Awareness and perception regarding health insurance in Bangalore rural population

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ABSTRACT

Background: Awareness and perception regarding health insurance was still very preliminary. Although health insurance is not a new concept and people are also getting familiar with it, yet this awareness has not reached to the level of subscription of health insurance products. Insurance as not been able to make inroads in the rural areas because of key reasons such as high cost of delivery and low awareness among the rural population about insurance products. There is a felt need to provide financial protection to rural families for the treatment of major ailments, requiring hospitalization and surgery. The present study is an effort in the area of health insurance to assess the individuals' awareness level and willingness to join and pay for it. The present study is an effort to examine what are the reasons behind those who have not in favour of subscription. **Methods:** Nandagudi a village in Bangalore rural district was selected because the Rural Health Training Centre of MVJ Medical College & RH is located. The houses were listed and by using systematic random sampling every 2nd house was included in the study. 331 houses were interviewed. The interview was taken either from the head of the family or the family member who takes financial decisions in the house. Data was collected and analysed. Findings were described in terms of proportions and percentages. Statistical analysis was performed by SPSS statistical package. **Results:** In our study population majority were males (94.9%), Hindus (60%), literate (85%),and manual workers (79.5%).Only one third of the houses were aware of health insurance but only 22% had health insurance coverage. The coverage was not for all family members. The subscription depended on education, socio–economic status, type of family. The willingness to pay a premium was Rs 500 per year in 31% of the families. It was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income (43%), are not reliable (27%), not taken by friends or relatives (18%), prefer to invest somewhere else (11%), not adequate knowledge regarding its benefits (16%), do not feel the need (29%).

Key words: Health insurance; awareness; willingness to pay; out of pocket expenditure

INTRODUCTION

For most people living in developing countries and especially in rural areas "health insurance" is still an unknown word. It is generally assumed that, with the exception of the upper classes, people cannot afford such type of social protection. For most people living in poor developing countries illness still represents a permanent threat to their income earning capacity. Beside the direct costs for treatment and drugs, indirect costs for the missing labour force of the ill and the occupying person have to be shouldered by the household.

India is the second most populous country of the world and has changing socio-political-demographic and morbidity patterns that have been drawing global attention in recent years. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population live.[1] Contagious, infectious and waterborne diseases, respiratory infections, pneumonia

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and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population.

The rural population face the same risks as the urban population such as death, illness, injury and accident. The rural population are more vulnerable to such risks because of their social and economic situation. There is a felt need to provide financial protection to rural families for the treatment of major ailments, requiring hospitalization and surgery. In order to bridge the gap in provision of health care facility particularly in rural areas the Government has taken a lot of initiatives. Health insurance could be a way of removing the financial barriers and improving accessibility to quality medical care by the poor and also an effective social security mechanism. The insurance sector for low-income families in the rural population remains at a very nascent stage in India. Not many are aware about it and very few are taking the advantages of it. Moreover those who are aware about it are not actively participating for one reason or another.

However, even among the poor, there is the need and willingness to pay for insurance that will cover the costs of uncertain, frequently expensive medical treatments that might otherwise result in indebtedness. Out-of-pocket medical expenses account for more than four-fifths of total health-care spending in India.[2] Members of lower socio-economic groups generally spend a higher proportion of their yearly income on health than do more advantaged groups.[2] One admission to hospital can consume a sizeable share of a poor household's resources, commonly leading to financial crisis.

The present study is an effort in the area of health insurance to assess the individuals' awareness level and willingness to join and pay for it. The present study is an effort to examine what are the reasons behind those who have not in favour of subscription.

Objectives

- To assess the awareness regarding health insurance
- To assess the various factors which act as barriers and ultimately obstruct the subscription of health insurance.
- To determine the willingness to join and pay for health insurance.

MATERIALS AND METHODS

Hoskote talukha of Bangalore rural district has around 300 villages. Nandagudi a village in Bangalore rural district was selected because the Rural Health Training Centre of MVJ Medical College & RH is located. The study period was from Oct 2011 to Dec 2011. A pretested questionnaire was used to collect the relevant details. A house to house to survey was conducted after obtaining informed consent. Care was also taken to ensure privacy and confidentiality of the interview. The houses in Nandagudi were listed and by using systematic random sampling every 2nd house was included in the study. The houses which were locked during our study period were excluded from the study after three visits. A total of 343 houses were selected for the study. Out of the 343 houses that were listed, 331 houses were interviewed. The interview was taken either from the head of the family or the family member who takes financial decisions in the house. Data was collected and analysed. Findings were described in terms of proportions and percentages. Statistical analysis was performed by SPSS statistical package.

RESULTS

Out of the total houses 343 houses were listed. 12 houses (11.6%) were excluded from the study due to non availability in spite of 3 visits. So the total study population was 331 households.

The socio-demographic details of the study subjects were as follows. Of the total population surveyed and interviewed males were 94.9% and females were 5.1%. The proportions of females were less compared to males as the head of the family and the financial decision maker in rural areas in India is mostly a male. Majority of the population were Hindus (60.1%), Muslims constituted 31.1% of the study group. Overall 14.5% of the population was illiterate. In the present study unskilled or manual labour was the predominant (79.5%). Most of them were working in the fields. The proportion of skilled workers was 20.5%. Hence this population occupationally represents a typical agricultural rural population. All of the study subjects interviewed were married. A joint family system (72.2%) was seen to be the most common than nuclear family. The mean number of family members per family was 7.Thus most of families were large families that is typically of a rural population.

Majority of the families belong to class III (46.5%) and class IV (38.7%) according to B. G. Prasad classification.

Most of the families had an income of Rs 4000–Rs 6000 per month from all sources. Majority of the families spent Rs 300 to Rs 500 i.e. 5% to 8% of their income on health needs.

Out of the 331 houses surveyed only 35.3% of them had heard of health insurance. It means only one third of the population were aware of health insurance. They had heard about health insurance through TV ads, through newspapers and some through health workers visiting their houses.

Out of the total households surveyed only 75 (22.7%) families had taken a health insurance policy. Out of the 117 families who were aware of health insurance only 75 (64.1%) families had taken health insurance. In the families who were insured almost half of the families (57.3%) had insured all the family members. So in most of the families the health insurance was partial. All the families surveyed thought that insurance for health is refund of cost of drugs during illness, (11%) provide compensation if something bad happens (38%) insurance makes life easier (23%), provide free of cost major surgeries (42%)

Awareness of health insurance depended on education, socio-economic status, occupation (Table 1). The subscription of health insurance also depended on the type of family and number of family members. It was found that the nuclear families and less number of family members the chances of the subscription increased.

Most of the families in lower socio-economic status had enrolled themselves in health insurance schemes by the Government i.e. community based health insurance schemes. Most of them aware of Yeshsawini and Janani Suraksha Yojana etc. Out of the 75 families who had health insurance 23 (30.7%) of the families had availed benefits. They had availed benefits for major and minor surgeries. Almost all the families that had availed health insurance benefits were not satisfied as most of the hospitals did not recognize their insurance policies. They also mentioned that they would prefer to be operated in private hospital because of the better care.

Table 1: Awareness of health insurance and the related variables

	Awareness		
Study Variable	**Yes**	**Total**	**p Value**
Education			p<0.05
Illiterate	11 (22.9)	48	
Literate	106 (37.4)	283	
Socio economic status			
Middle	41 (83.6)	49	p<0.001
Lower	76 (26.9)	282	

Out of the total families all the families wanted hospitalization, major and minor surgeries, deliveries to be included in the insurance cover. Some of them wanted a total health care that means they also wanted OPD, doctor charges to be covered or reimbursed. Few of them also wanted drugs to be given free of cost.

Most of the families (74%) wanted government to provide total health care right from the OPD to drugs to covered. Only 32% of the families felt that private firms may provide a better and a hazzle free coverage.

The willingness to pay a premium in most of the families was Rs 1000 to Rs 1500 (%). 31% the families were ready to pay at least minimum of Rs 500 per year. Most of the families involved in agricultural work were willing to pay the premium on half yearly basis or every year. While those involved in manual or daily wages were willing to pay per month depending on their monthly income.

In the present study it was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income (43%), are not reliable (27%), not taken by friends or relatives (18%), prefer to invest somewhere else (11%), not adequate knowledge regarding its benefits (16%), do not feel the need (29%).

DISCUSSION

For the low-income people, insurance was never considered to be an option in the past. They were assumed to be too poor to save and pay premium. Hence, the government assumed the responsibility of meeting health care needs of the poor. The government is continuing to provide free health services to the poor. The strategy of free public health provision has not worked well in most states. Shrinking budgetary support to the public health services, inefficiency in provision and unacceptably low quality of these services is reflective of this. Even in states like Tamil Nadu where public health care provision is reasonably developed, there were reasons for introducing health insurance. First, it is being increasingly realised that even low-income people can make small periodic contributions, which can add up to a significant amount, thereby taking some financial burden off from the already strained state revenues. Second, the insured individuals would have an option of going to either public or private service provider, which in turn

would generate competition among providers for better services.

Conceptually, a society can be thought of as consisting of two groups of individuals, those who can afford to buy health insurance that promises certain "minimum" level of benefit, and those who cannot afford to buy the "minimum" benefit on their own and need some public subsidy. As mentioned above, development of private health insurance may take care of those who can afford to buy insurance. For those who cannot afford, alternate approaches with some public subsidy are suggested

Insurance as not been able to make inroads in the rural areas because of key reasons such as high cost of delivery and low awareness among the rural population about insurance products.

Awareness and perception regarding health insurance was still very preliminary as observed in the present study. Although health insurance is not a new concept and people are also getting familiar with it, yet this awareness has not reached to the level of subscription of health insurance products.

Similar observations were found in other studies conducted by Sumindhar Kaur where 71.9% had no health insurance.[3]

Awareness in the present study was seen mainly through media. Studies conducted by Reshmi *et al.* showed 34% were aware through TV ads.[4] Thus media seemed to have played an important role in dissemination of information.

In the present study, awareness increased with education. This finding is similar to the finding by Sumindhar Kaur.[3] In our study awareness was found more in upper socioeconomic classes. Hence it can be stated that the socioeconomic status and education do play an important role in awareness, perceptions and subscription on health insurance. It was also found that the subscription was less in joint families as the number of family members increased. The insurance cover was also not obtained for all the members in such large families. A study conducted in Gujarat found out that the need for education for rural and urban population alike on the concept of health information is a crucial aspect on extending awareness about health insurance on large-scale.[5] This calls for effective information, education and communication activities which will improve understanding of insurance by the public.

In the present study it was seen that on an average the families spend 5 to 8% of their income on health. Garg and Karan (2009) assessed that the Out Of Pocket expenditure is about 5% of total households' expenditure (ranging from about 2% in Assam to 7% in Kerala) with higher proportion in rural areas.[6]

In the present study around forty eight percent of the respondents were aware of Yeshaswini scheme, Janani Suraksha Yojna. People were not all aware of other schemes such as Jana Raksha Scheme, Aarogya Raksha and Aarogya Bhagya scheme .This is in line similar to the studies conducted where people were aware of one or two schemes .The knowledge regarding those schemes was also inadequate.

Awareness regarding the coverage of the community based health insurance schemes was quite inadequate. Most of the families who had not availed the health insurance facilities thought that it covered everything right from OPD charges till the drugs. Only a few families were aware of the real coverage.

Purohit and Siddiqui (1994) examined the utilization of health services in India by making the comparison of Indian states in terms of low, medium and high household expenditure on health care and concluded that there is no serious Government initiative to encourage utilization of health services by means of devising health insurance.[7] Sanyal (1996) examined that the burden of health care expenditure in rural areas was twice in 1986–87 as compared to 1963–64 and also provided that household is the main contributor to the financing of health care in India.[8]

In the present study we made an attempt to study the amount of premium the population is ready to pay. In particular, the premium collection schedule matched with the cash flows. The cash flow varied for different categories of occupation groups. In farmers the premium depended on the number of crop cycles in a year as well as on the timings of harvest, whereas for wage labourer it depends on the working and lean season. Findings reveal that forty three percent of the respondent said that they are willing to pay a premium of Rs. 100–250 a year and another 10 percent reported a premium of Rs. 250–500. When asked about the choice of to pay the premium, around 47 percent reported half year cycle as preferred mode of premium and similar percentage reported a yearly cycle and 21% reported that they would prefer to pay a premium monthly. The payment mode depended on the type of occupation. Manual and daily wages earning

population preferred monthly premium and farmers half yearly or yearly cycles. Dror (2006) showed that most people are willing to pay 1.35% of income or more for health insurance.[9]

There are considerable variations in the amount to pay for health insurance because of multiple reasons like income, frequency of illness among households, chronic illness in the families, quality and proximity of providers (private, public) in different locations.

Ahuja and Narang (2005) concluded that health insurance schemes have considerable scope of improvement for a country like India by providing appropriate incentives and bringing these under the regulatory ambit.[10] The study suggested that in order to develop health insurance for poor in a big way, health care provisions need to be strengthened and streamlined as well as coordination among multiple agencies is needed.

The hindrances observed in the present study for subscription for health insurances were more or less similar to other studies done. The findings from the present study will be an eye opener to know where the patients stand with regard to their knowledge about health insurance covering the medical expenses. It can also help the hospitals to become aware of the present status of health insurance awareness among the patients and take the necessary steps to make them aware of the need for health insurance to meet the ever rising medical expenses in view of unpredictable illness and injuries to which anyone can be a victim.

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