2000)[149] had referred to the mediclaim policy as the most popular health insurance cover. The mediclaim policy has to its credit the policy with which the health insurance was first started in India, by the Government insurance companies under the name mediclaim in the year 1986. However, thereafter, it has been revised to be made as attractive product. Mediclaim has been the reimbursement base insurance for hospitalization which did not covered out-patient treatments.

The author had reviewed some of the features of the policy, viz., the category wise ceiling on items in terms of room charges, operation charges etc., and later which were removed with the revision of the policies allowing the total reimbursements within the limit of the policy amount along with other changes in the policy coverage, and the benefits from time to time.

The authors had also presented the reasons for the poor performance of the mediclaim policies India, viz., slack of popularity of the scheme; in-expertise of the general insurance companies to deal with the health insurance product; little focus of the companies on the small share of the health insurance business; acceptance hampered by the technicalities of the health service business; lack of appropriate marketing efforts in selling these products, with, only Government encouragement in terms of the exemption of the premium paid by the individuals for their mediclaim.

Although, it has provided a model for health insurance for the middle class and the rich due to the provision of the coverage for the catastrophic hospitalization costs. But, it has remained limited to the middle-class, urban tax-payers segment of the population.

The author had also outlined the negative consequences of the mediclaim policy, viz., frequent reporting of the case of deception and manipulation by the policyholders and the health insurance providers; due to the weak monitoring mechanism and risk of adverse selection as the policy is voluntary, lead to price rise in the private health care service sector due to its reimbursement of the health charges benefit.

The revision in the mediclaim policy with the objective of smoothening the reimbursement procedure of the hospitalization expenses, from the 1st September 1996, was reviewed by Anil Gumber (2002)[172] which had been raised of the sum insured from Rs. 83, 000 to Rs. 300, 000.

Moreover according to the author removal of the premium determination on the basis of the ward or the hospital shall be amended on the basis of the age groups; the rate of premium shall be reduced to less than 50 per cent for the sum insured in the higher segments; the coverage shall be extended to children falling in the age group of 3 months to 5 years, with the condition of the one of the parent being concurrently enrolled; compensation of the health check-up cost shall be extended in the format of one time in every four underwriting years, and, family discount and cumulative bonus shall be provided.

Ramesh Bhatt and Shrikant Rajagopal (2005)[184] had highlighted the reimbursement expenses which were to be not allowed by the mediclaim policy for the treatment of the diseases and illnesses such as, AIDS, venereal diseases, pregnancy, dental treatment, hearing aids, spectacles, and contact lenses. They had provided the basic understanding about the mediclaim policy in India, its introduction as well as growth of the health insurance industry in India. They had also referred to mediclaim as an indemnity based scheme in which policyholders on payment of the fixed premium are covered for insurance up to a certain amount of sum assured. The policy is renewed every year. The premium is based on age of the policyholder and amount of sum assured.

On hospitalization, the policyholder is expected to first bear the complete cost of payment out-of-pocket and later they are reimbursed after verification of claim submitted to the insurance company. However, with the development of the Third Party Administrators, the insurance companies have also started providing the cash less facility. They had also analyzed preliminary data of claims of mediclaim with the objective to examine the association between the disease pattern and the health care quality, and found that the reimbursements were linked to the hospital resources and not to the diagnostic related groups or outputs.

Moreover, the scope of potential modifications in the present insurance schemes in terms of modifying the product characteristics that would further increase the benefit and decrease the risk without having implications for number of policies issued or amount of sum insured was also explored, along with the possibility of designing and introducing the new health insurance products.

Ratnam and Venkata (1995)[222] and General Insurance Corporation (1995)[223] had provided an overview of the various mediclaim programme which presented the more favorable attitude towards mediclaim policies in comparison to the ESIS. Thus, even the low mediclaim penetration in India, it could get a boost as cost competitive and customer friendly services are likely to be provided to the policyholders with the implementation of the health insurance portability. The policyholders are able to compare policies from the context of the various facilities provided by the health insurer.

Apart from the service factor, the policyholders can also compare the insurers with relation to denial of their policy renewal or escalating costs of renewal premiums and thereby, can decide upon the portability of their insurance policy (Viral Dholakia, 2010)[224].

Ramesh Bhatt and Elan Benjamin Reuben (2002)[225] had analyzed 621 claims and reimbursement for the year 1997-1998 and 1998-1999 of one of the branch of subsidiary company of General Insurance Corporation in the City of Ahmedabad of Gujarat State as the part of the research project under taken on Health Policy Development Network (HELPONET) by Indian Institute of Management, Ahmedabad, India. The underlining objectives of the study as identified by the authors were, viz., to understand the trends and patterns in the city of Ahmedabad of the insurance policies offered by the selected branch of GIC subsidiary; to understand the magnitude of the reimbursements against premiums collected; to describe the profile of the claimant; to analyze the break-up of the expenditure for which the claims and reimbursements were made; to find the time period involved in the delay in settling the claim and the reasons responsible for the delay; and, to analyze the system of reimbursement and its relationship with costs and claims made.

They had found that averse selection or provider induced demands led to accelerate the about one third of the amount of claims and that the insurance company under study settled the claim in on average121 days. While, on the basis of the analysis of the break-ups of reimbursements, they suggested that about more than one-third and one-fourth of reimbursements were made against the doctor's fees and diagnostic charges, respectively.

Sukumar Vellakkal (2012)[226] had analyzed the level of financial protection to low-income people during illness in private health insurance and people's preferred health insurance, and also the out-of-pocket health care spending per episodes of illness in the selected four resources poor locations in India.

The author had formulated a hypothetical situation in which the selected respondents were being enrolled for both the plans, viz., a type of private health insurance that is mediclaim policy and the people's preferred health insurance, that is, Choosing Health Plans All-Together scheme (CHAT).

The researcher had used three types of sources of data collected under varied projects, viz., household survey in the year 2005 under European Union (EU) funded research project on Strengthening Micro Health Insurance for the poor in India; a field-based experiment to reveal people's preference for health insurance benefits for CHAT during November-December 2005, and the specification of conditions of mediclaim policy of the subsidiaries of GIC as on August 2005. Notably, the CHAT was the hypothecated health insurance plan outlined deliberately to be dissimilar to the existing mediclaim plans by the surveyed communities. The researcher had found that the illness episodes, health expenditure, and reimbursement levels were considerably varying between the mediclaim policy and CHAT as well as across the selected locations.

The researcher had concluded that lower level of financial protection was provided by the private health insurance in comparison to the people's preferred health insurance, and thereby recommended the insurance providers to offer the comprehensive health insurance package as well as the region-specific features in their health insurance plan in terms of income levels, health care infrastructure, location and region specific health problems and health care conditions, etc. The health insurance companies were required to evolve user-centric insurance products based on the detailed market study followed by marketable products with affordable and acceptable terms to wider range of insurance customers. However, the number of people picking up health insurance policy was still insufficient. It is the sole voluntary health insurance policy in India with about 8 Million policyholders, providing shield against disastrous health expenditure.

In addition, the complexities in compensating the patients, ranging from long delays to the partial reimbursements; poor monitoring systems providing loops for conducting deception and manipulation by policyholders and health insurance providers; mismatching of the exclusions being offered, contradicting the health system logic of covering risks; need of reviewing, and revising the benefit package as per the needs of the customers and unpopular payment method of reimbursement, as well as causes for the unsatisfactory performance of TPAs are also among the important issues and concerns of the mediclaim policies being offered by the insurance companies. Mediclaim insurance policy or Individual mediclaim policy has been formulated under the auspices of the Government of India. The common coverage of the mediclaim insurance policies are, viz., the hospitalization, day care treatment, pre-hospitalization, post-hospitalization, and the pre-existing diseases coverage.

The Indian Government allows tax deductions to promote the private health care financing mechanism. An individual can avail tax benefits up to Rs. 15,000 as premium paid to the mediclaim policy in India, and for any senior citizen Rs. 20,000 (http://www.emediclaim.com; Accessed on 07/07/11)[209].

2.7: CONCLUDING REMARKS:

Undoubtedly, the dynamic environment imposes pressure on the various environmental components, viz., Technological, Socio-Cultural, Demographic, Economic, Political and Legal Environment which imposes the change in the demand as well as supply side of the particular market. The development and growth of Indian economy has emphasized on the growth of the services sectors of India. Thus, compelling to marketers to identify the needs, the changes in the needs and preferences of the customers and thereby direct its efforts in the direction of the customer satisfaction, and gradually towards Customer Relationship Management. The development and growth of Indian economy has emphasized on the growth of the services sectors of India.

In this chapter, an attempt has been made to discuss some of such efforts of the marketers concerning to the marketing of the health care services, the marketing of the insurance services, and the marketing of the health insurance services as well as marketing of the individual mediclaim policies were reviewed. The marketing concept has evolved from the orientations of the Production, Product and Selling, and has developed imbibing the Societal Marketing Orientation, and the Holistic Marketing Orientation. Marketing is the process of identifying the needs and wants of the target market, thereby making efforts to satisfy these needs and wants at the particular time effectively and efficiently continuously and consistently, better than the competitors.

The health care market of India with the privilege of botheration for the crucial resources that is, its citizens has limitless scope to develop the products and services for its target markets involving various types of marketing efforts. Obviously, the marketing mix comprises of the 7 P's, viz., Product; Price; Place; Promotion; People; Process, and Physical Evidence respectively, befitting the other obvious features of the services, viz., Intangibility, Perishability, Variability, Simultaneous Production and Consumption, respectively which adds complexity to the marketing efforts and designing of the marketing mix in case of the health insurance services.

Moreover, the health care services and its availing by the target market is to a great extent has been influenced by the health care costs, developments in the technology, the product and services innovations, the political and legal framework, as well as the purchasing power and the income sources, education, preferences, etc. of the people of India.

At the same time, these are the services that generally possesses the characteristics of the urgent availing or emergency availing or in other words are related to the probability of the risk of loss due to the individuals' confronting with the life's uncertainties, and its impact on an individual's health care requirements.

This imposes challenge on the marketers to change their view from the customer to the health care customers who possesses certain unique health care product/service purchasing characteristic which may not be made willingly, but out of the expectation to get relief from some health problems or to do away with certain other health care related problems.

For framing the marketing strategies viz., the Market Segmentation, Targeting and Selection, Positioning, Branding, Pricing, Distribution, and Promotion along with the integration of the Process, People and Physical Evidence with the marketing accountability makes the marketing of the health care services not only complex and challenging, but also interesting in the light of the various issues revolving around the marketing efforts.

One of the most important challenge being faced by the health care marketers is to get the real worth of their health care services, the offering which is the outcome of their application of knowledge and the research for the target market. But, it has been found that many of the health care services are not been availed by the target market due to the major limitation of the high health care costs, and the absence of the adequate Government assistance to the people for availing the services, apart from the difficulty of the having access, information and proper infrastructure for availing the services. However, the mechanism of the insurance services has been relied upon to overcome these limitations of the risk of uncertain burden of the financial crunch due to some loss, in general or due to certain health related problems, and heavy catastrophic health care costs.

But, insurance services possesses some of the unique characteristic different from the other services, and it has been regulated by the separate authority subject to the designing of the elements of marketing mix, viz., product, price, place, promotion, people, process and physical evidence, according to the conditions and regulations framed by IRDA.

The health care sector of India have been experiencing the liberalization and privatization which shall offer huge scope to the marketers. It has also been offering the mechanism of the health insurance in various forms to enable them to overcome at least the limitation of huge uncertain health care cost regulated by IRDA with the framework and regulations announced in the context of the product, price, promotion, distribution of the services along with the rules and regulations for the people, process and physical evidence to be used, and in a way, it can become the part of the marketing mix strategy of the health insurance marketers. Moreover, the variety of the health insurance formats operating in India has also been reviewed.

Of which, the private health insurance, type of the health insurance, have been targeting the general public to buy or avail the insurance service at their will voluntarily from the insurance companies which offers the challenging marketing environment to the marketers to compete with the other companies, and meet the need and wants of the target market. Although, these are the services and the benefits of which will be accrue in future to the target market.

The entry of the private players, the effects of the changes in the technology on both the health care services and its cost, provision of the better health care and health insurance services, the changing demographics in India, the dynamics of the communicable and non-communicable diseases and illness and the lives of the human being exposed to variety of the uncertain future risks in India, the huge potential mediclaim market is yet to experience the aggressive marketing of the health insurance services. Moreover, the target market have till date witnessed the mediclaim policy and the services as provided by the groups of the public sector non-life insurance companies only and are eager cum reluctant to accept the private insurance companies, irrespective of the products offered by them.

Moreover, IRDA has also begun to approve the companies to conduct the business exclusively for the health insurance products, which add the essence of competition in the health insurance market and may influence even the offering of the various innovatively segmented and benefits wrapped services. Thus, the time has come to show case the marketing strengths by the health insurance marketers or else there are the competitors to do the task, by considering the requirements of the Indian health insurance market potentials in near future.

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GLOSSARY OF KEY TERMS OF HEALTH INSURANCE

The researcher has presented Glossary of the key terms of the health insurance as follows.

Actuary:
An Actuary is a person who is expert in mathematics and has specialized in forecasting of risks, rates, premiums, and other factors for insurance companies.

Actuarial Analysis:
Actuarial analysis refers to the method of calculating the insurance premium and the reserves required, using actuarial methods.

Administrative Costs:
These are the operations costs pertaining to the health insurance.

Age Limits:
It refers to the specified lower and upper age limits below and above within which the insurance company will accept applications or renew policies.

Agent:
An insurance company representative, licensed by the regulator, who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Ambulatory Care:
When the medical services, like, diagnosis, treatment and rehabilitation, are provided on an outpatient basis, i.e., non-hospitalized basis, it is called as the Ambulatory care.

Association Group:
A group formed by the members of a trade or a professional association for the purpose of the group insurance under one master health insurance contract, is called as the Association Group.

Asymmetry of Information:
Asymmetry refers to the situation where two people in a transaction have different amounts of relevant information.

Beneficiary:
A person who is eligible to avail, or is availing, benefits from an insurance policy is called Beneficiary.

Benefits:
Benefits refer to the amount of money received by an insured or an assignee in the form of compensation for the medical costs of the illness which are in accordance with the premium payment to an insurance company.

Blanket Medical Expense:
A provision that give the right to an insured person to collect up to a maximum limit of the hospital and medical expenses incurred as specified in the policy, exclusive of any limitations on individual medical expenses.

Brochure or Certificate of Coverage:
Brochure refers to the booklet that provides the entire information pertaining to the benefits, limitations, exclusions, and definitions, of the policy.

Cap:
It refers to the maximum value of benefit paid by the health insurance company, which may be specific to time or services availed.

Capitation:
The payment method for health services in which an individual or institutional provider is paid a predetermined per capita amount for providing treatment to each person, irrespective of the actual cost of the services provided.

Catastrophic Insurance:
It refers to the 'top-up' insurance or re-insurance provided to the policyholders for the soaring medical costs resulting out of consistent substantial illness.

Catastrophic Limit:
The benefit feature that facilitates the policyholder to limit the premium to be paid in particular calendar year, on account of the incidence of the unexpected and uncommon medical expenses is called as the Catastrophic Limit.

Cherry Picking:
It refers to the practice offering the health insurance to the healthy persons and avoiding the coverage to the person as believed to be unhealthy by the private health insurance companies.

Claim:
Claim is a request to an insurer by an insured person, or by the health care service provider on behalf of the insured person, for the payment of the benefits as specified in the insurance plan.

Claim Amount:
It refers to the amount or benefits payable by the policyholder under a policy on the raising the claim.

Co-Insurance:
A cost-sharing provision under the health insurance policy wherein the policyholder has to make the payment equal to a proportion of the cost of the services covered under the plan, and the remaining will be paid by the insured.

Collection Period:
It refers to a specific period in which the insurance premium is collected.

Community Financing:
It refers to the alternatives of raising money, organized and controlled by the group of people, wherein the contributions may also be provided in the form of materials or individual labour.

Community Rating:
A method of determining health insurance premiums on the bases of average cost of actual or anticipated healthcare used by all the policyholders in a the particular geographical area or industry.

Compulsory Insurance:
It is the type of insurance under which the population to covered, the benefits offered, the conditions of the eligibility and sources of funds are specified by legislation.

Contributory:
A group insurance plan issued to an employer in which contribution to cost of plan is collected from employer and employee.

Co-Payment:
The payment alternative which involves policyholder to pay a specific, fixed amount per unit of service or time and the remaining is paid by the insurance company.

Cost-Sharing:
It refers to the pattern of payment in which payment for providing a particular type of healthcare is distributed between the patient and agencies, and the employer of the policyholder.

Coverage:
It refers to the assurance against specific losses offered by the insurance plan.
Declination:
It refers to the denial by the insurance company to insure a person after cautiously examining the application for insurance and other related aspects.
Deductible:
The amount of money the policyholder has to pay 'at the front end' followed by the payment by the insurance company.
Diagnosis-Related Groups (DRGs):
It is reimbursement system under which the healthcare providers are reimbursed specific sum of for the health care provided by them under the standard diagnostic categories.

Dread or Specified Disease Insurance:
It is the type of insurance which provides an unallocated benefit with the maximum limit, of the treatment expenses for the specified diseases, under the policy.

Eligibility Conditions:
It refers to the conditions to be met by the insured persons for being eligible or qualified to the benefits of the health insurance plan.

Eligibility Period:
A specified length of time, following the eligibility date during which any person of a particular group will be qualified to enroll in the policy under a group health insurance policy, without any insurability proof is called as the Eligibility period
Evidence of Insurability:
Any statement of evidence of an individual's physical condition or the factual information related to the acceptance for insurance.
Exclusions:
It refers to the specified conditions which are excluded from benefits mentioned in the policy.
Experience Rating:
It is the method of determining the premium for a group risk, wholly or partially on the basis of that group's experience.
Ex Gratia:
A payment made without any legal liability.
Family Policy:
It refers to a type of policy under which a policyholder, as well as, his or her dependents is insured.
Fee Schedule:
A listing of accepted charges or established allowances for the specific medical procedures on the basis of standards for the physician or third party or as per the maximum charges for the mentioned procedures is called as the Fee Schedule.

Fee-for-Service:
It is the type of method for charging bills on the basis of per visit or the services provided by the physician or other health care practitioner.

Group Insurance:
It is the type of insurance which provides coverage to the group of employees as well as their dependents, or members of the homogeneous group, under a single policy issued to an employer or the group itself.

Group Contract:
It refers to the insurance contract with an employer or any other entity that provides coverage to the group of persons specified as individuals from the context of their relationship with the entity is called as the Group contract.

Grace Period:
The specified period after the premium payment is due, during which the policyholder shall make such payment without any late fees charges, and protection of the policy continues is called as the Grace Period.

Health Maintenance Organization:
The organization that offers the assortment of the health care services to a specified group at a fixed periodic payment likely to the premium is called as the Health Maintenance Organization.

Home Nursing Care:
A skilled health care offered at the residence of the policyholder by a nurse, as prescribed by a physician, for the limited time hours per day and visits per year, excluding homemaking services of any kind is referred to as the Home Nursing Care.

Hospice Care:
A synchronized programme provided at home or as the type of inpatient services, which simplifies the suffering and inconvenience of the patient, including supportive care, for a terminally ill person and his or her family, by a medically supervised specialized team under the course of a licensed or certified hospice-care facility or agency.

Hospital Indemnity:
The type of health insurance which provides the coverage on the specified daily, weekly, or monthly indemnity basis at the time of hospital incarceration, payable irrespective of the actual expenses is referred as the Hospital Indemnity.

Indemnity:
It refers to the benefits in nature of the cash payments rather than services.

Individual Insurance:
It is the type of insurance policy which offers coverage to the policyholder and/or his or her family members.

In-Patient Services:
The medical care provided to the bed patient who is insured under the policy.

Insuring Clause:
It refers to the clause that sets forward the categories of losses as covered by the policy as well as, the parties to the insurance contract.

Insured:
A person offered coverage under the insurance policy.

Lapse:
It refers to the discontinuation of the policy on account of the failure of policyholder in the payment of the premium within the specified time period.

Limitations or Limited Benefits:
These are the statements in a brochure specifying the services or the supplies partially covered under the plan, or are covered only in case of the service or supply subject to the fulfilling of the certain criteria.

Limited Policy:
It refers to the policy under which only specific diseases or accidents.

Loading Costs:
It refers to the administrative and other costs in connection with the underwriting of an insurance policy.

Loading Factor/Load:
It refers to the percentage of total premiums utilized for covering administrative costs, profits and all items excluding medical benefits.

Long-Term Care:
It refers to the variety of maintenance and health services, on an inpatient basis provided to the persistently ill or physically or psychologically disabled.

Managed Care:
Healthcare systems that incorporate the financing and appropriate healthcare delivery to the policyholders with the help of the set-up of the selected healthcare providers in order to offer a furnish all-inclusive set of healthcare services, overt criteria for choosing the healthcare providers, formal programmes for ongoing quality assurance and utilization assessment and important financial incentives for members to use providers and procedures associated with the plan, is referred to as the managed care.

Manual Rate:
The premium developed in order to provide coverage to the group on the basis of the standard rate table of the company.

Maternity Care:
It refers to the prenatal and postnatal delivery care by a empanelled hospital, physician, or other practitioner, including, in many cases, nurse midwives.

Minimum Group:
The least number of employees permitted to effect the group for insurance purposes is referred to as the Minimum Group.

Morbidity:
The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons is called as the Morbidity.

No Claims Bonus:
A reduction in the premium of an insurance policy due to an increase of the risk cover provided as a resulf of claim free years.

Non-Contributory:
It is employee benefit plans term under which the employer bears the complete cost of the benefits provided to the employees.

Out-of-Pocket Payments or Costs:
The costs borne directly by a policyholder who lacks insurance benefits is defined as the Out-of-Pocket or Costs.

Out-Patient Services:
The care provided to the individuals in the outpatient department of the hospital or in the clinic; or other medical facility; in a doctor's office.

Overheads:
It refers to the costs pertaining to the general services which do not essentially arise from the operation of a given programme.

Payroll Deduction:
It is the specific amount withdrawn from the earnings of an employee in order to finance a benefit, which may be in the form of the set payroll tax or a required payment for a benefit.

Policy:
The legal document issued to the policyholder which underlines the terms and conditions of the insurance contract.

Policyholder:
A person who pays a premium to an insurance company for the coverage offered by a policy is called as the Policyholder.

Pre-Admission Certification:
A procedure whereby the insured or his doctor is required to contact the insurance company before admission to a hospital, and get the latter's permission.

Pre-Existing Condition:
An injury that has been occurred, or a disease, that has been contracted, or a physical condition which existed prior to the issuance of a health insurance policy.

Premium:
The amount of money or consideration paid by an insured person, a policyholder, or on his or her behalf, to an insurer or third party for coverage under the policy.

Private Health Insurance:
The health insurance sold by either commercial firms or non-profit-making organizations to individuals or groups.

Provider:
A person or institution, specifically a hospital or a doctor, physically delivering healthcare goods and services is referred to as the Provider.

Referral:
The practice of sending a patient to another practitioner for services or consultation, which the referring source is not prepared or qualified to provide.

Regulation:
Regulation refers to the intervention of Government in the healthcare in order to restrict the entry into or change/monitor the behaviour of participants through specific rules.

Reimbursement:
It refers to the payment by an insurance scheme, to the healthcare provider or to the insured persons, as a refund for all or part of fees for services.

Reinsurance:
The acceptance of a fraction of risk, underwritten by another insurer who has contracted for the entire coverage, by one or more insurers is called as re-insurers.

Renewal:
When the coverage under a policy is continued beyond its original term by the insurer's acceptance of the premium for a new policy term is referred to as the Renewal.

Rider:
A document that amends the policy or certificate, through which the benefits covered under the policy, may be increased or decreased, or the coverage waives.

Risk:
Any chance of loss is called as the risk.

Schedule:
A list of coverage or amounts concerning things or persons insured is called as the Schedule.

Self-Insurance or Self-Insured Plan:
The programme providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial insurers is called as the Self-Insurance or Self-Insured Plan.

Skimming:
It refers to the practice of the insurance companies, which are paid for, on a prepayment or capitation basis of seeking to enroll only the healthiest people as a way of controlling programme costs is referred to as Skimming or Creaming.

Stop Loss:
The quantitative level up to which an insurer is qualifying the costs and beyond which risk is transferred to a re-insurer, is called as the Stop-loss.

Substandard Risk:
An individual who is unable to meet the qualifications of a standard risk, on account of the health history or physical limitations is referred to as the substandard risk.

Third-Party Administration:
Administration of a group insurance plan by some person or firm other than the insurer or the policyholder is referred as the Third-party administration.

Third-Party Payer:
Any organization, public or private, that pays or insures health or medical expenses, on behalf of beneficiaries or recipients, is called as the third-party payer.

Time Limit:
The period of time during which a notice of claim or proof of loss must be filed is referred to as the time limit.

Underwriter:
The term, as generally used applies either to a company that receives the premiums and accepts the responsibility for the fulfillment of the policy contract, or the company employee who decides whether or not the company should assume a particular risk.

Underwriting:
Underwriting refers to the process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Uninsurable Risk:
An individual, who is not acceptable for insurance, due to excessive risk, is called as the Uninsurable risk.

Universal Coverage:

Coverage of all the citizens of a country under a particular insurance scheme, or variety of schemes, is called as the universal schemes.

Utmost Good Faith:

A duty imposed on both the parties to an insurance contract, i.e., the legal duty that implies full disclosure of all facts material to the contract during negotiations of the contract is called as the Utmost good faith.

Waiting Period:

Waiting period refers to the period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced.

Waiver of Premium:

A provision included in certain policies that exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract, is called as the Waiver of premium.

Waiver:

An agreement attached to a policy that exempts from coverage of certain disabilities or injuries that are normally covered by the policy, is called as the Waiver.

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