PERCEPTION AND USEFULL TOWARDS HEALTH INSURANCE OF SCHEMES IN KARNATAKA

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Abstract:

The health insurance schemes in India are very necessity to improve the human life and health reforms in Indian country are with regards improve their life style and which is including for very essential for each and everyone for improving their health and some the strategies to improve the own insurance companies potential even insurance companies are majorly helping to the employees their health and family members. Insurance Corporation is a sector of Health Insurance that has emerged as more growth to driver as the most prominent segment in the expansion of insurance space.

Key words: Administration, Attitude, Benefit, Perception, Usefulness

Introduction

Health is an essential requirement of all irrespective of age, caste, race, religion and economic standard. Providing health insurance or health security for poor people continues to be one of the most important unresolved policy issues for the world. Health insurance in a narrow sense would be “an individual or group purchasing health is coverage by paying a fee called premium”. There are many programmes, agencies, schemes and medical services to the rural people who love in glorious surroundings. Even though, there are many schemes, programmes, medical services to serve the people, there is a great bulk of illness in our country. Prevalence of high rate of poor health and increasing cost of health services lead to the emergence of Yashaswini Scheme. (Saroja, 2000) The Yashaswini Scheme was conceived during 2003 by Dr. D. Shetty, a well-known heart surgeon and a group of private physicians who wanted to demonstrate that it is possible to extend the most sophisticated health care services to the poor. The concept relied on a preliminary survey conducted among various public and private hospitals operating in Karnataka which

revealed that occupancy rates remained every where as low as 35 per cent. Built upon the insurance model, the scheme intended from the outset to achieve a wider coverage spread all over the state of Karnataka. The only institution organizing a broad movement in the state was represented by the cooperative societies. Initiated in early 2003, the Yashaswini Scheme targets all co-operative society members in rural areas having a minimum six months membership. Age of insured range from new born to 75 years. The plan is open to members on a voluntary basis. Over the first two years, members paid Rs. 60 per year for each person insured. Third year the premium was set at Rs. 120. Now it is at Rs. 210 per year per individual. This was further increased in Year the fifth to include a marketing incentive (+Rs. 10) for co-operative societies. In addition, the Government of Karnataka provided each year a subsidy directly allocated to the premium, thus increasing the level of benefits to the members. The Trust invited Family Health Plan Limited (FHPL) to administer the scheme. FHPL was one of the very first third party administrators to be licensed under IRDA (Insurance Regulatory and Development Authority) regulations and one of the largest operating country-wide with in-depth experience in the administration of health schemes. Over a five-year period, the scheme could already perform some 135,000 surgical interventions, many of these were life-savings. The scheme also covered some 500,000 out patient department interventions provided through an extensive network of the health facilities. The Yashaswini InsuranceScheme may rightly claim to be one of the most cost-effective insurance schemes throughout the world. In Year III, the Administration Cost Ratio (ACR) was 1.5 per cent only, while the Administration Cost per Insured (ACI) was kept at the amazingly low level of 2.3 only. With this background, the present study was undertaken to ascertain the awareness and usefulness of Yashaswini Health Scheme (YHS) and identifying the direct and indirect benefits derived by beneficiary farmers.Material and methods The present study was on information collected from Belgaum district of Karnataka state. While selecting the respondents purposive random sampling technique was used for the selection of four blocks i.e., Ramdurg, Savadatti, Gokak and Bailhongal. The information so collected from the respondents was analysed using the statistical tools like Mean, Frequency, Percentage, Standard deviation and Karl Pearson's simple correlation test was used to find out the nature of relationship between independent and dependent variables considered for the study.

Review of literature :

Vishwanathan (1996) "Health insurance is the one of the measures of social security by which members of the community are assured benefits of both maintenance of health and medical care when they fall sick". The health insurance movement has a history of century and half. The origin of health insurance mainly related to the industrial revolution and the revolution in the medical field.

Sanyal (1996) examined that the burden of health care expenditure in rural areas was twice in 1986-87 as compared to 1963-64 and also provided that household is the main contributor to the financing of health care in India, so the health planners would have to pay more consideration regarding this.

Dabholkar et al (1996) proposed a model based on three levels: the first level relates to customer's overall perceptions of service quality; the second level focuses on five primary dimensions (physical aspects, reliability, personal interaction, policy and problem solving) and the third level consists of seven sub-dimensions (appearance, convenience, promises, doing it right, inspiring confidence, courteous and helpful). Despite such development across service quality measurement, little effort has been made to identify and standardize attributes that define the sub-dimensions.

Hurd and McGarry (1997) examine the impact of insurance coverage on health care service consumption in the elderly. They control for adverse selection of insurance by focusing on the economic resources necessary to purchase private insurance. Similar to other studies in this area, Hurd and McGarry find that the population with the most insurance is most likely to receive the highest frequency of services.

Manning and Marquis (1996) suggested that households will insure only if they perceive the benefits of enrollment to be higher than the costs, relative to being uninsured. However, the expected benefits are assessed not in terms of risk, but in terms of the advantages of being enrolled, i.e., access to better quality care, reduced waiting times, lower costs of care, etc.

Statement of the Problem:

Health insurance is one scheme that recognizes the health and well-being of individuals as an asset in the society. While ill-health is a liability whose adverse effects reach beyond the individual into the society at large. To ensure good health to all the people of the country is the responsibility of government irrespective of their income level. The high and medium-income group people are capable of availing healthcare services on their own capacities whereas the poor people are incapable of availing the health care services as well as healthcare facilities in the form of health insurance. Hence, it is the responsibility of the government to provide health care services directly to the needy people at affordable prices and protect the health risk in the form of insurance to cover the poor.

Need for the Study:

In the perception and useful of insurance is most developing countries including India the utilization of basic health services has remained poor. The situation is even worse in rural areas where both the living standards and the quality of healthcare services are low. Health risks pose the greatest threat to their lives and livelihoods. Even a minor health shock can cause a major impact on poor persons' ability to work and curtail their earning capacity. Moreover, there is a strong link between health and income at low-income levels. A health shock usually affects the poor the most.

Objectives of the Study:

The present study provides greater insight into the reach of government health insurance schemes the poor in terms of coverage, knowledge, utilization status, and satisfaction level for its existing beneficiaries. The present study also to make an attempt to recognize and identifies the hindrance involved in effective implementation and monitoring of government health insurance schemes in Karnataka. Following are the concise objectives of the study:

1. To study the government health insurance schemes in Karnataka;
2. To analyze the level of knowledge and awareness about government health insurance schemes;
3. To study the enrolment process of various government health insurance schemes;

Research Methodology:

The present study is engaged in a detailed understanding of existing government health insurance schemes in Karnataka state. An empirical study is being endeavored to capture the perceptions of government health insurance schemes – overall awareness, enrolment process, utilization status, and satisfaction level of its existing beneficiaries in Karnataka.

The following section covers the research methodology of the present thesis. It includes research Design, source of data, sampling design and statistical tools and techniques.

Research Design:

The study is explorative cum descriptive in nature. It is exploratory in the sense that, earlier few studies have focused preferably on evaluating the performance of government health insurance schemes. The present study is also descriptive in nature because the researcher has attempted to describe the current scenario in the health insurance awareness, enrolment, utilization status and satisfaction level of health insurance benefits, focusing on the existing beneficiaries of government health insurance schemes in the selected clusters and districts at Karnataka.

Sources of Data:

The present research will be carried out with the help of both primary and secondary sources of data.

Collection of Secondary Data:

The present study also gathers data from secondary sources. The data would be collected from various reports of Ministry of Labor and Employment, Census Survey reports, Economic Survey of Karnataka, ILO, Social Security plan documents about unorganized sector, plan documents of India, Karnataka State Government budget documents, Government of India budget documents, National Statistical Commission reports, NSSO Documents, Annual reports of social security schemes of various states, Newspapers, Journals, Magazines, thesis, dissertation reports, Books, etc. Furthermore, the required secondary data would also be gather from electronic sources.

Analysis of the study:

In the perception and useful of health insurance schemes in Karnataka which is more benefited for primary healthcare services, shall be provided only in the PHIs. Efforts shall be made to provide these services from PHIs most easily accessible to the residents. The outreach of those services shall be strengthened by visits of para-medical staff and ASHA workers to the homes of the residents, especially in respect of MCH services. Secondary Health Care Services All normal secondary healthcare treatments shall be provided only in the PHIs. All complex secondary healthcare treatments, shall also be provided in the PHIs subject to medical capability in the PHIs located within the taluka or district of the patient. In case of the PHIs within the district not having the medical capability for the required complex secondary healthcare treatment, the patient shall be referred for availing treatment from any of the empanelled private hospitals. Medical Capability of the hospitals will be published and updated on the websites www.sast

The National Health Policy read at (3) above envisages universal access to quality healthcare services without anyone having to face financial hardship as a consequence. The policy further envisages the following.

i. Assuring availability of free comprehensive primary healthcare services for all aspects of reproductive, maternal, child and adolescent health and for the treatment of the most prevalent communicable, non-communicable and occupational diseases in the population.

ii. Ensuring improved access and affordability, of quality secondary and tertiary healthcare services through a combination of public hospitals and well measured strategic purchasing of services in healthcare deficit areas, from private care providers, especially the not-for profit providers.

iii. Achieving a significant reduction in out of pocket expenditure of healthcare costs thereby reducing the proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

The Government of Karnataka provides a range of healthcare services through public health institutions administered by the Health & Family Welfare Department, and hospitals and centers of excellence attached to government medical colleges. These institutions, hospitals and centers (all referred collectively as PHIs hereafter) cater to about 687 lakh patients in a year providing about 3000 types of treatments. These services include hospital-based treatment for 41 lakh in-patients, 2.4 lakh major surgeries, 2.7 lakh minor surgeries and 5.7 lakh child birth deliveries in a year. In addition to the healthcare normally available in the PHIs, the State Government also implements the following health assurance and health insurance schemes, with support from Government of India and in partnership with private hospitals, to provide secondary and tertiary healthcare:

i. Yeshaswini Scheme providing specified secondary and tertiary surgical treatment for members of cooperative societies and their family members that make annual contribution;

ii. Vajpayee Arogyashree Scheme providing free specified tertiary healthcare for persons belonging to BPL families;

iii. Rajiv Arogya Bhagya Scheme providing specified tertiary healthcare for persons above the poverty line on co-payment basis;

iv. Rashtriya Swasthaya Bima Yojana (RSBY) providing free specified secondary healthcare to BPL persons and persons working in un-organized sectors and their family members, and providing specified tertiary healthcare to senior citizens among those;

v. Rashtriya Bala Swasthaya Karyakram (RBSK) providing free specified secondary and tertiary healthcare to students up to 18 years of age in government and aided schools and children in anganwadies;

vi. Mukhyamantri Santwana Harish Scheme providing emergency healthcare to all victims of road accidents.

vii. Indira Suraksha Yojane providing healthcare to dependent family members of farmers who committed suicide.

viii. Jyothi Sanjeevini Scheme providing specified tertiary healthcare to government servants and their dependent family members;

ix. Arogya Bhagya Scheme providing specified secondary and tertiary healthcare to police personnel and their dependent family members;

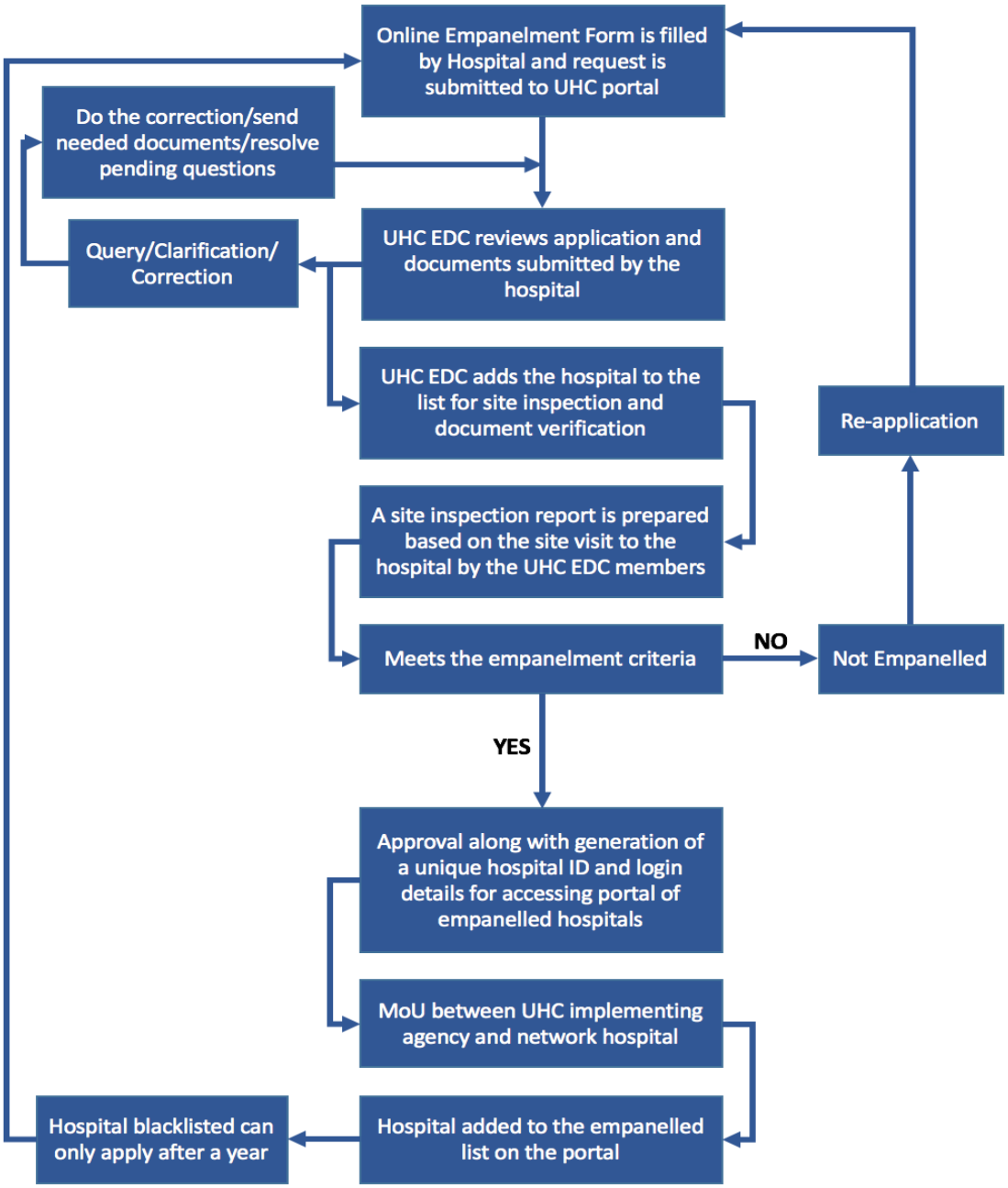
x. The Karnataka Legislative (Members, Medical Attendance) Rules 1968, for providing specified secondary and tertiary healthcare to members of Karnataka State Legislature.

The above listed schemes cover about 3.25 lakh cases of secondary healthcare and 1.25 lakh cases of tertiary healthcare treatments in a year at a total expenditure of about Rs. 900 Crore per annum. The Yeshaswini scheme gets an annual contribution of about Rs.100 Crore from the members, which is utilized to partly fund the scheme out lay of approx. Rs.400 Crore in a year. The schemes at sl.no. (iv) and (v), namely RSBY and RBSK are partly funded by the Government of India to an extent of 60 percent. The RSBY is implemented, except the component for the senior citizens, in insurance mode. In addition to the healthcare available to government servants under the scheme at sl. no. (vii), they also get reimbursement for their medical care as per Karnataka Government Servants' (Medical Attendance) Rules. The insights and learnings gained in implementing the above listed schemes suggest significant overlap across schemes in terms of scope and coverage, sub-optimal utilization of the PHIs, and variations in the treatment rates in private hospitals.

Historical timeline of Health Insurance schemes in India:

1907	First general insurance company
1952	Employees State Insurance Scheme Implemented (ESI Act 1948)
1954	Central Government Health Scheme
1973	General Insurance Corporation: 4 public insurers– National,New India, Oriental and United India
1999	Establishment of Insurance Regulatory Development Authority 100% Foreign Direct Investment In Health Insurance
2003	Yeshasvini Health Insurance, Karnataka
2007	De-tariffication of insurance
2007	Rajiv Arogyasri Scheme (RAS), Andhra Pradesh
2008	GOI 's Rashtriya Swasthya Bima Yojana (RSB Y)
2009	Kalaignar, Tamil Nadu
2010	RSB Y Plus, Himachal Pradesh and Vajpayee Arogyasri Scheme (VAS), Karnataka as pre- and post-hospitalisation expenses for some 700 medical and surgical conditions and procedures.
2018	Ayushman bharath and Arogya Karnataka (AB-ARK) - Karnataka

The process flow for hospital empanelment is depicted in the figure below:



For the above following figure can shown as empanelled and how useful to the society and the how it is going to activated for future days for improving the lifestyle.

Findings and suggestions:

Health sector in India are major contributing in India have registered considerable development and how it is growing panel wise with the onset of health care and health insurance sector reforms starting in the pre and post-independence. It is beneficiaries to note that the development in these markets has been in a gradual and calibrated manner, sequenced in line with the reforms in the real sector. The impact of these reforms has been evident in the process discovery process, the easing of restrictions, the higher and lowering of transaction costs. Apart from these, there has been evidence of a greater domestic educational system. The development of Higher education system is an on-going process and should not be considered as an event. It is therefore, that the authorities and participants should play proactive and complementary roles to sustain the future deeds and needs of a growing country such as India.

Conclusion:

Perception and useful towards health insurance of schemes in Karnataka health insurance schemes and health reforms. It was major legislation on social security for workers in independent India. The creation and development of a foolproof multidimensional social security system, when the country's economy was in a very fledgling state obviously a remarkable gesture towards the socio-economic amelioration of a workforce though limited in number and geographic distribution. As the administrator health insurance Scheme, IRDA Corporation provides social protection to employees in the organized sector and their dependents in contingencies such as sickness, maternity or death and disablement due to an employment injury or occupational disease with this platform can increase human lifestyle and health.

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