Research Article

Awareness of health insurance in a rural population of Bangalore, India

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Abstract

Background: Health insurance is a rapidly emerging social security instrument for the rural poor, for whom, chronic health problems, arising due to prevalence of diseases and inaccessibility to an affordable health care system is a major threat to their income earning capacity. Insurance is one of the risk management strategies.The need for an insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging premium from a wider population base of the same community. There is a need to increase the awareness of health insurance among rural population therefore this study was undertaken.

Objective: (1) To study the socioeconomic and demographic characteristics of study population; and (2)to analyze the awareness of health insurance of study population.

Materials and Methods: A pretested semi-structured questionnaire was used for collecting data on sociodemographic and economic characteristics of the study population and their awareness of the benefits and purpose of taking health insurance. Study was from October 2015 to December 2015. The data were analyzed using percentages and proportion. A total of 1084 sample houses were visited and among them 399 were interviewed.

Result: Of the 399 respondents, 302 (75.7%) of them were aware of health insurance. Among 302 only 202 (66.9%) had procured health insurance. Of these,187(95.5%) had government insurance and 15(7.5%) of them had private health insurance. Awareness of health insurance was associated with socioeconomic status and education ($p<0.05$).

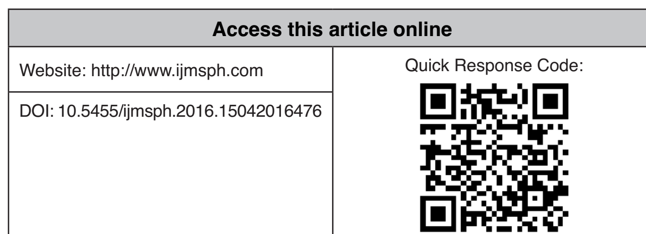
Conclusion: The determinants of awareness of health insurance were education and socioeconomic status. Though this study shows increased prevalence of awareness of health insurance there is still an alarming need to improve the awareness with regard to their knowledge about health insurance covering the medical expenses in the rural communities.

KEY WORDS: Health insurance, awareness, rural, sociodemographic, India

Introduction

Even after more than 60 years of independence, inequalities in access to health care is widely prevalent in Indian communities. These inequalities in access to health care are related to socioeconomic status, geography, and gender, and are compounded by high out-of-pocket expenditures, with more than three-fourths of the increasing financial burden of health care being met by households.[1] The rise in health care demand has increased the cost of health care system to the extent that specialized care is beyond the reach of common man, only 10% Indians have some form of health insurance, mostly inadequate.[1] As per National Family Health Survey-3, only 5% households are covered under any health scheme or insurance.

The rural populations are more susceptible to risks such as illness, injury, accident, and death because of their unique social and economic circumstances such as the inability to bear hospital expenses at an unpredictable moment. There is a need to provide financial shield to poor families for the same reason. Health insurance could be a way of removing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the financial barriers and improving accessibility to quality medical care. Health insurance is an instrument wherein “an individual or group” purchase health care coverage in advance by paying a fee called a premium.[1]

Health Insurance

Health insurance is a method to finance healthcare. The ILO 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” (ILO, 1996). To put it more simply, in a health insurance program, people who have the risk of a certain event contribute a small amount (premium) toward a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g.,hospitalization).

Health Insurance in India

Today many countries are shifting over to health insurance as a mechanism of financing their health-care program. In India, we need to shift from the current predominance of out-of-pocket payments to a health insurance program. The reasons are very clear: (1) direct out-of-pocket payments are a financial barrier to access health services. On the other hand, an insured patient can walk into a health facility without the fear of financial burden; (2) Direct out-of-pocket payments can push families into indebtedness or poverty. Health insurance protects the patient from the burden of raising funds at the time of illness; (3) Direct out-of-pocket payments are inequitable as they place the burden on the vulnerable. Insurance through its risk pooling mechanism is more equitable; and (4) Direct out-of-pocket payments do not permit patient’s participation in his/her treatment. On the other hand, by its collective nature, a health insurance program can negotiate for better quality care.

Most health insurance schemes can be classified into three broad categories, social health insurance (SHI), private health insurance (PHI), and community (or micro) health insurance. In India, we have a fourth category called government initiated health insurance schemes that do not fit into any of the above three categories. Each has its own specificities. However, there are some features that overlap among the three.

Social Health Insurance (SHI)

SHI schemes are statutory programs financed mainly through wage-based contributions and related to level of income. SHI schemes are mandatory for defined categories of workers and their employers. It is based on a combination of insurance and solidarity. The classical example of an SHI is the German or Belgian health insurance system. Here, employees and employers contribute to a “mutual fund(s)” that is then used to finance the healthcare for the entire population. Citizens have to enroll compulsorily in one of these mutual funds. The government also provides significant funding to cover those who are not able to contribute. In many low-income countries, SHI has been implemented mainly for the civil servants and the formal sector. This can lead to gross inequities. For instance, in India, 18% of the central government budget is used to finance an SHI for the civil servants who constitute only 0.4% of the population. In India, there are three well-known SHI schemes—the Employees’ State insurance Scheme (ESIS), the Central Government Health Scheme (CGHS), and the ECHS (Ex-serviceman’s Contributory Health Scheme).

Private Health Insurance (PHI)

PHI refers to insurance schemes that are financed through individual private health premiums, which are often voluntary and risk rated. For-profit insurance companies manage the funds. In low-income countries such as India, they provide primary insurance cover, that is, they insure hospitalizations. On the other hand, in high-income countries, they usually provide supplementary secondary insurance cover.

Community Health Insurance (CHI)

Community health insurance is “any not-for-profit insurance scheme aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management.” The important point to note is that in CHI, the local community takes the initiative in establishing a health insurance scheme, usually to improve access to healthcare as well as protect against high medical expenses. The solidarity element is strongest in CHIs as most of the members know each other. CHI as a movement is quite active in sub-Saharan Africa. Even in Asia, we have examples from India, the Philippines, Indonesia, Cambodia, Bangladesh, etc.

Government-Initiated Health Insurance Schemes (GHI)

As stated earlier, India has a fourth category that is not usually seen in other countries. This is the “GHI.” The specificity of this is that the government introduces a health insurance program, usually for the poorest and vulnerable sections of the community. In many of the schemes, the premium is totally subsidized by the government (from tax-based revenues) and is paid directly to the insurance company. Rarely, the community may be expected to pay a token amount. The insurance company or an independent body is the organizer of the scheme. These schemes last for a couple of years depending on the political will and longevity of the government. These are seen more as populist welfare schemes rather than a long-lasting intervention.[4,5]

In the present scenario, the annual expenditure on health in India amounts to about $7.00 in rural areas and $10.00 inurban are asper person.[5] The majority of care being provided by the private sector 2. With improved literacy, modest rise in incomes, and rapid spread of print and electronic media, there is greater awareness and increasing demand for better health services. There is growing evidence that the level of health care spending in India—currently more than 6% of

its total GDP—is considerably higher than that in many other developing countries. This evidence also suggests that more than three-quarters of this spending includes private out-of-pocket expenses.The opening up of the health insurance to the private sector by the Insurance Regulatory Development Authority (IRDA) Act 2000 has provided immense opportunities for both the public and the industry for better utilization of health-care facilities. With this kind of situation prevailing, there has not been much progress in the coverage of our population within the health insurance system; only a meager 3% coverage has been reported.[5] Whether this is due to lack of awareness on part of the public is to be determined.With this background information this study was conducted in the rural Bangalore to assess the awareness about health insurance among rural people.[6]

Taking into consideration of all the above facts, this study was planned with the objectives: (1) to study the socioeconomic and demographic characteristics of study population; and (2) to analyze the awareness of health insurance of the study population.

Materials and Methods

Rural field practice area ofVydehi Institute of Medical Sciences & Research Centre, Bangalore, Karnataka, India was taken as the study area with study population of 5903 with the study period from October 2015 to December 2015.

Sampling Technique

Field practice area of five villagesand two were selected randomlywith a total population of 3470, where all the houses (1084) were visited. Individuals aged ≥25 years and who were present at home at the time of visit were included in the study. The households that were locked and where the age criteria were not fulfilled were excluded. A totalof 399 individuals, one individual from each household, were selected for the study.

Study Method

Using a pretestedsemi-structured questionnaire,data collection was carried out regarding demographic, economic, awareness, benefits, and purpose of taking health insurance. Data were analyzed using SPSS version 21, χ^2-test, and percentages and tables.

Sample Size

Considering the prevalence of awareness of health insurance among the rural population as 50%,[6] relative precision as 10%,an α level of 5% with the sample size 356.356 +35(expecting a nonresponserate of 10%) and a sample size of 399 was taken.

Statistical Analysis

Data were entered and analyzed to find out the association between awareness of health insurance and independent variables such as socioeconomic status and religion. Data were further analyzed to find outthe association between awareness and other variables. χ^2-test was used and *p*-value less than 0.05 was considered as significant.

Result

Of the 399 respondents, 302 (75.7%) were aware about health insurance and 97 (24.3%) were not aware about health insurance [Figure 1]. The awareness of health insurance among different respondents and the χ^2-value and *p*-value for each character is given in Table 1. *p*-Value less than 0.05 was taken significant and it was significant for gender (awareness among men is more than females), type of family (awareness was more among nuclear family), socioeconomic status, education, and occupation (more among government and private employs). Most of the aware people had got the information regarding health insurance from family friends (i.e., 76.2%), television (4.3%), working place (4%), and others (15.5%) [Table 2].

Of the 302 people aware about health insurance, 202 (66.9%) respondents had done their health insurance and 100 (33.1%) did not have any health insurance [Figure 2]. As shown in Figure 3 among the 202 respondents having health insurance, 187 (92.5%) had perceived Government type of health insurance, and among the government health insurance people most of them had taken Yashashwini, Vajpayee Aroghya Shree, and Rashtriya Swasthya Bheem Yojana schemes. Of all, 15 (7.5%) of them had perceived PHI and 7.5% of PHI policy holders included most of the upper class respondents.

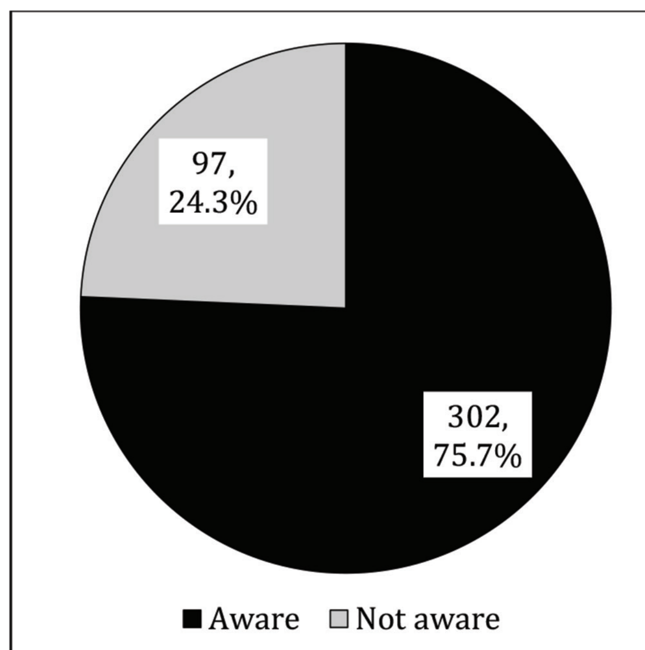

Figure 1: The awareness of health insurance among total population.

Table 1: Association of awareness of health insurance and the characteristics of the respondents

Characteristics of the respondents		Awareness		χ^2-value	*p*-Values
		Aware (%)	Not aware (%)		
Age (years)	25–34	96(24)	17(4.3)	8.377	0.78
	35–44	57(14.2)	19(4.8)		
	45–54	79(19.8)	31(7.8)		
	55–65	47(11.8)	22(5.5)		
	>65	23(5.8)	8(2)		
Gender	Male	190(47.6)	44(11)	9.327	0.03
	Female	112(28)	53(13.3)		
Religion	Hindu	256(64.2)	74(18.5)	4.935	0.099
	Muslim	44(11)	23(5.8)		
	Christian	2(0.5)	0(0)		
Type of family	Nuclear family	165(41.4)	10(2.5)	58.586	0.00
	Joint family	137(34.3)	87(21.8)		
Socio economic status*	Upper class	7(1.8)	11(2.8)	48.978	0.04
	Upper middle class	126(31.6)	20(5)		
	Middle class	120(30.1)	17(4.3)		
	Lower middle class	34(8.5)	34(8.5)		
	Lower class	15(3.8)	15(3.8)		
Education	Primary school	29(7.3)	49(12.2)	96.615	0.00
	Middle school	24(6)	0(0)		
	High school	52(13)	25(6.2)		
	Diploma/graduation	159(39.8)	17(4.2)		
	Postgraduate	389.5)	6(1.5)		
Occupation	Self employed	59(14.8)	58(14.5)	58.39	0.00
	Private employ	136(34)	19(4.8)		
	Government employ	105(26.3)	19(4.8)		
	Business	2(0.5)	1(0.25)		

*Based on modified Kuppuswamy classification.

Table 2: The source of information of health insurance

Source of Information	Number	Percentage
Family friends	230	76.2
Television	13	4.3
Working place	12	4
Others	46	15.5
Total	302	100

Table 3 depicts the purpose and benefits of health insurance as perceived by the respondents when they were queried on their awareness and knowledge of health insurance. A majority of the respondents 197 (96.2%) had taken health insurance to cover their medical expensesand others for employer compulsion (3.4%). When asked about the benefits of health insurance, 86.6% of them were aware about reducing kit expenditure, 18% of them were aware about better coverage of the entire family, 2.5% were aware about emergency health care, and 0.9% were aware about better utilization of medical facilities and other benefits.

Discussion

This study is an effort in the area of health insurance to assess the individual's awareness level and to know the determinants of awareness. The prevalence of the awareness of health insurance among 399 rural study subjects was 75.7%. This study finding confirms the views of Reshmi from Mangalore.[6] Study on awareness about health insurance

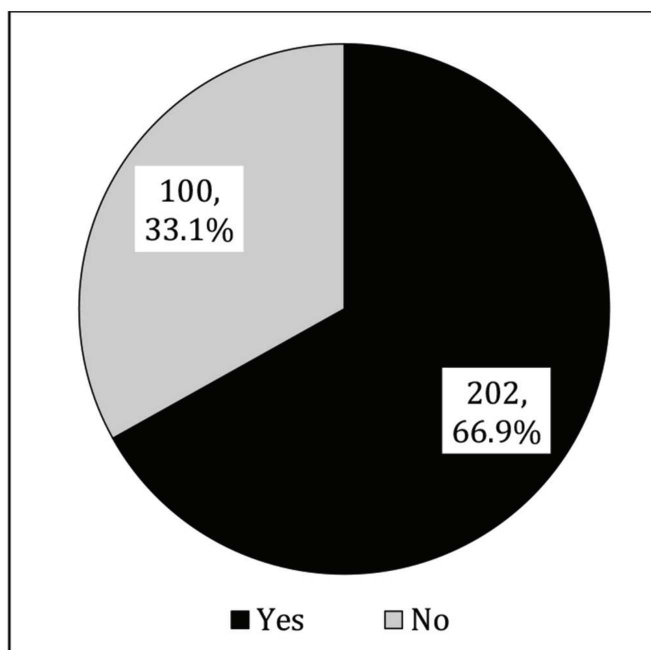

Figure 2: Population having health insurance (*N*=302, people aware about health insurance).

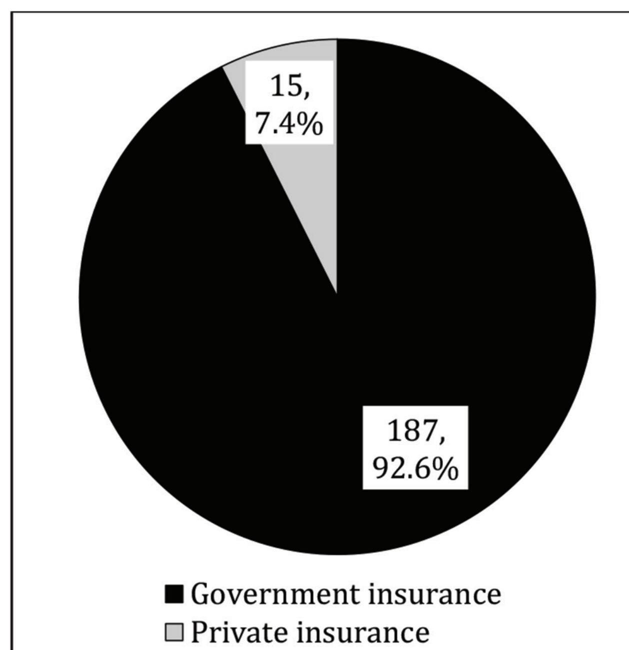

Figure 3: Type of health insurance procured among the respondents (*N*=202).

Table 3: Purpose of taking health insurance and awareness of benefits of health insurance

Parameters		Number	Percentage
Purpose of taking health insurance	Medical expenses	194	96.2
	Employer compulsion	7	3.4
	Others	1	0.4
Awareness about benefits	Emergency health care	5	2.5
	Reduces kit expenditure	175	86.6
	Better utilization of medical services	2	0.9
	Better coverage of the entire family	18	8.9
	Others	2	0.9

in a south Indian population showed 64%. Another study on the awareness of health insurance among rural north Indian population showed 43.4% of the respondents were aware of health insurance.[1] This study shows the increased prevalence of awareness compared to other studies which means media and government are fulfilling their responsibilities of creating awareness among the people about health insurance and also by making the process of making a health insurance policy easy and the sanctioningof the policy in crucial times easier and quicker. Various socioeconomic statuses have an impact on the awareness level. Awareness in this study was seen mainly through family friends and media. The information regarding health insurance is spread from one person to the other living in the rural area and also through Panchayat offices where the cards were issued to the people. In a study,by Jaganti Yellaiah in Hyderabad also reported that media and friends played a crucial role in awareness of health insurance.[2] It can be stated that socioeconomic status and education play a very important role in awareness of health insurance. An effective information, education, and communication activities will improve the understandingof the people about insurance.

Most of the respondents were of the opinion that it takes lots of procedures to make a health insurance policy and had vague ideas about various benefits and risks involved in a policy. Both government and PHI schemes should come out with a clear cut policy. To develop a viable health insurance scheme and people's confidence,PHI companies should understand people's perception and develop a package that is accessible, affordable, and acceptable to all sections of the society.

Conclusion

The determinants of awareness of health insurance were education andsocioeconomic status. Though this study shows increased prevalence of awareness of health insurance, there is still an alarming need to improve the awareness with regard to their knowledge about health insurance covering the medical expenses in the rural communities. It is a need to launch effective IEC activities to make them aware of the need of health insurance to meet the ever rising medical expenses in view of unpredictable injuries and illness.

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