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A study on awareness of community based health insurance schemes in Slum area households of Davanagere district

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1. 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. 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. 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 the financial barriers and improving accessibility to quality medical care. Health insurance is an instrument where in “an individual or group” purchase health care coverage in advance by paying a fee called a premium.

2. 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 the used to treat patients who experience that particular event(e.g., hospitalization).

3. 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 area 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' sparticipation 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.

4. 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).

5. 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.

6. 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.

In the present scenario, the annual expenditure on health in India amounts to about Rs7.00 in rural areas and Rs.10.00 in urban areas per person. The majority of care being provided by the private sector 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. 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.

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.

7. Objective:

1) To study the socioeconomic and demographic characteristics of study population; and

2) To analyze the awareness of health insurance of study population.

8. Materials and Methods:

Rural field practice area of Vydehi 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.

9.1. Sampling Technique:

Field practice area of two Slum areas and two were selected randomly with a total population of 1500, where all the houses (500) 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 total of 500 individuals, one individual from each household, were selected for the study.

9.2. Study Method:

Using a pre-tested-semi-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.

9.3.Sample Size:

Considering the prevalence of awareness of health insurance among the Slum area population as 50%, relative precision as 10%,an α level of 5% with the sample size 550 (expecting a non-response rate of 10%) and a sample size of 500 was taken.

9.4.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 out the association between awareness and other variables. χ^2-test was used and p-value less than 0.05 was considered as significant.

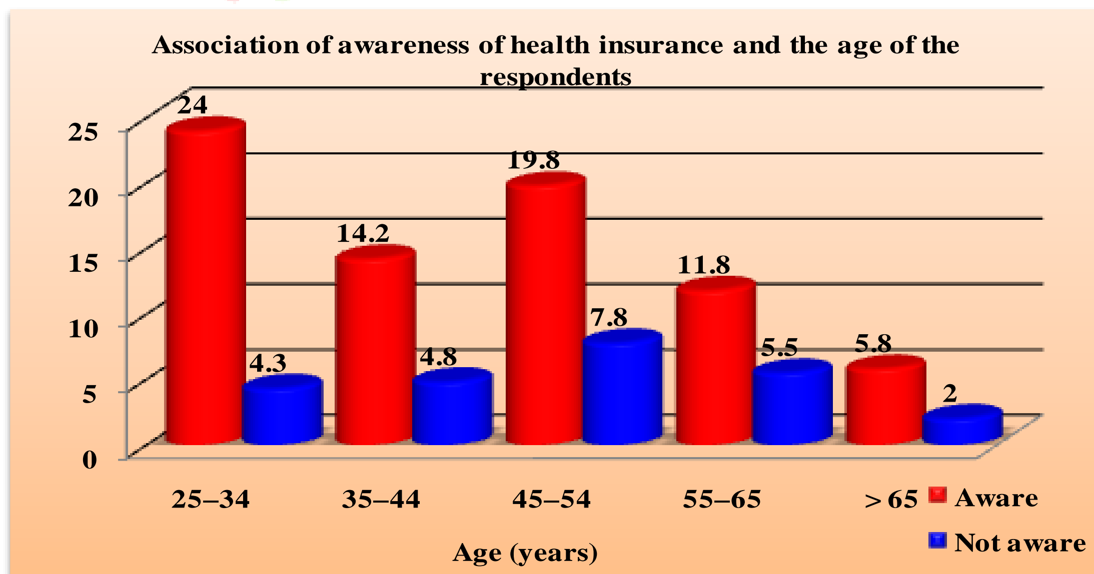
10. Result:

10.1. Association of awareness of health insurance and the age of the respondents:

Table-1: Association of awareness of health insurance and the age of the respondents

Characteristics of the respondents		Awareness		χ^2-value	p-Values
		Aware (%)	Not aware (%)		
Age (years)	25–34	125(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)		

Of the 500 respondents, 302 (70.0%) 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 χ2-value and p-value for each age character is given in Table 1. The χ2-Value more than table value at 0.05 was taken significant and it was significant for age (awareness among 25-34 younger is more than that of other aged respondents).

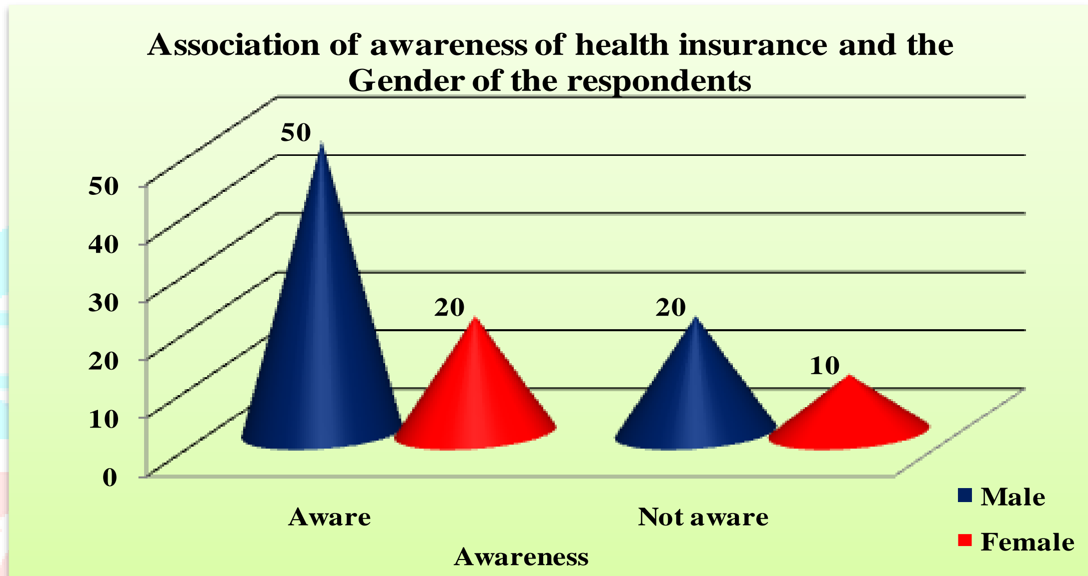


10.2. Association of awareness of health insurance and the Gender of the respondents:

Table-2: Association of awareness of health insurance and the Gender of the respondents

Characteristics of the respondents		Awareness		χ^2-value	p-Values
		Aware (%)	Not aware (%)		
Gender	Male	250(50)	100(20)	9.327	0.03
	Female	100(20)	50(10)		

Of the 500 respondents, 350 (70.0%) were aware about health insurance and 97 (24.3%) were not aware about health insurance. The awareness of health insurance among different respondents and the χ2-value and p-value for each age character is given in Table 1. The χ2-Value more than table value at 0.05 was taken significant and it was significant for gender (awareness among men is more than females).



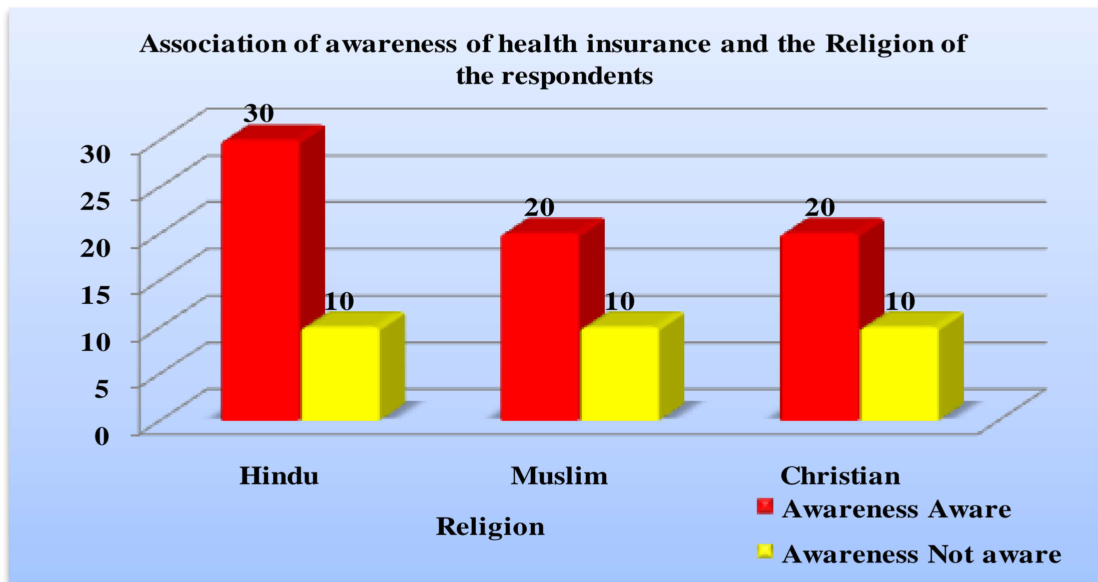
10.3. Association of awareness of health insurance and the Religion of the respondents:

Table-3

Association of awareness of health insurance and the Religion of the respondents

Characteristics of the respondents		Awareness		χ^2-value	p-Values
		Aware (%)	Not aware (%)		
Religion	Hindu	150(30)	50(10)	4.935	0.099
	Muslim	100(20)	50(10)		
	Christian	100(20)	50(10)		

Of the 500 respondents, 350 (70.0%) were aware about health insurance and 97 (24.3%) were not aware about health insurance. The awareness of health insurance among different respondents and the χ2-value and p-value for each age character is given in Table 3. The χ2-Value more than table value at 0.05 was taken significant and it was significant for Religion (awareness among Hindu is more than Muslim and Christian respondents).

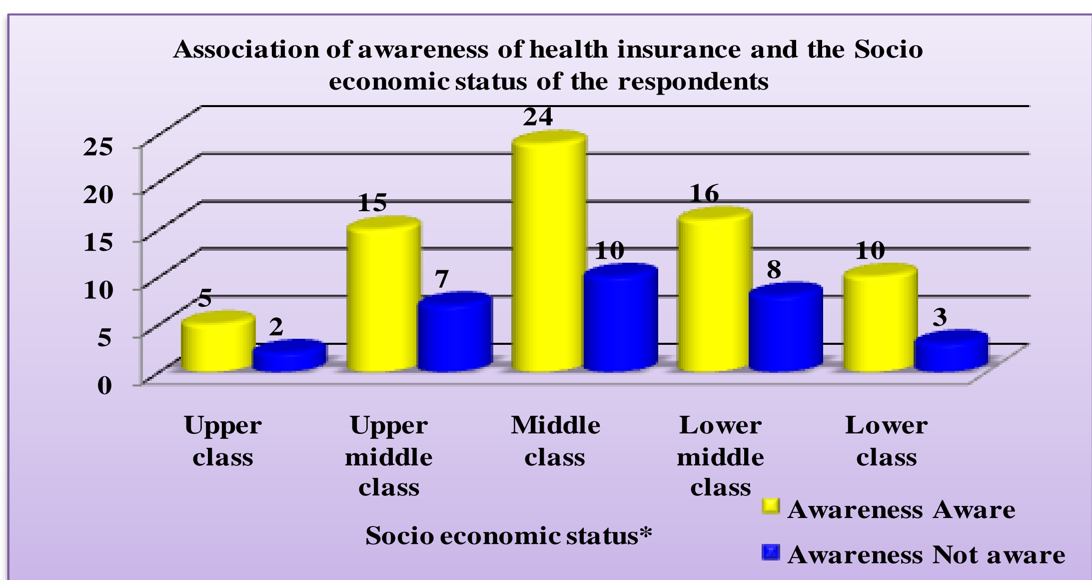


10.4. Association of awareness of health insurance and the Socio economic status of the respondents:

Table-4: Association of awareness of health insurance and the Socio economic status of the respondents

Characteristics of the respondents		Awareness Aware (%)	Awareness Not aware (%)	χ^2-value	p-Values
Socio economic status*	Upper class	25(5)	10(2)	48.978	0.04
	Upper middle class	75(15)	35(7)		
	Middle class	120(24)	50(10)		
	Lower middle class	80(16)	40(8)		
	Lower class	50(10)	15(3)		

Of the 500 respondents, 350 (70.0%) were aware about health insurance and 97 (24.3%) were not aware about health insurance. The awareness of health insurance among different respondents and the χ2-value and p-value for each age character is given in Table 4. The χ2-Value more than table value at 0.05 was taken significant and it was significant for Religion (awareness among Middle class respondents are more than that of other class respondents).

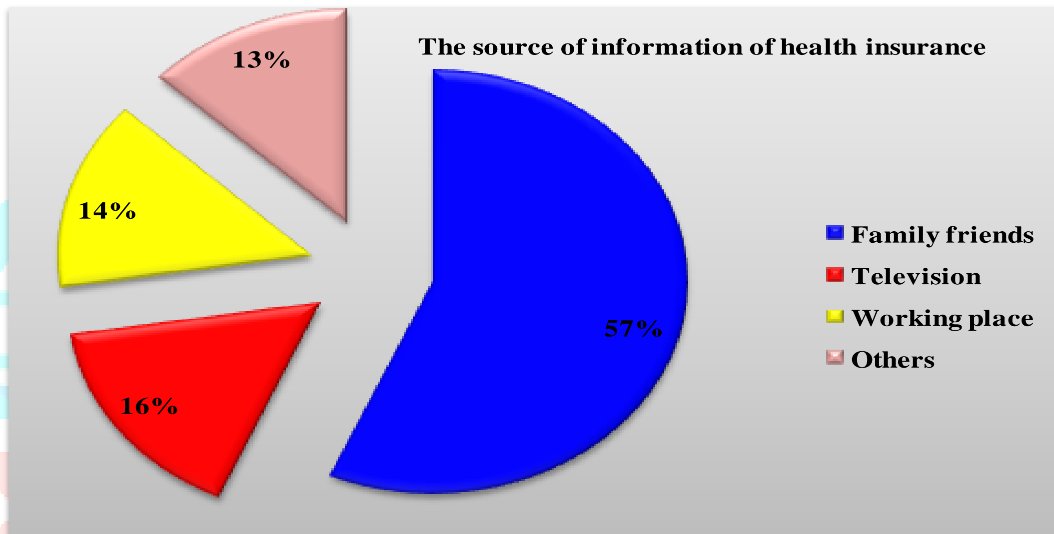


10.5. The source of information of health insurance:

Table – 5: The source of information of health insurance

Sl. No.	Source of Information	Number	Percentage
1	Family friends	198	56.6
2	Television	56	16.0
3	Working place	50	14.3
4	Others	46	13.1
	Total	350	100

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%)



10.6. Purpose of taking health insurance and awareness of benefits of health insurance:

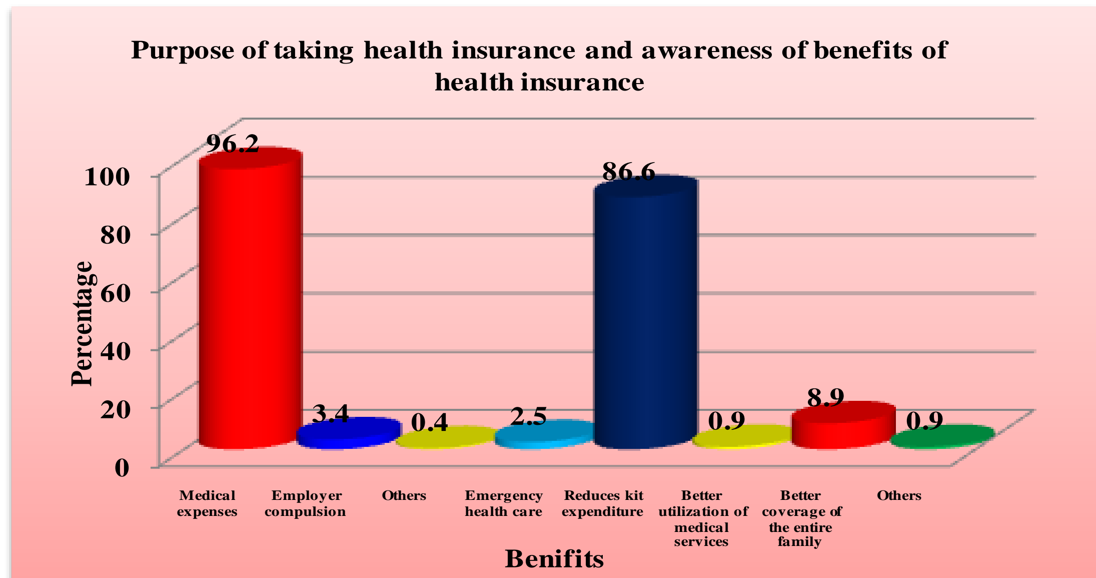
Table – 6

Purpose of taking health insurance and awareness of benefits of health insurance

Parameters	Benifits	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

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 194 (96.2%) had taken health insurance to cover their medical expenses and 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



11. 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 500 slum study subjects was 70.0%. 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 sanctioning of 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. 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 understanding of the people about insurance.

12. 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. 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.

References:

1. Bansal A, Goel S, Singh A, Singh AA, Goel AK, Naik SM, et al. A community-based study to assess the awareness of health insurance among rural Northern Indian population. Int J Health Syst. Disaster Manage 2015;3:41–3. 2
2. Jangati Y. Awareness of health insurance in Andhra Pradesh, Hyderabad. Int J Sci Res Publ 2012;2:1–6.
3. Reddy S, Selvaraj S, Rao KD, Chokshi M, Kumar P, Arora V, et al. A critical assessment of the existing health insurance models in India. Available at: http://www.planningcommission.nic.in/reports/sereport/ser/ser_heal1305.pdf (last accessed on October 1, 2015).
4. Bawa SK. Awareness and willingness to pay for health insurance: an empirical study with reference to Punjab, India. Int J HumanitSocSci 2011;1:100–8.
5. Reshmi B, Raghunath R, Unnikrishnan B. Awareness of health insurance among inpatients at a tertiary hospital in coastal Karnataka. Indian J Community Med 2010;35(3):445–6.
6. Reshmi B, Nair NS, Sabu KM, Unnikrishan B. Awareness of health insurance in a south Indian population: a community based study. Health PopulPerspectIssues 2008;30:177–88.