ASSESSING THE DEMAND FOR HEALTH INSURANCE IN THE MIDDLE AND THE UPPER MIDDLE CLASS POPULATION OF MUMBAI AND THE EXTENT TO WHICH THE EXISTING SCHEMES SATISFY IT

BY

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TISS

Abstract

The study endeavors to delve into the issue of demand for Health Insurance. As a large potential for the Health Insurance market rests in the urban metropolis like Mumbai, it was considered imperative to know the nature of requirements and the need for Health Insurance. Thus, with an aim to assess the demand for Health Insurance the study explores all the related determinants and tries to establish a relationship between demand and these determinants. It further tries to examine as to what extent these demands are satisfied, or remain unsatisfied.

For the study, the middle class and upper middle class people were selected and interviewed to garner the required information. This information was analyzed to achieve the objectives of the study.

The study reveals that the demand for Health Insurance is income elastic and price inelastic to some extent, while numerous other factors have varying affect on the demand for Health Insurance.

In the light of expert opinions, some feasible recommendations are also made towards the end of the thesis.

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First and foremost, I would like to express my heartfelt thanks to the Institute for having given me this opportunity and my parents for their unflinching support.

I would like to express my indebtedness to Dr. C. A. K. Yesudian for being a constant source of inspiration for all of us.

From the core of my heart, I would like to thank my guide, my mentor, Dr. Alka Parikh, without whom this study could never have been accomplished. She played the role of a sculptor, molding and shaping my study by providing timely guidance, as and when required.

I would also like to express my gratitude to Dr. Sudhakar and the scores of officials from the Insurance Company and Third Party Administration, chosen for the study for providing all the prerequisite information needed for the study. Unfortunately, I cannot thank all of them publicly for the sake of maintaining confidentiality.

It would be unfair if I failed to express my gratitude to all my colleagues and faculty of HSS Department for their invaluable inputs.

Thanks to all the respondents who spared their invaluable time and responded to my Interviews.

Neeta S. Rao.

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Thanks to all the respondents who spared their invaluable time and responded to my Interviews.

Neeta S. Rao.

Dedicated to my parents - - - - - -
for their incontestable faith in me.

Chapter 1

Introduction

Human life is said to acquire its real economic value from six basic factors, namely- character, health, willingness to work, desire to make an adequate investment in the mind for career purposes, creative ability and determination and persistency to complete thoughtful economic programs. Health is most important among these, for without health none of the factors can generate economic goods. This drives to the economic admonition – "keep the healthy person healthy."

This introductory chapter begins with introducing the reader to the concept of economic value of human life, following which it gives a general idea about Health Insurance, its importance to the health sector, individual and society. The experience from other developing countries shows how the ideal mechanism may always not work out. Its emergence in India, its existing scenario and its need forms the subsequent part of this chapter.

Against the backdrop of other studies conducted, related to this subject, a more detailed exploration on the demand side of Health Insurance was planned for the study.

The economic value of an individual depends on how much others i.e. persons, organization or the society at large, benefit from his/her existence. Thus, the earning ability of a particular person makes him worth crores of rupees. Over a period of time, the strengths of an individual are slowly converted into income; a part of which is used on self-maintenance and the rest on the dependents and savings for the whole family. 'Health' being a very critical component of keeping

one's earning ability intact, demand's for its preservation. The loss of health has larger consequences not only on his/her earning capacity, but also on his/her family and larger economy. The income dependency and wealth acquiring style of people put them more at risk to external changes over which they have no control and which cannot be forecasted. This very ability of health to generate income and the need for its safe keep constitutes the basis of insurance.

Besides this, there is an emerging parallel trend of the recognition of basic health care for all citizens as a right on one hand and difficulties faced by government in developing and maintaining resources to provide health care through general taxation revenues on the other. National health policies, conditions laid by international and bilateral funding agencies stress upon the aim of equitable distribution and access to health care. Governments are also forced to reduce subsidization of basic goods and to decrease budgets for the provision of health and social services. All this and its implementation, places urgency on the development of additional methods to finance the development of the health services system and of the health care.

The new trend of private inputs into the health sector reflects an increase in consumer involvement, through various cost sharing mechanisms like user charges or regular prepayment viz. 'Health Insurance'.

1.1 What is Health Insurance?

Legally Insurance is defined as the contract between Insurance Company (Insurer)
and the customer (Insured). In this legal contract, the insurer agrees to

indemnify (compensate) the insured in lieu of payment of premium, for any financial loss due to risks covered in the Policy (Mahal, 2002).

HI rests on three grounds; that illness cannot be predicted, hospitalization costs cannot be planned and the proportion requiring hospitalization in any large population is small and therefore permits risk pooling (Gumber, 2000).
Although, the mechanism is simple, a more complex picture emerges, due to the following reasons -

- There are various players at each stage of the process, both Individual and Institutions and Government and private.
- Variations in the range of care provided like serious sickness; routine treatments, private care.
- It leads to expensive and complex administering functions, like- Contracts between TPA and service providers, systems for assessing insurers and collecting contributions, systems for making agreements with providers and monitoring their performances, information system for recording payments, details of including contributions and service providers and management of insurance fund itself.
- It is likely to experience more problems because of imperfection in the insurance market.

1.2 Importance of Health Insurance

Besides the well known advantages of attracting additional money for health, procuring better value for money by increasing efficiency, improving the quality of health care and above all targeting health care; it benefits individual and the society in various ways.

Benefits to individual - It makes savings achievable i.e. a saving program can yield only a little in the beginning of saving, while the insurance policy guarantees the full value and other benefits spelt out in the policy right from the beginning. It develops a semi compulsory saving plan, which adds extra efficiency to one's performance and enables him/her to generate extra wealth. It also relieves the policyholder of all the worries and tensions and hence contributes to his/her efficiency.

Benefits to the society - The pooled funds contributed by individual are lent to government, business, etc. in the form of loans. It also facilitates economies of scale in investment and ensures efficient use of the accumulated capital.

The most important advantage of Health Insurance is that it assures timely aid for (hospitalized) treatment, to those who need it, using this mechanism. To provide health facilities to all is one of the functions of a government. Health insurance is one of the ways that helps in achieving it

However, actual experiences from different countries shows that -

- It might be an unrealistic aim to attract additional money. Because of absolute scarcity of resources people cannot afford to pay more towards their health care.

- The high cost of administration and the difficulty of collecting payments are crucial issues in low-income countries, because there may be weaknesses in the infrastructure and management capacity.

- A large population is often in informal employment sector (agriculture & labour work) and scattered geographically. All this renders hindrances in premium collection. Insurance also depends to a large extent on a number of factors, viz. fluctuations in employment, the nature of labour market, the state of economy in general, which are problematic in developing countries. Thus it is difficult to universalize health insurance.

- Insurance tends to make health care expensive because of behavior of providers leading to cost escalation and members leading to moral hazard and adverse selection.

- It may encourage growth of hospital services and high technology care in urban areas, as it would be more profitable and easier to manage. There may be inappropriate use of these resources in low-income countries where basic services for rural residents are still inadequate.

- As there are very few players, improved efficiency due to competitive pressure is less likely.

1.3 Emergence of Health Insurance in India

> Kautilya related the levels of risk and uncertainty to levels of profits and interests. He had indicated that the higher levels of risk and uncertainty must be compensated by the probability of receiving higher profits and interests (Sarkar Sam).

Insurance business is not new to India. It finds mention in the writings of Manu, Rishi Yagnavalkya, Kautilya and others, indicating that it has existed in India of

ancient times. It has evolved over time and has drawn heavily from the experience of other countries specially England, where insurance companies have a more than 500 years of history. Bombay Life Assurance Company was established in Bombay on 1st May 1823. Europeans started Oriental Life Assurance Company in Calcutta. The General insurance business in India, on the other hand, can trace its roots to the Triton Insurance Company Ltd., the first general insurance company was established in the year 1850 in Calcutta by the British. The recorded history of Insurance business in India, however, began in 1914 when the Government of India started publishing returns of Insurance Companies in India.

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize the insurance business. An Ordinance issued on 19th January 1956 nationalized the Life Insurance sector and 'LIFE INSURANCE CORPORATION OF INDIA' (L.I.C.) came into existence in the same year.

Before November 1972, a number of Indian and foreign companies were into general insurance business in India, which was linked with their branches abroad. Nationalization saw the business of all these organizations absorbed by the GENERAL INSURANCE CORPORATION (G.I.C.) with its four subsidiaries, viz. - The New India Assurance, The United Insurance, The Oriental Insurance and The National Insurance.

General Insurance Corporation of India in the field of general insurance has enjoyed absolute monopoly. However, the reforms in financial sector in the early

90s have since touched Insurance also. The Government of India set up a committee with Shri R.N. Malhotra as the Chairman to recommend suitable reforms in this sector. As a consequence of the recommendation of the Malhotra Committee, the Government of India set up an Insurance Regulatory Authority. On the 2nd December 1999, Indian Parliament passed, 'Insurance Regulatory and Development Act', throwing open the Insurance sector to Banks and other private parties. RBI then came out with draft guidelines for entry into this sector. This is seen as a major step in financial sector reforms, which has introduced an element of competition in this sector.

1.4 Privatization and its Repercussions

It is believed that privatization will bring customers into limelight and array 3 core features (Dasgupta, 1998)-

1. Relationship between Insurance companies and financial intermediary and customers will be strengthened.
2. Services will be more flexible and innovative, tailoring to the needs of the customers. Health insurance companies will design buyer friendly products and customers will be able to choose from a wide range of services.
3. It will provide efficient and professional services.

The experiences in liberalizing the private health insurance suggest that it has undesirable effects on the costs of health care. The Healthy Policy Development Network at Indian Institute of Management, Ahmedabad, recognizes that health sector policy formulation, assessment and implementation, is an extremely complex task especially in a changing epidemiological, institutional, technological and political scenario.

Further, given the institutional complexity of our health sector programs and pluralistic character of health care providers, health sector reform strategies that have evolved elsewhere may have very little suitability to our country's situation. [8]

Cross-subsidy is the heart and soul of insurance, the well subsidizing the ill. However, the logic of private enterprise is to maximize profit, which means discriminating between risk categories, fragmenting the market into high risk and low risk, like - insurance premium increases when one crosses the risk threshold at the age of 40 and skyrockets when one enters 60's and excludes pre existing conditions like chronic illness.

Thus social undertaking is being subverted by a process of fragmentation and individualization of risk whose logical end point is its own antithesis: The sick to bear their own cost burden of illness, the healthy to rejoice in their good fortune. (ET, Sep 28, 2000; Existing problems and a new face for medical insurance)

> The Blue Cross / Blue Shield was left carrying the baby i.e. elderly and sick with high premium. The Blues eventually introduced the their own risk rating to remain viable. (ET, Sep 28, 2000; Existing problems and a new face for medical insurance)

1.5 Existing Scenario

The insurance sector in India has come a full circle from being an open competitive market to nationalization and back to a liberalized market again. Tracing the developments in the Indian insurance sector reveals the 360-degree turn witnessed over a period of almost two centuries.

In India only about 2 per cent of total health expenditure is funded by public/social health insurance while 18 per cent is funded by government budget. In many other low and middle income countries contribution of social health insurance is much higher.

It is estimated that the Indian health care industry is now worth of Rs. 96,000 crore and expected to surge by 10,000 crore annually. The share of insurance market in above figure is insignificant. Out of one billion population of India, 315 million people are estimated to be insurable and have capacity to spend Rs. 1000 as premium per annum. Many global insurance companies have plans to get into insurance business in India. Market research detailed planning and effective insurance marketing is likely to assume significant importance. Given the health financing and demand scenario, health insurance has a wider scope in present day situations in India. However, it requires careful and significant effort to tap Indian Health Insurance market with proper understanding and training.

There are various types of health coverage in India. Based on ownership the existing Health Insurance schemes can be broadly divided into categories such as; Government or State-based systems, Market-based systems (private and voluntary), Employer provided insurance schemes, Member organization (NGO or cooperative)-based systems.

Government or State-based systems include Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS). It is estimated that employer managed systems cover about 20-30 million of population. The schemes run by member-based organizations cover about 5 per cent of population in various ways. Market-based systems (voluntary and private) have Mediclaim scheme which covers about 2 million of population. However, many private players have recently entered the market. There are many employers

who reimburse costs of medical expenses of the employees with or without contribution from the employee. It is estimated that about 20 million employees may be covered by such reimbursement arrangements. There are several government and private employers such as Railway and Armed forces and public sector enterprises that run their own health services for employees and families. It is estimated that about 30 million employees may be covered under such employer managed health services (Bhatt, 2002).

General Insurance Corporation (GIC) and its four subsidiary companies and Life Insurance Corporation (LIC) of India has various health insurance products. These are Ashadeep Plan II and Jeevan Asha Plan II by Life Insurance Corporation of India and various policies by General Insurance Corporation of India as under: Personal Accident Policy, Jan Arogya Policy, Raj Rajeshwari Policy, Mediclaim Policy, Overseas Mediclaim Policy, Cancer Insurance Policy, Bhavishya Arogya Policy and Dreaded Disease Policy. The health care demand is rising in India now days. It is estimated that only 10 per cent of health insurance market has been tapped till today. Still there is a scope of rise up to 35 per cent in near future. The most popular health Insurance cover is Mediclaim Policy. Thus the focus of this study has been on 'Mediclaim.' [9]

1.6 Problems in the existing scenario

Apart form the strict IRDA regulations the insurers face a number of problems in India, which prevents them from entering the market. Absence of provider network company, increasing trend in incurred claims ratio, inadequate pre-insurance health check up, provider malpractices, disparity in coverage of seniors, patients psychology - specific to India are some of the problems inhibiting the growing insurance sector. Even the insureds are not in a

comfortable position in India. They face few problems, which compels them to think twice before going for Insurance. Absence of provider network, medical assistance, viability to get admission in the hospital of choice, formalities of admission, deposit payment, avoidable investigations are some of such inconveniences faced by the insured. Anecdotal evidence from doctors also indicates that charges are increased if patients are insured. This will tend to increase the prices of private health care thus hurting the uninsured. With these conditions existing, the responsibility lies both on the government and the insurance regulatory authority to improve the health conditions in India and Indian insurance sector respectively.

1.7 Need for Health Insurance in India

Today people are more at risk than their ancestors. The physical and economic security provided by joint families is extinct. Moreover, people due to the fast paced life are getting more vulnerable towards ill health, accidents, death, desertion, social disruptions such as riots, loss of housing, job and other means of livelihood. In such a changing scenario individuals and families need to be prepared to face personal losses from incapacity.

The cost of medical care and treatment have also soared to new heights in recent years and is expected to rise even further in the years to come. The introduction of new technology has further added to the rising expenditures. Under the present health care system even the families above the poverty line will be pushed below the poverty line if a major illness occurs in a family. A Chinese Health survey conducted three years ago revealed that 40% of entrants to the poverty was attributed to illness [9]. A substantial number of people have fallen below poverty line due to catastrophic health expenditures in rural India.

Insurance provides defense against such disasters. Although, it cannot make up for the potential loss caused due to health contingency, it can minimize the financial losses due to such occurrences and thereby reduce tension and anxiety.

Besides, in recent years there has been tremendous increase in private health expenditure. Studies have also indicated that the public prefers private health care facilities than public hospitals. Mckinsey shortlisted 80.8 million households primarily on their ability to pay insurance premia. Of this, 20.5 million households are already insured in some form or the other leaving a market of 60.3 million households that can be insured. Thus, if this population is covered by Private Health Insurance Schemes, the pressure on the social welfare system will also be relieved, thereby allowing the government to put the saved resources to a better use, especially for the poor.

> " Health Insurance is virtually the only practical instrument governments can use to get out of the expensive business of providing across-the -board subsidies for hospital care"(Shaw & Griffin, 1995)

1.8 Other Studies on Health Insurance

The various problems exclusive to Health Care Market, especially for Health Insurance makes it essential to be explored both at macro level to study the feasibility and viability of the Scheme and at micro level to understand the utility and the demand by people. A number of studies have been carried out to explore more about this field.

A WHO book, 'Co-operation in the development of Health Insurance', states that the pressures generated by health, political, social and economic development

have stimulated interest in finding alternative ways to finance Health Care. A macro level cross country analysis (Preker, 2002) explores potential policies for tackling managerial, organizational and institutional weaknesses in community financing, rather than trying to replace them with direct government intervention, which has often proved unsuccessful. Some of the studies (WHO, 1993; Monash, 1998) examine various impacts on health financing, including Health Insurance, which helps in gaining an insight into these contentious issues. For instance (WHO, 1993) the political clout in China led to the development of rural Health Insurance Scheme in order to replace the Co-operative Medical Schemes. Similarly with the establishment of a multi party in Zambia, the concern for Health Development was accelerated.

A WHO document (Monash, 1998) brings together and analyses 82 Schemes that seek to promote risk sharing of the costs of health care for persons outside formal sector employment. The document does not canvass any specific scheme, rather suggests that what matters most is how well the design of a scheme responds to the local conditions. It states that an understanding of the local, national, economic, political and social context is fundamental to any analysis of the purpose and performance of a risk sharing scheme and is essential to identify barriers or opportunities for replicating that scheme elsewhere. The Health Insurance Scheme in East & South East Asia and Taiwan emanated when the economy was booming. The small size of local villages and their cohesiveness due to opposition to colonial powers has been contributing to the success of Health Insurance Scheme. In some instances (Monash, 1998), when NGO or the government failed to consider the links to broader health care system, the Insurance Schemes collapsed badly. Like the Bengali Scheme in India and the NGO CIMIGEN in Mexico failed to generate the necessary and anticipated demand for health services.

Experiences from other countries suggest that the entry of private firms into the Health Insurance Sector if not properly regulated, does have adverse consequences for the cost of care, equity, consumer satisfaction, fraud and ethical standards (Razvi, 2001).

> Health Insurance is not an easy panacea. International experience shows that health insurance is a complex technical exercise with many pitfalls. States in India need to be very careful about rushing into Health Insurance schemes because in other parts of the world such as ex- USSR countries, Philippines, etc., attempts to introduce US or Northern European style insurance schemes have been very slow to operationalise.
> - Dr. Christopher Potter, European Commission.

A World Bank publication by Bong-min Yang analyzes the efficacy of the national health insurance (NHI) system in the Republic of Korea and the role-played by the private health sector in the provision of health care services. The Korean example suggests that while private-sector participation in NHI is important, appropriate institutional mechanisms should be put in place to control system costs and to provide affordable access to low-income groups.

The various challenges, opportunities and concerns in Indian Health Insurance market are explored in his article by Ramesh Bhatt (2000). An assessment of private Health Insurance by Ajay Mahal (2002) states that the privatization of Health Insurance could have adverse implications for some of the goals of health policy, particularly for equity. However, an informed consumer and well-defined and implemented insurance regulation regime could potentially address many of the bad outcomes. Deepanjan Banerjee (2001) in his article emphasizes on the need for privatization of the Insurance Sector and elucidates how the

Health Insurance policy in India has been a burden of inefficiency of a government run system.

Some of the studies (Krishnan; Reddy, 1995) also suggest some alternatives; Prof. K. N. Reddy examines the existing health care system, which he considers is entangled in political and bureaucratic circles. He emphasizes on the need for National Health Insurance to reform health care in terms of financing, organization and delivery for speedy improvement in health status and to increase human development index in the comity of nations. He proposes on the urgent need for a detailed study on the feasibility of National Insurance.

Based on a study of rural India, T. N. Krishnan proposes a hospitalization Insurance plan for people below poverty line. He estimated total cost of 900 crore for hospitalization coverage for 300 million persons. This amount can be provided by government as a part of anti-poverty program, which can be found from unspent savings under anti-poverty programs currently in operation or by a reallocation of expenditures. The protection provided to a poor family against hospitalization will be far greater under an insurance scheme, than if the calculated average premium were to be given directly to the family. It is pointed that in anti-poverty program like Jawahar Rozgar Yojana the minimum leakage is about 40%. In case of hospitalized insurance there will not be any such large-scale leakage and the poor will benefit to the full extent.

Few micro level studies (Preker, 2002; Gumber, 2000) have also been conducted to explore the demand side. Micro level household data analysis from Asian and African regions indicates that community financing improves access by rural and informal sector workers to needed health care and provides them with some financial protection from the cost of illness (Preker, 2002).

As shown by the study of Gumber and Kulkarni (2000) among the members of SEWA, ESIS and Mediclaim schemes, information, knowledge and awareness of existing insurance plans is very limited [7]. At the micro level there are few Case studies done (Dave, 2000; Gumber, 2000); SEWA's Health Insurance Scheme for women of rural Gujarat. The case study of Gujarat by Gumber shows that the Insurance Companies are ill equipped to handle the present day complexities, especially in the context of lower income groups. The bureaucratic rigidities and poor monitoring mechanisms make it difficult for the poor to continue with these schemes. However, the case study on SEWA Social Health Insurance Scheme was successfully managed by the diligent efforts of the community and the Insurance Company.

A micro level study to examine the willingness to pay in rural Karnataka by K. Mathiyazhagan suggests an alternative framework for designing a viable rural Health Insurance Scheme in India. A study conducted in Delhi City by Gupta Indrani (2000) revealed that the willingness to participate in Health Insurance Schemes differed according to the nature and period of their coverage, premium for adults and children, withdrawal amounts and if the unused fund would be returned in future.

1.9 Need for this study

A large number of studies are carried out at the macro level, while very few are done at micro level. Most of the micro level studies are case studies. Even the empirical studies based on survey design are focussed on rural areas and community based social insurance. A huge potential for the Health Insurance market lies in the cities. Around 50% of India's strong middle class of 27 crore population can as well afford private health care [26]. It is also seen that the

demand for quality health care is increasing due to increasing health awareness as result of increased literacy levels, increasing economic activity and increasing investments as a result of increased life expectancy. In this emerging picture Health Insurance is seen as a potential area for high growth in the coming years. Thus it becomes indispensable to know the relative importance given to Health Insurance by this potential segment of the population.

Chapter 2

Objectives And Methodology

There is no short cut to truth, no way to gain knowledge of the universe except through the gateway of scientific method.

- *Karl Pearson.*

India has about 22% savings rate of which less than 5% is spent on insurance. Of this 5% a very small proportion is spent on Health Insurance. As already mentioned in Chapter 1, Health Insurance can be seen as a prospective tool to address some of the crucial problems related to financing in health sector. With a poor penetration of Health Insurance in India in comparison to other countries and looking at the huge population of India and about a quarter of them being

viewed as potential consumers of Insurance, the curiosity of the researcher was aroused to conduct a study assessing the demand for Health Insurance.

2.1 Aim of the study

"To Assess the demand for Health Insurance in the middle and the upper middle class population of Mumbai suburbs and the extent to which the existing schemes satisfy it."

2.2 The objectives of the study

1. To assess the awareness level regarding health insurance.
2. To study the nature of requirements of health insurance.
3. To assess the level of satisfaction among the claimants.
4. To study the existing popular health insurance schemes and their ability to meet the demands of people.

Like any other product or service that is traded in the market, insurance besides being influenced by the factors like economic security of human life, diminishing nature of economic value is also subjected to the laws of supply and demand. The higher the price lower the demand and higher the supply and vice-versa.

The behavior of buyers is based on the goal of maximizing the utility gained from the purchase and consumption of the good. As prices fall, holding income constant, the buyer finds that his/her purchasing power has increased allowing for buying greater quantities of a particular good. For the consumer, additional quantities of a good consumed provide less *additional satisfaction* relative to previous units consumed, with the consecutive fall in price. This notion known

as diminishing marginal utility implies that the consumer is willing to pay less for these additional units as it becomes more efficient to use his/her income for the purchase of other goods. For the buyer, these types of behaviors typically lead to a negative relationship between the market price and quantity demanded. The increase in income however increases the demand. This is known as demand analysis.

The quantity demanded is sum function of the price of the good, the prices of other related goods, income and the organizational and institutional structure of society and preferences and tastes of individual, which will depend on many socio-economic factors and attitude.

2.3 Why demand analysis?

Demand reflects individuals' wants, backed by a willingness to pay for them. However, in the health care sector, the consumer decisions are influenced by the supplier's preferences. Moreover, the imperfections in the Health Insurance market not only leads to the poor performance of the industry, but also poor consumer satisfaction.

Maximum population must be covered under Health Insurance Scheme, so that they have an access to medical care whenever they need it. If people are not getting insured we need to know the reason behind it.

The Insurance Company may carry out consumer Analysis to tap the right potential for the sale of their products. But, it is equally essential to know the same thing from a buyer's perspective i.e. the need and want of people must be known, without an underlying motive of selling the product. Thus the justifiable

and unjustifiable demand of people would be explored without trying to manipulate them.

This chapter is divided in to 4 sections; the first one includes area of study, sampling, data sources, data collection techniques, etc. The second section describes the methodology. The third section discusses the approach to analysis, while the fourth section gives a brief outline of the entire study.

2.4 Methodology

Western Mumbai Suburb is selected for the study. Mumbai houses a large number of middle and upper middle class population, with specific pockets of residential areas; which can be easily identified as middle class or upper middle class sections of the society. As mentioned in the need for the study that the affordable class of the society i.e. the middle and upper middle class have shown an increased demand for health care services especially for private services; this segment of the population, were considered as the target respondents.

2.4.1 Study Design

A Survey Design was adopted to collect all the relevant information. The middle and the upper middle class people were interviewed to know the demand for Health Insurance. From the initial survey it was revealed that the most popular Health Insurance Scheme among people is Mediclaim and following it is CGHS and ESIS. Due to time constraints and non-availability of key person who could furnish the required information for ESIS, CGHS was chosen for study. Thus, it was decided to study Mediclaim and CGHS, in order to know as to what extent these schemes satisfy the needs of the people. The Third Party Administration is

playing a key role in Insurance Sector and hence a need was felt to study one of them.

2.4.2 Sampling

49 respondents from different households, 16 claimants and 1 official each, from CGHS and a subsidiary of Mediclaim, and 2 officials from a Mumbai based TPA were interviewed.

The non-claimants were selected through snow ball sampling. A respondent is first selected who gives references of others who might be interested in the subject under study, who further gives more references. This is how the entire sample is selected. 50 such samples were selected through this technique. As already mentioned since each of the sample units was determined by the previous respondent, the last respondent did not seem to be keen in the subject and his responses were found to be invalid and hence is not included in this study. Thus, the total number of respondents turned out to be only 49.

A list of around 20 claimants was taken form an insurance company, their phone numbers were traced by telephone directory and a telephonic interview was conducted. As all of them could not be traced and some refused to respond, only 16 of them were interviewed.

Since the idea of interviewing the representatives of the insurance companies was just for understanding the supply side logic of the problem, it was not considered essential to interview the officials from all the subsidiaries of the General Insurance Corporation. Thus, only one among the four of the subsidiaries of General Insurance Corporation was selected. The rationale for

selection of CGHS and one TPA has already been mentioned. In order to garner the prerequisite information, any official who could provide it, was approached.

The methodology for different objective is different. To achieve the first two objectives of assessing the awareness about Health Insurance and the nature of requirements of Health Insurance a wide range of information was needed. In order to garner all the required information on demographic characteristics, social environment, social influences, opinion and attitude influencing the demand for Health Insurance, a general survey was conducted. Each of the respondents was interviewed for about 30 to 40 mins. and a wide range of questions were asked, the responses of which were elicited by probing. A contingent valuation or hypothetical qualitative response was initially tried to reveal the responses on the willingness to join and pay. However, it could not be exercised as the respondent felt offended when offered with a hypothetical situation of health emergency of their near and dear ones.

To achieve the third objective of assessing the satisfaction among the claimants, a telephonic interview was conducted. Each of the claimants was interviewed on the telephone for about 40 mins. and the same questionnaire was used as that for the other respondents. Some responses pertaining to the settlement of the claims were elicited more in details.

To collect the relevant information about the popular Health Insurance Schemes and to understand the extent of their pliability, few officials from Insurance Companies and TPAs were interviewed. Each of the officials was interviewed for about 1 hr. to 4 hrs. They were asked not only about the schemes but also about their general opinion about the schemes, the Health Insurance market and on the recommendations suggested by the respondents. These interviews were

preceded by the survey and hence it was possible to discuss the recommendations of the respondents with the representatives of the Insurance Companies and TPAs. The data thus obtained was analyzed both quantitatively as well as qualitatively.

The Primary data comprises of all the information collected from the 65 respondents i.e. people from middle & upper middle class and few officials form insurance companies and TPA's.

The Secondary data was collected form various manuals, write-ups of the companies, general write-ups on health insurance sector and also from Internet. These were the information about the Schemes under study in order to get a holistic picture of the same; the Health Insurance Sector in general to gain an understanding of the basic concept and principles of Health Insurance and also to know about other relevant studies conducted and to know about the experiences from other nations and schemes.

3 types of Interview Schedules were prepared - 1 for the general respondents, 1 for the officials from the Insurance Company and 1 for the officials from TPA.

The interview schedule meant to elicit responses from a lay man was pre-tested in order to ascertain the content and the validity of the questions asked. After pre-testing, realizing the need to alter the questionnaire some changes were made. The questionnaire, which was initially more semi-structured, was further structured to facilitate probing and give directions to the interview. However the schedule is not totally structured. As the study, is concerned with attitudes and perceptions about Health insurance of a common man, enough space and flexibility is rendered to elicit the responses.

The schedule designed for insurance companies and TPA's has slight variations, as per the context in which they function. These are semi-structured with no multiple-choice items. They could not be pre-tested due to restrictions in repeating the same interview in the same organization. However, the questions were modified in the field, during the interview to suit the context.

2.4.3 Approach for analysis

The awareness level is assessed by using 2 parameters i.e. people have heard of health insurance or not heard of it and how many schemes do they know. Each of these parameters will be weighed against various variables like age, sex, socio-economic status, employment status, education, etc and expressed in percentages. To further explore what people understand by Health Insurance they were asked about their basic understanding of the concept and these will be clubbed and expressed in proportion of the total. Each of these categories would reflect specific attitude towards Health Insurance.

The respondents were asked, if they would need Health Insurance and these responses will again be compared with all the variables. The relation between awareness and need will thus be examined.

The responses on the willingness and non-willingness to pay will again be compared with all the variables and a relation between awareness, need and willingness to pay and preference for Health Insurance will be explored to assess the demand. The utilization pattern i.e. the coverage under Health Insurance by different class, age group etc. further aids in assessment of demand for Health Insurance. The annual expenditure on health services will further be examined against the premium rates paid by the insured, in order to assess the effect of

prices of other products viz. expenditure on ambulatory care and medicines on the demand for Health Insurance.

Each of the respondents was asked to express their opinions and suggest recommendations as per their demand. The opinions will help in descriptive analysis. The recommendations will be clubbed and the relative demand would be assessed i.e. which of the components of Insurance Scheme are satisfying the demand and the change in which component would bring a change in the demand. The demand analysis will been aided by Scaling the demand with the help of Bogardus Social Distance Scale.

2.5 Outline of the Study

Each characteristic of the 65 respondents are explained, which is followed by the description of the scheme selected for the study. This information is collected directly from the officials, while the sources are both primary and secondary. Secondary information was obtained from manuals and write-ups. This is covered in Chapter 3. This chapter helps the reader in understanding the sample, under the study.

Chapter 4 covers demand side analysis. In order to logically analyze the demand for Health Insurance initially the awareness level is assessed which follows the morbidity pattern, health expenditure, health-seeking behavior among the respondents. The awareness assessment is followed by need assessment, which eventually leads to demand assessment. The utilization of services i.e. coverage for Health Insurance and preference for Health Insurance in comparison with Life Insurance further helps in demand analysis. This chapter focuses only on the demand (justifiable, unjustifiable) of the people for Health Insurance.

Chapter 5 deals with Supply side Analysis, with a background of general principles and constraints in Health insurance market. It describes the satisfaction level in claimants (i.e. Consumer Satisfaction) which is followed by the analysis of recommendations by the respondents. The chapter concludes by mentioning as to what extent the schemes satisfy the demand of the people and which components can bring about a change in the demand. The focus of this chapter is on what demands can be met by the suppliers.

Chapter 6 presents summary and recommendations.

Chapter 3

Contour Of The Sample

The Sampling enquiry gives significantly correct results with much less time, money and material.

- *S. R. Bajpai*

Mumbai was founded as a trading town and it has remained focused on the business of business ever since. As the country's busiest port and largest financial centre, it effectively remains the commercial gateway between India and the rest of the world. Parsis and Gujaratis dominate the city's economy and Gujarati is the lingua franca of business. Marathi-speaking Maharashtrians traditionally formed the bulk of the city's labour force, though today many are white-collar workers and members of the growing middle class. Like most maturing cities, over the past few decades Mumbai has shifted from its manufacturing base to become a centre for financial and commercial services. Over two-thirds of the city's workforce is now employed in the service sector and Mumbai is home to the country's largest stock exchange as well as the Reserve Bank of India. A third of the city's population still works in large-scale industries such as textiles, engineering, petrochemicals and pharmaceuticals. The city's also renowned for specialist fields such as film production, diamond cutting and computing.

Mumbai's economic muscle is backed by productive offshore oil fields, a nuclear power station and several of the country's top research establishments. The statistics trotted out to back up Mumbai's claim to be the centres of Indian capitalism are rubbery but impressive. It's said to contribute nearly half of the country's excise tax, a quarter of its income tax, and a fifth of its gross domestic product and more than three-quarters of the country's stocks are listed on Mumbai's Bourse. In 1998 Business Today, a leading business publication in India ranked Mumbai as the second best city in India in which to do business.

In this fast growing city, the income dependency and wealth acquiring style of people have put them more at risk to external changes over which they have no control.

3.1 Area of study

Mumbai is divided into straight lines in terms of places starting from South Mumbai to North Mumbai. Also Mumbai Suburbs are known as East or West as per their location on either side of the railway tracks.

The Mumbai suburbs on the Western line begins from Mumbai Central, with the 'Queens of suburbs' - Bandra at it's heart, terminating at Dahisar for octroi limits, beyond which the railway lines move on to Virar in Thane district; (which covers almost a distance of 147 kms). The Central suburbs extend from Chembur to Thane. The study area was however restricted to the Western suburb. The Municipal Corporation of Mumbai for the convenience of administration has divided the Mumbai district into 24 wards. The Western suburbs are represented

by the wards from F to R, excluding L, M & N, with approximately a total coverage area of about 124 sq.km and population of 40,43,575 (Census, 1991).

3.2 Why Mumbai suburbs?

Mumbai suburbs contain large pockets of residential belts. The middle and upper class conforms a large section of this society. The factors likely to affect their perception like education and occupation are also variegated. The locale ensured the availability of a heterogeneous group in one place, thereby allowing the researcher to explore more varied responses in the limited time.

3.3 Sample selection-

The voyage of exploratory study on the perception of Health Insurance began from Mumbai suburb of Borivali and took its course through the western line to Mumbai Central. As already mentioned in the Chapter 2, Snow Ball Sampling technique was adopted to select the samples.

Criterion for selection of the sample unit –

- Selection of non-claimants - All those who are above the age of 20 yrs, who are genuinely interested in the subject and from the middle or the upper middle class family were selected for the study. 49 such respondents were selected through snow ball sampling.

- Selection of claimants - All those who have claimed for reimbursements of hospitalization expenses, irrespective of whether their claims are settled or not were selected for this study. 16 such claimants were selected through the list obtained from the Insurance Company.

- Selection of the officials from Insurance companies and TPA - Any official willing to provide the required information and keen in discussing the concerned issues were interviewed. According to the convenience of these officials after fixing a prior appointment, all the needed information was collected from 4 officials -1 from a subsidiary of G.I.C., 1 from CGHS and 2 from TPA.

As the sample size is not even an iota of the large population none of the above mentioned samples are truly representative. However, within the constraints an endeavor has been made to make the sample as representative as possible. The sample is stratified based on different set of criteria like claimants/ non-claimants & based on organizations in which the respondents are employed. This helps in getting a comprehensive picture, with high probability of eliciting varied responses.

3.4 Sample Profile

3.4.1 Gender Specification

The proportion of gender was not predetermined, as all those available at home within the purview of the inclusion criteria were interviewed irrespective of their gender. Differences in perception and insured sum, as per gender differentials needs to be explored, for which it becomes mandatory to know the proportion of male and female respondents.

Table 3.1: Gender distribution of the 65 respondents.

Particulars	Gender		
	Male	Female	Total
No. of respondents	40	25	65
Percentage	61.5%	38.5%	100%

40 males and 25 females were interviewed who comprise 61.5% and 38.5% respectively of the total. The interviews were conducted after fixing an appointment. Thus all the men in the house could be interviewed. Some women were reluctant to communicate, as they felt that they lack knowledge about investments and it is the male folk who take such decisions. Some women although keen in the subject could not spare time because of the household chores, following hectic office work.

The sample is thus biased towards male.

3.4.2 Age distribution

The sample is confined with minimum age limit of 16 years, but with no upper limit. A basic level of erudition in terms of experience, literary or maturity; was identified as a prerequisite for the selection of the respondent. Although schooling was not fixed as a criterion, the above mentioned age limit would allow the individual substantial time to have gained wisdom.

Table 3.2: Age distribution in different genders.

Age in years	Gender		
	Male	Female	Total
20-35	12 (30%)	18 (72%)	30 (46.15%)

36-55	16 (40%)	6 (24%)	22 (33.85%)
56-75	12 (30%)	1 (4%)	13 (20%)
Total	40 (100%)	25 (100%)	65 (100%)

Of the total **women** interviewed, maximum 72% are from the **younger** age group of 20 to 35 years; whereas the proportion of **men** in different age groups is largely **uniform**. In the age group of 20-35 yrs., the proportion of men is 30% while that of women is 72%; 40% of men and 24% of women fall in the age group of 36-55 yrs.; and only 4% of women, while 30% of men are from the category of 56-75 yrs. of age.

The choice of making the groups is determined by the consideration of risk of illness, involved in different age groups. The individuals in the age group of 20-35yrs. are less vulnerable to ill-health, while those above 55 are more vulnerable to ill-health. Moreover, the middle age is a more stable period when most of the investments are made for future security, making headway towards old age i.e. towards chronic ailments. Thus the propensity to utilize the health care services increases in the later stage of life. All this is manifest in their perception.

As the proportion of women in the younger age group is larger, the sample is biased towards young, which will have its implications in analysis. However, this effect will be nullified to some extent through male responses.

3.4.3 Educational Qualification

None of the respondents have less then secondary level of education. Albeit, criteria of illiterate; primary, up to 4th std; secondary, up to HSC; graduate and post graduate were made; the first two stand invalid.

Table 3.3: Educational qualification of the respondents as per gender differentials

Educational Qualification	Gender		Total
	Male	Female	
Secondary	2 (5%)	2 (8%)	4 (6.15%)
Graduate	23 (57.5%)	16 (64%)	39 (60%)
Post graduate	15 (37.5%)	7 (28%)	22 (33.85%)
Total	40 (100%)	25 (100%)	65 (100%)

Of the total men, 57.5% are Graduates, while only 5% have only secondary education. 64% of women are Graduates. The high level of education can be attributed to the fact that the respondents are from middle and upper middle class families.

3.4.4 Socioeconomic status

This is completely subjective, based on the discretion of the researcher, as it was technically not feasible to elicit their exact income. Thus, those satisfying the following criteria of-

1. Either serving as lower or middle level officials in private or public organizations or retired from private or public service.
2. Living in 1 BHK flat in middle class societies, with any of the assets like television, VCR, telephone, computer, refrigerator, 2 wheeler, etc.

3. Expenditures limited to basic requirements like education and health.

were clubbed as 'Middle income group'

Those satisfying the following criteria-

1. Businessmen or serving in public or private organizations as upper level officials or retired as upper level officials.
2. Living in duplex 2 BHK flats in affluent societies, with assets as mentioned above and car.
3. Spending on shares, lavish lifestyle like high expenditures on frequent outings. were clubbed as 'Upper income group'

Table 3.4: Socio-economic status of the respondents with gender differentials.

Socio-economic status	Gender		
	Male	Female	Total
Upper middle	15 (37.5%)	6 (24%)	21 (32.31%)
Middle	25 (62.5%)	19 (76%)	44 (67.69%)
Total	40 (100%)	25 (100%)	65 (100%)

32.31% of the total are from upper middle class and 67.69% are from the middle class strata. More number of respondents of both the genders are from middle class.

3.4.5 Family size

As the number of dependents increase in a family the income gets more widely distributed, i.e. the expenditure increases; thereby affecting the attitude towards insurance.

Maximum number of respondents i.e. 31% of the 65 respondents have 4 members in their family (including themselves); while a very small proportion of respondents, i.e.6.2% have a large family size of 6 members. Thus, it is very obvious that the sample is biased towards smaller family size and more towards those who have a family size of 4.

Table 3.5: Family size of the 65 respondents

Number of family members	Number of respondents	Percentage of respondents
2	13	20
3	16	24.6
4	20	30.8
5	12	18.5
6	4	6.2
Total	65	100

3.4.6 Occupational status

The employment status manifests the ability to pay and to a great extent also affects their perception. In order to ensure a proper representation of the sample from different categories, the classification has been done as- unemployed, business, central government employee, state government employee, Mumbai Municipal Corporation (MMC) employee, private employee and retired. While selecting the sample a deliberate attempt was made to ensure that all the categories would be covered. However, the categories do not seem to be proportionately covered.

Table 3.6: Occupational status of the respondents.

Occupational status	Gender		
	Male	Female	Total
Unemployed	1 (2.5%)	4 (16%)	5 (7.69%)
Business	2 (5%)	2 (8%)	4 (6.15%)
Central government employee	11 (27.5%)	3 (12%)	14 (21.54%)

State government employee	2 (2.5%)	2 (8%)	4 (6.15%)
MCGM employee	3 (7.5%)	1 (4%)	4 (6.15%)
Private employee	17 (42.5%)	13 (52%)	30 (46.15%)
Retired	4 (10%)	-	4 (6.15%)
Total	40 (100%)	25 (100%)	65 (100%)

The private employees are more in both the genders, summing to 46.15% of the total.

3.4.7 Insurance Schemes & TPA

The branch manager of a subsidiary of G.I.C., was interviewed more then once, to collect the relevant data and to discuss on the various alternatives possible.

A Senior Medical Officer of Central Government Health Scheme (CGHS) was interviewed to collect the relevant information.

2 Senior Medical Officers from a Third Party Administration were interviewed to know more about their functions and prospective role in the market of Health Insurance.

3.4.7.1 Mediclaim

It was realized that there are no schemes for a larger section of the population, either employed in informal sector or private formal sector. Mediclaim was introduced in 1986, with an objective of providing Health Insurance coverage to this section of population.

Mediclaim is a reimbursement base insurance for hospitalization. It does not cover outpatient treatments. First there used to be category-wise ceilings on items such as medicine, room charges, operation charges etc. and later when the policies were revised these ceilings were removed and total reimbursements were allowed within the limit of the policy amount. The total limit for policy coverage was also increased. Now a person between 3 months to 80 years of age can be granted Mediclaim policy up to maximum coverage of Rs. 5 lakh against accidental and sickness hospitalizations during the policy period as per latest

guidelines of General Insurance Corporation of India. This scheme is offered by all the four subsidiary companies of GIC. Mediclaim scheme is also available for groups with substantial discount in premium. To make the scheme more acceptable government has exempted the premium paid by individuals from their taxable income. This provides 20-40% subsidy on the premium to taxpayers.

However, as the Insurance Scheme would be available to anyone who is able to pay the premium; the target population was too scattered and hence no market surveys could be conducted. Based on the general information about demographic structure, morbidity pattern, hospitalization episodes, economic condition, present expenditure on health, etc; the scheme was designed by few experts based on mathematical model with premium rates calibrated according to age of the individual. Different Group Insurance Schemes were designed with expert opinion from the Insurance Company and from private firms. The benefits provided and the beneficiaries covered i.e. spouse, family members, etc. in Group Insurance is determined on the basis of contribution by the employers and employees in private companies and the requirements of the Human Resources Department of the firm. The strategy adopted is an outcome of mutual consent. As the target population is too dispersed, it is difficult to monitor their behavior or assess their level of satisfaction. However, as the profitability is essential for the solvency of the Company, depending on the trends of the previous claims made and profits/losses made, based on the actuarial system, the premium rates with respect to age structure and conditionalities of the scheme are revamped time and again. However, the Company has no specific period in which the schemes have to be revised. Revamping of the schemes is triggered by losses or by poor performance of the Company with respect to other subsidiaries. The benefits were decided upon, based on segmented rates fixed on per diem or per bed, per investigation, etc. But as hospital offer package deals, these were conglomerated into package benefits, which is easy to manage. They are also introducing various innovative schemes for confined target groups like

Raj Rajeshwari Mahila Kalyan Yojana, Overseas Mediclaim Policy, Personal Accident Social Security Scheme, etc. All the Mediclaim subsidiaries are now tied with TPA to provide more benefits to the insured and to introduce more regulation into the field, for optimum utilization of resources.

3.4.7.2 Central Government Health Scheme

The Central Government Health Scheme (CGHS) was started in the year 1954 for providing comprehensive medical facilities to the Central Government employees and their family members. The scheme has since been extended to cover other categories like Freedom Fighters, Central Government pensioners, employees of semi-autonomous organizations and general public in Delhi.

The CGHS functions as a part of the Directorate General of Health Service. A Committee known as Central Government Employees Co-ordination Committee is formed which co-ordinates between all the departments and selects the panel which would decide on the structure and design of the scheme. The Committee also nominates doctors who are designated as AMA- Authorized Medical Attendant. Based on the salary structure, the Scheme was categorized into 4 groups, viz.- A, B, C, D. The contribution to each of these groups would be Rs. 100, Rs. 80, Rs. 30, Rs. 15 per month, respectively.

Presently 40 Lacs beneficiaries are covered in 17 cities of India. There are 87 dispensaries in Delhi itself. There are 312 dispensaries including different systems of medicine, viz. Homeopathy, Ayurvedic, Allopathic, Unani, Yoga & Sidha till 31st March 1995. Doctors and staff are paid through salaries. General physician refers cases to the specialist but there is also a direct consultation at scale above Rs.4, 001/-Nursing home facility is also provided at scale of above

Rs. 2,501/-. CGHS provides outdoor treatment, necessary drugs, laboratory and X-ray investigation at Dispensary/ Poly Clinic/Hospital. Domicilliary visits, Ambulance services, Immunization facilities, Specialist services and referral services of all Government hospitals are also recognized for consultation. By order of 18th Sep., 1996, private hospitals have been recognized for specialized and general purpose treatment and diagnostic procedures.

In order to prevent misuse and impose improved regulations all the beneficiaries are provided a card which has a family photograph of the employee, stamped and duly signed by the concerned employer. The reimbursement is directly made by the Additional Divisional General of CGHS to the private hospital, thereby avoiding cash transactions, a tight referral system is maintained, i.e. patients cannot directly go to the hospital without a referral letter from the physician at the dispensary and the beneficiaries are entitled to only certain classes (like ordinary, deluxe, etc.) in the private hospitals depending on his/her status.

Almost every year a survey is carried out for patient satisfaction. Only two patients are interviewed in each dispensary and the data is sent to the head office of Mumbai from where it sent to Delhi Head office. The method and the area of the study is decided at Delhi by some officials and patients are interviewed by the doctors in the dispensary. However no feed back is given or any changes brought about following the survey. Strategies adopted in other countries are studied at present to bring about improvements in the scheme.

3.4.7.3 Third Party Administration

In order to regulate the entire Health Insurance Sector, the TPA entered the market with an objective to provide best health care, at best place and best cost. In the wider sector with both the providers and the insurance schemes there was a large gap that was realized and needed to be filled i.e. a gap of regulation,

standardization between the two. With insurance there was cost escalation of health services and in the absence of regulating bodies or process, it would lead to severe repercussions. To act as the mediator, to smoothen the process, as well as to regulate the mechanism, which was the need of the hour, and seeing no other potential players in the field, the organization felt the need to start such a system. The numbers of beneficiaries are 2 lakhs and it has tied up with almost 900 hospitals spread out in 140 cities. It has recently tied up with the subsidiaries of G.I.C. for Mediclaim. From its own previous experiences and others' experiences, the Company devises new strategy and believes in continuous learning and progression. It offers innovative, client focussed services dedicated to developing creative, practical and customer benefit solutions for client's health care requirements. The range of services that it offers are- Preferred Service Provider Network, Cashless Medical Serivce Plan, Online Assistance Services, Back office Services, etc.

3.5 Conclusion

Thus, of the total 65 respondents, 61.5% are men and 38.5% are women. A large proportion of women are from the younger age group of 20 to 35 yrs., while the proportion of men is evenly distributed in all the age groups. All the respondents are educated, with maximum being graduates. 32.31% and 67.69% of the total respondents are from the upper middle and the middle class group respectively. Most of the respondents i.e. 31% are from nuclear family with the family size being 4. The sample includes respondents employed in all the sectors, with a majority of them (46.15%) being private employees.

Chapter 4

Exploring The Demand Side Of Health Insurance.

Life is said to be a process of change. Some even say that the only constant is "change". Yet amidst this constant change, there are perhaps three things that are certain: death, taxes and insurance.

Ever since the dawn of civilization, illness, chronic disability and death are perhaps the most haunting elements of mankind. In the age of sky rocketing medical expenses more is the anxiety, worry and fear.

The emphasis of this study is to assess the demand for Health Insurance in the middle class and upper middle class population of Mumbai suburbs. Beginning with the morbidity pattern and the health expenditures in the sample selected for the study, the chapter accentuates the importance of Health Insurance in the

context. The demand for Health Insurance is assessed by establishing a relationship between the need for Health Insurance and the willingness to pay. The various factors affecting the need for Health Insurance and the willingness to pay are analyzed in this chapter.

This has been achieved by gauging - the awareness about Health Insurance in the target population, the general characteristics of the insured population and its striking differences from the non insured, the perception regarding Health Insurance and finally how all these influence the factors affecting the demand for Health Insurance. The information on both utilization and need are analyzed to assess demand for Health Insurance. Thus, the chapter can be divided into three parts; 1) awareness about Health Insurance, 2) need for Health Insurance and 3) demand for Health Insurance.

There has been a transition in the paradigm of health problems, especially in the middle class population of a metropolitan city like Mumbai. (NFHS Maharashtra, 1998-1999). The communicable diseases are far yet from being controlled and the 'Life style diseases' have already invaded the city dwellers. This dual clout on the general public not only has an impact on their day to day activities but also on the economic value of human life.

4.1 Morbidity pattern in the respondents and their family members

The health problems reported by the respondents including that of their family members is more skewed towards common ailments, which seldom requires hospitalization. On an average the annual expenditure on health (excluding hospitalization charges) is Rs. 2000 as reported by the respondents. As the amount on health expenditure is too varied, the mean is affected by the extreme

values and hence, mode was taken into consideration for determining the average health expenditure.

Table 4.1: Ailments reported by 65 respondents.

Sr. no	Health Problems*	No. of respondents reporting it
1	Common ailments	54
2	Medical problems which may require hospitalization	22
3	Gynecological problems	8
4	Ailments requiring minor surgical intervention	6
5	Geriatric problems	15

* For the sake of convenience the health problems have been classified into broad categories.

Table 4.2: Detailed classification of the above mentioned ailments.

Categories	Health Problems*
Common ailments	Fever, cold, cough, acidity, skin ailments, fatigue, backache, bodyache, migraine, gastro-intestinal problems like amoebiasis, RTI.
Medical problems which may require hospitalization	Dyspnoea, Asthma, Arthritis, Hepatitis, Tonsillitis, UTI, Hypertension, Diabetes.
Gynecological problems	Menorrhagia, Metrorrhagia.
Ailments requiring minor	Hemorrhoids, Gall stone.

surgical intervention	
Geriatric problems	Osteoarthritis, Vascular disorders.

The above classification is based on the criteria - expenditure, continuity of the problem and chances of hospitalization. However, these are not separated by watertight compartments and most of the categories overlap with each other. Life style and Geriatric problems require medication for a long time and hence leads to a continuous and constant expenditure; whereas some medical, gynecological and ailments requiring surgical interventions, need hospitalization. Common ailments including skin ailments which although might aggravate does not need hospitalization. Many of the ailments mentioned above can be pooled down as life style diseases, like vascular disorders, hypertension, etc. In order to avoid duplication and confusion, diseases are not classified under this category.

4.2 Expenditure on Health Services

A 1991 national household expenditure survey carried out by the National Council for Applied Economic Research estimated that per capita household out-of-pocket spending in India was Rs. 240, which is about 75% of the total national health expenditure. (Policy and Financing Health Strategies for Strengthening Primary Health Care Services, 1995.)

Primary curative care-

Out of the sample of 65, the annual expenditure on primary curative care including drugs is about Rs. 500 in 47% of the respondents, more then 500 Rs. but

less then 3000 Rs in 44 %, and more then 3000Rs in 9% of the respondents. As already mentioned, the average expenditure is Rs 2000

The health expenditure being more commonly made on common ailments by a large number of respondents, it's frequency of occurrence in all the family members were recorded. However, this response is very specific to those occurrences of common ailments, when expenditures are made. These expenditures include expenditure on medicines by self-prescription or by doctor's prescription, on investigations and consultation.

Table 4.3: Frequency of the common ailments as reported by 64 respondents -

Frequency of the ailments, when expenditures are made.	Number of respondents reporting it	Percentage
Once a month	8	12.5
Once in 6 months	41	64
Once in a year	15	23.5
Total	64	100

* One of the respondents did not answer this question and hence the total number of respondents is reduced by one.

Maximum respondents, i.e. 64% of 64 respondents reported the occurrence of common ailments once in 6 months, while the frequency of once a month was reported by only 12.5% of the respondents. Thus, the average expenditure on common ailments for a large number of respondents was made once in 6 months.

The respondents were asked about the frequency of visit to the physician to know about their health-seeking behavior. This would include the expenditures

made only on consultation and medicines prescribed by the physician. As the respondents could not recollect the exact number of visits, the responses were classified under the broad categories of very often, sometimes and occasional visits to the physician. Seeking medical advice from the physician for every episode of common ailment was categorized as very often; seeking medical help only after trying home remedies or self-medication was classified as sometimes and seeking medical aid only in serious conditions, i.e. when the case requires urgent medical attention was classified as occasional.

Table 4.4: Frequency of visits to the physician for common ailments as reported by 64 respondents -

Frequency of visits to the physician	Number of respondents reporting it	Percentage
Very often	3	4.7
Sometimes	43	67.2
Occasionally	18	28.1
Total	64	100

* One of the respondents did not answer this question and hence the total number of respondents is reduced by one.

67% of the 64 respondents, visit the physician sometimes, i.e. only after trying self medication, while a very small proportion of respondents i.e. 4.7% seek medical help without self medication.

Thus Table 4.1, 4.3, 4.4 shows that common ailments being most common in a large number of respondents; the expenditures made on them by maximum respondents is once in 6 months, which necessarily does not include visit to the doctor. Thus, the visit to the doctor is rare by most of the respondents as even on

suffering from common ailments, most of them try self-medication first. This reflects **the health-seeking behavior** of the respondents, which may have implications on their attitude towards Health Insurance.

Hospitalization -

Overall inpatient expenditure accounts for one third of the total out-of-pocket spending. About, 70% of In-patient care expenditure is estimated to go to non-government facilities. (Policy and Financing Health Strategies for Strengthening Primary Health Care Services, 1995.) As already mentioned some studies (Gumber, 2000; Indrani, 2000) also show that the public prefers private health care facilities than the public ones.

20 of the 65 respondents, i.e. 31% had a history of hospitalization in the family. 7 (35%) cases spent 10000 Rs. or less, 9 (45%) between 10000 Rs. to 40000 Rs. and 4 (20%) had spent more then Rs.40000 per episode. The maximum expenditure made is 2 lakhs.

The ailments under all the categories mentioned in Table 4.1 may lead to hospitalization on aggravation of the problems. Thus, although the number of respondents reporting hospitalization is less, the probability of hospitalization is more. Moreover, the expenditure on hospitalization is also more.

Thus, it is difficult, if not impossible, for a typical individual to find financial resources to meet expenses in case of accidents or major illness. In such a scenario, one of the financial security tool available to the individuals in terms of timely treatment against maladies is Health Insurance.

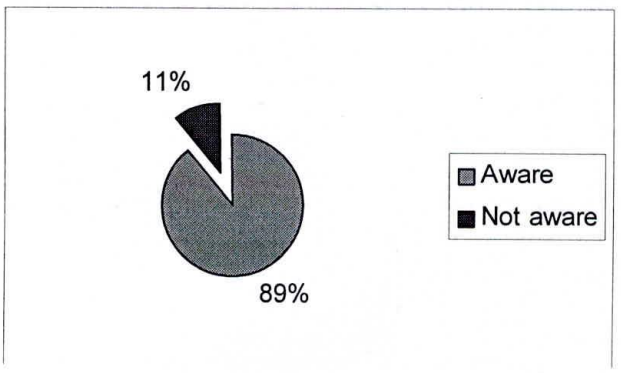
Health Insurance provides security against uncertainties associated with ill health and the consequent loss of earning ability and thereby eliminates worries, anxieties, and facilitates saving habits. However, hardly 3% of the Indian population are covered by some form of Health Insurance, either social or private. Although, Social Insurance is provided by the employers, Individual schemes are solely dependent on individual decision. It therefore becomes essential to investigate the acceptance of the people, which is determined by their awareness about insurance to some extent. Thus, the researcher attempts to delve into this issue by unveiling the awareness level in the population.

4.3 Awareness about the Scheme

It is expected that the awareness about insurance would have its implications on the felt needs and willingness to pay for the scheme. Thus, an attempt was made to know how many respondents have heard about Health Insurance and how many schemes do they know?

In a metropolitan city like Mumbai, the middle class population is exposed to all the consumer products including Health Insurance and hence the awareness is unregimented of educational qualifications and gender. Of the total 65 respondents interviewed, 58 i.e. **89.24%** are **aware** of Health Insurance which, is more popularly known as 'Mediclaim'. Of these 58 respondents; **95%** are **men** and **80%** are **women**.

Chart 4.1: Proportion of respondents aware and not aware of Health Insurance.



Among the 65 respondents interviewed 11%, i.e. 2 men and 5 women do not know about the scheme, which is 25.57% and 74.43% of the total men and women, respectively. Of these 7 respondents i.e. 10.76% **unaware** of Health Insurance; both the men are **postgraduates** and, of the women 4 are **graduates** and one is **postgraduate**. Thus, there is no relationship between educational qualification of the respondents and their awareness about Health Insurance. This implies that the media or peer communication plays an important role in creating awareness regarding Health Insurance. In both the genders, **all** the respondents of higher age group i.e. **above 36 yrs**. of age are **aware** of Health Insurance. This is due to the fact that such investment schemes are more popular in the middle and older age groups and the propensity to invest increases when the income is more consistent.

Table 4.5: Exposure to the scheme as per age and gender differentials.

Sex	Age	Exposure to the scheme		
		Aware	Not aware	Total
Male	20 -35	10 (83.33%)	2 (16.67%)	12 (100%)
	36 -55	16 (100%)	- (0%)	16 (100%)
	56 -75	12 (100%)	- (0%)	12 (100%)
Total		38 (95%)	2 (5%)	40 (100%)
Female	20 -35	13 (72.22%)	5 (27.78%)	18 (100%)
	36 -55	6 (100%)	- (0%)	6 (100%)
	56 -75	1 (100%)	- (0%)	1 (100%)
Total		20 (80%)	5 (20%)	25 (100%)
Grand Total		58 (89.23%)	7 (10.77%)	65 (100%)

Thus, awareness about Health Insurance is independent of educational qualification and is related to the exposure to the scheme, through various medium of communication.

4.3.1 How many have heard about how many schemes?

Inevitably, a very large proportion of **89.23%** of respondents know about **Mediclaim**, i.e. all those who know about Health Insurance, know Mediclaim. Only 12.3% of respondents know about all the schemes, 30.77% know about any 2 schemes and 46.15% know only Mediclaim. 31% and 36% of the respondents have heard of ESIS and CGHS, respectively. However, the number of beneficiaries under ESIS is 1 and CGHS is 2. Thus, not only the beneficiaries but also others are aware of such Government provided Health Insurance Schemes.

Table 4.6: Level of awareness about different insurance schemes in different age groups along with gender differentials.

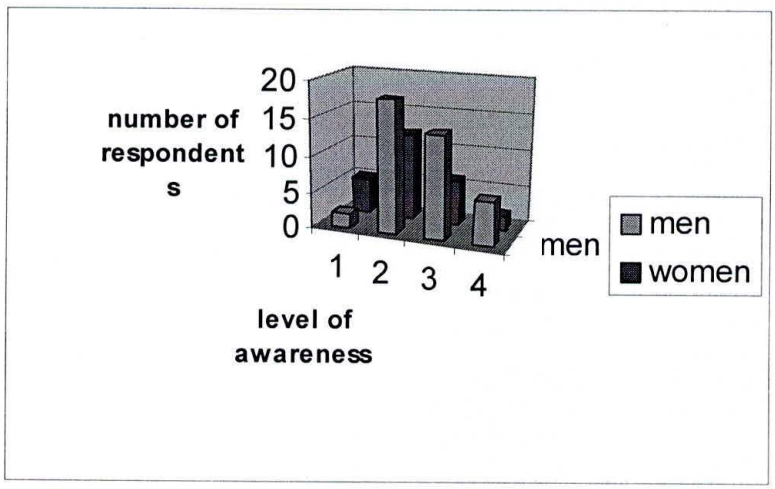
Sex	Age in years	Awareness about the Health Insurance schemes				Total
		Lack of awareness	Only Mediclaim	More then one scheme*	All the well known schemes**	
Male	20-35	2 (16.67%)	6 (50%)	3 (25%)	1 (8.33%)	12 (100%)
	36-55	- (0%)	7 (43.75%)	6 (37.5%)	3 (18.75%)	16 (100%)
	56-75	- (0%)	5 (41.67%)	5 (41.67%)	2 (16.67%)	12 (100%)
Total		2 (5%)	18 (45%)	14 (35%)	6 (15%)	40 (100%)
Female	20-35	5	8	5	-	18

		(27.78%)	(44.44%)	(27.78%)	(0%)	(100%)
	36-55	- (0%)	4 (66.67%)	1 (16.67%)	1 (16.67%)	6 (100%)
	56-75	- (0%))	- (0%)	- (0%)	1 (100%)	1 (100%)
Total		5 (20%)	12 (48%)	6 (24%)	2 (8%)	25 (100%)
Grand Total		7 (10.77%)	30 (46.15%)	20 (30.77%)	8 (12.3%)	65 (100%)

** - ESIS, CGHS, Mediclaim, Any other insurance schemes like Cancer Insurance Policy, etc.

* - Any two or more of the above schemes.

Chart 4.2: Level of awareness in different genders.

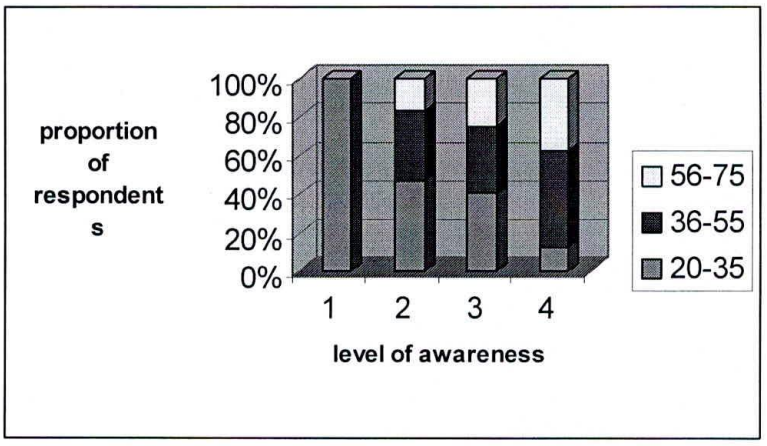


On the X-axis-
1- none of the schemes
2- only one scheme
3- more than one scheme
4- all the well known schemes

More number of schemes are known to men than women.

Chart 4.3: Level of awareness in different age groups.

[The legend denotes age groups of the respondents in yrs.]



On the X-axis -
1- none of the schemes
2- only one scheme
3- more than one scheme
4- all the well known schemes

The respondents in the younger age group know less number of schemes, while more number of schemes are known to respondents from the middle age group, i.e. 36-55 yrs. This could be attributed to the fact that the number of women in the younger age group are more and as seen from the chart 4.1, the level of awareness in women is less.

Table 4.7: Level of awareness about schemes as per the educational qualification and gender differentials.

Sex	Educational Qualification.	Awareness about the Health Insurance schemes				Total
		Lack of awareness	Only Mediclaim	More then one scheme	All the well known schemes	
Male	Secondary	- (0%)	1 (50%)	- (0%)	1 (50%)	2 (100%)
	Graduate	- (0%)	11 (47.83%)	9 (39.13%)	3 (13.04%)	23 (100%)
	Post Graduate	2 (13.33%)	6 (40%)	5 (33.33%)	2 (13.33%)	15 (100%)
Total		2	18	14	6	40

		(5%)	(45%)	(35%)	(15%)	(100%)
Female	Secondary	- (0%)	- (0%)	1 (50%)	1 (50%)	2 (100%)
	Graduate	4 (25%)	9 (56.25%)	3 (18.75%)	- (0%)	16 (100%)
	Post Graduate	1 (14.29%)	3 (42.85%)	2 (28.57%)	1 (14.29%)	7 (100%)
Total		5 (20%)	12 (48%)	6 (24%)	2 (8%)	25 (100%)
Grand Total		7 (10.77%)	30 (46.15%)	20 (30.77%)	8 (12.3%)	65 (100%)

The level of awareness is independent of the educational qualification. 37.5% of those, aware of all the schemes are post graduates, 37.5% are graduates and 25% have secondary level education. And as already shown from Table 4.5, among those **unaware** of Health Insurance; three respondents are **postgraduates** and, 4 are **graduates**. Thus, the awareness about Health Insurance schemes can be attributed to the media or self-awareness, through other modes like communicating with people.

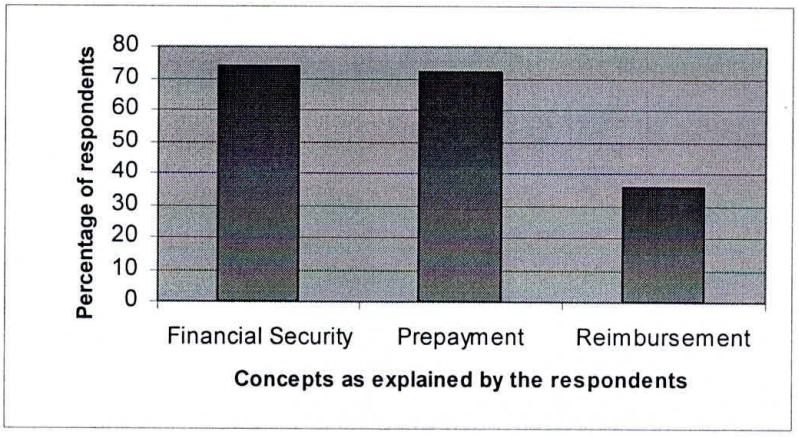
This shows that Health Insurance schemes are quite popular in the middle and upper middle class society, irrespective of their educational qualifications. Almost all of them have heard about Health Insurance Scheme. The level of awareness i.e. the number of schemes known is slightly more in men and in the middle age group.

4.4 Concept of Health Insurance as conceived by respondents

Health Insurance in general can be defined as "any form of insurance whose payment is contingent on the insured incurring additional expenses or losing income because of incapacity or loss of good health."

A detailed understanding of a scheme, its fundamental concept is required to be known by the people. The viability of a scheme is dependent on the acceptance of its basic concept. Thus, the survey tried to delve into people's notion about the scheme. The responses of the people were descriptive and so the essence of it was identified and clubbed under the broad categories of - prepayment to meet contingencies related to health, reimbursement mechanism and financial security against sudden crisis. Each of these reflects the focal point of attraction for the respondents towards Health Insurance. As the responses were subjective some of them could be included in more than one category.

Chart 4.4: Concepts as understood by respondents.



Financial Security against sudden crisis - A large number of about **74%** of the 65 respondents expressed that it is a mechanism by which financial burden is borne for the treatment by the insurance companies, in case of health emergencies, on making regular payments. Thus, these are the individuals whose focus is on the

entire scheme, with an interest of acquiring financial security. A change in any component of the scheme could effect their attitude.

Prepayment to meet contingencies- Almost **72%** of 65 respondents felt that one pays for his/her own health expenditures, in anticipation of future contingency. These are the individuals whose focus is on premium rates, i.e. the change in premium rates could effect their attitude towards Health Insurance.

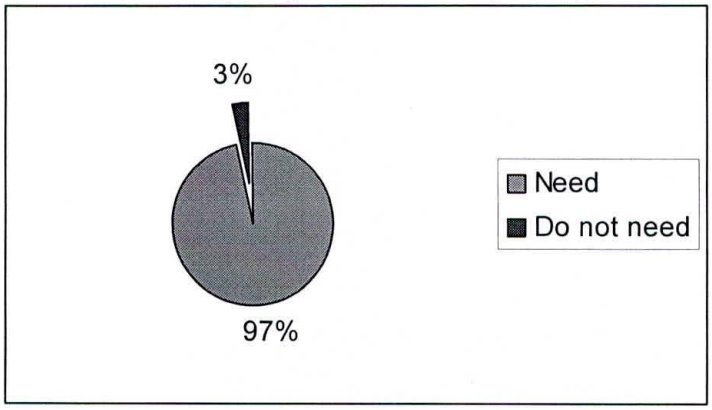
Reimbursement - Some respondents explained the concept as, the payment of huge sum for hospitalization by the insurance company, when claims would be made. These are the individuals whose focus is on the sum insured and their attitude might be effected by change in the total insured sum. Some of these might also be inclined towards more utilization of health services than needed, termed as 'Moral Hazard.' These responses accounted to almost 36% of 65 respondents.

Although there exist ambiguity about the exact underlying mechanism by which it conceptually operates, the concept is more or less known to people. It was also shown from the survey that most people saw Health Insurance as a part of Life Insurance Scheme.

4.5 Need for Health Insurance

The need for health Insurance is expected to be influenced by the awareness of the respondents about Health Insurance and the concept perceived by them.

Chart 4.5: Need for Health Insurance in 65 respondents.



Out of the total 65 respondents, 63 i.e. 96.92% felt that there is a need to have health insurance coverage, while 3.08% i.e. 2 respondents did not feel the need for Health Insurance. These 2 respondents quoted that they found Health Insurance to be worthless and would prefer to invest in some other saving schemes, which would yield better returns. Incidentally, both of them occasionally seek medical attention, and have never got any of their family members (including themselves) hospitalized. This kind of health-seeking behavior could also affect their attitude towards Health Insurance.

Table 4.8: Need as per the gender and age differentials.

Sex	Age in years	Need for Health Insurance		Total
		Need	Do not need	
Men	20-35	11 (91.67%)	1 (8.33%)	12 (100%)
	36-55	16 (100%)	- (0%)	16 (100%)
	56-75	12 (100%)	- (0%)	12 (100%)
Total		39 (97.5%)	1 (2.5%)	40 (100%)
Women	20-35	17 (94.44%)	1 (5.56%)	18 (100%)
	36-55	6 (100%)	- (0%)	6 (100%)
	56-75	1 (100%))	- (0%)	1 (100%)

Total		24 (96%)	1 (4%)	25 (100%)
Grand Total		63 (96.92%)	2 (3.07%)	65 (100%)

The need for insurance is 100% in the higher age group. With the rise in age, the tendency to fall ill and cater to the tertiary care services increases and so the need for such a financial security is high.

Table 4.9: Need for Health Insurance in different Socio-economic class.

Socio-economic class	**Need for health Insurance**		Total
	Need	Do not need	
Upper middle class	21 (100%)	- (0%)	21 (100%)
Middle class	42 (95.45%)	2 (4.54%)	44 (100%)
Total	63 (96.2%)	2 (3.08%)	65 (100%)

100% of the respondents from the upper middle class expressed that they need Health Insurance, while a major proportion of middle class group, i.e. 95.45% also expressed the need for it. The higher level of income allows the upper middle class people to invest in such schemes, which is also driven by the incentive of tax rebates.

The need for a product is highly affected by one's level of awareness and perception about the product. As seen above, the awareness being slightly more in the higher age group and in men, the findings for need also corresponds with it, i.e. the felt need for Health Insurance is little higher in men (by 1.5%) and in higher age group (by approximately 7%).

Thus, a large number of respondents felt the need for Health Insurance, and this felt need is influenced to some extent by age, the health seeking behavior and the socio-economic status.

4.6 Demand for Health Insurance

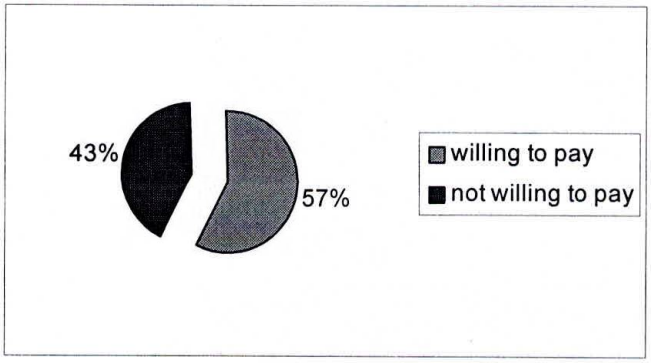
The demand for health care is fundamentally different from the demand for 'supermarket' type goods. There are variety of characteristics that distinguishes health care from other goods and there are number of failures specific to market, the most significant of them being that the demand and the supply do not interact in the conventional manner. Because of uncertainty and information gaps, the supplier is also involved in the decision making. Thus, the demand gets altered.

4.6.1 Willingness to Pay –

The demand for Health Insurance was elicited by 'willingness to pay', which also includes implicitly the ability to pay.

The survey included direct questions on the willingness to pay for the schemes. As the only Health Insurance scheme available is Mediclaim, the premium rates of Mediclaim were quoted to the respondents. However, the willingness of those who were already insured, pertains to the continuation of the scheme.

Chart 4.6: Willingness to pay for Health Insurance in 65 respondents.



37 of the total 65 respondents i.e. 57% are willing to pay for Health Insurance (Mediclaim), while 43% i.e. 28 of them are not willing to pay. Both these categories include both insured and non-insured.

Of the 37 respondents willing to pay, 30 respondents i.e. 81% of them are already insured under some scheme, the remaining 7 i.e. 19% of the total respondents have yet not been insured. This is the potential segment of the population that can be insured. Some of these 7 respondents said that they were not approached by any agent and did not even feel like taking an initiative; while some kept procrastinating. This shows the low preference given to health and hence, the low preference given to the need to have an insurance for health contingencies.

Table 4.10: Willingness to pay against Insurance status

Willingness to pay	Insurance status					Total
	Individual Mediclaim	Group Mediclaim	ESIS	CGHS	None	
Willing to pay	20	8	-	2	7	37
Not willing to pay	1	5	1	-	21	28
Total	21	13	1	2	28	65

Of the 28 respondents not willing to pay, 7are already insured under employer provided Insurance Schemes, as it included in the benefit package provided by the employers.

2 respondents insured under CGHS and 8 insured under Group Mediclaim, were also willing to pay, if they had not been provided any coverage by their employers, while 1 respondent who had already subscribed for Mediclaim

wanted to discontinue as her claim was rejected. Thus it becomes indispensable to know the factors like socio-economic status, family size, employment status, felt need of people for Health Insurance, etc. that influences their willingness to pay.

Table 4.11: Willingness to pay in different socio-economic group.

Socio-economic status	Willingness to pay		Total
	Willing to pay	Not willing to pay	
Upper middle class	15 (71.42%)	6 (28.58%)	21 (100%)
Middle class	22 (50%)	22 (50%)	44 (100%)
Total	37 (56.92%)	28 (43.08%)	65 (100%)

71.42% of the **upper middle class** respondents are willing to pay, while only **50%** of the **middle class** people are willing to pay. Of the 6 respondents not willing to pay from the upper middle class, 5 are men. This could be attributed to the fact that they must be financially secure to manage with emergency health cost. In both the classes 50% of respondents, not willing to pay for Health Insurance are from the younger age group. This is again, in consonance with the lower awareness level for Health Insurance expressed by the younger respondents and can also be attributed to the lower health risk in younger individuals. Some of these respondents are in the early ages of earning and hence may find it difficult to save money for investment on Health Insurance.

All those respondents employed under state government are unwilling to pay for Health Insurance, while only 1 out of 4 BMC employees i.e. 25% is willing to pay. This is due to the health benefits available to them, through their employers. However, for minor ailments they too cater to private services. 66.67% of private employees are willing to pay. Of these 66.67% of respondents, 80% are already

insured, which implies that most of them are willing to continue the schemes, while the target new consumers form a very small proportion of 20% of private employees. However, of the 80% of the private employees insured, 56% are of potential significance for the Insurance Companies as these respondents are insured under Individual Mediclaim and intend to continue with the scheme.

Table 4.12: Willingness to pay as per the family size.

Willingness to pay	Number of family members					Total
	2	3	4	5	6	
Willing to pay	8 (61.5%)	9 (56.3%)	9 (45%)	7 (58.3%)	4 (100%)	37 (56.5%)
Not willing to pay	5 (38.5%)	7 (43.7%)	11 (55%)	5 (41.7%)	- (0%)	28 (24.5%)
Total	13 (100%)	16 (100%)	20 (100%)	12 (100%)	4 (100%)	65 (100%)

Except in those respondents with a family size of 4, the willingness to pay in all the remaining respondents is more than the non-willingness to pay. However, the willingness to pay does not show any relationship with family size.

Table 4.13: Willingness to pay against Need for Health Insurance

Need for Health Insurance	Willingness to pay		Total
	Willing to pay	Not willing to pay	
Need	37 (58.73%)	26 (41.27%)	63 (100%)
Do not need	- (0%)	2 (100%)	2 (100%)
Total	37 (56.92%)	28 (43.08%)	65 (100%)

Of the total 65 respondents 56.92% were ready to pay as per the quoted premiums. However, of the 63 respondents who **feel** that there is a **need** for health insurance **only 58.73% are willing to pay** the premiums. Thus, it is obvious that although people feel the need for Health Insurance, they are not ready to pay for the premiums. One of the reasons cited by people are that they believe that they are in relatively good health condition and by following healthy life style they shall maintain it. Some felt that in the age of rising costs and rising demand for other items, they could not think of a new investment, whose returns are uncertain. Some respondents stated that they were unwilling to pay for the premiums, because they could not afford double expenditures on health, i.e. for drugs and minor ailments and on premiums. Although, various factors, like earning capacity, attitude, socio-economic status; may affect the willingness to pay, **uncertainty in returns** was found to be a major detrimental factor.

The willingness to pay is maximum in the age group of 36 to 55 yrs. which is 68.18% of the total respondents in this age group. This is due to the fact that at the middle age, individuals have a more stable source of income and tend to invest in some saving schemes. The rising age not only increases the susceptibility to illness and in a sequel which might lead to hospitalization, but also spawns the desire to be financially secured against such contingency.

Table 4.14: Need for Health Insurance against willingness to pay as per age differentials.

Need for Health Insurance	Age in years	Willingness to pay		Total
		Willing to pay	Not willing to pay	
Need	20-35	16 (57.14%)	12 (42.86%)	28(100%)
	36-55	15 (68.18%)	7(31.81%)	22 (100%)
	56-75	6 (46.15%)	7 (53.85%)	13 (100%)
Total		37 (58.73%)	26 (41.27%)	63 (100%)
Do not need	20-35	- (0%)	2 (100%)	2 (100%)
	36-55	- (0%)	- (0%)	- (100%)
	56-75	- (0%))	- (0%)	- (100%)
Total		- (0%)	2 (100%)	2 (100%)
Grand Total		37 (56.92%)	28 (43.08%)	65 (100%)

However, a remarkable finding has been that with increasing age beyond 55 yrs., the willingness to pay reduces. Only 46.15% of respondents in this age group are willing to pay. This can be attributed not only to the high premium rates for the aged but also to the frail financial condition towards the old age. Old people living a self-sustained life with minimal requirements and desires; seem to be least concerned of their health need. Some stated that since they are too aged they would die any day and did not want to waste money on such schemes. Some from the middle class section also said that although they wanted to avail for such schemes they could not afford it, as they were already spending huge sum on regular medicines and check up for chronic ailments, which were not covered by any health insurance schemes.

As shown in Table 4.15, almost 83% of men above the age group of 56 yrs. are insured. 50% of them are insured by their employers, while 50% are insured

under Individual Mediclaim. Although a large chunk from this age group are not willing to pay, such a large coverage implies that the premium of those who are insured under Individual Mediclaim must be paid by their children.

There was no conditional willingness to pay. When asked for the various conditions under which they would be willing to pay, the respondents expressed their despondency, stating their lack of faith in the entire system, it's management, lack of good quality and apt curative services, large distances to be traveled to seek health services, etc.

Thus, it is seen that more number of individuals from upper middle class and from middle age group i.e. 36 to 55yrs. are willing to pay. Private employees form a major chunk of those, willing to pay. The difference in the willingness to pay in both the genders is negligible. Therefore, Individual schemes must be so designed that it attracts both the genders from the upper middle class group, while the private employees can be taken care of by well-designed Group Insurance Schemes.

This certainly does not mean that the young and the middle class population have to be neglected, but separate scheme must be designed to target them.

As already mentioned the data on utilization aids in assessing the demand and also in determining the factors influencing demand. The analysis of the data on coverage of the respondents under various insurance schemes helps in cataloging the characteristics exclusive to insured and non-insured.

4.6.2 Utilization pattern

McKinsey, a management consultancy firm, estimates that there are some 315 million potential insurable lives in the country. 20.5 million households are already insured, leaving a market of 60.3 million households (or 315 million lives.) (based on data from NCAER).

Of the 65 respondents, **56.92%** are **insured** under some or other form of Health Insurance. Of the 56.92% insured, maximum are insured under Individual Mediclaim, which is 56.75%, the second largest insurance is under Group Mediclaim, while a very small segment is covered by CGHS and ESIS of 5.41% and 2.7% respectively.

Chart 4.7: Proportion of insured and uninsured in 65 respondents.

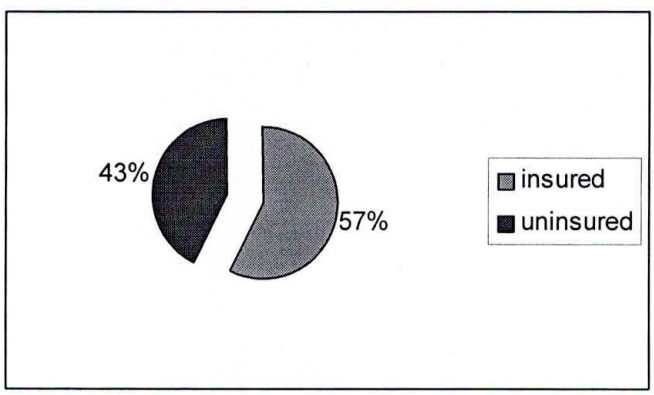


Table 4.15: Health Insurance Status as per gender differentials and age distribution.

Sex	Age in years	Insurance status		Total
		Insured under any scheme	Not insured under any scheme	

Male	20-35	8 (66.67%)	4 (33.33%)	12 (100%)
	36-55	8 (50%)	8 (50%)	16 (100%)
	56-75	10 (83.33%)	2 (16.67%)	12 (100%)
Total		26 (65%)	14 (35%)	40 (100%)
Female	20-35	7 (38.89%)	11 (61.11%)	18 (100%)
	36-55	4 (66.67%)	2 (33.33%)	6 (100%)
	56-75	- (0%))	1 (100%)	1 (100%)
Total		11 (44%)	14 (56%)	25 (100%)
Grand Total		37 (56.92%)	28 (43.07%)	65 (100%)

Of the 56.92% insured only **30%** of **women**, while **70%** of **men** are insured. This gender difference is due to the fact that men pay for their wives, especially if she is a house- wife. Some men do not insure their wives under such schemes, implying the low preference of women's health concerns in Indian society.

Among women, only one insured respondent (insured under Individual Mediclaim) belonging to the age category of 36 to 55yrs. is unemployed, rest all are employed. This suggests that women are insured either through their employers or pay from their self earned income. However, as seen from the previous explanation, the proportion of women willing to pay is almost the same as the proportion of men willing to pay. Thus, to attract this segment of population towards Health Insurance market, Health Insurance packages with different benefits and lower premium rates must be provided.

Table 4. 16: Health Insurance Status as per family size of the respondents

Insurance Status	Family size					Total
	2	3	4	5	6	
Insured	8 (61.5%)	10 (62.5%)	11 (55%)	6 (50%)	2 (50%)	37 (56.92%)
Not insured	5 (38.5%)	6 (37.5%)	9 (45%)	6 (50%)	2 (50%)	28 (43.08%)
Total	13 (100%)	16 (100%)	20 (100%)	12 (100%)	4 (100%)	65 (100%)

The maximum insured respondents are from the households with a family size of 3. The insurance status shows a relationship with the family size, i.e. as their family size increases, the number of respondents getting insured seems to be less. However, as the difference in the proportion of respondents getting insured, with respect to their family size is too less, this could just be a probability.

Of those insured 32.31% are from upper middle class; 67.69% are from middle class. This is due to the bias of the sample towards middle income group.

In the upper middle class group, of the 15 respondents insured only 1 respondent is insured under Group Insurance, rest all have taken Individual policy. While in the middle class group 15 out of 22, i.e. 68.18% are covered by employer provided scheme (Group Insurance, ESIS, and CGHS). It is due to the higher paying capacity of the upper middle class respondents that most of them are insured; while the middle class respondents have not consciously chosen to get insured, but have got insured through their employers. This shows that demand for health Insurance is **Income elastic**. Thus, the upper middle class

people should be the main target of the Insurance companies. For middle income group, more attractive schemes with lower premiums can be designed.

Table 4.17: Health Insurance Status against Socio-economic status

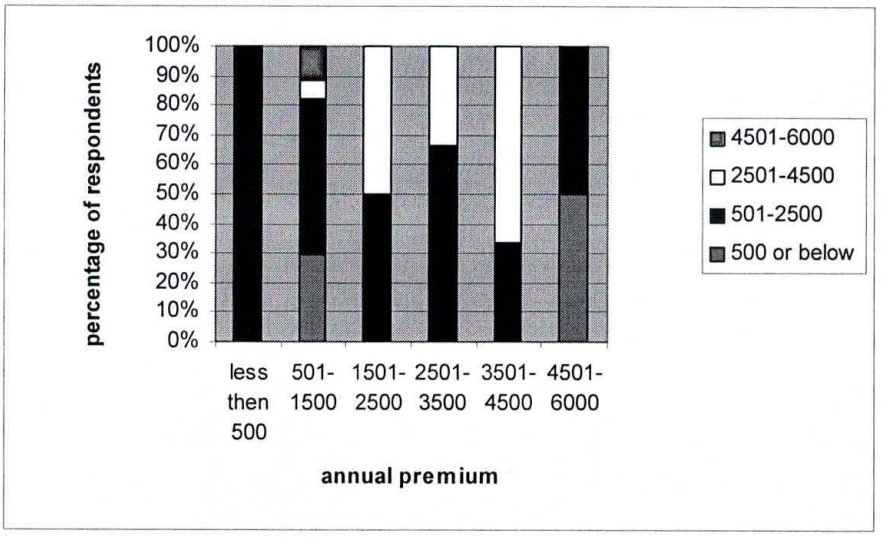
Socio-economic status	Insurance Status		Total
	Insured under any scheme	Not Insured under any scheme	
Upper middle	15 (71.43%)	6 (28.57%)	21 (100%)
Middle	22 (50%)	22 (50%)	44 (100%)
Total	37 (56.92%)	28 (43.08%)	65 (100%)

From Table 4.11 and Table 4.17, it is evident that the proportion of middle class group insured and not willing to pay i.e. wanting to discontinue the scheme is equal to the proportion of the those who are uninsured and are willing to pay i.e. are prospective customers of the insurance company. The first category includes all those who are provided insurance by their employers and this may influence their attitude and thus their demand for Health Insurance. However, in the second category of middle class people who are uninsured and are willing to pay, 4 respondents are private employees. These are the potential customers from the middle class population, who constitute only 9% of the total middle class population.

Thus, the characteristics of the insured are that all of them feel the need for Health Insurance and a large proportion among them are willing to pay i.e. are willing to continue the scheme. Most of them are men, from higher age group and from upper middle class.

As demand is also influenced by price of the product and prices of other products; a comparison of annual health expenditure (price of other products) with premium payment (price of the product) will aid in demand analysis. However, the limitation of this analysis is that only the annual health expenditure cannot be considered as the prices of other products; which must include prices of all the other commodities, including health and non-health components.

Chart 4.8: Annual premium in Rs. against Annual Health Expenditure in Rs.
[Legend - annual health expenditures in Rs.]



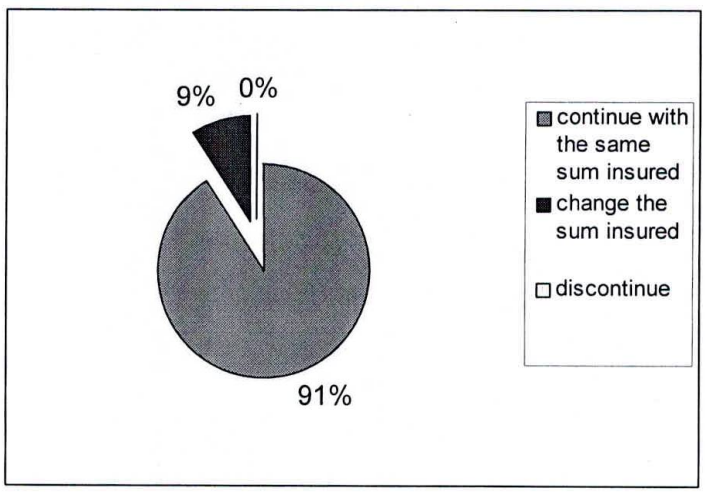
The graph shows the respondents spending more then Rs 4500. for their annual premium payment are the ones who have an annual health expenditure of less then Rs. 2500. This indicates that those who spend less on ambulatory care and medications throughout the year have a greater inclination towards insuring themselves against a higher amount by paying higher premium. Inductive logic can suggest that, as the annual health expenditure reduces the amount of premium payment increases. However, as the other categories (of annual Health expenditure, as seen from the graph) do not satisfy this, it is refuted. Thus, no

relationship can be developed between annual health expenditure and premium rates.

4.6.3 Effect of changes in price

During the course of the study, the premium rates were revised; thereby not only increasing the premium rate but also changing the age structure for the premium rates. (for details refer to the appendix) These were quoted to those respondents who were insured under Individual Mediclaim and asked if they would still continue with the same amount insured, or would reduce the sum insured or discontinue.

Chart 4.9: Affect on demand on change in price i.e. premium.



Of the 22 respondents insured, 20 respondents i.e. 90% said that they would continue for the same sum insured, a very small proportion of 10% of the insured i.e. only 2 of them said that they would want to reduce the insured amount, while none of them wanted to discontinue. Those who wanted to change the sum

insured in order to bring down their expenditure on premium were both from middle class group. Both these respondents had insured all their family members and hence expressed that the increase in premium rate would increase their cumulative expenditure on Insurance.

Thus the demand for Health Insurance is **price inelastic** to a great extent, as the change in price does not change the demand considerably. However, the demand for Health Insurance is **affected** to some extent in the **middle class group** with the **change in price**.

As the source of income in the middle and the upper middle class households is relatively more consistent, it is expected that the propensity to invest in various schemes would be greater. In this study, the propensity to save is estimated by examining the coverage under Life Insurance and Health Insurance.

The awareness regarding Life Insurance is almost 100%. This is not of much a difference from the awareness of Health Insurance, which is 89%. The coverage also does not show much variation. 64.62% have subscribed to Life Insurance, against 56.92% covered under Health Insurance Scheme. Thus, this implies that the coverage has a direct relation with awareness of the scheme. However, practically this is not found to be true.

Table 4.18: Coverage under Health insurance and Life Insurance.

Health Insurance Status	Life Insurance Status		Total
	Insured	Not Insured	
Insured under any scheme	27 (54.29%)	10 (43.48%)	37 (56.92%)
Not Insured under any scheme	15 (35.71%)	13 (56.52%)	28 (43.08%)
Total	42 (100%)	23 (100%)	65 (100%)

23.08% are insured only under Life Insurance; 15.38% only under Health insurance; 41.54% are insured under both; while 20% under none. There are various factors influencing the preference of Life Insurance over Health Insurance. As expressed by the respondents, the returns of investment in Life Insurance are indubitable. It ensures financial support to the family after the death of the breadwinner and hence warrants security to the dependents. Moreover, there are various innovative schemes designed to cater to the tastes of the consumers. It also provides other benefits like, claim free monetary bonus, dividends, etc. On the other hand Health Insurance does not guarantee return, i.e. if the insured does not get hospitalized in the insured period, he is not entitled to any monetary benefits. The Health Insurance Schemes do not even grant non-monetary benefits like preference in treatment or loan for major ailments, requiring huge sum for treatment. It even does not secure against total monetary loss caused due to illness, i.e. the loss caused due to loss in productivity.

Thus, it is obvious that the preference for Life Insurance is more then for Health Insurance, even if the propensity to save is more.

4.7 Conclusion

Health Insurance schemes are quite popular in the middle and upper middle class society, irrespective of their educational qualifications. Awareness is slightly more in men and in the middle age group. The findings for the need for Health insurance also corresponds with the awareness, i.e. the felt need is higher in men and in higher age group, albeit this finding is insignificant. The willingness to pay is seen to be more in the upper middle class group, middle

age group i.e. 36 to 55 yrs. and in the private employees. More number of individuals from the upper middle class group and higher age groups are covered under Health Insurance.

The differences in the age group for coverage and willingness to pay, reflects that the individuals from the higher age groups are covered by employer provided scheme or they are paid for by their children. Similarly, the gender bias becomes explicit as the willingness to pay is almost the same in both the genders, while the level of awareness and coverage is less in women than in men.

Health seeking behavior, need, willingness to pay, preference and perception of people about Health Insurance is also shown have its influence on the demand for Health Insurance.

The demand for health insurance is sum function of the price of the product, the prices of other goods, income, preference and taste of individuals, perception and attitude towards the product; which in all depends on the societal structure and socio economic factors.

As shown from the survey, the change in the premium rate did not change the demand to much an extent. The demand for Health Insurance is therefore **price inelastic**. However, the demand for Health Insurance is affected to some extent in the middle class group with the change in price.

The demand for Health Insurance is more in upper middle class income groups. And hence change in income alters the demand. Thus, the demand for Health Insurance is **income elastic**.

Thus, the main findings for the demand for Health Insurance are –

- Higher income status is associated for greater demand for health insurance.
- Price do not determine the demand for Health insurance to a great extent, but the demand may be affected to some extent in middle income groups than in upper income groups.
- Demand for Health Insurance is affected by the age of the individual, his/her socio-economic status and employment status; while it largely remains unaffected by certain variables like gender and educational qualification. Individuals from higher and middle age group and those employed in private firms demand more for Health Insurance.
- Demand is also affected by the level of awareness, the felt need for health insurance and the preference of the respondents for Health Insurance; while it is not much affected by other health expenditures. More the awareness and more the felt need for Health Insurance; more is the demand for Health Insurance.
- The demand would change with a change in the package of Health Insurance offered, as per the requirements of the people.

Chapter 5

Exploring The Supply Side Of Health Insurance

"Yogakshemam Vahamyaham"; "We aim to provide a high quality service"; "All claims falling within policy terms will be paid fairly and promptly" and so goes on the mission statements of most of insurance companies all over the globe. However, does this mean, "You lodge a claim, we pay it?"

This chapter attempts to achieve the aim of assessing the extent to which the existing schemes satisfy the demands of people. It begins with a brief mention of the fundamental principles and constraints under which Health Insurance functions in Indian market. In the light of these principles and constraints and the opinion sought from the representatives of the Insurance Company and Third Party Administration, the recommendations made by people and its feasibility are examined.

The objective of Health Insurance is to efficiently use the society's resources, maximizing consumer value and choices.

5.1 Principles of Health Insurance

Health Insurance basically rests on the principle of pooling risks associated with the same cause i.e. health, to share losses on some equitable basis. The risk sharing is either based on horizontal equity with the entire insured group cross-subsidizing the cost of hospitalization of each other known as "mutual insurance" or based on vertical equity, where the cost of hospitalization is transferred to an organization constituted privately that is willing to assume the risks and pay the resulting losses for a consideration, called premium. 'Mutual Insurance', which ensures horizontal equity is reflected in Group Insurance/Social Insurance. The second principle of loss sharing, which ensures vertical equity is reflected through 'Private Individual Insurance.'

A technique is used to determine whether a person is qualified or not for insurance and if so, what is the premium rate that he/she should pay for the insurance. This is known, as 'Underwriting' which is the backbone of insurance business. This technique aims at finding the future loss potential and choosing the price that exactly matches with it. Thus insured having identical risk ratings (equal loss potentials) are classified equally and charged same premiums and those, whose expected loss potentials are different, are classified differently and

charged different premiums. This method helps to attain actuarial fairness-charging rates that exactly align with the probable loss potential of every proposed insured so that "cross-subsidization" of different risk categories can be reasonably eliminated.

The technique of underwriting is extremely important for financial sustainability of the insurance company. The companies cannot remain solvent all the times unless government subsidizes their business. The main purpose of insurance is to help the insured in covering his losses, but not give him/her a chance to make profit. If the insured gets profit out of the policy he/she holds then the whole mechanism of the insurance will collapse down. On the other hand the insurer must be in a position to recover the operating expenses with desired profit margin. Hence the premium rates should be justified both for the insured and the insurer.

For the calculation of Health Insurance rates based on the information available, assumptions have to be made regarding - the probability of insured event occurring; the time value of money; the benefits promised; loadings to cover expenses, taxes, profits and contingencies. Based on these assumptions, appropriate methods are employed for risk classification and premium calculation.

Like any other financial services, insurance production greatly relies on financial and human capital. Financial capital underpins all operations by providing a cushion against the probability of actual expenses deviating negatively from the underlying assumptions. Thus the insurance companies insure themselves and transfer the risk of insured to the reinsurer by giving a part of their premium to them.

5.2 Constraints

A major constraint in Health Insurance market is information asymmetry. A market is competitive, only when the buyers and sellers are both well informed. However,

- In Health Insurance, the insurance contracts being considered complex and technical, the buyers tend to know less then the sellers. . This problem is termed as 'lemon problem.' As the provider has more technical expertise the insurer may mislead the customers, leading to adverse selection problems, wherein an individual with already some pre-existing conditions may be motivated to get insured. However at the time of emergency the Insurance Company may not reimburse on the grounds of exclusion of pre-existing conditions.

- The buyer knows more about his/her health conditions then the seller and hence may not disclose all the required information. This may lead to coverage of high risk individuals, who pays premium lower then the expected values of their losses, which imposes cost on other insured and distorts pricing. This is known as 'adverse selection problem.'

- 'Moral Hazard' is the tendency of the people (both provider and consumer) to change their behavior, to extract maximum benefits from the insurance company.

- The insurance agent's aim is to maximize his/her own personal gains, which is not always proportional to the principal's gain (Insurance Company's). This is known as Principal agent problem.

Besides all this, there is a non-existing information problem; i.e. neither the buyer nor the seller has complete information due to the fact that the required information does not exist. Both the insurer and the insured individual face uncertainty. Prices are set by the insurance company before the cost of production is known and individual too cannot have a complete knowledge about the consequences of their choices.

Environmental factors like the economy, inflation, new laws and regulations, changing consumer needs, attitudes and preferences, present great uncertainties to both buyers and sellers.

The strategy adopted by Insurance Company is already mentioned in Chapter 3, which shows that neither the private Insurance Scheme nor the government provided Scheme follow the market strategy of conducting an initial market survey to design a scheme, which is not only feasible but also acceptable. Thus it is obvious to find gaps between the consumer demand and supply.

5.3 Consumer Satisfaction/ Experience

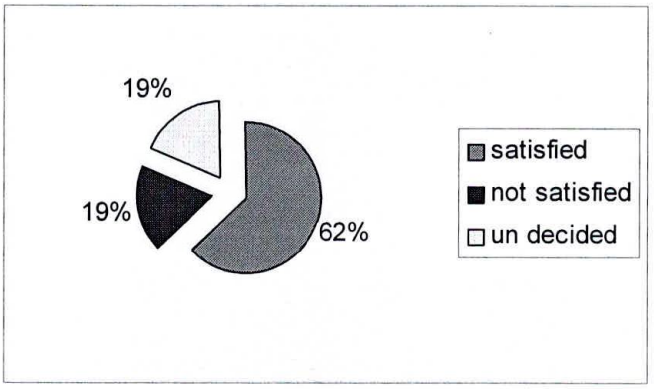
16 claimants i.e. those who are insured and have made claims for reimbursement of hospitalization costs, were interviewed to assess the consumer satisfaction about the services provided by Mediclaim.

The satisfaction is assessed on the parameters of –

- Status of claim settlement, i.e. whether claim is already settled, rejected or awaited,
- Time taken to settle the claims,

- Kind of procedures involved, in terms of paper work, number of visits or phone calls made,
- Problems encountered in terms of making arrangements for the money needed to pay for the hospital charges,
- Problems faced in settling the claims including mental tension and time and efforts spent.

Graph 5.1: Satisfaction levels among the claimants.



Out of 16 claimants 10 i.e. **62%** of the total are **satisfied**, 3 i.e. 19% are not satisfied and 3 i.e. 19% are undecided i.e. they are not able to decide whether they are satisfied or not. These categories are predominantly influenced by their reimbursement status, i.e. all the claimants whose claims are completely settled, are satisfied; those who are awaiting the settlement are in dicey situation and are yet not able to decide and those whose claims have been rejected are unsatisfied. All the 3 claims were rejected on the basis of pre-existing conditions. 2 of the rejected claims are awaiting justice in the consumer court.

Those who were satisfied expressed that the premium amount is almost negligible when compared to the catastrophic medical cost arising out of hospitalization and in the hour of high uncertainty. On an average the time taken for settlement of claims was 2 months ranging from minimum15 days to maximum 4 months. Only 2 claimants had problems with arranging money for the hospitalization costs. They had to borrow money from their kin /friends. 5 i.e. 31% of the claimants had their claims settled through agents and hence the procedure was smoother for them. Even for those who personally underwent the process, the average number of visits or phone calls made were 2. However, those claimants whose claims were not settled had to make more than 4 visits to the Insurance office. Those, whose claims were rejected, accused the insurance company of not providing adequate information to them, at the time of getting insured. As a consequence, they had to suffer monetary losses and also mental stress. One of the claimants stated that she feels 'humiliated' and 'cheated'.

The claimants who were satisfied with the schemes were all willing to continue. Of the 3 claimants who were unsatisfied, two were prepared to continue the scheme as they felt that there are no other options available for them. Incidentally, both of them happen to be from higher age group and hence this attitude could be attributed to their susceptibility to illness or hospitalization. The decision to continue of the remaining claimants depends on the settlement of their claims.

5.4 *To what extent does the demand and the supply converge?*

5.4.1 Period of coverage –

Instead of having an annual premium payment which, has to be renewed every year, 10% of the respondents suggested that it should be for more then a year's

period so that the insured is free of the responsibility of renewing the scheme every year.

The scheme can be designed as per this recommendation but the uncertainty due to non-existent information for both the insurer and the insured as mentioned above, would increase. Moreover, the premium rate would also increase; not only to cover the time value of money, but also to encompass the greater ambiguity created due to longer time period.

About 8% of the 65 respondents also suggested that it should be for less then a year, to enable those insured to discontinue in the face of financial constraints.

The premium rates in this case would reduce and hence in case of any emergency the loss borne by the insurance company will increase. Thus, even if this recommendation is accepted the sum insured will be reduced.
About 10% of the respondents recommended the flexibility of the period of coverage i.e. different scales of premium for different time period of coverage must be available, from which the individuals can select a desirable package.

As already evident for the above made explanation, tailor made schemes are possible but will require a lot of effort from the Insurance Company to design different models using different mathematical models.

5.4.2 Premiums –

15% of the 65 respondents recommended that premium structure must be on a sliding scale of income, while 14% of the respondents suggested that premium structure must be tailor made considering occupation, income, health condition,

age, etc. However, both the above recommendations are not feasible, as in India there is a dearth of information on different variables like occupation, income, etc. Even if one tries to conduct a survey and collect the data, the income can never be truly estimated, due to multiple sources of income that an individual has. Types of occupation are so varied that it will lead to more then 1000 categories, thereby increasing the complexity of premium calculation.

26% of the respondents suggested higher premiums to be charged from elderly individuals and those already suffering from illness, instead of excluding them. On this, the representative from the Insurance Company expressed that if such high risk groups are included; the premium rate of all the insured would increase. And if a separate scheme is designed for them, the premium rate would be so large that it would be deterrent for anyone to get insured. The risk involved in susceptible individuals and older people is almost 100%. Thus the total amount as per the principles of insurance, has to be recovered from the total contributions, which eventually will lead to propelling of the premium rates tremendously beyond the paying capacity.

5.4.3 Medical Benefits-

68% of the 65 respondents feel primary care must be included, 19% of respondents expressed the need to cover even the cost on ophthalmic treatment, dental treatment and charges on dentures, spectacles, etc. If all these are to be included in the existing Health Insurance in India no private Insurance Scheme would remain viable. However, a system of co-payment as suggested by few (12%) can be adopted which will not only reduce the abuse of the system, but also provide additional finance to the Insurance Company. However, the representative of the Insurance Company felt that it would be difficult to manage

and once implemented may not be even easily acceptable by all. The above mentioned 12% of the respondents represent those people who would accept the system of co-payments.

14% of the respondents wanted maternity benefits and 8% wanted only first Cesarean Section to be covered, while some even suggested co-payments or user fees to be charged in case of Cesarean Section. This recommendation was refuted on the grounds of tremendous cost escalation, as every insured pregnant woman would definitely claim for Cesarean Section. This would also lead to the termination of all the pregnancies into Cesarean Section; i.e. no one will go for normal delivery. Besides, every woman will get insured to avail this benefit. This might also have a tremendous impact on the number of Cesarean Section recommended by the Obstretician, as the coverage by Insurance Company will further motivate them to increase their earnings through this surgical procedure.

The recommendation of 24% of the respondents to include certain expensive Investigations like CAT Scan and MRI was turned off on the basis of 'Moral Hazard', leading to increased demand for such Investigations. This was included in Health Insurance Schemes some years back and was ceased due to the above mentioned problem.

29% of the respondents emphasized the need for mandatory health check up at the nodal point of entry and periodical medical examination to seek medical advice and take appropriate preventive measures. This suggestion was although appreciated, was not considered to be feasible as medical examination with investigation would incur a large amount of money and if people are rejected at the point of entry after charging for medical examination, it would lead to

discrepancies between the public (especially those refused) and the Insurance Company. However, on a pilot basis this can be tried out.

5.4.4 Non medical benefits-

Non monetary benefits-

Some (9%) suggested non monetary benefits to be provided to the insured like preference in treatment or consultation, thereby avoiding waiting time. This recommendation can be adopted by meticulously planning with the hospital. However, if not planned adequately would lead to discrimination of patients (i.e. insured and non insured), especially where waiting time is more. Other non monetary benefits like credit card seemed to be feasible.

Monetary benefits-

In order to attract more people towards Health Insurance, 28% of the respondents recommended promotion of claim free bonus, while 14% recommended other benefits like free passes for dramas, tours, etc. This is against IRDA rules and hence is ruled out at present. It may be possible in coming years if the rules are amended.

Easy loans on medical treatments and some investigative techniques were suggested by 10% of the respondents. This was completely ruled out by stating that it is not within the scope of Insurance business.

5.4.5 In general about Health Insurance

33% of the respondents suggested stringent regulations to be enforced in order to prevent false claims and 22% of the respondents demanded cash less transaction. Both the above mentioned objectives would soon be achieved with the advent of TPA in the Insurance Sector.

Almost none of the respondents were aware of the TPAs and when explained 55% of the respondents agreed that it is a good scheme and were hopeful that it would bring a change in the existing system. However few of them were skeptical. 15% of the respondents felt that this might lead to further increase in premiums as the new party is also a private entity and will also function for profit, while 5% of the respondents felt that they might tie up with the hospitals and Insurance Company with some hidden motives which might be harmful to the insured.

A very large number of respondents i.e. almost 68% of 65 respondents demanded comprehensive coverage to all i.e. all kinds of services should be available to all, irrespective of their income, age, occupation, etc. However, with the backdrop of all the above made explanations this suggestion is not feasible in any way for a larger mass. As seen in some Group Insurance Schemes, by designing an appropriate scheme for a community or a smaller section of society, this could be achieved.

5.5 Scaling the Demand for Health Insurance

"When inherent factors have been measured, the measurement of the whole phenomenon does not remain an impossibility."

In order to capture the entire findings on demand in one snapshot and to verify as to what extent they are being satisfied and would further be satisfied, based on 'Bogardus Social Distance Scale', a scale has been devised.

The demand made for Health Insurance by people is scaleable, as they are logically interrelated and are in a form of continuum along a scale of complexity i.e. one end of the continuum denotes the existing benefit provided, while along the scale to the other end the feasibility of implementation becomes more and more difficult.

To attain this logical flow, the opinion of the people and the recommendations made about various components of Health Insurance were first quantified in terms of percentage. Each of these were discussed with the experts to assess the feasibility of its implementation. Based on certain criterias, the complexities of each of these elements were decided. These criterias are

1. Can be satisfied but difficult to manage.
2. Difficult to satisfy.
3. Almost not possible to be satisfied.

The most prominent demands are classified in to 5 categories as mentioned below. The recommendations made under each of these categories have been rated from number 2 to 4. Number 1 denotes the existing clause -

Period of coverage -

1- The premium has to be paid annually thereby providing coverage only for a year, after which the scheme has to be renewed.

2- The coverage period must be increased to more then a year.

This can be satisfied by increasing the premium rate exorbitantly, considering various factors that are already mentioned in the preceding part of this chapter. However this could affect the demand and hence could be a threat to the viability of the scheme.

3- The coverage period must be reduced to less then a year.

As most of the financial estimates are made on annual basis, the calculation of premium rates would be more difficult. Moreover, the risk borne by the insurance company would also increase, as already mentioned.

4- Enough flexibility must be provided, such that the consumer gets an opportunity to select among a range for the period of coverage.

As already mentioned due to the non-availability of adequate data this is almost impossible.

Premium structure

1- The existing scheme gives a standard or universal premium tariff, which depends on age.

2- More premium must be collected for the one's with pre-existing conditions instead of excluding them.

As this entails almost 100% risk the financial sustainability and viability of the scheme would be questionable.

3- Premium structure to be based on sliding scale of income.

Very difficult to obtain such data.

4- Premium must be tailor made considering income, occupation, age, health status, susceptibility to occupational hazards, location of residence, etc.

Almost impossible to design taking into consideration the minute details about each individual in such populous nation with huge variations.

Primary Care-

1- The primary care service is totally excluded in the existing Health Insurance Scheme.

2- Co-payment for primary services including for drugs, spectacles, etc.

Experts anticipated that it is difficult to be managed and demand may reduce.

3- Certain benefits like ophthalmic care, dentures, drugs, spectacles, etc. must be provided free under the scheme.

   Although, it is included in other countries the Indian system is not geared to fulfill this demand.

4- Comprehensive care i.e. all types of health services to be made available under Health Insurance Scheme.

   The viability of the scheme would be threatened.

Other Medical Benefits -

1- Cost of health check up at the end of a block of 4 claim free years.
2- Annual Medical Check up and Medical Check up at the entry point of getting insured.

   This would lead to difficulty in financial management. However it is being tried out on pilot basis in small population.

3- Investigations like MRI and CAT scan to be included.

   As already mentioned this was included and has been curbed out due to undesirable consequences.

4- Reimbursement for Maternity Benefits and first Caesarian Section

   As already mentioned the problem of moral hazard, adverse selection and cost escalation almost rules out this option.

Non monetary benefit -

1- Cumulative bonus like increase in the sum insured by 5% for each claim free year and 10% discount on spouse and dependents.
2- Preference to be given to the insured in consultation and hospitalization.

   It can be satisfied but has to be well planned.

3- Other benefits like credit card, free passes, concessions, etc.

Difficult but not impossible to be implemented.

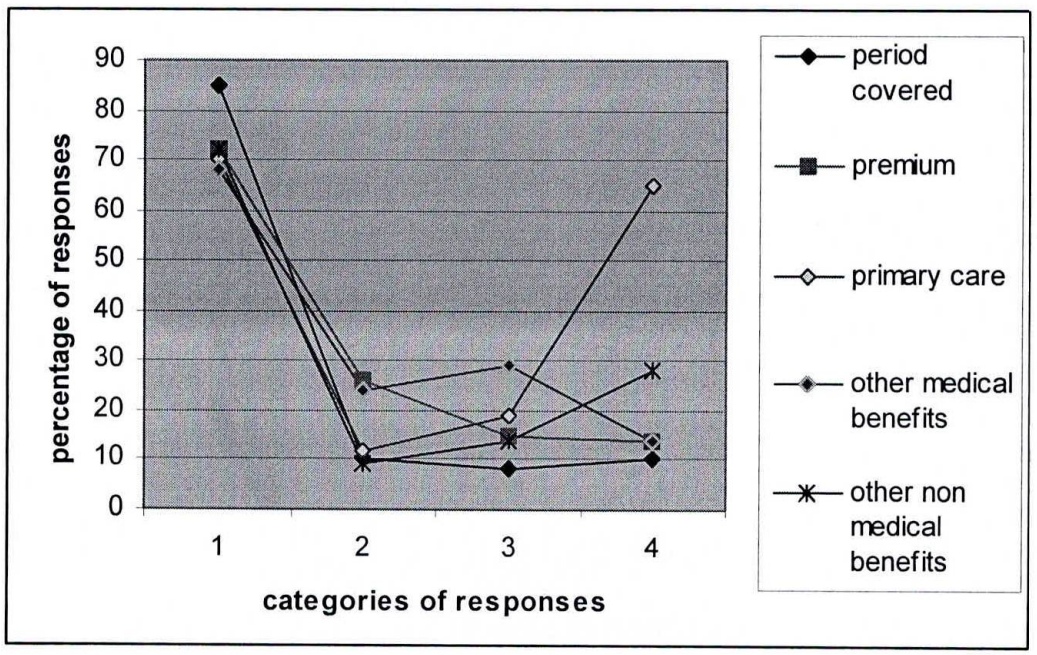
4- Claim free monetary bonus and loans for medical expenses.

It is beyond the scope of Health Insurance as these violate the IRDA rules.

Table 5.1: Changes demanded for Health Insurance by 65 respondents.

Category	Percentage of responses in different category			
	1	2	3	4
Period of coverage	85	10	8	10
Premium Structure	62	26	15	14
Primary Care	60	12	19	68
Other medical benefits	70	29	24	14
Other non medical benefits	72	9	14	28

Graph 5.2: Scaling of demand for Health Insurance



The study of this graph shows that a large number of provisions provided under the scheme are satisfactory. The graph immediately falls after 1 which shows that the number of respondents demanding a change in the existing provisions are very few. However, the line graph of primary care does not confirm with this finding. A large number of respondents have demanded comprehensive care to be made available under Health Insurance.
The downward trend of the line representing premium structure indicates that the changes demanded, with the increasing complexity is less.

The constant change in the upward and the downward trend of the line graph representing primary care, period of coverage, other medical benefits, and other non medical benefits; show that the demand is made irrespective of its feasibility to be implemented, for instance some demanded loans to be provided for health care which is beyond the ambit of Health Insurance.

Thus, to a large extent the demand for Health Insurance is being met by the existing schemes, while some can be met further on with innovations in the scheme and some are beyond the purview of being implemented.

5.6 Conclusion

The services provided by the Insurance Companies are commendable to a great extent as most of the claimants were satisfied and did not face any difficulty in settling their claims. However, as suggested by some of them, especially by those

whose claims were rejected; the Insurance Company must maintain transparency providing all the requisite information to their clients.

Considering the principle of Health Insurance and the constraints of the Health Insurance Market, the recommendations of the respondents were analyzed. Some of these recommendations are acceptable, while some are just not feasible. The recommendation of tailor made schemes; co-payments for some health benefits like Investigations and dentures, etc.; monetary benefits like claim free bonus, non monetary benefits like credit card and preference in consultation; were acceptable, although it would need further reshaping of the entire system. The recommendations of various health benefits like primary care, maternity benefits, reimbursements for Cesarean Section; restructuring of premium rates based on income, occupation, etc; inclusion of pre-existing conditions and availability of loans for medical treatment could not be accepted on any grounds as these would pose a threat to the solvency/financial sustainability of the company.

A well planned and detailed market survey for the consumer analysis can further explore the consumer behavior and the capacity of the supplier to innovate and provide new packages of insurance schemes to the middle class population.

Chapter 6

Conclusions and Recommendations

"One of the greatest investments which we can make is to invest in health, for there is no other investment like it.... Health is life insurance, success and happiness insurance".
-Mahatma Gandhi.

The awareness regarding Health Insurance in general is high among the middle and the upper middle class urbanites. However, the knowledge regarding Health Insurance and various schemes is inadequate. Moreover, the study shows that the knowledge or awareness regarding the scheme is unregimented to educational qualification, as there is no direct relationship between awareness and educational qualification of the respondents. This implies that the awareness is through peer communication and mass media exposure. Hence is a need for greater publicity. The level of knowledge and the curiosity to know about Health

Insurance is considerably less in younger population. Gender difference is evident in the level of knowledge and coverage. Thus, the marketing strategy adopted must be such that the product appears simple i.e. easy to understand and attractive.

The need for Health Insurance is almost absolute and the willingness is nearly equal in both the genders. Thus there is a potential market untapped which can be covered. Moreover, the need as well as the coverage is found to be higher in the higher age group although the willingness to pay is less in this age group. This implies that their kins must be paying for their premiums and hence a strategy to attract such groups must be adopted. A scheme, which would include the aged at high premium and also provide incentives for the kins to be a part of it, can well serve the purpose.

However, in general the willingness to join (felt need) is much more than the willingness to pay. The willingness to pay is seen to be more in upper middle class group than in the middle class group. More number of respondents from the middle age group and those employed in private firms are willing to pay. Thus, although almost everyone feels the need for Health Insurance, the propensity to get insured depends on a number of factors like- Socio-economic factors, attitude, preferences, health seeking behavior, etc.

Although, the coverage of Health Insurance in middle and especially upper middle class group is reasonably good, much more potential remains untapped in these classes. This is manifest in the finding that many uninsured are willing to pay, but have been procrastinating, due to lack of any incentive. This again indicates the need for a better marketing strategy.

It has not been possible to establish a concrete relationship between family size and demand for Health Insurance and total expenditure and demand for Health Insurance.

Most of those who have claimed for reimbursement for hospitalization costs are satisfied with the services rendered, except for few whose claims have been refused. Thus in all, the claim settlement does not take much time, but more transparency is required such that people do not unnecessarily undergo stress.

Thus comprehending the demand analysis, the study at large shows that with increase in income and increased awareness the demand for Health Insurance is rising. The demand for Health Insurance is price inelastic, i.e. even a change in the premium rate did not change their demand. However, the demand is ensued with few conditionalities, like modification in some services, in order to make it more acceptable and attractive. The consumer is ready to pay more but demands a wider range of services and pliability in the services provided. However for operationalization of these demands the existing schemes and the suppliers' perspective also needs to be understood.

Most of the respondents are satisfied with the provisions of Mediclaim, like the period of coverage, the premium structure and the promptness in the reimbursement of the claims. However, few demands, which are crucial for the people to decide whether to take up the schemes or not, are not being fulfilled, like coverage for ambulatory care, inclusion of pre-existing conditions, claim free monetary benefit, etc.

Besides these, Mediclaim is also infested with inherent problems like, it is most primitive kind with no innovations to attract customers. This is because of the

procedure used to fix the premium, and the kind of benefits provided, which has remained the same since many years. Regulations are also poor encouraging expensive corporate hospital treatment by not giving enough attention to the appropriateness of claims. The existing Mediclaim policy does not properly serve a large proportion of the population engaged in low paid informal activities. Pricing of the product is very important, when benefits to cover an event are predetermined. In Mediclaim, pricing of products is most non-scientific, has an arbitrary loading [a] pattern, even more arbitrary discount pattern [b], adjustment of premia is non-existent and bonus clause is outdated [c].

However, the policy is now tied up with TPAs and hence most of these problems, except for the coverage of individuals from low-income groups can be solved. The new tariff with revised premium rates is an outcome of this tie up with the TPAs.

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a - loading are amounts to cover expenses of insurer in selling, issuing and maintenance of policy, taxes, contingencies and its profits.

b - the amount subtracted by the insurance company from the covered expenses to determine recovery.

c - cumulative bonus is the same since the inception of Mediclaim.

The Central Government Scheme is meant for the Central Government Employees and their families. It thus belongs to the middle and high-income categories and they use more health service than average. People use the services disproportionately for access to specialist consultants, and problems include long

waiting periods and significant out-of pocket expenses on treatment, inadequate supplies of medicines, equipment, inadequate staff and unhygienic conditions.

Literatures on CGHS show that the beneficiaries do not get appointment with the specialist immediately. Visits of the specialists to the dispensaries are limited and hence the beneficiaries are required to travel considerable distances for examination by the specialists at the hospital to which they are attached. There appears a lack of co-ordination and desired level of feedback in so far as interaction of the dispensary doctor and the specialist is concerned. Patients also complain regarding delay of 7 to 8 days in issue of medicines procured through the chemists and delay in reimbursement of the amount spent by beneficiaries on purchase of medicines from the open market. At times beneficiaries are handicapped for procuring medicines against the authorization slips as some chemists are closed at times.

For many of the problems in Health Insurance Sector, TPA is seen as solution, which not only imposes fair means of regulations on the insured and hence prevents its abuse, but will also augment the efficiency of the services. Most of the respondents were in favor of this and it has already become an integral part of all Health Insurance Schemes.

6.1 Some Recommendations-

There has been a huge gap between the supply and demand for health Insurance. On one hand the supplier intends to supply huge amount for rare incidences, while on the other hand the consumer demands smaller sum for frequent occurrences.

However with the changing scenario this gap is being narrowed down. The consumer is getting more prudent and hence feels the need to secure himself/herself against huge monetary losses in case of contingency; while on the other hand with privatization more number of suppliers are planning to take a plunge into the market and provide a wide variety of innovative services.

Thus considering the demand for Health Insurance and the extent to which the components needs to be changed as to further increase demand, few feasible options are recommended here-

An accurate analysis of the market demand is essential before the development of a new product or any changes in the existing product. A consumer can never be completely satisfied. As shown in the study even those who appear to be satisfied have some suggestions, which would further satisfy their needs. These unsatisfied needs, needs to be explored and addressed.

In order to ascertain the customer satisfaction, the insurance company must undertake market survey and the information so collected must be analyzed logically and the product features to be subsequently improved.

An expert can only analyze the features of the product and recommend changes as per its feasibility. However a lay man who lacks expertise can give crucial inputs as per his felt needs which would increase the acceptability of the product. Thus designing of a product should not be confined to the creativity of the designer, but must also extend to the customer. A periodical market survey of the product will complement the above-mentioned process.

A general belief is that with increasing longevity the demand for Health Insurance is expected to move up. However, this study reveals that although the awareness and need for Health Insurance is more, the number of aged individuals insured does not conform with it. Thus, need for Health Insurance of this segment needs to be addressed. A product with low premium would attract this segment of the population, while as the risk entailed is more, this would pose threat to the viability of the scheme. Thus a proper balance needs to be struck between the two. The young populations are highly important as they are less susceptible to illness and hence are a good risk, who in the long run can boost the insurance business. As the study reveals that the awareness is less in this group, the emphasis on the normative need for Health Insurance for such groups and marketing of the products to attract them is extremely essential.

The security provided by the joint family is at decline due to emerging nuclear family structure. Strategies to attract small families like better benefits for spouses or children can be adopted.

Consumers should be given a time schedule so that uncertainties about reimbursement and arbitrary denial of claims are minimized and better monitored.

There is also a need to cover the growing cost of out patient costs. The insurance plan can provide incentive to those depending on referral, by giving lower reimbursement to those who by pass it.

The changes in the technological aspects are continuously influencing customs, beliefs, habits, level of education, preferences, standard of living etc. thereby changing the views of the people towards risk and uncertainty of life and health.

These also influence the emotional and mental capacity of individual. In the fast paced life one feels threatened even at the mere thought of illness due to incapacity which eventually leads to loss of earning capacity. Thus Health Insurance Scheme would relieve them of stress and tension, hence it needs to be propagated with proper message.

Thus, if a well developed private Health Insurance covers the affluent class, Social Insurance covers smaller groups through Community based Insurance and Group Insurance, the remaining vulnerable and most unaffordable class of people below poverty line can avail to quality services provided by the government. Thus, even in the pluralist nature of health care services optimal utilization of resources can be achieved.

6.2 Limitations of the study

Time, money, personnel have been the major constraints in this study leading to numerous limitations-

- ✓ The sample size is too small and hence none of the findings can be generalized.
- ✓ Demand is determined by many determinants like tastes, preferences, expenses on other goods, etc. Some of these like tastes and preferences are too subjective and hence could not be quantified or accurately measured. It was not possible due to time constraints to assess the expenditure on every goods/services.
- ✓ Due to the reluctance of the respondents to reveal their income, the exact income could not be assessed and hence for income elasticity of demand the over all socio-economic status based on some specific criteria was considered.