

HEALTH INSURANCE AND ITS NEED IN INDIA - AN EMPIRICAL ANALYSIS

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Abstract :

The dire need for health insurance and its importance cannot ever be magnified. In a country like India, where health is not exactly at its peak, the need for health insurance is even greater. This paper runs through a brief background of the status of insurance itself in India, continues with the status of the need for health Insurance in India and then discovers from fifty two respondents their opinion on four statements as regards health insurance. The reliability analysis is followed by the Factor Analysis which selects two more prominent factors as compared with the other two. The findings simply mirror the opinion of the respondents.

Key words: Health Insurance.

1.1 Introduction to health insurance:

Health insurance is drawing greater consideration in low- and middle-income nations as a means for refining health care application and defending homes against poverty from self-earned outflows. The health funding machinery was established to thwart the damaging results of consumer levies announced in the 1980s, which currently seem to hinder health care consumption, chiefly for side lined inhabitants, and occasionally result in disastrous health out flows. The World Health Organization (WHO) contemplates health insurance as hopeful ways for realizing worldwide health-care attention. The influence of health insurance in underdeveloped nations has not been written down fully. (Spaan, et al, 20102)

The Constitution of India consigns the accountability for different problems to the central government, to an individual State or together. Insurance is a central job. The Constitution assigns absorption, guidelines and closing up of trading corporations, including banking, insurance and financial corporations, but not including cooperative societies to the Central Government. The state is involved in the absorption, guidelines and closing up of trading corporations, including trade amalgamations, societal security and societal insurance, as well as non-profit organisations.

The insurance business was state-owned in India, life insurance by the year 1956 and overall insurance in 1973. In 1999, the insurance industry was resurrected for rivalry with the entrance of private corporations, when



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the establishment of the Insurance Regulatory and Development Authority (IRDA) happened through an Act of Parliament. Formulated by the Central government, the IRDA has wide spread obligations, influencers and capabilities to control, encourage and enable development of the insurance and re-insurance business, wherein licensing, prescribed circumstances, standards for credentials of management and intercessors, working activities and direction. IRDA also has the power to take off inquiries and inspect licensed insurance Institutions any time it thinks necessary, and may withdraw the registration or shut down an insurance Company.

The central government is permitted to sidestep the IRDA in policy associated matters (Section 18, IRDA Act 1999) and may overtake IRDA under several situations, e.g., in the interest of the general public (Section 19 IRDA Act 1999). Health insurance is unsatisfactorily attended to. Total health premiums in the year 2002-2003 have been assessed at Rs. 12.8 billion (\$290 million). It was composed to become a Rs. 250 billion (\$5.7 billion) business by 2009 and treble itself in the next ten years, which means that by the next year, it will have grown into a Rs. 500 Billion sector, despite several impending obstacles. (Radermacher, et al, 2005)

Many under developed nations endorse health insurance that serves the community as a whole, for enabling better access to health maintenance for the down stricken. Health insurance is a risk-sharing tool that drops the self-earned price for medical upkeep at the time of acquisition by leveling medical outflows across persons and intervals (Barr 1992). Studies accompanied in low-income contexts have found that families with entree to insurance can spread their financial risk and

hypothetically increase income heights (Townsend 1995).

This proposes that eliminating the poor from health insurance subsidizes to inequality in admittance to care and negatively affect health status. These are imperative health policy apprehensions in many nations (Wagstaff et al. 2001).

1.2 Impact of health insurance schemes :

The actual impression of health insurance on the superiority of maintenance and social enablement, is quite small. Therefore the assumptions gathered in this context are also minimal. yet, these spheres are of serious prominence to the presentation of health insurance patterns. It has been generally agreed that health insurance, augmented the consumption configurations and thereby created income amplification, thus enhancing the worth of upkeep, and, in turn, leading to advanced health insurance membership. Exploration is necessary to discover this conjoint bolstering. The deficiency of substantiation on the bearing of CBHI schemes on social enablement is not proven yet. Though such schemes have huge capabilities to clearly encompass society in the business of health amenities, whether this really occurs is an idea that requires greater thoughtfulness. (Spaan, et al, 2010)

1.3 Suggestions from Insurance Companies:

Insurance companies have given a few suggestions to generate a suitable health insurance

Framework in India:

- Build a dais for communication.
- Discover all the functional market places and introduce the correct product mix through value added advantages

- Present independent health insurance directives unique from life and non-life. Health care providers need to be in an approved panel, with regulated prices.
- Have compulsory health insurance upto Rs. 100,000 (\$2,273) for every Indian.
- Find the health care cost index for India.
- The Below Poverty Line (BPL) and villagers should have insurance with suitable subsidies.
- Workshops on health insurance should be organised
- Expert and specific health insurance companies must be encouraged.
- Announce family treatment- based insurance schemes.(Adapted from FICCI Survey 2004)

1.4 Role of the State :

The Employee State Insurance Scheme (ESIS) originated in 1948 is a source of recognized insurance, operational as a community health insurance arrangement. ESIS is mandatory in some sectors wherever the number of employees are above a specified number. The organization is funded by offerings composed of a certain percentage of the total income. Personnel pay 1.75% of their earnings and the management pays 4.75%. The whole arrangement is subsidized by the respective Governments.

Looked after by a state organization, the Employees State Insurance Corporation (ESIC) pattern provides coverage for sickness, maternity, infirmity and demise from job related calamities.

ESIS has a web of hospitals and doctors enrolled in the system. The amenities are a collection preventive and counselors ranging

from actual treatments to after treatment services. ESIS has a wide coverage in all Indian States. Nonetheless, ESIS is not unchallenged. Corporations escape the mandatory insurance or complement it with their specific facility proposals (Ellis / Alam / Gupta 2000).

The organization is answerable for administration flaws and lowly amenity delivery. ESIS hospitals also lack in their offerings. For the central government personnel and their wards, health care services are delivered through the Central Government Health Scheme (CGHS). Announced in 1954, the arrangement is delivered by the administration for its personnel, whereby employees obtain health facilities without salary deductions for the same. (Gumber / Kulkarni 2000). A total of 4.5 million persons are shielded by the CGHS. (Ellis / Alam / Gupta 2000). Like ESIS, this arrangement is also accused for insufficient and ineffective amenities. (Radermacher, et al, 2005)

1.5 Status in India : Many Indians are below the poverty line, and do not have an awareness and/or contact with financial services. Growing insurance consciousness in such an environment, is a big experiment but an essential stride. Medical insurance necessitates to nurture greatly in this direction because medical expenses and consciousness are growing. The government's current push on financial inclusion proclaims a significant difference. The declaration of reasonable the reasonable fusion defined benefit (DB) insurance plan can quicken inclusion.

Computer expertise, can join joins all Indians financially and has developed due to the advancement of three mass access channels -- mobile, Aadhar and Jan Dhan Yojana. The National Payment Corporation of India -- such as Rupay cards, the Immediate Payment

System (IMPS), and all else, may significantly increase money dealings in the right systems. Expertise in all sectors will decrease the charges of circulation, education and business dispensation. Generating insurance responsiveness will be the important task to attack. Being an impulse produce, insurance desires operative and simple distribution networks and tailored communication. Traditionally, insurance in India has been directed at the salaried class, yet, attentive administration exertions to progress financial inclusion may be an enhancer and thereby a facilitate or for the insurance industry.

CRISIL defines financial inclusion as “the extent of access by all sections of society to formal financial services, such as credit, deposit, insurance and pension services.” For India to be such an economy there is a necessity to have simple and not complex bureaucratic procedures for the uneducated to have no fear to approach financial institutions for financial assistance. Financial inclusion is required, because financial inclusion leads to community presence.

An Insurance Information Bureau summary that reads as, ‘Spread of life insurance agents across locations in India’ discloses that 63 of the bottom 120 districts were at the lowest of CRISIL Inclusix as per insurance inclusion. This creates a straight correlation between banking presence and insurance approach ability. Therefore an insurance index needs to be calculated and it should deliver granular, national-to-district level viewpoints to support policy makers, regulators, bankers and insurers to attain diffusion objectives. (Manish Jaiswal, Business head, CRISIL Research)

1.6 Literature review regarding health insurance : By means of relevant records from the UK, Propper (1993) scrutinized the

mandate for private health insurance that shields maintenance in a reserved segment that survives side by side a community health care system which supplies free care to patients. She discovers that private health insurance staffing can be clarified by demographics, revenue and the superiority of upkeep in the public and private sector. Lower income families may select different tools to battle financial issues, like income expansion, credit and hoarding money. (Besley 1995). In recent circumstances of reductions in public spending and an increasing consciousness of scarce resources, the representation of the right to health means an unique consideration of who belongs to the family and needs to be cared for. (Fassin, 2012). Selected families have entrée to indigenous community establishments such as a rice bank, a homemaker or rotating savings accounts. (Townsend 1995). Money-lenders, properties and credit marketplaces are some sources of funding used. Enhanced female and child labour contribution are also some additional sources of funding. (Dercon 2000). A strong sense of morality is involved when the decisions of who may be provided health care is being assessed. (Castañeda, 2012; Gottlieb, Filc, & Davidovitch, 2012; Horton, 2004 ; Rosenthal, 2007; Willen, 2011, 2012).

Information from the US aided Phelps (1973) to conclude that the level of income is correlated to the demand for health insurance. Other variables could be the level of education. Using the technique of analyzing data through the time-series, Phelps represents a positive relationship between insurance demand, and consumer fee levels, and with greater mean level of illness; and an egative connotation between insurance demand and premium level (Phelps 1973).

Results from such readings are constant with user model, suggesting that insurance is a

regular product. Families can get themselves insured by saving for a rainy day maybe in educating a child or buying cattle. (Townsend 1995).

Manning and Marquis (1996) appraised the level of demand for insurance by totaling the worth of medical care to the worth of risk evaded in the buyer's utility purpose. In the RAND study, contributors were to choose from imaginary insurance strategies with unlike co-insurance rates. Results submit that registration in an imaginary insurance is not exaggerated by the income of the family and premium stages but rather by the predictable revenue persons will obtain once they are ill. (Manning and Marquis 1996).

1.7 Research Methodology : The aim of this article is to present the conclusions of a survey targeted at finding the benefits of health insurance among certain respondents in Bangalore City. A questionnaire was administered to 57 respondents working in various Companies with a base in Bangalore City; since Bangalore City is a good representative of the country as a whole. The stratified method of sampling was used first, followed by random sampling. The questionnaire used here has been a part of a larger questionnaire regarding health insurance in the rural area of Karnataka.

The following statements were examined:

1. Health insurance is absolutely necessary in the modern day world.
2. It is not safe to ignore health insurance, and not take up any health insurance schemes.
3. Should the Government play an active role in providing health insurance comprehensively for all citizens.

4. The Government of our country is not giving sufficient support for health insurance for the common man.

1.8 Analysis and Findings:

Respondent profile: Thirty seven of the respondents were male and twenty were female. Ten respondents were below 30 years of age, twenty respondents were between 30 and 39 years of age, 21 respondents were between 40 and 49 years of age, and six respondents were above the age of 50 years. Fifteen respondents were not Degree holders, 34 were Degree holders, eight held a post Graduate Degree among the respondents. Thirty five respondents were from the manufacturing sector and twenty two were from the services sector. Six respondents had a work experience of less than ten years, twenty five respondents had an experience between 10 and 20 years, twenty one respondents had an experience 20 and 30 years and five respondents had an experience of greater than five years. The profile of the respondents given above signifies the representativeness of the samples chosen for the study.

The analysis regarding the study :

The Cronbach's Alpha for the five statements, is 0.835. A value of Alpha above 0.70 is deliberated as reliable, and therefore the data collected herein, is considered as reliable for additional analysis.

The values greater than 0.60, meaning closer to value 1, of the Kaiser-Meyer-Olkin Measure of Sampling Adequacy indicate that the collected data is suitable to be analysed through the factor analysis, which was conducted later. The KMO Bartlett's test indicated a value of 0.858.

The factor analysis extracted two statements, which are,

1. Health insurance is absolutely necessary in the modern day world.
2. The Government of our country is not giving sufficient support in terms of health insurance for the common man.

Findings : The respondents felt that health insurance is mandatory in modern circumstances and expect greater support from the Government towards insuring the common man in health.

1.9 Recommendations: Since the respondents who represent the Indian populace have felt the need for mandatory health insurance, more efforts in providing health insurance may be made in the country. This requires more efforts from the health insurance providers in terms of more schemes of health insurance plans. Further, the government is required to support health insurance more, whether in offering government based health insurance schemes or in supporting the health insurance provider Companies through suitable subsidies in their efforts.

1.10 Concluding remarks : Healthiness improvement constructs a novel nation wide example of a global like exposure, comprising provision for families with inadequate sources of funding. Decades of planning and subsequent implementation may be required to enlarge coverage and convert the health care

distribution network. The onus is on the administration of the nation, guarantors, hospitals and further such Institutions to commence the mega occupation of executing such required changes. (Ku, 2010)

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