Original Research Article

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Awareness and utilization of health insurance among patients of a tertiary care centre in South India

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ABSTRACT

Background: While health insurance may seem like just another form to fill, it has proven to be a literal life saver in case of medical catastrophes, saving those subscribed from possible health expense induced poverty. The objective of this study is to assess the proportion of patients aware of the provision of health insurance and have subscribed to them.

Methods: Cross sectional study conducted in a tertiary care center based in South India during the period July 2019 to September 2019. Convenience sampling with a sample size of 58 was used. Data collected with the help of an interviewer administered semi-structured questionnaire.

Results: Awareness of the provision of health insurance was found to be as high as 89.7%. But only 51.7% were found to be subscribed to a health insurance plan. Of which 70% had joined a Government insurance scheme and 30% had a private health insurance.

Conclusions: While a basic level of awareness is present, that itself does not lead to subscription to an insurance plan. The public should be exposed to the newer, more affordable government led plans which best suit their financial situations.

Keywords: Awareness, Health insurance, Subscription

INTRODUCTION

Health insurance is a scheme in which the subscriber is entitled to financial aid whilst availing health services. The concept of accident insurance first came about in 1850 in the US, which then evolved into the modern concept of health insurance by early 20th century. India first introduced health insurance as a part of the ESI Act in 1948. Since then many Government led public health schemes have been introduced targeting different groups. But with a population of 1.38 billion, insurance coverage and availability of government facilities to its citizens,

have been limited.² Many citizens also avail private health insurance schemes. Even then, India has a health insurance penetration rate of only about 29%.³ The rising costs of health care makes enrolment to a health insurance scheme almost mandatory. Because so few Indians now carry health insurance, India has one of the world's highest rates of out-of-pocket spending in health care. According to data from World Health Organization (WHO), the public sector in India spent just 1.46% of gross domestic product (GDP) on health care, ranking 187th among 194 countries.⁴ Out of pocket expenditure can have disastrous effects on many, especially those of the poorer strata. Some unexpected health emergencies

can even place those unprepared into 'health expenditure induced poverty'. A national survey carried out in the year 1999 found that an additional 37 million Indians were pushed into poverty every year due to health care costs, i.e. 12% increase in poverty levels. ⁵A study done in Rajasthan showed that medical costs were one of the top 3 reasons for poverty. ⁶

Kerala is a state that has shown exemplary improvements in the field of healthcare. Kerala, in the year 2016, has an infant mortality rate of 10 against India's 34.7 The average lifespan of a keralite male is 75 years against the national average of 64 years.8 The educational trends in Kerala are also quite impressive with Kerala boasting 100% literacy rate. It is safe to say the Kerala is a benchmark against which other states can be compared. Although mortality rates are at an all time low in Kerala, its morbidity rates are rising. Prevalence of chronic diseases, that can severely affect a person's quality of life, are high. Higher lifespans mean that geriatric problems are also rising. Kerala has the greatest number of palliative care centers in India. All this can mean that the trend of long term health spending is at a rise in Kerala, rather than acute health emergencies. Such trends in Health and healthcare make Kerala, an ideal candidate for widespread use of health insurance, as well as, the perfect setting for such a study.

METHODS

This is a cross sectional study set in a tertiary care center in Kerala, South India. The study population consisted of in-patients admitted in the hospital and bystanders during the study period July 2019 to September 2019. The sample size was calculated from a similar study done in Karnataka which found awareness to be 64%. 10 Using the equation 4PQ/D², (where P=64, Q= 100-P i.e. 36, D= 20% of P i.e. 12.8), sample size was found to be 58. Sampling technique was convenience sampling. Data was collected from the 58 in-patients and bystanders using an interviewer administered semi-structured questionnaire. Patients who were admitted in the hospital as well as bystanders were included in the study. Those who were younger than 18 years of age and those who did not consent to the study were excluded. Institutional ethics committee clearance was obtained prior to carrying out the study. Informed consent was obtained from the participants. Confidentiality was maintained throughout the study. Data was entered into Excel sheet. Statistical software SPSS version 23 was used to analyze the data. The appropriate statistical method such as Chi-Square was used.

RESULTS

The sample population consisted of slightly more females (55.2%). Most of them come from a rural set up (69%). 43% individuals are either below poverty line according to their ration card or do not possess a ration card while the remaining 57% are above poverty line.

Table 1: Respondent profile.

Gender	Frequency	Percentage
Male	26	44.8
Female	32	55.2
Residence		
Rural	40	69
Urban	18	31
Ration Card		
None	2	3.4
Yellow	1	1.7
Pink	22	37.9
White	10	17.2
Blue	23	39.7

Table 2: Respondent educational qualifications.

Education	Frequency	Percentage
Primary	3	5.2
Secondary	21	36.2
Higher secondary	14	24.1
College	17	29.3
Post graduate	2	3.4
Professional	1	1.7

Most of them have received a secondary education (36.2%) or higher (58.5%) (Table 2).

Table 3: Respondent occupation.

Occupation	Frequency	Percentage
Professional	5	8.6
Clerk	5	8.6
Teacher	1	1.7
Housewife	19	32.8
Skilled worker	10	17.2
Unskilled worker	10	17.2
Student	3	5.2
Unemployed	4	6.9
Retired	1	1.7

Table 4: Awareness about health insurance programs.

Response	Frequency	Percentage
Aware	52	89.7
Not aware	6	10.3
Total	58	100

Table 5: Subscription to a health insurance program.

Response	Frequency	Percentage
Subscribed	30	51.7
Not subscribed	28	47.3
Total	58	100

There were 32.8% of this study population formed by housewives, 5.2% students, 6.9% unemployed and 1.7% were retired. 53.3% of the study population was earning (Table 3).

Total 52 out of the 58 patients (i. e. 89.7%) were aware of the concept of health insurance (Table 4).

Out of the 52 patients who were aware of health insurance only 30 had subscribed to a health insurance plan (i.e. 51.7% of the total respondents) (Table 5).

Table 6: Type of insurance subscribed.

Insurance	Frequency	Percentage
Government insurance	21	70
Private insurance	9	30
Total	30	100

Total 21 out of 30 (70%) individuals were subscribed to a government insurance scheme, while the rest of the insured individuals (30%) chose to subscribe to a private insurance plan (Table 6).

The most frequent answer to not subscribing is that they are not aware (39.3%) of either the concept/availability of health insurance or the formalities to subscribe. The next most frequent answer being that they do not feel the need to subscribe/unreliable (35.7%) in spite of being hospitalized. This may be due to a misconception that health insurance plans are just another way to lose money or due to a previous experience of being denied assistance during a medical need. 17.9% individuals feel that the premiums were unaffordable. Cumbersome formalities for subscription as a barrier was also noted in 3.6% individuals. Another 3.6% individuals have not subscribed to health insurance as they do not know anyone else who has (Figure 1).

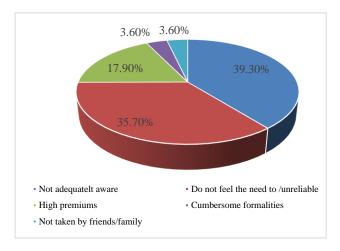


Figure 1: Barriers to subscription.

Total 17 out of 28 non-subscribers (i.e. 60.7%) are considering enrolment into a health insurance plan following this study. While the rest of the respondents do

not think they will enroll into a health insurance scheme in the future.

DISCUSSION

WHO marks 12th December as Universal Health Coverage day, to remind world leaders and citizens of the world to deliver on promises to achieve universal health coverage.¹¹ Health insurance is a very relevant topic that all citizens must have an informed opinion on, at the least.

The national average of insurance coverage is 29% ³ whereas our study found the coverage of inpatients and bystanders of a privately-owned tertiary care center in Kerala to be 51.7%. While Kerala might be ahead of the national average, it still lags behind the insurance coverage of states like Andhra Pradesh (75%). This is quite unexpected keeping in mind the higher literacy rate of the population of Kerala and the higher incidence of morbidity in Kerala.

A study based in Punjab found awareness of health insurance to be 91.3% but coverage was only 19.4%. The main barrier to enrolment was the unaffordable premiums. The most frequent reason for non enrolment in case of this study population was found to be inadequate awareness. Which means a high number of patients are getting treatment at a privately owned hospital and incurring medical bills which are completed borne out of pocket and are not aware of the possibility of having alternate means of affording medical treatment.

This study finds that, while a majority of the study population subscribes to a Government insurance scheme (70%), a sizable chunk does avail the services of privately owned insurance companies (30%). Whereas a study conducted in Karnataka in the year 2015 found that 92.6% of those subscribed to health insurance had a Government insurance plan. Relatively higher preference for private insurance maybe seen in Kerala as most people prefer visiting a private hospital. Private insurance providers may be more flexible when it comes to the choice of hospitals covered by the policy.

CONCLUSION

Kerala is a forerunner in many aspects but its health insurance coverage has room for improvement. This study has pointed out some of the issues with health insurance coverage in the state, upon which effective measures can be taken. The issues can be easily overcome with widespread awareness. The awareness programs could be integrated into government led ventures like Anganwadis where mothers can be given classes for financial literacy as well. As some of the most prevalent reasons for non-subscription are unawareness and that health insurance seems non essential, some real life examples of healthcare induced poverty maybe included into the awareness sessions along with instances where

people have escaped the same due to subscription to health insurance. Awareness classes may also introduce them to some public and private insurance plans that may be best suited for their financial backgrounds and healthcare needs. Once there is complete awareness of health insurance and its need, the country can move into the next phase, i.e. widespread subscription. This can be seen in countries like Japan where it is mandatory by law for all its citizens to be subscribed to a health insurance plan. The government can regulate the cost of premiums of health insurance schemes, as well as, healthcare costs such that it is affordable by all citizens in case they have to pay a proportion of the bill out of pocket.

This study has several limitations. As this study was conducted in a private hospital setting, the findings may be showing a higher level of subscription to health insurance and may not be a true reflection of the general public. As the lower strata of society cannot afford treatment at a private hospital, this study may have missed those from the lower socio economic class.

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