AWARENESS ON THE HEALTH INSURANCE SCHEMES – A STUDY

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Abstract: *Lack of access to healthcare is not only a cause for individual trauma and tragedy, but it also stunts the progress of the society on both economic and social planes. Conversely the ability to have access to healthcare has proved to be a powerful weapon against poverty as also against social and economic inequality. While poor have to deal primarily with the consequences of communicable diseases, the rich have to grapple with the fallout of the more expensive lifestyle diseases.*

Keywords: OOP expenditure, Industrial Revolution. General Insurance Council, IRDA, Financial security.

Introduction

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.

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.

Various Health Insurance Schemes Available In India:

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

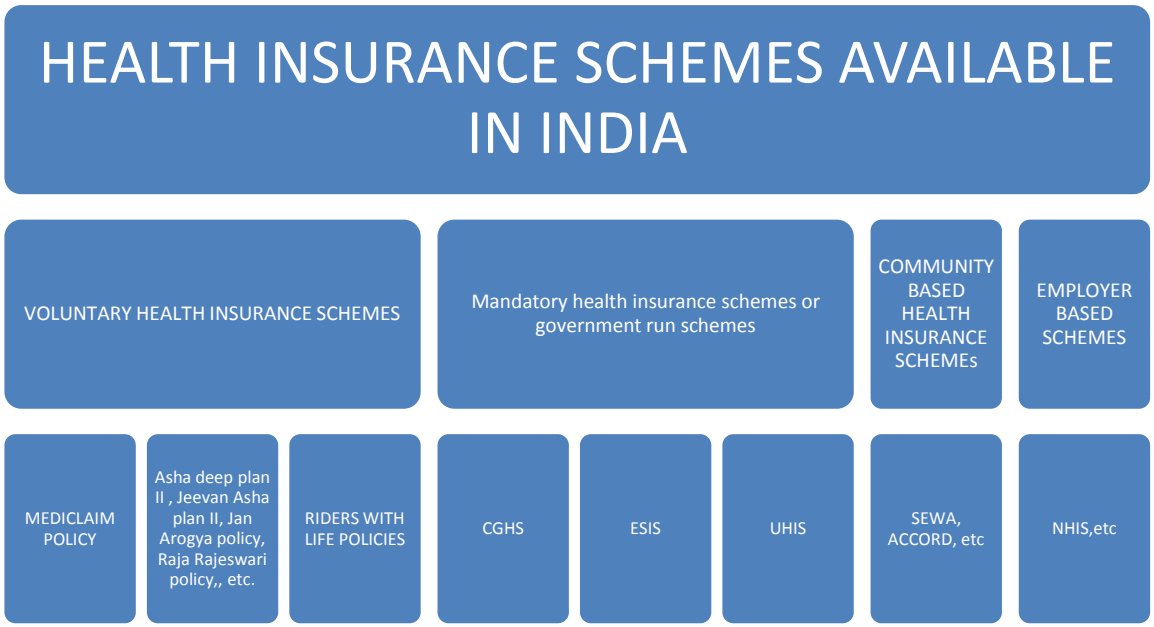
1. Voluntary health insurance schemes or private-for-profit schemes

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.

STATEMENT OF THE PROBLEM

Based on the above discussions and given the current state of health insurance in India, the problems are multiple. Starting from the lack of literature in the area of health insurance since the opening of the insurance market to problems related to products, services and processes. The key problem has been identified post literature review and also by analyzing the past, current and future growth prospects of health insurance in India.

OBJECTIVES OF THE STUDY

Following are the objectives of the study:

1. To measure the extent of awareness of the beneficiaries and satisfaction towards the schemes.
2. To study the perception of the beneficiaries about the service quality of the healthcare provided.
3. To examine the difficulties involved in the insurance schemes at all stages.
4. To render suitable suggestions for the development of the schemes and benefits.

Review of Literature

Dr. Praveen Chandra (2013)in this study suggested that insurers should insist on the hospitals for adopting modern versions of medical diagnosis and treatment, so that there is a check on more expensive and needless procedures being forced on the patients in a routine manner. Based on the health data, he recommended that Fractional Flow Reserve (FFR) should be incorporated as part of the standard treatment guidelines in India to treat Percutaneous Coronary Intervention (PCI).

Harvey Lee (2013) exhorted the importance of prioritizing the precious resources so that a proper balance of various functions is achieved through triage, which would eventually result in management efficiency. A triage team, usually a team of paramedics, makes sorting assessments based on both the current status of the casualty e.g. non-life-threatening injuries, life-threatening injuries or deceased and a prediction of the incremental benefit of treatment i.e. how much is prompt treatment likely to help in improving the outlook. Prudent and careful application of triage techniques can help insurers manage the bottom line without chasing their own tails.

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.

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.

Dr. Dhiraj Goud (2012) described how the guidelines described in the recent Exposure Statement might affect life insurance coverage for Persons Living with HIV/AIDS (PLHAs), in the future. Providing Health insurance cover to those living with; and to those vulnerable to the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), such as health care professionals, is an ongoing challenge for insurers in India. However, this could mean payment of many more claims, which could make the product far more expensive for the general public. Screening all health cover applicants for HIV status, might increase acquisition cost and time, even for small covers.

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.

Edith Patouillard, *et al* (2007) addressed the knowledge gap by presenting the results of a systematic literature review on the effectiveness of working with private for-profit providers to reach the poor. It was found that a few studies provided evidence on the impact of private sector interventions on quality and utilization of care by the poor. Interventions included social marketing, use of vouchers, pre-packaging of drugs, franchising, training, regulation, accreditation and contracting-out.

Rao B. S. R. (2004) observed that a policy-driven mass movement towards health insurance for all would not only augment the quality of life of the average citizen but also provide economies of scale, which would in turn lower medical costs. He further stressed that there should be no compulsion in regard to health insurance on grounds such as the general principle of free choice, freedom for a person to take chances if he prefers, and greater knowledge by an individual about his own circumstances.

Analysis of Awareness

Being beneficiaries of the insurance schemes, the respondents are expected to be aware of all the features of the same. But after the introduction of NHIS 2012, there are some significant positive changes in the same like inclusion more hospitals, diagnostic procedures, hospitals and sum assured. To know whether the respondents are aware of the features of the present scheme, eleven items were enquired, the results of which are enlisted in the following paragraphs.

The present NHIS 2012 is for the four years and it will not just end up when takes treatment.

Enquiring the *awareness about the period of insurance* 45 respondents i.e., 15% are not aware of whom 20 are the beneficiaries of NHIS and 25 are the beneficiaries of NHIS 2012. Similarly, 141 i.e., 47% respondents are less aware of whom 72 are the beneficiaries of NHIS and 69 are the beneficiaries of NHIS 2012. The rest of 114 beneficiaries are either sufficiently or fully aware.

Enquiring the level of *awareness about the amount of insurance at credit*, 192 respondents i.e., 64% are not aware or less aware of whom 100 respondents are the beneficiaries of NHIS and 92 respondents are the beneficiaries of NHIS 2012. The rest of 108 i.e., 36% respondents are either sufficiently /fully aware of the amount of insurance at their credit.

Enquiring *the amount of insurance* totally for 4 years 166 respondents i.e., 55% are either not aware or less aware of the same, of whom 101 respondents are NHIS beneficiaries and 65 respondents are NHIS 2012 beneficiaries. The rest of 134 respondents i.e., 45% are either fully or sufficiently aware of the sum assured.

Analyzing the *awareness about the extent of coverage to family members*offered by the present health insurance scheme, 184 respondents i.e., 61% are either less aware or unaware of the same. On the other hand, the awareness is comparatively higher among the 68 NHIS 2012 beneficiaries than the 48 NHIS beneficiaries.

Analysing the *awareness about the inclusion procedure* for the new born or spouse, only 8 NHIS beneficiaries and 29 NHIS 2012 beneficiaries are fully aware while 23 NHIS beneficiaries and 30 NHIS 2012 beneficiaries are sufficiently aware of the same. Totally out of the 300 respondents, 112 beneficiaries are completely unaware of the inclusion procedure.

Analysing the *awareness about the eligibility conditions* of the Insurance scheme, 191 beneficiaries are either not aware or less aware, of whom 101 respondents are NHIS beneficiaries and 90 respondents are NHIS 2012 beneficiaries. The rest of 109 respondents are either sufficiently or fully aware of the eligibility conditions.

Enquiring about the hospitals empanelled under the present health insurance scheme, 54 respondents are fully aware and 75 others are sufficiently aware of the same. Nearly all of the NHIS 2012 beneficiaries are sufficiently aware about the same. The rest of 171 respondents are either unaware or less aware.

Enquiring the *awareness about the preauthorization procedure formalities*to be fulfilled at the time of approaching for treatment, almost two-third of the respondents were not reasonably aware, irrespective of the Scheme covered.

Analysing the *awareness about the types of diseases* covered and treatments given 94 respondents are fully or sufficiently aware of the same, of whom 50 are the beneficiaries of NHIS 2012 and 44 are the beneficiaries of NHIS.

But when the *awareness about the types of diagnostic procedures recently added and follow-up procedures covered* under the present health Insurance scheme i.e., NHIS 2012 the awareness level is highly negatively skewed. Irrespective of the scheme covered, respondents are not sufficiently aware of these pre and post treatment coverage. Only 51 respondent beneficiaries agreed that they are fully or sufficiently aware of the new diagnostic procedures. Similarly, only 93 respondents are sufficiently or fully aware of the newly introduced follow-up procedures.

The mean and standard deviations of the data regarding awareness spell out the very high awareness being witnessed regarding the new total sum assured under the scheme with a mean of 2.47 out of 5 points. It is followed by the awareness about the networked hospitals under the scheme with a mean of 2.45 and the awareness about the period of insurance with a mean score of 2.41.

All the seven other items posed to test the awareness, which fell below the mean of 2 out of 4, needs to be addressed. Especially, the awareness about the diagnostic procedure is just around the weighted average figure of 1.77, as the least one. Another item that is found below 50% mark is the awareness about the preauthorization procedure with a weighted average score of 1.97.

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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