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Awareness Of Health Insurance In A Rural Population Of Madurai District

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Abstract

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

Objective: To study the socio economic and demographic profile of the study population and to analyze the awareness of health insurance of study population.

Methods: A the sample of 385 respondents was selected from Madurai District using a stratified random sampling method. A standardized questionnaire based on a thorough literature review was used to analyze the data. The data was analyzed using statistical techniques. A demographic profile of the respondents, KMO and Bartlett's Test, and factor analysis were employed on the data using SPSS.

Result: It shows that 61.8% of the respondents are male, which is the majority. 46.5% of the respondents fall within the 41–50 age bracket. Most respondents (60.5%) are married. 53.0% of respondents, or the majority. Kaiser-Meyer-Olkin Measure of Sampling Adequacy.761. Cronbach's alpha is.727.

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.

Keywords: Health Insurance, Awareness, Rural, Policyholders, Socio Demographic, India.

Introduction

Even after more than 60 years of independence, inequalities in access to health care is widely prevalent in Indian communities. These inequalities in access to health care are related to socioeconomic status, geography, and gender, and are compounded by high out-of-pocket expenditures, with more than three-fourths of the increasing financial burden of health care being met by households. 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 wherein "an individual or group" purchase health care coverage in advance by paying a fee called a premium.

Health Insurance

Health insurance is a method to finance healthcare. The ILO defines health insurance as "the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO, 1996). To put it more simply, in a health insurance program, people who have the risk of a certain event contribute a small amount (premium) toward a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g., hospitalization).

Health Insurance in India

Today many countries are shifting over to health insurance as a mechanism of financing their health-care program. In India, we need to shift from the current predominance of out-of-pocket payments to a health insurance program. The reasons are very clear: direct out-of-pocket payments are a financial barrier to access health services. On the other hand, an insured patient can walk into a health facility without the fear of financial burden; 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; Direct out-of-pocket payments are inequitable as they place the burden on the vulnerable. In- surance through its risk pooling mechanism is more equitable; and Direct out-of-pocket payments do not permit patient's participation in his/her treatment. On the other hand, by its collective nature, a health insurance program can negotiate for better quality care.

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

Social Health Insurance (SHI)

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

Private Health Insurance (PHI)

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

Community Health Insurance (CHI)

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

Government-Initiated Health Insurance Schemes (GHI)

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

In the present scenario, the annual expenditure on health in India amounts to about $7.00 in rural areas and $10.00 inurban are asper person. The majority of care being provided by the private sector 2. With improved literacy, modest rise in incomes, and rapid spread of print and electronic media, there is greater awareness and increasing demand for bet- ter 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 opportuni- ties 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 pop- ulation 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 Madurai to assess the awareness about health insurance among rural people.

Methodology

The current study uses both primary and secondary data and is both descriptive and analytical in nature. The selection of the sample size and the sampling technique make up the study's sampling framework. The stratified random sampling method selection approach is used to select 385 clients as the study's sample. Data interpretation is achieved by data analysis, which is essential. The following choices for the analytical instrument have been made correctly: in order to evaluate the distribution of issues with health insurance in the Madurai District.

Literature of Review

D. Jerusha Irene Chitra (2017) Minor millets are miracle grains in their nutritional content. Minor millets have more proteins, minerals, and vitamins than rice and wheat. Minor millets have several health benefits, such as anti-diabetic, anti-tumorigenic, and antioxidant properties. Minor millets need very little water for their production, which is not dependent on the use of fertilisers and pesticides. In spite of these amazing qualities and capacities of the minor millets farming system, minor millets production and consumption have decreased over the last five decades. **S. Sridhar (2013)** Focus intensively to find out reasons behind the health seeking behaviour of people at the micro level in rural Tamil Nadu. **Swaminathan (1987)** Awareness of immunization and family planning was high, although the BCG vaccine was known less than other. There was no significant relationship between literacy rate, age groups and awareness bu the younger age groups were adopted by higher proportion of respondents, BCG and smallpox were adopted least.

ANALYSIS OF THE DATA AND INTERPRETATION

Table: 1 Descriptive Statistics of Respondents

S.No	Explanatory Variables	Coding	Frequency	%
1	**Gender**	Male	238	61.8
		Female	147	38.2
2	**Age**	30	28	7.3
		31-40	56	14.5
		41-50	179	46.5
		Above 50	122	31.7
3	**Marital status**	Married	233	60.5
		Unmarried	152	39.5
4	**Educational Qualification**	Uneducated	20	5.2
		School Level	45	11.7
		Graduate	204	53.0
		Post Graduate	116	30.1
5	**Occupation**	Business	53	13.8
		Private Employee	112	29.1
		Government official	181	47.0
		Retired persons	39	10.1
6	**Area of Residency**	Rural	78	20.3
		Semi Urban	128	33.2
		Urban	179	46.5
7	**Family Income Per Month**	less than 20000	24	6.2
		20000-40000	56	14.5
		40000-60000	74	19.2
		60000-80000	131	34.0
		More than 80000	100	26.0
8	**Type of Family**	Nuclear	251	65.2
		Joint Family	134	34.8
9	**Family Size**	Less than 3 members	56	14.5
		3-6 members	205	53.2
		more than 6 members	124	32.2
10	**Source Of Information**	Through agents	58	15.1
		Internet	168	43.6
		News paper	30	7.8
		Advertisement	39	10.1
		Friends & relative	90	23.4
11	**Insurance Company**	Public sector	160	41.6
		Private sector	225	58.4

Source: *Primary Data*

Table 1 provides descriptive statistics for respondents' demographic characteristics, including gender, age, marital status, educational attainment, occupation, area of residence, family income per month, family size, type of family, and information source. It also lists the respondents' insurance provider. It shows that 61.8% of the respondents are male, which is the majority. 46.5% of the respondents fall within the 41 to 50 age

bracket. Most respondents 60.5% are married. 53.0% of respondents, or the majority, had graduate degrees in their fields of sytudy. The occupation of the majority of respondents, 47.0%, is government officials. The areas of residence of the majority of respondents (46.5%) are urban. The family income per month of the majority (34.0%) of respondents is Rs.60, 000 – Rs. 80, 000 per month. The majority of respondents (65.2%) have nuclear families. The family size of the majority (53.2%) of respondents is 3-6 members. The source of information for the majority of 43.6% of respondents is the internet. The majority (58.4%) of respondents work for private insurance companies.

Factor analysis

The Kaiser-Meyer-Olkin (KMO) measure of sample adequacy has been calculated to determine if factor analysis is appropriate to use. The applicability or appropriateness of factor analysis is shown by the range between 0.5 and 1.0. The KMO test results are shown in Table 2. The estimated value of KMO, which is given in Table 2 as 0.761, reveals a substantial number of correlations between the claims. All of the aforementioned parameters so facilitate the use of factor analysis on the data. The dependability of the scale has also been examined, and Cronbach,s Alpha is. 727. According to the reliability test shown in Table 4.53 (Hair et. al. 2010), factors with loadings greater than 0.45 were taken into consideration while making the selection.

Table: 2 KMO and Bartlett's Test

KMO and Bartlett's Test			**Reliability Statistics**	
			Cronbach's Alpha	**N of Items**
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		**.761**	**.727**	21
Bartlett's Test of Sphericity	Approx. Chi-Square	8077.459		
	df	210		
	Sig.	.000		

Source: *Primary Data*

Extraction method: Principal Components Analysis

Exploratory factor analysis has been performed using SPSS 20.0 version on the respondents of 385 issues of the Health Insurance Schemes regarding 21 statements to analyze the underlying dimensionality of the statements and to determine the necessary factor. A Principal Component analysis (PCA) utilizing orthogonal rotation and the varimax algorithm was utilized to extract the components from 21 elements. The selected factors have Eigen values that are higher than one. Table 3 displays the results of the factor analysis.

Table: 3 Total Variance Explained									
	Initial Eigen values			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.056	24.078	24.078	5.056	24.078	24.078	5.028	23.940	23.940
2	3.731	17.765	41.843	3.731	17.765	41.843	3.711	17.669	41.610
3	2.773	13.207	55.050	2.773	13.207	55.050	2.711	12.911	54.521
4	1.961	9.337	64.387	1.961	9.337	64.387	2.003	9.537	64.058
5	1.939	9.234	73.621	1.939	9.234	73.621	1.957	9.321	73.379
6	1.109	5.280	78.901	1.109	5.280	78.901	1.160	5.522	78.901
Extraction Method: Principal Component Analysis.									

Source:*Primary Data*

This demonstrates how well-suited the extracted communalities are to every factor analysis for internet buying found six underlying aspects. These four elements account for 24.078% of the overall variance. The statements are divided into various categories based on the rotated component matrix, as shown in table 3. Factors 1,2,3,4,5 and 6 each have Eigen values of 5.056, 3.731, 2.773, 1.961, 1.939, and 1.109, respectively.

ROTATED COMPONENT MATRIX

The Rotated Component Matrix assists in determining the component's meaning. It includes correlation estimates for each of the variables as well as the expected components. The researcher divided the rotated components matrix into six categories based on the greatest value (> 0.60) obtained from the rotated components matrix study.

Table: 4 Rotated Component Matrix

Rotated Component Matrix[a]							Eigen Value	Variance Explained	Cronbach's Alpha
	Component								
	1	2	3	4	5	6			
AWA1						.619	1.109	5.280	.212
AWA2						.778			
AWA3	.926						5.056	24.078	.931
AWA5	.874								
AWA6	.793								
AWA7	.837								
AWA9	.895								
AWA10	.828								
AWA11	.752								
AWA8		.979					3.731	17.765	.972
AWA13		.930							
AWA17		.946							
AWA18		.981							
AWA14			.951				2.773	13.207	.927
AWA15			.909						

AWA16			.933						
AWA19				.749			1.961	9.337	.738
AWA20				.904					
AWA21				.775					
AWA4					.980		1.939	9.234	.970
AWA12					.981				
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.									
a. Rotation converged in 4 iterations.									

Source:*Primary Data*

From the table, 4 indicated that factors influencing problems associated with health insurance schemes statements had six statements. The KMO measures the sampling adequacy of 0.761, which is a satisfactory value nearing 1, with Bartlett's test of Sphericity indicating that emerged factors were related at significance level 0.000.

Suggestions

In India's insurance market, health insurance is becoming one of the most dynamic and rapidly increasing segments. Various data collection methods for the most important public sectors are based on customer satisfaction. In this area, private enterprises are trailing behind. Private-sector enterprises will have to put client happiness on their priority list if they want to maintain their dominance in the health insurance sector.

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.

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