Analysis of consumer behaviour in health insurance sector

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Abstract---Health is riches. India is progressively becoming health aware. Indians have acknowledged the need of health insurance. Owing to this awareness, the medical insurance market is one of the fastest expanding areas in India today. The new economic strategy and liberalization approach implemented by the Government of India since 1991 prepared the door for privatization of insurance industry in the nation. According to the Investment Commission of India the healthcare industry has achieved exceptional growth of 12 percent per year in the previous 4 years. All increasing income levels and expanding older population elements are fueling this rise. In addition, shifting demographics, illness profiles and the move from chronic to lifestyle diseases in the nation has contributed to increasing expenditure on healthcare insurance products. The research seeks to analyze the consumers’ awareness degree of knowledge about health
insurance and the variables impacted them in choosing of policy(s) (s). It was revealed that customers are aware of insurance plans. And some elements such as policy characteristics, policy advantages have major impact on the choosing of insurance policy and purpose of keeping it.

**Keywords**---Health, Insurance, Customer, Sector, Policy, Industry, Employee.

**Introduction**

There is no market without consumers, and an understanding of their behaviour is of tremendous importance both conceptually and experimentally. Psychology, Sociology, Marketing Management, and Behavioural Economics all have a role in consumer behaviour. Consumer behaviour was described by [1] as "the behaviour that consumers demonstrate in looking for, acquiring, utilising and evaluating items and services that they anticipate would meet their requirements." Consumer behaviour and perceptions have a significant role in product and service purchasing decisions, according to the authors of the research. Among the topics covered are the answers to such inquiries as "what," "why," "who," "when," "where," and "how much."

It's vital to examine customer behaviour since tastes and preferences are always shifting and changing. Latent elements or impressions are factors that customers have in their brains and impact their desire for a product. It allows for the study of customers' pre- and post-purchase behaviour. The purpose of this research is to examine customer behaviour in the health insurance industry. Customers' pleasure and trust are critical to the long-term viability of Health Insurance services, hence this study is of crucial relevance. A primary survey of 386 people in Chandigarh city was conducted to evaluate the factors, beliefs, and concerns that influence the purchasing of health insurance. Design of the study was cross-sectional and descriptor. Since 1991, India's government has implemented a new economic strategy and liberalisation process, paving the path for the privatisation of the insurance business. India's nationalised insurance firms, which have remained undeveloped and less substantial in their product portfolios, are now preparing for a major shift in their management and approach to health insurance. Indian Parliament recently enacted the Insurance Regulatory and Development Authority (IRDA) Bill, a crucial beginning of reforms that would have substantial effects on the health industry. Insurers from the public sector, including the National Insurance Company, New India Assurance, Oriental Insurance, and United India Insurance, handle around Rs 6,000 crore worth of health insurance business in India. However, India's health insurance industry only covers a tiny percentage of the population (about 10%)[2]. At the present time, in India, there are a variety of health insurance options, including private for-profit plans, employer-based plans, non-profit health insurance, and mandatory government-run plans (such as ESIS and CGHS). An estimated US$280 billion would be generated by the Indian healthcare business by 2030, based on current trends. Estimated at US$35 billion in 2007, the Indian healthcare industry is predicted to grow from US$70 billion in 2012 to more than
$145 billion in 2017. The healthcare industry in India has grown at an annual rate of 13% over the previous four years, according to the Investment Commission of India[3]. This rise is being fueled by a combination of factors including increasing incomes and an ageing population. There has also been a rise in expenditure on healthcare insurance products as a result of shifting demographics, illness profiles, and the move from chronic to lifestyle diseases.

![Diagram showing the Health Insurance Model](image)

Figure 1. Health Insurance Model

India’s health care system has diverse medical systems, mixed ownership, and various delivery models. Key stakeholders in private health insurance are described in Exhibit 1 and their interactions are shown[4]. We can see from the above diagram that the health insurance system has three key stakeholders. Customers, providers of healthcare, and insurance companies round out the list. Other than this, the regulator and third-party administrators (TPA) play a vital role in the process.

**Literature Survey**

There has been a cohabitation of the public and private sectors in the Indian economy. The healthcare industry has a remarkable resemblance to this trend of growth. Beginning with the Indian Constitution’s mandate to protect the residents of the country’s good health, India adopted a public sector-dominated health care paradigm[5]. Governments are expected to improve nutrition and public health in order to increase the quality of life for people, as stated in Clause No. 47 of the
Directive Principles of State Policy. As a result of India’s federal government structure, the health sector is within the purview of the states, according to the Indian Constitution. In order to enhance the health of its residents, however, the Union Government may start, fund, and coordinate public health programmes[6]. With all due respect to this ideal function, a sensible programme for delivering health care was lacking." Even while public health initiatives made a concerted effort, their inefficacies hampered their capacity to keep up with the growing medical needs of the Indian population. The private health care industry saw room to grow because of a mismatch between supply and demand for public health services.

Figure 2. Domestic Health Expenditure of India

Figure.1 shows a visual representation of domestic health expenditures. With the passage of the IRDA Act, 2000, commercial health insurance firms were allowed to enter the Indian market. Up to 26% of an Indian company's capital might be invested by foreign companies having a capital of Rs 100 crore[7]. In 2015, the cap on foreign investment was raised to 49%. Many private businesses, both local and international, have joined the Indian insurance market. Over time, six independent insurance firms sprung up, each specialising on a different aspect of health insurance. Rao and Choudhary (2012) explained the significance of health insurance in India, a country with high mortality and morbidity rates and significant out-of-pocket expenditure. It has a great deal of potential, according to Kumar and Ramamoorthy (2014), who cite demographic trends and the prevalence of unorganised labour as reasons.

In 2003, the Indian government started this voluntary programme to pay the costs of healthcare for families living below the poverty line. In addition to Rs 30,000 in coverage, it provided Rs 50 to a sick earning member for up to fifteen days. In the event of the accidental death of the head of the family, the nominee
would get a guaranteed payment of Rs 25,000. Annual premiums ranged from little Rs 359 for a single person to Rs 548 for a family of five, to Rs 730 for a family of seven. The government also subsidised the price, however this programme did not reach its goal of ten million people being covered. Only 34,000 families (MOHFW, 2005) and 37,000 families (MOHFW, 2008) benefitted from the programme (USAID). States with a greater percentage of BPL households, like as Bihar, Uttar Pradesh, Madhya Pradesh, Orissa, and West Bengal, performed the poorest[8]. Public health care facilities were lacking and public insurance firms were not interested in participating in this endeavour. In terms of demand, the lack of knowledge about insurance was a fatal flaw for the programme.

**National Health Protection Mission**- During the Finance Minister’s Budget address on February 1, 2018, the largest health insurance plan was announced, and it went into effect on August 15, 2018. Ten million people are expected to get pre- and post-hospitalization insurance coverage of Rs. 5 lakh each family. Deprivation criteria from the 2011 Socio-Economic Caste Census will be used to identify beneficiaries in this programme[9]. The government aims to establish 1.5 lakh health centres around the nation in order to enhance access to health care. Because of its short lifespan, it would be impossible to conduct a review of this programme, yet 13,000 multi-specialty and 10,000 specialty hospitals have been granted accreditation under it. A total of 3.75 million hospitalizations, including 1.25 million tertiary care cases for difficult treatments, have benefited from this programme. Approval of claims of Rs 396 crore has been reported.

**Rajiv Arogyasri Insurance Scheme**: It was launched by the state government of Andhra Pradesh in 2007. Health services were still provided, even though the trust was in charge of administering them. The state’s health insurance programme was initially designed to benefit low-income residents, but it has now expanded to include the whole population[10]. Families enrolling in the programme were not required to pay a premium. 2.4 million households and seven million individuals, or around 85% of the state’s population, were included in the programme (Forgia & Nagpal, 2012). Inpatient and tertiary care were the primary emphasis of the plan, which covered 938 medical procedures with a maximum coverage of Rs 1.5 lakhs and an extra yearly buffer of Rs 50,000 per household. Only 97 of the 338 hospitals that offered hospitalisation coverage were public. According to the study by Fan, Karan, and Mahal (2012), this method reduced inpatient OOP costs but only made a minor difference in outpatient and catastrophic costs. From 2007 to 2013, Rs 47.23 billion was spent on this initiative, according to Sengupta (2013). For every dollar spent on healthcare, just two percent of the state's population was protected.

**Bhagat Puran Singh Sehat Bima Yojana**– Cashless medical Health Insurance was created by the Punjab Government to safeguard low-income households (including farmers, small merchants and construction workers) from health-related obligations. 'On floater basis,' it aimed to cover 30 lakh families with blue cards for up to Rs 50,000/- each year[11]. Additional coverage of Rs. 5 lakh per family member was granted to cover accidental death and total disability. There was no pre-existing condition exclusion in the plan, which covered one day of pre-hospitalization and five days of post-hospitalization benefits. As a result, the female beneficiaries of Punjab's public and private hospitals received maternity
benefits at 214 public hospitals and 216 empanelled hospitals. In the case of hospitalisation, the government additionally paid a travel stipend of Rs 100. Beneficiaries were only asked to pay a registration fee of Rs. 30 per household; the rest of the expenditures were covered by the State Government. In 1952, a ‘Student Health Home’ in Kolkata gave birth to CBHI programmes. These community-based health initiatives (CBHIs) originated and are now thriving at the local level. There are several micro insurance and mutual health organisations (MHOs) in India, which are mostly geared at rural populations. The local community or society often plays a significant role in raising awareness, collecting premiums, or managing claims. In order to eliminate health disparities, these CBHI programmes offer low premiums and lower out-of-pocket health expenses for the poor[12]. These vary in size, benefit package, geographic location, and the demographics of its beneficiaries. The number of members might range from a few thousand to a few million people. Individuals might expect to pay anything from Rs 20 to Rs 60 as a yearly premium. Thirty to fifty million people were covered by these programmes in India by 2004. (WHO 2004). By 2009, there were 115 similar schemes in operation. There are several CBHI groups based in India, but one that stands out is Gujarat’s Self Employed Women’s Association (SEWA). Figure 2. depicts the 23.79 percent growth in health insurance premiums over the last thirteen years.

Figure 3. Health Insurance Premium underwritten by Non-Life Insurance Sector
In their empirical research, Ramesh Bhat and Nishant Jain (2007) found that health insurance plans are increasingly seen as preferable financing mechanisms for health care delivery[13]. The relevance of micro health insurance schemes and community health insurance schemes is growing in this manner, covering a much larger population. This problem is investigated via the lens of a two-state model. There are a number of things to consider when making an insurance purchase choice, and one of the most important is determining which variables have an impact on how much insurance is purchased.

**Regulatory Regime**

Several private health insurance businesses - both local and international - have entered the market as a result of the privatisation and deregulation of the insurance industry. Competition in the health insurance industry has intensified as a result of the new regulations[14]. In order to keep their clients, many businesses have used aggressive marketing and management methods. There are still cases of misrepresentation and misunderstanding of policy terms and conditions. As a result, customers must be protected against insurance firms' fraudulent and unfair tactics, and they must be guaranteed that their claims will be paid on time. Capitalization, terms & conditions, pricing, and other operations of insurance businesses are regulated by Indian insurance legislation. The following are the most significant pieces of legislation:

a. The Insurance Act, 1938
b. Tariff Advisory Committee, incorporated in 1968
d. Insurance Regulatory and Development Authority (IRDA) Act, 1999
e. Insurance Laws (Amendment) Act, 2015

Regulation, promotion, and orderly expansion of the insurance industry, as well as protection of policyholder interests are all part of the mandate of the IRDA. Legislative measures such as the Redressal of Public Grievance Rules, 1998, were also enacted from time to time in the Indian context, which resulted in the appointment of Ombudsmen in order to settle policyholders' grievances about insurance claims[15]. It was in 2001 when third-party administrators, or TPAs, were established as mediators between health insurance companies and their policyholders. In 2013, new regulations were put in place to prevent insurance plans from being misunderstood and imprecise. The IRDA rewrote the rules on things like hospitals, sickness, and pre-existing conditions, among other things. The 2013 Standardization standards were superseded in 2016 by the IRDAI (Health Insurance) Regulations 2016. Pilot Products', services for preventative care or specialised objectives, bans on life insurers supplying indemnity products, and a one-year period for Health Insurance were among the items covered by these laws.

**Profile of Respondents**

The literature on the factors that influence the purchase of health insurance has showed that respondents' socioeconomic status was a significant factor; as a result, a socioeconomic profile of respondents has been identified. Data on various parameters such as age, gender, marital status, religion, number of family
members, number of dependents, education and occupation of the household head was acquired and statistically analysed. Figures 3-11 provide data on 386 people's varied traits[16]. Age-wise distribution of respondents is shown in Figure 3, and shows that the majority of respondents were between the ages of 41 and 50, which was essential for the research since the majority of lifestyle illnesses are encountered during this life span and so they may choose to acquire Health Insurance.

![Figure 4. Gender wise Distribution of Respondents](image)

Nearly two-thirds of the respondents were male, according to the gender-wise distribution (Figure.4). It's a plus for the research since they're the primary decision-makers in the home when it comes to financial concerns.

![Figure 5. Distribution of Respondents by Marital Status](image)

Most of the respondents were presently married, which suggests that they are aware of the increasing demands on families in the future.
The majority of the households in the sample were Hindus, as seen in Figure 6's breakdown of respondents by religion. Sikhs made up 24% of the population. The population of Chandigarh as a whole was well-represented in this sample[17]. Hindus and Sikhs formed just 13.11 percent of the city's population in 2011, a figure based on the 2011 census. Other faiths, such as Muslims, Christians, Jains, or Buddhists, made up the remainder of the population.

Small families with three or four individuals were the most popular choice among the survey participants, according to the results (Figure 7.). Increased female labour force involvement and high child-rearing costs in contemporary cities demand a modest family norm.
Figure 8. Distribution of Respondents by Educational Status

Figure 8. clearly demonstrates that 60 percent of household heads had a college degree or more. As Chandigarh has a relatively high literacy rate and is a centre for several public and private higher education institutions, this result was predicted.

Figure 9. Distribution of Respondents by Employment Status

More over half of the 386 people surveyed were working in private sector jobs, followed by self-employment, according to Figure 9. In the post-economic reform context in the Indian economy, this data shows a decrease in government employment and an increase in private sector chances.
Figure 9. shows the respondents' monthly income figures, which show a growing middle-class in cities. With Chandigarh's per capita income (Rs 2.42 lakh) ranking second among other states/Union Territories in 2019-20, it is consistent with this information.

Three-quarters of respondents had at least two children, according to Figure 11. In Andrapradesh, the tendency toward a nuclear family was evident. Males in their late 40s and early 50s were the most common socioeconomic category, with most of them having already been married and living in nuclear households[18]. Most of them were well-educated and working in the private sector, earning a monthly salary of about Rs 1,25,000.

Awareness Regarding Health Insurance

Conceptual knowledge is critical in the purchase of a product or service. Information on people's knowledge of health insurance was collected in order to
gauge the market’s need for it. All of these topics and more were discussed in depth with those who took the survey.

There are a wide variety of ways people learned about the Health Insurance programme, as shown in Figure 12. Insurance agents (279.9%) played a key role in raising knowledge about the need of health insurance, as seen in these charts and graphs[19]. Friends and family (24.9%), as well as employers (13.3%), tax consultants and physicians (11.3%), advertising (8%), the Internet (3.7%), and Government programmes (6.3%), were also engaged in spreading awareness about Health Insurance services. An insurance agent’s position is equally critical in the Indian health insurance industry, according to Vellakal (2013).

**Purchase of Health Insurance**

According to Figure.13, 51.8 per cent of respondents said that they signed up for health insurance in order to protect themselves from unexpected medical costs. It’s a reflection of our fundamental desire to be financially secure. The ability to get high-quality medical care was another consideration that prompted the majority of those polled to obtain health insurance (39.6 per cent). In the event of a medical emergency, most people want to ensure that their loved ones get the best possible care[20]. Households also mentioned declining public health services, tax planning, and persuasion as reasons for implementing it. In addition to tax benefits and employer mandates, Goel (2018) found that the primary motivation for purchasing health insurance was the ability to pay for unanticipated medical expenses. As revealed by Chithirai (2020) and Shanmugapriya (2020), cashless hospitalisation, security in covering unforeseen medical expenditures and excessive healthcare prices are among the reasons for purchasing Health Insurance.
Conclusion

There are several factors to consider when purchasing a health insurance policy. This sector's consumer choice-making may be assessed not just theoretically but also subjectively. Behavioural analysis may provide light on the multifaceted nature of Health Insurance usage. Andrapradesh families were sampled and their health insurance buying patterns, determinants, and attitudes were detailed in this article. A sample of 386 homes was selected for the study using a cross-sectional research design and an area sampling approach. It was found that 65.5 per cent of respondents were male, 87 per cent were presently married, and the average size of their families was four people. Three-fourths of the homes surveyed were Hindu, roughly a quarter were Sikh, and the rest were from a variety of other faiths. More than eight out of ten respondents were between the ages of 30 and 60, according to the survey’s demographics. Only 8% of the population was under the age of thirty, with the remaining 10% being beyond the age of sixty. In this research, the heads of home were all well-educated. Graduates formed 32 percent of the sample, while matriculates made up just 8 percent of the population. In terms of employment, 46% of those polled were working in the private sector, 15% worked for the government, and 27% worked for themselves. Only 20% of the families in the survey had a monthly income below Rs 50,000, while 79% had a monthly income of Rs 50,000 or above. Different elements of health insurance purchasing are examined, including the amount and kind of purchase made, factors, views, and impediments. Statistical approaches were used to identify and quantify the factors that led to its acquisition.

References


