"ANALYSIS OF AWARENESS AND PREFERENCES OF HEALTH INSURANCE IN PUNJAB"

A dissertation submitted in partial fulfillment of the requirements
for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Supreet Kaur Gandhi
Roll No. PG/08/056



International Institute of Health Management Research
New Delhi -110075
May, 2010

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under the guidance of

Mr. Anil Kumar
Area Manager
ICICI Lombard

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International Institute of Health Management Research

New Delhi -110075

May, 2010

Certificate of Internship Completion

Date:…….

TO WHOM IT MAY CONCERN

This is to certify that Supreet Kaur Gandhi has successfully completed her 3 months internship in our organization from February 1, 2010 to April 30, 2010. During this intern she has worked as Customer Service Manager - Provider Management and looked after the operation of Bhai Ghanhya Sehat Sewa Scheme in Punjab, under the guidance of me and my team at ICICI Lombard, GIC Ltd.

We wish her good luck for her future assignments

(Signature)
Mr. Anil Kumar
Area Manager
ICICI Lombard.
Chandigarh

Certificate of Approval

The following dissertation titled "**Analysis of Awareness and Preferences of Health Insurance in Punjab**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
_____	_____
_____	_____
_____	_____

Certificate from Dissertation Advisory Committee

This is to certify that **Supreet Kaur Gandhi**, a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled **"Analysis of Awareness and Preferences of Health Insurance in Punjab**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Mr. Harish Sihare
Assistant Professor
IIHMR
New Delhi

Mr. Anil Kumar
Area Manager
ICICI Lombard
Chandigarh

Acknowledgement

I was placed in ICICI Lombard, GIC Ltd. with anticipation for learning & hands on experience. I felt extremely privileged to work in this Organization where learning has no limits.

At this juncture of time this Report would be incomplete if I forget to thank all people who made my learning a possibility & an unforgettable experience.

At the outset I would like to thank the Almighty, Management of ICICI Lombard, GIC Ltd & IIHMR, New Delhi for providing me such unique learning experience.

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Abbreviations

IL	ICICI Lombard
CS	Customer Service
PA	Personal Accident
BGT	Bhai Ghanhya Trust
BGSSS	Bhai Ghanhya Sehat Sewa Scheme
RGSSBY	Rajiv Gandhi Shilpi Swasthya Bima Yojna
HI	Health Insurance
HIP	Health Insurance Policy
GIP	General Insurance Policy
CHI	Community Health Insurance
CBHI	Community Based Health Insurance
PHI	Public Health Insurance
SHI	Social Health Insurance
TPA	Third Party Administrator
OOPS	Out Of Pocket Spending
GDP	Gross Domestic Product
IRDA	Insurance Regulatory and Development Authority
ECHS	Ex-Serviceman Contributory Health Scheme
CGHS	Central Government Health Scheme
WHO	World Health Organization
WDR	World Development Report
MCO	Managed Care Organization
HMO	Health Maintenance Organization

PART 1

INTERNSHIP REPORT

ORGANIZATION: ICICI LOMBARD GIC LTD.

1.1 ORGANIZATION PROFILE

A Joint Venture of Powerful Brands

ICICI Lombard is a 74%:26% joint venture between ICICI Bank Limited and the $ 26 billion Fairfax Financial Holdings Limited, USA. Lombard Insurance is a part of Fairfax Holdings.
ICICI Bank is India's second largest bank, while Lombard Insurance, a part of Fairfax holdings, is the oldest insurance company in Canada.

Values-An Important Attribute

ICICI Lombard as an organization considers values as the most important attribute. employees are expected to conduct themselves with the highest level of values and imbibe the core values of organization to ensure personal and professional success and happiness.

Core Value of ICICI Lombard's are:-

- Integrity
- Positivity
- Humility
- Passion
- Sensitivity

Geographically Widespread Operations

ICICI Lombard's operations are geographically widespread across India. A Team of over 5000 employees and over 5500 trainees services over 4.5 million retail customers,100 million rural customer and 300 of the top 1000 corporate customers, Some of the business statistics are:-

- Premium of INR 3420 crores (2008-09)
- Operational from 380 offices and business is sourced from 500 locations.
- Over 4.5 millions policies issued in 2008-09
- 300,000 incremental policies issued per month
- Managing 90000 claims per month (approximately)

Product Bouquet

ICICI Lombard's products are categorized under three product lines.

Traditional Product:-Fire, Engineering, Marine, Motor, Health, Home

Specialized Product:-Directors & Officers Liability, Errors & Omissions, Product Liability, Public Liability.

Structured Product:- Secure mind (Critical illness),Credit Insurance, Weather Insurance, Performance Guarantee.

Leader in Product Categories

ICICI Lombard is the leading private sector General insurance Company with a market share of 11.2%.ICICI Lombard's market share in product categories is as high as 17 % in health Insurance.

Employees Profile

ICICI Lombard's employee profile comprises of management graduates, CA's, engineers and graduates. Around 2/3rd of ICICI Lombard employees are in sales, and the others in shared services.(63% Sales and 37% Shared & Support Services). Average age of employees is 27 years, with an average of 4 years of industry experience.

Employee Distribution across Functions

51% of ICICI Lombard's employees are dedicated to Retails and Banc assurance vertical. Another 33% of the employee strength is employed in support functions.

Business Structure

ICICI Lombard's business structure consists of Business Verticals (sales) and Shared Services (Support functions).While each business Vertical is focused on its own products and clients, Shared Services extend support to the whole company.

Business Verticals

1. **CSG Vertical**

ICICI Lombard's Corporate Solutions Groups (CSG) meets the general insurance needs of corporate houses in the private sector.

2. **GSG Vertical**

ICICI Lombard's Government Solution group (GSG) deals exclusively with the general insurance needs of government owned companies and public sector undertakings. The needs of government business are different from corporate business

3. **FIG Vertical**

ICICI Lombard's Financial Institutions Group (FIG) focuses on the general insurance needs of the financial sector and its constituents. It is a growing segment with innovative needs and requirement.

4. **Banc assurance Vertical**

Banc assurance is a business vertical that cross cell insurance product to the customer base of partner banks. This is usually done by offering the bank customers with the bundle of financial products-i.e. an insurance product is integrated with a core banking product.

5. **RABG Verticals**

The enormous rural and agriculture opportunity in India is driven by a shift in product mix, marketing freedom, international trade, private sector partnership and increasing role of micro finance and NGOs.

6. **E-Channel Vertical**

E-Channel leverages its web presence to sell retail policies directly to individual customers-Over the net (Buy Online) and Over the phone (Dial-a-policy).

7. **Travel Vertical**

Travel insurance is a policy for overseas travelers for emergency or unforeseen medical expenses and non-medical expenses such as passport loss/delay etc during their travel abroad.

Insurance claims are serviced through a third party service provider in the country where clientis travelling**.**

8. Worksites Marketing Vertical

ICICI Lombard's Worksites Marketing is a new business vertical set up to target employees of corporate by leveraging its good relationships in the corporate sector.

9. IBG Vertical

ICICI Lombard's IBG provides customized products and services to NRI's and PIOs residing across the world. These products and services primarily insure the NRI's families and assets in India. There are also customized and unique offerings like remit shield which insures the remittances. IBG's initial focus is on servicing NRI customers of ICICI Bank across the world and simultaneously setting up the International footprint for ICICI Lombard.

10. Broker Relations Vertical

The philosophy behind a broker relations vertical is to maximize the potential of brokers to bring in business for the entire range of products of ICICI Lombard.

11. Liability Insurance Vertical

ICICI Lombard's Liability Insurance business offers substantial scope for innovative products with high business potential.

ICICI Lombard's Liability Insurance business covers two lines-Casualty and Financial.

The Casualty line covers third party bodily injury or property damage liabilities.

The Financial line covers third party financial losses.

12. Channel Management Vertical

Insurance is an agent/channel driven business because of its vast retail market. ICICI Lombard's Channel Management Team is entrusted with the important task of creating, motivating and managing the channel or agent network.

Shared Services include:

1. Reinsurance
2. IT

3. Operations
4. Customer Service Corporate
5. Customer Service Motor
6. Internal Control & Loss Minimization
7. Human Resource
8. Marketing

ICICI Lombard: Quality Policy

Quality…A way of life

At ICICI Lombard, processes, development, achievement, performance evaluation and appraisals are driven by quality of output and result orientation.

Quality Policy

"Consistent quality output through technology enabled process improvements to enhance Customer Satisfaction"

Quality Objectives:

- Turnaround time
- Error-Free Transaction

1.2 DEPARTMENT WORKED IN

CS HEALTH & PA: GOVT. AND RURAL BUSINESS which covers Mass and Corporate Health Policies both.

1.3 A BRIEF OF TASKS PERFORMED IN ICICI LOMBARD, GIC LTD.

Job Responsibilities in ICICI Lombard GIC Ltd.

I.Bhai Ghanhya Sehat Sewa Scheme, Punjab (BGSSS): A Brief

It is a Social Health care Scheme for Punjab Farmers and other Co-operative societies with the following objective:

"To make equitable, affordable & quality health care accessible to the farmers & others comprising most vulnerable section of the society".

BGSSS is Insurance backed scheme insured by the Insurance Company i.e. ICICI Lombard GIC Ltd. ,Administered by Bhai Ghanhya Trust (BGT) and Implemented by MD India Healthcare Service (TPA) Pvt. Ltd.

a. **BGT:** Is the Government body administering BGSSS

b. **MD India:** Is the Implementing Agency. Major Role is to Empanel Hospitals at Bhai Ghanhya scheduled rates across the state of Punjab, Issue Authorization to the Network Hospitals for cashless treatment of the beneficiaries covered under BGSSS and settle their claims. A 24 hours dedicated service is provided by the TPA.

c. ICICI Lombard:

- Has signed Service level Agreement (SLA) with the Trust and TPA, thereby undertaking to execute and implement the Scheme in accordance with the terms and conditions as contained in the SLA.

- Has appointed MD India in capacity of a Third Party Administrator (TPA) to implement the Scheme.
- All financial and legal obligations/responsibilities arising consequent to the inception of the Scheme by the TPA, rest with the Insurer.
- Shall provide float fund to the TPA for settling cashless hospitalization claims of the Network Hospitals and reimbursement claims of the beneficiaries, who have taken treatment in the Govt. Hospital.

Key Tasks Performed in BGSSS:

1. **Enrollment Activity:**
   - Underwriting
   - Maintaining Enrollment Data
   - Handling TPA Issues faced during Data entry of Enrollment Forms and Card Printing
   - Co-ordination with BGT and District Coordinators on field.
   - Keeping Track of Enrollment of 19 Districts of Punjab.

2. **TPA Management**

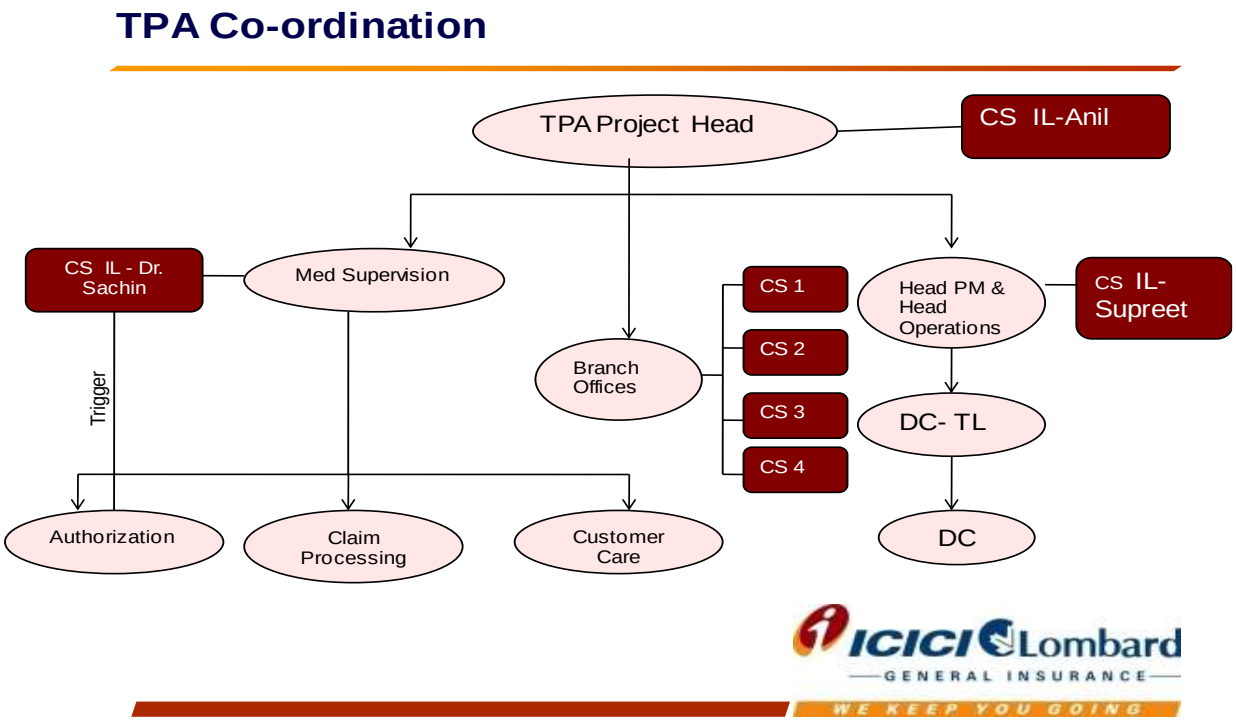


Fig I.1.3.A

Being the first level of contact with the TPA following is my KRA:

a. Co-ordination with TPA
b. Handling TPA Issues like:
    i. Cross checking Daily Claim MIS sent by the TPA
    ii. Reconciliation of claims
    iii. Reporting of 19 District Co-ordinators (DC)
    iv. Follow up for Authorization and Payment within TAT.
    v. Issues with Authorization and Claim Settlement
c. Collecting and Analyzing DC Report.
d. Giving Feedback on the reports.
e. Conducting Audits (self or in co-ordination with Internal Audit Team).
f. Conducting Meeting with TPA as and when required.

3. Co-ordination with Team Members

Chandigarh being the central location of BGSSS, following are the roles performed:

a. Collecting Field Visit Reports from the Team
b. Compiling and Analysing the Reports.
c. Giving Performance Feedback to the Team
d. Solving Daily Issues and Queries.
e. Conducting review meet as and when required.

4. Role in Investigation of Cases under BGSSS

a. Tracking suspicious cases / Suspicious Hospitals of Fraud and handing over to ICLM i.e. the Investigation Team of ICICI Lombard GIC Ltd.
b. Taking action on the suspected cases detected in the field by Team Members & ICLM in co-ordination with Senior Authorities.
c. Reporting the suspicious cases to the TPA and BGT.
d. Formulation of new strategies of Investigation in co-ordination with the team as and when required.

e. Cardiac and Joint Replacement Case Opinion (contributing maximum in the claim ratio) with Senior Cardiac and Orthopedic Consultants in New Delhi.

f. Conducting Meetings with ICLM every Thursday.

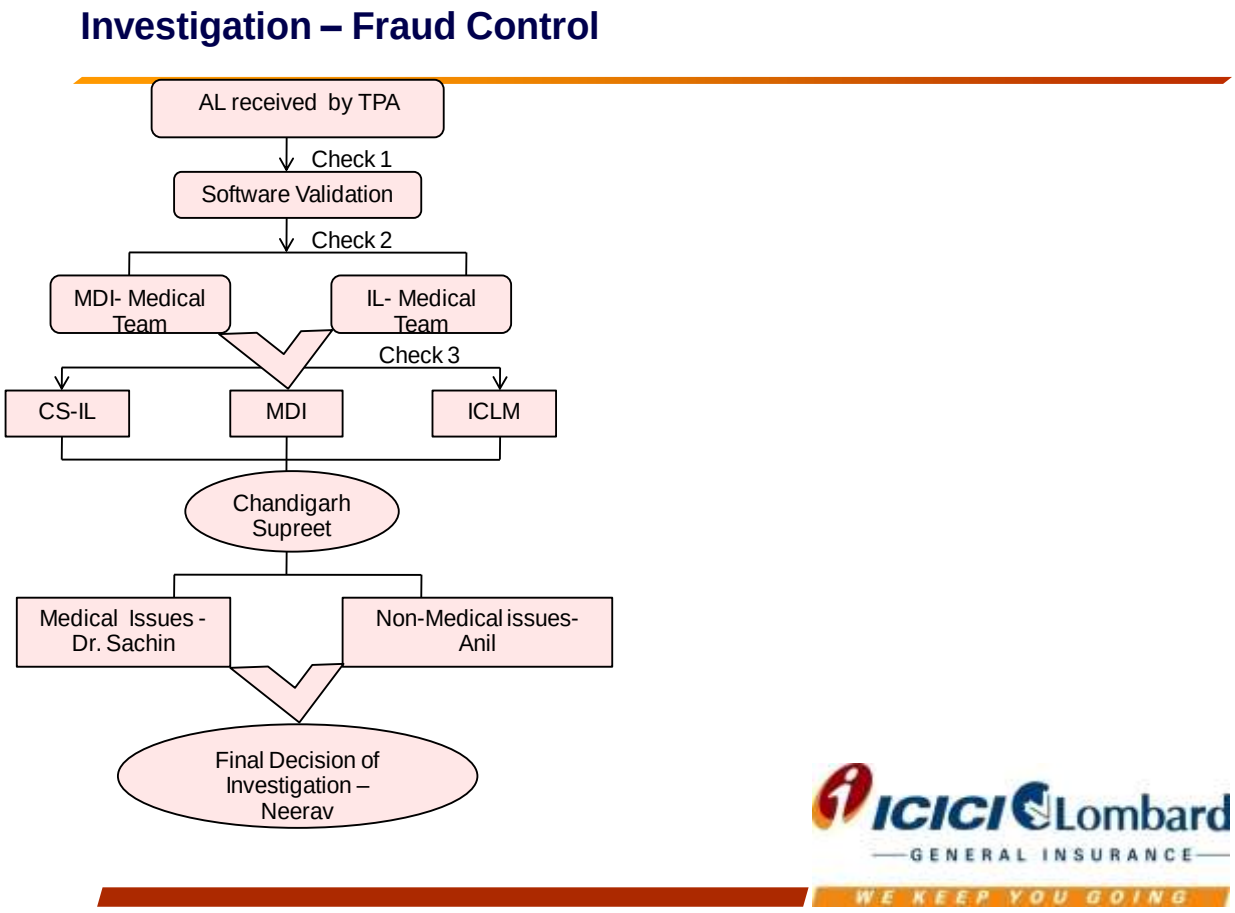


Fig I.1.3.B

5. **Co-ordination with FISG (Financial Institution and Solution Group) Vertical, ICICI Lombard and BGT:**

   a. Conducting monthly meeting with FISG.

   b. Review meets for BGSSS with BGT and other Govt. officials as and when required.

   c. Resolving issues of the Trust with TPA.

6. **Hospital and Beneficiaries grievances**
    a. Addressing and resolving any such issues in co-ordination with TPA.
    b. Payment Reconciliation with Hospitals fortnightly.

7. **Other Operations in BGSSS:**
    a. Monthly Claim Analysis of BGSSS.
    b. Co-ordination with IL Payment team.
    c. Updating the IL Tracker
    d. Giving weekly feedback of team members in field to senior authorities.
    e. Maintaining records and Trackers.

BGSSS is a boon to the farmers of Punjab. The scheme is helping the state to revolutionalize rural India's health and healing process. To state emphatically, Punjab has become a model state in North India with the introduction of this scheme.

II. Rajiv Gandhi Shilpi Swasthya Bima Yojna (RGSSBY) and Sericulture

It is the policy devised for Weavers and Artisans. My KRA is as follows for the particular Policy:

1. **Coordination with State Teams**
    a. Punjab
    b. Himachal Pradesh
    c. Jammu & Kashmir
    d. Haryana

2. **OPD/IPD Management**

3. **TPA Management**
    a. Coordination with TPA
    b. Assurance of claim settlement within TAT.

4. **Handling grievances of Hospitals and Beneficiaries**
5. **Co-ordination with IL Payment team**

6. **Resolving Daily Issues**
7. **Other Operational Tasks**

1.4 REFLECTIVE LEARNING DURING 3 MONTHS

Working in Mass Policy like BGSSS in ICICI Lombard GIC Ltd has gained me an incomparable experience. Some of the major Reflective Learning from the Company and the Policy have been enumerated below:

1. Practical Exposure is different from Classroom learning.
2. Handling different issues in different situations
3. Work as a part of Team
4. Co-ordination with team can only yield Cooperation from team.
5. Improvement of Communication skills, Problem solving, Team work, Computer Applications, Interpersonal skills, Networking and Presentation skills as well as product, company and career knowledge.
6. Developing Professional competency.
7. Improvement in Analytical skills.
8. Development of Leadership skills.
9. Dealing with vendor is more difficult than breaking iron walls but have to be competent enough to tackle it.
10. No place in the organization if the work done is not shown.
11. Have to be multitasking and dynamic.
12. Have to be innovative at every stage to yield better results.
13. Relationship building.
14. Every task done should be documented to avoid any future mismatch.
15. Value of Time and Money.

PART 2

A DISSERTATION ON

"Analysis of Awareness and Preferences of Health Insurance in Punjab"

Abstract

"Analysis of Awareness and Preferences of Health Insurance in Punjab"

The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered under any form of health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country. The Indian health insurance scenario is a mix of mandatory social health insurance (SHI), voluntary private health insurance and community-based health insurance (CBHI). Health insurance is thus really a minor player in the health ecosystem.

This research is focused on evaluating the awareness level, preference and consumption pattern of Health Insurance in Punjab. The general methodology of study is based on Descriptive Research where primary data is collected from survey and fact finding queries of different kinds. The research sites were 6 major cities of Punjab namely Chandigarh, Jalandhar, Ludhiana, Bathinda, Amritsar and Patiala.

The major Findings are:

1. Awareness level of Health Insurance is lower as compared to any other General Insurance.
2. Awareness about Health insurance is directly related to Education and Income level of the individual. Higher the Education and income level more is the awareness.
3. Males are more aware about Health Insurance than Females.
4. The most preferred Company and type of Health Insurance Policy is LIC and Cashless respectively.
5. The most important factor for consuming/purchasing Health Insurance is Medical Benefits followed by Cashless benefits.

Demand for health insurance has been growing at a rate of 25 percent per year, driven by rapidly increasing costs of health care and the expanding middle class. However, no one in the industry is taking responsibility to develop knowledge and awareness of health insurance

among the public nor is specific expertise in health insurance being developed within the private sector, an expertise that is essential to dealing effectively with provider of health care services. Because of this absence of specific capacity, Indian companies writing health insurance seem to have focused on controlling claims payout by following strategies designed to minimize the insured person's ability to collect on claims. Thus there is an excessive emphasis on disqualification because of pre-existing conditions and post-claim underwriting. Because of these practices health insurance has become one of the largest litigation areas for insurers, exceeded only by motor third party cases.

The study recommends the regulatory bodies to provide protection of health insurance to policyholders and beneficiaries, to promote access to healthcare, control pricing of health coverage vis-à-vis healthcare providers and enhance quality of healthcare.

Chapter 1: Introduction

Background

Since the liberalization of the insurance industry in 2000 India has been promoting private players to enter the health insurance sector. With the enactment of the IRDA, the industry now has a regulatory framework to protect the interests of policy holders. This was followed by another landmark decision in 2001 establishing Third Party Administrators (TPAs) to facilitate speedier expansion by providing an administrative–intermediary structure to the insurance industry. International experience and economic theory on private insurance markets however show evidence of widening inequity, excessive utilization, adverse selection, increase in inappropriate care, risk selection increasing overall cost of care and in a highly competitive, voluntary market, high administrative costs, unviable risk pools, undercutting and unrealistic pricing leading to market instability and bankruptcies. Private commercial-led health insurance systems resulting in, etc.—factors that contribute to inflation in costs. Yet of the 39(2001) countries having private insurance contributing to 5% of the total health expenditure, 46% were low- and middle- income countries where private insurance is perceived as an important source of health financing (Sikhri 2005), contributing to about 5%–20% of the country's total health spending.

Health insurance in India is usually associated with the 'Mediclaim' policy of the GIC, which was introduced in 1986 as a voluntary health insurance scheme offered by the public sector. The premium based on the age, risk and the benefit package opted for, ranged from a minimum premium of Rs 201 for those < 25 years of age, to a maximum benefit of Rs 15,000 with discounts for group memberships. In 2001, there were 78 lakh persons covered under Mediclaim (Gupta 2003). The subscribers are usually from the middle and upper class, especially since there is a tax benefit in subscribing to Mediclaim. The standard Mediclaim policy covers only hospital care and domiciliary hospitalization benefits. Most medical conditions are reimbursed though there are important exclusions, such as pre-existing diseases, pregnancy and child birth, HIV/AIDS, etc. Hospitals with more than 15 beds and registered with a local authority can be identified as providers.

The public insurance companies so far have paid very little attention to voluntary medical insurance because of low profitability and high risk together with lack of demand. From the consumer point of view, the insurance coverage is low because of lack of information about the private health insurance plans as well as the mechanisms used by the health insurance providers being not suitable to consumers. Further, in comparison to the ESIS and also to the community-based schemes, the private plans cover a modicum of benefits, i.e. only hospitalization and with a lot of exclusions. One analysis suggests that the existing voluntary health insurance plans cover only 55–67 per cent of the total hospitalization cost and in all just 10–20 per cent of the total outpatient care burden on households (Gumber 2000a).

Type of Health Care Burden on Households Covered under Health Insurance Schemes

Type of Care/Cost		ESIS	SEWA	*Mediclaim*
Inpatient	Medical	✔	✔	✔
	Transport and other direct cost	✘	✘	✘
	Loss of earnings	✔	✘	✘
Outpatient	Medical	✔	✘	✘
	Transport and other direct cost	✘	✘	✘
	Loss of earnings	✔	✘	✘
Preventive and Promotive	Immunisation	✔	✘	✘
	Ante- and post-natal care	✔	✘	✘
	Maternity care	✔	✔	✘
	Family planning	✘	✘	✘

Note: SEWA and *Mediclaim* are reimbursement plans (subject to sum assured) whereas ESIS is a facility-based plan.

Table II.1.1

Gender bias in health care use continues to persist with men having better access to facility as compared to women due to various socio-economic and cultural reasons. More specifically, poor women are most vulnerable to diseases and ill-health due to living in unhygienic conditions, heavy burden of child bearing, low emphasis on their own health care needs, and severe constraints in seeking health care for themselves. Institutional arrangements have so far been lacking in correcting these gender differentials. A pioneer study undertaken by Gumber and Kulkarni (2000) has carefully looked into issues related to the availability and needs of health

insurance coverage for the poor, especially the women, and the likely constraints in extending current health insurance benefits to workers of the informal sector.

The Main Issues in Health Insurance in India

1 *Barriers to entry into the market of insurance:* In the early 1990s, the Indian government established the Insurance Regulatory and Development Authority (IRDA), which has been responsible for developing the framework for de-monopolization of the insurance market. One of the severe barriers to entry into this market is the requirement to deposit Rs. 100 Crore as a precondition for being granted an insurance license. Not only is this amount out of reach for smaller insurers, but as this deposit does not bear a return, insurers must compensate for this lost yield by raising insurance premiums.

2. *Insufficient pooling of healthcare expenditure*: According to WHO figures (2002), total health expenditures represent 6.1% of India's GDP, but most of this amount, representing 4.8% of GDP is the share of private expenditures and only 1.3% of GDP is public expenditure. Of the 4.8% private expenditure, 98.5% are Out-of-Pocket-Spending of users (OOPS). In other words, 77.5% of total expenditure for healthcare costs must be paid by single individuals or households10, 11 and this huge flow of funds does not pass through any pooling mechanism. Without health insurance, and under the existing paradigm of (i) a very low share of public expenditure, and (ii) a very high share of unpooled expenditure, poor households are exposed to risk of impoverishment due to the cost of healthcare, and enjoy low access to healthcare due to its high cost. The same devastating effect occurs also in households that do not face a catastrophic hospitalization but must bear the aggregate cost of multiple episodes of less severe illnesses. Health insurance is therefore an urgent anti-poverty measure.

3. *Limited possibilities to buy health insurance*: Of those who do have health insurance in India at present, many (if not most) are covered by employer-sponsored schemes. These insurance products are designed for those with a steady and relatively high income, namely mainly men in formal employment in large urban areas. People wishing to buy health insurance as individuals (outside the framework of group policies) may encounter difficulties in doing so. These

difficulties are virtually insurmountable in rural areas, or if the insurance product should be very cheap, both because the pure risk premiums are high and because there is insufficient pressure to reduce the administrative costs.

4. *Administrative loading to fees*: Some insurers use the services of intermediaries (TPAs), whose role is to administer claims and maintain business books. TPAs and other intermediaries do not influence the cost of underwriting the pure risk, but they add to the cost of premiums due to the higher transaction costs. These transaction costs are generated by search and information costs, negotiation and decision costs, monitoring and implementation costs on the market side, as well as increasing transaction costs inside the insurance company due to growing size and complexity. It is claimed that the role of TPAs increases because they can operate for-profit activities, whereas health insurers are supposed to be not-for-profit. However, the fees of TPAs increase the administrative cost of the insurance, which translates to higher premiums. Higher premiums reduce the likelihood that poorer people would be willing or able to buy health insurance from commercial insurers. One can thus conclude that the present methods of administering insurance business interfere with extension of coverage to poor segments of the population.

5. *Insufficient supply of medical services*: On the service delivery side, it is self evident that health insurance can be attractive only if the insured can access sufficient supply of good quality healthcare services. In India, most of the medical facilities are located in urban areas, and therefore the urban population has a better option to access good healthcare providers. This is all the more important since there is almost no regulatory control of the quality of care provided by medical providers. Insurers are also not very active in ensuring the quality of care that the insured can get; in fact, there is relatively little information on links between providers of care and providers of insurance (the "managed care" model). Mediclaim, which offers mainly an indemnity product, has been criticized that its benefit package was not comprehensive enough, and that it was responsible for undue delays in claim settlements. In summary, health insurance is for the time being mainly sold in urban areas where there is ample supply of healthcare services. People living in rural areas have a more restricted choice, and often may be required to co-pay part of the cost even if they are insured. Therefore, poorer people, women, and those

living further away from urban centers are much less likely to be interested in commercial health insurance.

Consumer and social perspective on health insurance

With the liberalization of insurance and entry of private companies in this business it is very important that specific interventions are developed which focus on increasing the consumer awareness about insurance products. One of the major challenges after privatization of insurance would be how to develop such mechanisms, which help making consumers aware about the various intricacies of insurance plans. As of now information, knowledge and awareness of existing insurance plans is very limited. This is also shown by the study of Gumber and Kulkarni (2000) among the members of SEWA, ESIS and mediclaim schemes. With Consumer Protection Act coming in force it has become easy for aggrieved consumers to complain and seek redressal for their problems. Consumer organizations such as CERC of Ahmedabad have been helping consumers to get due justice in disputes with the insurance companies. Their experience would be varying valuable in guiding development of health insurance plans that are transparent and just.

Many a times the insurance claims are rejected due to some small technical reasons. This leads to disputes. Most of the time the conditions and various points included in insurance policy contracts is not negotiable and these are binding on consumers. There is no analysis on what is fair practice and what is unfair practice. Given that insurance companies are large and almost monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this create confusion and disputes. (Shah M 1999)

The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions. A number of cases of litigation are disagreement on these pre-existing conditions. These problems also arise because of lack of specification of number of areas and properly spelling out the conditions. This is also because some chronic conditions such as high blood pressure and diabetes can increase the risk of many other disease of organs such as heart, kidney, vascular and eyes diseases. The patients with these pre-existing conditions are denied claims for treatment of complications. This is not fair and leads to disputes.

Health insurance is typically annual and has to be renewed yearly. Policy, which is not renewed in time lapses and a new policy has to be taken out. Medical conditions detected during the interim period are treated as pre-existing condition for the new policy, which is not fair. This is seen as major issue as it changes the conditional ties about what constitutes pre- exiting conditions. Courts, however, have ruled that even if there is delay in renewing the policies it should be considered as renewed policy. In case two doctors give different reports one favouring consumer and other insurance company, the insurance company generally follows the later opinion. There are several such consumer-related issues, which need to be addressed in health insurance.

One of the planks on which the insurance has been deregulated is the gain in efficiency and passing on these benefits to the consumers. It is very unrealistic to assume that insurance companies will be able to gain efficiency, which helps them to reduce the price of schemes. At least one should not be expecting this thing happening in the short-run. But providing full information to the consumer and dealing with claims in a just and expeditious manner is the minimum expected outcome of the deregulation process. Consumer organizations have to play very active role in future development of the health insurance sector in India.

There are several social issues such as exclusions of sexually transmitted diseases, AIDS, delivery and maternal conditions etc. These are not socially and ethically acceptable. "Insurance companies much take care of all the risks related to health. The companies may charge additional premium for certain conditions. Secondly the present mediclaim policy premiums are high and do not differentiate between people living in urban and rural areas where the costs of medical care are different. Thus the present policy is less attractive to poor and rural people. The tax subsidy provided to the mediclaim is also going largely to the rich who are the taxpayers. The newer health insurance policies have to improve upon the shortcoming of the existing policies

Literature Review

Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of nonfood expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it. On average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill [Peters, Yazbeck et al 2002].

So far, the literature evaluating the impact of insurance in low-income countries is not just relatively limited; it is also rather unbalanced between different types of insurances. The main emphasis has been on different types of health insurance schemes, and their impact on health care-utilization, out-of-pockets expenditure or social inclusion (Chankova et al., 2008; Dong, 1999; Dror et al. 2006; Gumber 2001; Jowett et al., 2003; Jütting, 2004, Preker et al., 2002; Ranson, 2001, Wagstaff 2007, Wagstaff et al, 2007). Very few studies evaluate the impact of insurance on overall household income, nutrition, or other dimensions of welfare than those directly related to the insurance. Exceptions include Wagstaff and Pradhan (2005), who evaluate the impact of health insurance on health outcomes (anthropometric indicators), health care utilization and non-medical consumption expenditure for households in Vietnam using panel data and propensity score matching. They find that voluntary health insurance had a positive impact on height-for-age and weight-for-age of young school children, and led to an increase in non-medical household consumption. Building on Gruber and Yelowitz (1999)'s evidence from Medicaid in the U.S., Chou et al. (2003) find that public health insurance in Taiwan has caused a reduction in savings for precautionary reasons, with the effect negatively proportional to the size of savings.

Adverse selection is perceived to be a major source of market failure in insurance markets and is present in all lines of insurance due to hidden information (Akerlof 1970; Knight and Coble 1997). Adverse selection is one of the major hurdles for insurance companies in selling their HI schemes to clients. It is a situation of high-risk people buying HI with the result that there is over-representation of such high-risk people in the risk pool. Individuals know more about their health conditions than the insurance companies; people who insure themselves are those who are

increasingly certain that they will need health insurance and buy more insurance (Akerlof 1970; Rothschild and Stiglitz 1976; WDR 1993).

For many years health economists have tried to explain why many individuals remain uninsured. Some of these cases are easier to explain - there is a large portion of individuals that are poor but not poor enough to be eligible for public insurance, and who are either not working or working but not offered health insurance in the workplace. Some workers ostensibly choose to work at a firm that does not offer insurance, while others choose to work at a firm that does offer health insurance. However, there are many Americans that are offered health insurance in the workplace but who turn it down. Even controlling for income, the decision to remain uninsured cannot be fully explained (Cooper and Schone, 1997). In an innovative study, Bundorf and Pauly (2002) define affordability in different ways and consider where affordability is a real barrier to access. They find, regardless of the definition used, that affordability is not a very good predictor of coverage, nor is unaffordability clearly a major barrier to gaining access.

Given the limitations of a public health care system, private health insurance (PHI) offers a potential alternative to insure against the cost of illness. As indicated by the WHO (2000), private schemes can serve as "a preparatory process of consolidating small pools into larger ones" to eventually achieve universal coverage. Such development would indeed correspond to the experience of many industrialized countries, where universal social insurance emerged out of private risk-sharing programs (e.g., Germany and Sweden, comp. Sekhri/Savedoff, 2005: 129)

	Low-Income Countries		Lower-Middle-Income Countries		Upper-Middle-Income Countries		High-Income Countries		Total	
	n	%	n	%	n	%	n	%	n	%
Total	**64**	**100**	**57**	**100**	**33**	**100**	**38**	**100**	**192**	**100**
OOP < 33 % of THE	22	34.4	30	52.6	19	57.6	33	86.8	94	49.0
OOP > 33 % of THE	42	65.6	27	47.4	14	42.4	5	13.2	98	51.0
OOP > 50 % of THE	21	32.8	9	15.8	4	12.1	2	5.3	36	18.8
OOP > 66 % of THE	8	12.5	0	0.0	0	0.0	0	0.0	8	4.2

Note: Existence and volume of OOP spending are measured as percentage of total health care expenditure.
Source: Own calculation. Data: WHO (2003).

Table II.1.2

In low- and middle-income countries that are prone to epidemics and infectious diseases it isequally important to consider the overall effects of PHI on a country's health indicators. Private risk sharing programs arguably represent "a threat to the control of, and care for, [the] WHO's ten basic community diseases" (Sbarbaro, 2000: 14). Shifting resources from public to private entities may consequently pose additional risks if people are deprived of sufficient preventive health care such as vaccination and immunization (Khaleghian, 2004; Scott-Herridge, 2002). The state must either continue to provide such services or persuade people through information campaigns to include preventive measures in their private health care coverage. As argued by Sbarbaro (2000, 12), the introduction of PHI may even detract from development potentials as "public health services have the greater effect on a community's economic development". Sustainable economic development could consequently prove more difficult to attain the more a country relies n private insurance

The persistent poverty and disease syndromes have pushed the families of the unorganised sector into the process of de-capitalization and indebtedness to meet their day-to-day contingencies. Both macro and micro studies on the use of health care services show that the poor and disadvantaged sections, such as Scheduled Castes and Tribes, are forced to spend a higher proportion of their income on health care than the better off. The burden of treatment is particularly unduly large on them when seeking inpatient care (Visaria and Gumber 1994; Gumber 1997).

There are also concerns about problems in the accessibility and use of subsidized public health facilities. A majority of the poor households, especially rural, reside in backward, hilly and remote regions where neither government facilities nor private medical practitioners are available. They have to depend heavily on poor quality services provided by local, often unqualified, practitioners and faith healers. Further, wherever accessibility is not a constraint, the primary health centres are usually either dysfunctional or provide services of low quality. The government's claim to provide free secondary and tertiary care does not hold; in reality the government is charging for various services (Gumber 1997).

Estimates based on a large-scale health care utilization survey of 1993 suggest that overall about six per cent of the household income is spent on curative care which amounts to Rs. 250 per

capita per annum (Shariff et al. 1999). However, the burden of expenditure on health care is unduly heavy on households engaged in the informal sector, indicating the potential for voluntary comprehensive health insurance schemes for such sections of the society.

Overall, the health insurance coverage is very low. Only nine per cent of the Indian workforce is covered by some form of health insurance (through the Central Government Health Scheme (CGHS), Employees' State Insurance Scheme (ESIS) and Mediclaim), a majority of them belonging to organised sector (Gumber 1998). The low level of health insurance coverage is due to the fact that the government policies have been to provide free health services through the public hospitals/dispensaries/clinics. In reality, despite having a poor outreach, the public sector providers charge for various services. According to estimates based on the National Sample Survey (NSS) 1986–87, 42 and 30 per cent of inpatients and outpatients, respectively, using public sector facilities had paid for various services; the percentages varied substantially between rural and urban areas and amongst states (Gumber 1997). Further, over time the cost of health care has increased enormously. A comparison of NSS data for 1986–87 and 1995–96 suggest that the cost of inpatient care and outpatient care grew annually at 26–31 per cent and 15–16 per cent respectively, which in turn has put severe strains on achieving equity in health (Gumber 2001).

Indian Scenario

In India, out-of-pocket spending by households on healthcare occupies about 72 percent of the total health expenditure (WHR 2006) and it pushes 2.2 per cent of the population below the poverty line each year (Peters et al. 2002). Health Insurance (HI) can be a viable and feasible financial solution [Churchill et.al 2006; O'Donnell et al. 2005] on both efficiency and equity grounds. However, HI coverage is very low in India. The existing public HI schemes such as the Central Government Health Scheme (CGHS) and the Ex-servicemen Contributory Health Scheme (ECHS) are limited to central government employees, retired army personnel and their eligible dependants. Similarly, the Employees State Insurance (ESI) schemes only cover workers in the organized sector.

There are some micro health insurance schemes being operated by various civil society organizations for special target groups; however, these are limited to some specific geographical locations and their penetration is also still very low. Private Health Insurance (PHI) schemes by insurance companies seem to be another viable option for all segments of society, but these have covered only 1.4 per cent of the population until now (IRDA 2005). The underlying reasons for such low coverage are mostly unexplained.

The existence of a partially subsidized public healthcare system, absence of proper awareness on risk pooling forms of HI, poor trust in insurance companies and the inability of the people in the informal sector to deal with insurance companies are some of the other plausible reasons for the low level of HI intake in India (Vellakkal 2008).

Health insurance is insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government.

By estimating the overall risk of healthcare expenses, a routine finance structure (such as a monthly premium or annual tax) can be developed, ensuring that money is available to pay for the healthcare benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Rational or purposeful choice among consumers is possible depending upon their disposable income and knowledge about their own preferences; when consumers have trouble in gathering and understanding information on preferences, the ability to make informed decisions is compromised (Rice 1998). A key element for the smooth functioning of HI markets is the premise that all consumers have access to the same information as the providers and purchasers of HI and also they understand this information. If this condition is satisfied, individuals will be able to judge the value of the products offered in the HI market, like for instance, the HI package, its price, its quality and related customer services. Thus, one can expect that a well-informed consumer can make wise decisions in the market—whether to buy or not, what to buy, from whom to buy and how much to buy for.

Insurance Regulatory Development Authority (IRDA) has embarked upon a nationwide awareness programme on health insurance in order to educate the public on its benefits.
Stating that the health insurance scheme has been evolving at a fast pace in the country, United India Insurance CMD G. Srinivasan said it has not reached the expected levels."The number of people voluntarily taking health insurance is 4-5 per cent only and there is a big challenge on the penetration of health insurance in the country". Lack of awareness, affordability issues and enrollment are barriers; the formalities required are particularly the main reasons for this, he said. (PTI, Friday, October 9, 2009)

Need of the study

India is a low-income country with 26% population living below the poverty line, and 35% illiterate population with skewed health risks. Insurance is limited to only a small proportion of people in the organized sector covering less than 10% of the total population. Currently, there are no mechanism or infrastructure for collecting mandatory premium among the large informal sector. Even in terms of the existing schemes, there is insufficient and inadequate information about the various schemes. Data gaps also prevail. Much of the focus of the existing schemes is on hospital expenses. There continues to be lack of awareness among people about health insurance. Inspite of existing regulation in some states, the private sector continues to operate in an almost unhindered manner. Health insurance per se, suffers from problems like adverse selection, moral hazard, cream-skimming and high administrative costs.

There is a need to evolve a criteria to be used for deciding upon target groups, who would avail the HI schemes. Health insurance can improve access to good quality health care only if it is able to provide for health care institutions with adequate facilities and skilled personnel at affordable cost. Given this scenario, the challenge, then, for Indian policy-makers is to find ways to improve upon the existing situation in the health sector and to make equitable, affordable and quality health care accessible to the population, especially the poor and the vulnerable sections of the society.

Chapter 2: Research Methodology

Research Problem:

With less than 2 percent of the population covered by health insurance in India, and with low public spending on health, most of the financial burden of illness falls on single individuals and households. Healthcare costs are thus the most serious cause of impoverishment in India today. This study tries to find out the awareness of Health Insurance and their preferences in the people of Punjab.

Research Objectives:

- To evaluate the awareness level of HI in the people of Punjab
- To assess the individual awareness about Health Insurance in people of Punjab with respect to their education and income level.
- To know the preference of individual regarding Health Insurance.

Research Hypothesis (H):

H1: Males are more aware than females regarding Health insurance.

H2: Awareness is directly related to education and income level. More is the awareness level in individuals with higher education and Income level.

H3: Still majority of population buy Health Insurance not to cover health risks but to save taxes.

Research Design:

The general methodology of study is based on Descriptive Research where primary data is collected from survey and fact finding queries of different kinds.

160 respondents from 6 major cities of Punjab namely Chandigarh, Jalandhar, Ludhiana, Bathinda, Amritsar and Patiala were approached for this survey. Out of these 17 refused to respond so this study is based on response of 143 respondents. The Interrogation was through Personal Interview from the people of Punjab.

Sampling Design:

Population: Includes people from 6 major cities of Punjab namely Chandigarh, Jalandhar, Ludhiana, Bathinda, Amritsar and Patiala.

S**ample Size:** A sample size of 143 was selected.

Sample Design:

A **Random Sampling Method** based on Probability Sampling Technique has been used to conduct this study. Each individual has been chosen randomly so that each member of the population gets an equal opportunity of being included in the sample.

Data Collection and Data Analysis:

Instrument: Self designed Questionnaire has been used to analyze the awareness level, preference and consumption pattern of HI in Punjab.

Data Collection Method: Interrogation through Personal Interview.

Scaling Technique Used: Likert Ranking Scale (5 point scale) has been used to evaluate the Factors responsible in availing HI in the people of Punjab.

1 is considered as of the Least Importance and 5 as Highest Importance.

Data Analysis Method: Survey Based. Quantitative research method has been used to collect data which is analyzed by using SPSS and Microsoft Excel.

Chapter 3: Data Analysis and Findings

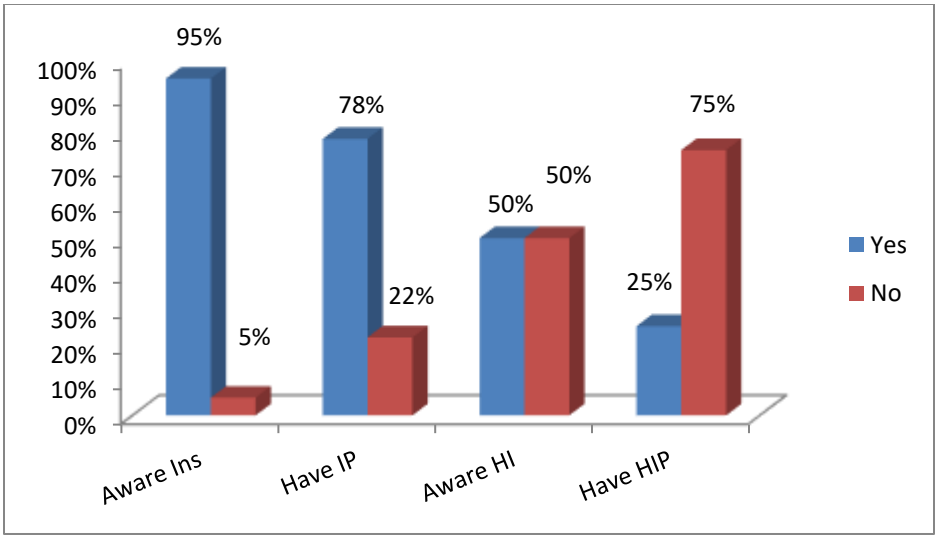
This section discusses some of the principal findings that emerged from the Survey conducted based on Questionnaire undertaken in 6 major cities of Punjab. The objectives of the study were: (i) To assess the individual awareness about Health Insurance in the people of Punjab with respect to their education level and monthly income; (ii) To know the preference of individual regarding health Insurance; and (iii) To evaluate consumption patterns of health Insurance.

The study is based on a primary survey undertaken in Punjab. The survey includes 143 respondents classified into five categories according to their qualification and monthly income.

The idea of selecting people from different cities of Punjab was to understand whether the awareness level is related to environment or qualification and income level of the individual and to analyze individuals who are aware but did not avail any Health Insurance policy for any reason.

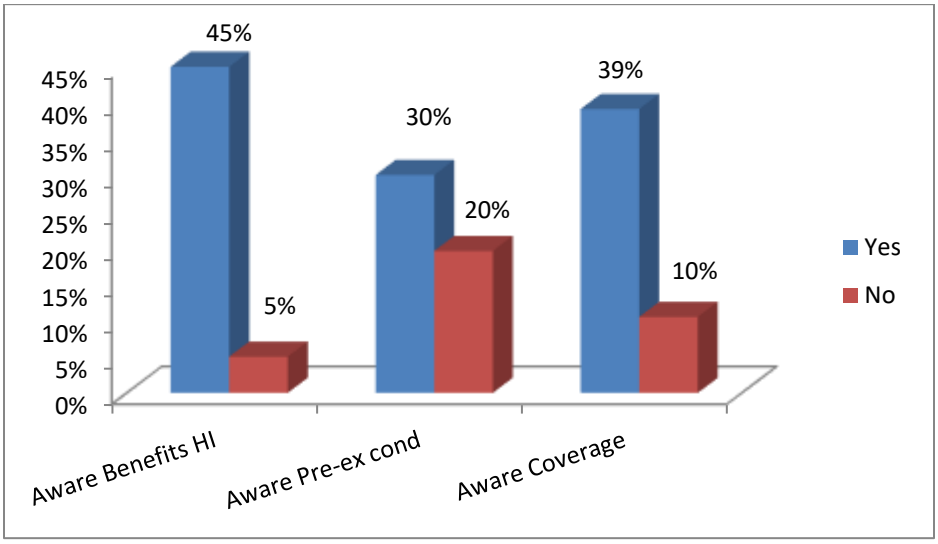
The main results of the study are discussed below and the salient statistics in tabular format are presented:

Fig II.3.1 Awareness of Insurance compared to Health Insurance



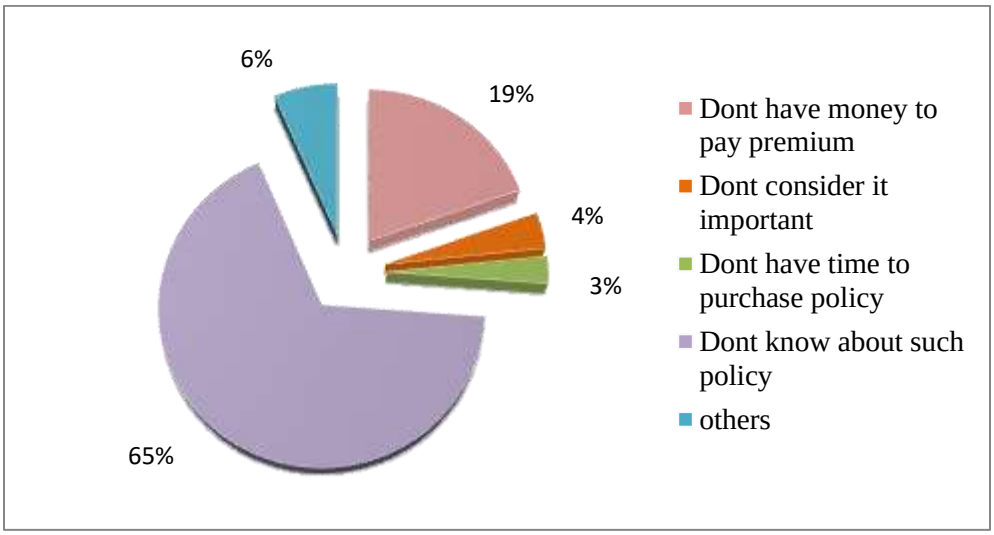
Of 143 respondents interrogated, 72 people (approx 50%) were found to be aware about HI out of which only 50% had HIP while 95% of the people were aware regarding Insurance out of which 84% had purchased some or the other IP, the most common being Agriculture and Motor Insurance.

Fig II.3.2 Awareness regarding Benefits of HI in the Individuals who are aware about HI



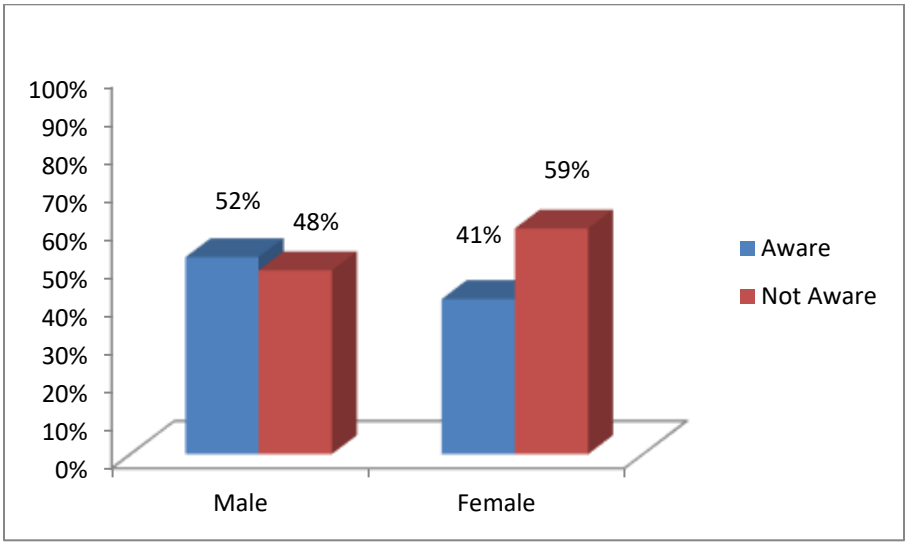
When the question regarding the awareness about benefits of HI was raised, 45% of individuals (out of 50% aware people) claimed that they were aware regarding the same but when they were asked whether they were aware regarding their Pre-existing conditions and Disease Coverage of HI, only 30% and 39% respectively responded positively. The remaining were unknown.

Fig II.3.3 Reasons for Not Purchasing HI



The major reason for not availing any HIP amongst those who were aware was found to be Lack of money to pay the premium (19%) followed by People don't consider it to be important (4%) with 65% of the people being unaware. Need to mention that the other reason (6%) found through this study was Govt. employees do not feel the need to buy HI as they get enough benefits through Govt. itself.

Fig II.3.4 Effect of Gender on Awareness of HI



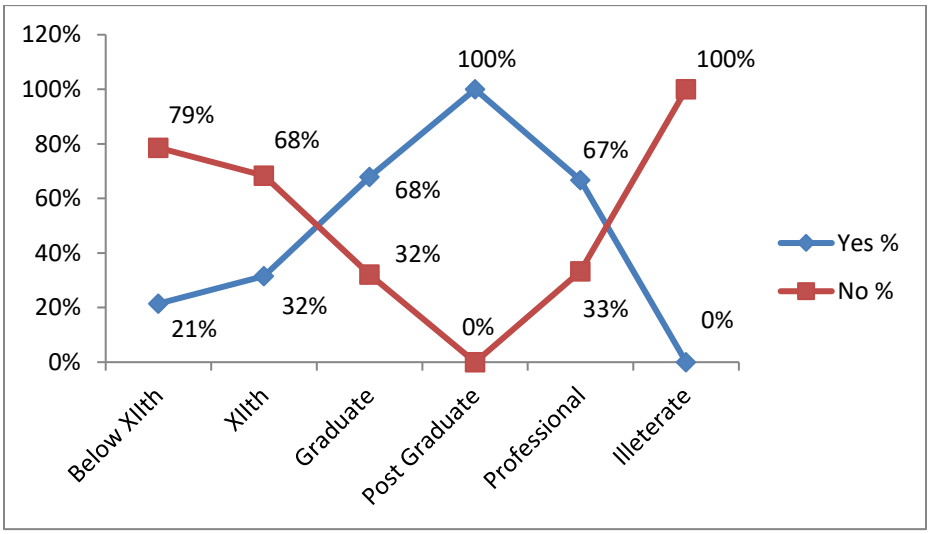
Of 143 respondents interrogated, 72 people (approx 50%) were found to be unaware about HI. 51% of male and 40 % of females had knowledge about Health Insurance out of 81% males and 19 % female respondents interviewed in the survey.

Table II.3.1 Correlation of Gender and Awareness of HI

Correlations		
		Aware HI
Gender	Pearson Correlation	0.086
	Sig. (1-tailed)	0.154
	N	143
Aware HI	Pearson Correlation	1
	Sig. (1-tailed)	.
	N	143

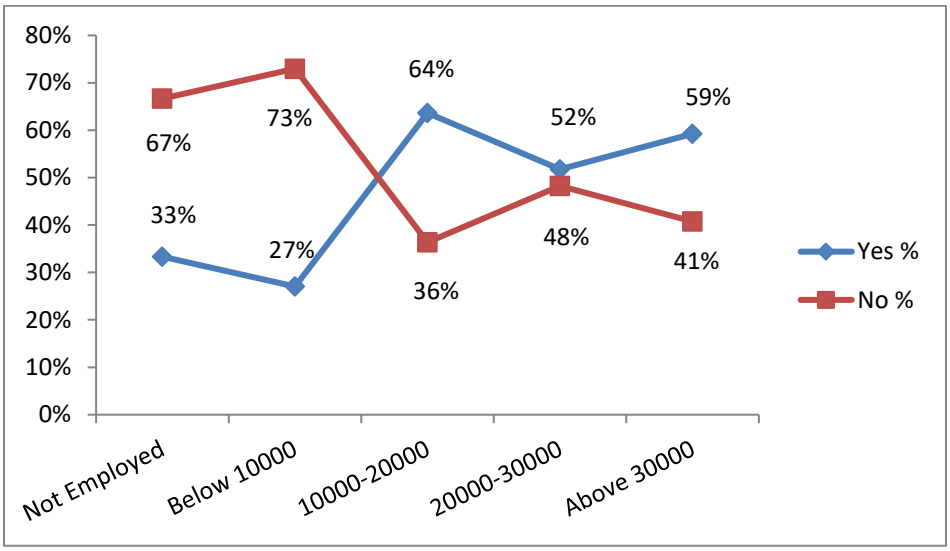
Correlation has been used to analyze the difference in Awareness level of males and females. Since the significance value is 0.154. No concrete conclusion can be drawn for Hypothesis H1 that males are more aware than females regarding HI. This may be due to the reason that there is a major difference between the number of males and females interrogated. The perception before conducting the research was that approximately equal number of both the genders would be interviewed.

Fig II.3.5 Effect of Qualification on Awareness



The awareness level was found to be 78% in individuals qualified above XIIth while only 22 % in individuals till XIIth or below and 0% in illiterates.

Fig II.3.6 Effect of Income level on Awareness



People with monthly income below Rs. 10,000, generally were those with small scale business and illiterate / qualification below XIIth with least awareness level (27%) and maximum in those with income level between 10000-20000 and private / govt. employee or with own business. (64%) It was also observed that people with high salary package (> 20000) but low qualification level were less aware (26%) as compared to those with high salary package & high qualification (74%).

Table II.3.2 Correlation of Qualification and Monthly Income with Awareness

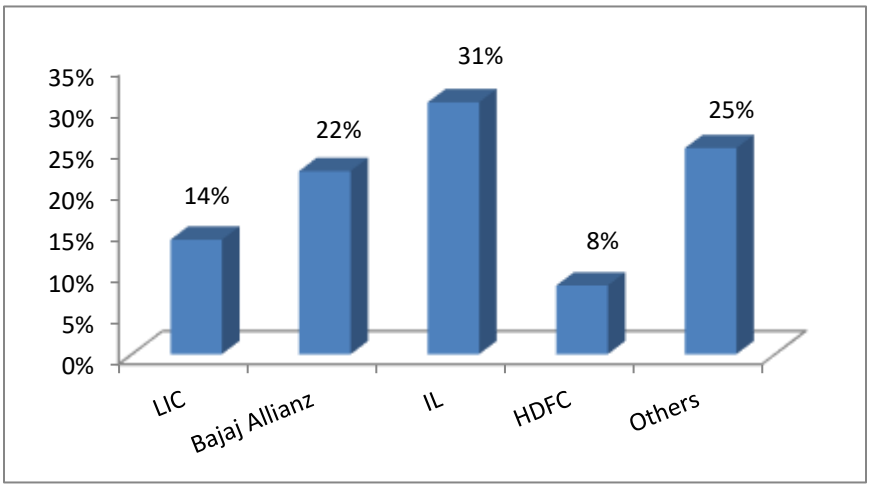
		Monthly Income	Qualification	Aware HI
Monthly Income	Pearson Correlation	1	.048	-.196(*)
	Sig. (2-tailed)	.	.573	.019
	N	143	143	143
Qualification	Pearson Correlation	.048	1	-.262(**)
	Sig. (2-tailed)	.573	.	.002
	N	143	143	143
Aware HI	Pearson Correlation	-.196(*)	-.262(**)	1
	Sig. (2-tailed)	.019	.002	.
	N	143	143	143

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Correlation is used to analyze the relationship between Qualification and Awareness level (-.262) which is significant (.002) at 0.01 level. Between Monthly Income and Awareness level (-.196), it is significant (.019) at 0.05 level.

Hence, the Hypothesis H2 that Awareness level is directly related to Qualification and Income level. Higher is the Qualification and Income level of the individual, more is the awareness regarding HI.

Fig II.3.7 Most Common HI Company amongst the individuals who have HIP



One major observation of the study is that the 78% of the people availed some or the other GIP while out of 50% of the people aware, only 50% availed HIP. The most common company being ICICI Lombard (31%) followed by Bajaj Allianz (22%) amongst those who availed any HIP.

Fig II.3.8 Most Preferred HI Company

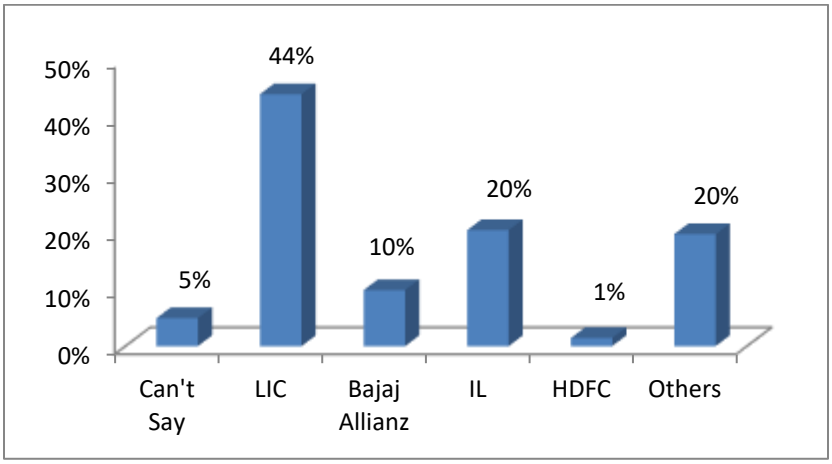
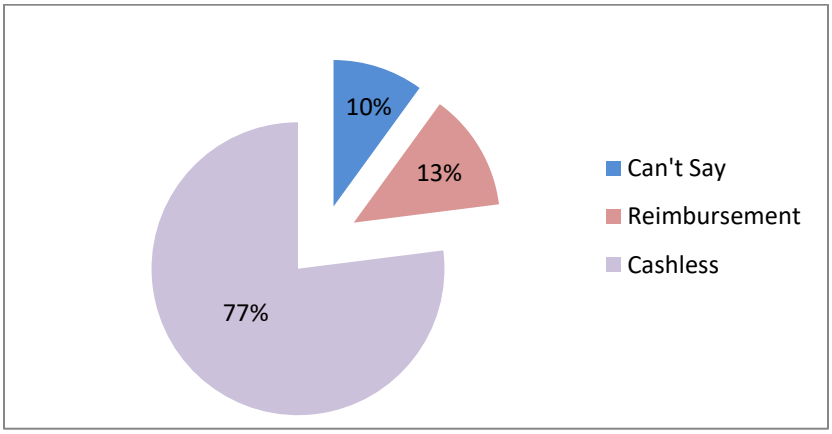


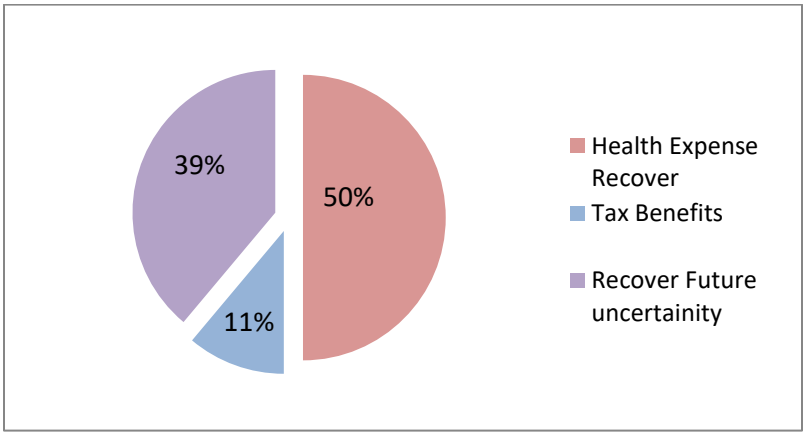
Fig II.3.9 Preferred Type of HIP



When people were told about HI, the most **preferred** Company to buy HIP was found to be LIC (44%) followed by ICICI Lombard (20%) and Bajaj Allianz (14%).

Also, the people prefer to have HIP which gives Cashless benefits (77%) over Reimbursement (13%).

Fig II.3.10 Reason to Purchase HIP



In maximum cases the HIP was purchased by the individuals themselves (53%).The main reason for availing HIP was to ensure Health expense recovery (50%) followed by Recovery of future uncertainty (39%) and Tax benefits (11%) with premium found to be paid 10000-15000 in most of the cases (47%). Second, being 1000-5000 (33%).

Factor Analysis

Table II.3.3 Analysis of Factors for availing Health Insurance Policy (5 point Likert Scale)

3a. One-Sample Statistics

Category	N	Mean	Std. Deviation	Std. Error Mean
Premium	71	2.35	1.299	.154
Company Reputation	71	2.35	.927	.110
Network Hospital	71	2.34	.985	.117
Diseases Covered	71	2.41	1.103	.131
Tax Benefits	71	2.49	1.170	.139
Cashless Benefits	71	4.14	1.018	.121
Medical Benefits	71	4.44	.841	.100
Free Access Benefits	71	4.04	1.048	.124
Other Benefits	71	2.44	1.180	.140

3b. One-Sample Test

	Test Value = 0					
Category	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Premium	15.252	70	.000	2.352	2.04	2.66
Company Reputation	21.372	70	.000	2.352	2.13	2.57
Network Hospital	20.005	70	.000	2.338	2.10	2.57
Diseases Covered	18.400	70	.000	2.408	2.15	2.67
Tax Benefits	17.961	70	.000	2.493	2.22	2.77
Cashless Benefits	34.263	70	.000	4.141	3.90	4.38
Medical Benefits	44.472	70	.000	4.437	4.24	4.64
Free Access Benefits	32.502	70	.000	4.042	3.79	4.29
Other Benefits	17.400	70	.000	2.437	2.16	2.72

Description of Factors:

1 is the lowest in the ranking scale and 5 is the highest.

1. **Medical Benefits:** This factor depicts that it is the most preferred factor amongst the people of Punjab for availing HI with highest Mean value (4.437) and t value (44.472) which is significant at 5% level. So, it is being considered the most important contributory factor for availing HIP.

2. **Cashless Benefits:** With Mean Value of 4.141 and t value (34.263) significant at 5% level, it is an equally important factor amongst the people of Punjab for availing HIP.

3. **Free Access Benefits:** Free Access Benefits is the third most important factor (Mean 4.042) and t value (32.502) significant at 5%; it is also an important contributory factor for availing any HI scheme.

4. **Tax benefits.** With Mean value of 2.493 and t value (17.961) significant at 5%; tax benefits through investment in various HIPs is also considered a contributory factor but on lower scale.

5. **Disease Covered:** Disease coverage before purchasing any HIP is considered a less contributory factor with mean value 2.408 and t value of 18.4 significant at 5%. This may be due to the reason that many were unaware regarding the coverage of HI.

6. **Network Hospitals:** With mean value of 2.338 and t value 20.005, it is also a contributory factor for availing HIP.

7. **Company Reputation:** Also contributes towards the purchase of HIP with mean value 2.352 and t value 21.372 significant at 5%.

8. **Premium:** From the study it was observed that people with high salary package pay higher premium and do not consider it an important factor for availing HI but India's maximum population being poor consider premium a contributory factor due to unaffordability.

Hence, the Hypothesis H3 cannot be concluded that people buy HI to only save taxes.

Reliability

Reliability test was carried out for the above factors using SPSS software and the reliability of the items was measured. The result is as follows:

Cronbach's Alpha 0.964

It can be seen that the reliability value is more than 0.7. So, the scale used is highly reliable.

Chapter 4: Conclusion & Recommendations

Conclusion

One of the most urgent and vexing problems in the developing world, more so in India, is how to finance and provide health care for more than a billion persons, most of whom are impoverished or belong to low income group. This is brought out clearly in the World Development Report 2000/2001. In most Asian countries, health care is financed by out-of-pocket (OOP) payments by individuals. These expenditures result in jeopardizing an equitable health system in developing countries. In the absence of financial risk pooling, the poor have to meet the costs of health care from their own pocket, pushing them further down the abyss.

In India, around 94% of the total workforce is in the unorganized sector. In absolute terms too, the numbers (around 433million) are mind boggling. One of the major insecurities of these workers and their families is the frequent incidence of illness and need for medical care and hospitalization. Despite expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation.

The study of this research work was focused to determine Awareness level of HI in Punjab. The objectives of the study were to evaluate the awareness level with respect to Education and Income level of the individuals and know the factors accountable for availing HI scheme.

Three hypotheses were made out which 1 was completely accepted.

The test used was Reliability test to check the reliability of the Scale used and the result was 0.964. Therefore, the factors were highly reliable.

The people in Punjab are not well versed with Health Insurance and its schemes. 50% people were found to be unaware about HI and 75 % people did not avail any HI scheme. The major reason found to be lack of money to pay the premium.

The major factors for availing Health Insurance were found to be Medical and Cashless benefits. Premium being an important contributory factor towards unaffordability.

The Health Insurance industry has to go ahead. A lot of opportunities are still waiting. This research will help in developing the market share, loyalty and further development in insurance sector.

Recommendations

1. The Govt. has to make a major effort to educate the public about the importance of primary care and prevention, particularly with regard to the purchase of insurance coverage whether publicly or privately provided (multi-line as well as health insurance only) there should be separate health-insurance-focused requirements and separate regulations that must be met by all participants in health insurance.
2. Create training and education programs that specialize in health insurance and require special licenses for people who sell health insurance.
3. Involve the Ministry of Health in insurance regulation with respect to quality improvement and medical effectiveness. For example, health ministry expertise in accreditation, practice guidelines and licensing standards is needed to establish and require these credentials for providers included in insurance networks.
4. Provide for dedicated funding of public education about health insurance through IRDA and insurance companies. For example, use dedicated licensing fees paid to IRDA for public awareness about health insurance. Similarly, require insurance companies, through their associations and with oversight from IRDA, to provide better information on both the pitfalls and the promises of health insurance coverage.
5. Large efforts should be laid towards developing health insurance as an alternative and acceptable method of personal finance risk management tool. The whole aim should be to diverted towards popularizing health insurance as a concept in rural areas under the guidance of the ministry of finance and the IRDA.
6. Additional and separate educational and practical training should be required in the licensing of health insurance agents and intermediaries to strengthen policyholder protection and to promote and develop industry’s technical competence in health insurance.

7. Separate “file and use” guidelines that address special features and characteristics of health insurance should also be adopted as a measure to monitor and ensure that the premium charged under a health cover is reasonable in relation to benefits covered.

Regulations, aside from their aim of providing protection of health insurance policyholders and beneficiaries, can be potent tools to promote access to healthcare, control pricing of health coverage vis-à-vis healthcare providers and enhance quality of healthcare. Allowing the participation of other entities that provide health coverage, such as MCOs, HMOs, Hospital and/or Professional entities, and self-insured health insurance schemes of Mutual Benefit Associations and Cooperatives would further increase the reach and depth of private health insurance. Private health insurance cannot grow if reasonable consumer expectations relating to access, cost and quality of healthcare remain promises rather than realities.

Limitations of the Research

1. The research was based on primary collection of data through Structured Schedule, so there may be chances of human error and biasness.
2. The research was dependant on the information provided by the respondents who were very reluctant in providing right information and often provides carelessly and results are drawn out of this information only. So, sometimes all effort might fail to find the right result.
3. As associated with every project, time and money were the major limitations with project.
4. Due to time constrains more time could not be devoted to individual respondent.
5. Due to unwillingness of providing any information, the respondents filled the questionnaire casually which might have affected the consolation.
6. The projection is purely based on verbal meetings and may be influenced by unprecedented factors.
7. Non-co-operative behavior of respondent was a big problem in this survey.

While studying the report the above fact should be taken into consideration.

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Annexure 1

QUESTIONAIRRE

1. **Name of Respondent……..……..**
2. **Location……**
3. **Date…….....**

4. **Age**
   i) 18-30 years
   ii) 31-40 years
   iii) 41-50 years
   iv) 51-60 years
   v) More than 60 year

5. **Gender**
   i) Male
   ii) female

6. **Qualification**
   i) XIIth
   ii) Graduate
   iii) Post-Graduate
   iv) Professional
   v) N/A

7. **Monthly Income (in Rs.)**
   - Below 10,000
   - 10,001-20,000
   - 20,001-30,000
   - Above 30,000

8. Occupation

i) Student
ii) Private Employee
iii) Govt. Employee
iv) Business Man

9. Do you know about Insurance?

i) Yes ii) No

10. Do you have any Insurance Policy?

i) Yes ii) No

11. Are you aware about Health Insurance?

i) Yes ii) No

12. If yes, do you know benefits of health insurance?

i) Yes ii) No

13. Do you have any Health Insurance Policy?

i) Yes ii) No

14. If No, the reason:

i)Do not have money to pay the premium
ii)Don't consider it important
iii)Don't have time to purchase the policy
iv)Don't know about any such policy
v)Others

15. If yes, which company's plan do you avail?

i) LIC ii) Bajaj Alliance iii) ICICI Lombard iv) HDFC v) Others

16. What kind of health insurance policy, do you prefer?

i) Reimbursement ii) Cashless

17. Are you aware that all conditions are not covered under health insurance:

i) Yes ii) No

18. Do you know about the pre-existing conditions:

i) Yes ii) No

19. How did you get this health Policy?

i) Employer Provides ii) Own purchase iii) Family Provides

20. How much premium do you pay annually for HI?

i) 1000- 5000 ii) 5001- 10000 iii) 10001 – 15000 iv) Above 15000

21. Why did you purchase this Health Insurance Plan?

i) Health Expenses Recover ii) Tax Benefits iii) Recover Future Uncertainity

22. Please Rank all these factors for availing Health Insurance from 1-5

Factors	**1**	**2**	**3**	**4**	**5**
Premium					
Company Reputition					
Network Hospitals					
Disease Covered					
Tax Benefits					
Cashless Benefits					
Medical Benefits					
Free access health services					
Other Benefits					