FINANCIAL EDUCATION, COMMUNITY PARTICIPATION AND PURCHASE OF HEALTH INSURANCE

A REPORT ON
MINOR RESEARCH PROJECT

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Health insurance is one of the most important viable solutions to the problem of meeting the healthcare needs of people

A number of barriers restrict potential clients from joining health insurance schemes in India. Among the barriers, the “literacy gap” or the lack of knowledge about insurance (mechanism, utility etc.) is the most predominant one.

While many health awareness (educational) programs for disease prevention and health promotion are available, education about protection against financial risk during illness is not generally found. In such a condition, a comprehensive education intervention on health insurance, its mechanisms, utility and role of solidarity can be useful. The aim of this study is to assess the impact of an educational intervention on willingness-to-pay for health insurance. The main objectives of the study are

- To assess the awareness echelon regarding health insurance as well as various sources of awareness for it.
- To examine and explore the knowledge ,Attitude, practices and general concept of insurance
- To evaluate the impact of health insurance education programme
- To determine the willingness to join and pay for health insurance by non-health insurance holders.

One hundred persons from various parts of Bangalore were selected as samples for the study .The study was conducted in three phases

Phase I - Pre-test to assess the knowledge possessed regarding health insurance

Phase II - Sensitization programme to education about health insurance

Phase III - Post –test to evaluate the impact of sensitization programme and their willingness to purchase health insurance protection.

Based on the results of the study, it can be concluded that lack of information, insufficient advertisement and lack of awareness were the main barriers in the optimum utilization of health insurance facilities. Proper information dissemination and aware programmes can increase person s willingness to purchase a health insurance protection.

CHAPTER I

INTRODUCTION

The health of an individual is a multi-dimensional state, which varies over the life of the individual. In the statement of WHO 1946 constitution, it is stated that health "is a state of complete physical, mental and social well-being". These dimensions are not completely independent of each other. A deterioration of one dimension can adversely affect the other two. Recently, many authors have added two more dimensions namely emotional n spiritual health.

Health is an infrastructure upon which an economically viable society can be built upon. Whereas, unhealthy people can hardly be expected to make any valid contributions to society. Healthy people are considered a pre-requisite for economic development and social welfare.

Socio-Economic development and health of community are related with each other in such a way that it is impossible to achieve one without other i.e. one cannot be achieved in isolation. No doubt, the economic development in India is gaining momentum over the last few decades because of the government initiatives in public health care facilities, yet its health system is at crossroad today. As these initiatives' outcome are only moderate by international standards, because India is ranked 118 among 191 WHO members countries on the basis of overall health performance. To a large extent the health indices of a country is determined with reference to the ways with which its health care gets financed. Although, in India the total health care expenditure is increasing steadily, but the mix of public and private spending is a major area of concern (Bhat and Jain, 2006).

As the various studies to the people who cannot afford to pay full premium reveal that in India more than 80 per-cent of health care's expenditure is borne by individuals i.e. health care financing is mainly in the form of out-of-pocket which gradually pushing them in to a vicious circle of poverty. In such a situation health insurance is a widely recognized and preferable mechanism to finance the health care expenditure of the individuals.

The poor in India face many barriers to access health care. Private health expenditure constitutes 64.3% of total healthcare expenditure of which 97.4% is covered through out of pocket payments (WHO, 2011). Reliance on out-of-pocket payment for health services likely leads to a catastrophic burden for many households in the country. Pre-payment mechanisms of healthcare financing, like health insurance, is thus important for health-related financial protection in the population, particularly for those in vulnerable situations.

The World Bank (2002) estimates that one-quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalisation. One of the important challenges facing the Indian health policy experts is: how to convert predominantly private out-of-pocket spending into health insurance premium whereby this amount is collected from a much larger group of insured individuals rather than from the limited number households affected by illness. Another important challenge is: how to provide health insurance

A literature review by the International Labor Organization and Micro Insurance initiation facility, identified a number of barriers that restrict potential clients from joining health insurance schemes in low- and middle-income countries. Among the barriers, the "literacy gap" or the lack of knowledge about insurance (mechanism, utility etc.) was found to be predominant.

Insurance is a form of risk management which is used primarily to hedge against the risk of a contingent, uncertain loss. Insurance is defined as the equitable transfer of the risk of loss, from one entity to another, in exchange for payment. Insurance is essentially an arrangement where the losses experienced by a few are extended among many who are exposed to similar risks. It is a protection against financial loss that may occur due to an unexpected event. The transaction involves the assuming a guaranteed and known, relatively small, loss in the form of payment to the insurer in exchange for the insurer's promise to compensate or indemnify the insured in the case of a large, possibly devastating, loss. The insured receives a contract called an insurance policy which details the conditions and circumstances under which the insured will be compensated(NCAR 2011)

In a survey conducted by NCAER for IRDA in 2012,14 most people link insurance with death. Of those surveyed, only 54% were aware of health insurance which implies that the difference between health and financial security is not well understood. Effective campaigns highlighting the differences between health and financial security are necessary to highlight the need for health insurance among the population

While many health awareness (educational) programs for disease prevention and health promotion are available in India, education about protection against financial risk during illness is not generally found. In such a condition, a comprehensive education intervention on health insurance, its mechanisms, utility and role of solidarity for informal sector workers of the country can be useful. The aim of this study is to assess the impact of an educational intervention on willingness-to-pay for health insurance.

CHAPTER II

REVIEW OF LITERATURE

Various studies related directly or indirectly with the objectives of the present study were reviewed.

Gumber (1997), Visaria and Gumber, (1994). Health care financing in India can be considered almost unique in several respects-:

One, the share of public financing in total health care financing in the country is considerably low--just around 1% of GDP compared to the average share of 2.8% in low and middle-income countries or even relative to India's share in disease burden.

Two, the beneficiaries of this limited public health financing are not only the poor as one would expect in a limited public spending to be, but also the well-off section of the society.

Third, over 80% of the total health financing is private financing, much of which takes the form of out-of-pocket payments (i.e., user charges) and not any prepayment schemes

*Four,*Reliance on out-of-pocket payments is not only inefficient and less accountable than other methods of financing, it is also iniquitous to the poor on whom the disease burden falls

disproportionately more, who are more susceptible to disease and who are much likely to be pushed into poverty trap.

Purohit and Siddiqui (1994) examined the utilization of health services in India by making the comparison of Indian states in terms of low, medium and high household expenditure on health care and concluded that there is no serious government initiative to encourage utilization of health services by means of devising health insurance.

Sahi(2001) opines that insurance is a contract between the insurer and the insured, where by, in consideration of a payment of premium by the insure. The insurer agrees to make good any financial loss the insured might suffer due to operation of an insured peril.

According to encyclopaedia **Britannica (1969)** insurance is a social device whereby a large group of individuals through a system of equitable contribution may reduce or eliminate certain measurable risk of economic loss, common to all the member of the group.
Health insurance is not separately defined under **Insurance Act 1938,** it falls under "miscellaneous insurance" which has been defined in clause (13-B) of section 2 of Insurance Act 1938,to mean the business of affecting the contract of insurance which is not primarily or wholly of life insurance business as defined in clause 11 or fire insurance business as defines in clause (6-A) or of marine business as defined in clause (13-A) of the Section 2. Taking into account the law of and practice of health insurance of various countries, it is proposed to define health insurance as: "effecting and carrying out contracts of insurance providing fixed pecuniary befits or benefits in the nature indemnity(or a combination of both) against risks of the person insured or a person for whose befit the contract is made :-
1) Sustaining loss/expenses attributable to sickness or infirmity
2) Sustaining injury as a result of an accident or of an accident of a specified class
3) Becoming incapacitated in consequence of disease of a specified class or an accident of a specified class.
4) Dying as result of an accident or of an accident of a specified class

According to **Green and Hark (1973)** the committee on health insurance terminology of the American risk and Insurance association (1965) has recommended the definition for health insurance as insurance against loss by sickness or accidental bodily injury. The committee

also recommended the use of one term "medical insurance expenses" to embrace other types of health insurance.

Green and Hark (1973) Health insurance may also be defines as that type of insurance which provided indemnification of expenses and loss of income resulting from loss of health-

Ahuja and De (2004) confirmed that the demand for health insurance is limited while supplies of health services is weak and explained interstate variation in demand for health insurance by poor in relation to variation in healthcare infrastructure. Beside this the study also provided that healthcare infrastructure is positively related to demand for health insurance by poor, whereas the proportion of Below Poverty Line (BPL) population is negatively related. In order to build demand for health insurance, it is necessary to address the demand side and at the same time design the insurance schemes by taking into consideration the paying capacity of the poor.

Ahuja and Narang (2005) provided an overview of existing forms and emerging trends in health insurance for low income segment in India and concluded that health insurance schemes have considerable scope of improvement for a country like India by providing appropriate incentives and bringing these under the regulatory ambit. The study suggested that in order to develop health insurance for poor in a big way, health care provisions need to be strengthened and streamlined as well as coordination among multiple agencies is needed.

Dror (2006) laid seven myths regarding health insurance and examined the realities behind these myths. The evidence shown that most people are willing to pay 1.35% of income or more for health insurance and the solvent market for health insurance business exist in India; however tapping of it is contingent upon understanding the customer's needs and wants

Dror (2007) examined why the "one-size-fits-all" health insurance products are not suitable to low income people in India and provided that there is presence of considerable variability to pay for health insurance which is because of multiple reasons like variability in income, frequency of illness among households, quality and proximity of providers (private, public) in different locations.

Joglekar (2008) examined the impact of health insurance on catastrophic out-of-pocket (OOP) health expenditure in India and taken zero per-cent as threshold level to define and examine such impact. It showed that in India, OOP health expenditure by households account for around 70% of total expenditure on health and thereby pushes households in to poverty

Garg and Karan (2009) assessed the differential impact of out-of-pocket (OOP) expenditure and its components between developed and less developed regions in India. The results showed that OOP expenditure is about 5% of total households' expenditure (ranging from

about 2% in Assam to 7% in Kerala) with higher proportion in rural areas. Further in order to reduce OOP expenditure targeted policies are needed which in turn could help to prevent almost 60% of poverty.

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Srinivas (1999) states health insurance is a growth sector with considerable future potential though the poorest20%of the population with per capita GDP of$527may not be able to afford insurance coverage, the richest 20% of the population(around180million)per capita real GDP of $2641(HRD1998) gives an indication of the market potential

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According to **Kulkarni (1999)**the health insurance market in India is under developed and under penetrated, with less than 1% of its potential being realised. India's population of more than 1 billion makes it the second largest country in the world. Till this date is not an attractive market due to its pervasive poverty, nationalised insurance industry and under development.

V S Nehra and S. Devihave reviewed many studies related to Health Insuranceand its related issues. Some of them, which are moresignificant in respect to their proposed study, are highlighted hereas follows:-

D. Mavalankar and R. Bhat (2000) in their article, "Health Insurance in India Opportunities, challenges and concerns" reviews health insurance situation in India, opportunities it provide, the challenges it face and concerns it raises. The author discuss several imperative for opening of the health insurance sector in India for private investment,

some of them are: government is unable to provide more resources for healthcare and institute cost recovery, Need for long-term financial resource on sustainable basis for the development of infrastructure sector etc.

R. P. Ellis et al., (2000) in their article, "Health insurance in India- Prognosis and Prospects" attempts to review a variety of health insurance system in India, their limitation and role of the general insurance corporation as an important insurance agency. They highlighted the need for a competitive environment. This paper recommends improvement in delivery of health care and its financing, efficient functioning of the ESIS and CGHS and amending the mediclaim system and alteration in exclusion clause.

Ajay Mahal(2002) assessed that the entry of private health insurance could have adverse implications for some of goal of health policy, particularly for equity. However an informed consumer and well defined and implemented insurance regulation regime could potentially address many of bad outcomes. There are areas where regulation with regard to health insurance would be clearly useful in instituting benefits packages, restrictions on risk-selection procedure and addressing aspects of consumer protection.

Bhat at el (2005) in their paper "Third party administrator and health insurance in India: perception of policyholders and providers" found that there is low level of awareness among policyholders about existence of TPAs and empanelled hospitals. They rely on their insurance agents. TPAs insist on standardisation of fee structure of medical services. Healthcare providers experience substantial delay in setting of their claim by TPAs. Provider
Perceive significant burden in terms of effort and expenditure after introduction of TPAs. There is no substantial increase in patient's turnover after empanelling with TPAs.

P. Jain et al., (2010) in their paper, "Problems faced by the Health Insurance Policyholders of Different Public and Private Health Insurance Companies for Settlements of their Claims" measure the problem faced by customers. The objectives were to study reason for rejection of claim, satisfaction level of customer and difficulties faced by insured in getting their claim. Main reason for claim rejection was pre-existing disease and in complete document. From public sector Undertaking (P.S.U.) out of 56, 48respondents were satisfied with their insurer.

From private sector undertaking, out of 44, 16 are satisfied and 20 are highly satisfied with their insurer.

Bawa et al (2011) in their paper "Third party administrators(TPAs) in India: An insight into role defined and role played with reference to IRDA" tell about introduction of TPAs was made by IRDA in order to regulate the healthcare services and costs .In this paper an attempt was made to examine all those conditions ,code of conduct/role which is defined by IRDA and role in practice played by TPAs. The results of the study provided that parity exist in case of: providers of services as and when need; streamline and simplifies the claim process; automatic development of information system etc. Alternatively, deviation exist in case of: lack of knowledge about coverage and exclusion in policies; failure to meet the expectations of parties involved; delay in settlement of claims; failure to meet the service responsibility; indirect cost to consumer etc.

T.N.R.Kavitha et al.(2012) in their article, "Customer attitude towards general insurance- A Factor Analysis Approach" make an attempt at Erode district with the sample of 750 respondents to find out the influencing factor of the policyholder in the study areas. For this, respondent's opinion on the various related statements were collected with a 5 point scaling. Factor analysis, an important multivariate technique has used. 25 factors are considered.
Respondents are highly satisfied for factors like product price, officers/agents location etc. Respondents are neutral towards factor like product type, office appearance, and guidance/help at time of purchasing the policy.

Jaypradha (2012) in the article, "Problems and prospects of health insurance in India" highlighted that the health insurance sector has registered 30% growth rate in 2008-09. The penetration health insurance in India had risen to 4.8%, in 2008 as compared to 1.2% in 1999-2000. The average medical expenditure of an Indian household is 6.7% of the annual income. There are many factors for low penetration, some are- a) non availability of attractive health insurance products, b). Lack of awareness, c) Absence of stringent rules by IRDA, e) monopoly of health insurance market prior to 1999. Market size of health insurance business in India in 2008 is Rs 5125. Crore. In 2008-09, gross premium of all health insurance companies was Rs 30601 Crore

Amsaveni and S. Gomathi(2013) made an attempt to find out medi-claim policy holder satisfaction, to identify the reason for preferring medi-claim policy to safe guard themselves and avoid future risk, majority of the respondents have taken personal scheme to employees. The major problems faced by the respondents are lack of timely communication and limited list of hospitals covered by the insurance companies. Primary data were collected from 300 respondents for a period of 6 months from Jan. 2012 to June 2012. Secondary data have been collected from various books, journals, magazines and internet. Tools thatare applied percentage, chi-square, ANOVA, factor analysis and weighted average ranks score. Among 300 respondents, 90 are facing problems with regard to mediclaim policy. Majority of respondents are satisfied. Age, education and income of respondents
are influenced by reason for preferring mediclaim.

K. Selva Kumar and Dr. S. Vijay Kumar (2013) in their article, "Attitude of policy holders towards administration of general insurance companies with reference to Madurai region" The study reveals that 23% policy holders belongs to low level of attitude,46% to medium level of attitude and 31% to high level of attitude .There is significant relationship between ages, sex, education ,and marital status, type of family, community and level of their attitude towards Administration of services of public sector general insurance companies holds good. Out of nine factors eight factors are significant; only one factor i.e. social group of policyholder is not significant.

Poursamad et al (2013) in their paper determine the method of providing health insurance service. The present research is a descriptive plan in which 502 insured individuals, 316 of service providers and 8 managers of insurance organization took part. Obtained results from testing quality to show that 82.66% insured as average, 83.54% employees knew the quality as well and62.5% managers declared it as average. Since most insured people, employees and managers evaluated insurance services in an average rate and there is considerable difference between views of managers and employees about the quality.

Thus, Health insurance is one of the growing segments of nonlife insurance industry. It holds 22.24% of non-life insurance business (IRDA Annual Reports 2012-13).This is one of the recent origins in India and still it is an embryonic stage. This sector have both opportunities

and challenges which should be kept into mind by all insurance companies dealing in health insurance in order to maximum their market share

CHAPTER - III

RESEARCH METHODOLY

Health insurance is a necessity. Good medical care is often essential for survival and is invariably necessary for leading a relatively a pain free life. In the absence of adequate national health care delivery system in our country there is a great need for private health care insurance. The role of insurance companies in providing comprehensive and affordable health insurance products cannot be over emphasized. This study focused on educating selected families regarding health insurance and to increase their perception of the same.
This study was undertaken to collect information regarding the extent of awareness of health insurance and the impact of educational intervention on willingness to buy health insurance.

Objective of the study:

The present study is an effort in the area of health insurance to assess the individuals' awareness level and willingness to join and pay for it.

The main objectives of the study are

- To assess the awareness echelon regarding health insurance as well as various sources of awareness for it.

- To examine and explore the knowledge, Attitude, practices and general concept of insurance
- To evaluate the impactof health insurance education programme
- To determine the willingness to join and pay for health insurance by non-health insurance holders.

Hypothesis of the study

In the present study following hypothesis has been formulated and tested:

1)Awareness regarding health can be increased with education

2) Insufficient advertisements and awareness programmes were the main causes for low demand for health insurance

Selecting of sample

Using judgement sampling technique hundred persons not possessing health insurance were selected as samples from four different locations of Bangalore like Jayanagar, J.P Nagar, Basavanagudi and Koramangala.

Saravanavel(1999) opines that a judgment sample is one which is selected according to someone's personal judgment. In the other words, the investigator uses his judgment in the choice and include only those items of the universe in the sample which he considers are most typical of the universe.

The selected respondents were requested to assemble at a pre- determined venue at a specified time for participating in this study. This study was done in three phases.

Phase I: Pre- survey

A pre- survey was conducted to ascertain the respondent's awareness regarding health insurance using a structured questionnaire as a tool apart from the preliminary question, the questionnaire consisted of a series of 28 statements both positive and negatives on knowledge, attitude, practices and generally other statements on insurance and in particular on health insurance. The respondents were asked to indicate their agreement, disagreement and neither agree or disagree, marks were awarded as 2,1,0 marks for each positive statement that was agreed, neither agree nor disagree and disagree respectively and similarly in case of

negative statement marks was given as 2 for disagreeing 1 for neither agree nor disagree and 0 for agreeing.

The questionnaire also consisted of 30 statement regarding the characteristics, advantage and disadvantage of health insurance and the respondent were requested to indicated to indicate their awareness, partial awareness, unawareness and they were marked 2,1 and 0 respectively for their awareness. Other questions were aimed to elicit information with regard to need for health insurance, impact of advertisement, willingness to purchase health insurance and other relevant details.

This phase of study was conducted before phase II of the study. Based on the result of this phase an estimation of the respondent's awareness regarding health insurance was made.

Phase II: Education programme

A series of lectures on health insurance was organized for the respondents, who had participated in the pre-test.Importance of insurance was highlighted by the investigator, meaning of insurance and its importance and significance in today's world were also explained in detail.

Personnel from various insurance companies were invited to give a power point presentation on different types of health insurance policies available, the lectures were focused on the importance of health insurance, its availability and its suitability to different group. Salient features of each and every health policy were discussed in details to give the participant an in-depth insight into the subject. The presentation was emphasized by use of visual aids like charts, folders and transparencies.

Interaction between the participant and insurance personnel was initiated and encouraged, so that doubts, misunderstandings and misconceptions could be clarified and cleared. Pamphlets, folders and other printed literature on health insurance were also distributed to the participant for further references**.**

Phase-II: Post - survey

This part of study was conducted 15 days after phase II programme. The selected samples were requested to assemble again at the same venue and were asked to fill up the questionnaire used in phase I once again. Based on the result of this survey, an evaluation of the impact of sensitization program was estimated and suggestions were made to popularize health insurance.

Relevant statistical analysis was done to ascertain the significance of the difference in scores during pre and post –test.

The questionnaire used to collect the data for the study is given in Appendix-C

CHAPTER IV

RESULTS AND DISCUSSIONS

Health insurance is a risk sharing approach whereby communities or individuals pool their resources to cover uncertain costly events, which would be difficult for individuals to afford at time of need. Thus health insurance provides financial protection against the high cost of medical treatment and unpredictable health risks. It also provides for earmark savings to take care of more predictable needs.This study was carried out elicit information regarding respondent's awareness of health insurance and to evaluate the impact of a sensitization programme.

TABLE-1

CLASSIFICATION OF RESPONDENTS BYSEX AND AGE

Characteristic		**Respondents**	
		Number	**percentage**
Sex	**Male**	**70**	**70**
	Female	**30**	**30**
Year(years)	**21-30**	**17**	**17**
	31-41	**51**	**51**
	41-50	**32**	**32**

(n=100)

Table -1 indicates the sex and age range of the respondents who had attended the impact study programme. It can be noted from the table majority of percent of the respondents were ladies at seventy percent and the remaining thirty percent were men. The mean age of the respondents was 43.2 years with a variation of 9.72. More than 50 percent of the respondents were in the age range between 31-40 years, while the age of 32 percent was between 41-50 years only a small percentage of 17 percent were aged below 30 years.

TABLE-2

CLASSIFICATION OF RESPONDENTS BY EDUCATION AND OCCUPATION

CHARACTERISTIC		**RESPONDENTS**	
		NUMBER	**PERCENTAGE**
Education	Up to SSLC	13	13

	PUC	14	14
	Degree	34	34
	Post graduate	39	39
Occupation	Govt. Service	31	31
	Public/private	27	27
	Professional	6	6
	Business	36	36

From Table-2 it can be seen that majority of the respondents were well educated with 34 percent of them being graduate and 39 per cent being post-graduates. The respondents who had studied till S.S.L.C. and PUC were only 13 and 14 percent respectively. All of the respondents were occupied in various occupations. Majority of the respondent i.e.36 percent had their own business, whereas 42 percent were in government service and 27 percent worked for public/ private enterprises. Only a minority of 6 percent were occupied in specialized professions.

TABLE-3

CLASSIFICATION OF RESPONDENTS BY TYPE OF FAMILY, FAMILY SIZE & INCOME

CHARACTERISTIC		**RESPONDENTS**	
		NUMBER	**PERCENTAGE**
Type of family	Nuclear	88	88
	Joint	12	12
Family size	Up to 3	41	41
	4 members	37	37
	5 members	22	22
Income/month	Up to Rs.10,000	42	42
	Rs.10,000=20,000	46	46
	Rs.20,000=30,000	12	12

(n=100)

It can be seen from table-3 that a majority i.e88 percent of the respondents lived in nuclear type of family and only a minority of 12 percent of respondents lived in a joint family. It is interesting to note that the family size of 41 percent of the respondents was limited to only 3 members, while the family size was 4 members in 37 percent of respondent's families. Only in case of 22 percent of the respondents the size of the family was 5.

Only 42 percent of the respondents selected for the study had a family income up to Rs10,000 while the income ranged between Rs.10,000 to 20,000 in case of 46 percent of the respondents. Twelve percent of families had a monthly income, ranging between Rs 20,001-30,000.

TABLE-4

RESPONSE ON AWARNESS ON INSURANCE

Response (pre-test)	Response (post-test)						X2 VALUE
	Yes		No		Total		
	N	%	N	%	N	%	** 10.67
Yes	58	58	2	2	60	60	
No	30	30	10	10	40	40	
Total	88	88	12	12	100	100	

(n=100)

**significant value @ 1% level

Table -4, revealed the extent of awareness regarding insurance in pre-test as well as in post-test. While in pre-test 60 percent of the respondents were aware of insurance and 40 percent were aware, but after the education programme in the post-test the percentage of awareness was found increased to 88 percent while 12 percent was still not aware. Statistically, it has been proved that the different in the pre-test and post-test response is significant and it can be concluded that the education programme had an impact on creating awareness.

TABLE-5

RESPONSE ON AWARENESS OF INSURANCE COMPANIES

Insurance companies	Test	Awareness				X2 Value
		Yes		No		
		N	%	N	%	
National Insurance	pre	67	67	33	37	7.81*
	post	84	84	16	16	
United India Insurance	Pre	71	71	29	29	4.85*
	Post	84	84	16	16	
New India Insurance	Pre	61	61	39	39	5.21*
	Post	76	76	24	24	
Oriental Insurance	Pre	67	67	33	33	4.34*
	post	80	80	20	20	
General Insurance	Pre	65	65	35	35	10.67*
	Post	85	85	15	15	
Life Insurance Corporation	Pre	91	91	9	9	NS 1.23
	Post	95	95	5	5	

Significant at 1% level

NS-Not significant

Awareness regarding various insurance companies is indicated in table -5. There is significant different in the pre- test and post-test awareness regarding various insurance companies. In the pre-test less than 70 percent of the respondents were aware of the name of the 4 subsidiary of General Insurance. While in the post-test the awareness had substantially increased by 10 to 15 percent for each insurance company. The difference between pre and post survey result is statistically significant.

It is also interesting to note that while 91 percent of the respondents were aware of Life Insurance Cooperating in the pre-test. The awareness increased to 95 percent in the post-test,

which is not a significant increase. High percentage of awareness of LIC could be attributed to the fact that all the families possess life insurance protection as risk to life is very definite and due to aggressive marketing of LIC policies. The saving facility, loan facilities and long-term commission plan to marketing personnel, also act as an incentive for sales and motivation to purchase a policy.

TABLE-6

RESPONSE ON DIFFERENCE BETWEEN LIC & GIC

Response	Respondents				X2 value
	Pre-test		Post-test		
	NO	%	NO	%	
Both same	6	6	3	3	9.44**
No idea	42	42	24	24	
Both different	52	52	73	73	

** Significant at 1% level

Table-6 examines the respondents awareness regarding difference between Life Insurance Corporation and General Insurance Corporation. In the present 6 percent of the respondents stated that both were same and 42 percent of the respondents had no idea of the difference. A high percentage of 52 percent of the respondents who had stated that both were same and those who had no idea decreased 3 percent and 24 percent respectively. While it increased from 52 to 73 percent and 24 percent increase of respondent who had stated that both were different. The test results also revealed that the different is significant at 1% level and that education was beneficial in imparting proper knowledge.

TABLE-7

RESPONSE ON AWARENESS ON HEALTH INSURANCE

RESPONSE (Pre-test)	Response Post-test						Value
	Yes		No		Total		
	No.	%	No.	%	No.	%	
Yes	49	49	4	4	53	53	6.87**
No	34	34	13	13	47	47	
Total	83	83	17	17	100	100	

**Significant at 1% level.

0.01, 1dt= 6.635

Awareness regarding health insurance is indicated in table-7, while in the pre-test 53 percent of the respondents were aware of health insurance and 47 per cent were not aware of the same. The increases in awareness were significant after the lecture programme as the percent of awareness increased to 83 percent and not aware decreased to 17 per cent.

TABLE-8

OVERALL KNOWLEDGE SCORES OF RESPONDENTS BY SEX

Sex		Overall knowledge scores (%)		Mean Difference	T test
		Mean	SD		
Males (n=30)	Pre-test	35.2	12.7	17.0	13.29**
	Post-test	72.2	13.4		
Females (n=70)	Pre-test	60.8	8.2	9.0	8.96**
	Post-test	69.8	5.5		
Combined	Pre-test	56.9	12.0	14.6	13.39**
	Post-test	71.5	11.6		

n=100

**Significant at 1% level

From table -8 it can be inferred that the overall knowledge regarding health insurance had significantly increased from pre-test to post-test. The percentage of increase in knowledge was much higher among males. The increase was prominently noticeable among females also. The difference in means between pre-test and post-test for both males and females combined was 14.6 which clearly indicate the effectiveness of the learning programme.

TABLE-9

ASPECT-WISE SCORES OF RESPONDENTS

Aspects	Statements	Scores (%)				Mean Difference	'T' test
		Pre-test		Post-test			
		Mean	SD	Mean	SD		
Knowledge	5	58.2	21.0	77.6	24.0	19.4	12.93**
Attitude	6	43.2	20.0	61.1	19.2	17.9	15.43**
Practice	6	66.1	16.7	81.5	17.5	15.4	14.26**
General	11	58.8	20.0	68.9	19.1	10.1	12.32**

n=100

**Significant at 1% level

It is very interesting to note from table -9, the increase in aspect wise scores of respondents in both pre and post-test. The increase in knowledge regarding insurance is more than 19%, while the increase in mean score is 17.4 and 15.4 in case of attitude and practices of insurance respectively. Only in case of general aspects of insurance the mean increase was only 10%. Using 'T' test, it has been proof statistically that in post-test there has been significant increase in knowledge, attitude, practice and general concepts of insurance from pre-test score this increase can be attributed to effective awareness programme.

TABLE – 10

RESPONDENTS AWARENESS SCORES ON HEALTH INSURANCE

Aspects		Scores (%)		Mean Difference	'T' test
		Mean	SD		
Males	Pre-test	50.5	20.2	36.8	22.47**
	Post-test	87.3	11.7		
Females	Pre-test	49.4	15.7	39.7	16.50**
	Post-test	89.1	5.2		
Combined	Pre-test	50.2	19.0	37.6	22.38**
	Post-test	87.8	10.2		

n=100

**Significant at 1% level

Table 10 reveals the respondents awareness score on various aspects of health insurance. The mean awareness in the pre-test for male respondents 50.5% and it increase to 87.3 per cent in the post-test survey. On contrary the increase was more in case female respondents from 49.4 percent in pre-test to 89.1 percent in post-test. The combined mean difference in pre-test and post-test was 37.6 percent, which is significant at 1% level of significance, indicating the

positive impact of the sensitization programme in enhancing awareness regarding health insurance.

TABLE – 11

RESPONDENTS AWARENESS SCORES ON HEALTH INSURANCE SCHEMES

Aspects		Scores (%)		Mean Difference	'T' test
		Mean	SD		
Males	Pre-test	33.1	24.0	35.6	14.39**
	Post-test	68.7	22.0		
Females	Pre-test	35.7	22.0	32.1	8.66**
	Post-test	67.8	20.0		
Combined	Pre-test	33.9	23.7	34.5	19.49**
	Post-test	68.4	21.3		

** Significant at 1% level

Awareness regarding various insurance schemes available is indicated in table -11 while in the pre-test the mean awareness was 33.1 for males and 35.7 for females, it increase to 68.7 and 67.8 in males and females respectively in post-test significantly proving that lack of exposure was the men reason for their limited awareness.

TABLE – 12

TRAINING IMPACT ON RESPONDENTS WILLINGNESS TO BUY HEALTH INSURANCE POLICY

Response (Pre-test)	Response Post-test						Value
	Don't know		Yes		Total		
	N	%	N	%	N	%	
	16	16	9	9	25	25	32.95**
	9	9	28	28	37	37	
Yes	0	0	38	38	38	38	
Total	25	25	75	75	100	100	

**Significant at 1% level. 0.01, 2df= 9.210

From table 12, an evaluation of the impact of education programme conducted can be made by the respondent's willingness to buy health insurance policy. In the pre-test 25 percent of the respondents were not willing to buy a health insurance policy and 37 percent were indecisive only 38 percent were willing to buy health insurance protection, but in the post-test, 75 percent of the respondents were willing to cover themselves with health insurance only 25 percent were indecisive about their willing to purchase health cover. Using test, statistically it has been proof that the result obtained is not a sampling error, but impact of other variable, which in this study is the education programme.

TABLE-13

SEXWISE RESPONSE ON COVERAGE OF HEALTH INSURANCE FOR FAMILY MEMBERS

Coverage to members on health insurance	**Response by sex**					
	Female(n=70)		**Male(n=30)**		**Total (n=100)**	
	No	**%**	**No**	**%**	**No**	**%**
Complete family	57	81	29	97	86	86

Husband/wife	39	56	22	73	61	61
All children	32	46	17	57	49	49
Grandfather/mother	28	40	17	57	45	45

Table -13 indicates that majority of respondents both males (97%) and females (81%) were of the opinion that the entire family should be covered by health insurance policy. While 56% of women and 70% of men felt that is sufficient if only husband and wife had health insurance cover. A small percentage of 46 % females and 57 % males were of the opinion that all children should be included under health cover. Only 45 percent of respondents from both the sex stated the grandfather/ grandmother should be included under health insurance policy. Hence it can be deducted that health insurance is important to all family members.

TABLE-14

RESPONCE THROUGH ADVERTISING MEDIA ON HEALTH INSURANCE

ADVERTISEMENT MEDIA	**Response by sex**					
	Female(n=70)		**Male(n=30)**		**Total (n=100)**	
	No	**%**	**No**	**%**	**No**	**%**
Newspaper	51	73	25	83	76	76
Magazine	56	80	26	87	82	82
Television	48	69	26	87	74	74
Radio	39	56	14	47	53	53
Hoardings	33	47	15	50	48	48
Auto rickshaw/bus panels	33	47	14	47	47	47
Slide in theatre	32	46	14	47	46	46
Cable T.V	35	50	11	37	46	46

Pamphlets/ folders/ booklets	46	66	15	50	61	61

Recollection of seeing advertisement on health insurance in various media is depicted in table 14. A high percentage of 82 percent of the respondents stated that they had seen advertisement on health insurance in magazines, while 76% had seen it in newspapers. 53 % and 60% of the respondents stated that they remember seeing advertisement on health insurance in television and in pamphlets / folders/ booklets, etc., respectively, radio, hoarding, and auto rickshaws/ bus panels were not very effective advertising media as only a small percentage of respondents recall seeing advertisement in them. Only a negligible percentage of 20 and 9 percent of respondent stated that they recalled seeing advertisement of health insurer in slide at theatres and cable T.V. respectively.

CHAPTER V

SUMMARY AND CONCLUSION

Medical advances has given one an arsenal of weapon to fight illness and cure accident victim,the cost of such treatment is very high and over the past few years has sky rocked. In spite of this, only a fewpeople have some form of insuranceprotecting them to meet healthcare cost .Even though medical insurance is a very important aspect of one's financial planning, not much importance has been given to it as it has been perceived not as necessity but as an occasional expense that could be thought of when need arise.Ignorance about the availability of health insurance has added to the poor response of health insurance.

The mean age range of the respondents was 43.2 years with a variation of 9.72; the male – family ratio was 30.70. The average monthly income ranged between Rs15001-25000. Majority of 88 percent of the respondents lived in nuclear type family members in a family ranging between 3and 5.

With regard to educational qualification, a higher percentage of 34 & 38 percent were graduates, and post – graduate respectively, about 13 percent had studied only till S.S.L.C professionally qualified persons was limited to only 6 percentage.

While in pre-test majority 60 percent of the respondent was aware of insurance, in general, only a small percentage knew the term insurance. But after the educational programme, the percentage of awareness had increased to 88 percent. Statistically it has been proved that the difference in significant and it can be concluded that the educational programme had an impact on creating awareness.

It was interesting to note that all most all the respondents had heard about LIC. Only a limited number of respondents had heard about GIC. This disparity could be due to fact that life risk is very definite, and also due to the aggressive marketing of LIC policies, the saving features and loan facilities. The long-term commission plan to marketing personnel, also act as an incentive to sales.

There was a significance difference in pre-test and post- test awareness regarding various insurance companies. In the pre-test less than 70 percent of the respondents were aware of the names of the 4 subsidiary of general insurance. While in the post – test the awareness had substantially increased by 10 to 15 percent for each insurance companies. The difference between pre and post survey is statistically significant.

Awareness regarding difference between LIC and GIC also differed. In the pre-test 6 percent of the respondents stated that both were same 42 percent of the respondents had no idea of the difference and a high percentage of 52 percent opined that both were entirely different. But after the sensitization programme, the percentage of respondents who started that both were same and those who had no idea, decreased to 3 percent and 24 percent, respectively. While it increased from 52 to 73 percent in case of respondents who had stated that both were different.

A significant difference was noticed in awareness regarding health insurance, before and after lecture programme, as awareness increased from 47 percent to 83 percent and not aware decreased from 47 percent to 17 percent.

The overall knowledge regarding health and significantly increased from pre- test to post – test. While the percentage increase in knowledge was much higher among males. The increase was prominently noticeable among females also. The difference in means between pre-test and post-test for both males and female combined was 14.6 which clearly indicate the effectiveness of learning programme.

There was an increase in aspect wise scores of respondents in between pre and post-test. The increase in knowledge regarding insurance was more that 19 percent, while the increase in mean score was 17.4 and 15.4 in case of attitude and practices of insurance respectively. Only in case of general aspects of insurance the mean increase was only 10 percent. Using T-test, it has been proved statistically that in post-test there has been a significant increase in knowledge, attitude, practice and general concepts of insurance from pre-test score, this increase can be attributed to effective awareness programme.

The respondent's awareness score on various aspects of health insurance was computed and it was found that the mean awareness in the pre-test for male respondents was 50.5 percent and

it increased to 87.3 percent in the post test survey. On contrary increase was more in case of female respondents from 49.4 percent in pre-test and 89.1 percent in post- test. The combined mean difference in pre and post-test was 37.6 percent, which is significant at 1% level of significance, indicating the positive impact of the sensitization programme in enhancing awareness regarding health insurance.

With regard to awareness regarding various insurance schemes available, in the pre-test the mean awareness was 33.1 for males and 35.7 for females, it increased to 68.7 and 67.8 in males and females respectively in post-test, significantly proving that lack of exposure was the main reason for their limited awareness with education, the awareness regarding various health insurance could be increased.

It was interesting to note the respondent's willingness to buy health insurance policy. In the pre-test 25 percent of the respondents were not willing to buy a health insurance protection, but in the post test, 75 percent of the respondents were willing to cover themselves with health insurance only 25 percent were indecisive about their willing to purchase health cover. Using X^2 test, statistically it has been proved that the result obtained is not a sampling error, but the impact of other variable, which in this study is the education programme.

The majority of the respondents both male (97%) and females (81%) were of the opinion that the entire family should be covered by health insurance policy. While 56% of women and 73 percent of men felt that is sufficient if only husbands land wife had health insurance cover. A small percentage of 46 percent females and 57 percent males were of the opinion that all children should be included under health cover. Only 45 percent of respondents from both the sex stated that grandfather/ grandmother should be included under health insurance policy. Hence it can be deducted that health insurance is important to all family members.

A higher percentage of 82 percent of the respondent stated that they had seen advertisement on health insurance in magazines, while 76 percent had seen it in newspapers. Fifty three percent of the respondents stated that they remember see advertisement on health insurance in television and in pamphlets / folder / booklets, etc, respectively. Radio, hoardings, and auto rickshaws/ bus panels were not very effective advertising media as only a small percentage of respondents' recall seeing advertisement in them. Only a negligible percentage of 20 and 9 percent of respondents stated that they recalled seeing advertisement of health insurance in slides at theatres and in cable T.V. respectively.

CONCLUSION

Based on the results of the study, the following conclusions can be drawn:

(a.i.1.a) The extent of awareness regarding health insurance is very limited and this is the main reason for underutilization of this product.

(a.i.1.b) Lack of proper information, insufficient publicity, and lack of awareness were the main barriers in the optimum utilization of health insurance facilities.

(a.i.1.c) Proper dissemination of information and public awareness programmes on need and benefits of health insurance can create an enormous market for the same.

(a.i.1.d) The burden on Government to provide quality healthcare to a large population can be reduced, if more people protect themselves with health cover.

RECOMMENDATION

Further, research could be taken in the following areas of health insurance

a) Study on health needs, healthcare services available and utilization by a cross section of population.
b) Micro insurance and community insurance models could be studied in depth and adopted by government and non-government organisations to extend health insurance coverage to a larger section of the society.
c) Devise effective marketing strategies to improve awareness and increase sales of health insurance.

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APENDIX – A

STATISTICAL ANALYSIS

The following statistical tests have been applied in the analysis of data to interpret the results obtained.

1) **Chi square test:**

Formula used – $x^2 = \frac{(0-E)^2}{E}$

When:

O – Observed frequency

E – Expected frequency

RT – The row total for the row containing cell.

CT – The column total for the column containing the cell.

DF – Degree of freedom = R-1 x C-1

2) **Karl Pearson's Co-efficient of correlation :**

Formula used – $r = \frac{Exy}{Ex^2 \; xEy^2}$

Where $x = (X-X)$ and

$y = (Y-Y)$

X- Mean of the first sample.

Y- Mean of the second sample.

3) **Student –t-test:**

$$t = \frac{X_1 - X_2}{S} \sqrt{\frac{n_1 \, n_2}{n_1 + n_2}}$$

Where

X_1 – mean of the first sample

X_2 - Mean of the second sample

n_1- Numbers of observations in first sample

n_2 - Numbers of observations in second sample

APPENDIX – B

A QUESTIONNAIRE TO ELICIT INFORMATION REGARDING AWARENESS OF HEALTH INSURANCE AND TO EVALUATE THE IMPACT OF SENSITIZIATION PROGRAMME AND WILLINGNESS TO PURCHASE HEALTH INSURANCE

1) Name
2) Address
3) Sex Male / Female
4) Type of family
5) Monthly income
6) Age
7) Educational qualification
8) Occupation
9) Do you know what is Insurance Yes/No

10 Have you heard of these insurance companies?

1) National Insurance
2) United India Insurance
3) New India Insurance
4) Oriental Insurance
5) General Insurance Corporation
6) Life Insurance Corporation

11) According to you what is the difference between L I C and G I C?

1) Both are exactly same
2) No Idea
3) Both are completely different

12) Are you aware of the following types of Insurance?

Sl no	Type	Fully aware	Partially aware	Not aware
1	Life Insurance			
2	Annuity Insurance			
3	Health Insurance			

4	Personal Accident Insurance			
5	Motor Insurance			
6	Burglary Insurance			
7	Fire Insurance			
8	Break down of Domestic appliance Insurance			
9	Baggage Insurance			
10	Jewellery Insurance			
11	Any Other			

13) Are you aware what health insurance is?

14) Do you agree with the following statements regarding Insurance and Health Insurance?

Code - A - Aware, PA – Partially Aware, NA – Not Aware

SL NO	Statement	A	PA	NA
1	Insurance is not at all needed for human beings			
2	Insurance is a must because future is uncertain			
3	Insurance is a better way of getting compensated in case of death and / of loss of property.			
4	Insurance should be made compulsory to all			
5	In insurance, money is god only after death			
6	Insurance safeguards the family in case of loss.			
7	Insurance is important for all the valuables we possess			
8	All type of insurance are same			
9	Insurance is needed for all age groups			
10	Insurance companies cheap people			
11	Profit can be made by taking insurance policy			
12	Group insurance(health) is cheaper			

13	Health insurance is only for rich people			
14	Health insurance protection is very limited			
15	Health insurance is the only solution to tide over emergency medical expenditure.			
16	Men more than women require health insurance			
17	Only fools buy health insurance			
18	Most prefer ignorant about health insurance			
19	The claims procedure is too lengthy			
20	There is not much publicity about health insurance			
21	Buying insurance is a step in sound financial management			
22	Health insurance is needed more by poor people			
23	Health insurance premium is nominal			
24	Not all medical needs are covered in a healthy policy			
25	Insurance personals are very helpful			
26	Agent influence the purchase of health insurance policy			
27	There are too many exclusions in a healthy policy			
28	Only sick/ ill people should take health insurance			

14) Are you aware of the following statements regarding Health insurance?

Code - A - Aware, PA – Partially Aware, NA – Not Aware

SL.NO	Statements	A	PA	NA
1	Health insurance provides for reimbursement of hospitalization expenses			
2	Premium paid for health insurance cover is exempted from income tax			
3	Children as young as 5 years can take a health insurance policy			
4	While taking a policy, pre medical check-up is provided			
5	Cost of all diagnostic test are paid in case of hospitalization			
6	People aged above 80yrs cannot take health insurance			
7	Entire family can be covered under a single policy			
8	Sum insured can be varied according to once premium paying capacity			
9	Health insurance provides protection against all major illness			
10	Cumulative bonus is provided			
11	Ambulance service is provided, free of charge in certain types of policies			
12	Cancer can also be covered by health insurance			
13	Maternityexpense care no covered routinely, extra premium are charged			
14	Relevant medical bills have to be submitted for a claim			
15	Health insurance can be provided by employers as an additional benefits			
16	The term of the policy can be varied according to once choice			
17	Disease/ illness/ injury which are pre-existent			

	are not covered			
18	Domiciliary hospitalization (treatment taken at home area also paid)			
19	Emergency medical expenses will abroad is covered under overseas medical expenses			
20	Pre medical examination is necessary while taken the policy			
21	Subsequentpremiums are wavered in case of affricated by any of the listed major illness			
22	Withdrawal of health insurance scheme can be done when desired			
23	Routine eye and dentalcheck-up are not covered			
24	Post- hospitalization medical expensesupto 60days paid			
25	Double/ triple accident benefits can be availed			
26	Medical requirements of old age can be planned when one is young			
27	Pre - hospitalization medical expenses up to 30days reimbursed			
28	Hospitalizationexpense of person donating organ to the insured is also paid			
29	Unborn child can also be coved by health insurance			
30	Private hospitals also have their own health insurance schemes.			

15) Are you aware of the following types of health insurance schemes?

Schemes	Aware	Somewhat aware	Not aware
ESI			
C.G.H.S			
Asha Deep			
JeevanAsha			
Medi Claim			
Personal Accident			

Group Health Insurance			
Janarogya			
Bhavishya Agora			
Overseas Mediclaim			
Senior Citizen Unit Plan			
Birthright Insurance			
Cancer Insurance			
Critical Illness Policy			
Tertiary Care			
Private Hospital Schemes			

16) In your opinion, the Health insurance cover should be for?

a. Complete family
b. Husband/ wife
c. All children
d. Grandfather/ grandmother

17) Do you remember seeing advertisements' on health insurance in the following Medias?

A) Newspaper
B) Magazines
C) Television
D) Radio
E) Hoardings
F) Auto Rickshaw / Bus Panels
G) Slides In Theatres
H) Cable T.V
I) Pamphlets/ Brochures/ Booklets