A STUDY ON SOCIO-ECONOMIC DETERMINANTS OF HEALTH INSURANCE IN KANYAKUMARI DISTRICT (TAMIL NADU)

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ABSTRACT

A health insurance policy is a contract between an insurer and an individual or a group, in which the insurer undertakes to provide specified health insurance benefit to the insured in consideration of a fixed price called premium payable either in lump sum or in installment. In India, there are various types of health coverage based on ownership the Existing health insurance schemes can be broadly divided into four categories, such as: Government or state-based systems, Market-based systems (private and voluntary), Employer provided insurance schemes and Member organization (NGO or cooperative)-based systems. The objectives of the study are to examine the equity aspects of Health Insurance coverage and to analyses the socio-economic determinants of Health Insurance coverage in Kanyakumari District. The primary data are collected from the respondents of Kanyakumari District and for analyzing the primary data, statistical tools such as Chi-square test & F-test are used. From the analysis of data that there is an inequity in access to health care for the different level of income groups. The socio-economic factors such as age, gender, educational qualification, occupation and community are also affecting the demand of Health Insurance.

Key Words: Health Insurance, Policy, Health care, Health Insurance Company.

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INTRODUCTION

Health is an important constituent of human resource development. Good health is the real wealth of society. It is not only enhances human efficiency but also leads to a decline in the private and public expenditure on sickness and disease. Healthcare services help to reduce infant mortality rates, check crude death rates, keep diseases under control and raise life expectancy. Improved health contributes to economic growth in four ways (World Bank, 1993). It reduces production losses caused by worker illness, it permits the use of natural resources that had been totally or nearly increasable because of disease, it increases the enrolment of children in schools and makes them better able to learn, and it free for alternative uses resources that would otherwise have to be spent on treating illness. Health has been declared as a fundamental human right in India along with several other countries. The policy concern in developing countries including India is not only to reach the entire population with adequate healthcare services; but also to secure an acceptable level of health for all the people through the application of primary healthcare programs. A health insurance policy is a contract between an insurer and an individual or a group, in which the insurer undertakes to provide specified health insurance benefit to the insured in consideration of a fixed price called premium payable either in lump sum or in installments. Health insurance usually provides either direct payment or reimbursement for expenses associated with illnesses and injuries. The rate of premium charged and extent of cover provided by the health insurance depends on the specific policy bought under the insurance contract between the insured and the insurer.

ORIGIN OF HEALTH INSURANCE

The English word "health" comes from the Old English word *hale*, meaning "wholeness, a being whole, sound or well,". At the time of the creation of the World Health Organization (WHO), in 1948, *health* was defined as being "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. For an individual, either at a personal level or the family front, of which he or she is a part, health is an extremely important subject, which needs to be given priority.

The same concept can be extended to the level of the country, where the health of the citizens, comes at the core for its long term sustainable development.

*The history of the concept Health insurance can be traced back to the year **1883-84,** when in Germany, compulsory accident and sickness insurance was initiated by **Otto von Bismarck.*** The same concept was also adopted by Great Britain, France, Chile, the Soviet Union, and other nations after World War I. In the year 1946, in Britain the National Health Insurance which went into effect in 1948 provided the most comprehensive compulsory medical care plan. In which individual obtained free medical attention by participating doctors of National Health Service. The cost was met by the national government and local taxation & nominal charges for some services were levied. Similarly 1958 the Canadian Hospital and Diagnoses Act provided full hospital services almost free of charge in public wards. The concept of National health insurance widely adopted in Europe and parts of Asia.

Social Security for Health Insurance is a new thing for the Indians. It is a common practice for villagers to take a 'piruvu' (a collection) to support a household with a sick patient. However, health insurance, as we know it today, was introduced only in 1912 when the first Insurance Act was passed. The current version of the Insurance Act was introduced in 1938. Since then there was little change till 1972 when the insurance industry was nationalized and 107 private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). Private and foreign entrepreneurs were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered under any form of health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country. The Indian health insurance scenario is a mix of mandatory Social Health Insurance (SHI), Voluntary Private Health insurance and Community- Based Health Insurance (CBHI). Health insurance is thus really a minor player in the health ecosystem.

Before independence in India, health care has been based on voluntary work. Since ancient times traditional practitioners of health care have contributed to the medicinal needs of society. Acute knowledge in the medicinal properties of plants and herbs were passed on from one generation to another to be used for treatment. The colonial rule and the dominance of the Britishers changed the scenario. Hospitals managed by Christian missionaries took centre stage. Prior to

independence the healthcare in India was in shambles with large number of deaths and spread of infectious diseases. After independence the Government of India laid stress on Primary Health Care and India has put in sustained efforts to better the health care system across the country.

In 1947, the **'Bhore Committee Report'** attempted to analyze the state of *health* care in *India* and to make recommendations for the improvement of *health* care services in *India.* On the eve of India's independence in *1947*, the Bhore Committee Report became the template for the structure of *health* care services in *India* in the postcolonial era, as reflected in the postcolonial government of India's Five-Year Plans.

The current Health Insurance scenario

India spends about 6.5 to 7% of GDP on Health care (official estimates around 6%) out of which 1.2% is in the Govt. sector (this accounts for 22% of overall spending) and 4.7% in private sector (78% of overall spending).

In India, we yet do not have any universal health insurance plan, which caters to all the citizens of our country. There are various types of health coverages in India. Based on ownership the Existing health insurance schemes can be broadly divided into 4 categories, such as:

1. Government or state-based systems.
2. Market-based systems (private and voluntary).
3. Employer provided insurance schemes.
4. Member organization (NGO or cooperative)-based systems.

1. Government or state-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. But there are some special insurance schemes promoted by the Government, which provide medical benefits to specific sections of our society.

The under-mentioned initiatives & schemes are those which have been promoted by the Government or with the help of the Government.

a. Central Government Health Scheme (CGHS)

It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also

covered. This scheme is mainly funded through Central Government funds, with premiums ranging from Rs 15 to Rs 150 per month based on salary scales.

b. Employee and State Insurance Scheme (ESIS)

The enactment of the Employees State Insurance Act in 1948 led to formulation of the Employees State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Medical care is also provided to employees and their family members without fee for service. Originally, the ESIS scheme covered all power-using non-seasonal factories employing 10 or more people. Later, it was extended to cover employees working in all non-power using factories with 20 or more persons. While persons working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded. Service establishments like shops, hotels, restaurants, cinema houses, and road transport and news papers printing are now covered. The monthly wage limit for enrolment in the ESIS is Rs. 15,000.

c. Other Government Initiatives

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen's Compensation (Amendment) Act 1984, Plantation Labour Act 1951, Mines Labour Welfare Fund Act 1946, *Beedi* Workers Welfare Fund Act 1976 and Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996. The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services.

2. Market-based systems (private and voluntary)

In the Open Market based category, there are various Health Insurance plans being offered by both Private & Public Insurance companies. A Broad outline of the health plans, available is provided below:-

a. Individual health plan

These are the so-called 'traditional' health insurance covers, commonly known as 'Mediclaim' policies. They mainly cover hospitalization expenses provided it is for at least 24 hours. The expenses for hospital bed, nursing, surgeon's fees, consultant doctor's fees, cost of blood, oxygen and operation theatre charges are the usual inclusions. However, unlike the past, most plans now come with sub-limits for each of these heads. They usually do not cover pre-existing diseases or complications arising from them for the first four years of the policy. Besides, claims for specific ailments may not be allowed in the first or second year. For every claim-free year, most plans add 5 per cent to the sum insured. Market-based systems (voluntary and private) have Mediclaim scheme which covers about 2.5 million of population. 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.

History of Mediclaim scheme

The government insurance companies started first health insurance in 1986, under the name Mediclaim; thereafter Mediclaim has been revised to make it attractive product. Mediclaim is a reimbursement base insurance for hospitalization. It does not cover outpatient treatments. First there is 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. Mediclaim has provided a model for health insurance for the middle class and the rich. It covers hospitalization costs, which could be catastrophic.

b. Family floaters Plans

These can be seen as agglomerations of individual health plans, for a family. The benefits remain largely the same, but the sum insured can be availed by any or all members of the family and not a single person. Rather than buying, say, a Rs 200,000 health cover for each member of the family of four by spending for a total cover of Rs 800,000, if you bought an Family Floaters for

Rs 800,000, each person covered under it can avail benefits up to Rs 800,000 as opposed to Rs 200,000 in the earlier instance. This reduces the need for you to pay from your pocket. Also, it comes at a lower premium than otherwise. A Family Floaters can be bought by an individual who becomes the proposer along with spouse, dependent children up to 25 years or even unmarried, divorced, widowed daughter and dependent parent.

c. Critical illness plan

This is not a substitute for a 'Mediclaim', but you should ideally add this layer to the latter. It provides financial assistance if the insured develops a serious ailment, such as cancer, or has a stroke. Each cover has a list of ailments, usually 9-12 of them. One can get it in the form of a rider attached to a life insurance cover, or as a standalone policy from either a life insurer or a non-life insurer. If critical illness occurs, it pays the entire sum insured and terminates and can happen only once for any particular illness. To get the payout, the insured has to survive for 30 successive days after the diagnosis. No claim can be made during the first 90 days of the inception of the policy. The policy term is usually longer (10-20 years) if this cover is bought from a life insurer as a rider than from a general insurer (1-5 years).

d. Senior citizens health plan

Most Individual Health plans, cap the entry age at around 60 years, while Senior Citizen Health Plans, are generally for the age group of 60-80 years. Most can be renewed lifelong or up to the age of 90, and has a fixed coverage of, say, Rs 100,000 or Rs 200,000. Besides looking for sublimit, those taking Senior Citizens Health Plan should watch out for certain illnesses as many ailments are excluded from the plan. Senior Citizen Health Plans might even have the option to attach a Critical Illness plan

e. Daily hospital cash benefit

This should be the last option when buying health plans. Most hospital cash plans might also inconvenience you as they offer the benefit after discharge from the hospital, and only after the policyholder produces proof of the number of days he stayed there. Hospital cash benefit has a pre-defined limit in most cases, say Rs 500 per day for up to 50 days\ in a year and up to 250 days during the entire term.

f. Unit-linked health plans

These are mostly defined benefit plans - usually for the long term - and, unlike a standard health insurance policy, the payout is not dependent on the costs actually incurred. Health Ulips are

made up of two parts - a health plan and a unit-linked investment plan. Although these policies are being sold by life insurers, they may not cover life risk. Out of the premium one pays, a portion goes towards medical coverage and the rest of the premium is invested in a fund that operates like a mutual fund.

g. Covers from life insurers

Life insurance companies, too, have started offering health plans. Most of these are, however, defined benefit plans - the prespecified amount which is the sum insured is paid as compensation, irrespective of the actual amount of expenses incurred. Also, these are long-term, having a fixed premium for, say, three, five, or even 10 years. Most of the types of plans discussed above are on offer. Some will even throw in a life cover for good measure.

h. Note on Pre-existing diseases

This is a common problem area since there was no standard definition of pre-existing illness earlier. In June 2008, the General Insurance Council said "the benefits (of health insurance) would not be available for any condition, ailment or injury or related condition for which the insured had signs or symptoms, and/or was diagnosed and/or received medical advice/treatment, prior to inception of the first policy, until 48 consecutive months of coverage have elapsed, after the date of inception of the first policy."

3. Employer provided insurance schemes

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 (Ellis et al. 1996). General Insurance Corporation (GIC) and its four subsidiary companies and Life Insurance Corporation (LIC) of India have 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 (Srivastava 1999). 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.

4. Member organization (NGO or cooperative)-based systems - Community Health Insurance

CHI is "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." Various other terms are used in reference to community health insurance, including: 'micro health insurance' 'local health insurance' and 'mutuelles' They are generally targeted at low-income populations, and the nature of the 'communities' around which they have evolved is quite diverse: from people living in the same town or district, to members of work cooperative or microfinance groups. Often, the schemes are initiated by a hospital, and targeted at residents of the surrounding area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory.

The Gaps & improvements area in Health Insurance

Over the last 50 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators. In case of government funded health care system, the quality and access of services has always remained major concern. A very rapidly growing private health market has developed in India.

This private sector bridges most of the gaps between what government offers and what people need? However, with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

The proportion of insurance in health care financing in India is extremely low. Public spending in health care is very low at 17% and the National Health Policy has recognized this More than 86% of healthcare financing is through unplanned or, non-contributory spending 86% from out-of-pocket expenses 83% from private sector spending Health care financing in India.

Some of the main reason, as to why there has been restraint in the growth of Health Insurance, during the last decade is listed down:-

- Inadequate healthcare infrastructure
- Limited reach

- Significant underwriting losses for Health Insurance business in India
- Lack of standardization and Accreditation norms in healthcare industry in India
- Insufficient data on Indian consumers & disease patterns resulting in difficulty in product development and pricing.

The factors will play important role, in driving the Health Insurance Industry to the next platform.

- Increasing awareness of Health Insurance as rising healthcare costs have increased need for health insurance
- Supporting Demographic Profiles (Prospering Middle Class, increasing disease state, population).
- De-tariffing of the general insurance industry (which has increased emphasis and efforts by insurance companies towards health insurance and other personal lines of business)
- Rationalization of premium rates (e.g. trend of upward revision in respect of Group Health policies)
- In order to encourage foreign health insurers to enter the Indian market the government has recently proposed to raise the foreign direct investment (FDI) limit in insurance from 26% to 49% , Government initiatives are always supportive to Healthcare Insurance Environment.
- The average annual household consumption in healthcare (discretionary spending) is expected to double between 2005 and 2025.
- There is a clear indication that seekers (annual income between INR 2,00,000 and 4,99,999) and strivers (annual income between INR 5,00,000 and 10,00,000) population is significantly increasing in the next future. There will be a direct proportionality of this increase to healthcare spending parity.
- Salient Demographic Features that support the growth of Health Insurance in India: Adult literacy rate in India is 61.3% and the youth literacy rate in India is 73.3% and is expected to increase in the future.
- The Disease rate in India is increasing. India has one of the highest heart disease and diabetes rates in the world.

- It is home to one-sixth of the world's population occupying less than 3% of the world's area.

S O W T Analysis of the Health Insurance Opportunity in India

Strengths [future Growth Factors]	**Weakness [Gaps in the Industry & System]**
• India is now the second fastest growing major economy in the world. • Third largest economy in the world, • Indian healthcare has emerged as one of the largest service sectors in India. • Healthcare spending in India is expected to rise by 15 per cent per annum. • Healthcare spending could contribute 6.1 per cent of GDP in 2012 and employ around 9 million people.	• Inadequate healthcare infrastructure • Limited reach • Significant underwriting losses for business in India. • Lack of standardization and Accreditation norms in healthcare industry in India. • Insufficient data on Indian consumers & disease patterns resulting in difficulty in product development and pricing.
Threats **[Areas needing immediate concern]** • New modern private insurance companies are indulging in money making businesses with little interest in insurance. • Insurance policies contain too many exclusion clauses. • Most insurance companies now use "Call	**Opportunities [Untapped Potential]** • Increasing awareness of Health Insurance as rising healthcare costs have increased need for health insurance. • Supporting Demographic Profiles [Prospering Middle Class, increasing disease state, population].

centers" and Staff attempt to answer questions by reading from a script. It is difficult to speak to anybody with expert knowledge.	• There is a clear indication that seekers [annual income between INR 2,00,000 and 4,99,999] and strivers [annual income between INR 5,00,000 and 10,00,000] population is significantly increasing the next future. There will be a direct proportionality of this increase to healthcare spending parity. • The Disease rates in India are increasing. India has one of the highest heart disease and diabetes rates in the world. • Shift to lifestyle related diseases.

REVIEW OF LITERATURE

Bansal (1999) has examined the status of health care financing in India and concludes that increase in health expenditure is mainly due to salary and non-salary components and not because of higher share of health expenditure in State Domestic Product.

Gumber and Kulkarni (2000) tried to explore the availability of health insurance system for the poor and especially women, their needs and expectations of a health insurance system and the likely constraints in extending current health insurance benefits to workers in the informal sector.

Mahal (2002) has examined the entry of private health insurance. He suggested for a comprehensive and long-term perspective at issues of health insurance and health care provision in India.

Nyaman (2002) says that the demand for health insurance is a demand for an income transfer in the event of illness. This income transfer allows those who become ill to purchase more health care and other goods and services than they would if uninsured.

Mudgal et al. (2005) and others have tried to verify whether consumption expenditure of households in rural India was insured against medical ailments and have concluded that the villagers were not able to perfectly share the risk of all shocks.

'Kirigia et al (2005), in their study on developed countries claimed that individual and household level variables are important determinants of health insurance ownership.'

Srinivasan (2006) has studied about the economics of health insurance in India. The author concluded that the increased public health spending and revamping of public health facilities are must for the success of the community based health insurance scheme in India.

Menon (2006) has attempted to explore whether the system can be made to generate better health outcomes, enable participation of civil society, optimize utilization of existing capacities and promote more need based on the development of resources.

Bhat and Jain (2006) have studied the micro health insurance schemes and communities based on health insurance schemes and have concluded that the household income is an important determinant.

Sethi and Bhatia (2009), stated that demand for health insurance in India is due to aggravation of environmental pollution, poisonous gasses, life style changes, difficulties in meeting the cost of medical treatment and hospitalization, government policies and regulations in the form of taxation benefits. In addition, most companies these days are providing the advantage of health insurance to their workforce.

J. Yellaiah , G. Ramakrishna (2012) have Suggested that, Income, health expenditure, and occupation are being the most important factors, and are positively connected to income; the Governments should aim at generating sufficient incomes to the people through various employment guarantee schemes and through cash transfer methods.

Health Finance Indicators

Health Finance Indicators include allocations under Five Year Plans, details of expenditures on health, trends in public and private spending. Investment on Health & FW, AYUSH and Health Research for 11th Plan (2007-12) is Rs.1,31,650.92 crore, Rs. 3,988.00 crore and Rs.4,496.08 crore respectively. Total budgetary allocations under Health Sector are Rs.1, 40,135.00 crores.

Objectives of the study

1. To examine the equity aspects of Health Insurance coverage in Kanyakumari District.
2. To analyses the socio-economic determinants of Health Insurance coverage in Kanyakumari District.

Analysis of the Study

The primary data are collected with the help of well-structured questionnaire. Totally 150 respondents are randomly selected from four Taluks of Kanyakumari District and for analyzing the primary data, statistical tools such as Chi-square test & F-test are used.

Table: 1 Respondent from Taluks

Sex	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Male	11	35	23	66	28	64	18	45	80	53
Female	20	65	12	34	16	36	22	55	70	47
Total	**31**	**100**	**35**	**100**	**44**	**100**	**40**	**100**	**150**	**100**

Source: Primary data

Name of the Taluks	Number of Respondents	%
Agastheeswaram	31	21
Thovalai	35	23
Kalkulam	44	29
Vilavancode	40	27
Total	**150**	**100**

Source: Primary data

The present study has covered the respondents from four taluks of Kanyakumari District viz, Agastheeswaram (21%), Thovalai (23%), Kalkulam (29%) and Vilavancode (27%).

Socio-Economic Profile of the respondents

Table: 2 Sex

Age	Agastheeswaram	Thovalai	Kalkulam	Vilavancode	Total

The above table reveals that out of the total 150 respondents, 53 percent of the respondents are male and remaining 47 percent of the respondents are female.

Table: 3 Ages

	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
<25yrs	3	10	4	12	4	9	7	18	18	12
25-35yrs	11	35	15	43	17	39	8	20	51	34
35-45 yrs	10	32	11	31	14	32	11	27	46	31
>45 yrs	7	23	5	14	9	20	14	35	35	23
Total	**31**	**100**	**35**	**100**	**44**	**100**	**40**	**100**	**150**	**100**

Source: Primary data

Majority of the respondents are in the group 25-35 years of age (34%), followed by 35-45years of age (31%). Only 12% of the respondents are below 25 years of age.

Table: 4 Occupations

Occupation	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Government employee	7	23	6	18	9	20	6	15	285	19
Private employee	9	29	11	31	18	41	8	20	46	31
Self employed	15	48	18	51	17	39	26	65	76	50
Total	**31**	**100**	**35**	**100**	**44**	**100**	**40**	**100**	**150**	**100**

Source: Primary data

Majority of the respondents are Self-employed (50%). Out of these 15 respondents from Agastheeswaram Taluk, 18 respondents from Thovalai Taluk, 17 respondents from Kalkulam Taluk and the remaining respondents from Vilavancode Taluk. It also reveals that majority respondents (41%) from Kalkulam Taluk are employed in private concerns.

Table: 5 Monthly Incomes

Income (monthly)	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
<Rs.10000	10	32	15	43	15	34	10	25	50	33
Rs.10000-Rs.20000	13	42	10	29	17	39	15	38	55	37

Rs.20000- Rs.30000	4	13	9	26	7	16	12	30	32	21
>Rs.30000	4	13	1	2	5	11	3	7	13	9
Total	**31**	**100**	**35**	**100**	**44**	**100**	**40**	**100**	**150**	**100**

Source: Primary data

The above table reveals that majority of the respondents' monthly income from all the four sample taluks are Rs.10,000- Rs.20,000.

Table: 6 Educational Qualifications

Qualification	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
High School level	1	3	8	23	7	16	8	20	24	16
Higher secondary	8	26	7	20	5	11	9	22	29	19
Graduates	10	33	10	29	18	41	15	37	53	36
Post Graduates	11	35	9	26	12	27	7	18	39	26
Illiterate	1	3	1	2	2	5	1	3	5	3
Total	**31**	**100**	**35**	**100**	**44**	**100**	**40**	**100**	**150**	**100**

Source: Primary data

It is witnessed from the above table that majority of the respondents are Graduates (36%) and Post Graduates (26%). Only about 3% of the respondents are illiterate.

Awareness of Health Insurance and reason for not having Health Insurance policies

Table: 7 Insured on the basis of Community

Community	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
BC	6	46	7	44	15	60	7	54	35	53
MBC	4	31	2	13	5	20	2	15	13	19
SC\ST	2	15	3	18	0	0	1	8	6	9
OC	1	8	4	25	5	20	3	23	13	19
Total	**13**	**100**	**16**	**100**	**25**	**100**	**13**	**100**	**67**	**100**

Source: Primary data

Insured respondents based on community are presented in the above table. Only 67 respondents have Health Insurance policies either in Government or Private Insurance companies. 53 percentage respondents from backward class (BC) from all the four sample taluks are having

Health Insurance policies. It also indicates that the awareness of buying Health Insurance policies among SC\ST communities in Kanyakumari District is very low.

Hypothesis: There is significant difference between the taluks and the community to buy Health Insurance policies in Kanyakumari District.

(X^2=10.094, ndf=9, Table value of X^2 at 5% level= 16.919)

Test result accepts the hypothesis. There is significant difference between taluks and communities to buy different types of Health Insurance policies in Kanyakumari District.

Majority of the respondents of SC/ST communities in Kanyakumari district are unaware of the importance of Health Insurance policies. The Government and the Private players in the Health Insurance Industry may launch new schemes to reach socially under privileged people in Kanyakumari District.

Table: 8 Reason for uninsured

Reason	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Earning low income	6	33	12	63	9	47	13	48	40	48
Higher premium	2	11	0	0	2	11	2	7	6	7
Formalities to get medical treatment	5	28	2	11	3	16	5	19	15	18
Difficult in claim the benefit	5	28	5	26	5	26	7	26	22	27
Total	**18**	**100**	**19**	**100**	**19**	**100**	**27**	**100**	**83**	**100**

Source: Primary data

The above table clearly indicates that the low income of the respondents from four sample taluks is the major hurdle for buying Health Insurance policies. Difficulties in getting claim benefits is an another cause for not taking Health Insurance policies.

Hypothesis: There is no significant difference between the four taluks in Kanyakumari district and reason for not having Health Insurance policies.

(F-test=.258, ndf=3, 12, Table value of F at 5% level= 3.49)

F-test reveals that there is no significance difference between various taluks in Kanyakumari District and reason for not having Health Insurance policies.

Table: 9 Preferences of Health Insurance Schemes

Category	Number of respondents	%
Government based Insurance schemes	15	22
Private or market based schemes	48	72
Employer provided Insurance schemes	4	6
NGO or Co-operative based schemes	0	0
Total	**67**	**100**

Source: Primary data

Majority of the respondents are preferred private based Health Insurance schemes (72%) than the Government based Health Insurance schemes.

Hypothesis: There is no association between the taluks and the category of Health Insurance policies.

(X^2= 8.056, ndf=9, Table value of X^2 at 5% level= 16.919)

The X^2 test shows there is no association between the taluks and the category of Health Insurance policies.

Table: 10 Preferred Health insurance Companies

Name of the Company	Number of respondents	%
Star Health Insurance company	30	45
Reliance Health Insurance company	12	17
LIC of India	11	16
ICICI	4	6
ESIC ICICI	3	4
United India Assurance company	2	3
Bajaj Alliance	2	3
Tamilnadu Govt. retired employees HI	1	2
IOB Jeevan HI	1	2
Bharath Axsha HI	1	2
Total	**67**	**100**

Source: Primary data

Out of 67 insured respondents, 45% of the respondents are preferred Star Health Insurance Company's policies, followed by Reliance Health Insurance company's policies (17%), LIC of India (16%) and rest of them preferred ICICI, ESIC, United India Insurance Company, Bajaj Alliance etc.

Table: 11 Reason for selecting particular Companies Health insurance Policy

Reason	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Easily accessible	7	54	8	50	12	48	8	62	35	52
Credibility of the Company	2	15	2	13	6	24	3	23	13	19
Do not know about other company	0	0	1	6	2	8	0	0	3	5
Employer decided	1	8	4	25	4	16	2	15	11	16
Friends \neighbors induced	2	15	1	6	0	0	0	0	3	5
No cashless option	1	8	0	0	1	4	0	0	2	3
Total	**13**	**100**	**16**	**100**	**25**	**100**	**13**	**100**	**67**	**100**

Source: Primary data

The reason for selecting a particular company's Health Insurance policies by the respondents are given in the above table. 52 percentage respondents are said that their preference of having Health Insurance policies from a particular company is its easily accessibility, followed by 19 percentage of the respondents are opined that the credibility of the company, 16 percentage of the respondents are taken the policy due to the compulsion of the employer and very few percentage (5%) of the respondents are having no knowledge about other companies.

Hypothesis: There are no significant differences between respondents from the four taluks and their opinion related to selection of particular companies Health Insurance policies.

(Fc=3.52, Fr=26.125, ndf=15, 3 and 15, 5; Table value of F test at 5% level=3.29&2.90)

The F-test analysis result shows significant differences between the respondents from the four taluks and their opinion related to selecting particular company's Health Insurance policies.

Table: 12 Opinions about Premium Amount

Response	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Low	2	15	2	13	10	40	3	23	17	25

Average	9	70	13	81	12	48	7	54	41	61
High	2	15	1	6	3	12	3	23	9	14
Total	**13**	**100**	**16**	**100**	**25**	**100**	**13**	**100**	**67**	**100**

Source: Primary data

The good percentages of the respondents (61%) are opined that the current premium is in average level. 25 percentages of the respondents are said that the current premium is very low and the rests of the respondents are viewed that the current premium is high.

Hypothesis: There is evidence that the premium of Health Insurance policies are in average level.

(X^2=6.999, ndf=6, Table value of X^2 at 5% level= 12.592)

The Chi-Square analyses accept the hypothesis that, there is evidence that the premium of Health Insurance policies are in average level.

Table: 13 Claims

Type	Agastheeswaram		Thovalai		Kalkulam		Vilavancode		Total	
	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%	Number of respondents	%
Medical benefit	4	67	9	82	8	67	7	88	28	76
Cash benefit	2	33	2	18	4	33	1	12	9	24
Total	**6**	**100**	**11**	**100**	**12**	**100**	**8**	**100**	**37**	**100**

Source: Primary data

The table reveals that out of 67 insured respondents, only 37 percentages of respondents made claims on their policies. Of that 76 percentage of the respondents are claimed medical benefit and the remaining 24 percentage of the respondents claimed cash benefit.

Table: 14 Knowledge about terms and conditions about Health Insurance Schemes

Information about HI	At the time of decision taken to buy Health Insurance	At the time of buying Health Insurance	After Buying Health Insurance	At the time of making claims	Total
	Number of respondents	Number of respondents	Number of respondents	Number of respondents	Number of respondents
Does not cover all Health Care expenditure.	24	35	5	3	**67**
Does not cover the outpatient care	23	36	5	3	**67**

treatment.					
Does not cover pre-existing diseases.	20	36	7	4	**67**
It is a reimbursement scheme.	21	36	7	3	**67**
Will not get money back if illness does not occur.	35	24	6	2	**67**

The table reveals that the knowledge about the terms and conditions of Health Insurance schemes. The more number of insured respondents are having information about Health Insurance schemes and its benefits at the time of buying the Health Insurance policies.

Findings of the study

1. Respondents belonging to Backward Community have highest percentage (53%) of insured in various Health Insurance policies.
2. The awareness of Health Insurance among the SC\ST communities is very low (9%).
3. Majority of the insured respondents are preferred Private based Health Insurance policies.
4. Low income level of the respondents of four taluks is the major hurdle for buying Health Insurance policies.

CONCLUSION

From the analysis of data that there is an inequity in access to health care for the different level of income groups. Non availability of necessary finances is a major obstacle for getting various Health Insurance policies. There are enabling other socio-economic factors such as age, gender, educational qualification, occupation and community are also affecting the demand of Health Insurance. It is true especially in the case of high income and educated people of the district who were remain uninsured. Here an attempt is made to test the level of awareness about Health Insurance among the insured and non-insured. It is obvious that the absence of proper information on Health Insurance schemes is one of the main causes for low level of Health Insurance coverage. The study finally concludes that the socio-economic factors bring an inequity on demand for buy the various Health Insurance policies in Kanyakumari district.

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