HEALTH INSURANCE: "IDENTIFY IN KNOWLEDGE LEVEL OF EMPLOYEE OF URBAN AGARTALA."

PALLAB DEBNATH,
MAHARAJA BIR BIKRAM COLLEGE, Department of STATISTICS

DR. SANDIP CHAKRABORTY

M.Sc.(statistics), Ph.D.

Associate professor of

Department of Statistics, MAHARAJA BIR BIKRAM COLLEGE

INTRODUCTION

Insurance is a means of protection from financial loss. It is a form of risk management primarily used to hedge against the risk of a contingent, uncertain loss.

An entity which provides insurance is known as an insurer, insurance company, insurance carrier or underwriter. A person or entity who buys insurance is known as an insured or policyholder. The insurance transaction involves the insured assuming a guaranteed and known relatively small loss in the form of payment to the insurer in exchange for the insurer's promise to compensate the insured in the event of a covered loss. The loss may or may not be financial, but it must be reducible to financial terms, and usually involves something in which the insured has an insurable interest established by ownership, possession, or preexisting relationship.

Terrorism insurance provides protection against any loss or damage caused by terrorist activities. In the United States in the wake of 9/11, the Terrorism Risk Insurance Act 2002 (TRIA) set up a federal program providing a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism. The program was extended until the end of 2014 by the Terrorism Risk Insurance Program Reauthorization Act 2007 (TRIPRA).

Health insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons. By estimating the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance

structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care 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. According to the Health Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury.

How many accidents we need to realize that we need health cover? It takes just one visit to hospital to make us realize how vulnerable we are, every passing second. For the rich as well as poor, male as well as female and young as well as old, being diagnosed with an illness and having the need to be hospitalized can be a tough ordeal. cardiac problems, diabetes, stroke, renal failure, cancer, major pulmonary diseases, problems with nervous system – the list of lifestyle diseases just seem to get longer and more common these days. Thankfully there are more specialty hospitals and specialist doctors but all that comes at a cost. The super-rich can afford such costs, but what about the average middle-class family and poor peoples. For an illness they also requirehospitalization or surgery, but the cost can easily touch the skyline. A health insurance policy can help you get out of such situations.

Briefly, health Insurance is an insurance policy that ensures that you get cashless treatment or expense reimbursement, in case you fall ill. A health insurance policy reimburses the insured for medical and surgical expenses arising from an illness or injury that leads to hospitalization.

The concept of health insurance was proposed in 1694 by Hugh the elder chamberlen from the petterchamberlen family. In the late 19th century, “accident insurance” being available, which operated much like modern disability insurance.

Insurance in India had its origins in the United Kingdom with the establishment of British firm, the oriental life insurance company in 1818 in Calcutta, followed by the Bombay life insurance company in 1823. Indians were charged an extra premium of up to 20% as compared to the British. The first stationary measure in Indiato regulate the life insurance business was in 1912 with the passing of the Indian life assurance companies Act, 1912 (“Act of 1912”). Non-life insurance passing as regulated in 1938 through the passing of the insurance Act, 1938 (“Act of 1938”). At last insurance

regulatory authority set up by the central government through regulation no. 17(2)/ 94-ins-V dated the 3rd January, 1996.

Now, insurance companies in India providing policies like Hospitalization, Family floater health insurance, Pre-exiting disease cover plan,senior citizen health insurance, maternity health insurance, Hospital daily cash benefit plans, Critical illness plan, Proactive plans, Disease specific special plans.

The best time to avail a health insurance plan is when the insured is still in a good physical condition. The normal logic among young people is that since they are rarely afflicted by physical ailments they do not need such a plan. In reality nobody can be sure of a life fully free of such issues. Normally as someone gets older the probers increaseand the possibility of some major disease are always there. A problem with trying to get a medical insurance during old age is not actually possible because premium is often high. So, the one-way solution of this certain problem is, do health insurance in time and get rid of such money problems.

Review of Literature

When a person experiences a bad shock to health, their medical expenses typically rise and their contribution to household income and home production (e.g. cooking or childcare) declines (e.g. Wagstaff and Doorslaer, 2003; Gertler, Levine &Moretti, 2003; Gertler and Gruber, 2002). According to the WHO, each year, approximately 150 million people experience financial catastrophe, meaning they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs. (WHO Factsheet N°320, 2007) Low income and high medical expenses can also lead to debt, sale of assets, and removal of children from school, especially in poor nations. A short-term health shock can thus contribute to long-term poverty (e.g. Van Damme et al, 2004; Annear et al, 2006). At the same time, because households often cannot borrow easily, they may instead forego high-value care. When they do access care it will often be of low quality (Das, Hammer and Leonard, 2008), which can lead to poor health outcomes. Theory suggests that health insurance can address some of these problems.

By covering the cost of care after a health shock, insurance can help to smooth

consumption, reduce asset sales and new debt, increase the quantity and quality of care sought, and can improve health outcomes. Unfortunately, rigorous evidence on the impact of insurance is scarce, and there are even fewer studies on the effects of insurance in developing countries. One reason for the lack of evidence is that it is difficult to find a valid control group for the insured. We cannot simply compare the outcomes of insured and uninsured households, since health insurance status is typicallystrongly correlated with other household characteristics. For example, rich and well-educated households typically have both better health (Asfaw, 2003) and better health insurance coverage (Jutting, 2004; Cameron and Trivedi, 1991), but the positive correlation between health and insurance status tells us nothing about the impact of insurance. On the other hand, those in poor health may be more likely to pay for health insurance (Cutler and Rebar, 1998; Ellis, 1989), but finding that the insured tend to be sicker would not imply that insurance causes illness. Below we review past evidence on the impacts of health insurance, focusing on studies where health insurance status is plausibly exogenous, or where studies have attempted to eliminate bias due to self-selection. A majority of the rigorous studies are based on United States data. W The present empirical based study was conducted with an objective to understand the growth of health insurance in Indian health Insurance Industry and to measure the customer awareness, satisfaction and perception towards buying health insurance products from insurers. The various concepts related to health insurance have been discussed in this paper. Health insurance is accelerating the growth of Insurance business, decrease cost, Low awareness of health insurance among customers. This paper concludes that there is a tremendous scope and growth opportunity available for health insurance in future in the Indian Insurance market. (Ramamurthy and Dr. SenthilKumar ,2013) People are not purchasing the health insurance because of low awareness, lack of finance and high premium charges in India. (Panchal.N ,2013) The rural population are more vulnerable to risks such as illness, injury, accident and death because of their social and economic situation. There is need to provide financial protection to poor families for the same. Health insurance could be a way of removing the financial barriers and improving accessibility to quality medical care by the poor and also an effective social security mechanism. Awareness regarding

health insurance is poor; therefore, awareness creation is needed. Education, socio-economic status and occupation were favorable determinants for opting health insurance. (Choudhary Mahesh Kumar. L,2013e follow Levy and Meltzer (2004, 2008) in both our choice of U.S. studies and in our main conclusions.

OBJECTIVE OF THE STUDY

The purpose of this study is to find out the knowledge level of the employee of urban Agartala. Health Insurance is viable solution to ensure access to basic Health care services to the masses, the number of people with Health Insurance coverage is low in India. There are some structural issues with system. The present study is an attempt to find the cause for low Health Insurance coverage. The study addresses the awareness and buying pattern of Health Insurance and scope of the private Health Insurance companies schemes. Given the growing interest on the importance of Health Insurance, the outcome of the present study is considered useful in guiding policy making and to help to knowing the complete process of Health Insurance.

OBJECTIVE OF THE STUDY

- To assess the individual knowledge level of employee of urban Agartala about HealthInsurance.
- To know the preference of individual regarding health insurance.

.

Research methodology

D.Slesinger and M. Stephenson in the Encyclopedia of Social Sciences define the research as "the manipulation of things, concepts or symbols for the purpose of generalizing to extend, correct or verify knowledge, whether that knowledge aids in construction of theory or in the practice of an art." In short, the research for knowledge through objective and systematic method of finding solution to a problem is research. The systematic approach concerning generalization and the formulation of a theory is also research. Research design provides the glue that the research project together. A designed is used to structure the research to show how all of the major parts of the research project, the sample or group measurement, treatments and methods of assignment work to gather try to central research question. Hence, it is clear that research design is the blueprint for

researcher it lays down the methodology involved in the collection of information and answering at meaningful conclusion from the same. This classification is made according to the objective of the research, in some causes the research will fall in to one of this category but in other cases research will fall in to two categories.

- **At first, the municipal area of Agartala was selected and sample size was drawn.**
- **Questionnaire for collecting data for was prepared.**
- **By stratified purposeful sampling, the data was collected.**
- **All collected data are primary data which were collected by face to face questioning.**
- **Then the data was analyzedusingstatistical package for social sciences (IBM SPSS 23).**
- **Forgetting results, Univariate analysis and Bi-variate analysis (chi-square test)were conducted.**

Socio economic indicator

Land area	0.0000395% of world area and 0.00179% of India area.
Burden of disease (%)	10% of global disease burden
Population	0.00525% of world population and 0.0296% of India population
Urban: Rural	100:0
Literacy rate (%)	94.45% people are literate.
Sanitation (%)	95% sanitized
Safe drinking water supply (%)	67.5% drinking water is safe.
Poverty (%)	Below the poverty line 44.9%
sex ratio	999 females per 1000 male
Forest Cover (% of geographical area)	55% area forest covered

Table: socio economic information.

Demographic changes	2009	2010	2011	2012	2016
Life expectancy	Female (71), Male (64)	Female (71), Male (64)	Female (71), Male (65.8)	Female (71), Male (66)	Female (71.5), Male (66.3)
Crude birth rate	15.4	14.5	14.6	13.7	13.7
Crude death rate	4.6	4.7	4.9	4.7	4.6
Infant mortality rate	31	27	29	28	28

Table: Demographic information.

Background characteristics of the studied population

Out of collected information, in a total of 399 samples, 135 samplewere found to be employee of urban Agartala which were analyzed thoroughly.

GENDER	PERCENT	AGE	PERCENT	MARITAL STATUS	PERCENT
MALE	67.4	UPTO 35	25.9	MARRIED	85.2
FEMALE	32.6	36 AND ABOVE	74.1	UNMARRIED	14.8

Table: percentage of my collected data.

QUALIFICATION	PERCENT	INCOME	PERCENT
UPTO MATRIC	18.5	UPTO 20000	40.7
HIGHER SECONDARY	11.1	20001 - 30000	15.6
GRADUATION	28.9	30001 AND ABOVE	43.7
PG AND ABOVE	41.5		

Table: percentage of my collected data.

Where, with respect to gender male and female were 67.4 and 32.6 percent respectively; with respect to marital status, 85.2 % were married whereas 14.8% were unmarried. When it comes to age perspective, 25.9% of the collected sample were found to be up to 35 years old and 74.1% people were 36 and above.

The qualification levels revealed that 18.5% were qualified up to matric level and 11.1% were found to be up to higher secondary level and in higher educations, 28.9% were graduated and 41.5% were post graduated and above.

From the perspective of salary, 40.7% were having salary up to 20000 and 15.6% had salary of the scale, 20001 to 30000 and 43.7% of the sample have 30001 and above level of salary.

Results and discussion

The findings were diagrammatically represented in graphs:

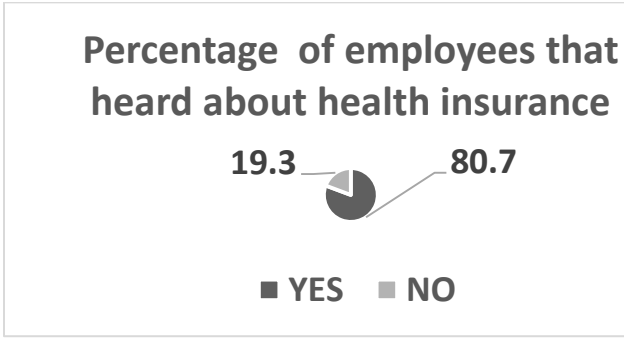

Chart 1: pie chart showing percentage of employees that heard and have not heard about health insurance.

After analyzing the collected data, it was found that 80.7% of employees heard about health insurance and 19.3 % had no idea about it.

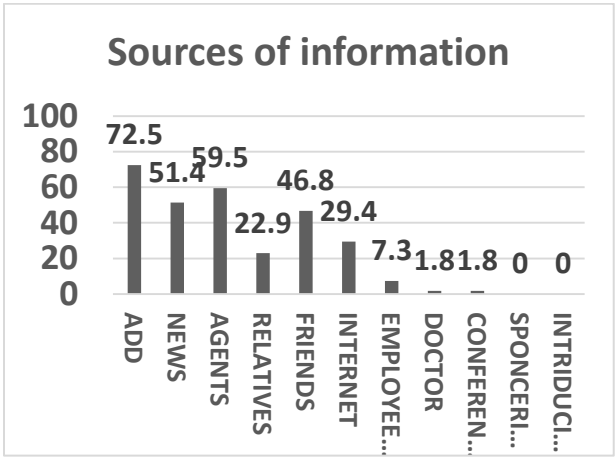

Chart 2: Bar diagram showing contribution of different sources of information about health insurance.

After analysis of the collected data, it was revealed that maximum contribution as source of information of health insurance, advertisement processes had 72.5% covered and right next to it, 59.5% employee were covered by agents, 51.4% were approached through newspapers. Whereas, 46.8% and 22.9% came to know about health insurance from friends and relatives respectively.

29.4% of employees were found to have known about health insurance from virtual media (internet). Whereas only 7.3% of employee were approached by employees of the companies and only 1.8% were approached through doctors and several conferences.

Sponsoring events by insurance companies and introduction to savings linked insurance, had zero percent of approach line.

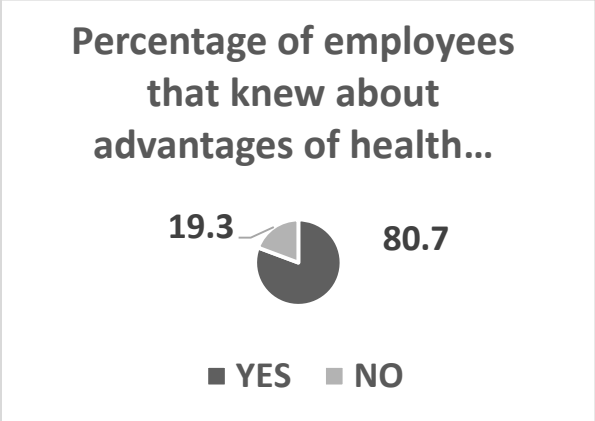

Chart 3: Pie chart showing Percentage of employees that knew about advantages of health insurance.

After analysis, it was found, among people who heard about health insurance, 80.7% people were aware of advantages of health insurance and 19.3% were totally unknown about it.

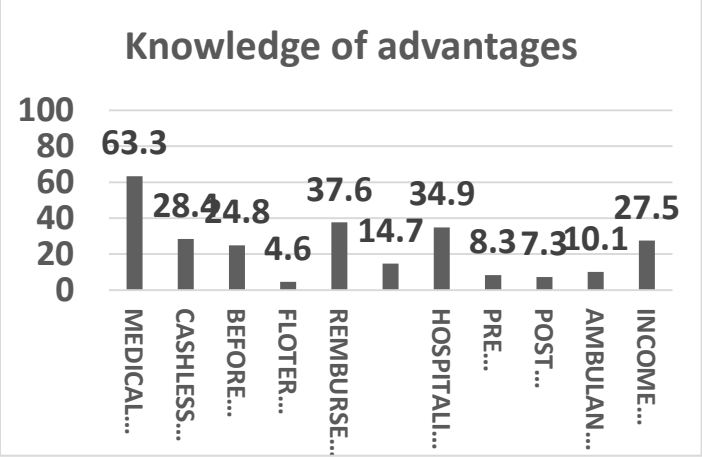

Chart 4: Bar diagram showing advantages of health insurance that are known to employees.

Regarding the collected data, maximum number of employee were aware about medical cash benefits (63.3%),Reimbursement for hospitalization due to illness/disease/surgery (37.6%), Hospitalization (34.9%), Cashless access (28.4%), Income tax benefits (27.5%), Before and after expenses (24.8%).

But less people were known about Reimbursement for domiciliary hospitalization (14.7%), Floater benefits (4.6%), pre and post hospitalization expanses (8.3%, 7.3%), ambulancecharges (10.1%).

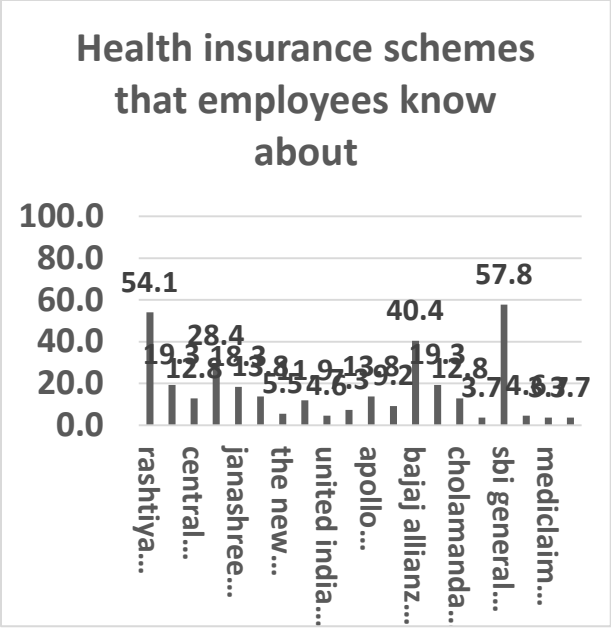

Chart 5: Bar diagram showing health insurance schemes that employees know about.

Regarding the collected data, schemes that maximum people had heard about were SBI general nsurance (57.8%), bajajallianz general insurance (40.4%), rashtriyaswasthyabimayojona (54.1%).

Where is employment state insurance schemes, aamaadmibimajoyona(LIC) , janashreebimayojona, and Tata AIG general insurance schemes had the percentage of 19.3%, 28.4%, 18.3%, 19.3% respectively, and the minimum percentage were covered by Central Government Health Scheme (12.8%), National Insurance Company Limited (13.8%), The New India Assurance Company Limited (5.5%), the Oriental Insurance Company Limited (11.9%), United India Insurance Company Limited (4.6%), Reliance general insurance company limited (4.6%), Apollo Munich Health Insurance Company Limited (13.8%), future general India Insurance Company Limited(9.2%). Cholamandalam MS general insurance company limited (12.8%), HDFC ergo general insurance company limited (3.7%), religare health insurance company limited (4.6%),mediclaims health insurance (3.7%) and others (3.7%).

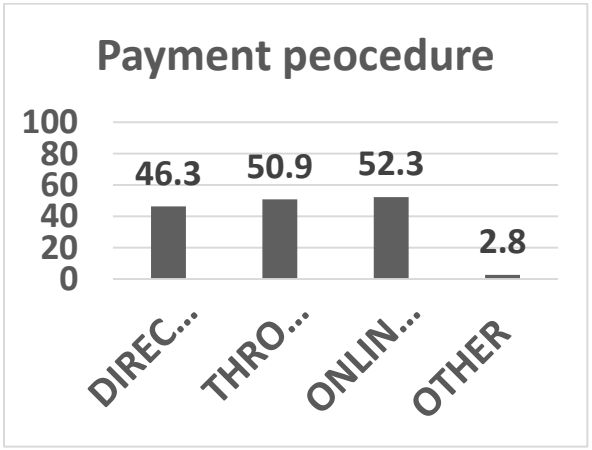

Chart 6: Bar diagram showing payment procedure that employee know about.

Maximum employee was seemed to have known about online payment services (52.3%) and following that percentage, 50.9% of employee were aware about payment through agents of different schemes. Whereas, 46.3% employee knew about direct cash method and 2.8% were aware about other processes.

To ensure their knowledge level about health insurance, they were examined over advantages, health insurance schemes and payment procedures. This test was conducted on 21 marks. In this test, the scores were classified like following,

0 - 7 = Low

8-11 = Medium

12 – 21 = high.

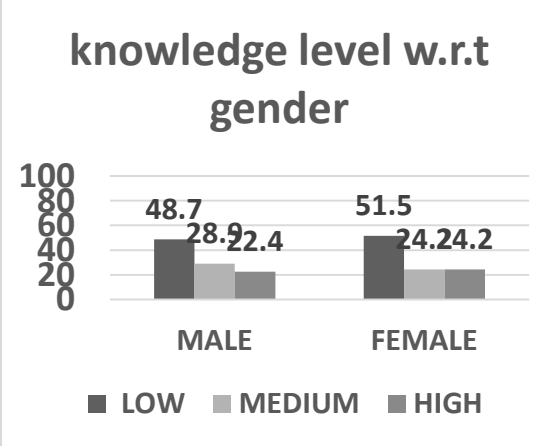

Chart 7: Multiple bar diagram showing knowledge level of employee w.r.t gender.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that ther3e was no significant effect of gender issues on knowledge level about health insurance.

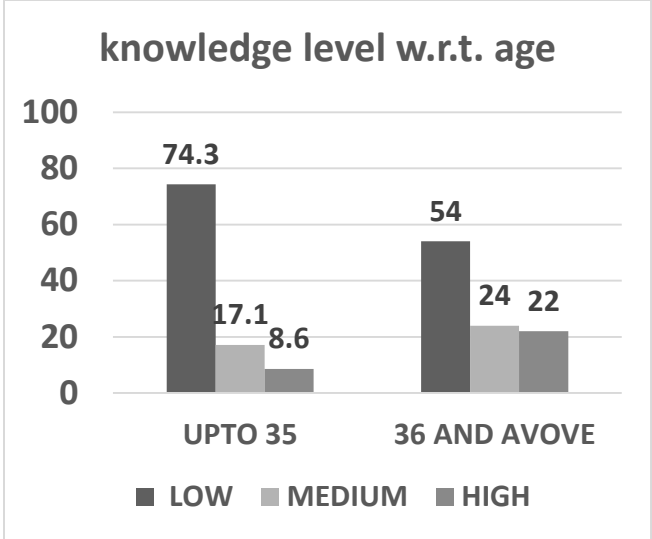

Chart 8: Multiple bar diagram showing knowledge level of employee w.r.t age.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that there were significant effects of age on knowledge level about health insurance.

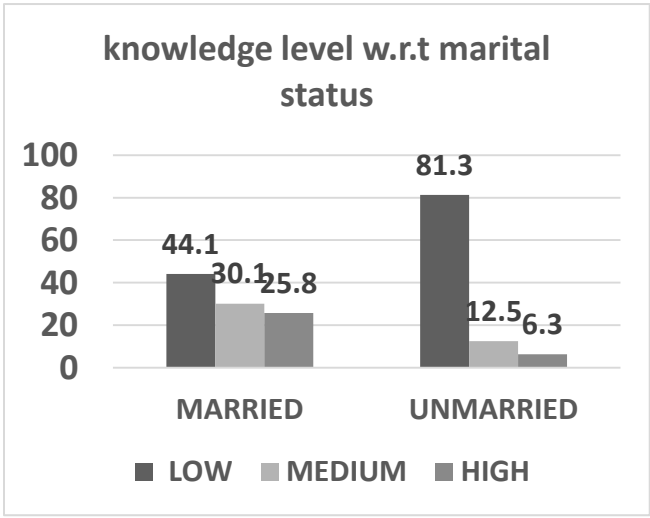

Chart 9: Multiple bar diagram showing knowledge level of employee w.r.t marital status.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that there were significant effects of marital status on knowledge level about health insurance.

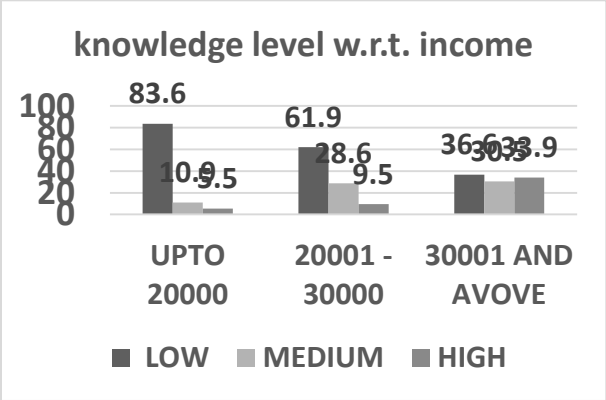

Chart 10: Multiple bar diagram showing knowledge level of employee w.r.t income.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that there were significant effects of income level on knowledge level about health insurance.

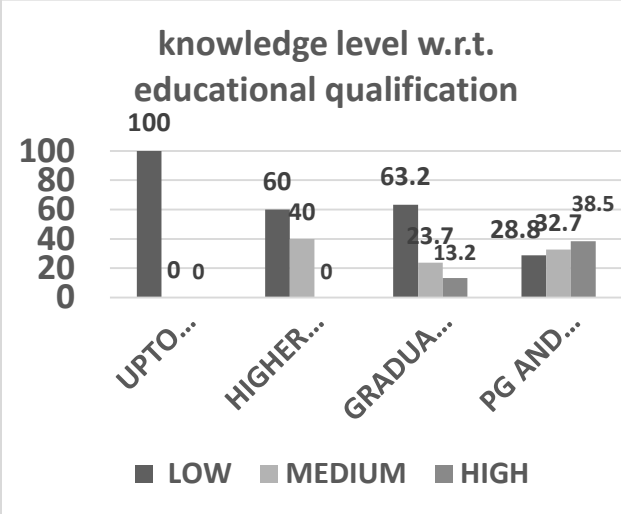

Chart 11: Multiple bar diagram showing knowledge level of employee w.r.t educational qualification.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that there were significant effects of educational qualification on knowledge level about health insurance.

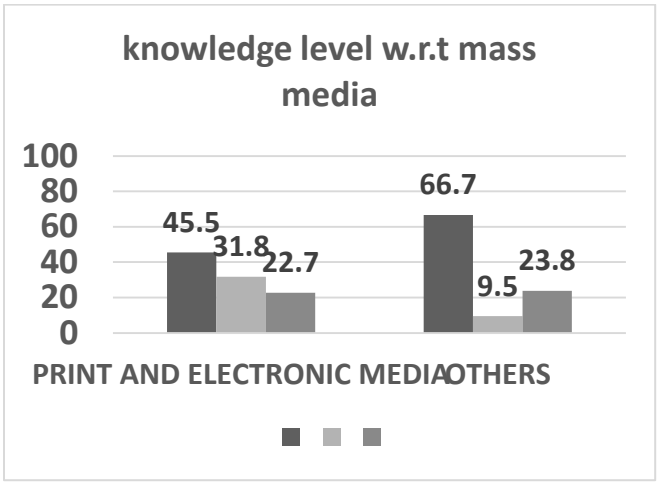

Chart 12: Multiple bar diagram showing knowledge level of employee w.r.t mass media.

After complementation of bivariate analysis (Chi-square test at 10% level of significance), it was found that there were significant effects of mass media on knowledge level about health insurance.

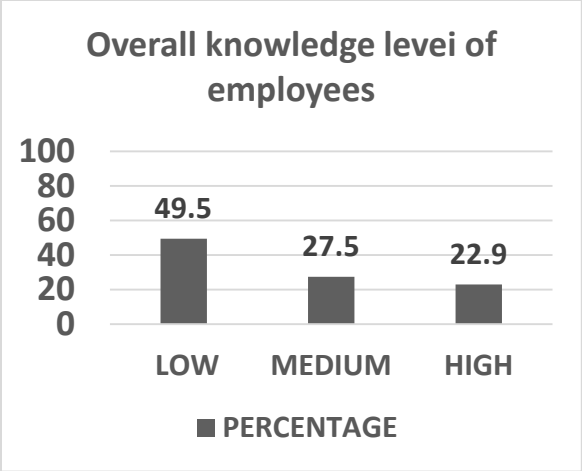

Chart 12: Multiple bar diagram showing knowledge level of employee w.r.t mass media.

In overall study, 49.5% of employees had low level knowledge about health insurance and 27.5% were mildly aware about it. Where only 22.9% were highly aware about health insurance.

Conclusion

Out of total 135 employee surveyed on, 80.7% heard about health insurance and 19.3% of them were totally uninformed about it. It may be because of lack of approach.

Maximum employees who knew about health insurance, had this from adds, news, agents, friends, relatives and internet. Whereas, there were very low percentage of approach through doctors, conferences, employee of company, and no approach was caused by sponsored events and introduction of savings linked account. So, it can be concluded that the companies and scheme officials should do more sponsored events and approach through doctors, their employees, conferences and should introduce savings linked account for the fulfillment of knowledge among the employees. Same goes in case of percentage of employees that were aware about advantages of it and their different schemes. Only proper approach to them can solve the gap.

Maximum number of employees wereintertester in payment through online methods. So, this particular method along with, other major methods like, through agents and direct cash/cheques should be implemented in all the schemes.

In the bivariate analysis, it was found that there was no significant effect of what gender the person belongs to on the knowledge level of health insurance, but there was significant effect of age, income, educational qualification, mass media, and marital status. With increasing level of age, educational qualification and salary, the knowledge about health insurance also increased. And in case of marital status, the married were much more aware about this than the unmarried ones. And maximum

high level of knowledge was seemed to be coming from print and electronic media.

Overall, the employees who are considered to be most educated personnel of the society, were found to be carrying much less high-level knowledge and maximum were carrying low level knowledge which is not a very good sign with respect to the developing surroundings. So, the scheme operating companies and organizations should try better ways of approach for increasing knowledge of health insurance among the employees. They should sponsor some events to attract the employees and should approach through social media which is ultimately an universal platform for spreading knowledge among people.

References

Presentation at one day workshop on ―Health Insurance in India. 'Indian Institute of Management, Ahemdabad Oct 30. 1999. Ramesh Bhat and Nishant Jain (2006), Factor affecting the demand for insurance in macro health insurance scheme, IIM Ahemdabad.

Jyitsnasethi and nishwanBhatia(Dec.2008):To study the Type of Health Insurance and Health Insurance scheme in India, PHI Learning pvt.ltd publication

Hima Gupta, (2007) "The role of insurance in health care management in India", International Journal of Health Care Quality Assurance, Vol. 20 Iss: 5, pp.379 – 391.

Hopkins S. &M.Kidd(1966). The determinants or the demand for private Health Insurance under Medicare.