A Study on Performance of Health Insurance Schemes in India

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Abstract: Health insurance is an insurance coverage purchased in advance by an individual or a group after paying a fee called 'premium'. It is a complimentary financing mechanism for enhancing access to quality health. Health insurance is one of the products offered by the general insurance companies as well as by life insurance companies in India. Health indicators of a nation are assessed through parameters like infant mortality, maternal mortality rate, life expectancy, birth and death rate. India recorded notable achievement in all the parameters since independence. The Eleventh Plan observed that the cost of health care services in the country was higher in the private sector in comparison with the public sector. A study group appointed by the Ministry of Health and Family Welfare suggested to explore a risk pooling system with a view to reduce the burden of the poor.

Key words: Health delivery, NSSO, Insurance Act, IRDA, Mediclaim

Health financing in India

During the last 50 years India has developed a large government health infrastructure with more than 150 medical colleges, 450 district hospitals, 3000 Community Health Centers, 20,000 Primary Health Care centers and 130,000 Sub-Health Centers (Mavalankar, D. and Bhat, R.2000) . On top of this there are large number of private and NGO health facilities and practitioners scatters throughout the country.

The health care needs of India are vast and divergent. Concerted efforts are required in bridging the shortfall in the availability of health infrastructure and its delivery for better health outcomes. The health delivery channels and access thereto need to be structured and sequenced. Health financing accordingly assumes great importance in the architecture of the health system. A desirable health financing structure is one which not only reduces the 'Out Of Pocket' (OOP) expenditure on health care but also lessens the probability of any financial impoverishment while meeting healthcare needs.

As per National Health Accounts 2009, the OOP expenditure in India in 2004-05 was more than two- thirds of total health spending, which is high compared to global standards. Moreover, rural households accounted for 62 percent of the total OOP expenditure by households for availing different health care services while urban households accounted for 38 percent. Such high share of OOP expenditure needs to be reduced as it aggravates the inequities by impoverishing the poor further. Therefore, the role of the Government assumes importance in this context.

The breakup of total health expenditure, in terms of source of financing, shows that around 78 percent of the expenditure was financed by private entities with households accounting for the major share (71 percent). About 20 per cent of the total health expenditure was financed by the Central Government, State Government and local bodies while external flows accounted for 2 percent of the total health expenditure (MoHFW, 2011). Breakup of total health expenditure between public and private providers show that private providers of health in 2004-05 accounted for about 77 per cent of health expenditure incurred.

The Eleventh Five Year Plan had targeted for increasing the public spending on health to at least 2 percent of GDP by the end of the Plan. However, total public health expenditure as a percent of gross domestic product currently stands at around only 0.9 percent.

The Need of Health Insurance

According to a survey by NSSO (National Sample Survey Organization), 40% of the people hospitalized have either had to borrow money or sell assets to cover their medical expenses. A significant proportion of population may have had to forego treatment all together. Thus, more than the disease it is the cost of treatment that takes its toll. To get rid of health worries health insurance is the answer.

In a globalizing environment, the cushion that could have been available by way of joint families, social groups or government support, is not available as earlier. In this context it is the insurer's duty to organize, transfer and spread risks so that the society consisting of individuals, families and communities is genuinely protected (P. C. James, 2004). Increasing incidence of lifestyle diseases such as obesity, diabetes mellitus, hypertension and cardiovascular diseases to name a few, and rising medical costs, further emphasize the need for health insurance. Health insurance policy not only covers expenses incurred during hospitalization but also during the pre as well as post hospitalization stages like money spent for conducting medical tests and buying medicines.

History of Insurance in India

In India, insurance has a deep-rooted history. It finds mention in the writings of Manu (*Manusmrithi*), Yagnavalkya (Dharmasastra*)* and Kautilya (*Arthasastr)*. The writings talk in terms of pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. This was probably a pre-cursor to modern day insurance. Ancient Indian history has preserved the earliest traces of insurance in the form of marine trade loans and carriers' contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular.

The year 1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta. This Company however failed in 1834. In 1829, the Madras Equitable had begun transacting life insurance business in the Madras Presidency. 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. This era, however, was dominated by foreign insurance offices which did good business in India, namely Albert Life Assurance, Royal Insurance, Liverpool and London Globe Insurance and the Indian offices were up for hard competition from the foreign companies.

In 1914, the Government of India started publishing returns of Insurance Companies in India. The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protecting the interest of the Insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers.

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business.

An Ordinance was issued on 19th January, 1956 nationalizing the Life Insurance sector and Life Insurance Corporation came into existence in the same year. The LIC absorbed 154 Indian, 16 non-Indian insurers as also 75 provident societies—245 Indian and foreign insurers in all. The LIC had monopoly till the late 90s when the Insurance sector was reopened to the private sector.

The history of general insurance dates back to the Industrial Revolution in the west and the consequent growth of sea-faring trade and

commerce in the 17th century. It came to India as a legacy of British occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd was set up. This was the first company to transact all classes of general insurance business. The year 1957 saw the formation of the General Insurance Council, a wing of the Insurance Association of India. The General Insurance Council framed a code of conduct for ensuring fair conduct and sound business practices.

In 1968, the Insurance Act was amended to regulate investments and set minimum solvency margins. The Tariff Advisory Committee was also set up then.

In 1972 with the passing of the General Insurance Business (Nationalization) Act, general insurance business was nationalized with effect from 1st January, 1973. 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd. The General Insurance Corporation of India was incorporated as a company in 1971 and it commence business on January 1st 1973. This millennium has seen insurance come a full circle in a journey extending to nearly 200 years.

The process of re-opening of the sector had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of RN Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000. The key objectives of the IRDA include promotion of competition so as to enhance customer satisfaction through increased consumer choice and lower premiums, while ensuring the financial security of the insurance market.

The IRDA opened up the market in August 2000 with the invitation for application for registrations. Foreign companies were allowed ownership of up to 26 per cent. The Authority has the power to frame regulations under Section 114A of the Insurance Act, 1938 and has from 2000 onwards framed various regulations ranging from registration of companies for carrying on insurance business to protection of policyholders' interests.

In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002.

Today there are 27 general insurance companies including the ECGC and Agriculture Insurance Corporation of India and 24 life insurance companies operating in the country.

Objectives of the study

Following are the objectives of the study:

1. To study the nature and extent of coverage of health insurance schemes

2. To measure the extent of awareness of the beneficiaries and satisfaction towards the schemes.

3. To study the perception of the beneficiaries about the service quality of the healthcare provided.

Review of literature

A number of studies both conceptual and empirical have been conducted regarding various aspects of health insurance in India and abroad. The review of these studies has been done to explore the extent of research conducted on concept, framework and state of health insurance. For the purpose of present study, the review of literature has been divided broadly into five sections. Section I deals with the review of studies in relation to conceptual contributions. Section II covers the review of studies in relation to Community Based Health insurance (CBHI). Section III includes the review of studies in relation to Third Party Administrators (TPAs). Section IV deals the review of studies in relation to employer based insurance schemes and the Section V deals with the customers' perception.

R.Venugopal (2013) was of the opinion that although the portability associated with Health insurance may not be the panacea for all ills, it is bound to be a game-changer in the days to come. Till now the customer was reluctant to change the Health insurer even though he/she was not satisfied with the services of the insurer in view of the fear that the customer would lose all the present benefits of the health plan like waiting period cover to the pre-existing diseases like Diabetes, Heart ailment etc., and the 'No Claim Bonus'. But the portability clause approved by IRDA recognizes these issues, according to the researcher.

Dr. N. Sivakumar (2013) observed that for a sustained growth of the health insurance industry, the vision of the insurers matters a great deal, although technology would be there to support this vision, in times of need. To sustain visionary growth, the sector must realize that they are trustees of huge amounts of public money collected in the form of premiums and hence insurance professionals must develop high level of ethics and integrity. Also, firms must have social conscientiousness in all its strategies and action plans.

Mayur Trivedi and Indrani Gupta (2012) explored the HIV insurability in India tracing the early history and Current Status. They pointed out that scheme like Yeshasvini Arogyasri covers all HIV positive people irrespective of economic status. They stressed that a systematic analysis of all the existing schemes needs to be undertaken to document the experience the experience of providing coverage for HIV related illness.

Sanjay Dutta (2012) traced the origin and the progressive metamorphosis that Health insurance recorded in India; and hoped that a great deal can be achieved in the near future with co-operation from several stakeholders. He forecasted that a combination of demographic and economic factors is expected to bring about increased healthcare coverage in India which is expected to drive the growth of the sector.

Thomas K.T. and R.Sakthi Vel (2011), evaluating emerging business models in Private health insurance in India, observed that the biggest drawback of the industry is the lack of standard terminology and protocol in treatment and billing of common illnesses. In many instances, different Hospital across the country use differing terms and follow different treatment protocols and charges, for treating the same medical condition.

Dale Mudenda *et al* (2008) revealed that contracting-in and contracting-out are prevalent in Zambian health system. Contracting-in is seen where the government is providing health service to the people on a wide scale. Different levels of the referral system within the public health sector contract with each other through the concept known as "purchase of beds." Contracting-out is evidenced by the relationship existing between government and the faith-based organizations and not-for-profit nongovernmental organizations where the latter are providing health services to the people on behalf of the government.

Ruchismita, Ahmed and Rai (2007) highlighted the challenges in financing health in India and examined the role of health insurance in addressing these challenges. The study provided with an operational framework for development of sustainable health insurance model under National Rural Health Mission which will respond to the contextual need of different states.

Ramani and Mavalankar (2006) examined the health system in India and showed that health and socio economic development are so closely related that it is impossible to achieve one without other. The study found that no doubt the economic development in India has been gaining momentum over the last decade, but the health system is at cross roads today. The study concluded by identifying the role and responsibilities of various stakeholders for building efficient and effective health system.

Nitya KalyaniK (2004) examined the coding systems and standards to be followed as per the IRDA subgroup recommendations like Diagnosis Codes, Procedure Codes, Service/Revenue Codes, Clinical Observation Codes and Explanation of Benefits Codes.

Randall P Ellis, *et al* (2000) unearthed the problems in the Indian health insurance industry and observed that only those in the organised sector are covered by health plans. But the majority of the low-income people are left to suffer either from poor health-care delivery or to incur high out-of-pocket expenses, or both. The researchers came up

with a series of recommendations including improvements in delivery of health care and its financing, efficient functioning of the ESIS and the CGHS, amending the Mediclaim system to tap the huge market potential, modification of the benefits and claims system of Mediclaim policies, alterations in the exclusion clause, enhanced competition and the possible privatization of health insurance within a strict regulatory regime.

Sanyal (1996) scaled the intensity of use of the government and private source of treatment by the households and expenditure incurred by them; changes in the utilization pattern and the differentials across the rich and poor. The study used the results of three surveys conducted by National Sample Survey Organization (NSSO), National Council of Applied Economic Research (NCAER) and National Institute of Public Finance and Policy (NIPFP) on health care expenditure and utilization in order to elicit information. The results showed that the burden of health care expenditure in rural areas was twice in 1986-87 as compared to 1963-64 and support the view that avenues for additional revenue earning lie more in the secondary and tertiary hospitals.

Rama and Baru (1994) examined the structure of health care provision existed in public, private and voluntary sectors and utilization patterns for both inpatient and outpatients care across the states. The study showed the presence of high variation in the availability of non-government health services across states. In most of the states, public sector was the main source of provider of curative services and private and voluntary sector marked by uneven spread and regional variations. However, the researchers suggested that the private and voluntary sector should move only into those areas, where they can show better results and get profit.

Health Insurance in India-Current scenario

Health insurance has become one of the fastest growing segments in the non-life insurance industry with premium to the tune of Rs.13,092 crore underwritten in 2011-12, reporting a growth of 14.05 per cent over the premium of Rs.11,480 crore underwritten in 2010-11.

Apart from the multi-line non-life insurers, Apollo Munich Health Insurance Co. Ltd., Star Health and Allied Insurance Co. Ltd. and Max Bupa Health Insurance Co. Ltd. contributed much to Health insurance business. The total premium underwritten by these three standalone health insurers stood at Rs.1,660 crore in 2011-12 as against Rs.1,536 crore in 2010-11(IRDA Annual Report 2011-2012). Number of persons covered under the health insurance has also seen a steady increase over the years; however it is small vis-à-vis the potential. In the absence of specific financial protection against high medical expenses, the financial impact of hospitalization is more pronounced, and as one of the leading causes for impoverishment in the country (IRDA Annual Report 2008-2009). The IRDA has taken a number of initiatives for development of health insurance sector, strengthening protection of policyholders' interest and orderly growth of the insurance sector. During 2010-11, the Authority implemented the portability in health insurance products in 2011-12, which has benefited the customers and industry as a whole.

Table - 1

Sl.No.	Name of the insurer	2012-13			2011-12		
		Health Premium	Total Premium	Total market share in%	Health Premium	Total Premium	Total market share in%
1	Royal Sundaram	209.23	1561.09	2.26	208.86	1479.79	2.55
2	TATA-AIG	181.87	2135.04	3.09	137.69	1641.57	2.82
3	Reliance	295.53	2010.01	2.91	225.28	1712.55	2.95

4	IFFCO Tokio	210.79	2570.18	3.72	162.44	1975.24	3.4
5	ICICI Lombard	1665.17	6133.98	8.88	1499.28	5150.14	8.86
6	Bajaj Allianz	594.85	3999.81	5.79	427.08	3286.62	5.65
7	HDFC ERGO	521.5	2453.2	3.55	411.5	1839.46	3.16
8	Cholamandalam	287	1620.9	2.35	235.72	1346.54	2.32
9	Future Generali	139.13	1105.27	1.6	130.55	921.38	1.59
10	Universal Sompo	55.27	534.35	0.77	35.84	404.58	0.7
11	Shriram	0	1541.19	2.23	0	1266.45	2.18
12	Bharti Axa	195.49	1190.22	1.72	145.43	884	1.52
13	Raheja QBE	0.02	21.3	0.03	0	14.79	0.03
14	SBI	6.74	770.85	1.12	3.74	250.14	0.43
15	L&T	26.37	182.07	0.26	5.75	143.51	0.25
16	Magma HDI	0	95.14	0.14	NA	NA	NA
17	Liberty Videocon	0	2.19	0	NA	NA	NA
18	Star Health & Allied Insurance	843.8	860.5	1.25	1067.52	1085.06	1.87
19	Apollo MUNICH	598.75	619.99	0.9	458.95	475.85	0.82
20	Max BUPA	206.42	207.34	0.3	99.08	99.08	0.17
21	Religare Health	38.39	38.8	0.06	NA	NA	NA
	Private Total	6076.33	29653.42	42.94	5254.72	23976.76	41.25
22	New India	2757.71	10035.65	14.53	2349.17	8542.86	14.7
23	National	2372.22	9155.65	13.26	2065.2	7790.7	13.4
24	United India	2642.81	9266.04	13.42	2231.81	8179.33	14.07
25	Oriental	1491.94	6543.51	9.48	1310.64	6047.88	10.41
26	ECGC		1157.22	1.68	0	1005.11	1.73

27	AIC of India		3235.25	4.69	0	2577.07	4.43
	Public Total	9264.69	39393.31	57.05	7956.83	34142.96	58.75
	Grand Total	15341.01	69046.73	100	13211.54	58119.72	100

Health and Gross premium underwritten by non-life insurers within India as on 31st March 2013 (Provisional & Unaudited)

Source: Extracted from IRDA Records

The above table details all the 27 general insurers operating in India today, along with their provisional health and gross premiums underwritten in the bygone financial year 2012-2013. Barring the AIC and ECGC all other 25 insurers can transact health insurance business of whom 4 are standalone health insurers including Apollo Munich Health Insurance Co. Ltd., Star Health and Allied Insurance Co. Ltd. , Max Bupa Health Insurance Co. Ltd. and Religare Health Insurance Co. Ltd, the new entrant in the financial year 2012-13. The health segment is dominated by the 4 public health insurers i.e., out of the gross premium underwritten in the year 2012-13, Rs.15341.01 crores, Rs.9264.69 (i.e 60%) crores were underwritten by these insurers. While New India Assurance Co. Ltd. with Rs.2757.71 crores (i.e.18% of the total health premium/30% of public sector premium) is the frontrunner among the public sector, it is the ICICI Lombard with Rs. 1665.17 crores (i.e., 11% of total health premium / 27% of the private sector health premium) in the private sector.

Various Health Insurance Schemes Available In India:

The existing health insurance schemes available in India can be broadly categorized as: (www.actuariesindia.org)

1. Voluntary health insurance schemes or private-for-profit schemes

2. Community Based Health Insurance (CBHI)

3. Employer based schemes

4. Mandatory health insurance schemes or Government run schemes

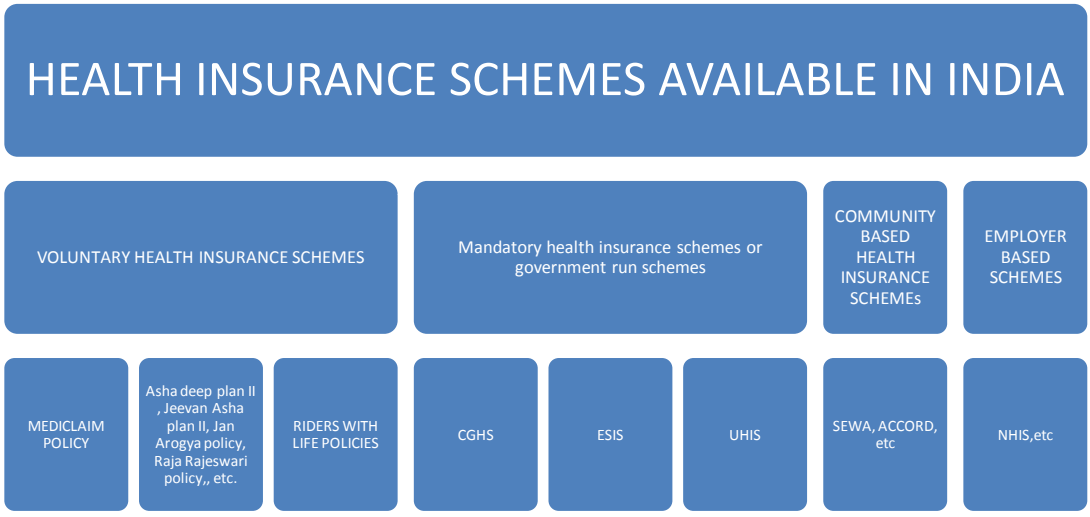

Figure – 1: Health Insurance Schemes in India

1. Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools similar risks and insures them for health related expenses. The main distinction is that the premiums are set at a level, which are based on assessment of risk status of the consumer and the level of benefits

provided, rather than as a proportion of consumer's income. The most popular health insurance cover offered is Mediclaim policy.

Mediclaim policy: It was introduced in 1986. It reimburses the hospitalization expenses owing to illness or injury suffered by the insured, whether the hospitalization is domiciliary or otherwise. It does not cover outpatient treatments. Government has exempted the premium paid by individuals from their taxable income. Because of high premiums it has remained limited to middle class, urban tax payer segment of population.

Despite its inadequacies, Mediclaim has experienced dramatic growth over the years mainly for want of substitutes. From 1995-96 to 2002-03, the number of persons covered increased by 29 per cent per annum and premiums went up from Rs. 129 crore to over Rs.1,000 crore. The percentage of total population covered under Mediclaim rose from 0.084 per cent in 1990-91 to 0.359 per cent in 1998-99 and to 0.9 per cent in 2002-03 (Aloke Gupta, 2004).

Other policies: Some of the various other voluntary health insurance schemes available in the market are Asha deep plan II , Jeevan Asha plan II, Jan Arogya policy, Raja Rajeswari policy, Overseas Mediclaim policy, Cancer Insurance policy, Bhavishya Arogya policy, Dreaded disease policy, Health Guard, Critical illness policy, Group Health insurance policy, Shakti Shield etc.

Riders: Health insurance is also provided specifically in the form of critical illness riders by Life Insurance companies also.

2. Community based health insurance

Community Based Health Insurance (CBHI) schemes are typically targeted at poorer population living in communities. Such schemes are generally run by charitable trusts or Non-Governmental Organizations (NGOs). In these schemes the members prepay a said amount each year for specified services. The premium is usually flat rate and therefore not progressive. The benefits offered are mainly in terms of preventive care, though ambulatory and inpatient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with for-profit insurers for the purchase of custom designed group insurance policies.

CBHI schemes suffer from poor design and management. Often there is a problem of adverse selection as premiums are not based on assessment of individual risk status. These schemes fail to include the poorest of the poor. They have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes.

Some of the popular CBHI schemes are: - Self-Employed Women's Association (SEWA), Tribuvandas Foundation (TF), The Mullur Milk Co-operative, Sewagram, Action for Community Organization, Rehabilitation and Development (ACCORD), Voluntary Health Services (VHS), etc.

3. Employer based insurance schemes

Employers in both public and private sector offer employer based insurance schemes through their own employer. These facilities are by way of lump sum payments, reimbursement of employees' health expenditure for outpatient care and hospitalization, fixed medical allowance or covering them under the group health insurance schemes. The Railways, Defense and Security forces, Plantation sector and Mining sector run their own health services for employees and their families.

4. Government Sponsored Health Insurance Schemes (GSHISs)

Till the end of the last decade, health insurance was generally meant for rich and even to them mainly as a mode of evading income tax. The introduction of GSHISs changed the whole scenario. In an environment challenged by low public financing for health, entrenched accountability issues in the public delivery system, and the persistent predominance of out-of-pocket spending, particularly by the poor, GSHISs have introduced a new set of arrangements to govern, allocate, and manage the use of public resources for health, including an explicit package of services, greater accountability for results, and a "built-in" bottom-up design to reach universal coverage by first covering the poor.

In 2010, about 240 million Indians were covered by GSHISs. Accounting for private insurance and other schemes, more than 300 million people, more than 25 percent of the population, have access to some form of health insurance (LaForgia,Gerard, and Somil Nagpal, 2012). The new generation of GSHISs launched after 2007 including Rashtriya Swasthya Bima Yojana (RSBY), Rajiv Aarogyashri in Andhra Pradesh, Vajpayee Arogyashri in Karnataka, RSBY Plus in Himachal Pradesh, Apka Swasthya Bima Yojana (ASBY) in Delhi, and Chief Minster's Health Insurance Schemes in Tamil Nadu aim to provide financial protection to the poor against catastrophic health shocks.

Performance Analysis of Health Insurance Schemes

The Table showing the claims data of New Health Insurance Scheme 2012 reveals the claim figures for the year 2012-13. The table shows that the total number of claims was 39499 and the total amount of claims made under the Scheme was to the tune of Rs. 169.04 crores in that year. The monthly subscription to be contributed by each employee insured under the NHIS 2012 was Rs.150. The total amount thus collected from the Government Servants under the NHIS2012 was Rs.151 crores for the year 2012-13. The amount of premium paid by the Government to the insurer, United India Insurance Company was Rs. 215.34 crores under the NHIS 2012, in the first year of the implementation of the Scheme. In other words, Rs.64.34 crores of premiums was subsidized by the Government of Tamil Nadu in the year 2012-13 alone.

Table – 2: The performance ratios of New Health Insurance Scheme 2012

Particulars	2012-13
Average Amount per Claim (in Rs.)	42796.02
Premium to Contribution Ratio	143%
Claim to Contribution Ratio	112%
Claim to Premium Ratio	78%

Source: Researcher's own calculations

Table – 3: Correlation analysis for the relationship between the awareness and type of scheme, family coverage and receipt of smart card

CORRELATION with awareness of the beneficiaries'	Scheme		Family Coverage		Receipt of Smart Card	
	r	p	r	p	R	P
Period of insurance	-0.01	0.81	0.06	0.33	0.14	0.01
Amount of insurance at credit	0.06	0.29	0.04	0.54	0.16	0.01
Amount of insurance totally for 4years	0.27	0.00	-0.03	0.56	0.14	0.01
Coverage to family members	0.19	0.00	-0.01	0.83	0.16	0.01
Inclusion procedure for new born/spouse	0.27	0.00	0.01	0.92	0.10	0.08
Eligibility conditions of the insurance	0.12	0.04	0.02	0.78	0.20	0.00
Empanelled hospitals in your area	0.05	0.40	0.01	0.84	0.14	0.02
Formalities to be fulfilled at the time of approaching for	0.15	0.01	0.00	0.94	0.13	0.03

treatment						
Types of diseases covered and treatments given	0.11	0.06	-0.02	0.74	0.11	0.05
Types of diagnostic procedures covered	0.00	0.94	-0.04	0.51	0.16	0.01
Types of follow up procedures covered	0.08	0.17	0.00	0.95	0.12	0.04

Source: Output generated from SPSS 19

The correlation analysis was made to establish the relationship between the awareness and type of scheme, family coverage and receipt of smart card.

The awareness about the total sum assured, coverage to family, inclusion procedures, eligibility conditions and preauthorization formalities is positively and significantly correlated with the Scheme as their correlation coefficients are positive and p values are less than the level of significance of 5%. In other words, the respondents of the NHIS 2012 are more aware than the previous scheme beneficiaries on these aspects. For these aspects alone H_{01} is rejected and H_{11} is accepted. On the other hand, there is no significant correlation between the type of Scheme and awareness about the period, sum assured at credit, empanelled hospitals and types of diagnosis, diseases and follow up procedures covered because of higher p values. For these aspects H_{01} is accepted.

Number of family members covered under the Insurance Scheme has no significant relationship with the awareness of any aspects on account of higher p values. So, H_{02} is summarily rejected.

Except the inclusion procedures, the receipt of Biometric Cards along with the information bulletin has positively and significantly correlated with the awareness of all the aspects of the Insurance Scheme because of positive correlation coefficients and lower p values than the level of significance. So, H_{03} is rejected for all these aspects and H_{13} is accepted.

Conclusion

The report on Universal Health Coverage (UHC) identified ten principles behind the formulation of UHC system of in India namely (i) universality; (ii) equity; (iii) non-exclusion and non-discrimination; (iv) comprehensive care that is rational and of good quality; (v) financial protection; (vi) protection of patients' rights that guarantee appropriateness of care, patient choice, portability and continuity of care; (vii) consolidated and strengthened public health provisioning; (viii) accountability and transparency; (ix) community participation; and (x) putting health in people's hands. The Government Sponsored Health Insurance Schemes also work on the same Ten Commandments that will make easy integration with the much-awaited Universal Health Care concept in future.

The duty of the Government does not end by just by implementing health insurance schemes. It is also expected to ensure the proper working of the same. The health system should be regulated and higher amount of transparency and standardization needs to be ensured. Because in the words of Elizabeth Edwards "Successful health reform must not just make health insurance affordable, affordable health insurance has to make health care affordable".

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