Pacific Business Review International
Volume 7, Issue 1, July 2014

Prospective Growth of Health Insurance in India: Trends and Challenges

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Abstract

The importance of a healthy nation and of a healthy workforce is a key to survival and wellbeing of any economy. Any hint of dwindling health standards would be a source of worry for the nation concerned. To this extent, amenities that guarantee access to health care for population may need to be supported. In the present paper an attempt has been made to examine the growth and trends of health insurance in India. It was found that health insurance was growing at a healthy rate in India. But still the claim paid ratio is higher that can cause a problem of sustainability of health insurance in India. Factors that have contributed to the growth of health insurance are more options in coverage, increase in medical care costs driving people towards insurance, introduction of cashless hospitalization, quicker turnaround times for claims settlement, government schemes like RSBY etc. Health insurance can become an alternate tool to finance health care. The study suggested that if properly managed health insurance can be tool for obtaining cost effective healthcare in India as out-of-pocket payments are the highest in the world. Once the penetration of health insurance increases in India, out of pocket payments will automatically come down.

Keywords:

Health insurance, Performance, Prospects, Implications.

Introduction

The Health status of the people in the country is an important flag-post to evaluate the success of the economy. Health of the individual impacts the economy growth of the nation in a very material sense. It has been estimated that the difference in the growth performance of many countries can be attributed to health status of the people. Public expenditure on health support programmes in fact contributes quite tangibly in spurring the growth in the country. According to a study by the WHO, India is estimated to lose more than $ 237 billion of its GDP over the period 2006-15 on account of premature death and morbidity from non-communicable disease alone. It is worth pondering that public expenditure on health care is probably a far more efficient economic investment than many other kinds of investments (Yojana, 2014). Knowing this, many governments in developing countries have increased efforts to improve the provision of health care in both urban and rural areas. Despite these efforts, many developing countries are still far from achieving universal coverage. The situation is even worse in rural areas where the living standards are very low (WHO, 2000) and access to quality health care services is low due to the absence of the absence of formal financial protection in the form of insurance schemes. As pointed out by Khan (2001), a majority of rural households (more than 90%) in many developing countries

do not only face limited access to health care but also endure poor quality water and unsafe sanitation (Donfouet, 2011).

Health insurance, or health cover, is defined in the registration of Indian insurance companies regulations 2000, as the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in patient, or out patient, on an indemnity, reimbursement, services, prepaid hospital or other plan basis, including assured benefits and long term care (Sahoo and Das, 2011). The international labor organization defines health insurance as the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member. The essentials in a health insurance programme are prepayment and risk pooling (Devadasan and Nandraj, 2006). The legislation concerning health insurance in India is fairly comprehensive in terms of licensing regulations, auditing, investment guidelines and financial controls. There is much less regulatory focus on the consumer of insurance products and the overall goals of health policy in the form of regulation that curbs risk selection, protects consumers, promotes health insurance companies and health products etc. The Insurance Regulatory and Development Authority (IRDA) bill was passed in December 1999 and the bill created a regulatory Authority to govern the insurance industry in India. It also enabled provisions for foreign players to enter the Indian market with de-tariffing and de-regulation occurring in 2000, which significantly opened up the market. India's insurance market still lags behind other countries in terms of penetration. With the penetration level at three percent in India it is far behind UK (12.5%), Japan (10.5%), Korea (10.3%) and US (9.2%) (Sanjay Dutta, 2012). The entire insurance industry including the health insurance segment is governed by the IRDA which has presented certain challenges and limitations with regard to streamlining establishing key controls of governance in terms of standardizing provider practice variations, establishing pricing guidelines for hospitals services and procedures and establishing standards for health insurers to track and report on claims data and utilization trends which can drive more effective underwriting processes for the industry (Public Health foundation of India , 2011).

The objective of the present study is to examine the trends and implications of health insurance in India. To accomplish the objective, the paper has been divided into five broad sections. Section I introduces role and relevance of health insurance in India. Section II deals with review of the work done on health insurance. Section III presents a research methodology to work out the growth and challenges in health insurance in India. Section IV examines the trends and challenges of health insurance in India. The Section V concludes the discussion along with certain policy implications.

Review of Literature

Gumber and Kulkarni (2000) explored the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and constraints in extending the current health insurance benefits to workers in the informal sector. In rural and urban areas the private sector has played a dominant role in providing services for ambulatory care (acute and chronic morbidity). Over 92 per cent of the non-insured households in both rural and urban areas have no awareness about the existing health insurance schemes. Asgary et al. (2004) analyzed the rural households willing to devote part of their income to health insurance and factors that determine households' willingness to pay for the insurance in Iran. Rural households of Iran were found to be willing to pay an average of 22,044+13,060 rials per month for medical insurance. The results of regression analysis on households willingness to pay show that age, education level, health care facilities of rural areas and access to medical care services, and households medical needs have statistically significant impacts on household's WTP. Majumdar (2004) stated that health insurance can grow healthily in India. The study examined that actuary has an essential role to play in transacting health insurance business for example in product design and premium rating. The group health insurance business was then intended to be operated more or less on no loss/no profit basis and the cover was being granted to the company's valued clients on accommodation basis. Bhat and Jain (2006) analyzed firstly the factors which affect the insurance purchase decision and secondly the factors that which affect the amount of insurance purchase. The results indicate that income and health care expenditure are important determinates of health insurance purchase. Age, coverage of illness, no of children in the family, perception regarding future health care expenditure and knowledge about health insurance also have a positive effect on health insurance purchase. Dror (2006) analyzed the seven myths related to health insurance in India and highlighted that most Indian are willing to pay 1.35 per cent of their income or more on health insurance and most people prefer a holistic benefit package at basic coverage over high coverage of only rare events. Ahuja and Narang (2005) provided an overview of existing forms and emerging trends in health insurance for low income segment in India and concluded that health insurance schemes have considerable scope of improvement for a country like India by providing appropriate incentives and bringing these under the regulatory ambit. Dror (2007) examined that perceived medical needs of low-income people living in rural and slum India are context specific and multiple. The study indicates that out of pocket spending on medical services exceeds current levels of willingness to pay for the health insurance. Therefore a health insurance package that will compensate such costs is more likely to be more relevant for the financial protection and attractive to the clients. Asfaw (2008) analyzed the willingness to pay for health insurance in Namibia through the double bounded contingent valuation method. The findings suggest that 87 percent of the uninsured respondents are willing to join the purposed health insurance scheme and on an average are willing to insure 3.2 individuals. The factors that affect the willingness of respondents to join the proposed insurance product are education and age. Ghosh (2010) explored the health insecurities of workers in informal employment based on an empirical study conducted in Delhi. The average share of health related expenditures was 4.3 per cent of the total household expenditure. The findings show that more than half of the households (53.8 per cent) borrowed money and almost one-third of the households (31 per cent) had to sell their productive assets in their native place if the illness lasted for a longer duration. Bawa and Ruchita (2011) have concluded the presence of seven key factors which are acting as barriers to subscription to health insurance. These were lack of funds, lack of willingness and awareness, lack of intermediaries, lack of reliability and lack of accessibility to services. Study also found that their exist

significant relationship between age, gender, education, occupation and income of the respondents and their willingness to pay for health insurance while no significant relationship was found between marital status and their willingness to pay for health insurance.

On the basis of the literature review it is evident that in no study an attempt had been made to examine the trends and challenges in Indian health insurance segment. Thus study in hand tries to examine the trends and challenges in health insurance in India.

Research Methodology

The study is based on secondary data on health insurance obtained from insurance information bureau. This study is descriptive in nature. For the analysis simple linear regression technique had been used to analyze the effect of number of policies on the number of claims. For the attainment of other objectives bar diagrams, annual growth rate, compound annual growth rate (CAGR), percentages had been used.

Growth rate has been computed as per the following formula:

Growth Rate= {(present value-past value) / past value} x 100

Therefore the regression equation is formed as:

Number of Claims= a+ b (Number of policies)

Similarly, Compound growth rate has been calculated as under:

$$CAGR\,(t0, tn) = \left(\frac{V(tn)}{V(to)}\right)^{\frac{1}{tn-to}} - 1$$

Where, V (t_0) indicates the start value, V (t_n) indicates the finish value, $t_n - t_0$ refers to the number of years. As long as the real or standardized values retain the same mathematical proportions, they can be used for calculation. The compound annual growth rate can also be calculated as the geometric mean of 1 added to each year's return, minus 1.

The objective of the present study is to examine the trends and implications of health insurance in India. With the orientation to achieve the stated objectives following hypothesis has been formulated which possibly justifies the important variables of the study:

Hypothesis of the present study:

H_o: There is no significant effect of number of policies on number of claims of health insurance in India.

Analysis and Interpretation

For the attainment of above objectives this section is composite of following parts. Part I includes the growth of health insurance in India, Part II deals the effect of number of policies on number of claims, Part III includes the preference of type of cover, number of policies and premium. Part IV states state-wise number of claims, total claim paid amount and average claim paid and finally Part V explains disease-wise number of claims, total claim paid amount and average claim paid.

Part I. Growth of Health Insurance in India:

In the present study an attempt have been made to examine the growth rate of health insurance in India in terms of number of policies, number of members, number of claims and the claim paid. The following table represents the growth rate of health insurance in India. The figures in bracket represent the annual growth rate of the respective column heading.

Table: 1
Number of Policies, Number of Members, Number of Claims, Premium and Claim Paid of Health Insurance (2003-04 - 2011-12)

Year	Number of Policies	Number of Members	Number of Claims	Premium (In crores)	Claim Paid (In crores)
2003-2004*	2265451	83,61,629	3,60,088	944	785
2004-2005*	20,59,449	89,87,239	5,55,273	987	948
	(-9.09)	(7.48)	(54.20)	(4.55)	(20.76)
2005-2006*	38,28,495	1,63,45,575	10,16,785	1,947	1,777
	(85.90)	(81.87)	(83.11)	(97.26)	(87.45)
2006-2007*	31,10,475	1,79,07,430	10,60,047	2,820	2,198
	(-18.75)	(9.55)	(4.25)	(44.83)	(23.69)
2007-2008*	37,90,838	2,41,21,625	14,36,998	2,758	2,904
	(21.87)	(34.70)	(35.56)	(-2.19)	(32.12)
2008-2009*	45,75,725	3,27,10,604	20,81,297	3,976	4,087
	(20.70)	(35.61)	(44.84)	(44.16)	(40.74)
2009-2010**	68,84,687	5,48,93,453	32,63,597	7,803	7,456
	(50.46)	(67.81)	(56.81)	(96.25)	(82.43)
2010-2011**	77,42,076	5,25,08,111	38,43,285	10,932	10,797
	(12.45)	(-4.34)	(17.76)	(40.09)	(44.81)
2011-2012***	82,25,112	2,91,34,940	25,91,781#	10,942	8,499#
	(6.24)	(-44.51)	(-32.56)	(0.91)	(-21.28)
CAGR	19.50	24.84	32.10	39.88	40.29

Source: Author's Calculation from the data obtained from IIB.

*Note: The figures in parentheses indicate annual rate of change, * Policies serviced by TPAs only, ** Figures of Policies serviced by TPAs and directly serviced by Insurer, *** Data submitted online by PVT insurers and offline by PSU insurers, # Inclusive of Claim Records where Claim Paid Amount > 20 lakh*

Table-1 shows that number of health insurance policies rose from 2265451 to 82, 25,112 from 2003-04 to 2011-12. The highest growth in number of polices was observed in 2005-06 of 85.90 percent. Whereas, the negative growth has been found in two years i.e. (-) 9.09 in 2004-05 and another in (-) 18.75 in 2006-07.The compound annual growth rate of number of polices was 19.50 percent per annuam. It was examined that the highest growth in terms of number of members was of 81.87 percent in 2005-06. Whereas negative growth rate was found during two years, one in 2010-11 of (-) 4.34 percent and another in 2011-12 of (-) 44.51 percent.But compound annual growth rate of number of members was 24.48 percent per annuam. In case of number of claims the

highest growth of 83.11 percent was observed in 2005-06. The number of claim reflects a decreasing growth of (-) 32.10 percent in 2011-12. The compound annual growth rate was 32.10 percent per annuam. The highest growth of premium was 97.26 percent in 2005-06 and lowest growth of (-) 2.19 percent was noticed in 2007-08 over the previous year. As a whole, compound annual growth rate of premium of health insurance was 39.88 percent per annuam. The highest growth in claim paid was of 87.45 percent in 2005-06 and negative was found in 2011-12 of (-) 21.28 percent. The compound annual growth rate of number of claim paid was 40.29 percent per annuam. On the basis of table I, it was examined that compound annual growth rate of number of claim paid was 40.29 percent followed by premium of 39.88 percent, number of claims of 32.10 percent, number of members of 24.84 percent and number of policies of 19.50. As the CAGR of claim paid was highest among other parameters consequently lot is to be needed on the front of health insurance to make it financially viable.

Part II. Effect of Number of Policies on Number of Claims:

In order to find out the effect of number of policies on the number of claims the regression technique has been applied. For the application of regression analysis number of policies considered as independent variable and number of claim as dependent variable. Therefore the regression equation is formed as:

TABLE : 2

REGRESSION ANALYSIS

Model	R	R Square	Adjusted R^2	Std. Error	F- Test	p-value
Regression	.988*	.976	.972	212587.499	242.600	.000*

Source: Author's calculation from the data obtained from IIB.

**Significant at p<0.05*

TABLE: 3

COEFFICIENTS

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	-901431.649	183279.027		-4.918	.003
No. of Policies	.608	.039	.988	15.576	.000

Source: Author's Calculation from the data obtained from IIB

From the table-2, it was found that the value of R Square is 0.976, Table-3 shows that number of policies had influence on number of claims of health insurance. As the p-value is less than 0.05, therefore our null hypothesis is rejected. The overall regression model is significant. The beta coefficient (number of policies) is also significant. From the above results we can conclude that if number increase by one unit the corresponding change in the claim is 0.608 units.

Part III. Preference of Type of Cover, Number of Policies and Premium:

The following table deals with the preference of different health insurance policies in India

TABLE: 4

TYPE OF COVER, NUMBER OF POLICIES AND PREMIUM

(2011-12)

Type of Policy	Number of Policies	Policy Premium (in Crs.)	Share in Total Policies (in %)	Share in Premium (in %)
Individual	58,06,907	3,449	70.60	31.52
Individual Floater	15,92,326	977	19.36	8.93
Group	34,844	1,147	0.42	10.48
Group Floater	1,78,868	4,935	2.17	45.10
Declaration and Others	6,12,167	433	7.44	3.96
Total	82,25,112	10,942	100	100

SOURCE: IIB

It was observed from table-4 that individual policies were found to be more preferred followed by individual floater, declaration and others, group floater and group respectively. Whereas the highest share in premium (in %) was found in case of group floater policies followed by individual policies.

Part IV. State-Wise Number of Claims, Total Claim Paid Amount and Average Claim Paid:

TABLE :5
State-wise Number of Claims, Total Claim Paid Amount and Average Claim Paid
(2011-12)

States	Number of Claims	Total Claim Paid Amount (In crore)	Average Claim Paid (In crore)
MAHARASHTRA	2,54,536	682.25	26,804
GUJARAT	1,39,803	269.18	19,254
WEST BENGAL	1,15,615	226.73	19,611
TAMIL NADU	1,12,215	227.33	20,259
DELHI	1,04,314	329.18	31,556
KARNATAKA	91,527	204.86	22,383
KERALA	60,874	75.42	12,390
ANDHRA PRADESH	53,744	143.5	26,701
UTTAR PRADESH	47,577	111.67	23,472
HARYANA	45,450	113.16	24,897
MADHYA PRADESH	30,199	43.49	14,401
PUNJAB	21,776	43.7	20,068
RAJASTHAN	15,291	34.42	22,510
JHARKHAND	10,176	3.99	3,921
ORISSA	9,366	10.3	10,993
ASSAM	8,652	6.28	7,256
GOA	3,396	8.37	24,643
BIHAR	2,463	3.55	14,431
TRIPURA	2,171	0.16	722
UTTARAKHAND	2,159	3.84	17,785
CHATTISGARH	2,077	4.59	22,115
CHANDIGARH	1,390	3.15	22,676
PONDICHERRY	1,027	1.78	17,307
States with <1000 Claims	1512	0.02	177359
Pin codes not Specified	14,52,707	4,707.01	32,402
Total	25,90,017	7,260.49	28,033

SOURCE: HB

It was examined from table-5 that on an average 28,033 claims have been paid. But it was highest in Delhi followed by Maharashtra and Goa. Whereas lowest average claims were recorded in Tripura.

Part V. Disease-Wise Number of Claims, Total Claim Paid Amount and Average Claim Paid:

TABLE :6
State-wise Number of Claims, Total Claim Paid Amount and Average Claim Paid
(2011-12)

Disease Name	ICD Codes	Number of Claims	Total Claims Paid (In Rs. Crore)	Average Claim Paid (in Rs.)
INFECTIOUS	A00-B99	1,82,136	206.61	11,344
CLINICAL FINDINGS	R00-R99	1,10,748	111.23	10,044
UROLOGY	N00-N99	97,418	193.29	19,841
DIGESTIVE	K00-K93	95,884	213.2	22,236
PREGNANCY	O00-O99	91,017	204.63	22,483
INJURY	S00-T98	73,058	216.11	29,580
RESPIRATORY	J00-J99	71,903	117.75	16,377
CIRCULATORY	I00-I99	63,364	298.22	47,065
EYE	H00-H59	63,313	113.61	17,944
NEOPLASM	C00-D48	47,182	163.09	34,567
ARTHROPATHIES	M00-99	28,141	116.45	41,382
SKIN	L00-L99	15,900	27.26	17,144
ENDOCRINE	E00-E99	14,243	31.82	22,338
NERVOUS	G00-G99	13,276	36.8	27,716
PERINATAL PERIOD CONDITIONS	P00-P96	10,865	21.99	20,244
HEALTH SERVICES RELATED	Z00-Z99	9,325	16.65	17,857
EAR	H60-H95	8,852	18.68	21,098
BLOOD DISEASES	D50-D89	4,929	11.37	23,063
ACCIDENT	V00-Y99	4,500	8.36	18,569
MENTAL DISORDERS	F00-F99	2,864	5.17	18,058
MALFORMATIONS/DEFORMATIONS	Q00-Q99	2,003	8.81	43,986
CODES FOR SPECIAL PURPOSES	U00-U99	7*	0.04[3]	53,417*
Diseases Not Specified		15,79,089	5,119.36	32,420
TOTAL		25,90,017	7,260.49	28,033

SOURCE: HB

From the above table it was found that highest average claim have been paid to Circulatory followed by Malformations /Deformations and Injury, whereas the lowest average claim was found in case of Clinical Findings.

Conclusion

Health is necessary for well-being and for attainment of millennium development goals. As implied by the theory of endogenous growth, good health by the general population underlies higher productivity, an essential factor for economic growth. In the present paper an attempt had been made to examine the trends and challenges of health insurance in India. It was found that the CAGR in number of policies were 19.50 percent, in members 24.84 percent, number of claims of 32.10 percent and premium 39.88 percent and claim paid 40.29 percent. It was observed that the claim paid percentage had risen than premium percentage. This can be hindrance in the path of health insurance in

India. From the regression results it was found that if premium increases by one unit the corresponding change in the claim is 0.608 in units. The important constraint in health insurance was its sustainability due to high claim paid ratio, which was also observed by results of regression analysis. It was observed from table IV that individual policies were found to be more preferred followed by individual floater, declaration and other, group floater and group respectively. But the highest share in premium is of group floater policies followed by individual policies. After comparing state –wise claim paid, it was found that claim paid was highest in Delhi followed by Maharashtra and Goa. Whereas lowest average claims were recorded in Tripura and he highest average claim had been paid to circulatory followed by malformations/deformations and injury, whereas the lowest average claim was found in case of clinical findings. So, the growth in the health insurance portfolio has been phenomenal in the past 10 years though the penetration levels are still in single digits, the prospects of the health insurance industry seem very bright. The public and private health insurance companies should generate consumer related innovation towards improving consumer awareness. One innovative practice which can be emulated in this aspect is the use of non-government organizations and self-help groups to improve awareness. Further, targeted advertising to specific groups of customers can also be used. Social network marketing channels can be effectively and innovatively used for effective distribution of insurance products. Health insurance for the masses in India and spread of awareness towards it are the crying needs of the hour and let us be happy that we are moving in the right direction. The huge escalating costs of hospital treatment are ruining a large number of families in this country. By taking Health insurance at the right time for a right amount, may be, we will be able to save a lot of expenditure and fortune in the future for the families and even create wealth.

Despite of all these challenges there are huge opportunities in the way of health insurance. Some of the opportunities are medical cost has risen, specialized treatment become frequent due to the rise in income pattern, low public expenditure on health and family welfare i.e. 2.06 percent out of total expenditure (Economic survey, 2013), In India 86 percent expenditure on health is out of pocket (World Bank, 2012), Health risk is a not a temporary but a recurrence risk among all the classes, and age groups and also rising day by day with environmental degradation ,urbanization, industrialization , changes in lifestyle, occupation and food habits of the people. This indicates towards a huge potential for this market. Once the penetration of health insurance increases, out of pocket payments will come down. The use of new distribution methods, IT tools, high commission on sale of health insurance policies can be used to widen the scope of the industry for a longer period.

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