DETERMINANTS OF CONSUMER PURCHASE DECISIONS OF HEALTH INSURANCE IN KERALA

Thesis submitted to
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by

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Determinants of Consumer Purchase Decisions of Health Insurance in Kerala

Ph.D. Thesis under the Faculty of Social Sciences

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Certificate

This is to certify that the research work for the thesis entitled '**Determinants of Consumer Purchase Decisions of Health Insurance in Kerala'** by Mr. Thomas Varghese, part time research scholar, under my supervision and guidance at the School of Management Studies, CUSAT, is adequate and complete for the requirement of the Ph.D. thesis.

Dr. Moli P. Koshy
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Declaration

I, Thomas Varghese, hereby declare that the thesis entitled '**Determinants of Consumer Purchase Decisions of Health Insurance in Kerala'** is a bonafide record of research work done by me under the supervision of Dr. Moli P. Koshy. (Professor, School of Management Studies, Cochin University of Science and Technology) for the Ph.D. programme in the School of Management Studies, Cochin University of Science and Technology. I further declare that this work has not formed the basis for the award of any Degree, Diploma, Associateship, Fellowship or any other title or recognition.

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Thomas Varghese

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List of Abbreviations

ACCORD	Action for Community Organization, Rehabilitation and Development
APL	Above Poverty Line
ASHA	Accredited Social Health Activists
BPL	Below Poverty Line
CAD	Coronary Artery Diseases
CADI	Coronary Artery Diseases Among Asian Indian Research Foundation
CBHI	Community Based Health Insurance
CGH	Central Government Health Scheme
CHIS	Comprehensive Health Insurance Scheme
ECGC	Export Credit Guarantee Corporation
ESI	Employee's State Insurance
FDI	Foreign Direct Investment
FICCI	Federation of Indian Chambers of Commerce and Industry
GDP	Gross Domestic Product
GIC	General Insurance Corporation (of India)
HoE	Hierarchy of Effects
ICICI	Industrial Credit and Investment Corporation of India
IRDA	Insurance Regulatory and Development Authority
LIC	Life Insurance Corporation (of India)
LTC	Long-Term Care
MHI	Micro Health Insurance
MoH	Ministry of Health & Family Welfare
NGO	Non Governmental Organization
NIC	National Insurance Company
NRHM	National Rural Health Mission
PHI	Public Health Insurance
PPP	Public Private Participation
RBI	Reserve Bank of India
RSBY	Rashtriya Swasthya Bhima Yojana (National Health Insurance Scheme)
SPSS	Statistical Package for Social Sciences
TPA	Third Party Administrator
UHI	Universal Health Insurance Scheme
WDR	World Development Report
WHO	World Health Organization
WHR	World Health Report
WoM	Word of Mouth
WTP	Willingness to Pay

Chapter 1

INTRODUCTION

Contents

1.1 Introduction

A healthy and competent workforce is the biggest asset of any nation. Therefore every progressive country is keen on providing access to healthcare to its citizens. World Health Organization (WHO) defines health as complete physical, mental and social well being and not merely the absence of disease and injury. As per WHO, a country's health systems comprise of all the organizations, institutions and resources that are devoted to produce health actions (World Health Report, 2000).

Providing health care also has a cost component. This is met by several groups that include the central government, state government, local bodies, private or voluntary organizations, insurance companies and the affected individual himself. Though the concept of risk pooling was in practice from vedic times, and finds mention in the writings of Manu

(Manusmrithi), Yagnavalkya (Dharmasastra) and Arthasastra of Kautilya (Siddaiah, 2011), people have not taken the health insurance concept in a big way in India. It is reported that nearly three fourth of health related expenses are met by personal savings (IRDA, 2010), often landing the poor in long term financial indebtedness. Health insurance is no longer a luxury for Indians, but has become a need. Even with the increasing disposable incomes, ordinary families are finding it difficult to meet the medical expenses due to the increasing cost (Annexure II).

Health Insurance in India was introduced in 1986 in the form of Mediclaim by the public sector general insurance companies. Post liberalization, several private insurance companies entered the market with attractive packages and as of 31st March 2012, there are 22 organizations, that include stand alone health insurance companies, providing health insurance scheme of some form or other to the consumers (Annexure III).

The state of Kerala, well known for educational and social advancement equaling the levels of developed countries is facing the problem of increased life style diseases. Further, people have started considering medical check-up and preventive health care as means to have better health management. Therefore, health insurance is expected to have a huge potential to grow.

In spite of this, the managers of health insurance companies are of the opinion that the response to health insurance schemes by consumers of the state is not very encouraging. They are keen to learn the reasons for the purchase behavior of consumers: why people buy health insurance, why they do not buy, and what influences decisions like amount of cover, brand selection, re-purchase etc.

Therefore this study aims at understanding the determinants of consumer purchase decision of health insurance in the state of Kerala. The major consumer purchase decision models are reviewed and identifying some gaps, a model incorporating three sets of variables, related to personal, marketing and social factors is developed. Based on data collected from a sample of consumers and potential consumers, the proposed model is evaluated.

It is hoped that the findings of the study are relevant to the marketing organizations to understand consumer expectations better and to the government agencies to enhance their efforts to provide better health care to different social sectors.

1.2 Research Problem

There is general feeling that health insurance is needed - but not many take a health insurance cover. It is something that can 'wait', and often it doesn't happen. When fallen ill/met with accident, which involves considerable expense on hospitalization, people regret their postponed decision.

Customer awareness on health insurance is increasing due to marketing communication from companies, social changes, influence of activities by Non Governmental Organizations (NGOs) and word of mouth communication. Recent efforts by government to provide health insurance to lower sections of the society through schemes like Rashtriya Swasthya Bhima Yojana (National Health Insurance Scheme), micro insurance schemes etc are likely to influence the consumers from various sections of society in creating a favourable disposition towards health insurance.

The ministry of health has come out with statistics that life style diseases like diabetes, high blood pressure, cholesterol related problems, cancer and heart diseases are on the rise. The prevalence of risk factors is high even in rural Kerala: diabetes 20%, high blood pressure 42%, high cholesterol (>200mg/dl) 72%, smoking (42% in men), obesity (body mass index >25) 40%, physical inactivity 41% and unhealthy alcohol consumption 13%. The age-adjusted Coronary Artery Disease (CAD) mortality rates per 100,000 are 382 for men and 128 for women in Kerala. These CAD rates in Kerala are higher than those of industrialized countries and 3 to 6 times higher than Japanese and rural Chinese (CADI, 2010). The cost of health care including diagnosis and treatment, especially in specialty areas are increasing rapidly.

On the supply side, more and more health insurance providers – stand alone or multi-business – are entering the health insurance scenario. Innovative products and attractive packages are being offered. Marketing communication in the health insurance context is developing and being widely used by companies. Internet based communication has been tapped by several organizations for this purpose. It is important to understand how these market realities are influencing health insurance purchase behavior.

According to health insurance company executives, there is reluctance among the population, especially the younger age group to opt for health insurance due to many reasons. Studies conducted by governmental agencies have shown that in spite of the higher level of education, health consciousness, rising occurrence of lifestyle diseases and increased cost of health care, the state of Kerala is yet to accept in full health insurance as a means of better health care. With several groups in society – the government, agencies involved in health care, marketing organizations involved in health insurance

business for example – interested in understanding the underlying factors that lead to a consumer buying or not buying a health insurance cover, this presents an important topic for research.

There may be several factors which influence an individual to take or not to take health insurance policies which are quite unknown or unexplored. From the preliminary studies, it was observed that health care costs are on the rise, public awareness on health issues is growing, chronic diseases that necessitate long term treatment are becoming common and many health insurance companies are making a variety of offers; but large section of people are not taking health insurance policy. In a country of 1.2 billion with an insurable population assessed at 250 million, only 15% of the population has any form of health insurance coverage (Nagpal, 2008).

In this context, it becomes important to understand the factors influencing the purchase of health insurance policies in the state of Kerala.

1.3 Objectives of the Study

1) To trace the pattern of health insurance subscription among people of Kerala.
2) To understand the factors influencing the purchase decision of health insurance policies.
3) To assess the extent of influence exerted by dominant factors on purchase decision of health insurance policies.
4) To develop an integrated model of dominant factors in an individual's health insurance decision.
5) To identify factors that distinguish a health insurance subscriber from a non subscriber.

1.4 Hypotheses

The following major hypotheses are developed in this study

Hypothesis One

H_{01}: There is no significant difference in awareness about health insurance among respondents of various socio-economic groups.

H_{A1}: There is significant difference in awareness about health insurance among respondents of various socio-economic groups.

Hypothesis Two

H_{02}: The variables that constitute personal factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A2}: The variables that constitute personal factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Hypothesis Three

H_{03}: The variables that constitute marketing factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A3}: The variables that constitute marketing factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Hypothesis Four

H_{04}: The variables that constitute social factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A4}: The variables that constitute social factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Hypothesis Five

H_{05}: The personal, marketing and social variables collectively do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A5}: The personal, marketing and social variables collectively have the discriminating ability to distinguish a health insurance buyer from a non buyer.

1.5 Scope of the Study

Geographical: The study is conducted in the state of Kerala with samples taken from three legislative constituencies from the three geographic regions of south, central and northern Kerala.

***Population*:** The study is conducted among individual respondents of age above 18 years, who may be either consumers or non consumers of health insurance. The electoral list of the state of Kerala is the population frame.

1.6 Context of the Research

Several studies and government records have shown that in India, substantial part, even up to three fourth of health care expenses are borne by individuals and in about 40% of the cases, this leads to huge financial liability for the affected families. This is further compounded by the government policy to gradually withdraw from secondary and tertiary medical care, opening up the field for private sector which inherently is profit motivated.

Life styles are changing resulting in new disease patterns that call for long term medication and cost of medical care is on the rise. The state of Kerala has been considered to be educated, advanced in health care and

people are believed to be health conscious, especially in preventive medical care. In spite of this, the incidence of life style diseases is high in Kerala.

Liberalization of the Indian economy has led to entry of several competitors with attractive heath insurance schemes in to the market. Further, the marketing communications from these companies have added to awareness level of the average consumer. From the marketer's perspective, meeting the people's health insurance needs effectively with suitable products, while reducing operational costs by covering the large spectrum of population including low risk sections of the society presents a good marketing opportunity with sustainable business growth potential.

1.7 Rationale for Selecting the Topic

With the above context, a study of literature to understand the trends in the area was done. Though the health insurance concept and usage are widely spread in the developed countries and large number of studies has been done in the consumer behavior part of health insurance marketing, there is a shortage of similar studies in the Indian, especially Kerala context.

Further, during interviews with the managers of health insurance companies it was noted that the people of the state of Kerala have not awakened to the benefits and need of health insurance and the managers were keen to understand the factors preventing wider use of health insurance as a means of meeting health care expenses.

Therefore a study on factors influencing consumer purchase decision in the health insurance market is relevant for two reasons:

a) The existing shortage of studies and research gap in an area which is having social relevance.

b) The need expressed by practicing managers to understand consumer disposition towards health insurance concept and the reasons for purchase or non-purchase of health insurance.

1.8 Significance of Research

This research work was to study the level of awareness of consumers about health insurance concept and market, consumer perceptions about health insurance providers, schemes and various factors that influence buying decision of health insurance.

There is need to bring entire age group – high risk and low risk under health insurance cover. Widening the cover of health insurance calls for in-depth understanding of consumer thinking and extensive marketing efforts based on that. Hence the study of consumer perceptions and the impact of different contributing factors on consumer purchase decision assume significance to the marketer. Understanding the consumer thinking on health insurance will also be of relevance to governmental/non governmental agencies, as affordable health care to all is a policy objective of the government and new schemes are being launched in this area.

1.9 Methodology of Research

The present research used secondary and primary sources of data, as explained in chapter IV. Consumer data was collected using structured questionnaire. Population under study is limited to the state of Kerala. A sample size of 617 consumers are taken. Collected data has been coded, tabulated and analyzed using the statistical package, SPSS.

Statistical tools used for data analysis include Chronbach Alpha for reliability of research instrument, tests of Chi-Square, independent sample-t

test, One way ANOVA, Discriminant Analysis and Factor Analysis. Details are given in Chapter IV.

1.10 Limitations of the Study

Limitations are common for studies based on sample survey methods. The present study also faced problems due to some external factors which could not be controlled. The following limitations may be noted:

a) Though effort has been made to ensure correctness of data collected, it is possible that some of the respondents would not have provided accurate data.

b) The data collection was spread over a period covering several months and it is possible that introduction of new schemes into the market and personal reasons could have caused some changes in the attitude of people towards health insurance coverage.

c) Though effort has been made to include all relevant factors in the model, it is possible that some factors are missed out.

d) The geographical scope is limited to the state of Kerala, which is significantly different from many other states in terms of literacy and lifestyle patterns. The generalisability of findings may be limited to societies similar to Kerala.

1.11 Chapter Scheme

The study report is organized into ten chapters.

Chapter I Introduction to the Study

Chapter II Health Insurance in India

Chapter III Review of Literature

Chapter IV Design of the Research

Chapter V Profiles and Data Analysis

Chapter VI Influence of Personal factors on health insurance purchase decision

Chapter VII Influence of Marketing factors on health insurance purchase decision

Chapter VIII Influence of Social factors on health insurance purchase decision

Chapter IX Influence of Personal, Marketing and Social Factors on health insurance purchase decision- an integrated model

Chapter X Summary of Findings, Conclusions and Recommendations

a) In the introduction chapter, an overview of the study is laid out. The main intention of this chapter is to provide the reader a brief idea regarding this particular analysis. This chapter outlines the research problem, the research objectives, hypotheses made, scope and context, rationale and significance of the study and limitations of the study.

b) The second chapter deals with the concepts of health insurance and its background in the Indian context.

c) The third chapter provides the review of the literature on insurance as a service, health insurance, the consumer buying process and consumer decisions in health insurance, based on which a model of purchase decision making in health insurance context is evolved. The sources for this secondary data are different journals, articles, text books, websites etc.

d) The fourth chapter deals with the research methodology and design of research. Statistical tools used for data analysis are introduced. The chapter details the population, sample and sampling method, tools of data collection used and how analysis has been carried out.

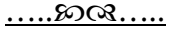
e) The fifth chapter contains the profile of respondents and the analysis of the observations on personal and demographic data gathered through the survey.

f) The sixth, seventh and eighth chapters contain the statistical analysis of the data and its interpretation with regard to the influence of personal, marketing and social factors on consumer purchase decision. Testing of various hypotheses are made and analyzed.

g) The ninth chapter analyzes the integrated influence of the personal, marketing and social factors collectively on consumer purchase decision.

h) The tenth chapter includes the major findings and recommendations. A part of this is the concluding section, which will be giving the details in connection with the subject under study. The major part of this chapter will deal with the summation of the individual sections of the entire topic under study.

i) The final section contains the bibliography part, including the references of various articles, text books, journals, and websites etc used for the purpose of secondary data collection; following which, there is the questionnaire used for the purpose of data collection and an appendix part.



Chapter 2

HEALTH INSURANCE IN INDIA

Contents

2.1 Introduction

India's rapid rate of economic growth over the past decades has been one of the most significant developments in the global economy. This growth has its roots in the introduction of the economic liberalization in the early 1990s, which has allowed India to exploit its economic potential and raise the standard of living of the people. 'Developing countries which invest in better education, healthcare, and job training for their record numbers of young people between the ages of 12 and 24 years of age, could produce surging economic growth and sharply reduced poverty' (WDR 2007). India has been making large scale investments in the recent years in this direction.

Insurance has a key role to play in this process of economic development. It transfers some sort of risk (accident, theft, natural disasters, illness etc) from one person or a group of persons to a more financially

sound entity in exchange for a payment (also known as premium). Accurate risk pricing is one of the most powerful tools used by the insurance sector for setting the right incentives for the allocation of resources, a feature which is significant to a fast developing country like India.

2.2 Evolution of Insurance in India

In India, insurance has a deep-rooted history. The Vedic writings talk in terms of pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. This was probably a pre-cursor to modern day insurance. Ancient Indian history has preserved the earliest traces of insurance in the form of marine trade loans and carriers' contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular.

1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta. This Company however failed in 1834. In 1829, the Madras Equitable had begun transacting life insurance business in the Madras Presidency. 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. This era, however, was dominated by foreign insurance offices which did good business in India, namely Albert Life Assurance, Royal Insurance, Liverpool and London Globe Insurance and the Indian offices were up for hard competition from the foreign companies.

The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1914, the Government of India started publishing returns of Insurance Companies in India. In 1928,

the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protecting the interest of the insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers. The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business. An Ordinance was issued on 19th January, 1956 nationalizing the Life Insurance sector and Life Insurance Corporation came into existence in the same year. The LIC absorbed 154 Indian, 16 non-Indian insurers as also 75 provident societies—245 Indian and foreign insurers in all. The LIC had monopoly till the late 90s when the Insurance sector was reopened to the private sector.

The history of general insurance dates back to the Industrial Revolution in the west and the consequent growth of sea-faring trade and commerce in the 17th century. It came to India as a legacy of British occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd was set up. This was the first company to transact all classes of general insurance business.

1957 saw the formation of the General Insurance Council, a wing of the Insurance Association of India. The General Insurance Council framed a code of conduct for ensuring fair conduct and sound business practices.

In 1968, the Insurance Act was amended to regulate investments and set minimum solvency margins. The Tariff Advisory Committee was also set up then. In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business was nationalized with effect from 1st January, 1973. 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd. The General Insurance Corporation of India was incorporated as a company in 1971 and it commenced business in Jan. 1973.

This millennium has seen insurance come a full circle in a journey extending to nearly 200 years. The process of re-opening of the sector had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of Shri. R N Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. The objective was to complement the reforms initiated in the financial sector. The committee submitted its report in 1994 wherein, among other things, it recommended that the private sector be permitted to enter the insurance industry. They stated that foreign companies should be allowed to enter by floating Indian companies, preferably a joint venture with Indian partners. Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000. The key objectives of the IRDA include promotion of competition so as to enhance customer satisfaction through increased

consumer choice and lower premiums, while ensuring the financial security of the insurance market.

The IRDA opened up the market in August 2000 with the invitation for application for registrations. Foreign companies were allowed ownership of up to 26%. The Authority has the power to frame regulations under Section 114A of the Insurance Act, 1938 and has from 2000 onwards framed various regulations ranging from registration of companies for carrying on insurance business to protection of policyholders' interests. In December, 2000, the subsidiaries of the General Insurance Corporation of India (GIC) were restructured as independent companies and at the same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002. Today there are 24 general insurance companies including the ECGC and Agriculture Insurance Corporation of India and 23 life insurance companies operating in the country. The insurance sector is a colossal one and is growing at a speedy rate of 15-20%. Together with banking services, insurance services add about 7% to the country's GDP. A well-developed and evolved insurance sector is a boon for economic development as it provides long-term funds for infrastructure development, at the same time strengthening the risk taking ability of the country.

2.3 Indian Healthcare System

In spite of the great achievements and progress India has made post independence, when measured by international standards, it is way behind developed countries in many aspects, especially in matters that have direct bearing on health and well being of the citizens.

Based on the thinking 'health is wealth', and lack of health leads to loss of production and productivity, India has placed lot of importance on healthcare after Independence. Indian health care programmes were designed based on two fundamental principles: 1) state responsibility for health care and 2) post independence, free medical care for all. But, resultant to the financial crisis faced by the governments at the centre and states, and in its efforts to contain deficit by controlling government spending, post liberalization, there has been an abrupt switch to market based governance styles and much influential advocacy to reduce the state role in health. People have therefore been forced to switch between weak and inefficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases sliding into indebtedness. This brings forward, the need to provide quality health care at controlled cost to the lower sections and to the middle class of the society.

Over the years, the life expectancy in India has been going up and this has resulted in an increase in the population of the elderly needing geriatric care. The size of India's elderly population aged 60 and above is expected to increase from 77 million in 2001 to 179 million in 2031 and further to 301 million in 2051 (Iirudayarajan, 2006)

Several initiatives by the government post independence have succeeded in controlling a number of life threatening diseases and eradicating many. Classic example is small pox which had taken several lives a few decades back. Leprosy, tuberculosis etc have been brought under control. But another menace has emerged. The incidence of heart problems, cancer, type II diabetes, obesity issues, hyper tension and cholesterol related health problems etc are on the rise. Being diseases

associated with the way a person or group of people lives, these are generally called life style diseases. This is compounded by work/family related stress and poor food habits. Lack of physical exercise is another factor contributing to the increase in these non-contagious type problems. They have long term consequences on the health of a person and therefore are of critical importance to the health insurance providers.

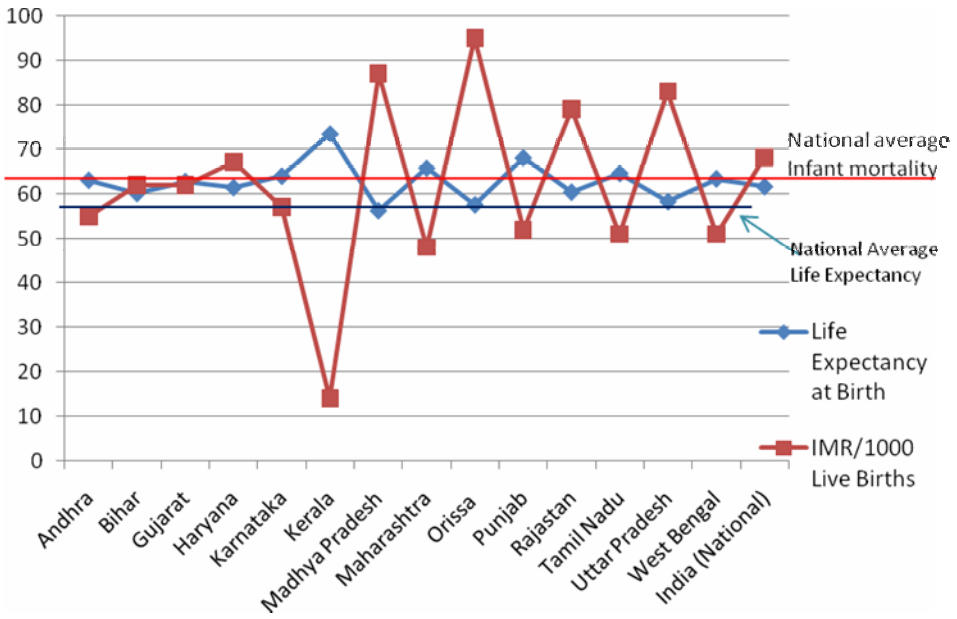
The introduction of technology in to medical care has improved diagnostic and procedural practices in health care in India. There are scores of such biomedical equipments being pressed into service by corporate hospitals. Many of these are very costly but these have improved the confidence of patients in medical treatment offered by the hospitals (Venkatesh, 2008). Further to this, the large number of laboratory tests conducted today have increased the cost of healthcare.

The Indian healthcare industry has grown manifold during the last few years, though there is still a wide shortfall in terms of availability of doctors per 1000 patients, quality medical care and number of beds per thousand people. The assessment by various agencies is that to meet the minimum international standards, there is a need to double the capacity of hospitals, which calls for large scale investments. The number of doctors per 1000 population also needs immediate attention. A major seminal trend in modern societies is the increasing privatization of health promotion (Kickbusch, 2003). The government of India is looking forward to large scale involvement of private sector – for construction of hospitals as well as providing quality healthcare at affordable cost to the consumers. One of the other major trends that are evident is the move towards specialist treatment and specialty hospitals which increases the cost of medical care to the average house hold. All these are expected to raise the cost of medical care

in the country, making it difficult for the average household to ensure its medical needs are met effectively.

On observation of the changes taking place in the health care sector, it is found that there is need to analyze the opportunities that exist, the challenges to be faced, emerging trends and the future scenario of the healthcare service sector in India to gain a comprehensive understanding of the healthcare market and practices, customer attitudes and behavior in India. Any health system would have three important goals. Health sector or health system should work for improving the health status. Health systems have to be responsive to the needs of the clients and the community and it should generate customer satisfaction, which WHO refers to the health systems responsiveness. Financial risk protection is another goal of health systems. It is necessary to start thinking about how health systems are covering for the financial contingencies and financial risk. Are people protected against the high cost of medical care? So any health system should see to it that the financial protection is extended against the catastrophic illnesses and the poor people who are really worst affected with the high cost, are not constrained to seek care (Agarwal, 2006).

The performance of health systems in the national level are not uniform and there are some areas where wide variations in key parameters are observed. The chart below gives the details of two important health parameters, life expectancy and low infant mortality rate. In both these indicators of health performance, the state of Kerala leads with 14 per 1000 live births in Infant Mortality Rate as against 64 in the national average and life expectancy of 74 as against national average of 63 years.



Source: Ministry of Health and Family Welfare, Government of India

Fig. 2.1 Infant Mortality and Life Expectancy in Major States of India

A comparison of health expenditures of some leading countries with India shows that though health expenditure as a percentage of GDP is high or comparable, public health expenditure as a percentage of total expenditure on health is low, which means higher percentage of health care related expenditure is coming from non-governmental sources, mostly self generated.

Table 2.1 Public Health Spending in Select Countries

Country	Percentage of Health expenditure to GDP	Percentage of public health expenditure to total expenditure on health
India	4.1	17.3
China	5.1	25.9
Srilanka	2.9	45.4
UK	9.6	96.9
USA	17.9	44.1

Source: World bank report (http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS_) as of 2010

A factor that is going to affect health services planning is the composition of the population and related issues. In India with majority of its population aged less than 30, the problems and issues of its grey population has not been given serious consideration and only a few studies on them have been attempted in our country. Both the share and size of elderly population is increasing over time. From 5.6% in 1961 it is projected to rise to 12.4% of population by the year 2012. India will have another kind of a problem as despite the rapid and consistent economic growth, it will have a huge ageing population who may be far poorer than their counterpart in the west. For the developing countries like India, the ageing population may pose mounting pressures on various socio-economic fronts including pension outlays, health care expenditures, fiscal discipline, savings levels etc. (Jeyalaksmi et al, 2011).

In the post liberalized economy in India, a number of steps, many with innovative nature have been taken by central as well as state governments which has impact on the way health care is provided to its citizens. These initiatives included public-private participation in health sector, decentralization of funds for health care to local bodies, regulation and setting of standards and bringing accountability by performance monitoring. Some of them are briefed here:

Table 2.2 Indian Health Care Scenario:
Innovation in the Health Sector in India – Post Liberalization

Areas of Innovation	Broad Directions of Innovation
Private-Public Partnership	Handing over of management of public facilities to NGOs, contracting private specialist services and outsourcing other services
Decentralization	Transfer of funds to and involvement of local bodies, management boards of health services
Human Resources	Contracting professionals for services delivery, multi-skilling, pre-internship training, mandatory pre-post graduate rural service
Financing	User fees and financial autonomy to hospitals, health insurance, direct transfer of funds from government to districts under national health plan
Accountability	Delegation of powers to district level officials, performance based monitoring
Community mobilization	Link couple schemes, village planning and community health worker
Regulation and setting of standard	Quality control circles, blood transfusion standards, ISO Certification, Centralized drug procurement

National Rural Health Mission (NRHM):

With an objective to strengthen and improve the public health delivery and health of the rural sector in India, the Ministry of Health introduced the National Rural Health Mission in 2005. NRHM tries to improve the monitoring and planning process involved within health care and also aims to bring private sector players to help in the rural health. The scheme proposes a number of new mechanisms for healthcare delivery including training local residents as Accredited Social Health Activists (ASHA), and the Janani Suraksha Yojana (motherhood protection

program). It also has schemes to improve hygiene and sanitation infrastructure. NRHM has been able to create a significant improvement in health indicators in a short period especially in the focus areas of 18 states viz., Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

The plan of action envisioned in the National Rural Health Mission includes:

- Increasing public expenditure on health
- Reducing regional imbalance in health infrastructure
- Pooling resources
- Integration of organizational structures
- Optimization of health manpower
- Decentralization and district management of health programmes
- Community participation and ownership of assets
- Induction of management and financial personnel into district health system
- Operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

2.4 Health Care Funding in India

Most of the developed countries, especially US and Europe have established health insurance schemes that take care of citizen's medical

expenditure. However, a comparison of the health care spending patterns across the world vs. that of India give the picture of household's contribution in meeting the health care expenditures in India. While out of pocket expenditure on health care in India is about 68%, the world average is about 18% (Fig 1.a and Fig 1.b) (MoH, 2005). In many of the cases this leads to huge financial liabilities for the affected families. According to the National Sample Survey Organisation, the year 2004 saw 28 per cent of ailments in rural areas go untreated due to financial reasons while this is 20 per cent in urban areas (MoH, 2010). Life styles are changing resulting in new disease patterns that call for long term medication and cost of medical care is on the rise. This is further compounded by the government policy to gradually withdraw from secondary and tertiary medical care. In India, in spite of the fact that economy has grown at around 6% during the post-reform period (since 1991-92), the government health spending in per capita real terms, as percentage of GDP and in relation to other sectors has actually declined (Arora and Gumber, 2005).

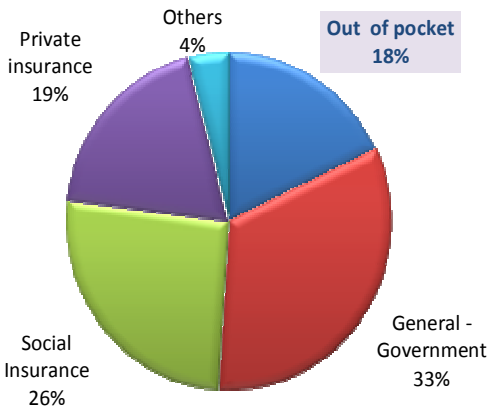


Fig 2.2(a) Health care cost bearing by groups – World Trends

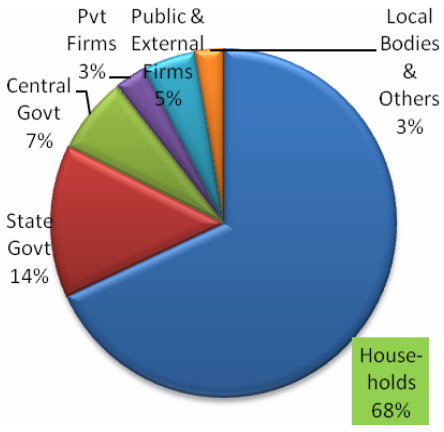


Fig. 2.2(b) Health care cost bearing by groups –Indian Pattern

Source: Ministry of Health & Family Welfare, 2005

MAPHealth, a multi-country project, which evaluated the effects of macro-economic and sectoral reforms on health systems in eight countries found that 10% of households spend more than their annual income on health care. Clear inequalities exist (Devadasan, 2004) as the burden of health care is three times higher for the poor (14.4% of their income) compared to the rich (4.4% of their income). This realization has led to a number of initiatives by the central and state governments to make healthcare accessible to the common man, detailed in subsequent parts.

2.5 Health Insurance in India

During the past several years in India, health spending averaged 11% of non food expenditures and almost 5% of the total annual expenditures of households. Almost 40% were reported to have taken loans to meet such expenditures and nearly 10% sold assets resulting in intergenerational poverty (MoH, 2006). According to the Planning Commission report on Vision 2020, Health insurance can play an invaluable role in improving the overall health care system (Planning Commission, 2002). The setting up of Insurance Regulatory Commission of India IRDA is expected to contribute:

- To maintain a stable and viable market
- To protect and safeguard consumers' interest
- To improve the fairness of private insurance
- Controlling the charges of premium with reference to benefits offered by the policy

The health insurance market traditionally was characterized by three main players which are closely associated with each other. They are:

- The insured person and policyholder / patient

- The insurance company
- The medical service provider (doctor, dentist, hospital etc.)

Third Party Administrators

As a recent development, another organization, the Third Party Administrators, have come to occupy an intermediary role of facilitating health insurance process. This has immensely contributed to the improvement of claim processing in health insurance. As per the information published in the annual report of IRDA for the year 2011-12, there are 29 Third Party Administrators operating with hospital network of 78,207 across India.

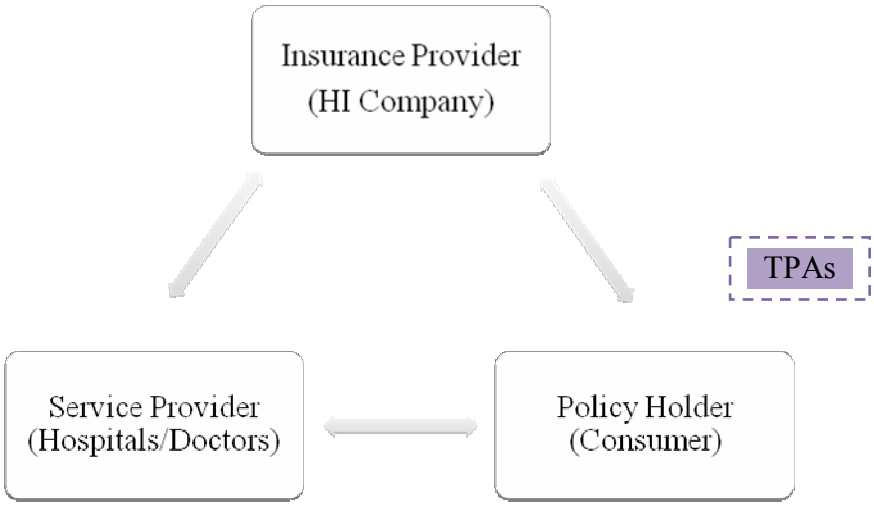


Fig. 2.3 The Triad of Health Care Market

While one studies Health Insurance in India**,** it is found that certain constraints in extending coverage exist, like:

- 75% of the population works in the informal sector
- 25% of the population is below poverty line
- 65% of the population resides in rural areas

- Under insured country, where any insurance is seen as unwanted by a large section of people
- Health insurance is an ill understood subject

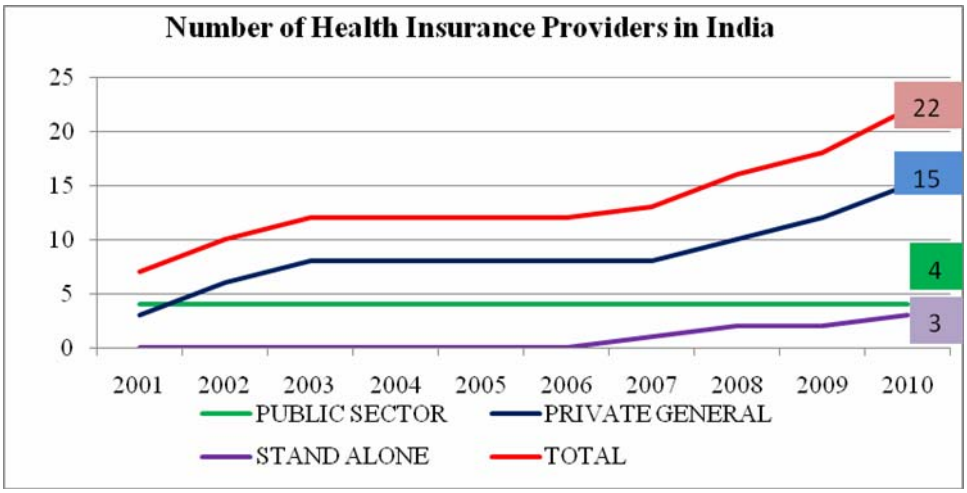
The aging of the Indian population calls for the expansion of insurance mechanisms to finance new social risks, such as that of needing Long-Term Care (LTC) to old age. A number of health insurance companies are entering the market place with promises of innovative products. This has resulted in growth of health insurance in India. Health insurance premium collected in 2005-06 was Rs.2222 Crores, which grew nearly four fold to Rs.13,092 Crores in 2001-12 as per statistics of IRDA (Annexure IV). Ernst & Young in a study has estimated the annual premium collections of Rs.17, 000 Crores by 2012-13 while according to estimates of Swiss Re, by 2015, annual premium collection is expected to be about Rs.30,000 Crores (FICCI, 2007). Increasing FDI limits from 26% to 49% may attract more foreign players and more customized offerings.

2.6 Health Insurance Providers and Schemes in India

Considering the vast Indian market in terms of population as well as geographical size and diversity, different players have to play crucial roles in ensuring health to its population. Health insurance coverage in India is very limited, particularly among those who work outside the formal sector. Health insurance in both Government and private sectors including Employee's State Insurance (ESI) Scheme and Central Government Health (CGH) Scheme, covers less than 10 per cent of the population. However, several initiatives of the government and non-governmental agencies have contributed to the growth of health insurance in India and it has a CAGR of 34% in the last 5 years. It is estimated that by 2015, 20% of the population will be covered by

health insurance. There are the Public Sector undertakings like Life Insurance Corporation of India (with its LIC Health Plus offer etc), The General Insurance Companies – National Insurance, New India, United India Insurance and Oriental – with the Mediclaim presently in the Health Insurance Sector.

It is the Private Sector that has witnessed arrival of a number of Insurance companies – companies with multiple activities like ICICI, stand alone health insurance companies like Star Health and initiatives by hospitals like Apollo-DKV joint venture. In constituting the origins of health insurance, private health schemes traditionally initiate and facilitate health care progress. Continuously seeking possibilities to improve the service offered to their clients, private health insurers are, almost by nature, social entrepreneurs. This social entrepreneurship forms the basis of the innovative added value that private health insurance may offer (Gupta 2007). The expansion seen in the number of companies offering health insurance products is given in fig. 2.4. The details of the companies offering health insurance are given in annexure III.



Source : IRDA

Fig. 2.4 . Number of Health Insurance Providers in India as of 31st March, 2010

The health insurance schemes in India are of three types viz., Private, Social and Community based. The major functional areas of these schemes are shown below:

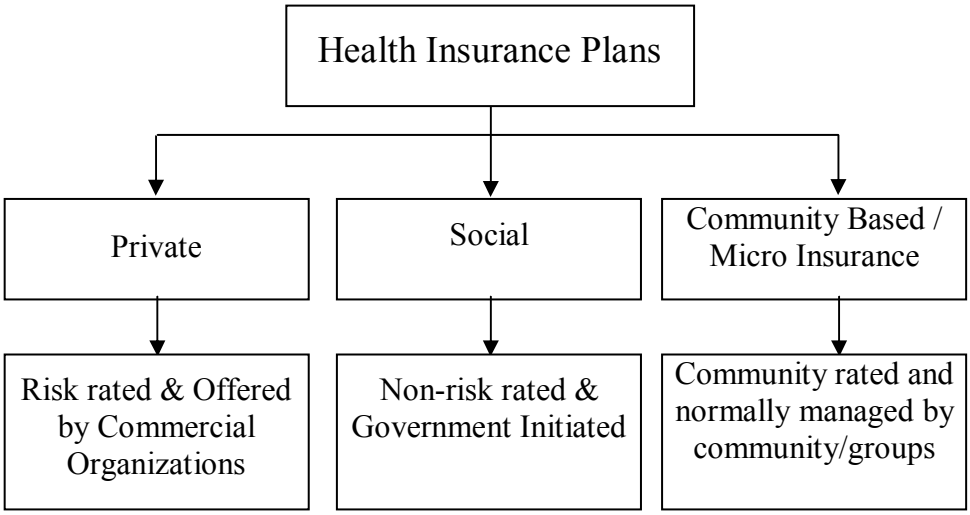


Fig.2.5. Types of Health Insurance Schemes in India

2.6.1 Public (Social) Health Insurance Schemes

Social insurance is an appropriated fund which provides benefits in return for a payment. It is a compulsory scheme for certain groups in population and the premiums are determined by income and hence the ability to pay. The benefit packages are standardised. The prominent schemes are discussed below:

1) Employees State Insurance Scheme (ESIS)

The ESIS was formed with regard to the enactment of the Employees State Insurance Act 1948. This scheme provides protection to the employees against loss of wages due to the inability to work due to sickness, maternity, disability due to permanent injury and death. It offers medical and cash benefits, preventive and promotive care, and health education. Non fee based medical care is also provided to employees and

their family. The ESI Act is applicable to any premises, where 10 or more persons are employed. A factory or an establishment located in a geographical area notified for implementation of the scheme falls under the purview of the Act. Employees of the aforesaid categories of factories and establishments, drawing wages up to Rs.15,000/- (w.e.f. 01.05.2010) a month, are entitled to social security cover under the ESI Act. The wage ceiling for coverage of employees is revised from time to time, to keep up with increasing cost of living and consequent wage hikes.

The appropriate Government, State or Central, is empowered to extend the provisions of the ESI Act to different classes of establishments, industrial, commercial or agricultural or otherwise. Under these enabling provisions most of the State Governments have extended the ESI Act to certain specific class of establishments, such as, shops, hotels, restaurants, cinemas, preview theatres, motors transport undertakings and newspaper establishments etc., employing 20 or more persons. The ESI Scheme is mainly financed by contributions raised from employees covered under the scheme and their employers, and the state governments as a fixed percentage of wages, with a prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of the employees' wages to be paid by the employers and 12.5% of the total expenses to be borne by the State Governments. However, employees earning up to Rs.70/- a day as wages are exempted from payment of their part of contribution. The State Governments bear one-eighth share of expenditure on Medical Benefit within the per capita ceiling of Rs.1200/- per annum and all additional expenditure beyond the ceiling.

Employees covered under the scheme are entitled to medical facilities for self and dependants. They are also entitled to cash benefits in the event of specified contingencies resulting in loss of wages or earning capacity.

The insured women are entitled to maternity benefit for confinement. Where death of an insured employee occurs due to employment injury, the dependants are entitled to family pension.

2) Central Government Health Scheme (CGHS)

This scheme was formed to reduce the inapt and expensive system of reimbursements. It covers employees and retirees of the central government, and certain autonomous, semi-autonomous and semi-government organisations. It aims at providing comprehensive medical care to the central government employees and the benefits offered include all outpatient facilities and all preventive and promotive care facilities in dispensaries. The scheme is funded through central government funds, with premium ranging from Rs.15/- to Rs.150/- per month based on salary scales. The Central Govt. Health Scheme in India is a comprehensive health care to the CGHS beneficiaries. The Central Govt. Health Scheme is applicable to the following categories of people residing in CGHS covered cities:

- All Central Govt. Servants paid from Civil Estimates (other than those employed in Railway Services and those employed under Delhi Administration except members of Delhi Police Force).
- Pensioners drawing pension from Civil Estimates and their family members – (Pensioner residing in non- CGHS areas also may obtain CGHS Card from nearest CGHS covered City)
- Honourable Members of Parliament
- Hon. Judges of Supreme Court of India
- Ex- Members of Parliament
- Employees & Pensioners of Autonomous Bodies covered under CGHS (Delhi)

- Ex- Governors and Ex-Vice Presidents
- Former Prime Ministers
- Former Judges of Hon'ble Supreme Court of India and Hon'ble High Courts
- Freedom Fighters
- It provides service through following categories of systems:- Allopathic, Homeopathic, Indian System of Medicines (e.g. Ayurveda, Unani, Yoga, Siddha System)

3) Universal Health Insurance Scheme (UHI)

The UHI scheme was launched in the year 2003 by the Central Government with an objective to provide health insurance for the poor irrespective of the states. This scheme is made available only to individuals below poverty line. The benefit package includes medical expenses, compensation for the loss of wages due to illness and death due to personal accident. The scheme is operated by the four non- life public insurance companies and managed with the help of Third Party Administrators (TPAs). TPAs are independent agencies that arranges for cashless hospitalisation by coordinating between insurance companies, customers, and healthcare providers.

2.6.2 Micro (Community Based) Health Insurance (MHI) Schemes

MHIs aim at under privileged sections of the society and purely dependent on not-for-profit principle. Currently, more than 20 MHI units operate in India. The MHIs are also known as Community Based Health Insurance (CBHI) Schemes. Community Based Health Insurance provides financial protection from the cost of seeking health care. It has three main features: prepayment for health services by community members; community control; and voluntary

membership. While from a policy perspective the primary purpose of CBHI is not economic development—rather it is to improve access to health care services—CBHI is a financial mechanism (Mladovsky and Mossialos, 2008). Community-based health insurance schemes in India and elsewhere can protect poor households against the uncertain risk of medical expenses. They can be implemented in areas where institutional capacity is too weak to organize nationwide risk-pooling (Ranson, 2002).

Issues in processing and settlement of claims have contributed to health insurance being not popular among the common public. The documentation and procedural requirements are often more complex and time consuming leading to many health insurance consumers opting not to make claims on relatively smaller medical expenditures. Frauds in the micro-insurance sector can be from the supply side or demand (customer) side. Some customers resort to inflate the claims by misstatements and inflation of claims, while on the supply side it can arise from the insurance company, its employees and the intermediaries. Added to that is the potential of the hospitals/doctors contributing to a part of fraud. It is necessary to arrest these planned frauds in order to realize the objectives of micro insurance, thereby making health care services affordable and accessible to the poor (Sekhar, 2007). Introduction of the Third Party Administration (TPA) system is expected to improve the processing, making it faster, reliable and easier. However, a number of consumers are holding the view that health insurance processing is a difficult process.

Micro Health Insurance Schemes can be classified into three:

- Type 1: The provider of the health care performs dual functions of providing care and running the insurance scheme. (e.g. ACCORD, VHS)

- Type 2: The insurer is a voluntary organisation or an NGO, while purchasing care from the independent providers. (e.g. Tribhuvandas Foundation, DHAN Foundation)
- Type3: The NGO plays the role of the agent purchasing from providers and insurance companies. (e.g. SEWA, Karuna Trust, BAIF).

Non Governmental Organizations involved in Micro Health Insurance can play different roles such as that of an intermediary, that of a manager or as a provider of health insurance to the intended consumer group according to the NGO's objectives. The offerings to the beneficiaries can differ according to the role it plays.

Table 2.3. Important Differences in CBHI Arrangements

Type of arrangement	NGO is an intermediary	NGO is a Manager	NGO is a Provider
Examples	SEWA/ACCORD	Thribhuvandas Foundation	Sewagram/VHS
Types of Risk covered	Inpatient care and non-health risks	Inpatient care	Inpatient and Outpatient care
Pre-existing or chronic conditions	Excluded	May not be excluded	Not excluded
Membership size	Medium to Large	Small to medium	Medium to Large
Availability of benefit	After certain period	At the time of discharge	At the time of utilization
Admin. Costs	Moderate	Low	Low
Group formation	Occupation or Geography based	Occupation or Geography based	Geography based

Source : Ranson (2002) and general sources

Some of the major Micro Health Insurance Schemes in India are discussed below:

1) Self Employed Women's Association (SEWA)

SEWA is a trade union registered in 1972. It is an organisation of poor, self-employed women workers. These are women who earn a living through their own labour or small businesses. They do not obtain regular salaried employment with welfare benefits like workers in the organised sector. They are the unprotected labour force of our country. Constituting 93% of the labour force, these are workers of the unorganised sector. Of the female labour force in India, more than 94% are in the unorganised sector. However their work is not counted and hence remains invisible.

The scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. This scheme operates in collaboration with the National Insurance Company (NIC). Under SEWA's most popular policy, a premium of Rs.85/- per individual is paid by the woman for life, health and assets insurance. At an additional payment of Rs.55/- , her husband too can be covered. Rs. 20 per member is then paid to NIC per month which provides coverage to a maximum of Rs. 20,000/- per person per year for hospitalization.

2) Tribhuvandas Foundation (TF)

Another popular CBHI scheme in Gujarat is Tribhuvandas Foundation, Anand. The foundation was established in the year 2001 with the membership being restricted to members of AMUL Dairy Cooperatives.

Since then, over 1,00,000 households have been enrolled under this scheme, with the TF functioning as third party insurer.

The Foundation derives its uniqueness from the fact that it is a need-based programme for villagers and is run by the villagers themselves. It fulfils the basic health care needs of the villages. Apart from providing primary treatment for various common ailments, the foundation is also actively involved in promoting preventive health practices. It is headquartered at Anand with sub-centers spread over the district Anand and Kheda in Gujarat state of India. The foundation has a dedicated team of medical officers, nurses, administrative staff, dais (traditional birth attendants) and village health workers to provide health services to the needy members.

3) Action for Community Organisation, Rehabilitation and Development (ACCORD)

ACCORD, Nilgiris, Tamil Nadu was established in the year 1991 with an objective of enhancing human rights, health, education, housing and culture. Around 13000 Adivasis (tribals) are covered under a group policy purchased from New India Assurance.

4) The Yeshasvini Scheme

Yeshaswini, the self-funded health care scheme to access quality healthcare at a nominal amount of Rs.5/- per month covering over 1700 surgical procedures for the farmer's family was initiated by the government of Karnataka and Narayana Hridayalaya as a Public Private Participation (PPP) initiative. It was launched in the year 2002 with the objective of making healthcare facilities available to members of Karnataka's State Cooperative Societies. It is a voluntary programme which provides free

hospitalization for 1600 predefined surgical procedures, subject to a maximum Rs.2,00,000/- per member per annum and Rs.1,00,000/- per hospitalization. It is managed by a trust called Yeshasvini Trust. Within the first three years itself, the scheme was able to benefit 1.7 Million farmers from 35800 co-operatives and 9000 surgeries conducted (Kashyap, 2012).

2.6.3 Rashtriya Swasthya Bima Yojana (RSBY)

With an objective of providing health security to the unorganized sector, the Government of India, Ministry of Labor and Employment has launched the Rashtriya Swasthya Bima Yojana, the health insurance scheme for Below Poverty Line (BPL) families where the central government contributes 75 per cent of the annual premium and the state government has a share of 25 percent. Protection to BPL households from financial liabilities arising out of health shocks and that involved hospitalization was the objective of this scheme. The government has tied up with some private hospitals in each locality, along with the government hospitals for the smooth functioning of the scheme. Under the scheme each family is issued a health insurance card which needs to be processed in computer at the time of admission in a hospital. Each family under the scheme will get coverage of Rs. 30,000 per year for minor diseases like fever and others and an amount is also given to the patient as travelling expenses at the time of discharging from the hospital.

The Benefits of the RSBY Scheme

The beneficiaries need to pay only an amount of Rs.30/- for registration and the Central and State Government pays the premium to the

insurer selected by the State Government on their own grounds. In the case of APL families, no subsidy is paid by the government, but they can still avail the facility by paying Rs.450/- to Rs.750/- per year. There is no age limit for getting benefits from this scheme. The beneficiaries will be able to get coverage of up to Rs. 30,000/- for most of the diseases which require hospitalization. For diseases like heart ailments and other major treatments, they will get coverage up to Rs. One lakh. Government can fix package rates for hospitals for a large number of interventions. The benefits will be received by the beneficiaries from the day one of hospitalization.

Features of RSBY

1) Empowering the beneficiary

RSBY allows the beneficiaries to select between private or public hospitals. The scheme does not restrict its benefits to a hospital or some category of hospitals. This can help potential client worth attracting on account of the significant revenues that hospitals stand to earn through the scheme.

2) Business model for all stakeholders

The model is a well planned one which provides space for further expansion as well as for its sustainable growth in a long run. The parties in this model are insurers, hospitals, intermediaries and government.

3) Information Technology (IT) intensive

This is the first public scheme which has employed IT at such a large scale. Everyone who is registered under this scheme is given a biometric card with their fingerprints and photographs which will be checked at the hospitals at the time of admission. These hospitals are connected to a server at the district level for smooth and easy working of the scheme.

3) Safe and fool-proof

The use of IT services and the bio-metric card makes the system fool proof. Then the finger prints on the card make sure that the benefits are received by no one other than the registered user.

4) Portability

This is the most unique feature of this scheme because in this the card can be registered in one district and the benefits can be obtained from any other area also. It is not needed that the card should be used in the place of registration. This is of great help to families who migrate from one place to another. Cards can also be split for migrant workers to carry a share of the coverage with them separately.

5) Cashless and paperless transactions

The beneficiaries need not carry any paper cash to the hospital for the treatment nor have they to send any papers to the insurers after the treatment. They just have to carry their bio metric card and allow for the finger print testing. Records are sent to the insurers electronically and the payment is also made electronically.

6) Robust Monitoring and Evaluation

Periodic and analytical data is being provided by an elaborate backend data management system being put in place which can track any transaction across India. The basic information gathered by government and reported publicly should allow for mid-course improvements in the scheme.

Mechanism of Rashtriya Swasthya Bhima Yojana (RSBY)

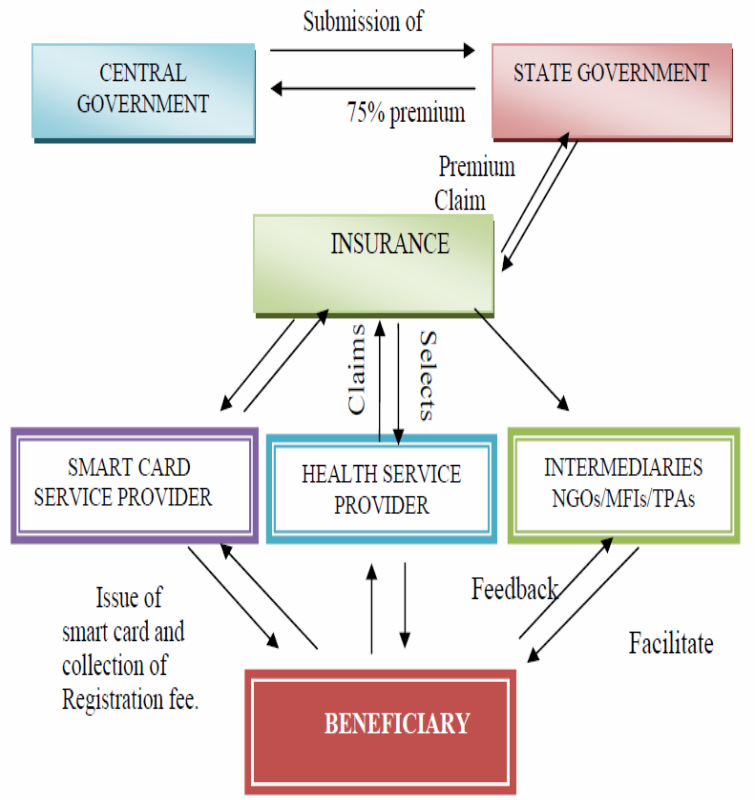


Fig. 2.6 Schematic Diagram of the System of Rashtriya Swasthya Bhima Yojana in Kerala

Response of Public Towards the Scheme

There is good response from the public as they can avail health treatments free of cost. This is particularly suitable for the BPL families who were finding it difficult to finance their health treatments. Therefore the scheme is widely accepted by the people and has been regarded as a very good initiative from the government.

Comprehensive Health Insurance Scheme (CHIS):

In addition to RSBY, the Government of Kerala has decided to provide similar benefits to such other poor families as are not covered

under RSBY and to those who opt to subscribe to the scheme by paying such amount as may be prescribed. The special feature of CHIS is that it extends to all the families other than the BPL families (absolute poor) as per the Planning Commission's guidelines who come under the RSBY. The APL families that belong neither to the State government list nor to the list prepared as per guidelines of the Planning Commission can take benefits from the smart card scheme implemented by the government.

2.6.4 Private Health Insurance Schemes

In private health insurance schemes, the buyers will be willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key feature is that the premiums are set at a level, which provides a profit to the third party and provider institutions. The prominent private health insurance schemes are:

Mediclaim Policy

Started in 1986 by the National Insurance Company Limited and subsequently followed by other public limited general insurance companies, it provides for hospitalization for illness, disease or accident, which may or may not include surgery. It offers benefits such as:

- Reimbursement of hospitalization expenses which are reasonably and necessarily incurred.
- Premium paid for the policy towards self, spouse, dependent children, and dependent parents are exempt from Income Tax under sec 80D of the IT Act.
- Cost of health check up and cumulative bonus- benefits will accrue only if the policy is a renewed in time.

The private and public companies in India offer PHIs. GIC, which constitutes four other companies offer policies such as Jan Arogya Bima, Personal Accident Policy, Nagarik Sureksha Policy, Overseas Mediclaim Policy and so on. LIC has also come up with a number of health insurance schemes out of which Ashadeep and Health Plus have gained popularity. Currently, a number of private players such as Bajaj Allianz, ICICI, Royal Sundaram, and Cholamandalam also offer health insurance schemes.

Liberalization of the Indian economy has led to entry of several competitors with attractive heath insurance schemes in to the market. Though this has led to competition in health care insurance market, a substantial part of the market is yet to be seriously targeted by these companies and it can be said that the health insurance business is still in nascent stages in India. The marketing communications from these companies have added to awareness level of the average consumer.

2.7 Issues in Health Insurance in India

There is a variety of problems with India's health coverage plans. One such issue is, health insurance in India is misunderstood as life insurance by a substantial section of the population, and there is a need to create awareness and educate the people about the importance of health insurance and the various benefits that they can avail (Memon, 2011). The common negative factors include (Gupta 2007):

- Grossly inferior service when the plan giver ESIS, CGHS etc owns facilities.
- Rejection and unwarranted delays in reimbursement.

- Service limitations – either low policy limits on reimbursement amounts or restrictions applied to pre-existing and chronic ailments.
- Inadequate information regarding health, ailments, procedures and treatments, corresponding costs and outcomes.
- Provider malpractice.
- Inadequate medical care coverage.

While the consumers are benefitted by health insurance schemes, often there is lack of clarity as to how to approach the health insurance issue. With different types of health insurance policies available depending on consumer's requirement and budget, some fundamental preparation and information gathering will help in choosing the right provider and scheme. In a nut shell these can be stated as:

- Define what one wants to cover against – is it just critical illness, or injuries resulting from an accident, hospitalization expenses or other expenses as well.
- Decide which members of the family need to be part of the health insurance policy – while in some cases a total family package is beneficial, sometimes splitting policies may be better. When buying for a family, one should check multiple options. Sometimes it is beneficial from a cost perspective for the oldest member of the family to have a separate policy. Usually all insurance companies offer policies for coverage of individual and spouse; and up to three children under one policy. Some policies also give coverage for dependent parents in the same policy. One of the disadvantage of family floater

health insurance is the policy can only be renewed upto the senior most member reaches the age of 65-70 years (depending on the company). At this time other family members have to take a new health policy and that policy will not cover existing diseases.

- The total amount of coverage needs to be determined by the number of people that one wants the policy to cover, the estimate of the health care costs and the existing coverage that consumer might have from other sources like employee provided group insurance.
- Awareness of exclusions from policy coverage is important. Exclusions define the ailments and the conditions under which the health insurance coverage will not be valid. A common permanent exclusion is cosmetic surgery. Such surgery is discretionary and usually not life threatening and performed at the insistence of the patient. A common first year exclusion is cataract; cataract surgery is covered from the second year onwards. Depending on the terms of the policies followed by different companies, existing diseases are often not covered for a specific period, sometimes up to four years of policy life.
- Consumers must clarify the network coverage of the Third Party Administrator (TPA) being employed by the health insurance company as regard to the hospitals near the consumer's residence which might be used in case of an emergency as well as the hospital where one seeks regular or specialist treatment.
- In the case of cashless claims, the settlement is done directly by the Third-Party Administrator on behalf of the health insurer.

However, prior approval is required from the TPA before the patient is admitted into the hospital. In case of emergency hospitalization, approval can be obtained post-admission. Cashless facility is available only at the network hospitals of the TPA.

- The maintenance of records related to diagnosis, treatments and expenditures are essential and often disputes in claim processing arise due to ignorance or negligence from the consumer's part.

2.8 Health and Health Insurance Scenario in Kerala

The state of Kerala with a population of about 33.4 million and a literacy rate of above 90%, is a fertile ground for health insurance marketing. Kerala has a highly literate and health conscious population playing an active role in politics and public affairs and adopting hygienic practices (Shah and Rani, 2003). Many factors in the social milieu of Kerala were conducive to the high growth of demand for health care. The high level of education, especially female education, ensured that people were easily sensitized to the newer developments in treatment. The settlement pattern in Kerala, with comparatively easy accessibility to the towns and other centres where medical institutions were situated, was another contributory factor. The rapid proliferation of health facilities in the government sector during the 1960s and 1970s ensured a growing awareness of modern methods of medical care, which people then became used to (Ramankutty, 2000). The contribution from private organizations like the church run hospitals also had a considerable impact in growth of health awareness and health facilities in the state.

Healthcare Scenario in Kerala is going through a phase of transition and evolution. Private expenditure on healthcare is increasing. Quality of

health services offered by private institutions is perceived to be better and there is shift from government's free medical services to chargeable services offered by private hospitals. The proportion of persons seeking care from private rather than government hospitals increased from 55% in 1986-87 to 65% by 2004 (Dilip, 2010). However, in this sector, there is observed to be more focus on infrastructure without laying emphasis on processes and monitoring the outcomes. And there is need for quality in service delivery. As this becomes a priority area, usage of sophisticated diagnostic equipments and tests will further increase the medical services cost. Based on a study on outpatient care utilization in urban Kerala, Levesque et al (2007) conclude that even in a context of high public availability, relying on the development of the private sector to respond to increasing health care needs could create inequalities in access. Escalation of costs of private services and reduced public investments could generate some inequalities in access for the poor.

Lifestyle diseases are on the rise in Kerala. A study initiated by Health Action by People in 2005, observed that among the persons of 35 years and above in the state, the prevalence of diabetes ranged from 21 per cent in the rural areas to 28 per cent in the urban areas, while the prevalence of hypertension was 34 to 43 per cent in the same age group. About 38 to 54 per cent in the age group was overweight, while the average cholesterol levels in any segment of the State's population was 225 mg (Maya, 2005). In Kerala, lifestyle diseases ─ heart disease, diabetes, high blood pressure, and obesity ─ are paradoxically high and result in very high mortality and morbidity from malignant heart disease (CADI, 2010). According to another study conducted in Trivandrum, the major cause of death is found to be related to cardio vascular diseases (Sauvaget et al, 2011).

Morbidity rates that help insurers predict the likelihood that an insured will contract or develop any number of specified diseases, is reported to be on higher side for the state of Kerala. Incidence of morbidity is higher in Kerala than India as a whole (Suryanarayana, 2008). The annual hospitalization rate increased from 69 per 1000 population in 1986-87 to 126 per 1000 population by 2004. An interesting finding observed in an earlier study conducted on hospitalization patterns was that people who were more likely to have a better lifestyle had a higher level of morbidity and hospitalization (Dilip, 2002).

The proportion of elderly in India was around 9 percent of the total in 1991, and with the decline in fertility and mortality rates, population projections expect it to increase to 19 percent in 2021 and 35 percent in 2051 (Census 2001). In Kerala too, there is a steadily aging population which comprises of about 11.2% of people above the age of 60, against 7.4% national average. It has an average life expectancy at birth of 74 years, which is comparable to developed countries of the world. The elderly are likely to have more health concerns than the rest of the population. The expenditure on healthcare in Kerala is higher than the average in India for the elderly, both as regards outpatient and in-patient care (Prasad, 2007). The process of ageing is likely to be accompanied by changes in patterns of diseases in the transition in the morbidity pattern across time. Prevalence of heart diseases among elderly population was much higher in urban areas than in rural parts in India. Kerala, the state with a more urban style living has reason to be concerned about. The health risks of the presence of an aged person in a household can result in a catastrophic shock for the family and render such households more exposed to poverty. The hospitalization of non-elderly members results in catastrophic payments in both poor and

rich households, as in both they result in loss of income and employment. But in the case of elderly who are prone to more health eventualities, the shock is more for the poor than the rich. Therefore, a search for alternative policy options such as health insurance or alternative health finance strategy for the state of Kerala in the context of rapid ageing is very important (Prasad, 2007).

Although Kerala is known for its achievements in health, poor and vulnerable populations are often excluded from accessing fair quality health care. In addition, Kerala faces a particular challenge due to its ageing population and shift from communicable diseases to chronic disease, both of which will generate additional financial burdens (Devadasan et al., 2004). The Government of Kerala, individually and with support from the Government of India has initiated several activities to make health care affordable to the people of Kerala, especially the Below Poverty Line (BPL) section of society. Comprehensive Health Insurance Agency of Kerala, shortly called Chiak, is the Nodal Agency constituted for the implementation of the RSBY-CHIS health insurance schemes in Kerala. Some of the aims of Chiak are:

a) To provide health insurance cover to the workers and their families in the unorganized sector under the 'Rashtriya Swasthya Bima Yojana'(RSBY) announced by the Central Government

b) To provide health insurance cover to all sections of the society under the 'Comprehensive Health Insurance Scheme'(CHIS) announced by the State Government.

c) To identify, formulate, implement and support implementation of all projects aimed at the welfare of workers in Kerala.

d) To identify and negotiate with consultants of repute for implementation of any project of the Central Government or the State Government towards minimizing heavy expenditure on medical care and hospitalization of the citizens which is a major insecurity leading to their poverty.

e) To provide technical, financial or other assistance for the formulation of programmes meant for social security to workers.

f) To co-ordinate with various departments and agencies of the Central or State Government, Financial Institutions, Health Insurance Providers, Health Service Providers, Cooperatives or Non Governmental Organizations (NGOs) for implementation of any project meant for the welfare of workers.

These schemes and initiatives have helped in creating a higher awareness among the entire population of Kerala and sensitised the other segments to the need and benefits of health insurance. The high health awareness and the knowledge that medical care is getting costlier have contributed to creation of a positive attitude towards health insurance concept among people – as felt by many health insurance marketers and opinions shared during interactions. Most of the health insurance companies have opened wide network of services in the state of Kerala understanding the market potential and have made service relationships with network hospitals across the state.

2.9 Health Insurance Marketing

Health Insurance Marketing is one of the most difficult jobs in insurance marketing. It is because of the everlasting conflict between the

insurance companies which want to profit the most and the insured person who wants to get as much compensation as possible from the insurance company. Commissions for the health companies are very low and they very seldom make profits out of health insurance.

Till recently, the health insurance companies were paid very little premiums by young children or healthy people and thus the scope for profit was very small and those who paid high rates of premium were the older people who often get ill and the health insurance companies compensate for that. The entry of several players in to the health insurance market has invited tough competition for the health insurance companies as most of them offer similar types of premiums and facilities.

The dominant type of health insurance contract contains a formula containing partial reimbursement to the consumer for expenditures on selected goods and services. The consumer pays a pre-determined amount per period, the premium. At the beginning of the period specified in the insurance contract, the consumer is uncertain about many future developments - the occurrence of various illnesses, the amount of medical services consumed, and the 'out of pocket' monetary expenses cannot be perfectly foretold.

When it comes to health insurance, the marketing of single disease cover also has been in force, such as cancer insurance in the United States. The basic reason for this is inadequate cover or rejection of parts of expenses in the treatment of some diseases. Cancer insurers also point to the inadequacy of health care policies in dealing with cancer's financial costs: 'The best health insurance policy in the world doesn't pay all the expenses associated with a fight with cancer!' (Neilson et al 2000).

For consumers to purchase health insurance, several things need to exist:

Financial incentives – While the desire to protect savings by itself is a strong motivator, India may well consider proposing enhanced tax treatment of insurance costs for individuals (some of which exists.) Another path not currently present in India is structuring financing alternatives such as medical savings accounts, which combine higher-deductible insurance coverage with money set aside in tax-favoured accounts for future health costs.

Competitively priced products with choice – to make prudent purchases, consumers should be able to choose among hospitals and other healthcare providers, along with coverage scope and insurers. Not every family situation is the same, nor does every person need or want the same coverage. Likewise, providing for non-inpatient services encourages smarter buying: Fairly priced, affordable products will ensure accessibility to the highest number of people.

Understandable information – Educating consumers about health insurance, in general, will be extremely important. Beyond awareness of insurance coverage, information on disease, cost of treatments, alternative treatment options, and the quality of the treatments provided must be available to consumers to make informed choices.

Employer-sponsored programs – Financing of health insurance through employer-sponsored programs is likely to improve access to insurance for some. Employers would have to be motivated to provide such coverage; again, more favourable tax treatment might be a motivating force. While it is important that health insurance provide sufficient protection to make it attractive to the buying public, care must be taken to design coverage that

sufficiently involve the consumer in the cost of care, so that individuals are encouraged to behave in a cost-conscious way. A health insurance policy that provides 100% coverage for all services removes the patient entirely from the economic consequences of his course or place of treatment. The patient, then, has no incentive to pursue cost-effective treatment options.

2.10 Challenges in the Health Insurance Market for the Marketing Organizations

As observed, marketing of health insurance and ensuring its growth present many challenges to the organization and this can have two basic origins, one resulting from consumer perceptions and consumer behaviour, and the second one due to the limitations resulting from the marketing company's activities. However, on the positive side, the marketing environment is conducive with the rising awareness, growing risk factors & rising cost of medical care necessitating some sort of insurance protection.

Studies by researchers like Liberman and Trope (1998) have shown that consumers weigh the feasibility of purchasing and using a product or service more heavily when they consider it for immediate consumption than for future consumption. Marketer's face this problem in the health insurance market as what is offered is a protection against an event that is more probable not to happen than to happen. A product or service that is considered for future adoption is likely to be represented in memory primarily in terms of features with implications for its intrinsic desirability (Kim et al, 2009)

The marketing of insurance products is highly influenced by attitude of agents. However, with nominal benefits only expected, agents do not promote health insurance aggressively. Further often the companies also

do half hearted marketing as financially health insurance is not very attractive.

In the marketing of health insurance, a major concern is adverse selection, where the high risk population is the major component of customer base, increasing vulnerability of the insurance companies as can be seen from high claim – premium ratio. On the other hand, attracting low age, low risk category to take policy is not yielding much result. The need is often not felt by the younger age group as they have not faced a major health problem. The increase in premium rates applicable to various age groups and the increase in rates for higher age groups over a span of five years are shown in table 2.4.

Table 2.4 Annual Premium for Rs 2 lakh Mediclaim Policy of a Public Sector Health Insurance Company.

Age group	Annual basic premium (w/o tax) (March 200)	Annual basic premium (w/o tax) (March 2013)
Up to 35 years	Rs. 2329/-	Rs. 2530/-
36-45 years	Rs. 2531/-	Rs. 3575/-
46-55 years	Rs. 3679/-	Rs. 6280/-
56-65 years	Rs. 4206/-	Rs. 8110/-
66-70 years	Rs. 4726/-	Rs. 9110/-

Source : New India Assurance Co, as of 2008 and 2013

In view of these factors, to ensure wider health insurance coverage and reduce the cost to senior citizens, it is necessary to broaden the net by offering schemes that will attract the apparently healthy segment of the market. Proper administration and timely settlement are other areas to be addressed by the companies.

2.11 Conclusion

Objective of this chapter is to provide an overview of the health services and health insurance in India in general and Kerala in particular. In India, there are two sections of the society from health insurance view point. There is a large part of the population that is at the lower end where government schemes and micro health insurance are ideal. There is also another equally important middle/upper segment where private health insurance companies will find a potential market. The second most populous country in the world offers a large number of insurable persons if proper schemes at reasonable price are available. Kerala with its advancement in literacy and health facilities is yet to adopt health insurance as a major means of health care financing. Hence an overview of the market environment is very relevant to the present study.

Chapter 3

REVIEW OF LITERATURE

Contents

3.1 Introduction

'*If I can see further, it is because I am standing on the shoulders of giants':* this famous statement of Sir Isaac Newton sets the framework for this chapter. An effort to understand how various academicians in the past have looked at the concepts of services, insurance, consumer purchase process and the factors that influence consumer purchase decision in health insurance products is made here with an intention to find out research gap that may be addressed. Through this process, a suggestion of incorporating certain identified variables as contributors to consumer buying in the health insurance market is made and proposed as a 'model of consumer purchase decision of health insurance products'. A brief report of the literature study is presented here.

3.2 Services

The global economy in the recent past has moved from agriculture to manufacturing and then manufacturing to services. Today, services contribute to more than 60% of GDP in most developed and even some developing countries. Zeithaml and Bitner (2000) defines services as: 'Services are deeds, processes and performances'. Parasuram et al (1985) defines the characteristics that separate goods and services as intangibility, heterogeneity and inseparability. These are factors that offer challenges to a manager in the insurance industry.

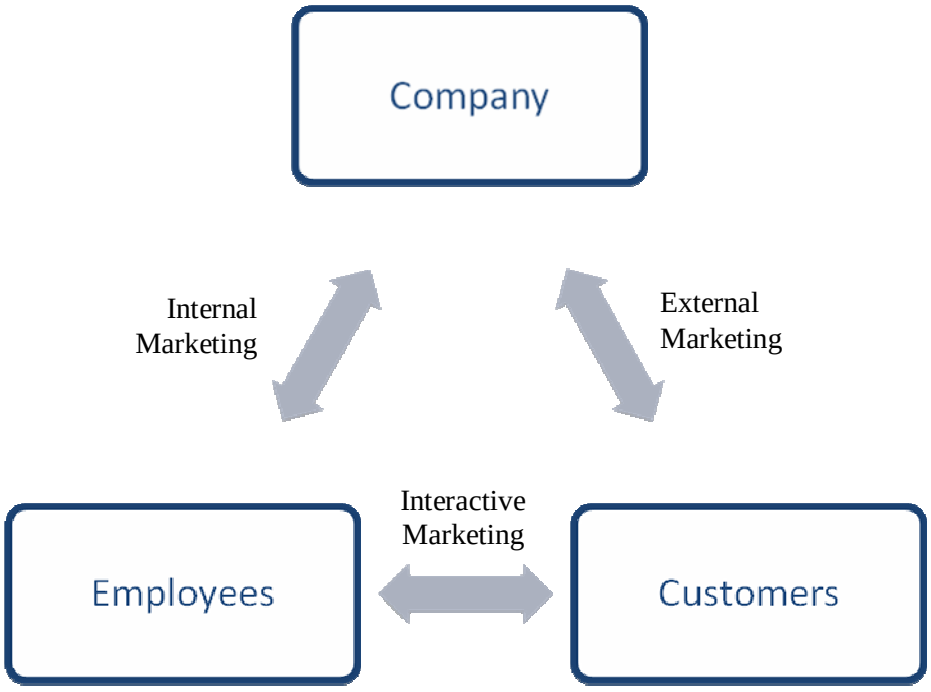
An important aspect of services is that depending on service concerned, customer partnership is required at varying degrees in the creation and delivery of services (Lovelock and Young, 1979), (Bettencourt, 1997). Customers form opinion of firms during various interactions with the service providers. These constitute the various 'moments of truth' during which customer forms impression about the service provider. These encounters, whether face-to-face, over phone or through other communication medium like the internet are crucial in forming customer's perception regarding service quality and determining customer satisfaction (Bitner, 1990).

The need for services-related research is considerable because services are thought to have unique characteristics to which techniques for the marketing of goods may not be directly applied (Berry, 1980; Uhl and Upah, 1983; Zeithaml *et al.,* 1985). While the number of services-related studies continues to increase, this body of research has largely emphasized understanding consumer decision behavior for professional services; i.e., those professions that have a recognized group identity and that require

extensive training and advanced study in a specialized field (Crane, 1993; Freiden and Goldsmith, 1989; Hite and Fraser, 1988; Webster, 1988). These typically involve health, legal, or financial specialists. Considerably less is known about how consumers evaluate and select nonprofessional services; e.g. dry cleaners, auto repair, hair care, restaurants (Hill and Motes, 1995; Turley and LeBlanc, 1993). Because consumers tend to purchase these types of services on a more regular and frequent basis, it is particularly important for marketers to develop an understanding of consumer decision making for nonprofessional services. And yet, while the distinction between them may be important, both nonprofessional and professional service providers must develop carefully formulated marketing programs based on a systematic and thorough understanding of the factors that underlie the decision making of their customers.

One of the important frameworks in the services marketing literature is the Services Marketing Triangle that demonstrates the interrelationship between the three important players in services setting viz., the service providing firm, the customer and the frontline employees (Bitner, 1995) (Kotler, 2000). The promises made by the organization to customers through the external marketing activities are complimented by the interactive marketing that happens between employees of the firm and the customer. The employees are made capable to deliver this through internal marketing done by the organization. This is schematically depicted below in Fig. 3.1. In order to facilitate proper interactive marketing, internal marketing by way of appropriate training and motivational measures are to be given to the service employees (Berry, 1981).

Services Marketing Triangle



Source : Kotler, Philip (2000)

Fig 3.1. The Services Marketing Triangle

An effort of compiling a definition of the phenomenon of services has been made by Christian Grönroos, a distinguished researcher in service management. "A service is an activity or series of activities of more or less intangible nature that normally, but not necessarily, take place in interactions between the customer and service employees and/or physical resources or goods and/or systems of the service provider, which are provided as solutions to customer problems" (Grönroos, 1990).

3.3 Service Quality and its Relationship with Customer Satisfaction

Early research efforts on quality research in the 1920s focused on measuring the quality in manufacturing and assembling industries. As

service activities have become the fundamental and dominant factors of the economic system over the past three decades, studies in service quality started to increase. Relevant studies indicated that service quality is a key factor for survival and development in today's keen competition, the significance and attention in service quality has grown noticeably (Ghobadian et al, 1994). Researchers (Buttle, 1996; Caruana, 2002; McDougall & Levesque, 2000; Teas, 1994) argued that good service quality is antecedent to customer satisfaction and then customer satisfaction is antecedent to customer loyalty. Su (2004) pointed out that service quality is a critical factor for any business to become successful. Regarding the difficulty in studying service quality, Frochot and Hughes (2000) showed that the assessment of quality for services is more complicated and complex than for physical products because of the intrinsic characteristics of heterogeneity, inseparability of production and consumption, perishability and intangibility. Such intrinsic characteristics and the elusive concept of service make it hard to define and measure service quality. Realizing the significance and influence of service quality on survival, success and growth of service industries as well as the difficulty in measuring service quality, many researchers devoted time to the development of generic instruments which could be widely employed to measure service quality across different service sectors (Lin,2010).

The plentiful methods provided in literature (Erto & Vanacore, 2002; Franceschini & Rossetto, 1997; Parasuraman et al, 1985; Philip & Hazlett, 1997; Teas, 1994) can be roughly categorized into two types, as incident-based or attribute-based methods (Stauss & Weinlich, 1997). Among the successive variants of the latter, the SERVQUAL instrument has attracted the greatest attention.

As Lewis & Booms (1983) suggests, in the service industry, definitions of service quality focus on meeting customers' needs and requirements, and how well the service delivered meets customer's expectations. Service quality is determined by the differences between customer's expectations of services provider's performance and their evaluation of the services they received. Service quality can be defined as the difference between customer's expectations for service performance prior to the service encounter and their perceptions of the service received. Several studies have been conducted to identify traditional service quality dimensions that contribute most significantly to relevant quality assessments in the traditional service environment (Parasuraman et al., 1985, 1988). Identification of the determinants of service quality is necessary in order to be able to specify measure, control and improve customer perceived service quality. Parasuraman et al. (1985) identified 10 detailed determinants of service quality through focus group studies: They are tangibles, reliability, responsiveness, communication, access, competence, courtesy, credibility, security, understanding/knowledge of customer. Later these ten dimensions were further purified and developed five dimensions- tangibles, reliability, responsiveness, assurance and empathy to measure service quality, SERVQUAL (Parasuraman et al, 1988). They are stated as follows:

a) Tangibles: Physical facilities, equipment and appearance of personnel.

b) Reliability: Ability to perform the promised service dependably and accurately.

c) Responsiveness: Willingness to help customers and provide prompt service.

d) Assurance: Knowledge and courtesy of employees and their ability to inspire trust

e) Empathy (including access, communication, understanding the customer): Caring and individualized attention that the firm provides to its customer.

Despite the difficulties inherent in delivering and measuring service quality, Berry et al. (1988) view high quality as one of the most significant sources of differentiation and competitive advantage in service organizations. The service quality and the satisfaction improvement has become a vital ingredient in the strategy for making insurance offers more competitive. Further, renewal of policies is dependent up to a great extent on the satisfaction derived from the quality of service provided by the company. Customer satisfaction has its roots in the global quality revolution. Further, it is not just users, but non users who also form perceived satisfaction about services provided by a company based on his inputs like word of mouth communication, other related experiences etc. The relationship between service and product quality and overall customer satisfaction has been repeatedly demonstrated.

Relationship between quality and satisfaction: The first research involving the measurement of customer satisfaction occurred in the early 1980s. Works by Oliver (1980), Churchill and Surprenant (1982), and Bearden and Teel (1983) tended to focus on the operationalization of customer satisfaction and its antecedents. By the mid-1980s, the focus of both applied and academic research had shifted to construct refinement and the implementation of strategies designed to optimize customer satisfaction, according to Zeithaml, Berry, and Parasuraman (1993, 1996). Their

discussion of customer satisfaction, service quality, and customer expectations represents one of the first attempts to operationalize satisfaction in a theoretical context. They proposed that, the ratio of perceived performance to customer expectations was key to maintaining satisfied customers. Several years later, Parasuraman, Berry, and Zeithaml (1988) published a second, related discussion that focused more specifically on the psychometric aspects of service quality.

One of the major issues of service quality in health insurance is in preparation and processing of claims and customer's complaint of unwarranted rejections of the claims. Quite often the inadequacies are result of lack of awareness of customers in the procedures and process to be followed like proper documentation and submission of supporting information. To enhance service quality, service employee training programs should emphasize the customer's role in the service experience to increase perceptions of shared responsibility and to create a positive emotional experience for the customer (Sierra and McQuitty 2005).

3.4 Insurance as a Service

A service is individually perceived on the basis of rational assumptions by customers and providers, and often described by abstract expressions such as trust, feeling, security, and experience. Financial services are highly intangible. The more intangible the service, the more important the management of relationships which has to be stressed in the insurance business. Even though all financial services have an intangible dominant factor, they vary in their degree of tangibility in terms of the consumer's ability to grasp the particular service mentally — to comprehend the service rendered (Mikael, 1998). In the case of insurance

products, it is also based on the perceptions of risks and need to cover the risk that a consumer evaluates in the service.

The Commission on Insurance Terminology of the American Risk and Insurance Association has defined insurance as: "Insurance is the pooling of fortuitous losses by transfer of such risk to insurers, who agree to indemnify insured for such losses, to provide other pecuniary benefits on their occurrence, or to render services connected with the risk". A fundamental characteristic of insurance is the transfer of risks from an individual (the insured) to a group (the insurer). The insurer then reimburses the insured for "covered" losses i.e., those losses it pays for under the policy terms (Debasish, 2004). Health Insurance has taken more meanings than this today.

Insurance literature identifies the major determinants of purchase as being the probability of loss, the extent of loss, the insurance premium charged, and buyer's risk. These determinants have been shown to influence purchase of flood, life and health insurance (Chen, Kalra and Sun 2009).

3.5 Health Insurance

The concept of healthcare insurance is quite a popular one in the countries of the west. In countries like the US, Canada, Australia, New Zealand, UK, Germany, France and Scandinavian countries, healthcare insurance is an integral part of the insurance plans. In India though, the concept has so far a limited appeal and very little following. However, with the increasing awareness among the common people and the tough competition in the insurance sector, healthcare insurance in India has got a boost.

Healthcare Insurance in India is now gaining popularity very fast. More and more people are opting for health insurance schemes from

popular insurance companies which offer good deals to the customers. As part of the healthcare insurance policy, the insured persons have to fill in a form and pay annual premiums to secure the benefits of the scheme/ policy. An important aspect of the healthcare insurance policy however relates is the variation in terms and conditions offered by the different insurance providers. Usually, the higher the age, the higher is the amount of premium. This policy goes by the dictum that a person with a higher age is likely to suffer more diseases and hence, s/he has to pay a higher rate of premium. But all is subject to the policy of Healthcare Insurance in India you take and from whom you are taking.

Healthcare insurance in India also provides for the list of authorized hospitals and nursing homes where the insured can get him treated as part of the policy. Since the name and details of the said health centers are fairly described, one has to get himself treated in one of the centers in order to avail the health insurance benefits. Some insurers however provide treatment at any of the healthcare centers within a stipulated budget. The budget or the higher limit of the treatment cost to be reimbursed is determined by the premiums that are paid and according to the policy availed as part of the healthcare insurance coverage.

Healthcare insurance in India used to provide for the reimbursement of claims only after the completion of the said treatment. The insured can file claims with the support of all relevant papers and documents after the treatment is over. The surveyors from the insurance company will make verifications and within a stipulated time frame, usually within 15 days will submit their report to the company. Based on that, the insured is expected to be reimbursed of the cost of treatment as per the provisions of the healthcares insurance coverage as taken by him. This has changed with introduction of

cashless cover schemes, where when treatment is taken at the specified hospital payment need not be made by the insured. However, this is subject to prior approval from the insurance company and nature of treatment.

With greater reach of the insurance companies in India and the higher degree of awareness, one can only hope for the best of medical insurance coverage reaching out to the large sections of Indian society. It will enhance the healthcare coverage while making sure that the insurance companies also enlarge their customer base. Healthcare Insurance in India is a very important concept and needs to be promoted and encouraged in a big way. Healthcare costs have gone up recently and resulted in more and more people who are opting for Healthcare Insurance in India.

An analysis of how the health care expenditures are met by different group of people in India shows that, for nearly three fourth of the cases, the expenditures are met from personal sources. In comparison with USA or European countries where the personal spending component is about one fifth, this is quite high. It is also observed that 40% of the families facing a major health problem have to either sell land, household property or become indebted for long term. People, particularly in poor households, can be protected from catastrophic health expenditures by reducing a health system's reliance on out-of-pocket payments and providing more financial risk protection. Increase in the availability of health services is critical to improving health in poor countries, but this approach could raise the proportion of households facing catastrophic expenditure; risk protection policies would be especially important in this situation (Xu, Evans etal, 2003).

Understanding who chooses to purchase voluntary health insurance is important for understanding both how well targeted the insurance product

is and the financial viability of the insurance program. As explained below, the latter will be particularly sensitive to the existence of adverse versus positive selection.

The extent of adverse selection or positive selection into insurance has important repercussions for an insurance provider's ability to cover its costs. Standard insurance theory predicts that health insurance markets will suffer from adverse selection, which occurs when less healthy people or people who are more risky with their health are more willing to purchase health insurance because they know that the amount they spend on healthcare will be larger than the premium they will pay (Rothschild and Stiglitz 1976; Akerlof, 1970). Voluntary health insurance cannot be financially sustainable if adverse selection is severe, since only the most costly patients would find it worthwhile to purchase insurance, and premium levels will not be able to cover the high costs of care. On the other hand, another group of people that may buy health insurance are those who are very risk averse with both their health and their finances. These people may buy insurance to protect themselves financially, but may also be very healthy because they take extra care with their health. This phenomenon, known as positive selection, may balance out adverse selection and allow an insurance company to pool risks and thus remain financially viable without subsidies. Despite the importance of calculating the extent of adverse selection, there are limited experimental studies of adverse selection in health insurance markets in poor nations, and existing studies in rich nations provide mixed results.

Non-experimental studies from developing countries sometimes find enrollment to be more common in households with chronically sick members, evidence of adverse selection (Wagstaff, 2007), and commonly

find higher enrollment rates in wealthier households, potentially leading to positive selection if wealthier people also tend to be healthier (Wagstaff, 2007; Wagstaff and Pradhan, 2005; Jütting, 2004; Lamiraud et al., 2005). Some studies in wealthier nations find evidence that people with higher expected medical expenditures (measured in a variety of ways across studies) are more likely to buy insurance or pay for health insurance at higher premiums than those with lower expected medical expenditures (Cutler and Zeckhaus, 1998). However, the extent of adverse selection in health and other insurance is often found to be minimal (Wolfe and Goddeeris, 1991; Finkelstein and Poterba, 2004) or non-existent (Finkelstein and McGarry, 2006; Cardon and Hendel, 2001; Cawley and Philipson,1999). There is also some recent evidence of positive selection into health insurance (Fang et al., 2008).

Recent theoretical work has focused on how the problem of adverse selection may be mitigated by factors such as wealth - which could both increase the probability of insurance purchase and improve health outcomes. (Case, et al., 2002; Smith, 2005 and Currie, e al., 2003), risk aversion - which could increase the probability of insurance purchase and decrease the amount of risk one takes with one's health (Chiappori, et al., 2004 and Jullien, et al., 2003) or optimism - where some people underestimate their accident probability, and thus don't buy insurance, but are also less willing to take precautions, leading to a higher probability of a health shock (Koufopoulus, 2005).

A service is individually perceived on the basis of rational assumptions by customers and providers, and often described by abstract expressions such as trust, feeling, security, and experience. Financial services are highly intangible. The more intangible the service, the more

important the management of relationships, a factor which has to be stressed in the insurance business. Even though all financial services have an intangible dominant factor, they vary in their degree of tangibility in terms of the consumer's ability to grasp the particular service mentally — to comprehend the service rendered (Mikael, 1998). In the case of insurance products, it is also based on the perceptions of risks and need to cover the risk that a consumer evaluates the service.

3.6 Consumer Decision Making

Several perspectives have been considered in the consumer behaviour and consumer decision making process. The price affected perceived quality, which in turn affected attitude, which in turn affected buying intention of the consumer (Hansen,2005). Consumer decision making involves a number of sub-concepts. Some researchers have suggested that consumers are 'value driven' (Zeithaml, 1988; Levy, 1999). A consumer's perceived value may be seen as an expression of 'an overall assessment of the utility of a product (or service) based on perceptions of what is received and what is given' (Zeithaml, 1988). Researchers like Celsi and Olson, 1988; Petty et al. 1983; Petty and Cacioppo, 1986; Blackwell et al, 2001, have underlined the role of involvement in explaining how likely consumers are to process, for example, cognitive information (Swinyard, 1993) and to engage in extensive evaluations of attributes and products. Low-involved consumers may use simple decision rules in arriving at attitudinal judgments. For instance, according to 'cue utilisation theory' (Steenkamp, 1989; Richardson et al., 1994) consumers simply may use one or more indicators (price) of the quality or the overall performance of a product. The behaviour of high-involved consumers may be analysed and described on the basis of the information processing perspective.

According to the information processing perspective (Ostergaard and Jantzen, 2000; Blackwell et al., 2001) the interaction between the consumer and stimuli in the environment is an ongoing cognitive process in which the consumer develops beliefs and attitudes towards the environment. The information processing perspective assumes that the consumer, in order to avoid cognitive dissonance, seeks an equilibrium in which there is balance between the consumer's attitudes and beliefs and the actual environment (Ostergaard and Jantzen, 2000). In contrast to the information processing perspective, other researchers (Holbrook and Hirschman, 1982; Holbrook and Batra, 1987; Bagozzi et al., 1999) propose that consumers' affective responses, like emotional responses, should be included in the explanation of consumer decision making. The consumer looks for new experiences via consumption. In this connection, the primary purpose is not to evaluate relations between attitude, beliefs and the environment, but to fulfil desire and to obtain pleasure in life. The various perspectives on consumer decision making differ on several important dimensions. The value perspective emphasises situations in which consumers make value trade-offs, such as price versus quality in purchasing a food product. The construction of such trade-offs, however, may be difficult and may involve uncertainties. For example, the consumer does not always have a clear picture of the quality of a food product that is offered in a supermarket. This problem of uncertainty is not explicitly dealt with within the value-perspective, which does not include suggestions on how consumers will reduce the risk that follows from not knowing the outcome (the quality of a food product) or the negative consequences (eg. 'will a low quality food product harm my health?') of carrying out a certain decision.

Cue utilisation theory, on the other hand, suggests that consumers may try to reduce risk by using cues (eg price, brand name, advertising, colour, etc) as indicators of the quality of a product or service. Thus, the reliance on one or more cues is one risk-reduction strategy. Based on an extensive literature review, Dawar and Parker (1994) concluded that cues mostly serve as heuristics in assessing product quality when (among other factors) there is need to reduce the perceived risk of purchase and when consumer involvement is low. From an information processing perspective a product can be conceived as an array of cues (Steenkamp, 1989), where cues can be regarded as 'pieces of information'. When consumers are highly involved in the decision making they can be expected to engage in a more extensive internal and/or external information search for the purpose of reducing the risk of making a 'wrong' choice. Thus, such a consumer will have a high degree of cognitive activity and will make strong efforts in conducting evaluations and comparisons of products before reaching a reasoned decision. As in the value perspective (in which perceived poor quality can be 'compensated' by a low price) consumers can make trade-offs between various attributes (compensatory decision making) or the consumer can decide that one or more attribute must be represented in the product on a certain level (non compensatory decision making). From an emotional perspective, however, consumers do not make cognitive (compensatory or non-compensatory) evaluations when considering purchasing a product. Emotions should not be regarded as the result of an evaluation procedure but as an affective response to consumers' perceptions of stimuli in the environment (Bagozzi et al.,1999).

3.7 Consumer Buying Process

The consumer purchase decision process has been the subject of research since the 1950s. There have been studies of the amount of

consumer information seeking; the types of information sought; and the sources consulted. Commonly two types of consumer information sources are referred to; internal and external sources. The search of internal sources of information is characterized by Bettman (1979) as a scan of memory. When faced with a purchase decision consumer first examines memory for information which may be relevant to the decision. This information may be result of previous experiences, which constitute a body of knowledge about or an attitude toward, a product or a product class. When information gained from previous experience is not available to consumers, or the information they have is insufficient to distinguish between two product classes, the consumer may search for information from external sources. This information is dependent on the product category experience, product complexity or the degree of buyer uncertainty.

The study of consumer buying process is complex as the stimulus to buy and its response ie., the buying decision are influenced by a host of intervening variables. The stimuli can itself be very complex. What makes consumers buy – this is the most important question in front of the marketers.

The classical five stage consumer decision process model introduced by John Dewey in 1910 which gave a generalized view of the purchase decision, still remains valid as a basic approach to consumer purchase decision process.

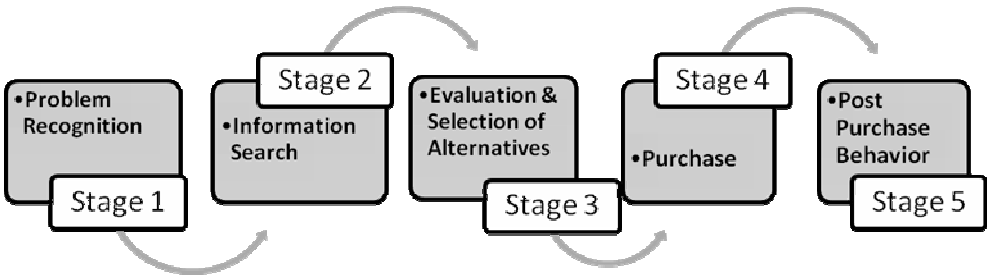


Fig 3.2. The Five Stage Buying Decision Process

Stage 1: Problem or Need recognition

According to this concept, Needs can be triggered by internal or external stimuli. In the case of Internal stimuli, the normal needs become strong enough to drive behavior. The sources for external stimuli include: advertisements, friends or relatives, use of the product or service by other customers etc.

Stage 2: Information search

In this second stage, once a need has been felt or observed, consumers exhibit heightened attention or actively search for information. Their sources of information could be personal, commercial, public, experiential or word-of-mouth.

Stage 3: Evaluation of alternatives

The Evaluation procedure depends on the consumer and the buying situation. Most buyers evaluate multiple attributes, each of which is weighted differently. At the end of the evaluation stage, purchase intentions are formed.

Stage 4: Purchase decision

Two factors intercede between purchase intentions and the actual decision, that could be attitudes of others and unexpected situational factors

Stage 5: Post purchase behavior

One of the major observations in the post purchase behavior is the cognitive dissonance – a customer getting a feeling whether the decision to purchase the specific product, from the specific supplier, at that point of time was the right decision. Satisfaction

as a post purchase feeling is important as delighted consumers engage in positive word-of-mouth whereas unhappy customers tell on average 11 other people, creating negative publicity. This can influence the perceived satisfaction of potential customers.

In general there are three ways of analyzing consumer buying decisions. They are:

- Economic models - These models are largely quantitative and are based on the assumptions of rationality and near perfect knowledge. The consumer is seen to maximize their utility.
- Psychological models - These models concentrate on psychological and cognitive processes such as motivation and need recognition. They are qualitative rather than quantitative and build on sociological factors like cultural influences and family influences.
- Consumer behaviour models - These are practical models used by marketers. They typically blend both economic and psychological models.

The classical micro economic approach developed in the nineteenth century focused on the results of economic behavior (supply, demand, quantity demanded, price etc) rather than actual behavior of consumers themselves (Louden & Bitta, 2007). George Katona observed this inadequate and in the 1950s initiated a behavioral economic perspective and introduced the concept of index of consumer sentiment, which claimed to represent the confidence consumers have on the economy. This model of consumer behavior in the simplified form is depicted here:

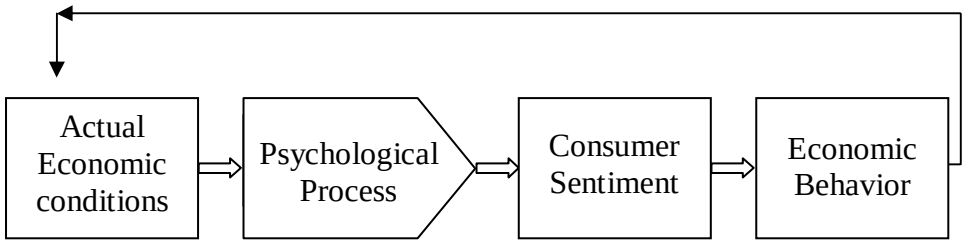


Fig. 3.3. Katona's Behavioral Economics Perspective

A subsequent model, that looks at the consumer purchase process from an awareness to purchase action is called the *hierarchy of effects model.*

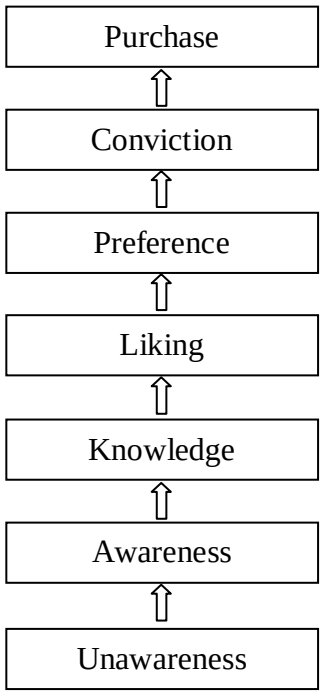


Fig. 3.4. The Hierarchy of Effects Model

Originally conceived to explain how advertising affects consumer's purchase decisions, the hierarchy of effects (HoE) model focuses on consumer learning that takes place as he/she processes information from the external world (DeLozier, 1976). The HoE model begins with the state

where a consumer has no awareness about the brand (unaware) then develops awareness triggered by external stimuli, such as advertising message or "word of mouth." As he/she obtains and processes more information, the consumer develops more specific knowledge about the brand. The knowledge, then, is used as basis to form a liking (or disliking), leading to a preference of brand(s) relative to the others. However, people need to be pushed beyond the preference stage to actually buy the brand of preference. The preference stage, after all, simply means that the consumer has formed a preference psychologically. Now it takes conviction for him/her before actually buying the brand.

Though there can be several approaches to buyer decisions study, which is often quite complex and influenced by a number of factors, the multi-variate model proposed by Frank Nicosia (Nicosia, 1966) in which numerous independent variables were assumed to determine buyer behavior, can be considered to be relevant and applicable.

In an early study of the buyer decision process literature, Nicosia identified three types of buyer decision making models. They are the univariate model (He called it the "simple scheme") in which only one behavioural determinant was allowed in a stimulus-response type of relationship; the multi-variate model (He called it a "reduced form scheme".) in which numerous independent variables were assumed to determine buyer behaviour; and finally the "system of equations" model (He called it a "structural scheme" or "process scheme") in which numerous functional relations (either univariate or multi-variate) interact in a complex system of equations. He concluded that only this third type of model is capable of expressing the complexity of buyer decision processes.

Further, Nicosia built a comprehensive model involving five modules. The encoding module includes determinants like "attributes of the brand", "environmental factors", "consumer's attributes", "attributes of the organization", and "attributes of the message". Other modules in the system include, consumer decoding, search and evaluation, decision, and consumption.

A Summary View of Nicosia Model of Consumer Behavior

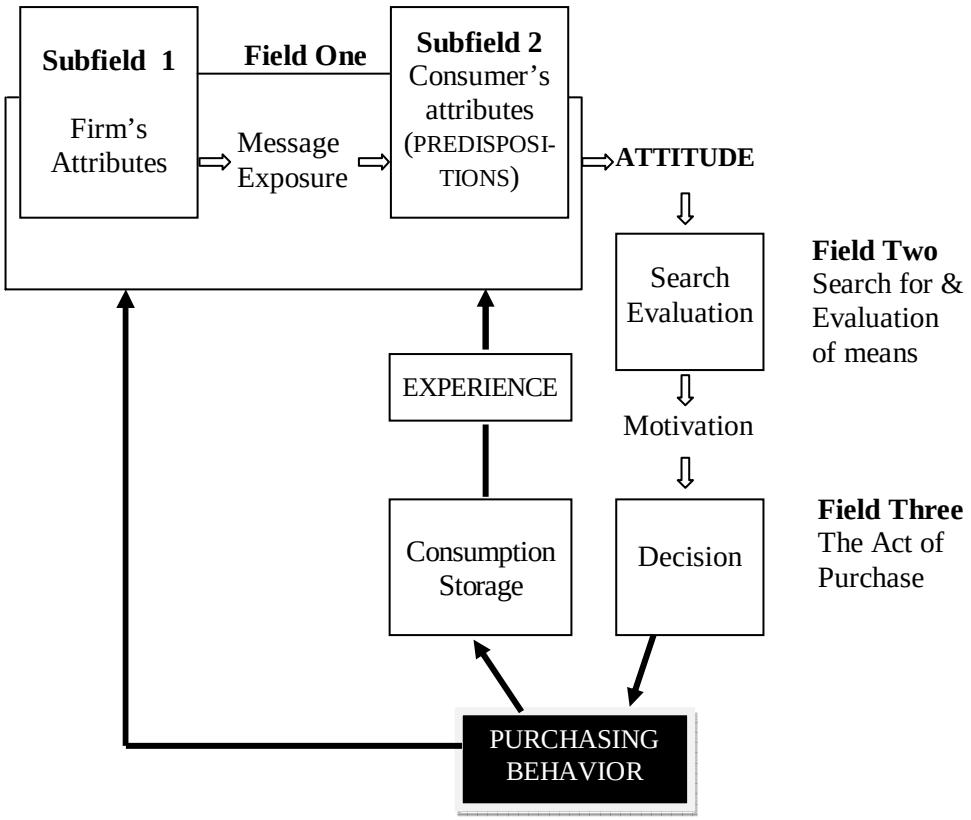


Fig 3.5. The Nicosia Model of Consumer Behavior

In 1968, Engel, Kollat and Blackwell developed the Engel-Blackwell-Miniard model, where consumer behavior has been depicted as a decision process of five activities which occur over time: 1) motivation and need

recognition 2) search or information 3) alternative evaluation 4) purchase and 5) outcomes. The authors recognize two significantly different modes of operation by the consumers. One is described as Extended Problem Solving behavior (EPS) which is characterized by high levels of involvement and/or high levels of perceived risk and the other limited problem solving behavior (LPS) where the consumer is operating under low levels of involvement or low levels of risk.

Another model of buyer behaviour is the Stimulus Response Theory, shown below, where marketing and other stimuli enter the customer's buyer decision process depicted as "black box" and produce certain responses. Marketing management must try to work out what goes on in the mind of the customer – the "black box". The Buyer's characteristics influence how he or she perceives the stimuli; the decision-making process determines what buying behavior is demonstrated.

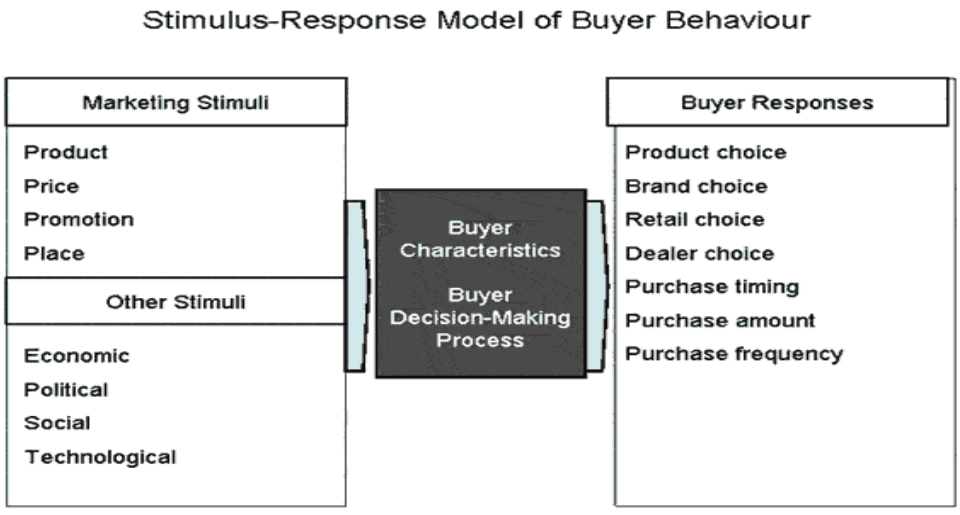


Fig. 3.6. The Stimulus Response Model of Buyer Behavior

In 1991, Cohen proposed a model of consumer purchase decision, suggesting marketing inputs and psychological inputs results in consumer purchase decision.

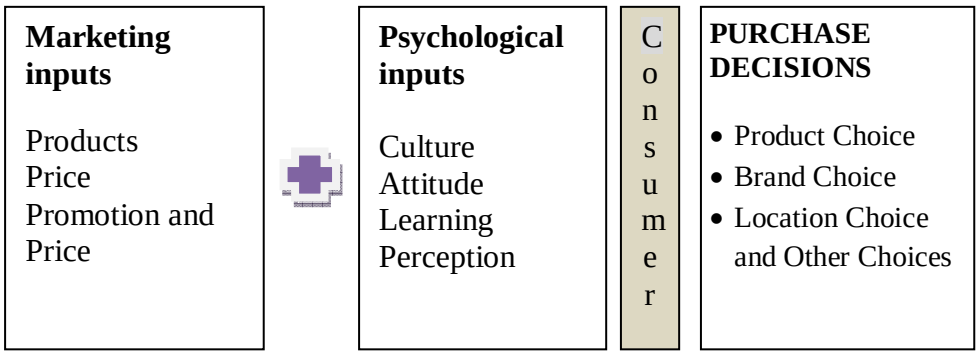
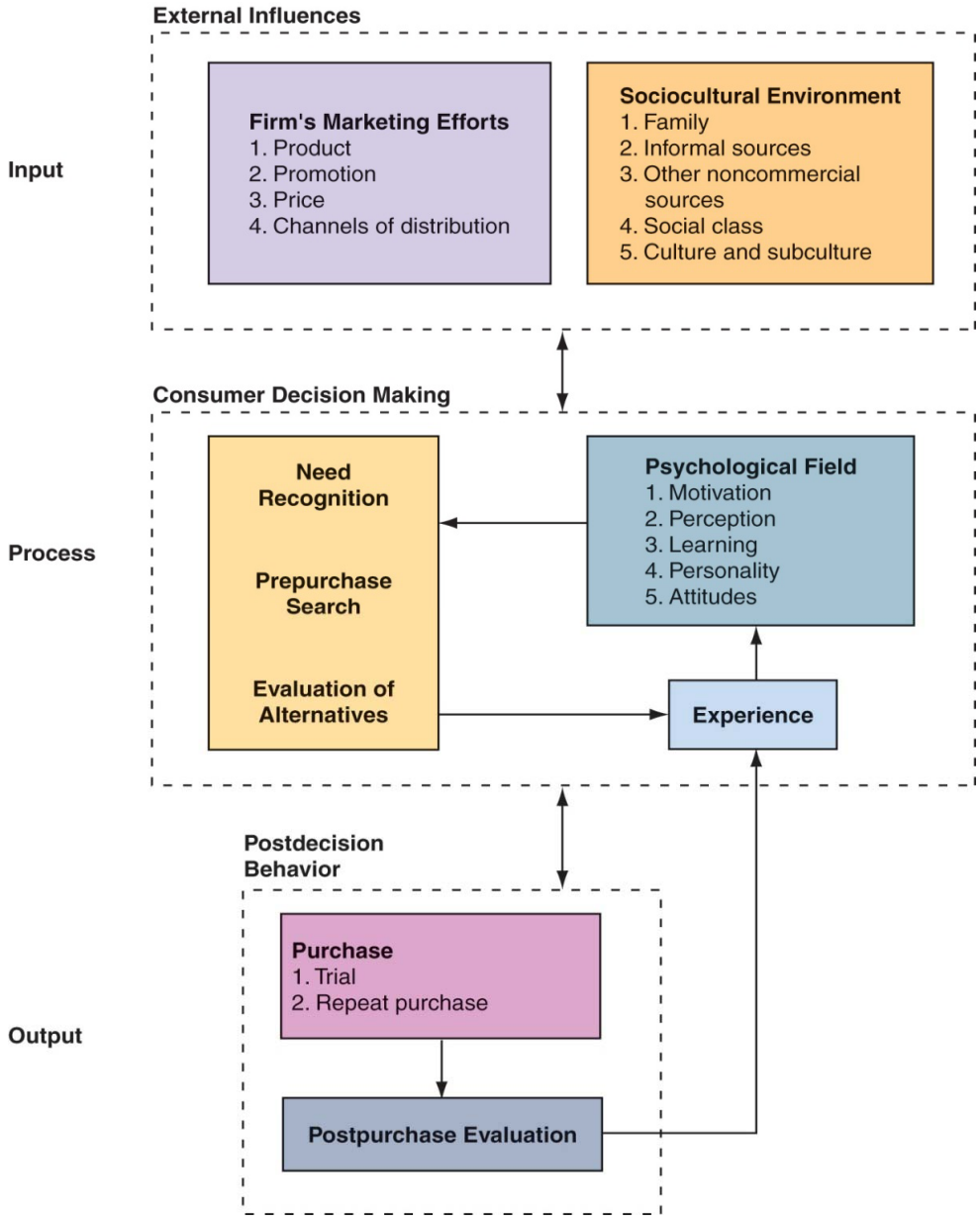


Fig. 3.7. Cohen's Model of Consumer Purchase Decision

The Howard & Sheth model of consumer behavior tried to serve as an integrating framework for a sophisticated and comprehensive theory of consumer behavior. They distinguished three levels of purchase decision making viz., extensive problem solving, limited problem solving and routinized response behavior. This appears to be more appropriate for the organizational buying situation.

Schiffman and Kanuk, while discussing the consumer decision making suggested it to have three stages, viz., input, process and output as demonstrated in Fig 3.8.



Source : Consumer Behavior, 9e, Schiffman and Kanuk, Prentice Hall 2007

Fig. 3.8. Schiffman & Kanuk Model of Consumer Purchase Decision

While marketing activities create more customer awareness and higher levels of consumer awareness leads to higher levels of favourable consumer purchase decisions, studies also bring in moderating impact on

the purchase decision by many factors related to the consumer and the market like education, age, gender, income, family status, number of dependent family members etc.

The decision process is affected by four kinds of factors or variables: (1) Personal system variables (conscious and unconscious needs), (2) social system variables (eg. membership and reference groups), (3) exogenous variables (eg. relative price and purchase convenience), and (4) risk reducing variables (eg. Trusted stores and brands) (Brody, Cummingham 1968). It is therefore necessary to look at each of these variables to identify contributing factors that influence the consumer purchase decision in the health insurance market. The Theory of Reasoned Action suggests that the best way of predicting behaviour is to ask the respondent his intention of performing that behavior. It is necessary to look at three major aspects – the action, the object and the time frame.

When evaluating a product or service, consumers seek out information to judge whether that specific product will meet certain criteria. The main concern of the sales providers is how to increase their customers' willingness to buy a product. Consumers use information to form beliefs about the likelihood of a product meeting a specific need. (Herve & Mullet, 2009). In order to reduce cognitive effort, consumers may simply choose the brand that they perceive most others are buying. Thus, the perceived purchase decisions of other consumers may be influencing purchase decisions. Without direct interaction with other consumers, social influence may take the form of perceived behavior of others, or social norms. Social norms are defined by Cialdini et al as what is commonly done or what is approved by others, as quoted by Montoya, Mandel and Nowlis (Montoya etal, 2009).

As a whole, obtaining information and analysing it is a difficult task for the consumers and this play a major part in making the purchase decision. The process of information search leads the consumer to make comparison between the products. All products have characteristics for eg: tangibility, but the comparison between services and making a purchase decision becomes more difficult in the case of services because they lack characteristics such as tangibility. Therefore in case of services the main problem of the consumer would be identifying the cues or information that would lead to making an effective purchase decision. In spite of the difficulties in conducting studies regarding purchase decision making, they are considered as areas of immense research interest because the findings are often associated with customer satisfaction. For example, it is commonly thought that a positive relationship exists between (a) amount of information sought and (b) buyer satisfaction. The latter, however, seldom has been addressed directly. Buyers have been pictured by critics as being frustrated by inability to obtain appropriate pre-purchase information, resentful about a lack of personal attention in dealing with sellers, confused by a proliferation of product models and brands, and upset over inability to find products and services which meet their needs well."

3.8 The Proposed Model

From this review of literature, a number of factors contributing to the process of consumer decision making are identified – which can be broadly classified in to three categories: 1) that relates to the personal and demgraphic factors pertaining to the consumer 2) that can be attributed to the activities initiated by the marketing organization and 3) external factors that can be attributed to the social environment like government policies,

health care related issues, living styles of people, rising cost of health care, availability of competitive offers etc.

Based on the study of literature, inputs from marketing executives of healh insurance porvider companies and discussions with existing/potential consumers of health insurance, and the outcome from factor analysis based on pilot study is proposed as the determinants of consumer purchase decision in health insurance, as a starting point in the context of study of the determinants of consumer purchase decision of health insurance which is given in chapter 4 (Ref. Fig.4.1).

3.8.1 Personal factors

Personal factors are the individual specific factors like attitudes, age, family composition, knowledge etc that can influence a purchase decision. The impact of marketing activities on consumers in creating preference vary due to factors that influence his cognitive and thought process such as educational background, profession/employment, locality of residence, age, gender, income and social class, marital status, number of minor children and chronic health problems like diabetes, asthma etc in the family of the respondent (Devi, Sarkar 2007).

Age has been observed to be an important factor in the purchase decision of health insurance. Younger customers are averse to health insurance as individuals with a low risk of becoming disabled before retirement may prefer to buy insurance late in order to avoid losses in expected income (Meier, 1999a).

The Perception of Risk Protection

Health insurance, for that matter any form of insurance, is a precaution taken by individuals or organizations to minimize damages and losses in case of an adverse eventuality. Risk management and insurance are concerned with the financial security of individuals and business firms and efficient use of resources in managing pure or non-speculative risks associated with such adverse contingent events as the destruction of property, legal liabilities arising from various sources, premature death, loss of health or disablement of individuals and occupational hazards of employees. Insurance allows an individual or business firm to convert the uncertainty of potential large losses in to relatively small certain loss through the payment of an insurance premium (Witt and Hogan, 1993).

Awareness is the state of having or showing realization, perception, or knowledge as defined by UCADIA.com. Awareness of the customer about the product that can lead to the understanding that it can satisfy a specific need he has. Barron's Marketing dictionary defines awareness as the first stage in the process of learning about a new product, service, or idea in which the consumer has received information about the existence of the innovation but has not yet formed an opinion.

'Lack of consumer awareness of where to get health insurance, what it costs and what options exist is a critical barrier that prevents many people from obtaining coverage in the individual market' (Patel,2007). The employee's indifference towards the insurance schemes can be overcome at least partly through education efforts and products that make LTC insurance contingent on life and disability sales.

In the present context of this study, awareness is measured by five questions viz., awareness of companies offering health insurance, different schemes offered by major health insurance companies, diseases not covered in (exclusions in coverage) health insurance schemes, the approximate cost of health insurance premium, the health insurance claim procedure and knowledge of benefits of health insurance.

The nature of involvement level of a customer is a critical factor in the purchase decision. High-involvement purchases call for detailed information search and evaluation of alternatives while low involvement purchases have very simple evaluation processes. Health insurance decisions can be critical and high involvement especially if the family expects health issues and the cover is expected to provide long term coverage.

The attitude of a customer towards health insurance is also an important factor in the purchase decision. This is further related to the awareness aspect also. An **attitude** may be defined as a learned disposition to behave in a consistently favourable or unfavourable way with respect to a given object (Schiffman and Kanuk, 2007). Stated differently, it positions people into a frame of mind of liking or disliking things, of moving toward or away from them (Kotler and Armstrong, 2008). It is acknowledged that people have attitudes toward almost everything - religion, politics, clothes, music, food (Kotler, 2003). In marketing context, it is stated that consumers can develop attitudes to any kind of product or service, or indeed to any aspect of the marketing mix, and these attitudes will affect behaviour (Brassington and Pettitt, 2003).

Customer satisfaction is a post-purchase evaluation of a service offering (Oh, 1999, Bolton and Drew 1991). A traditional definition of customer satisfaction followed the disconfirmation paradigm of consumer satisfaction/dissatisfaction (CS/D), suggesting that CS/D is the result of interaction between the consumer's pre-purchase expectations and post purchase evaluation (Cadotte et.al., 1987). Anton (1996) gave a more current approach. He defined customer satisfaction as a state of mind in which the customer's needs, wants, and expectations throughout the product of service life have been met or exceeded, resulting in future repurchase and loyalty. Some researchers support the idea that satisfaction can be measured from a perspective of performance evaluations, making the inclusion of the disconfirmation process needless. Furthermore, satisfaction not only consists of cognitive element but includes emotional element in determining customer satisfaction.

Customers expect good **Service Quality.** Service quality has multiple components including the quality of offering, quality of the way in which it is delivered, quality of information content, quality of service personnel in terms of ability to clear doubts etc. Ruyter et al (1998) brought three concepts of service loyalty generated through service quality namely; preference loyalty, price indifference loyalty and dissatisfaction response. Study by Harris on impact of good service quality in offsetting other weaknesses of service providers observed that, quality ratings based on the proportion of survey respondents ''extremely satisfied with results of care'' had the greatest impact on plan choice (Harris, 2002). It also observed, consumers are willing to trade high quality for restrictions on provider access.

Focused attention on quality issues stands as one of the dominant challenges affecting all business, as consumers hold both products and

services to increasingly higher standards of quality. Most managers agree that high quality products and services are fundamental to a successful competitive strategy (Arora and Stoner, 1996)

3.8.2 Marketing Factors

The various initiatives undertaken by service providing companies to create customer preference with the ultimate objective of prompting a purchase of a policy: include advertising, sales promotional activities, internet communications, direct sales through agents, events for promoting health insurance and brand building activities that lead to positive brand perception among consumers. The major responsibility of marketing is to make the product or service accessible to customers. Access is viewed as the general concept which summarizes a set of more specific areas of fit between the patient and the health care system. The specific areas, the dimensions of access are: availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas, 1981). In the context of this study, the 4Ps, namely, Product, Price, Promotion, Place and brand perception can be the reference for marketing activities. People, Processes and Physical Evidence from the services marketing context will form part of the study.

The insurance **product** expected by the consumers includes suitable schemes that cover diseases, diagnostics, treatment and coverage of losses. The expectation from consumer to consumer will vary as the specific needs are different. Therefore understanding what products do the consumer want and creating proper segmentation are important. From the time where a standard medi-claim policy was offered, we have moved to where companies are offering a variety of schemes like basic health insurance schemes, critical illness schemes, domiciliary treatment products, cashless

schemes, family floaters and so on. Thus the consumers are given the freedom to choose.

There is a need for these product offering to provide value as consumers expect **value** from the service providers. Perceived value may be generally defined as the consumer's overall assessment of the utility of a product based on perceptions of what is received and what is given. Zeithaml defines value as: though what is received varies across consumers (i.e., some may want volume, others high quality, still others convenience) and what is given varies (i.e., some are concerned only with money expended, others with time and effort), value represents a tradeoff of the salient give and get components Zeithaml (1988). Cronin et al proposes that service value is a central construct in consumer decision processes. Specifically, we test the proposition that when added to models of consumers' decision-making for services, the service value construct increases the ability of such models to explain variance in purchase intentions above that independently accounted for by a consumer's perception of the quality of the service and the sacrifice made to acquire it (Cronin et al, 1997).

In a competitive environment companies with innovative ideas are more accepted by customers and are more likely to be successful. In their endeavor to grow, organizations resort to three types of innovation :

1) Market innovation – improving the mix of markets they serve; Innovative companies ground their approach in an understanding of the potentials of distinct market segments. They go out of their way to emphasize to staff that understanding the potentials offered by markets requires well-honed analytical skills. Further, that successful

action requires a willingness not only to read market opportunities in new ways, but also a willingness to approach markets in new ways.

2) Product innovation – improving the mix of products offered, it ensures that appropriate offers are available to serve chosen markets.

3) Process innovation – Improving the mix and efficiency of internal operations. In a market like health insurance where companies operate with narrow and often negative bottom lines, it is often the efficiency of the processes that determine costs and thereby profitability and survival (Johne, 2000).

In the distribution area, consumers have shopping centers and stores to experience. However, the **price** variable is a rather abstract concept which, while represented as a sign or tag, has relatively little direct sensory experience connected with it. Perhaps because of this, basic research on pricing issues in marketing has been relatively modest compared to work done on the other marketing-mix elements. These differences should not lead to underestimating the importance of price to marketing and consumer behavior. The effects of price changes are more immediate and direct, and appeals based on price are the easiest to communicate to prospective buyers. However, competitors can react more easily to appeals based on price than to those based on product benefits and imagery. It can be argued that the price decision is perhaps the most significant among the decisions of the marketing mix strategy for a branded product or service.

Price is perhaps the most unusual element of the marketing mix, partly because it is the only element that generates revenues. All other elements, as well as marketing research, involve expenditures of funds by organizations. Another difference is that although price may seem tangible

and concrete, it is perhaps more intangible and abstract than other elements of the marketing mix. For example, in the product area, consumers often have a tangible product to examine, or at least information about a service to evaluate. In the marketing communication area, consumers read magazine and newspaper ads and get information from salespeople to see, listen to, and evaluate. The price factor is having more significance in the health insurance scheme as the premium paid is non-refundable and in the more likely event of not having a claim made, the consumer has no apparent return for his investment. Further, the calculation of the premium are often not comprehendible to the average consumer.

Price being an important factor, there is also a price range that is acceptable to customers. Under all circumstances, price communicates the firm's asking rate of exchange for its product. However, there are circumstances in which a firm might use price to communicate status, snob appeal, quality, low purchase risk, or economy. The pricing manager should consider the characteristics of the product, the characteristics of the consumer, the objectives for the marketing communications strategy, and the means at his disposal to desensitize the consumers to the price variable. In general, the executive must consider both economic and noneconomic factors in arriving at a final price for the product (DeLozier and Arch, 1976). The stability in the price also influences the employee to stay on a particular health insurance scheme. Higher the increase in the price, greater possibility of plan switching (Buchmueller & Feldstein,1996).

Accurately gauging consumers' **Willingness to Pay** (WTP) for a product or service is critical for formulating competitive strategies, conducting value audits, and developing new products (Anderson, Jain, and Chintagunta, 1993). Willingness to Pay can be measured with real purchase

data (REAL), the open-ended (OE) question format, choice-based conjoint (CBC) analysis; Becker, DeGroot, and Marschak's (BDM) incentive-compatible mechanism; and incentive-aligned choice-based conjoint (ICBC) analysis. Indirect approaches, such as conjoint analysis, may be better suited for the product category in which a more extensive decision process is involved. Indirect methods seem to be more suitable for relatively higher-priced, less frequently purchased product categories. (Miller et al, 2011)

Another earlier study found that consumers have in mind an upper limit of price beyond which the item would be judged too expensive and a lower limit below which the quality would be suspect (Funkhouser, 1984). A research stream, including about 40 experimental studies carried out over 30 years, sought to determine whether consumers infer quality from list price. A review of these studies indicates that customers do infer quality from price under certain circumstances (Tellis, 1987).

Role of Information in consumer decision making is undisputed. However there are certain issues related to consumers response to the way information is provided by companies today. Some research shows that consumers do not understand the features of, or coverage offered by, different types of health plans. Moreover, consumers do not have a context in which to evaluate how a plan's coverage and benefit limitations may affect them at a future date for unexpected illness, disease or injury. Consumers currently without health insurance had difficultly determining which questions to ask to determine if a health plan was right for them. Further, the data revealed that consumers are confronted with more technical information than they understand, and information is often presented in an inconsistent or confusing manner (Wroblewski, 2007).

One of the major reasons for respondents opting out of insurance schemes is the fear that many of the common health problems are not covered by health insurance schemes and often there is lack of clarity of the information available. In a study on insurance disclosure conducted on behalf of the American National Association for Insurance Commissions, respondents offered various reasons for not reading the insurance disclosures and suggested they would be more likely to read disclosures if the more important information appeared first, the disclosures were short and used titles and headings and the disclosures looked important and readable (Cude 2006).

In many instances, individuals are unlikely to understand the risks associated with their decisions, resulting in inefficient choices (Laury and McInnes, 2003). They study the effect of information on risk perception by customers while opting for a health insurance cover and suggests providing right information can lead to right choices.

Communication is important; that reminds customers to renew policy can help. While bringing more population to the protection of health insurance is a social need and requirement for growth of marketing companies, retention of consumers and ensuring timely renewal is the essential second part of the marketing activities (Manivannan 2007). While advertising is an important means of communication, studies have shown that framing of ad matters. In health insurance, a consumer directed advertisement may highlight risk factors (negatively framed) or highlight benefits (positively framed ad). Consumer's perceptions of risk is also associated with purchase decision of insurance products. Insurance marketing companies convey this message through two advertising frames. On one hand, negative frame of advertising is used which highlights the

drawbacks or losses the individual is likely to suffer in the event of a crisis and on the other hand a positive advertising frame is created by highlighting the satisfaction, security for family and happiness derived by opting for insurance. Studies have indicated that people with lesser education are influenced by the negative frame of advertising where as more educated people prefer the positive framing approach (Smith, 1996). When consumers are faced with advertising that features happiness or pride appeals, they are likely to use their feelings as input to their ad judgment (Mukhopadhyay and Johar, 2007).

O'Cass and Grace (2003) while studying perceptions on service brand associations observed word of mouth communication as a very important factor in forming service brand perceptions. For example, interviewees commented that, "I rely more on my friends and family to give their opinions on places they have stayed at, than anyone else," "I relied on people's recommendations, that is why I was willing to try it. That is the only reason I tried it," and, "I am highly influenced by anything I hear (about services)."

Advertisement is one of the effective tools of integrated marketing communication to emotionally motivate consumers to buy the products. It also has strong linkage with entertainment and the proliferation of media has blurred the distinguishing lines between advertisements and entertainment (Moore, 2004). Advertising is to create brand awareness, preference, and selection of product or services. The most influencing theory in marketing and advertising research is attitude-towards-the-ad. However, the attitude that is formed towards the ad help in influencing consumer's attitudes toward the brand until their purchase intent (Goldsmith and Lafferty, 2002). Consumer buying behavior is based on the

concept and idea that he/she simply decided to purchase a product or service at the spot (Adelaar et al. 2003). As the goal of effective advertising is to form positive attitude toward ad and the brand, to increase the number of purchase, then a positive emotional response to an ad may be the best indicator of effective advertising (Goldsmith and Lafferty, 2002). That's why basic aim of advertising to encourage people to buy things and creates awareness (Bijmolt et al. 1998).

Advertising proliferate the beliefs that possessions are important and desirable qualities like beauty, achievement, prominence and happiness can be acquired only by material possessions (Latif & Abideen, 2011). According to the traditional attitude theory, consumer behavior is predicted from consumer attitude when consumers buy the brand, which they like the most.

Advertising and promotion offer a new function to consumers. Viewers of ads learn about new products and services available to them, much like they learn about events in the news. This information function has a neutral role. It provides facts without approval or disapproval from consumers. Customer behaviour at this stage comprehends expressions of curiosity. Consumers have a rational response to advertising when they look at the features of a product or service. This response focuses on a logical listing of all the functional aspects of the offering. This is an intellectual response, rather than an emotional one. When customers weigh benefits, they become emotionally involved with advertising and promotion. Consumers identify ways the product or service can make them happier, improve their lives or give them pleasure. This part of the consumer response is irrational and can lead to impulse buying and competition to obtain the product. Repeated advertising messages also

affect consumer behavior. This repetition serves as a reminder to the consumer. Behavior that stems from reminders includes suddenly thinking of a product while shopping and making a decision to buy it, as if it had been on the consumer's "to-do" list.

Effective use of Electronic Media like Internet as a medium of communication can help in marketing Health Insurance. When a service is available via the internet, a medium that can subdivide and rebuild the service to personalized offerings, potential customers become better informed in advance of what the service provides (Chau & Ho 2008).

Sales promotion has been defined as 'a direct inducement that offers an extra value or incentive for the product to the sales force, distributors, or the final consumer with the primary objective of creating an immediate sale. Belch and Belch have proposed a similar definition. The many definitions of sales promotion have a common viewpoint: they all involve a temporary and tangible modification of supply, for the ultimate goal of direct impact on the behaviour of the consumer, retailer or sales force. Within the marketing mix, sales promotion has one of the strongest impacts on short-term consumption behaviour. It is an 'action-focused' marketing event (Prendergast, Shi, Chieung, 2005). However, the application of sales promotion by Health Insurance companies is relatively low. There is also the observed problem of less interest from agent's part: Sales people often emphasize the schemes that gives them better returns (Pons, 1995). During the interactions with consumers, the respondents have indicated their preference to go for the agents as the primary source to get additional information on health insurance, but the percentage of cases where health insurance is promoted by the agents is low. This possibly is because of the

low returns the agents get by selling health insurance policy compared to life policy.

Positive Perceptions of Brand contributes to customer's purchase decision

Consumers of insurance frequently rely on two primary sources of information as predictive of quality. The first relates to the perceived knowledge of what constitutes that quality insurance 'Brand'. This knowledge is often based on heuristics or what could be classified as the advertised reputation of the insurance firm providing the coverage. In a services marketing environment, brand plays a vital role in attracting customers. At the end of the day, a brand is a promise and consumers assess brands through the lens of that explicit or implicit promise (Blackshaw, 2008). Further, he identifies six drivers to brand credibility as trust, authenticity, transparency, listening, responsiveness and affirmation. Erdem et al have studied the effect of Brand on price sensitivity. Consumer price sensitivity, that is, the weight attached to price in a consumer valuation of a product's overall attractiveness or utility, is impacted by brand credibility. The magnitude of brand credibility's impact on consumer choices and price sensitivity vary across product categories, as a function of product category characteristics that affect potential consumer uncertainty and consumer sensitivity to such uncertainty (Erdem et al, 2002). Health insurance being a service based product offered with uncertainty of occurrence, is likely to be highly influenced by brand credibility. Effective communication and continuous contact with the customer is important here to create a positive brand image. When the brand image is positive, the effect of public relations activities of the company will be more successful in creating customer loyalty (Hsieh, 2008). Service quality can be an important factor in creating customer loyalty and when the quality of

service is not meeting the customer expectation, customers consider brand switching as an option. Brand switching is influenced by quality of service and whether an individual has a good existing relationship with a healthcare provider (Abraham, Feldman 2006).

A good brand image provides an element of trust that helps in decision making. **Trust** reduces the transaction costs of searching for information on prices and alternatives available in the market, of inspection and measurement of the objects exchanged, of communication between the parties, and of legal advice. The higher the level of customer's trust, the lower the transaction costs and the greater the customer's commitment to the supplier (Kramer 1999). Empathy and politeness are particularly important to the establishment of trust in the early stages of a service relationship (Coulter, 2002). The creation of trust in the brand is a critical factor in creating brand preference (Friedman, 1974).

Insurance is an area where trust is a matter of paramount importance as it deals with customer's belief that in the event of a difficult situation, his interest will be taken care of. The customer's trust in relational sales context can be defined as *"a confident belief that the sales person can be relied upon to behave in such a manner that the long-term interest of the customer will be served"*. Successful marketing of insurance products like health insurance call for creating trust among consumers. Most of the literature concerning the evolution of sales strategies, activities and organizations underlined the shift towards a relational approach: "Relationship selling focuses on the building of mutual trust within the buyer/seller dyad with a delivery of anticipated, long term, value added benefits to buyers in order to create long term

relationships, alliances, and collaborative arrangements with selected customers whenever possible" *(Guenzi, 2002)*.

Insurance being a subject matter of solicitation, competence of the agent helps in creating consumer confidence and purchase. Consumers of insurance frequently rely on the perceived competence of the agent in terms of the advice he provides (Joseph 2008).

The effect of Competition: With the liberalization of the economy, a number of competitive players with innovative schemes have entered the health insurance market, this has opened up the avenue of choice and led to fair pricing by health insurance providers as they have the opportunity to switch plans. As Buchmueller observes, the success of competition as a strategy for controlling health costs depends largely on the willingness of consumers to switch health plans in response to a change in plan premiums (Buchmueller and Feldstein, 1997).

3.8.3 Social Factors

The consumer is exposed to a number of signals from the market related to health insurance resulting from activities of the government, marketing companies and other media. Further developments in the society related to public health, inflation that leads to higher service cost, availability of new services etc are important cues. For example an introduction of surgery treatment for diabetes in to the market is of importance to the person seeking health insurance, especially if he is diabetic. Reports on rising incidence of cancer in his social group and introduction of government policies related to health care are similarly important. Most of the related factors in this context have been discussed in Chapter 2 under health insurance scenario.

3.9 Gaps in Existing Research

The health insurance market has changed substantially during the past few decades. The literature study conducted related to the factors contributing to purchase decision of health insurance indicates that various socio-environmental factors observed by the researcher during the different stages of the study are not taken in to consideration. Such major factors are related to rising consumer awareness, increased occurrence of life style diseases, gradual withdrawal of government from healthcare leading to entry of private sector, government initiatives to provide health insurance cover to lower sections of society, changing age composition of population, new but costly diagnostic and treatment facilities, entry of several new companies in to health insurance sector and availability of different health insurance packages to suit specific needs of consumer groups. It was understood from the discussions with academicians, marketing executives dealing with health insurance services and representatives of several consumer segments, that these factors have a definite and growing impact on the consumer purchase decision of health insurance.

In this context, it is relevant to look at some of the reports on health insurance related developments and current research. The governments of India and Kerala, after independence, took several initiatives to control contagious diseases like cholera, tuberculosis, diphtheria etc which were widespread with preventive medical care like vaccinations and hygiene improvement. The developments in medical research contributed to its success. But as this was immensely successful in controlling communicable diseases, the health scenario in India has changed and a new threat in the form of lifestyle diseases emerged. Lifestyle diseases are diseases that appear to become ever more widespread as countries become more

industrialized. In many countries, peoples' diet changed substantially in the second half of the twentieth century, generally with increases in consumption of meat, dairy products, vegetable oils, fruit juice, and alcoholic beverages, and decreases in consumption of starchy staple foods such as bread, potatoes, rice, and maize flour. Other aspects of lifestyle also changed, notably, large reductions in physical activity and large increases in the prevalence of obesity (Key et al, 2002). Lifestyle diseases are different from other diseases because they are potentially preventable, and can be lowered with changes in diet, lifestyle, environment, and by supplementing with vitamin D. Non-communicable diseases including cancer are emerging as major public health problems in India (Sudhamony et al, 2008).

"Over 40 per cent of low income group families in India end up incurring huge debts owing to the rising cost of health care. These families, which do not have access to safe drinking water, proper sanitation, nutrition and pollution-free environment, also fall ill more often owing to their circumstances, adding to their health care spending, says a report by the World Health Organization, which studied the impact of increasing health care costs in six states in India" (Maya, 2007).

The state of Kerala is widely known for its superior social and health achievements despite low levels of income. Per capita spending on health care and education in Kerala is the highest among all the states, which translates into high indicators of social development (Parayil, 1996). Kerala also exhibits less inequality in health and educational achievements between social groups than is observed in other Indian states (Mukherjee et al, 2011). In the 1970s and 1980s, Kerala recorded outstanding progress in many of the demographic health indicators, such as low birth

rates, low infant and maternal mortality rates and improved life expectancy at birth, which set it apart from the rest of the country and seemingly on a par with the developed world. By the late 1980s, Kerala saw a rise in the proportion of adults and the elderly in its population, a result of the decline in fertility, and an increase in the "diseases of the rich", the so-called lifestyle or chronic diseases such as diabetes, heart diseases and high blood pressure, just as in the developed world (Krishnakumar, 2009).

Increasing cost of health care has made it necessary to look at alternate healthcare funding sources than own savings for many people. Expenditure on health care includes all payments made to hospitals, physicians, laboratories or any other health care provider including medical stores. It also includes expenses related to obtaining health care services, such as transportation costs to the health facility, lodging or accommodation costs and food consumed away from home during a health visit. 'The high burden of non-communicable diseases, aging population, and increasing use of technology in health care were some of the factors pushing up the health-care costs in the State. The proliferation of super-specialty hospitals in the private sector in the state indicates that a lot of money is being spent on secondary and tertiary care as well and that there is an increasing demand for such facilities' (The Hindu, 2012).

The health insurance providers are realizing the fact that traditional schemes like medi-claim no longer attracts the consumers. Most of the existing social health insurance schemes typically focus their attention on providing coverage for hospitalization expenditure, the fact remained that out-patient clinic expenses, costs of drugs and lab diagnostics accounted for over two-third of the out-of-pocket expenditure on health. (The Hindu, 2012).

3.10 Key Findings From the Study of Literature

The key findings from literature research in the context of consumer buying decision and health insurance purchase are noted below:

Year	Author	Major Findings
1910	Dewey, John	Proposed the classical five stage model of the consumer buying process. Stage 1: Problem or need recognition Stage 2: Information search Stage 3: Evaluation of alternatives Stage 4: Purchase decision Stage 5: Post purchase behavior
1966	Nicosia F.M.	Nicosia built a comprehensive model involving five modules. The encoding module includes determinants like "attributes of the brand", "environmental factors", "consumer's attributes", "attributes of the organization", and "attributes of the message". Other modules in the system include, consumer decoding, search and evaluation, decision, and consumption.
1976	Rothschild, M. and J. Stiglitz	This study was about the interest of consumers towards the health insurance. The purchase decision of consumers regarding health insurance was also determined based on several factors. Standard insurance theory predicts that insurance markets will suffer from adverse selection, which occurs when less healthy people or people who are more risky with their health are more willing to purchase health insurance because they know that the amount they spend on healthcare will be larger than the premium they will pay.

1980	Berry, Leonard, L.	Highlights the importance of service related research and explained the requirement of such a research from a services perspective. It also gives the major differences between marketing of goods and the marketing of services.
1981	Berry, Leonard, L.	This study focuses on the interactive marketing concept which has great relevance in the services marketing area. In order to facilitate proper interactive marketing, internal marketing by way of appropriate training and motivational measures are to be given to the service employees.
1983	Lewis, R.C., and Booms, B.H.	The study suggests, in the service industry, definitions of service quality focus on meeting customers' needs and requirements, and how well the service delivered meets customer's expectations. Service quality is determined by the differences between customer's expectations of services provider's performance and their evaluation of the services they received. Service quality can be defined as the difference between customer's expectations for service performance prior to the service encounter and their perceptions of the service received.
1985, 1988	Parasuraman, A., Zeithaml , V.A, and Berry, Leonard, L.	Several studies have been conducted to identify traditional service quality dimensions that contribute most significantly to relevant quality assessments in the traditional service environment. Identification of the determinants of service quality is necessary in order to be able to specify measure, control and improve customer perceived service quality. This study identified 10 detailed determinant of service quality through focus group studies: They are tangibles, reliability, responsiveness, communication, access, competence, courtesy,

		credibility, security, understanding/ knowledge of customer. Later these ten dimensions were further purified and developed into five dimensions-tangibles, reliability, responsiveness, assurance and empathy to measure Service Quality.
1988	Zeithaml, V. A	Consumer decision making involves a number of sub-concepts. Some researchers have suggested that consumers are 'value driven'. A consumer's perceived value may be seen as an expression of 'an overall assessment of the utility of a product (or service) based on perceptions of what is received and what is given. The consumer decision making happens after the consumer's evaluation of their perception.
1989	Freiden, J. and Goldsmith, R.	The research in the services area has been largely done from a customer decision making perspective. For this various studies have been done on consumer behavior and the criteria used by the customer in making a purchase decision.
1995	Bitner, M.J	Importance of the Services Marketing Triangle has been emphasized. The promises made by the organization to customers through the external marketing activities are complimented by the interactive marketing that happens between employees of the firm and the customer. The employees are made capable to deliver this through internal marketing done by the organization.
1997	Buchmueller, Thomas C; Feldstein, Paul J,	As Buchmueller observes, the success of competition as a strategy for controlling health costs depends largely on the willingness of consumers to switch health plans in response to a change in plan premiums.

1998	Mikael, Gidhagen	This gave an insight to the risk perception of customers. A service is individually perceived on the basis of rational assumptions by customers and providers, and often described by abstract expressions such as trust, feeling, security, and experience. Financial services are highly intangible. The more intangible the service, the more important the management of relationships, a factor which has to be stressed in the insurance business. Even though all financial services have an intangible dominant factor, they vary in their degree of tangibility in terms of the consumer's ability to grasp the particular service mentally — to comprehend the service rendered. In the case of insurance products, it is also based on the perceptions of risks and need to cover the risk that a consumer evaluates the service.
2002	Goldsmith, R. E. & Lafferty, B.A.	The most influencing theory in marketing and advertising research is attitude-towards-the-ad. The attitude that is formed towards the ad help in influencing consumer's attitudes toward the brand until their purchase intent.
2006	Brassington, F. and Pettit, S.	They pointed out that in marketing context, it can be stated that consumers can develop attitudes to any kind of product or service, or indeed to any aspect of the marketing mix, and these attitudes will affect behaviour.
2005	Hansen T.	Several perspectives have been considered in the consumer behaviour and consumer decision making process. Some factors that form these perspectives are price, attitude, awareness, risk perception etc. The price affected perceived quality, which in turn affected attitude, which in turn affected buying intention of the consumer.

2007	Patel, V	Patel in his paper remarked that 'Lack of consumer awareness of where to get health insurance, what it costs and what options exist is a critical barrier that prevents many people from obtaining coverage in the individual market. The employee's indifference towards the insurance schemes can be overcome at least partly through education efforts and products that make LTC insurance contingent on life and disability sales.
2007	Louden, David L and Bitta, Albert J Della	They said that the classical micro economic approach developed in the nineteenth century focused on the results of economic behavior (supply, demand, quantity demanded, price etc) rather than actual behavior of consumers themselves.
2008	Joseph, Mathew; Stone, George and Anderson, Krista	In his study, he stated that insurance being a subject matter of solicitation, competence of the agent helps in creating consumer confidence and purchase. Consumers of insurance frequently rely on the perceived competence of the agent in terms of the advice he provides.
2009	Herve, Catherine and Mullet, Etienne	Herve & Mullet studied more on the information component i.e. the customer's awareness of a particular service and its relation to the buying process. When evaluating a product or service, consumers seek out information to judge whether that specific product will meet certain criteria. The main concern of the sales providers is how to increase their customers' willingness to buy a product. Consumers use information to form beliefs about the likelihood of a product meeting a specific need.

3.11 Conclusion

An effort is made to understand the existing literature on concepts relevant to this study. The literature review starts with the concept of services, how service quality affects customer satisfaction, the functions played by insurance in general and health insurance in particular in social well being, consumer decision making and consumer buying process. Further the review looks at the models of consumer purchase decision making and proposes a model suitable for the current market context. It identifies two major factors, viz., personal factors and marketing factors that influence a consumer at the time of purchase of a health insurance policy. A new factor called social factor, that is observed to have critical influence on buyer behavior and that creates consumer awareness is identified. Adding this factor, a model is proposed for consumer purchase decision making. The variables that contribute to the three factors are explored further and built in to the proposed model.

Chapter 4

DESIGN OF THE RESEARCH

Contents

4.1 Introduction

Kerlinger in his 'Foundations of Behavioral Research defines research design as 'a plan, structure, and strategy of investigation so conceived as to obtain answers to research questions or problems'. The plan is the complete scheme or program of the research. It includes an outline of what the investigator would do from writing the hypothesis and their operational implications to the final analysis of the data' (Kerlinger, 1986). Aaker etal (1998) defines research design as the detailed blue print which guides a research study towards its objectives. These definitions form the backdrop for the various steps like research approaches, sampling design, questionnaire design, data collection methods and data analysis processes used in this study and are discussed in this chapter.

4.2 Research Perspective

The research methodology used in academic research takes in to consideration the research approaches used in the research studies of

similar nature in the past, the kind of research problem and the questions to be asked. There are fundamentally two research paradigms, the positivist paradigm and the phenomenological paradigm. Positivist studies focus on quantitative methods for empirical testing of formulated hypothesis (Buttery and Buttery, 1991). Data collection with relatively large samples using surveys and analysing the data using statistical tools are common in this approach. The stress here is on an objective or logical reasoning for the factors or reasons for the social phenomenon without a subjective interference from the researcher. Precision, objectivity and rigour are the guiding forces rather than experience, hunches and intuition for investigating research problems (Collis and Hussey, 2003). On the other hand, the phenomenological paradigm deals with exploration and understanding the phenomenon from the researcher's own frame of reference.

This study, to identify the 'Determinants of Consumer Purchase Decisions of Health Insurance in Kerala' uses a positivist approach, relying on quantitative data collected from a large sample using structured questionnaire based survey and interviews, a structured research design and objective methods forming a cross sectional study.

4.3 Research Approach

A look at fundamental forms of research gives two approaches viz., the qualitative and quantitative forms. Quantitative research is 'explaining phenomena by collecting numerical data that are analysed using mathematically based models, especially statistical methods' (Mujis, 2004). This is fundamentally an objective method that calls for measurement of a phenomenon. On the other hand, Qualitative research focuses on

observations to find out underlying meanings and relationships. Methods like focus groups, depth interviews, projective techniques etc to understand factors influencing behaviour of people in particular situations are commonly used in qualitative research.

Basically, this is a quantitative study. However, during the early exploratory stages of problem formulation and development of research instruments, the concepts of qualitative research have also been incorporated.

Research designs of different types are described in academic literature including major text books on research. The commonly seen categories are exploratory research, descriptive research and causal research. The type of research design depends on the specific problem under investigation and the type of information required to understand it (Malhotra, 2007; Zikmund, 2003).

In an exploratory research, the emphasis is on finding out the general nature of the problem and associated variables that contribute to it. While descriptive research tries to describe the variables and their contributions in a research situation, causal research aims at understanding the functional relationship between different variables in the problem under study. Depending on the type adopted the methods of conducting research will vary.

Keeping aside the initial exploratory part, the study on 'Determinants of Consumer Purchase Decisions in the Health Insurance Market' is a descriptive research. Descriptive Research is used to make descriptions of the phenomena or the characteristics associated with a subject population: who, what, when, where and how of a topic (Cooper and Schindler, 2003). Different forms of data collection like observation methods, panels or

surveys can be used in descriptive studies. According to Cooper and Schindler (2003), correlation study to find out relationship among variables when done can be considered as a subset of descriptive study. Study of relationship among variables in the health insurance purchase decision process is also a part of this work.

Cross-sectional Nature of the Study

For the present study, data collection from various sources of sample populations has been done only on a single occasion and hence it has a cross sectional study nature in contrast to a longitudinal study where data from same samples are collected at different time periods. Opinions of different groups of people are taken and analysis is done to arrive at the contributing factors of purchase decisions in this case.

4.4 Data Sources

The present study that aims at understanding the determinants of consumer's purchase decision of health insurance policy is structured in the manner outlined below. The study uses secondary and primary data sources.

4.4.1 Secondary Data Sources:

The major sources of secondary data used here are:

a) Text Books on Research Methodology, Statistics and Marketing, as listed in references.

b) Published studies in various international and national journals mostly accessed through academic databases like EBSCO, Emerald, JStore etc to get inputs related to conceptual design and literature study.

c) IndiaStat for statistical information on health insurance company performance and socio-economic information

d) Articles published in business related journals like IRDA journal and periodicals on the subject

e) News magazines and news paper articles on health insurance, government policies, company information & published information from health insurance companies and agencies

f) Web sources for inputs on academic, industry related and government policy information

4.4.2 Primary Data Sources

The source of primary data that has been used in this study are individual respondents of the age above 18 years, who may be either consumers or non consumers of health insurance in the state of Kerala.

Inputs from interview of a number of marketing executives of health insurance companies and insurance agents have been found relevant to the study.

Survey Research:

The data have been collected using pre-tested structured questionnaire. Structured questionnaires allow arrangement of questions in a planned sequence facilitating easy coding, analysis and interpretation of data. Individual information, awareness, attitude, perceptions, satisfaction levels, impacts of marketing activities by companies and contextual business environment were brought under the purview of the study.

Different ways of administering survey method are possible. The mode of administration could be: telephonic personal interviews, by postal mails or using internet. The last two have much less response rate. A survey response rate of 25% is considered satisfactory (Clark etal 2010). However, to get better response to survey, the study has been done by personally meeting the respondents in most cases. The purpose and nature of study were informed to the respondents and confidentiality of gathered information was assured. Substitution was done in case of non-availability of respondents.

4.4.3 Sampling Plan

4.4.3.1 Geographical coverage:

After independence of India in 1947, the three geographical regions of Travancore, Cochin and Malabar were combined to form the state of Kerala on 1st November 1956. The state of Kerala has a population of 33.4 million as per 2011 census and has been divided into 14 districts. The districts are normally grouped in to the three regions as: Trivandrum, Kollam, Alleppey, Pathanamthitta, Kottayam and Idukki in south Kerala; Ernakulam, Thrissur and Palakkad in central Kerala and Malappuram, Kozhikode, Wayanad, Kannur and Kasargod in northern Kerala (Districts of Kerala, 2009). Though religious composition and cultural practices in these regions vary in view of historical factors, educationally and in terms of social development they are similar. The state became 100% literate state in 1991 and is rated high in HDI comparable to western countries.

Table 4.1. Details of Population and Sample Size

	South Kerala	Central Kerala	North Kerala
Districts	Trivandrum, Kollam, Alleppey, Pathanamthitta, Kottayam, Idukki	Ernakulam, Thrissur and Palakkad	Malappuram, Kozhikode, Wayanad, Kannur, Kasargod
Region's Voters	9011648	6400901	7735326
District selected	Kottayam	Ernakulam	Kozhikkode
Constituency	Changanacherry	Ernakulam	Kozhikode North
Constituency's Voters	148860	135516	149890
Sample Size	240	171	206

Source: Voters list as of 2009, extracted from www.keralaassembly.org

4.4.3.2 Population of the study

The universe of a study is defined in Research Methodology as the total of the items or units in a study while the term population refers to the total of items about which information is desired. India follows a democratic system of administration with universal franchise and every individual above the age of 18 is an eligible voter. Therefore, the population frame of the study is taken as the electoral list published by the Chief Electoral Officer of the state of Kerala, as of 2009. The total number of voters in the state based on this list is 23147875. The regional break-up of the list is, south: 9011648, central: 6400901 and north: 7735326.

4.4.3.3 Unit of Study

The units of study (sampling elements) of consumers are individuals above the age of 18 years, who are included in the electoral list of the state. The terms customer and consumer have been used interchangeably in the study. Marketing executives as representative of the organization and agents as mediators are also taken for the study.

4.4.3.4 Sampling Method:

Since a defined population is available and it is desired to give equal opportunity for all respondents from all regions, this study uses multi stage random sampling as the method of sampling. Of the three regions, randomly one district each is selected. Further, one legislative constituency is selected randomly and respondents are selected on a random basis using the electoral list of the constituency. Substitution was done in case of non-availability.

The selection of districts from the regions resulted in identifying Kottayam, Ernakulam and Kozhikode districts. From these districts, Changanacherry, Ernakulam and Kozhikode North were selected as the constituencies from which data collection was to be done. The voters' population in these constituencies as per list are: 148860, 135516 and 149890 respectively.

Judgment sampling methods was used for choosing marketing executives and agents of health insurance.

4.4.3.5 Sample size:

This study considered several statements to assess the various components in the study variable. Since the population for this study is infinite, for an assumed level of 5% error in estimates of means of these responses, using the information on variance from the pilot study, sample size was obtained based on each response.

If 'n' is the sample size, 's' is the estimate of standard deviation and 'd' is the estimate of error under the assumption of 5% error in estimate and the critical value from Normal test at 5% level of significance is 1.96, then n with 95% confidence level is given by $n = (1.96\ s / d)^2$

The sample size of 610 is the maximum among the sample sizes obtained from responses for all the statements.

The total size of the sample taken for study of consumer/non consumers is 617, and data was collected from respondents in proportion to the total population of the region, detailed earlier. Thus, data was collected from 240 respondents in Changanacherry, 171 from Ernakulam and 206 from Kozhikode North.

Thirty five marketing executives and thirty insurance agents were also taken for the study.

4.4.4 Data Collection Method

Data was collected using a structured questionnaire based on literature study. The questionnaires were delivered in person to the respondents to ensure better response rate and completed questionnaires were collected, providing opportunity for the respondents to clarify any point.

4.4.4.1 Research Instrument : Questionnaire

The survey instrument questionnaire was designed and developed after an extensive literature review, discussions with academic experts and discussions with managers of insurance companies dealing with health insurance products. In order to develop the questionnaire, the literature survey covered areas like consumer purchase decision process, consumer awareness, consumer attitudes, satisfaction and how satisfaction affects purchase decisions, influence of service quality on satisfaction and purchase, decision making in insurance in general and health insurance in particular, impact of marketing activities on consumer decision, contribution of brand image in consumer choice of service provider, social trends,

government policies on health insurance etc. A number of websites were referred to get information on current market trends. Publications like IRDA Journal provided very relevant information. Trends in hospitalization and cost, different schemes, changing life styles and its impact on health and diseases, consumer perception of risk and risk mitigation etc were mostly obtained from various web sources.

4.4.4.2 Reliability and Validity of the Research Instrument Used

Reliability and Validity are the two main criteria to measure the goodness of the measures used in a research instrument. Testing Reliability is necessary, but is not sufficient for the validity of an instrument.

Content Validity – the Validity of the questionnaire, whether the questions measure what it is intended to measure was tested through prima facie verification, literature review, discussions with experts, pilot testing and subsequent factor analysis and suitable modifications incorporated. Checking the reliability of the questionnaire is essential for any type of data collection. Chronbach Alpha is a measure of reliability based on the internal consistency of the constructs used. Reliability has been tested after data collection using Chronbach's Alpha. Post data collection, each of these variables were tested for the suitability of questions to measure the intended behaviour using Chronbach's Alpha test. According to Liu and Zumbo (2007) and Pallant (2005), a Chronbach's Alpha of 0.70 and above is acceptable reliability co-efficient, while some researchers consider a Chronbach's Alpha value above 0.6 to be satisfactory.

Using the data obtained from the pilot study, a reliability analysis using the classical Cronbach Alpha Model for reliability was attempted. The procedure starts with all statements considered and sequentially eliminating

statements whose elimination may improve the Alpha. The procedure ends when there is no more improvement. From a set of 64 statements, when 10 statements get deleted in this way, the summated scale was set to use the remaining statements which provide a reliability coefficient of 0.905. The current reliability with all these variables is 0.905 and it is observed that this value cannot be improved by deletion of some variables.

4.5 Pre-Testing Using Factor Analysis

The survey questionnaire was pilot tested with a total of 70 respondents from major constituent groups providing diversity to the pilot test sample. The initial questionnaire had two parts, with the first section having 25 questions to collect demographic information, reasons for purchase, medical history, health insurance preferences etc. This section of the questionnaire covered basic demographic data regarding the respondent including age group, gender, education, employment, monthly income, monthly medical expenses etc. Further information on health insurance was sought, like source of funds for health related expenses, source of information about health insurance, status of health insurance coverage, claim history etc. The questionnaire further moves on to find out respondent's reasons why health insurance is necessary and what are the reasons he feels for people not taking health insurance cover. The factors which are considered important while selecting a health insurance provider and the respondent's ranking of major health insurance providers from a selected list (based on responses in pilot study) with opportunity to add a provider if the same is not included in the list, followed. This part of the questionnaire also attempts to find out the purchase intention (renewal in the case of existing policy holders) and possibility of switching in case of

poor service. Most of the questions in the first section are given as choice from a list provided.

Factor Analysis using Principal Component Analysis and Rotation Method (Varimax with Kaiser Normalization) was carried out for the data collected from the pilot study. The analysis of the questionnaire data resulted in identifying three major factors, viz., personal factors, marketing factors and social factors. Thus, the final questionnaire used for the complete sample of 617 respondents had 54 questions in the second section, of which, 20 items were under personal factors, 18 under marketing factors and 16 under social factors. The first section was retained.

On the basis of the outcome of pilot study and factor analysis, a model was proposed with the three factors described above.

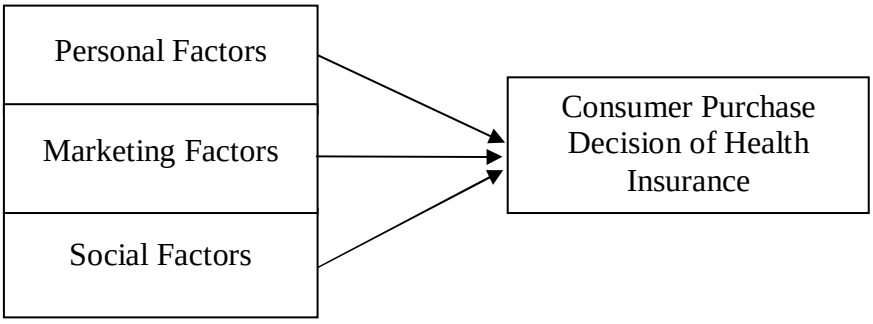


Fig. 4.1 Proposed Model of Consumer Purchase Decision

Questions Related to Personal Factors Influencing Consumer Purchase Decision

Based on the study of literature and discussions with the marketing executives of several health insurance marketing companies, it was found that a number of factors relating to the personal knowledge, attitudes, motivation and satisfaction of the consumer contributed to favourable or

non-favourable decision towards health insurance purchase. In personal factors, consumer' awareness is measured using six questions checking awareness of provider companies, benefits, schemes, exclusions, cost of premium and claim procedures. Consumer's attitude towards health insurance, whether it can reduce risk, provide a sense of security, advantage of taking health insurance at a younger age, sense of security provided to family etc are covered in this part. Ease of the process of taking health insurance policy, process of claim and settlement, response to queries etc form the satisfaction part of the personal factors that contribute to purchase decision making process.

Questions Related to Marketing Factors Influencing Consumer Purchase Decision

The Marketing factors that contribute to purchase decision making mostly focuses on the 7P approach, where the three 'P's of People, Processes and Physical Evidences are added to the original four 'P's of Product, Price, Place and Promotion to adapt to the services marketing context and the impact of Brand. The schemes offered, benefits offered by schemes like domiciliary treatment cover, schemes to suit different category of clients, coverage of critical illnesses, the rate of premium, benefits of the schemes to consumers, the returns for the investment made, availability of agents or officials to provide policy related information, persuasion and guidance from agents, information and content value of brochures, fliers and literate, renewal intimations, new product information, brand image perception, role of brand name in decision making, etc. Consumer's opinion is also sought on whether marketing efforts taken by companies really impact purchase decision.

Questions Related to Social Factors Influencing Consumer Purchase Decision

The health insurance market environment is changing and several factors contribute to this positive change. The rising social awareness in matters related to health care is visible in Kerala. Added to that is the realization that health insurance cover is a good option. The various schemes introduced by the government, mostly intended for lower sections of the society are being observed by the non-beneficiaries. The impact of all these add to social awareness and therefore questions are included from these areas. Recently, especially after the arrival of international health insurance providers, a variety of schemes are available in the market, often tailor made to specific customer groups. Competition between providers has helped in developing consumer oriented schemes. The changing food habits and sedate life style have increased the incidences of major health problems. This is compounded by stress, mostly originating at work place or due to work-family balance issues. Thus increasing risk factors have been noticed by the society and hence included in the questionnaire. Post liberalization, the governments at centre and state are gradually coming out of medical care other than primary sectors. Consumers, especially from middle and upper class of society are moving towards private health care, and this is costly. Experience of people who have met with accidents, major illness resulting in hospitalisation and own experiences are prompting consumers to look for some form of protection and health insurance is generally agreed to be one of the major ways. Therefore, the contribution of the rising cost of healthcare in decision making process finds a place in the questionnaire used to study factors contributing to purchase decision making in health insurance market.

4.6 Data Coding and Tabulation

The data collected were edited for useful responses and incomplete ones have been discarded. Where minor clarifications only were required, the respondents were contacted over phone and information recorded. Coding has been done by identifying and denoting a numerical to the responses given by a respondent, to facilitate quantification and statistical analysis.

4.7 Statistical Analysis

The primary data collected were coded and tabulated using MS Office-Excel and analysis conducted using IBM PASW Statistics (SPSS). Weighted means, Cross tabulations, Chi-Square tests, independent sample-t test, one way ANOVA and Log-linear multinomial model have been used for conducting analysis at different parts of the study as called for.

Discriminant Analysis is done to find out the ability of the three factors – personal, marketing and social – individually and collectively in discriminating an insurance buyer to a non buyer. The discriminant analysis results can be used to describe each group in terms of its profile, using the group means of the predictor variables. These group means are called centroids. 'Functions at Group Centroid' indicates the average discriminant score in the two groups.

4.8 Conclusion

This chapter describes the basic approach adopted in conducting the study 'Determinants of Consumer Purchase Decisions of Health Insurance in Kerala' and the research methodology used. The details related to the research approaches used, sources of data, methods of sampling, description of the research instruments employed and analysis tools have been explained. Effort to conduct a systematic and scientific study in the selected topic is made here, adopting established principles of marketing research.

Chapter 5

PROFILES AND DATA ANALYSIS

Contents

5.1 Introduction

The survey of consumers numbering 617, spread across the three geographical areas, of the state of Kerala, who have given information based on the questionnaires provided to them, was the major source of primary data for this research. The second source of primary data was the managers of health insurance companies in the state of Kerala.

A profile of these respondents based on key socio-economic parameters is relevant to understand the behavior pattern of consumers as regards to purchase of health insurance policy as well as to analyze the responses to various questions used for ascertaining his thought process and attitudes towards health insurance concept and organizations.

The major factors that prompt a customer to purchase a health insurance policy and the factors that prevent purchase – these are important considerations for the health insurance marketer. The study also tried to identify the factors that a potential customer considers while deciding the service provider. Further, the marketing organizations are interested in

knowing consumer preferences towards different service providers in the country and how they are rated.

The profile of executives interviewed showed representation from a number of companies from private and public sector and experience ranging from one year to thirty plus years. Their perceptions towards customer's awareness, reasons for purchase and non-purchase are also recorded.

This chapter attempts to record the observations from the study on these areas.

5.2 Customer Profile

5.2.1 Age Category of Respondents

The age group of the respondent is an important factor as age represents where the respondent is located in the family life cycle. The 617 respondents were found to be distributed among different age groups evenly. All regions have fair distribution of respondents in different age groups.

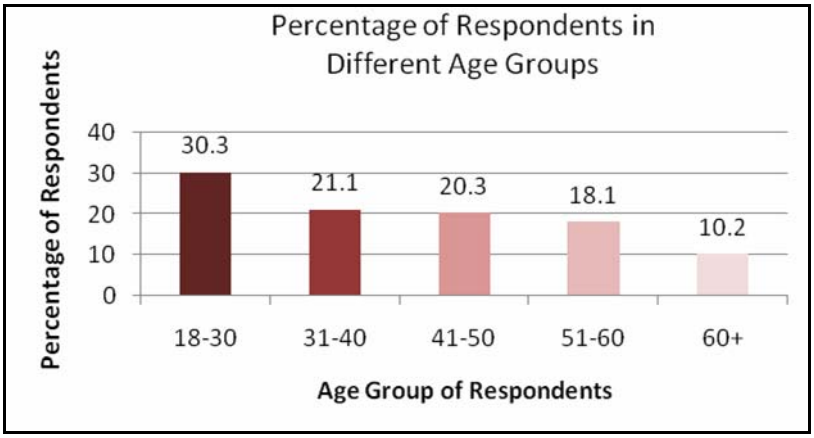


Fig. 5.1 Age category of Respondents

5.2.2 Region-wise Breakup

The state of Kerala has been taken as three geographical regions viz., southern, central and northern Kerala, which also has identifiable cultural and religious population differences. The sample gave fair representation to all these regions.

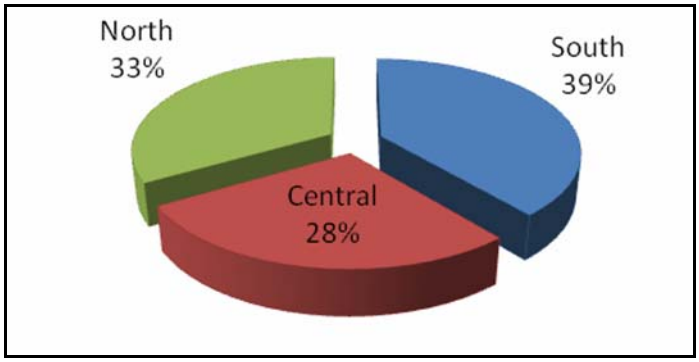


Fig. 5.2 Region-wise Break-up of Respondents

5.2.3 Region * Age group Cross-tabulation of Respondents

Table 5.1 Region * Age Group Cross-tabulation

			Age Group					Total
			18-30	**31-40**	**41-50**	**51-60**	**>60**	
Region	South	Count	69	70	45	47	9	240
		% within Region	28.8%	29.2%	18.8%	19.6%	3.8%	100.0%
		% of Total	11.2%	11.3%	7.3%	7.6%	1.5%	38.9%
	Central	Count	61	27	48	31	4	171
		% within Region	35.7%	15.8%	28.1%	18.1%	2.3%	100.0%
		% of Total	9.9%	4.4%	7.8%	5.0%	.6%	27.7%
	North	Count	97	33	32	34	10	206
		% within Region	47.1%	16.0%	15.5%	16.5%	4.9%	100.0%
		% of Total	15.7%	5.3%	5.2%	5.5%	1.6%	33.4%
Total		Count	227	130	125	112	23	617
		% of Total	36.8%	21.1%	20.3%	18.2%	3.7%	100.0%

5.2.4 Gender-wise Breakup

With, the state of Kerala having good level of education among women and many of them employed, analysis of the reach of and attitudes towards heath insurance among women is worth studying. The sample had a fairly good representation of women respondents and is seen across the three regions.

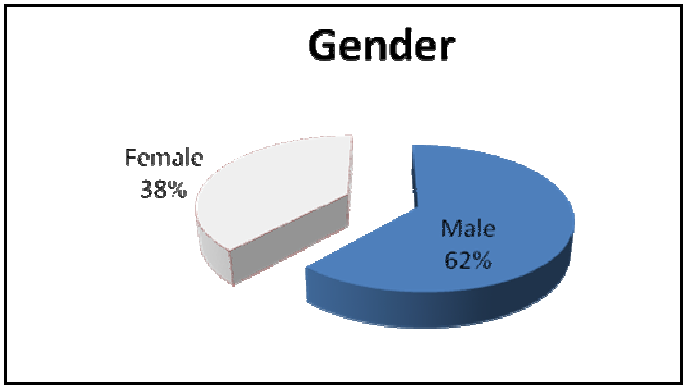


Fig. 5.3 Gender-wise Break-up of Respondents

5.2.5 Region * Gender Cross-tabulation

Table 5.2 Region * Gender Cross-tabulation

			Gender		Total
			Male	Female	
Region	South	Count	139	101	240
		% within Region	57.9%	42.1%	100.0%
		% of Total	22.5%	16.4%	38.9%
	Central	Count	108	63	171
		% within Region	63.2%	36.8%	100.0%
		% of Total	17.5%	10.2%	27.7%
	North	Count	134	72	206
		% within Region	65.0%	35.0%	100.0%
		% of Total	21.7%	11.7%	33.4%
Total		Count	381	236	617
		% of Total	61.8%	38.2%	100.0%

5.2.6 Residential Area of the Respondent

Though the state of Kerala cannot be strictly classified as urban and rural in view of comparable literacy, exposure to public services etc, there could be differences in view of working environment, peer interaction etc. Hence a break-up of the sample on residential locality is made and the two groups have fairly equal representation among the sample elements.

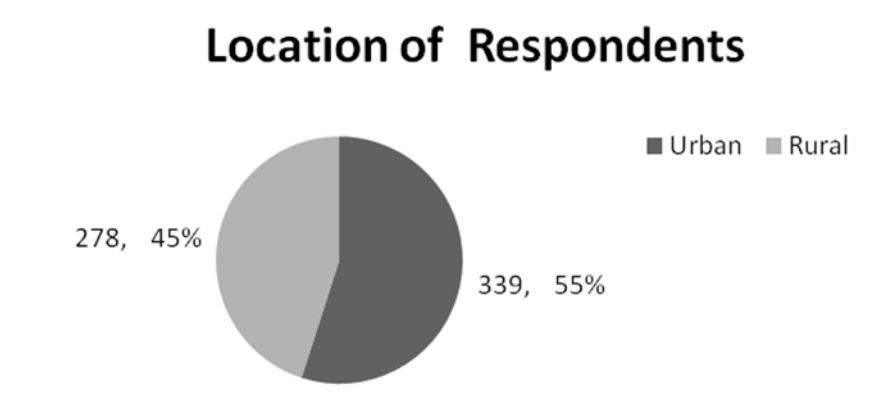


Fig. 5.4 Residential Area of the Respondent

5.2.7 Average monthly medical expenses

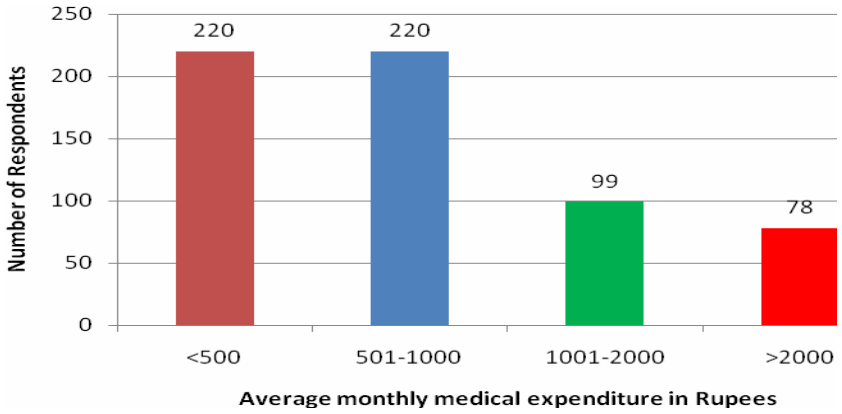


Fig. 5.5 Average Monthly Medical Expenses

Average monthly medical expenses reported by the respondents in the case of more than two third of the sample were below Rs.1000/- per family. This includes the cost of medicines purchased, occasional minor hospitalization and doctor's consultation charges.

5.2.8 Average Monthly Medical Expenditure * Monthly Income Cell Counts And Residuals

Table 5.3 Average Income-Medical Expenses Tabulation

Monthly family income	Average monthly medical expense of the family	Observed		Expected	
		Count	%	Count	%
Less than Rs.5000/-	Upto Rs.500/-	19	3.1%	13.193	2.1%
	Rs.501-1000	11	1.8%	13.193	2.1%
	Rs.1001-2000	5	.8%	5.937	1.0%
	above Rs.2000/-	2	.3%	4.677	.8%
Rs.5001-10000	Upto Rs.500/-	37	6.0%	30.665	5.0%
	Rs.501-1000	35	5.7%	30.665	5.0%
	Rs.1001-2000	7	1.1%	13.799	2.2%
	above Rs.2000/-	7	1.1%	10.872	1.8%
Rs.10001-25000	Upto Rs.500/-	78	12.6%	76.305	12.4%
	Rs.501-1000	81	13.1%	76.305	12.4%
	Rs.1001-2000	25	4.1%	34.337	5.6%
	above Rs.2000/-	30	4.9%	27.053	4.4%
Rs.25001-50000	Upto Rs.500/-	56	9.1%	64.538	10.5%
	Rs.501-1000	62	10.0%	64.538	10.5%
	Rs.1001-2000	36	5.8%	29.042	4.7%
	above Rs.2000/-	27	4.4%	22.882	3.7%
Above Rs.50000	Upto Rs.500/-	30	4.9%	35.300	5.7%
	Rs.501-1000	31	5.0%	35.300	5.7%
	Rs.1001-2000	26	4.2%	15.885	2.6%
	above Rs.2000/-	12	1.9%	12.515	2.0%

The traditional approach to testing for independence, calculates expected counts under independence and compares observed and expected counts using Pearson's Chi-square statistics. This test requires the expected count to be greater than 5. Otherwise, reclassification is suggested as a correction. Loglinear models adopt a more formal approach that relies on Maximum Likelihood estimation and Likelihood Ratio test (LR). The random variable representing the cell counts is assumed to be having a Multinomial distribution and use more powerful LR tests for independence. Also, it provides tools to identify the possible patterns of dependence between the variables, in the event of dependence.

To prove the statistical significance of the relation explained in Table 5.3, a Loglinear Multinomial Model test was attempted as exhibited in Table 5.4.

H_0: There is no relationship between income and medical expenditure

H_A: There is relationship between income and medical expenditure

The test was found to be significant with ($p < 0.05$). Hence the relationships explained above are statistically significant.

Table 5.4 Results of Goodness of Fit Test

Goodness-of-Fit Tests[a,b]			
	Value	**df**	**Sig.**
Likelihood Ratio	26.003	12	.011
Pearson Chi-Square	25.858	12	.011
a. Model: Multinomial	b. Design: Constant + A6 + A8		

It is concluded that there is an association between monthly income and average monthly medical expenditure. This could be because the higher income group people take medical facilities from high end hospitals.

5.2.9 Educational background of the respondents

Kerala state is well known for high literacy rates and share of population with higher levels of education. The newspaper circulation and availability of television in the households are quite high in the state. Education level of the respondents is of significance as the effect of advertisements and the impact of different marketing cues can vary with education. It is observed that adequate number of respondents is present in each education group in the state.

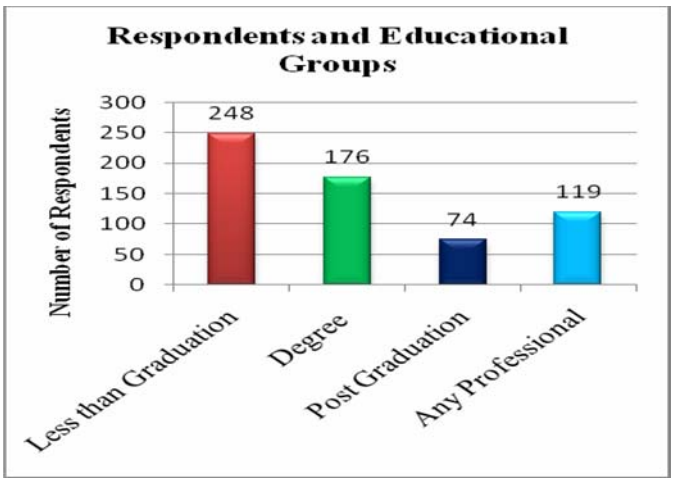


Fig. 5.6 Respondents' Education Groups

5.2.10 Educational Qualification * Total Awareness

Table 5.5 Relationship between Educational Qualification and Overall Awareness of Health Insurance

			Total Awareness Level					Total
			Very Low	Low	Neither high, Nor low	High	Very high	
Educational Qualification	Less than Degree	Count	17	66	98	59	8	248
		% within Educational Qualification	6.9%	26.6%	39.5%	23.8%	3.2%	100.0%
		% within Total Awareness Level	65.4%	61.7%	40.3%	29.1%	21.1%	40.2%
		% of Total	2.8%	10.7%	15.9%	9.6%	1.3%	40.2%
	Degree	Count	5	22	74	61	14	176
		% within Educational Qualification	2.8%	12.5%	42.0%	34.7%	8.0%	100.0%
		% within Total Awareness Level	19.2%	20.6%	30.5%	30.0%	36.8%	28.5%
		% of Total	.8%	3.6%	12.0%	9.9%	2.3%	28.5%
	Post Graduate	Count	2	3	30	31	8	74
		% within Educational Qualification	2.7%	4.1%	40.5%	41.9%	10.8%	100.0%
		% within Total Awareness Level	7.7%	2.8%	12.3%	15.3%	21.1%	12.0%
		% of Total	.3%	.5%	4.9%	5.0%	1.3%	12.0%
	Professional	Count	2	16	41	52	8	119
		% within Educational Qualification	1.7%	13.4%	34.5%	43.7%	6.7%	100.0%
		% within Total Awareness Level	7.7%	15.0%	16.9%	25.6%	21.1%	19.3%
		% of Total	.3%	2.6%	6.6%	8.4%	1.3%	19.3%
Total		Count	26	107	243	203	38	617
		% within Educational Qualification	4.2%	17.3%	39.4%	32.9%	6.2%	100.0%
		% within Total Awareness Level	100.0%	100.0%	100.0%	100.0%	100%	100.0%
		% of Total	4.2%	17.3%	39.4%	32.9%	6.2%	100.0%

5.2.11 Test of Awareness vs Educational Qualification

Table 5.6 Table showing results of Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	50.933[a]	12	.000
Likelihood Ratio	53.315	12	.000
Linear-by-Linear Association	31.655	1	.000
N of Valid Cases	617		

The awareness rating of respondents with different educational qualifications is checked for any association between education group and awareness level reported.

H_0: There is no association between education and awareness level

H_A: There is relationship between education and awareness level

The test was found to be significant with ($p < 0.05$). Hence the relationships explained above are statistically significant.

It is inferred that there is an association between education level and level of awareness of health insurance. Respondents of higher education level showed a higher level of awareness of health insurance.

5.2.12 Hospitalization or accident causing a major expenditure

The number of families that have reported major hospitalization either due to sickness of some of the family members or due to an incidence of accident, amounted to 24% in the previous two years. An amount of Rs 29 lakhs was spent by 151 respondents, resulting in an average expenditure of Rs.19,000 per family.

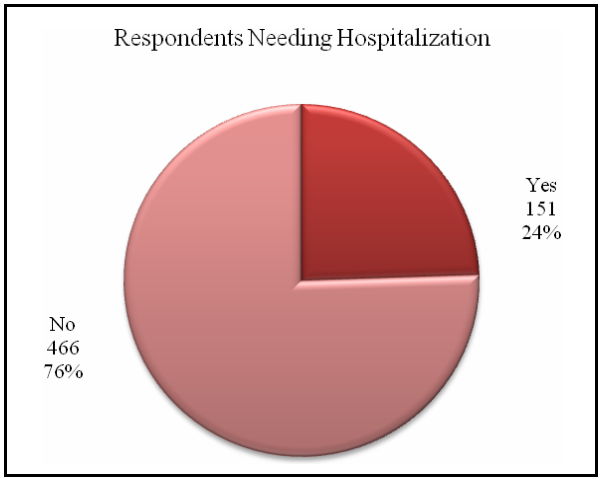


Fig. 5.7 Cases of Hospitalization

5.2.13 Source of funds for health coverage

Table 5.7 Most used source of fund for meeting medical expenses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Free medical service from Government	39	6.3	6.3	6.3
	Own savings	425	68.9	68.9	75.2
	paid by employer/company	79	12.8	12.8	88.0
	Health Insurance	54	8.8	8.8	96.8
	Others	20	3.2	3.2	100.0
	Total	617	100.0	100.0	

The two categories of regular monthly expenses and cost of hospitalization being the expenditures for health care of the family, more concern is about the hospitalization expenditure. Responses indicate that these expenses are met from personal sources or in some cases by loans, as 69% of the sample has shown personal funds as source. 9% of the people have used health insurance cover to meet the hospitalization expenses.

5.2.14 Respondents having health insurance

63% of the respondents have informed that they do not have health insurance of any kind. Relating this with the national level of 68% of the people of the country meet health care expenses from their personal savings, the state of Kerala is no different.

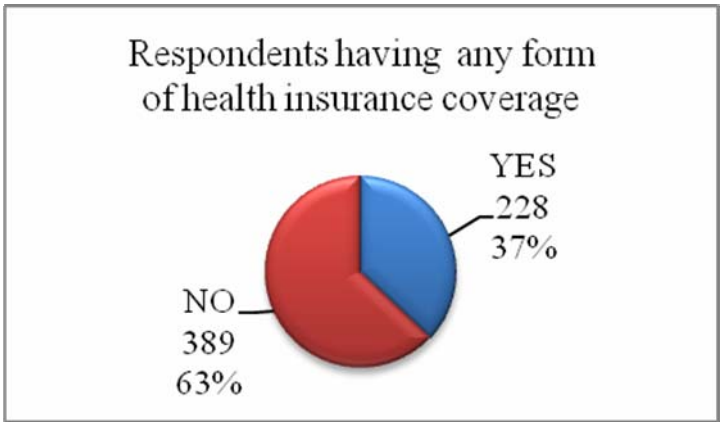
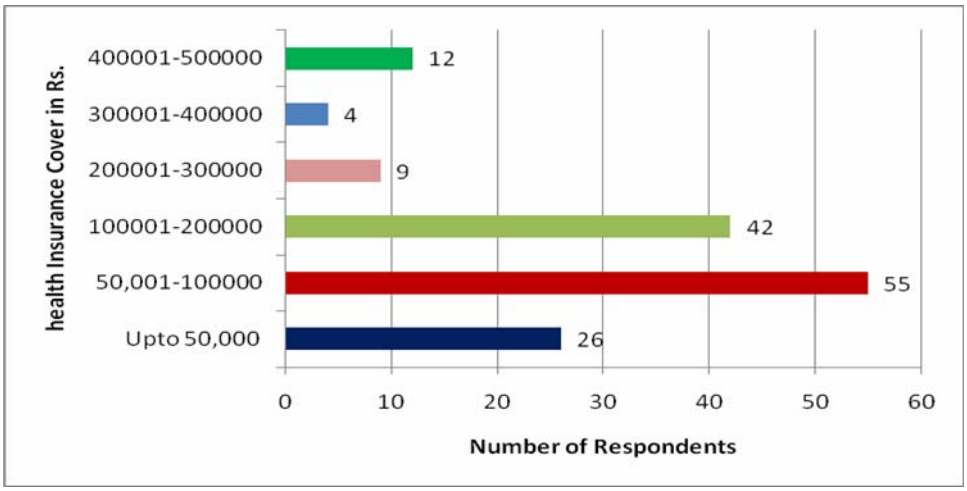


Fig. 5.8 Having any form of Health Insurance

5.2.15 Extent of health insurance cover



Fig, 5.9 Extent of Health Insurance Cover

Of the 148 resondents who provided information regarding the value of their health insurance coverage, more than 50% have stated that the cover is less than Rupees One Lakh. Inspite of many private companies offering high value schemes, the highest reported insurance cover is only Rs.5 Lakhs. Overall the information available in this area indicate inadequacy of health isnurance coverage among the people of Kerala.

5.2.16 Dependent family members

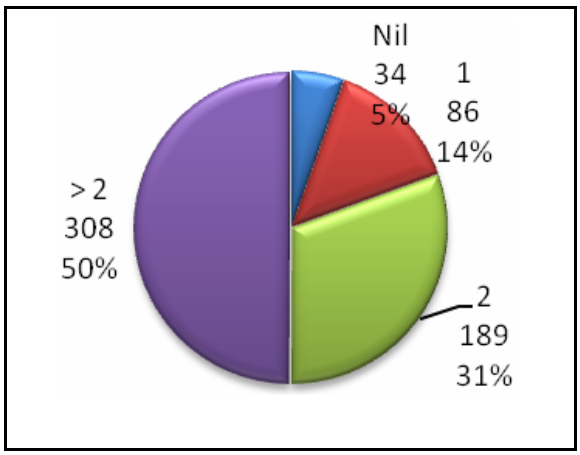


Fig 5.10 No of Dependent Family Members

Quite often the families have only one major earning member and dependents include spouse, parents, siblings and children. Half the respondents have a family of more than two members to support their medical expenses and another 31% has two members. This makes the need for health insurance important.

5.2.17 Employment * Most used source of fund for meeting medical expenses Cell Counts and Expected Count

Table 5.8 Employment * Most used source of fund for meeting medical expenses

Employment	Most used source of fund for meeting medical expenses	Observed		Expected	
		Count	%	Count	%
Agriculture	Free medical service from government	3	.5%	1.201	.2%
	Own savings	15	2.4%	13.088	2.1%
	paid by employer/company	0	.0%	2.433	.4%
	Health Insurance	0	.0%	1.663	.3%
	Others	1	.2%	.616	.1%
Self Employed/ Business	Free medical service from government	1	.2%	4.361	.7%
	Own savings	60	9.7%	47.528	7.7%
	paid by employer/company	2	.3%	8.835	1.4%
	Health Insurance	4	.6%	6.039	1.0%
	Others	2	.3%	2.237	.4%
Practicing Professionals	Free medical service from government	2	.3%	3.666	.6%
	Own savings	41	6.6%	39.951	6.5%
	paid by employer/company	8	1.3%	7.426	1.2%
	Health Insurance	5	.8%	5.076	.8%
	Others	2	.3%	1.880	.3%
Private Organization Service	Free medical service from government	4	.6%	11.378	1.8%
	Own savings	121	19.6%	123.987	20.1%
	paid by employer/company	27	4.4%	23.047	3.7%
	Health Insurance	21	3.4%	15.754	2.6%
	Others	7	1.1%	5.835	.9%
Government service	Free medical service from government	23	3.7%	10.619	1.7%
	Own savings	105	17.0%	115.721	18.8%
	paid by employer/company	32	5.2%	21.511	3.5%
	Health Insurance	5	.8%	14.703	2.4%
	Others	3	.5%	5.446	.9%
Others (like NRI)	Free medical service from government	6	1.0%	7.775	1.3%
	Own savings	83	13.5%	84.724	13.7%
	paid by employer/company	10	1.6%	15.749	2.6%
	Health Insurance	19	3.1%	10.765	1.7%
	Others	5	.8%	3.987	.6%
a. Model: Multinomial					

Table 5.9 Log linear Multinomial Goodness-of-Fit Tests

	Value	df	Sig.
Likelihood Ratio	70.216	20	.000
Pearson Chi-Square	64.666	20	.000
a. Model: Multinomial			

From the above analysis, it is found that from the group of people who are occupied in agriculture, self employed or in own business and practicing professionals, a higher percentage are spending for medical expenses from their own savings. These groups can be beneficiaries of the health insurance schemes.

5.2.18 Awareness about Health Insurance

With the understanding of the type and extent of health related expenditures and the way it is being met, it is observed that health insurance as a financial source for health care is being utilized by a small percentage of the affected people. Awareness about the service and its availability being pre-requisites for purchase decision, the level of awareness about health insurance among the sample under consideration was measured based on six factors on a self rating basis and the consolidated value taken. These factors contributing to awareness are:

a) Awareness of companies offering health insurance

b) Awareness of benefits of health insurance

c) Awareness of different schemes offered by companies

d) Awareness of diseases covered and exclusions in health insurance schemes

e) Awareness of cost of health insurance coverage

f) Awareness about basic health insurance claim process

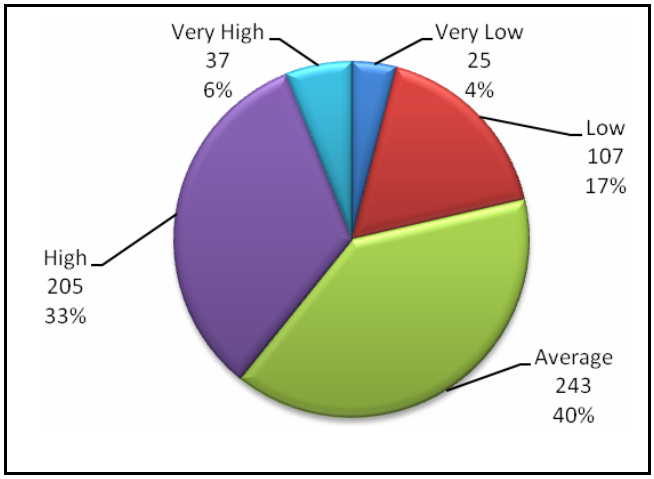


Fig. 5.11 Overall Awareness of Health Insurance Among Respondents

5.2.19 Educational Qualification * Total Awareness Level

Table 5.10 Educational Qualification * Total Awareness Level Cross-tabulation

		Total Awareness Level					Total
		Very Low	Low	Neither high, Nor low	High	Very high	
Educational Qualification	Less than Degree	5	19	35	30	3	92
	Degree	5	25	74	58	13	175
	post Graduate	7	18	64	54	9	152
	Professional	8	45	70	63	12	198
Total		25	107	243	205	37	617

5.2.20 Reasons for consumers taking HI or Not taking HI

One fundamental objective being addressed in this study is to understand the reasons for consumers to take or not to take health insurance.

5.2.20.1 Reasons for people taking health insurance

The response from 617 respondents of the study are recorded here. As can be seen from the chart, protection from rising cost, coverage of big expenses and better health care to family have been cited as major reasons for opting for health insurance by customers. Unexpected expenses like surgeries and accidents can be covered by Health Insurance cover and the marketing people need to highlight the advantage the schemes can offer in these aspects in order to attract customers.

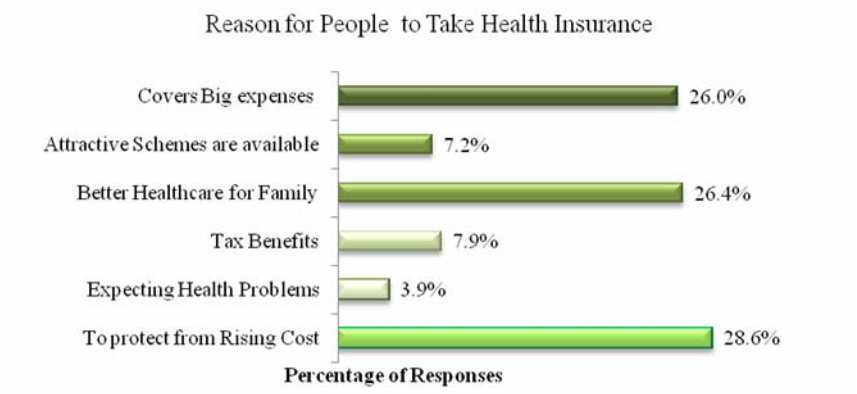


Fig. 5.12 Reason for People Taking Health Insurance

While 28.6% of the respondents cited the reason for opting for health insurance as to protect from rising cost of health care, 26.4% are looking for better health care for the family and another 26% would like to cover unexpected big expenditures through health insurance cover.

5.2.20.2 Reasons for not taking health insurance

The most commonly cited reasons for not taking health insurance policy are that there is no return for the investment (179 out of 617), high premium charged (151), did not feel the need (130), and poor service provided (64). 56 of the respondents (9.08%) mentioned lack of disposable

funds as the reason for not talking health insurance cover. While analyzing the data, it is found that a good number of people who do not have health insurance policy have given the response of poor service provided being a reason for not taking a health insurance policy. This is a matter of concern to the health insurance service provider since the potential consumers may keep away based on negative publicity due to word of mouth communication and often unfound reasons. The possibility of poor service from one provider can create a negative impression for all the operators in the system.

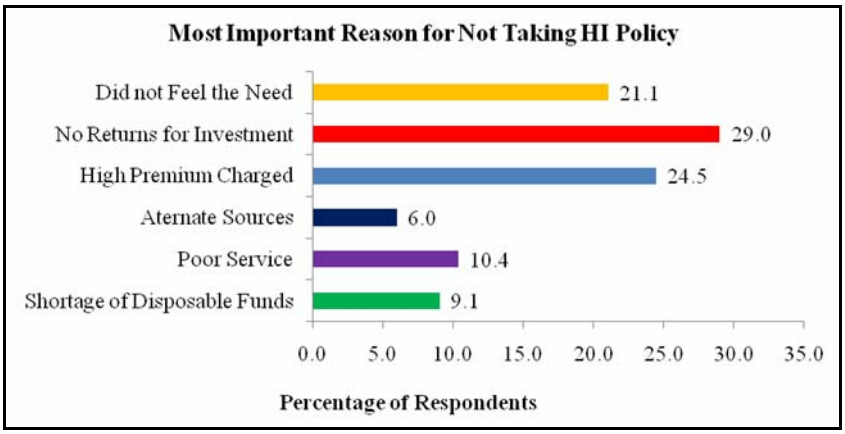


Fig. 5.13 Reason for People Not Taking Health Insurance

5.2.21 Intention to buy or renew health insurance

It is important to learn the purchase intention of the consumers as what matters in the end is converted sales. The responses are tabulated here:

Table 5.11 Consumer's intention to buy or renew health insurance

SNo	Intention to buy or renew	Number of Responses	Percentage of Respondents
1	In the near future	132	21.4
2	After some time	222	36.0
3	Cannot say	202	32.7
4	Not responded	61	9.9
	Total	617	100

5.2.22 Accident or hospitalization * intention to take/renew policy

Table 5.12 Accident or hospitalization * intention to take policy : cross tabulation

			Intention to take policy			
			in the near future	after some times	cannot say	Total
accident or hospitalization	yes	Count	44	56	28	128
		% within accident or hospitalization	34.4%	43.7%	21.9%	100.0%
	no	Count	88	166	174	428
		% within accident or hospitalization	20.6%	38.8%	40.7%	100.0%
Total		Count	132	222	202	556
		% within accident or hospitalization	23.7%	39.9%	36.4%	100.0%

Table 5.13 Chi-Square Test to find out association between intention to buy and hospitalization

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.325(a)	3	.010
Likelihood Ratio	10.879	3	.012
Linear-by-Linear Association	1.609	1	.205
N of Valid Cases	556		

As the marketing professionals are looking for groups that have a higher intention to opt for health insurance policy, and considering that a person who has experienced hospitalization and has paid the expenses, is more likely to opt for health insurance than people who have not; it is hypothesized that there is an association between hospitalization and intention

to take policy. The chi-square test, gives a significance value of 0.01, which is less than the critical value of 0.05, it is to be concluded that there is an association between hospitalization and intention to take policy.

5.3 Findings from the survey of marketing executives

In order to get a picture of perceptions of the service provider, 35 branch managers of various companies marketing health insurance products from private and public sector organizations were interviewed and data collected using a questionnaire. The profile of the executives in terms of organizations they represent and the years of experience in the field are recorded in figures 5.14 and 5.15. Break-up of the sample of 35 executives interviewed consists of a fair distribution of public sector and private sector companies, with experience from 3 to 30 years.

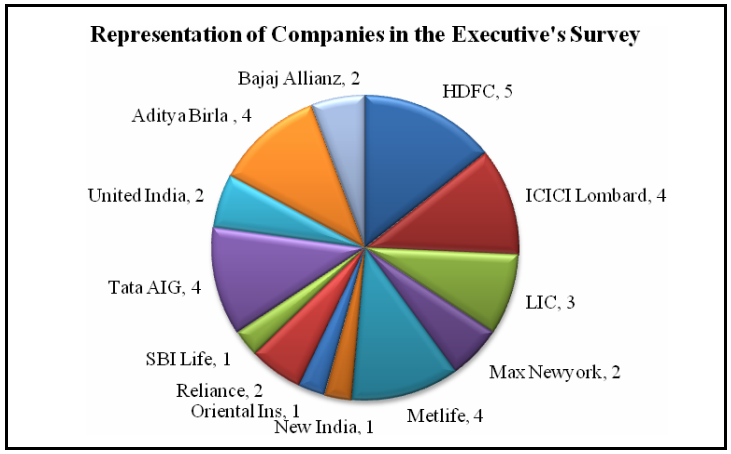


Fig. 5.14 Company Representation in managers' sample (out of 35)

5.3.1 Break up of Marketing Executives interviewed

35 branch managers/branch in-charges of health insurance companies from public and private sector were interviewed on various aspects of health insurance marketing and their feedbacks are incorporated appropriately in the report.

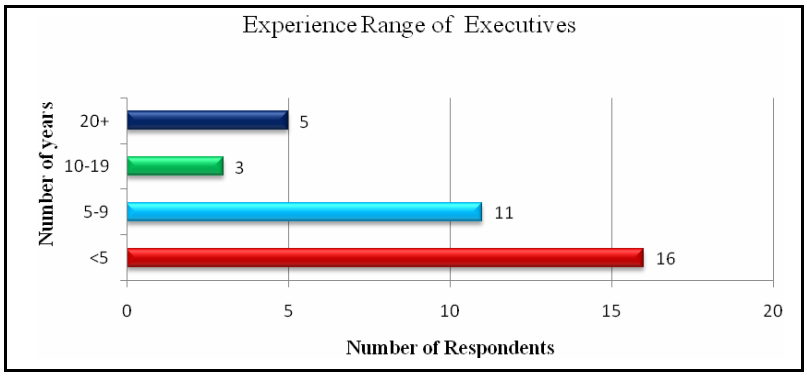


Fig 5.15 Number of Years of Service of Managers Interviewed

5.3.2 Comparison of perceptions of consumers and marketers

The important questions before the marketing professional in the field of health insurance marketing are often: what are the factors that consumers consider important while making the purchase decision of health insurance and why they don't buy? Executives in some cases agree with what customers say, while have different reasons in some other. A general comparison of perception of consumers' reasons for these and company executives' view it is made here.

Most Important Reason for Not Taking Health Insurance Policy - Consumer vs Company Executives' Perception

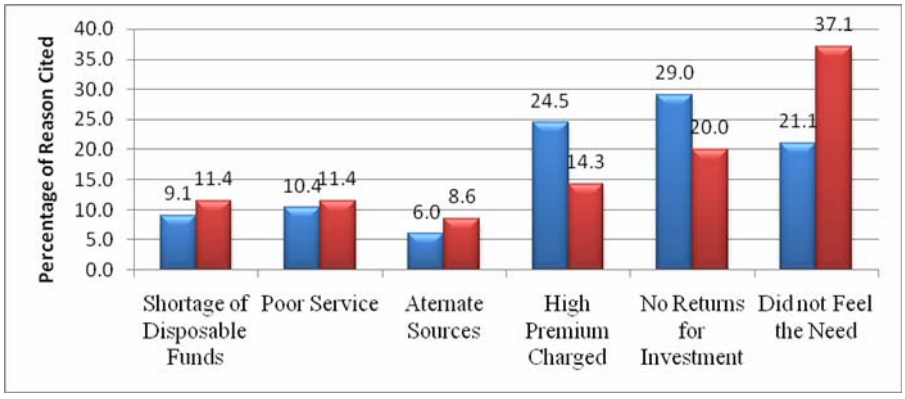


Fig. 5.16 Comparison of Perception of Managers & Consumers on Reasons for Not Taking Health Insurance

While consumers indicate no return for the premium paid as the major reason for not taking a HI policy (29%, 179 respondents), 37% of the company executives felt, the customer not feeling a cover is required, is the biggest hindrance to sale of health insurance. Other reasons cited by consumers are high premiums (24.5%), did not feel the need (21.1%) and poor service (10.4%) while 20% of company executives agree no return for the investment is a reason for customers keeping away from health insurance. Nearly 10% of consumers as well as company officials viewed poor service as a hindrance.

5.4 Findings from the survey of insurance agents

Insurance agents are a group of people who not only make take the health insurance product to the customers, but also create market awareness as well as influence the health insurance purchase decision. In view of this, it is worthwhile to study their views and opinions on determinants of consumer purchase of health insurance. 30 insurance sales professionals with different back grounds in terms of experience, service provider etc were approached to collect information in these lines using a set of questions. The general opinion is that entry of private health insurance companies has contributed to health insurance market and more promotion is required in this area. They also are of the view that taking a health insurance cover is good for ensuring better health for the family.

The details of other findings are recorded below:

5.4 .1. Occupational status of health insurance agents: Majority of the people interviewed included fulltime insurance agents while a fair representation of part time agents was also observed (ref Fig. 5.17).

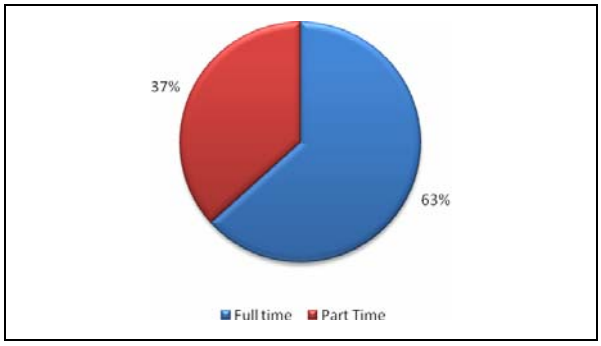


Fig: 5.17 Status of Occupation of Insurance Agent (Total 30)

5.4.2 Type of company being represented by the agent : With the market opening up fir private sector insurance, long standing insurance companies like General Insurance Companies are getting tough competition from private insurance companies. A reflection of this was seen in the sample of agents. Substantial number of insurance agents was seen in private sector as observed in Fig 5.18. The number of part time agents (7 out of 11) was more from private sector companies compared to LIC (6 out of 13) and PSUs (2 out of 6).

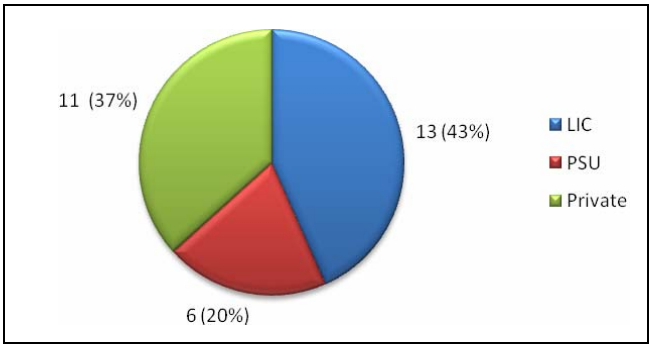


Fig 5.18 Type of company being represented

5.4.3 Frequency of offering health insurance to customers: This question raised mixed response. The general observation was that while life and related insurance policies are getting preference, the agents are offering health related products lesser, as can be seen in Fig. 5.19.

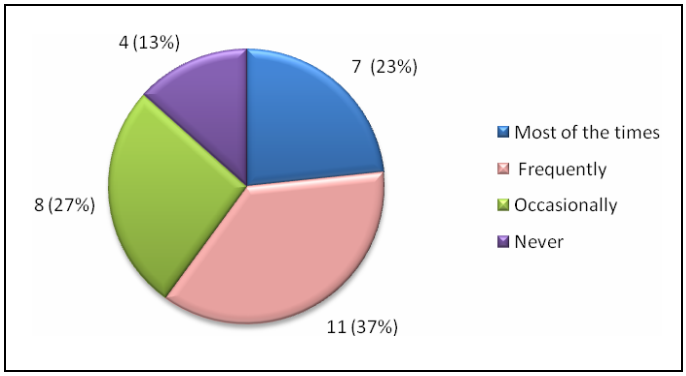


Fig 5.19 Frequency of offering health insurance to customers

5.4.4 Reason for less promotion of health insurance by agents: Mainly three reasons were cited by the agents for their not actively promoting health insurance. They are shown in Fig.5.20. The most important reason shown was that they do not offer much returns to the agents, while less demand for health insurance expressed by the customers is observed to be an important factor.

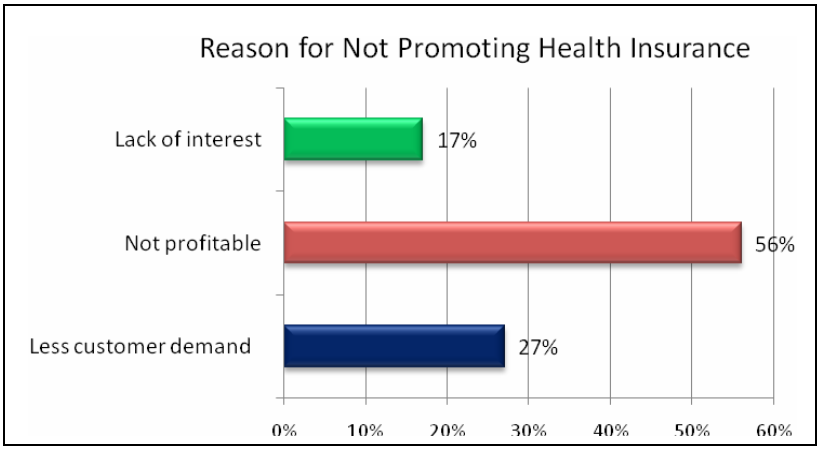


Fig. 5.20: Reasons for less promotion of health insurance by agents

5.4.5 Customer's reason for opting for health insurance: The opinion of insurance agents about customers' reason for taking health insurance policy suggested the reasons shown in Fig.5.21 below, where we observe risk cover as the most often cited reason. 20% of the agents indicated that people expecting health problems, in order to cover a critical eventuality, opt for health insurance cover.

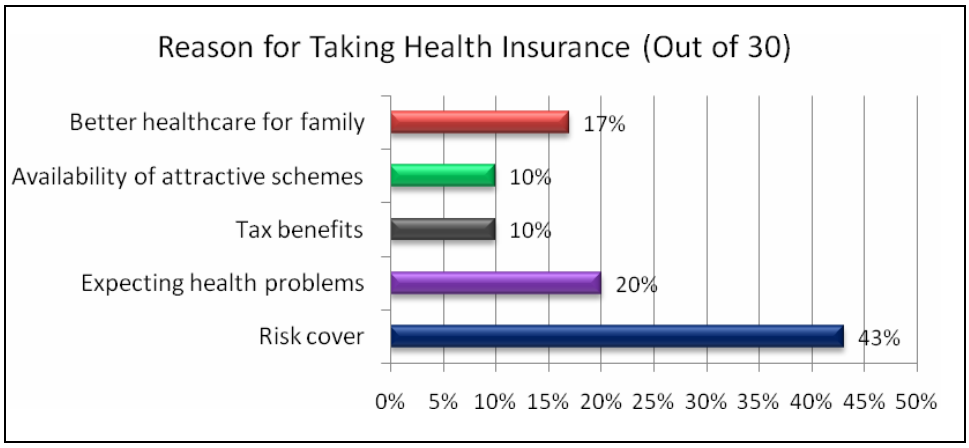


Fig.5.21 Reason for consumers opting for health insurance, as opined by agents

5.4.6 Reason for consumers not opting for health insurance: Some agents (9 out of 30) are of the opinion that the customers have not felt the need for health insurance, may be due to having no major health expenditure. Less than ten percent of the agents opinioned that agents may not be taking adequate efforts to promote health insurance products. Fig.5.22 graphically displays the response of agents.

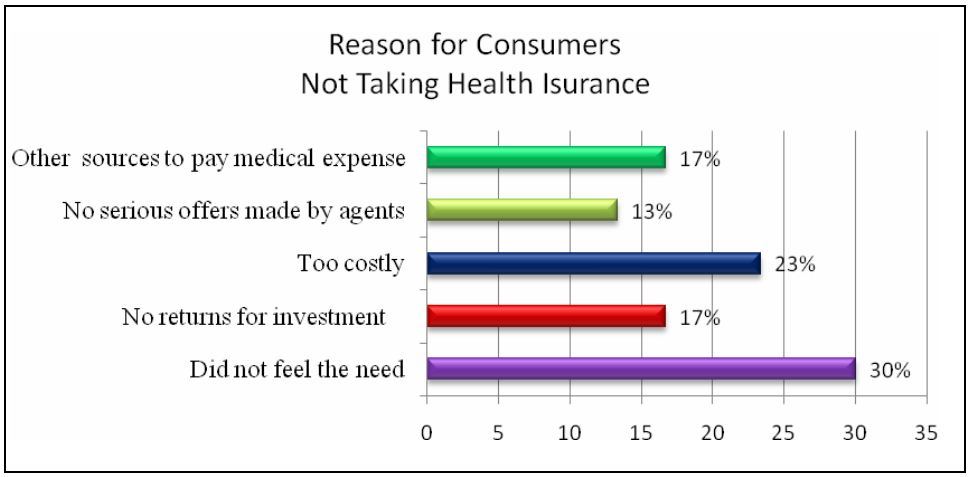


Fig.5.22. Reason for consumers opting for health insurance, as felt by agents

From the responses of the agents, low levels of financial gains on the part of agents; and customers do not feeling the need and the perception of health insurance premium as costly are hindering the growth of health insurance purchases.

5.5 Factors Influencing Selection of a Health Insurance Provider Company

The top-most factor suggested by consumers as well as company executives that consumers consider while selecting a health insurance policy provider is trustworthiness of the company, with a relatively small variation of 2.32%. Ease of claim settlement process has been named as second important reason. Significantly, premium charged is considered important by about 1/6th of the consumers as well as executives. There is reasonable amount of agreement in this aspect.

Table 5.14 Factors affecting selection of a health insurance provider

Most important factor in Selection of a Provider			
Factor	**Consumers %**	**Company Executives %**	**Difference in rating %**
Trustworthiness of Co	20.54	22.86	-2.32
Better Schemes Offered	13.39	11.43	1.96
Existing Insurance with the co	7.02	5.71	1.30
Personal relationship	5.04	3.81	1.23
Easy claim settlement	18.37	18.10	0.27
More coverage of diseases	9.95	10.48	-0.53
Low Premium cost	16.01	16.19	-0.18
Better marketing by agents	1.79	2.86	-1.07
Tax savings	6.38	7.62	-1.24
Advertisements	1.53	0.95	0.58

The significant observation to be made here is that the top five factors that consumers consider important while deciding a health insurance policy are same from consumers' point of view as well as marketers' point of view; being trustworthiness, easy claim settlement, low premium cost, better schemes offered and more coverage of diseases which account for 78.25 % and 79.05 % which is more or less same.

5.6 Analysis of Awareness of Consumers Based on Demographic Factors

One of the basic requirements of purchase decision in health insurance market is the awareness about the various issues related to the product and the provider. The study has identified six factors to contribute to awareness ie., awareness of companies offering health insurance, benefits of health insurance, different schemes offered by companies, diseases covered and exclusions in health insurance schemes, cost of health insurance coverage and awareness

about basic health insurance claim process. With the state of Kerala high in literature, health care and wide reach of communication media, the awareness is expected to be high. However, this need not be uniform and demographic and personal factors can cause variations in the level of consumer awareness. This knowledge is important to the various groups like government, local administration, health department, involved NGOs and health insurance marketing companies.

Considering the importance of awareness on health insurance among the consumers in its purchase decision, a hypothesis formed was to check this variation.

Hypothesis:

H_{01}: There is no significant difference in awareness about health insurance among respondents of various socio-economic groups

H_{A1}: There is significant difference in awareness about health insurance among respondents of various socio-economic groups

The ANOVA Table and that of Independent Sample-T Test for Awareness against various demographic factors – region, age group, income group, education and employment, gender, marital status and locality of residence are given in table 5.15.

Table 5.15 Significance values obtained by ANOVA for awareness across demographic groups

SNo	Component of Awareness	Significance value				
		Across Regions	Across Age Groups	Across Education Groups	Income Groups	Education Groups
1	Aware of providers	.769	.293	.445	.652	.589
2	Aware of Schemes	.286	**.021**	.245	.082	.536
3	Aware of Cost per Lakh cover	.919	**.013**	.700	.421	**.047**
4	Aware of Benefits	.271	**.045**	.355	.427	.059
5	Aware of Diseases Not Covered	.214	**.035**	.317	.541	.362
6	Aware of Claim Process	.201	**.005**	.025	.118	.114

Table 5.16 Significance values obtained by Independent Sample-T Test for awareness between demographic groups

Sl. No	Component of Awareness	Significance value		
		Between Genders	Between Family Status	Across Locality
1	Aware of Companies	**.000**	.206	0.055
2	Aware of Schemes	.089	**.035**	.893
3	Aware of Cost per Lakh cover	**.021**	.315	.119
4	Aware of Benefits	.064	.088	.393
5	Aware of Diseases Not Covered	**.032**	.287	.932
6	Aware of Claim Process	**.018**	.119	.462

Table 5.17 Average values of awareness level of various factors among different education groups.

Factors of Awareness	Educational Groups	N	Mean	Std. Deviation
Aware of Companies	Up to Graduation	91	3.60	1.124
	Degree holder other than Professional	176	3.82	1.015
	PG other than Professional	152	3.73	1.092
	Professional Degree or PG	198	3.69	1.081
	Total	617	**3.72**	1.071
Aware of Schemes	Up to Graduation	91	3.00	1.135
	Degree holder other than Professional	176	3.19	1.089
	PG other than Professional	152	3.14	1.055
	Professional Degree or PG	198	2.98	1.155
	Total	617	**3.08**	1.110
Aware of Cost per Lakh cover	Up to Graduation	91	3.09	1.189
	Degree holder other than Professional	176	3.22	1.116
	PG other than Professional	152	3.19	1.138
	Professional Degree or PG	198	3.10	1.122
	Total	617	**3.15**	1.133
Aware of Benefits	Up to Graduation	91	2.89	1.130
	Degree holder other than Professional	176	3.10	1.114
	PG other than Professional	152	3.09	1.076
	Professional Degree or PG	198	2.96	1.153
	Total	617	**3.02**	1.120
Aware of Diseases Not Covered	Up to Graduation	91	2.70	1.111
	Degree holder other than Professional	176	2.94	1.122
	PG other than Professional	152	2.95	1.249
	Professional Degree or PG	198	2.81	1.184
	Total	617	**2.87**	1.173
Aware of Claim Process	Up to Graduation	91	2.81	1.210
	Degree holder other than Professional	176	3.18	1.105
	PG other than Professional	152	3.18	1.159
	Professional Degree or PG	198	2.95	1.174
	Total	617	**3.05**	1.162

An analysis of the difference in different factors of awareness across demographic groups showed that:

a) There is no significant variation in awareness across regions, income groups and locality.

b) Between age groups, there is significant difference in awareness other than in awareness of companies

c) Across education groups, significant difference is not there in awareness except about claim process

d) Between married and unmarried people there is not much significant difference except in awareness of schemes

e) Between respondents of different genders, significant difference in awareness is reported in awareness of companies, cost of coverage, exclusions of illnesses from coverage and claim process.

From the mean values (Table 5.17) it is found that the awareness of companies happens to be around 3.72 among all education groups, the other factors it stayed around 3.10, which shows that while people's awareness on companies may be reasonably good, the awareness of other areas did not score high.

5.7 Major sources of information about Health insurance

About 72% of the respondents cited news paper advertisements or related news items as an important source of information about health insurance while friends and relatives came in second position. Insurance agents are felt to be an important source of health insurance information, that consumer may look up on. This is important from marketer perspective because, agents can provide company specific and scheme specific

information to the consumer and can create favourable brand opinion than other sources which are more generic.

Table 5.18 Major Sources of Information on Health Insurance for Consumers

SNo	Information Source	Percentage of Respondents
1	News paper Advertisement and related news	72.3
2	Friends & Relatives	57.2
3	Insurance agents	56.7
4	TV Advertisements	54.1
5	Company brochures/ events	10.2
6	Internet	10.2
7	Hospitals	6.48
8	Outdoor ads	6.32

5.8 Conclusion

In this chapter, an attempt is made to understand the average Kerala consumer of a health insurance policy in related factors, as well as what are the basic reasons that prompt or prevent him in health insurance purchase situation. The average consumer has reasonable levels of education and general awareness of health insurance while it has to be noted that this awareness, when taken in to different dimensions of awareness can not be treated as high. This shows there is scope for improving awareness through more effective communication and enhanced activities of selling agents. While selecting a health insurance policy, sample group consumers gave importance to trustworthiness of the provider, of which brand name is an important indicator. Therefore, competing companies need to highlight brand specific communication, to attract consumers to their fold while offering attractive schemes. Ease of claim settlement (perception in case of people who do not already have a policy) and service quality matters to the consumer and are therefore action areas for the marketing professional.

Chapter 6

INFLUENCE OF PERSONAL FACTORS ON HEALTH INSURANCE PURCHASE DECISION

The decision in health insurance purchase include decisions about whether to buy, how much coverage, which service provider, when to buy, whether to renew and so on. These are influenced by a number of factors related to the individual. Part of these is related to demographic factors that include age, education, income, family status, dependent family members, health condition, experience in health related expenditure etc. The other part of factors related to an individual are his level of awareness about health insurance, attitude towards health insurance about its need and benefits, the satisfaction derived from earlier experiences, interactions with friends and relatives or arising from opinion about services based on word of mouth inputs. Consumers' desire for particular preventive health options should influence the degree to which they make active choices in health care (Walsh et al, 2011).

Personal factors can also lead to another purchase decision, to do nothing; that is, when they fail to make an active choice. This passive/no-choice option results perhaps from inadequate knowledge or understanding of the situation, from perceptions that the matter has little personal relevance, or from decision heuristics such as inertia or status quo bias in which consumers might dismiss the decision with a shrug. (Thaler and Sunstein as quoted by Walsh et al, 2011).

Factor analysis was attempted here to identify underlying variables, or factors, that explain the pattern of correlations within a set of observed personal variables which may influence insurance buying. Factor analysis is often used in data reduction to identify a small number of factors that explain

most of the variance that is observed in a much larger number of manifest variables. Factor analysis is primarily used for data reduction or structure detection. The purpose of data reduction is to remove redundant (highly correlated) variables from the data file, perhaps replacing the entire data file with a smaller number of uncorrelated variables.

In this chapter, the consequent effects of personal factors on the insurance buying habits are ascertained using a measurement instrument under Likert framework consisting of 20 statements. Further, statements were reduced to 16 based on the communalities in the extraction. Four statements were excluded from the analysis frame because of the low extraction values (communalities with values more than 0.5 may be taken as important as a thumb rule when the sample size is sufficiently large). It is observed that the communalities after deleting four statements show sufficiently large values suggesting that the statements are equally important for the contemplated problem. The responses, which are in five point scale, are used with factor analysis to reduce dimensions and to identify such dimensions resulting from the exercise. The results and the findings are narrated in the following sections.

Table 6.1 KMO and Bartlet Test results for Personal Factors

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.864
Bartlett's Test of Sphericity	Approx. Chi-Square	11878.300
	df	120
	Sig.	.000

Source : Survey Data

Kaiser-Meyer-Olkin Measure of Sampling Adequacy is a minimum standard which should be passed before a factor analysis (or a principal components analysis) should be conducted. Kaiser-Meyer-Olkin Measure of Sampling Adequacy measure varies between 0 and 1, and values closer

to 1 are better. Here in this case the value is 0.864 which is very high and hence the standard is met.

Bartlett's measure tests the null hypothesis that the original correlation matrix is an identity matrix. For factor analysis to work, some relationship between variables is to exist and if the matrix were an identity matrix, then all correlation coefficients would be zero. If the test is significant, it can be concluded that the matrix is not an identity matrix and therefore can expect some relationship between variables and can include these for a factor analysis. Bartlett's Test was significant with chi square = 11878.300, df = 120, $p < 0.05$ and hence it can be concluded that correlation matrix is not an identity matrix.

Table 6.2 Factor analysis results of Personal Factors

Total Variance Explained									
Component	Initial Eigen values			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.850	36.561	36.561	5.850	36.561	36.561	3.927	24.543	24.543
2	2.967	18.547	55.107	2.967	18.547	55.107	3.674	22.961	47.504
3	1.854	11.586	66.694	1.854	11.586	66.694	2.917	18.230	65.734
4	1.124	7.023	73.717	1.124	7.023	73.717	1.182	7.385	73.119
5	1.055	6.595	80.312	1.055	6.595	80.312	1.151	7.193	80.312
6	.709	4.433	84.745						
7	.685	4.279	89.024						
8	.509	3.183	92.207						
9	.419	2.621	94.827						
10	.363	2.268	97.095						
11	.318	1.989	99.085						
12	.047	.291	99.376						
13	.042	.265	99.641						
14	.035	.216	99.856						
15	.016	.100	99.956						
16	.007	.044	100.000						

Extraction Method: Principal Component Analysis.

It is seen that 80.31 % variation in the responses on 16 variables can be reduced to 5 different factors using the standard procedure to consider those factors having Eigen values greater than 1.

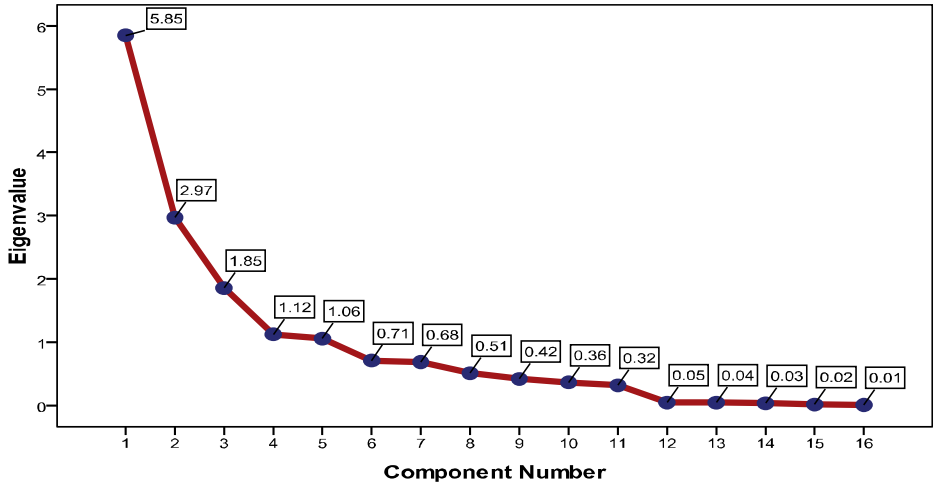


Fig. 6.1 Scree Plot of Eigen Values of variables in Personal factor

(Ref Table 6.2)

The Scree plot graphs the Eigen value against the factor number. It can be seen that the line is almost flat after the fifth factor which means that, each successive factor is accounting for smaller and smaller amounts of the total variance. Thus five factors are considered and the factor loadings after rotation are reported in table 6.3.

Table 6.3 Factor analysis results of Personal Factor, Rotated Component Matrix

	Component				
	1	**2**	**3**	**4**	**5**
Aware of companies	.070	.682	.123	-.204	.069
Aware of benefits	.132	**.769**	.112	.096	.007
Aware of schemes	.119	**.788**	.044	.000	.083
Aware of diseases not covered	.066	**.798**	.062	-.014	-.024
Aware of cost per lakh of coverage	-.009	**.744**	.152	.169	.140
Aware of claim process	.053	**.798**	.098	.113	-.072
HI reduces risk of major medical expenditure	**.961**	.098	.169	.039	.044
It is good to have HI	**.967**	.100	.192	.051	.028
Good to take HI when young	**.959**	.123	.186	.048	.037
HI gives tax benefits	.068	.022	.097	-.137	**.886**
HI provides sense of security	.235	.175	**.946**	.044	.074
Process of taking claim is easy	.234	.170	**.948**	.038	.077
Response to queries is good	.029	.212	.136	.574	.531
HI policy is a worth investment	**.963**	.082	.190	.055	.018
Satisfied with services	.115	.001	.032	**.852**	-.167
Satisfaction with services influences decision to take policy	.224	.150	**.945**	.044	.061

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 5 iterations.

In table 6.3, the variables having high loadings are indicated. These variables are collected and organized based on their loadings.

Based on the common thread seen among the statements in each group, appropriate names were suggested after discussion with experts. Thus the information contained in the responses may imply the information contained in factors named as:

F1 - Risk Cover
F2 - Awareness
F3 - Sense of Security
F4 - Satisfaction
F5 - Monetary

Table 6.4 Basic statistical details of the variables in personal factor

Statistics					
	Risk Cover	**Awareness**	**Sense of Security**	**Satisfaction**	**Monetary**
Mean	9.9083	17.0146	11.1986	3.4973	3.4856
Std. Deviation	2.39793	3.79398	1.72309	.93374	.85062
Minimum	5.00	5.00	8.00	2.00	2.00
Maximum	15.00	25.00	15.00	5.00	5.00

Five factors were thus generated by following the procedures explained in the initial paragraph of this chapter. Table 6.4 gives the basic statistics of all the five factors.

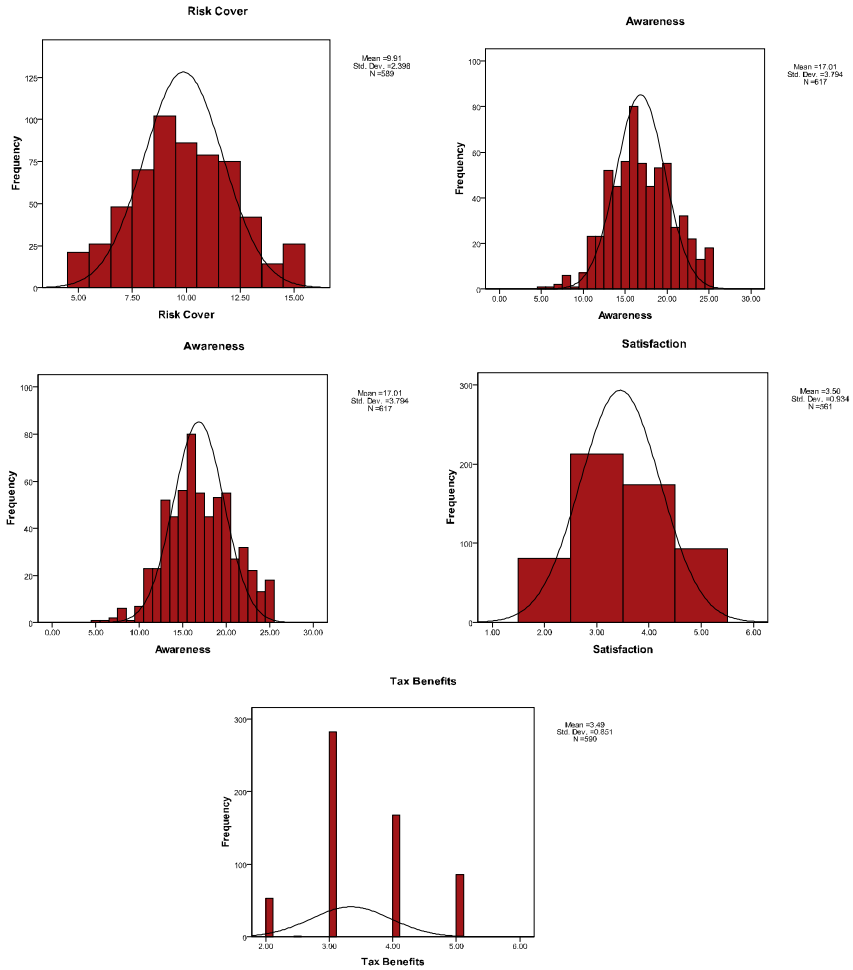


Fig. 6.2 Histogram of Personal factor data

Figure 6.2 displays the normality of all the five factors. From the histogram – normal curve, it can be understood that, the data is almost normal. There is a concentration of values to the centre.

A box plot indicates which observations, if any, might be considered as outliers. It is often used in exploratory data analysis. It is a type of graph which is used to show the shape of the distribution, its central value, and variability. The picture produced consists of the most extreme values in the data set (maximum and minimum values), the lower and upper quartiles, and the median.

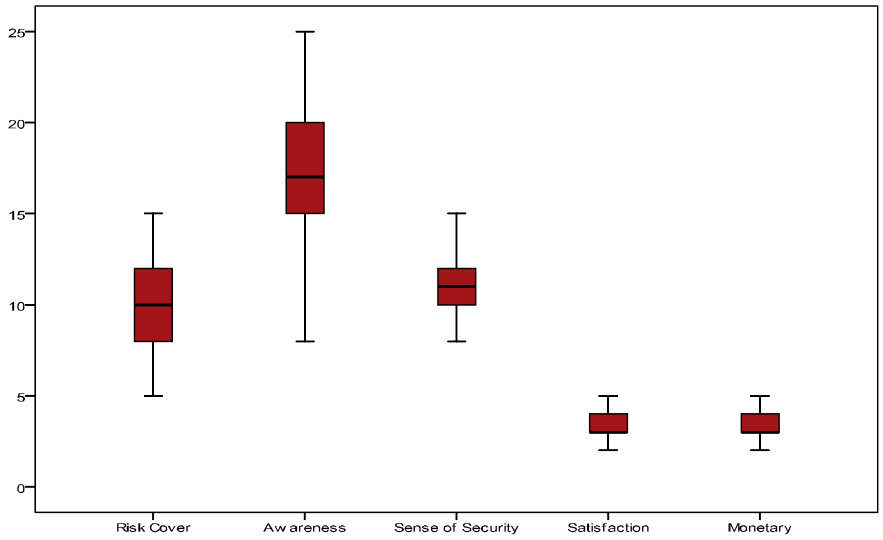


Fig. 6.3 Box Plot of Personal factor data

Here, the box plot diagram shows that, there are no outliers in the data and hence there are no extreme values to influence the mean. Since the evidence of normality is found, parametric methods of data analysis can be applied.

Discriminating an insurance buyer from a non buyer

This part of the analysis is directed towards finding out the ability of the personal factors in discriminating an insurance buyer and a non buyer.

Discriminant analysis is used to model the value of a dependent categorical variable based on its relationship to one or more predictors. Discriminant analysis builds a predictive model for group membership. The model is composed of a discriminant function (or, for more than two groups, a set of discriminant functions) based on linear combinations of the predictor variables. Predictor variables are variables that provide the best discrimination between the groups.

The group statistics of the five personal factors which are taken to find out the discriminating ability are furnished in table 6.5. If the means of all the five variables are considered along with the grouping variable, it is observed that, the means for people with insurance policy is high when compared to people without an insurance policy.

Table 6.5 Group statistics details of the variables in personal factor

Group Statistics			
Do you have a health insurance policy ?		**Mean**	**Std. Deviation**
yes	Risk Cover	10.6091	2.22337
	Awareness	18.1320	3.43048
	Sense of Security	11.3249	1.60866
	Satisfaction	3.7259	.94545
	Monetary	3.5381	.82982
no	Risk Cover	9.5213	2.24642
	Awareness	16.9016	3.41005
	Sense of Security	11.0295	1.62093
	Satisfaction	3.3836	.86625
	Monetary	3.5261	.85232
Total	Risk Cover	9.9482	2.29755
	Awareness	17.3845	3.46721
	Sense of Security	11.1454	1.62096
	Satisfaction	3.5179	.91269
	Monetary	3.5308	.84275

Table 6.6 Tests of Equality of Group Means of variables of personal factor

Tests of Equality of Group Means					
	Wilks' Lambda	**F**	**df1**	**df2**	**Sig.**
Risk Cover	.946	28.294	1	500	.000
Awareness	.970	15.508	1	500	.000
Sense of Security	.992	3.998	1	500	.046
Satisfaction	.966	17.384	1	500	.000
Monetary	1.000	.024	1	500	.877

Table 6.6 gives the results of an attempt made to check the significance of the difference in the means across two classifying groups.

From Tests of Equality of Group Means table, it was found that the means significantly differs ($p < 0.05$) among the two categories for all the factors except for monetary factors. This shows that, there is no difference among mean monetary score among people with an insurance policy and people without an insurance policy. It can be generally concluded that monetary factor does not have much of a discriminating ability. Even though it was seen, this has to be proved by attempting further tests.

Table 6.7 Eigen Values of Personal Factors

Eigen values				
Function	**Eigenvalue**	**% of Variance**	**Cumulative %**	**Canonical Correlation**
1	.094[a]	100.0	100.0	.293

a. First canonical discriminate function was used in the analysis.

The Eigen value (0.094) indicates the proportion of variance explained. In this model only one canonical function is taken and thus the percentage of variance is 100%. The canonical correlation (0.294) is the correlation between the discriminant scores and the levels of the dependent

variable which was found to be positively correlated. The square of the canonical correlation is 0.085 and hence 9% of the variance in the discriminating model is due to changes in the five personal factors. Addressing only 9% of the variance may be small in a collective sense, but if an effort is made to explain the impact of personal factors on insurance product buying, that argument is nullified. Other major discriminating factors are explained in the chapters to follow. The significance of the discriminant function is tested by framing the following hypothesis:

Hypothesis

H_{02}: The variables that constitute personal factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A2}: The variables that constitute personal factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Table 6.8 Wilk Lambda Results

Wilks' Lambda				
Test of Function(s)	**Wilks' Lambda**	**Chi-square**	**df**	**Sig.**
1	.914	44.649	5	.000

The statistical test of significance for Wilks Lambda was carried out with a chi square transformed statistic which in this case is 44.64 with 5 degrees of freedom and was found to be significant ($p < 0.05$). Hence the hypothesis is rejected and the discriminant function can be further used for explanations.

Table 6.9 Standardized Canonical Discriminant Function

Standardized Canonical Discriminant Function Coefficients	
	Function
	1
Risk Cover	.698
Awareness	.182
Sense of Security	-.043
Satisfaction	.616
Monetary	-.373

Each of the Standardized Canonical Discriminant Function Coefficients in absolute values reflects the relative contribution of each of the predictor variable on the discriminant function. Here it was found that risk cover (0.698) is exerting more influence in discriminating between an insurance buyer to a non buyer. It is followed by satisfaction and monetary factors and the least effect is for sense of security.

Table 6.10 Canonical Discriminant Function Coefficients

Canonical Discriminant Function Coefficients	
	Function
	1
Risk Cover	.312
Awareness	.053
Sense of Security	-.026
Satisfaction	.686
Monetary	-.442
(Constant)	-4.583
Unstandardized coefficients	

The 'Canonical Discriminant Function Coefficients' indicate the unstandardized scores concerning the independent variables. It is the list of coefficients of the unstandardized discriminant equation.

Here,

Insurance Buying = -4.583 + (0.312 RC) + (0.053 A) + (-0.026 SS) + (0.686 S) + (-0.442 M)

The coefficients with large absolute values correspond to variables with greater discriminating ability.

Table 6.11 Functions at Group Centroids

Functions at Group Centroids	
Do you have a health insurance policy	Function
	1
yes	.389
no	-.246
Unstandardized canonical discriminant functions evaluated at group means	

A further way of interpreting discriminant analysis results is to describe each group in terms of its profile, using the group means of the predictor variables. These group means are called centroids. 'Functions at Group Centroid' indicates the average discriminant score in the two groups. Cases with scores near to a centroid are predicted as belonging to that group.

Table 6.11 is used to establish the cutting point for classifying cases. More specifically, the discriminant score for each group of the variable means (rather than individual values for each subject) are entered into the discriminant equation.

If the scores of the first function for each case is calculated, and then looked at the means of the scores by group, it will be found that people who had not bought an insurance policy produce a mean of -0.246, while people

who had bought an insurance policy produce a mean of 0.389. These findings are shown diagrammatically in fig 6.4.

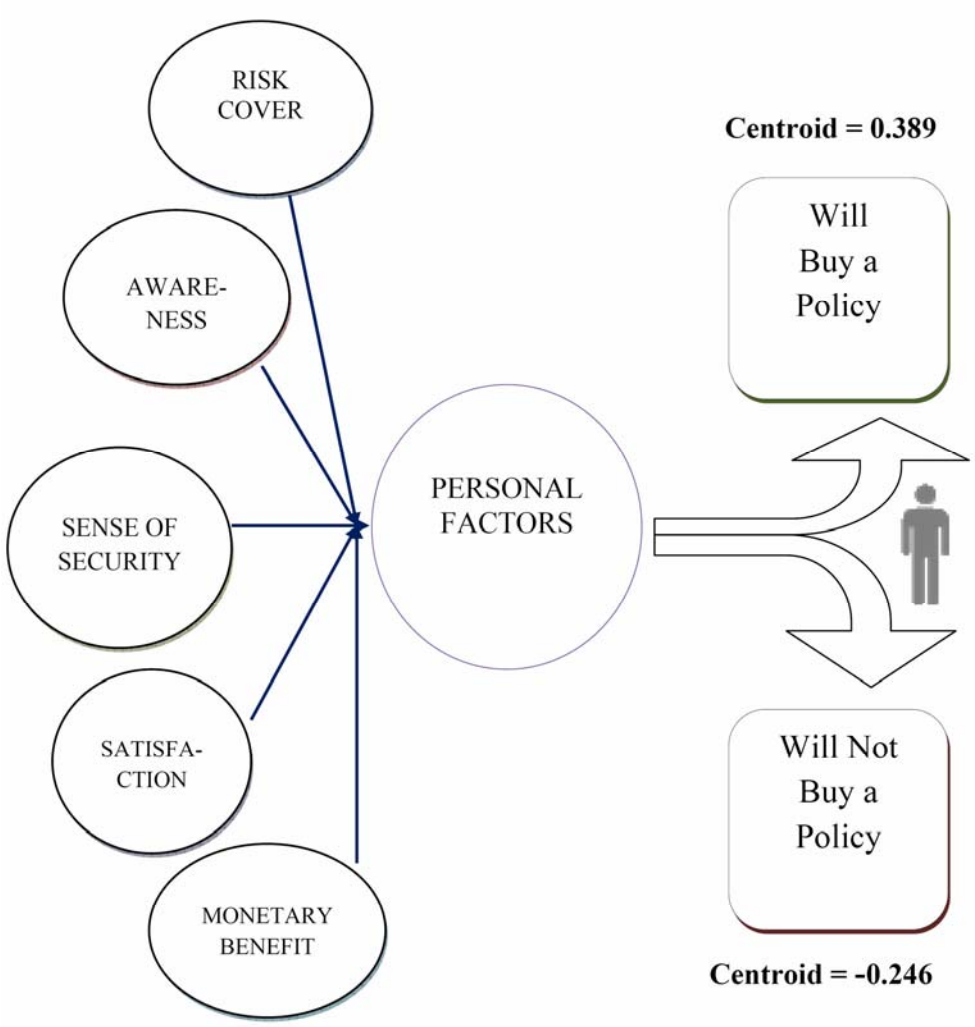


Fig. 6.4 Discriminating ability of Personal Factors

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Chapter 7

INFLUENCE OF MARKETING FACTORS ON HEALTH INSURANCE PURCHASE DECISION

In this study, the consequent effects of marketing factors on the insurance buying habits were ascertained using a measurement instrument under Likert framework consisting of 18 statements. Further, statements were reduced to 11 based on the communalities in the extraction. Seven statements were excluded from the analysis frame because of the low extraction values (Communalities with values more than 0.5 may be taken as important as a thumb rule when the sample size is sufficiently large).

It is observed that the communalities after deleting seven statements show sufficiently large values suggesting that the statements are equally important for the contemplated problem. The responses, which are in five point scale, are used with factor analysis to reduce dimensions and to identify such dimensions resulting from the exercise. The test results and the findings are narrated in the following sections.

Table 7.1 KMO and Bartlet Test results for Marketing Factors

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.694
Bartlett's Test of Sphericity	Approx. Chi-Square	10138.504
	Df	55
	Sig.	.000

Kaiser-Meyer-Olkin Measure of Sampling Adequacy is a minimum standard which should be passed before a factor analysis (or a principal components analysis) should be conducted. Kaiser-Meyer-Olkin Measure

of Sampling Adequacy measure varies between 0 and 1, and values closer to 1 are better. Here in this case the value is 0.694 which is high and hence the standard is met.

Bartlett's Test of Sphericity generally tests the null hypothesis that the correlation matrix is an identity matrix. If the test is significant, it can be concluded that the matrix is not an identity matrix and therefore can expect some relationship between variables and can include these for a factor analysis. In this case the test was significant with chi square = 10138.5, df = 55, $p < 0.05$ and hence hence it can be concluded that correlation matrix is not an identity matrix.

Table 7.2 Factor analysis results of Marketing Factors

Total Variance Explained									
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.803	34.576	34.576	3.803	34.576	34.576	3.773	34.299	34.299
2	2.840	25.814	60.389	2.840	25.814	60.389	2.044	18.582	52.880
3	1.900	17.270	77.659	1.900	17.270	77.659	2.004	18.222	71.103
4	1.279	11.624	89.283	1.279	11.624	89.283	2.000	18.180	89.283
5	.882	8.014	97.297						
6	.143	1.298	98.595						
7	.056	.511	99.106						
8	.029	.264	99.370						
9	.029	.260	99.630						
10	.023	.206	99.836						
11	.018	.164	100.000						

Extraction Method: Principal Component Analysis.

It is seen that 89.28 % variation in the responses on 11 variables can be reduced to four different factors using the standard procedure to consider those factors having Eigen values greater than 1.

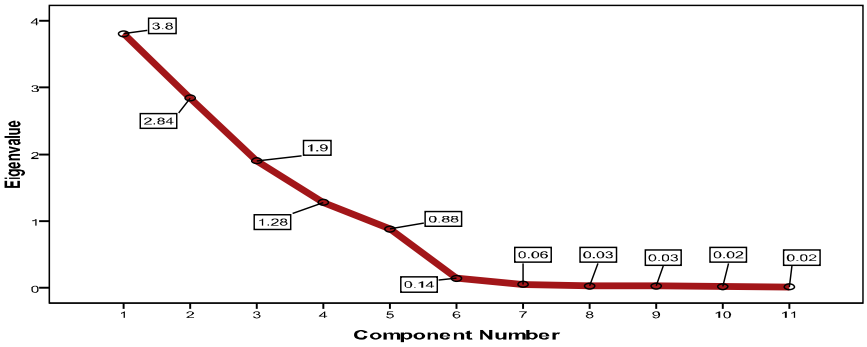

Fig. 7.1 Scree Plot of Eigen Values of variables in Marketing factors

The Scree plot graphs the Eigen value against the factor number. Thus four factors are considered and the factor loadings after rotation are reported in table 7.3.

Table 7.3 Factor analysis results of Marketing Factor, Rotated Component Matrix

Rotated Component Matrix				
	Component			
	1	2	3	4
Attractive schemes are available	.041	**.961**	.160	-.055
There are suitable covers for all categories of customers	.020	**.962**	.145	-.035
Domicile treatment health insurance covers are useful	**.986**	.051	-.005	.011
Critical illness covers are useful	**.969**	.058	-.001	.013
Company personnel are available for queries	**.946**	-.005	-.047	-.008
It is easy to obtain a HI policy	**.981**	.046	.014	.010
Promotional offers influence my decision	.006	.036	.183	**.966**
Advance information is given for renewal	.052	.411	-.095	.267
Advertisements have influence on my decision to take HI	-.006	.031	.183	**.968**
Brand name is an important factor for selecting HI provider	-.010	.091	**.967**	.175
Brand gives an assurance about quality of service	-.018	.095	**.972**	.153

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. (Rotation converged in 5 iterations.)

In the above table, the variables having high loadings are indicated. These variables are collected and organized based on their loadings.

Based on the common thread seen among the statements in each group, appropriate names were suggested after discussion with experts. Thus the information contained in the responses may imply the information contained in factors named as:

F1- Benefits

F2 – Schemes

F3 – Brand

F4 – Promotion

Table 7.4 Basic statistical details of the variables in Marketing factor

Statistics				
	Benefits	**Schemes**	**Brand**	**Promotion**
Mean	9.19	5.15	5.89	5.31
Std. Deviation	2.02	1.67	1.72	1.94
Minimum	4.00	2.00	2.00	2.00
Maximum	20.00	10.00	10.00	10.00

Four factors were thus generated by following the procedures explained in the initial paragraph of this chapter. Table 7.4 gives the basic statistics of all the four factors.

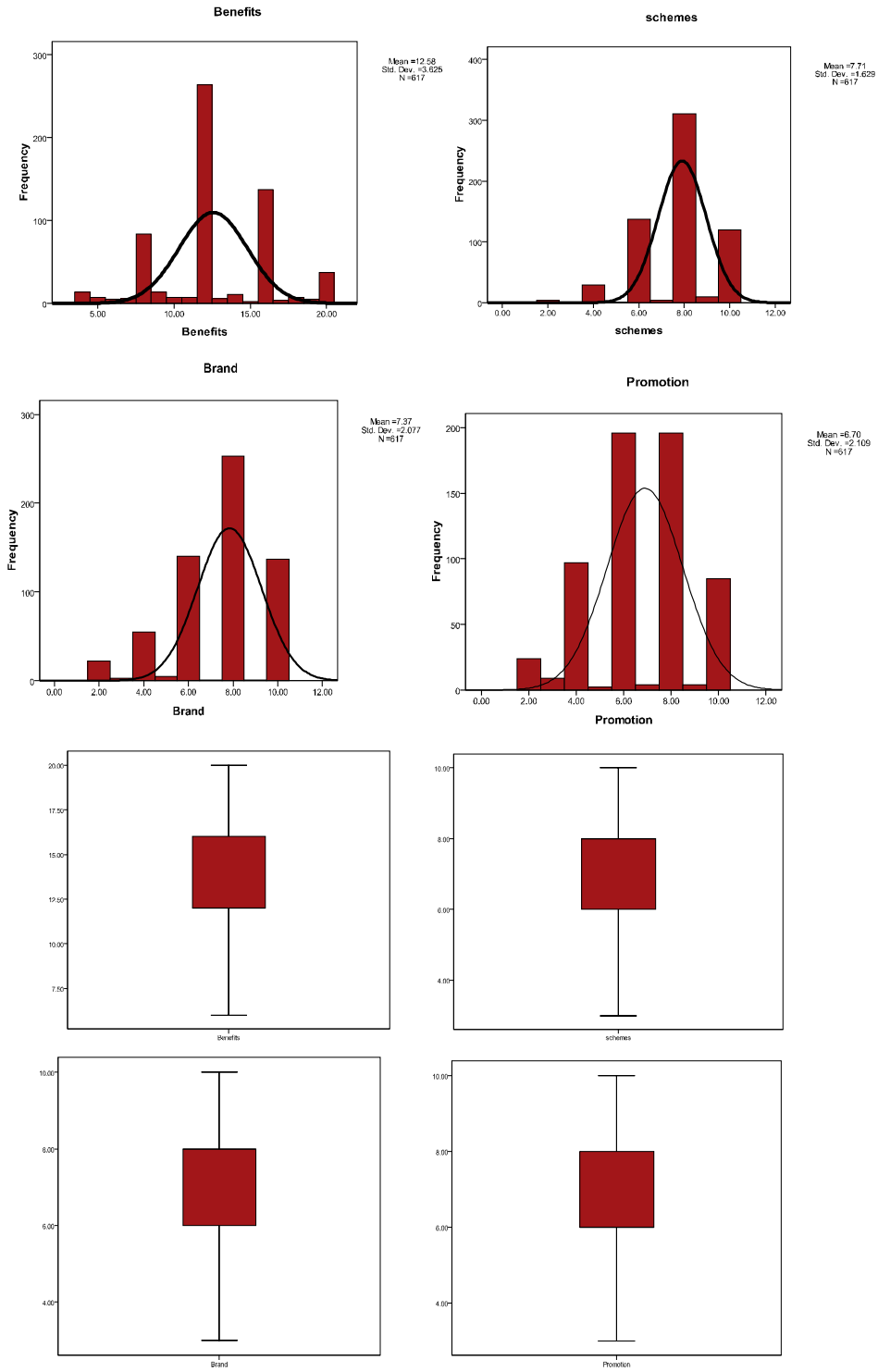

Fig. 7.2 Histogram and Box Plot of Marketing Factors data

Figure 7.2 displays the normality of all the four factors. From the histogram – normal curve, it can be understood that, the data is almost normal. There is a concentration of values to the centre. A box plot indicates which observations, if any, might be considered as outliers. It is often used in exploratory data analysis. It is a type of graph which is used to show the shape of the distribution, its central value, and variability. The picture produced consists of the most extreme values in the data set (maximum and minimum values), the lower and upper quartiles, and the median. Here, the box plot diagram shows that, there are no outliers in the data and hence there are no extreme values to influence the mean. Since the evidence of normality is found, there is freedom to apply parametric methods of data analysis.

Discriminating a Health Insurance Buyer from a Non-Buyer

This part of the analysis is directed towards finding out the ability of the marketing factors in discriminating an insurance buyer from a non buyer. The group statistics of the four marketing factors which are taken to find out the discriminating ability are furnished in table 7.5. If the means of all the variables are considered along with the grouping variable, it is observed that, the means for people with an insurance policy is high when compared to people without an insurance policy.

Table 7.5 Group statistics details of the variables in Marketing factor

Group Statistics					
Do you have a health insurance policy		**Mean**	**Std. Deviation**	**Valid N (listwise)**	
				Unweighted	**Weighted**
yes	Benefits	10.0570	.95322	228	228.000
	Schemes	5.8553	.98942	228	228.000
	Brand	6.4342	1.66859	228	228.000
	Promotion	5.8684	1.72575	228	228.000
no	Benefits	8.6941	2.29443	389	389.000
	Schemes	4.7378	1.85510	389	389.000
	Brand	5.5810	1.67355	389	389.000
	Promotion	5.0797	2.00677	389	389.000
Total	Benefits	9.1977	2.02094	617	617.000
	Schemes	5.1507	1.67922	617	617.000
	Brand	5.8963	1.72047	617	617.000
	Promotion	5.3712	1.94402	617	617.000

An attempt was made to check the significance of the difference in the means across two classifying groups.

Table 7.6 Tests of Equality of Group Means of variables of Marketing factor

Tests of Equality of Group Means					
	Wilks' Lambda	**F**	**df1**	**df2**	**Sig.**
Benefits	.894	73.023	1	615	.000
Schemes	.897	70.881	1	615	.000
Brand	.943	37.446	1	615	.000
Promotion	.962	24.567	1	615	.000

From Tests of Equality of Group Means table 7.6, it was found that the means significantly differs ($p < 0.05$) among all the categories for all the factors. This shows that, there is significant difference among mean among people with an insurance policy and people without an insurance policy.

Table 7.7 Eigen Values of Marketing Factors

Eigenvalues				
Function	Eigenvalue	% of Variance	Cumulative %	Canonical Correlation
1	.400[a]	100.0	100.0	.534

a. First canonical discriminant function was used in the analysis.

The Eigen value (0.400) indicates the proportion of variance explained. In this model only one canonical function is taken and thus the percentage of variance is 100%. The square of the canonical correlation is 0.285 and hence 29 % of the variance in the discriminating model is due to changes in the four marketing factors. Addressing 29% of the variance by marketing factors alone is very important and this shows the predominance of marketing factors in influencing a buyer. Other major discriminating factors are explained in the other related chapters. The significance of the discriminant function is tested by the following hypothesis:

Hypothesis

H_{03}: The variables that constitute marketing factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A3}: The variables that constitute marketing factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Table 7.8 Wilk's Lambda Test Results

Wilks' Lambda				
Test of Function(s)	Wilks' Lambda	Chi-square	df	Sig.
1	.714	206.154	4	.000

The statistical test of significance for Wilks Lambda was carried out with a chi square transformed statistic which in this case is 206.15 with 4 degrees of freedom and was found to be significant ($p < 0.05$). Hence the discriminant function can be further used for explanations.

Table 7.9 Standardized Canonical Discriminant Function

Standardized Canonical Discriminant Function Coefficients	
	Function
	1
Benefits	.819
Schemes	.651
Brand	.519
Promotion	.004

Each Standardized Canonical Discriminant Function Coefficients in absolute values reflects the relative contribution of each of the predictor variable on the discriminant function. Here it was found that Benefits (0.819) is exerting more influence in discriminating between an insurance buyer and a non buyer. It is followed by schemes and brand.

Table 7.10 Canonical Discriminant Function Coefficients

Canonical Discriminant Function Coefficients	
	Function
	1
Benefits	.428
Schemes	.409
Brand	.311
Promotion	.002
(Constant)	-7.890
Unstandardized coefficients	

The 'Canonical Discriminant Function Coefficients' indicate the unstandardized scores concerning the independent variables. It is the list of coefficients of the unstandardized discriminant equation.

Here,

Insurance Buying = -7.89 + (0.428 B) + (0.409 S) + (0.311 BR) + (0.002 P)

The coefficients with large absolute values correspond to variables with greater discriminating ability.

Table 7.11 Functions at Group Centroids

Functions at Group Centroids	
Do you have a health insurance policy	Function
	1
yes	.825
no	-.483

Unstandardized canonical discriminant functions evaluated at group means

A further way of interpreting discriminant analysis results is to describe each group in terms of its profile, using the group means of the predictor variables. These group means are called centroids. 'Functions at Group Centroid' indicates the average discriminant score in the two groups. Cases with scores near to a Centroid are predicted as belonging to that group.

The table 7.11 is used to establish the cutting point for classifying cases. The discriminant score for each group of the variable means (rather than individual values for each subject) are entered into the discriminant equation. When the scores of the first function for each case are calculated, and then looked at the means of the scores by group, it has been found that

people who had not bought an insurance policy produce a mean of -0.483, while people who had bought an insurance policy produce a mean of 0.825.

These findings are shown schematically in fig 7.3.

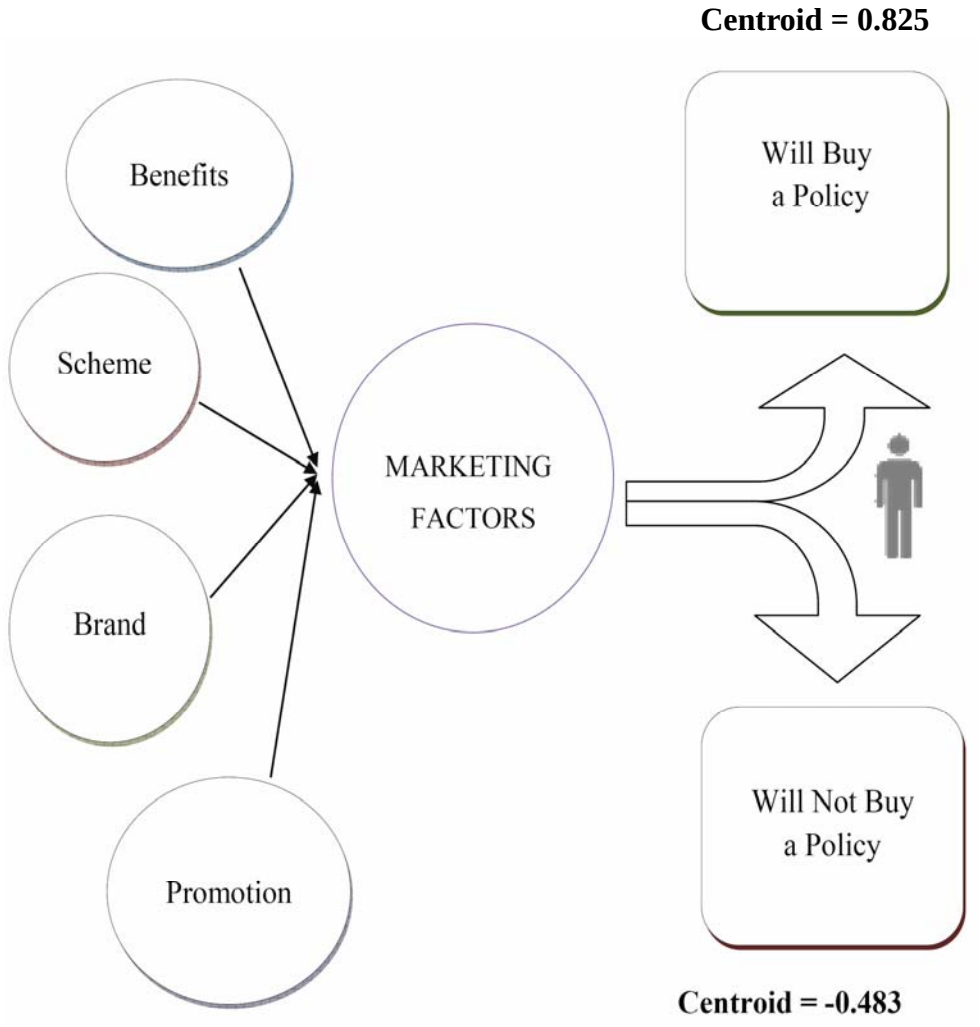

Fig. 7.3 Discriminating Ability of Marketing Factors

Chapter 8

INFLUENCE OF SOCIAL FACTORS ON HEALTH INSURANCE PURCHASE DECISION

In this chapter, the consequent effects of social factors on the insurance buying habits are ascertained using a measurement instrument under Likert framework consisting of 15 statements. Further, statements were reduced to 13 based on the communalities in the extraction. Two statements were excluded from the analysis frame because of the low extraction values (communalities with values more than 0.5 may be taken as important as a thumb rule when the sample size is sufficiently large). It is observed that the communalities after deleting two statements show sufficiently large values suggesting that the statements are equally important for the contemplated problem.

The responses, which are in five point scale, are used with factor analysis to reduce dimensions and to identify such dimensions resulting from the exercise. The test results and the findings are narrated in the following sections.

Table 8.1 KMO and Bartlet Test results for Social Factor

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.884
Bartlett's Test of Sphericity	Approx. Chi-Square	14602.592
	Df	78
	Sig.	.000

Kaiser-Meyer-Olkin Measure of Sampling Adequacy: This test is a minimum standard which should be passed before a factor analysis (or a

principal components analysis) should be conducted. Here in this case the Sampling Adequacy value is 0.884 which is high and hence the standard is met. Bartlett's Test of Sphericity generally tests the null hypothesis that the correlation matrix is an identity matrix. In this case the test was significant with chi square = 14602.5, df = 78, $p < 0.05$ and hence it can be concluded that correlation matrix is not an identity matrix.

Table 8.2 Factor Analysis results of Social Factors

Total Variance Explained									
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.720	59.381	59.381	7.720	59.381	59.381	6.361	48.932	48.932
2	2.073	15.946	75.327	2.073	15.946	75.327	2.948	22.681	71.613
3	1.504	11.569	86.896	1.504	11.569	86.896	1.987	15.283	86.896
4	.991	7.625	94.522						
5	.335	2.580	97.102						
6	.089	.684	97.786						
7	.080	.615	98.401						
8	.063	.484	98.884						
9	.043	.331	99.215						
10	.037	.283	99.498						
11	.030	.233	99.732						
12	.025	.195	99.927						
13	.010	.073	100.000						

Extraction Method: Principal Component Analysis.

It is seen that 86.89 % variation in the responses on 13 variables can be reduced to three different factors using the standard procedure to consider those factors having Eigen values greater than 1.

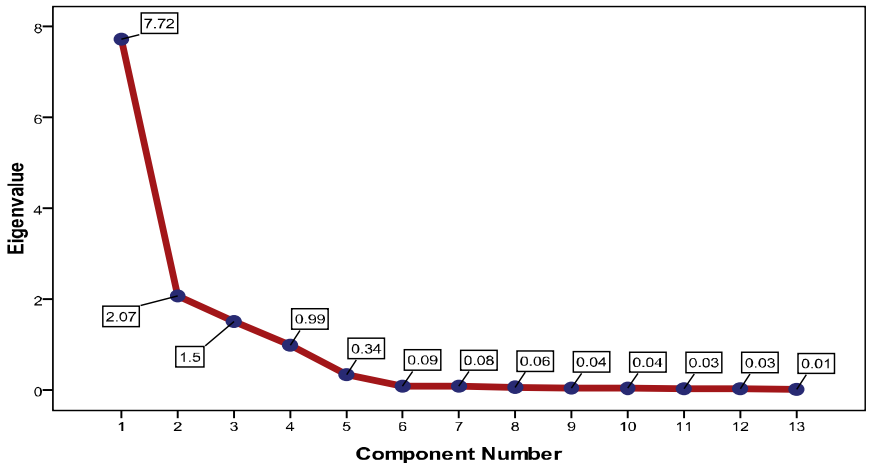

Fig. 8.1 Scree Plot of Eigen Values of variables in Social factor

The Scree plot graphs the Eigen value against the factor number. Thus three factors were generated and the factor loadings after rotation are reported in table 8.3.

Table 8.3 Factor analysis results of Social Factor, Rotated Component Matrix

Rotated Component Matrix[a]			
	Component		
	1	2	3
Hi coverage can improve preventive health care	.223	.126	**.952**
Government schemes for other sections motivate me to buy health insurance	-.005	.025	**.750**
Rising social awareness has positive influence on hi purchase	.284	.086	**.940**
Availability of preventive check-up schemes improve health care	.257	.124	**.943**
HI companies have come up with attractive schemes	.194	.220	**.908**
Work related stress is causing increased health problems	**.897**	.208	.188
Modern food habits cause more health problems	**.953**	.177	.123
Sedate life style is causing more health problems	**.915**	.212	.170
There is increase in occurrence of lifestyle diseases	**.933**	.252	.114
Number of costly medical tests advised is increasing	.165	**.957**	.102
Cost of health care is increasing rapidly	.166	**.955**	.090
More privatization will cause increase in healthcare costs	.181	**.922**	.076
I find it difficult to meet expenses	.227	**.945**	.145

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
Rotation converged in 5 iterations.

In the above table 8.3, the variables having high loadings are indicated. These variables are collected and organized based on their loadings.

Based on the common thread seen among the statements in each group, appropriate names were suggested after discussion with experts. Thus the information contained in the responses may imply the information contained in factors named as:

F1 – Life Style Issues

F2 – Concern Over Increasing Healthcare Cost

F3 – Social Awareness

Table 8.4 Basic statistical details of the variables in Social factor

Statistics			
	Life Style Issues	**Concern Over Increasing Healthcare Cost**	**Social Awareness**
Mean	27.6418	10.7715	7.3938
Std. Deviation	4.80156	2.81023	1.72515
Range	18.00	12.00	8.00

Three factors were thus generated by following the procedures explained in the initial paragraph of this chapter.

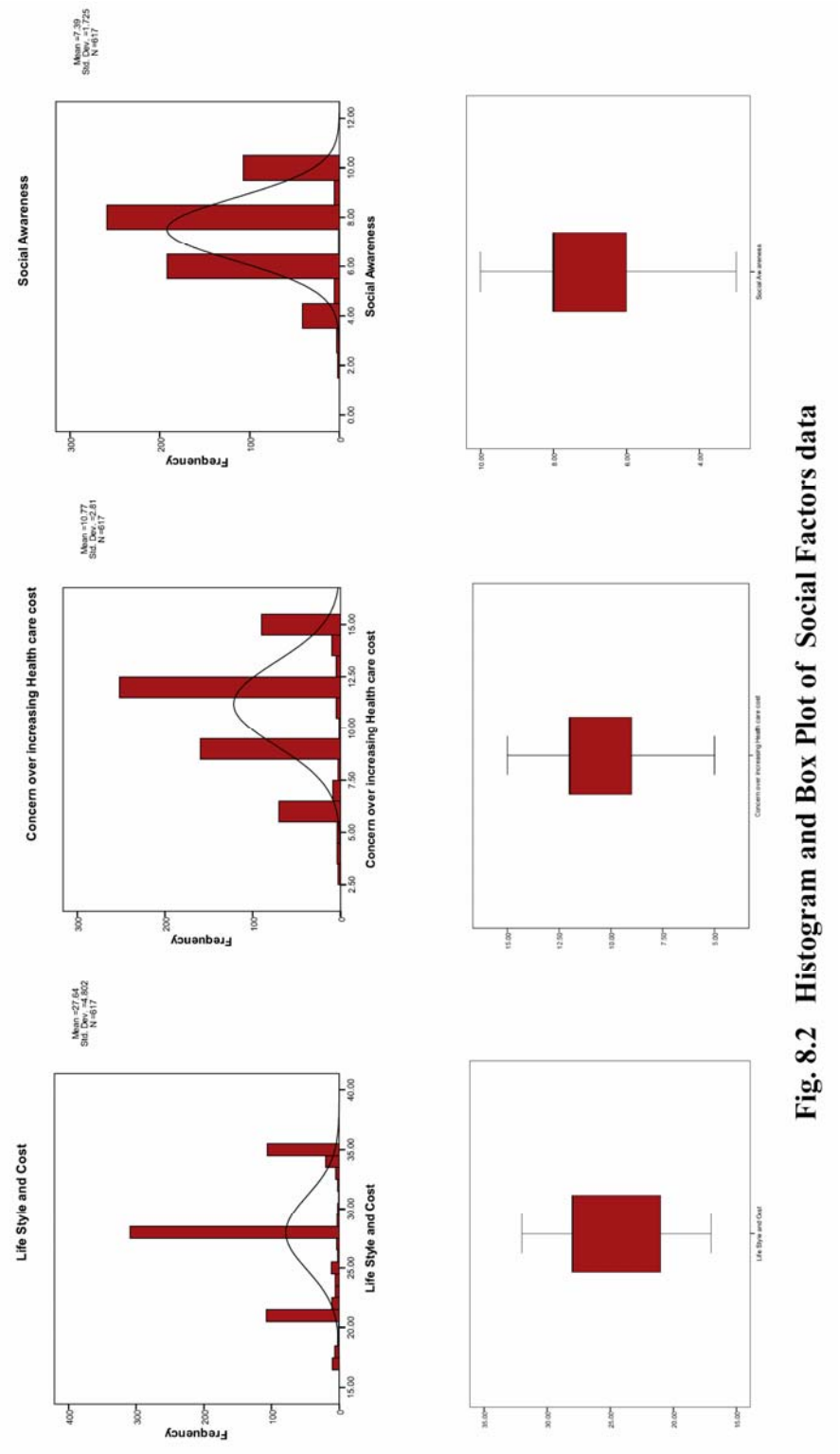

Fig. 8.2 Histogram and Box Plot of Social Factors data

Figure 8.2 displays the normality of all the three factors. From the histogram – normal curve, it can be understood that, the data is close to normal. There is a concentration of values to the centre, even though slight skewness is seen. A box plot indicates which observations, if any, might be considered as outliers. The box plot picture produced consists of the most extreme values in the data set (maximum and minimum values), the lower and upper quartiles, and the median. Here, the box plot diagram shows that, there are no outliers in the data and hence there are no extreme values to influence the mean. Since the evidence of normality is found, parametric methods of data analysis can be applied.

Discriminating an insurance buyer from a non buyer

This part of the analysis is directed towards finding out the ability of the social factors in discriminating an insurance buyer from a non buyer. The group statistics of the three social factors which are taken to find out the discriminating ability are furnished in table 8.5.

Table 8.5 Group statistics details of the variables in Social factor

Group Statistics					
	Do you have a health insurance policy	Mean	Std. Deviation	Valid N (listwise)	
				Unweighted	Weighted
Yes	Life Style Issues	28.2675	4.60831	228	228.000
	Concern over increasing Health care cost	10.8202	2.89586	228	228.000
	Social Awareness	7.4430	1.74379	228	228.000
No	Life Style Issues	27.2751	4.87989	389	389.000
	Concern over increasing Health care cost	10.7429	2.76218	389	389.000
	Social Awareness	7.3650	1.71573	389	389.000
Total	Life Style Issues	27.6418	4.80156	617	617.000
	Concern over increasing Health care cost	10.7715	2.81023	617	617.000
	Social Awareness	7.3938	1.72515	617	617.000

If the means of all the variables are considered along with the grouping variable, it is observed that, the means for people with an insurance policy is high when compared to people without an insurance policy.

An attempt was made to check the significance of the difference in the means across two classifying groups.

Table 8.6 Tests of Equality of Group Means of variables of Social factor

Tests of Equality of Group Means					
	Wilks' Lambda	**F**	**df1**	**df2**	**Sig.**
Life Style Issues	0.990	6.193	1	615	.013
Concern over increasing Health care cost	0.960	1.108	1	615	.042
Social Awareness	1.000	.293	1	615	.588

From Tests of Equality of Group Means table, it was found that the means significantly differ ($p < 0.05$) among the two categories for all the factors except for social awareness. This shows that, there is no significant difference in social awareness between people with an insurance policy and people without an insurance policy.

Table 8.7 Eigen Values of Social Factors

Eigenvalues				
Function	**Eigenvalue**	**% of Variance**	**Cumulative %**	**Canonical Correlation**
1	.012[a]	100.0	100.0	.207

a. First canonical discriminant function was used in the analysis.

The Eigen value (0.012) indicates the proportion of variance explained. In this model only one canonical function is taken and thus the percentage of variance is 100%. The square of the canonical correlation is 0.042 and hence 4 % of the variance in the discriminating model is due to changes in the three social factors. Addressing only 4% of the variance may be small in a collective sense, but if an effort is made to explain the impact of social factors on awareness creation, more than insurance product buying, that argument is nullified. Other major discriminating factors are explained in the previous two chapters. The significance of the discriminant function is tested by the following hypothesis:

Hypothesis

H_{04}: The variables that constitute social factors do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A4}: The variables that constitute social factors have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Table 8.8 Wilk's Lambda Test Results

Wilks' Lambda				
Test of Function(s)	**Wilks' Lambda**	**Chi-square**	**df**	**Sig.**
1	.989	7.074	3	.040

The statistical test of significance for Wilks Lambda was carried out with a chi square transformed statistic which in this case is 7.07 with 3 degrees of freedom and was found to be significant ($p < 0.05$). Hence the discriminant function can be further used for explanations.

Table 8.9 Standardized Canonical Discriminant Function

Standardized Canonical Discriminant Function Coefficients	
	Function
	1
Life Style Issues	1.158
Concern over Increasing Health care Cost	-.334
Social Awareness	-.186

Each of the Standardized Canonical Discriminant Function Coefficients in absolute value reflects the relative contribution of each of the predictor variable on the discriminant function. Here it was found that Life Style Issues (1.15) is exerting more influence in discriminating between an insurance buyer to a non buyer. It is immediately followed by concern over increasing health care cost and social awareness.

Table 8.10 Canonical Discriminant Function Coefficients

Canonical Discriminant Function Coefficients	
	Function
	1
Life Style Issues	.242
Concern over increasing Health care cost	-.119
Social Awareness	-.108
(Constant)	-4.617
Unstandardized coefficients	

The 'Canonical Discriminant Function Coefficients' indicate the unstandardized scores concerning the independent variables. It is the list of coefficients of the unstandardized discriminant equation.

Here

Insurance Buying = -4.617 + (0.242 LSI) + (-0.119 CHC) + (-0.108 SA)

The coefficients with large absolute values correspond to variables with greater discriminating ability.

Table 8.11 Functions at Group Centroids

Functions at Group Centroids	
Do you have a health insurance policy	**Function**
	1
yes	.140
no	-.082
Unstandardized canonical discriminant functions evaluated at group means	

As described in Chapters 6 and 7, a further way of interpreting discriminant analysis results is to describe each group in terms of its profile, using the group means (centroids) of the predictor variables. 'Functions at Group Centroid' indicate the average discriminant score in the two groups. Cases with scores near to a Centroid are predicted as belonging to that group.

In this case it can be interpreted that, people who had not bought an insurance policy produce a mean of -0.082, while people who had bought an insurance policy produce a mean of 0.140 (fig.8.3).

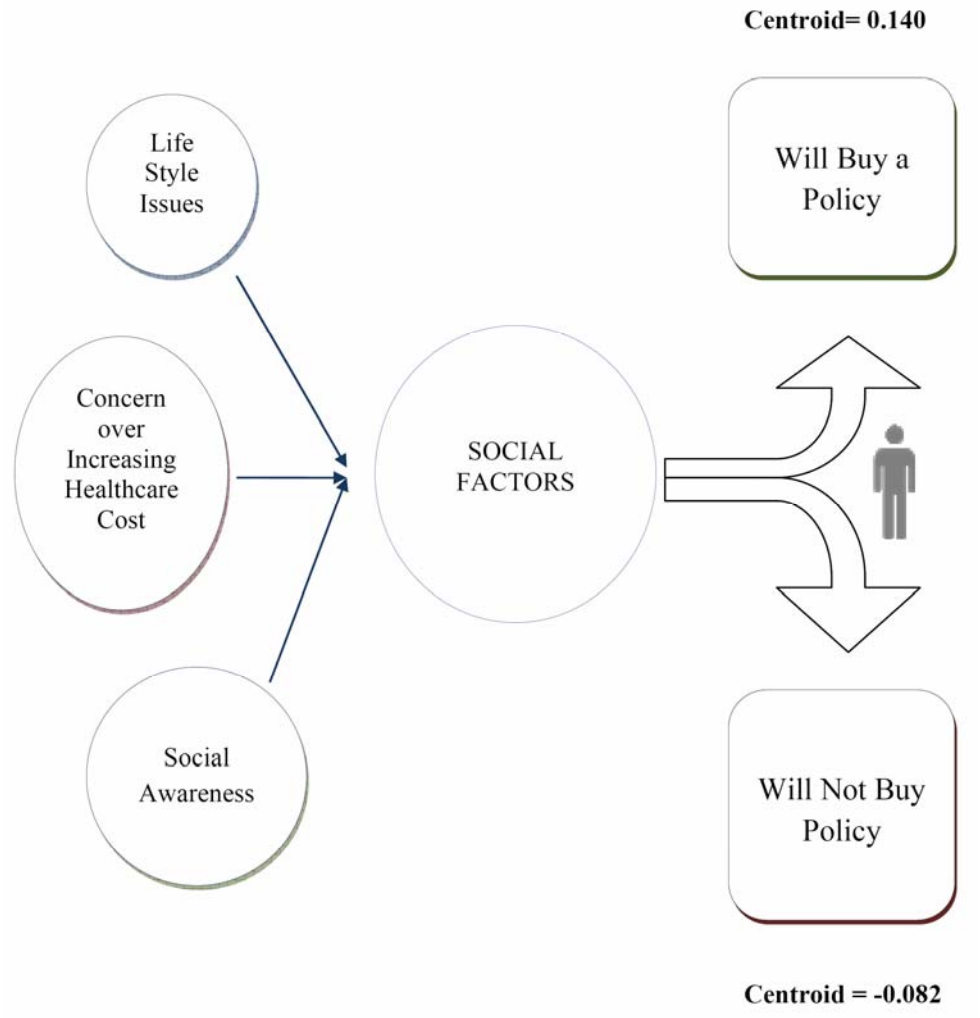

Fig. 8.3 Discriminating Ability of Social Factors

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Chapter 9

INFLUENCE OF PERSONAL, MARKETING AND SOCIAL FACTORS ON HEALTH INSURANCE PURCHASE DECISION - AN INTEGRATED MODEL

The earlier three chapters, presented the discriminating ability of the three identified factors, viz., personal, marketing and social in the consumer's decision of health insurance purchase. This part of the analysis is directed towards finding out the combined ability of the personal, marketing and social factors in discriminating an insurance buyer from a non buyer. The group statistics of the three factors which are taken to find out the discriminating ability are furnished in table 9.1. If the means of all the variables (table 9.8) are considered individually and as groups, it is observed that, the means for people with a health insurance policy are high when compared to people without a health insurance policy.

Table 9.1 Statistics of Group Factors in Combined Model

Group Statistics					
Do you have a health insurance policy		Mean	Std. Deviation	Valid N (listwise)	
				Unweighted	Weighted
Yes	Personal	45.6355	6.67543	214	214.000
	Marketing	34.9159	9.68142	214	214.000
	Social	48.9533	6.60684	214	214.000
No	Personal	42.4457	7.08611	369	369.000
	Marketing	26.3550	7.13353	369	369.000
	Social	45.4444	6.92057	369	369.000

An attempt was made to check the significance of the differences in the means across two classifying groups viz., people with health insurance and without health insurance.

Table 9.2 Tests of Equality of Group Means of Factors

Tests of Equality of Group Means					
	Wilks' Lambda	**F**	**df1**	**df2**	**Sig.**
Personal	.953	28.627	1	581	.000
Marketing	.796	149.065	1	581	.000
Social	.942	35.988	1	581	.000

From Tests of Equality of Group Means table 9.2, it was found that the means significantly differs ($p < 0.05$) among all the categories. This shows that, there is a significant difference among people with an insurance policy and people without an insurance policy with regard to personal, marketing and social factors.

Table 9.3 Eigen Values of the Combined Model

Eigen values				
Function	**Eigen value**	**% of Variance**	**Cumulative %**	**Canonical Correlation**
1	.324[a]	100.0	100.0	.695

a. First canonical discriminant function was used in the analysis.

The Eigen value (0.324) indicates the proportion of variance explained. In this model only one canonical function is taken and thus the percentage of variance is 100%. The square of the canonical correlation is 0.48 and hence 48 % of the variance in the discriminating model is due to changes in the three factors. The significance of the discriminant function is tested by framing the following hypothesis:

Hypothesis

H_{05}: The personal, marketing and social variables collectively do not have the discriminating ability to distinguish a health insurance buyer from a non buyer.

H_{A5}: The personal, marketing and social variables collectively have the discriminating ability to distinguish a health insurance buyer from a non buyer.

Table 9.4 Wilk's Lambda Test Results

Wilks' Lambda				
Test of Function(s)	**Wilks' Lambda**	**Chi-square**	**df**	**Sig.**
1	.755	162.617	3	.000

The statistical test of significance for Wilks Lambda was carried out with a chi square transformed statistic which in this case is 162.617 with 3 degrees of freedom and was found to be significant ($p < 0.05$). Hence the null hypothesis is rejected and the discriminant function can be used for further explanations.

Table 9.5 Standardized Canonical Discriminant Function

Standardized Canonical Discriminant Function Coefficients	
	Function
	1
Personal	.138
Marketing	.886
Social	.362

Each Standardized Canonical Discriminant Function Coefficient in absolute values reflects the relative contribution of each of the predictor

variable on the discriminant function. Here it was found that marketing (0.886) is exerting more influence in discriminating between an insurance buyer to a non buyer. It is immediately followed by social and personal factors.

Table 9.6 Canonical Discriminant Function Coefficients

Canonical Discriminant Function Coefficients	
	Function
	1
Personal	.020
Social	.053
Marketing	.109
(Constant)	-6.550
Unstandardized coefficients	

The 'Canonical Discriminant Function Coefficients' indicate the unstandardized scores concerning the independent variables. It is the list of coefficients of the unstandardized discriminant equation.

Here,

Insurance Buying Decision= -6.550 + (0.020 PF) + (0.053 SF) + (0.109 MF)

The coefficients with large absolute values correspond to variables with greater discriminating ability.

Table 9.7 Functions at Group Centroids

Functions at Group Centroids	
Do you have a health insurance policy	**Function**
	1
Yes	.746
No	-.433
Unstandardized canonical discriminant functions evaluated at group means	

A further way of interpreting discriminant analysis results is to describe each group in terms of its profile, using the group means (centroids) of the predictor variables. 'Functions at Group Centroid' indicate the average discriminant score in the two groups. Cases with scores near to a Centroid are predicted as belonging to that group.

In this case it was observed that, people who do not have an insurance policy produce a mean of -0.433, while people who have an insurance policy produce a mean of 0.746.

The factors included in the combined model and schematic representation of findings in relation to the discriminating ability of the personal, marketing and social factors are shown in table 9.8 and figure 9.1 respectively.

Table 9.8 List of Variables Referred in the Combined Model

Factor reference	Description of the factor
P1	Risk Cover
P2	Awareness
P3	Sense of Security
P4	Satisfaction
P5	Monetary
M1	Benefits
M2	Schemes
M3	Brand
M4	Promotion
S1	Life Style Issues
S2	Concern over Increasing Healthcare Cost
S3	Social Awareness

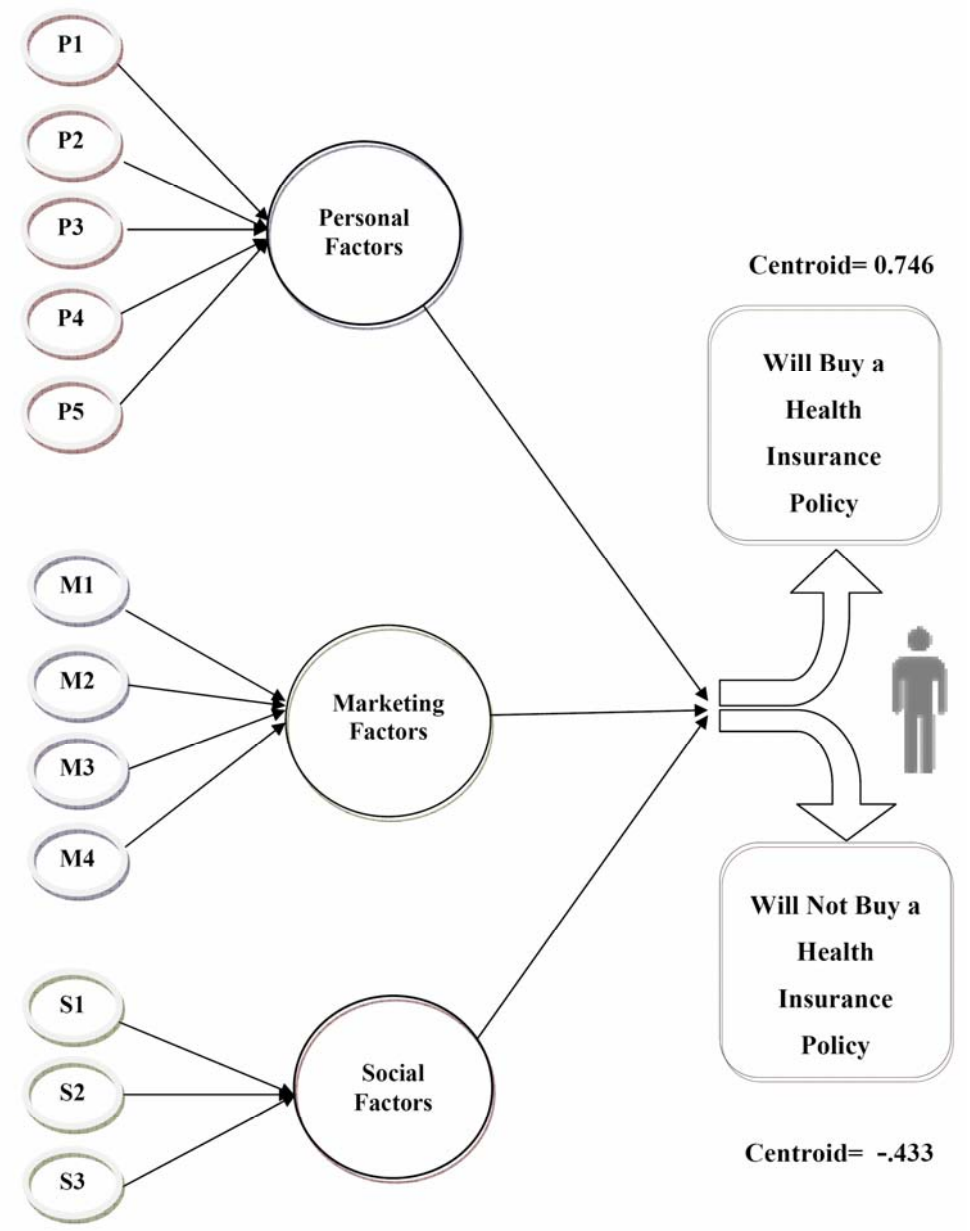

Fig. 9.1 Discriminating Ability of Combined Model

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Chapter 10

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Contents

10.1 Current Scenario

A healthy and competent workforce is the biggest asset of any nation and ensuring health for all therefore, is a priority objective of every progressive government. With increasing standards of life, need for advanced medical care and rising cost of health care, this is one area that forms a considerable part of GDP. Compared to international standards, the percentage of healthcare expenditure spent from personal sources is high in India. The state of Kerala is advanced in terms of literacy, human development index and general standards of living, and at the same time facing the problem of higher incidences of life style diseases. There is considerable potential for health insurance, but the percentage of cover of all forms of health insurance in India is inadequate. With liberalization of

Indian insurance sector, consumers are presented with a number of schemes to choose from. In this context, it becomes important to understand the factors that influence purchase decisions of health insurance.

10.2 Summary of Objectives of the Study

This study aims at understanding the pattern of health insurance awareness and consumption among various demographic groups and to learn the determinants of consumer purchase decision in health insurance in the state of Kerala. Further, effort is made to assess the influence of important factors on purchase decision, individually and collectively. The specific objectives include:

a) Identifying the factors those distinguish an insurance subscriber from a non subscriber, and

b) Suggesting an integrated model by connecting dominant factors that influence an individual's health insurance purchase decision.

10.3 The Summary of Design and Methodology of the Study

Consumer data has been collected using structured questionnaire. Population under study is limited to the state of Kerala. A sample size of 617 consumers were taken. Multistage random sampling was used.

The data collected for the study were processed and analysed with the help of the computer software Microsoft EXCEL and IBM - PASW Statistics. Suitable mathematical and statistical techniques were used for drawing meaningful interpretation. The basic analyses were attempted by using percentages, average, standard deviation and other statistical summaries. The standard techniques like Loglinear Multinomial Analysis,

Factor Analysis, ANOVA and DFA were used to analyse relative merits of the variables among different groups.

10.4 Findings from the Analysis of the Consumer Profile

The profile of the sample selected showed that the respondents are fairly distributed in the demographic factors like among regions, education groups, income groups, genders and age groups.

- The average monthly medical expenditures for a family was found to be about Rs.1000/-. Nearly 25% of the households reported hospitalization for illness or related to an accident during the past two years to any member and an average spending of Rs.19000/- is reported here. There is found to be relationship between income group and medical expenditure, with higher income groups reporting relatively higher medical expenditure which may be explained by the type of hospitals visited by the different income groups for medical care.
- While 37% of the respondents have some sort of insurance cover for medical expenses that include government schemes, 68.9% of the respondents have used own funds for meeting the health care expenses. The health insurance coverage appears to be inadequate with majority of the respondents having health insurance reporting less than rupees one lakh coverage and the highest reported cover is only rupees five lakhs.
- Though there is fairly good awareness in the market about health insurance, even in the state of Kerala with highly educated population, till now there exists a group who are unaware of the relevance of health insurance cover. Awareness

of health insurance measured in six components namely knowledge of companies, benefits, schemes, exclusions, cost and claim process using Likert scale data was analyzed and the major findings are:

- There is fairly good awareness about health insurance across the population groups, with 6% rating their awareness on various factors as very high, 33% as high and 40% as average. The depth of knowledge about schemes, coverage and exclusions are not good as average score is about 3.1 on a scale of 1 to 5.
- An association between education level and level of awareness was observed with lower classes of education reporting lesser levels of overall awareness of health insurance.
- Across the geographic regions of the state and different income groups, significant variation was not observed. The urban – rural divide is not seen in the state of Kerala. There is significant difference in awareness of companies, cost of coverage, exclusions of illnesses from coverage and claim process between genders with male respondents showing higher levels of awareness. Disparity in awareness is seen between age groups with younger groups showing lower awareness.
- Analysis of consumers showing inclination towards health insurance purchase indicate younger age groups are less favourable to health insurance purchase, mostly because they do not anticipate health problems and have not felt the

need for health insurance cover. But with the potential of adverse selection faced by marketers, covering wider spectrum is necessary. It therefore becomes imperative to address the youth section with suitable offers and ensure more spread of cover across age groups.

- The most important source of information about health insurance is news paper advertisement and health/health insurance related news. Friends and relatives, television advertisements and insurance agents are found to be other major sources. About 10% of the respondents refer to internet for health insurance information while about 6% have shown hospitals as a source.
- The main reasons for consumers to opt for health insurance are to protect from rising cost of health care, to provide better health care to family and to meet unexpected major expenditures. Therefore the cost of medical care is a major driving factor.
- On the other hand, lack of return for investment, haven't felt the need, poor service and high premium are cited as reasons for not taking health insurance. Higher percentage of the younger age group have cited the reason of 'not having felt the need', for not opting for health insurance. About 9% of the respondents have stated lack of disposable funds as the reason for not opting for health insurance.
- A good part of the respondents have shown favourable response to an intention to take health insurance with 21.4% in the near future and 36% after some time. 32.7% are undecided while 9.9% did not give any response to the question. However, how much of this positive intention gets converted to purchase is

uncertain and an area marketers can focus on. People who have experienced hospitalization are observed to be more favourable to purchase of health insurance.

- There is general agreement between marketing personnel and consumers on the reasons for purchase or non-purchase of policy. While the feeling that there is no return for the investment is what more consumers give as the reason for not taking health insurance, marketers feel the most important reason for non-purchase is customer's have not felt the need and no returns for the investment comes as a second reason for them. To the consumer, higher premiums are the second most important factor.
- Trustworthiness of the company emerges as the most important factor in selection of a service provider. Ease of claim settlement comes as the second reason. Premium cost and schemes are the other major factors. On these counts there is agreement between the provider and the consumer. These are important observations to the marketer in creating brand preference.

10.5 Specific Findings

10.5.1 Factors Influencing the Purchase Decision of Health Insurance Policies

Factor Analysis in the pilot study resulted in identifying three major factors viz., Personal, Marketing and Social, which were used to create the initial model.

Data collected was subjected to Factor Analysis and within the three factors, 12 variables were determined. Thus identification of factors influencing purchase decision of health insurance resulted in identifying:

A. Personal Factors

1. Risk Cover
2. Awareness
3. Sense of Security
4. Satisfaction
5. Monetary

B. Marketing Factors

1. Benefits
2. Schemes
3. Brand
4. Promotion

C. Social Factors

1. Life Style Issues
2. Concern Over Increasing Healthcare Cost
3. Social Awareness

Discriminating ability of the three factors on the buyer

The three factors that influence consumer's purchase decision being personal, marketing and social, were tested individually and collectively for their ability to discriminate between a buyer and non-buyer of health insurance among the groups of those who have health insurance and those who do not have. Four hypotheses were formed and subjected to statistical analysis using discriminant analysis.

10.5.2 Discriminating Ability of Personal Factors on a Health Insurance Buyer

It is observed that risk cover (0.698) is exerting more influence in discriminating between an insurance buyer to a non buyer. It is followed by satisfaction and monetary factors (tax benefits) and the least effect is for sense of security.

Based on the analysis of the 'Functions at Group Centroid', it was found that people who had not bought an insurance policy produced mean of -0.246, while people who had bought an insurance policy produce a mean of 0.389. Cases with scores near to a Centroid are predicted as belonging to that group. Canonical correlation analysis showed that 9% of the variance between those who have and those who do not have health insurance policy is explained by the personal factors.

10.5.3 Discriminating Ability of Marketing Factors on a Health Insurance Buyer

Analysis of the data showed that benefits (with function co-efficient of 0.819) is exerting more influence in discriminating between an insurance buyer to a non- buyer. It is immediately followed by schemes and other variables.

From the values of the 'Functions at Group Centroid' it was inferred that people who had not bought an insurance policy produced mean of -0.483, while people who had bought an insurance policy produced a mean of 0.825, indicating significant variation in mean values. Cases with scores near to a Centroid are predicted as belonging to that group.

Canonical correlation analysis showed that 29% of the variance between those who have and those who do not have health insurance policy is explained by the marketing factors.

10.5.4 Discriminating Ability of Social Factors on a Health Insurance Buyer

It is found that life style issues (with function co-efficient of 0.1158) is exerting more influence in discriminating between an insurance buyer to a non- buyer. Analysis of the canonical correlation shows that 4% of the

variance between those who have and those who do not have health insurance policy is explained by the social factors.

The 'Functions at Group Centroid', showed that people who had not bought an insurance policy produced mean of -0.082 while people who had bought an insurance policy produced a mean of 0.140, marking significant variation in mean values. Cases with scores near to a Centroid are predicted as belonging to that group.

10.5.5 Discriminating Ability of Personal, Marketing and Social Factors Collectively on a Health Insurance Buyer

Analysis of the 'Functions at Group Centroid', showed that people who had not bought an insurance policy produced mean of -0.433, while people who had bought an insurance policy produced a mean of 0.746. Cases with scores near to a Centroid are predicted as belonging to that group.

The three factors collectively have a discriminating ability of 48%, of which marketing contributes highest influence in discriminating between an insurance buyer to a non- buyer. This is substantial and the remaining 52% can be accounted for by various factors including demographic factors like age, health status, marriage, education, income etc.

The four hypotheses stated earlier in chapter I test the ability of the model to differentiate a buyer and non-buyer and the outcome is satisfactory.

10.6 Conclusions

a) Of the 617 respondents surveyed, about one fourth had a major expense due to accident or illness resulting in hospitalization of a family member during the previous two year period and 68%

of the consumers surveyed have shown own sources to be the main contributor for paying the medical expenses. This provides an opportunity for the marketing organizations to attract consumers with suitable schemes.

b) Awareness of health insurance, a pre-requisite for market growth, was good but the depth of knowledge about schemes, exclusions, claim process etc were not adequate. Further, the less educated group has lower levels of awareness about health insurance. News paper advertisements, news items etc are the most widely reported sources of information, followed by TV ads and insurance agents. Insurance agents being a relied source, can be used to create company specific preference by promoting its products. There is much scope here because it is understood from marketing professionals that the insurance sales force do not focus adequately today because of relatively low returns from sale of health insurance products.

c) Companies face the problem of adverse selection in marketing health insurance as more consumers expecting health problems are inclined to take policy resulting in higher rate of claims. Analysis of premium–claim ratio points towards this. This results in relatively high premiums for the elderly, keeping the healthier elderly group away from health insurance. Attracting the young age consumers, who do not respond to health insurance promotion probably as they do not anticipate health problems and have not felt the need for health insurance cover, with suitable schemes thereby spreading the insurance coverage across a wider span of customers is what marketing should focus on.

d) The consumer purchase decision is found to be influenced by three factors namely personal, marketing and social factors up to a great extent, as high as 48%. Out of this, marketing contributes 29%. While social factors can create an awareness about health insurance in the minds of the customer, the tilt towards purchase can be done by marketing initiatives like making good schemes, offering benefits and making good promotional efforts. Further, agents can influence in converting a favourable potential consumer to a consumer by active marketing. This shows the great role marketing activities can play in developing the health insurance in Kerala.

e) The most important factor influencing consumers while selecting service provider is trustworthiness of the company. In this area, it is found that public sector companies fare better than private sector companies. Brand image is an important factor and perceived service quality, most often built through word of mouth communication is playing a vital role in creating positive market image as opinions and suggestions from friends and relatives is an important factor for decision making in health insurance purchase.

10.7 Marketing Implications

Based on the study, some important observations arise, that have implications for the marketer.

a) In spite of high literacy and higher levels of social life indicators compared to other parts of the country, the state of Kerala is also mostly dependent on personal sources when it comes to paying health expenses. About 68% of the health

spending is from personal source and only about 10% have health insurance coverage. Though about 10% of the respondents have shown lack of disposable funds as a reason for not taking health insurance, this section mostly get covered by government schemes like Rashtriya Swasthya Bhima Yojana and government health services, and the big share of the market is open to the private health insurance provider. This offers a sizable, sustainable market for the health insurance marketer.

b) Though consumers rate overall awareness to be good, there is a sizable group that is not familiar with health insurance schemes and its benefits. With wide reach of news papers in the state and print medium communication being rated by consumers as the most important source of information on health insurance, marketers and organizations interested in health insurance promotion should focus on print advertising and periodic publication of relevant articles on health insurance that can enhance awareness on various aspects of health insurance and create favourable response.

c) The younger age group have been mostly keeping away from health insurance due to perception of less need and the observation is that the existing consumer grouping tilted more towards the elderly, which is also a vulnerable group in terms of health issues and hospitalization. This has resulted in high claim-premium ratio and result in loss in health insurance market. To the consumer, the impact is a higher premium rate. Bringing younger age group to more coverage and spreading the health insurance spectrum are to be focus areas of activity for marketing.

d) While analyzing the reasons for not taking health insurance, it is found that a large number of consumers feel health insurance does not provide much returns for the investments made and on the other hand, the reason for taking health insurance cited by majority of respondents is to cover major expenses and protection from rising cost of health care. It is found in studies on advertising impact in insurance marketing that negatively framed advertising, highlighting risk factors has high impact, especially among lesser educated groups. Marketing organizations and companies may use the advertisements focusing risk and risk coverage as a major area to create awareness and enhance purchase intention in marketing leading to more sale.

e) The analysis of influence of the three factors identified and their constituent variables show marketing has a great impact, up to 29% in purchase decision making. This shows the importance of marketing in converting a potential consumer to a consumer. Benefits of health insurance offer, appropriate schemes for specific category of consumers and active involvement of agents are important to consumers and are to be planned and implemented by companies.

f) Customer satisfaction on service quality is important on two counts as consumers look for easy interactions and claim settlement processes. Further, word of mouth communication is an important opinion forming source and nature of service received by persons who have utilized the service will result in positive or negative word of mouth communication. Prompt and

reliable service and good service recovery in case of failure are essential in creating positive word of mouth communication. Conscious efforts must be made in these areas.

g) Consumers have indicated trustworthiness of a company to be important while selecting a service provider. Many studies on brand have suggested trust as an important factor in branding and creating of brand image is an activity that call for action from multiple angles. Competing companies need to create a favourable brand image which will deliver better market share.

10.8 Generalization of Findings

The sample selected has been distributed in the three geographical regions of the state of Kerala with the regions having ensured adequate sample size to give equal chance to all members of the areas selected. Considering the findings that critical factors like education, income levels, awareness of health insurance etc are widely spread and near uniform in the state, the findings from the study of the sample can be considered to be a fair representation of the population of the state and close to generalization of the findings to the state's behavior in the subject.

10.9 Contributions from the Research

With the government of India and that of the states keen on achieving the target of 20% health insurance coverage by 2015, the topic of health insurance is of great importance. A substantial section of the society, that does not come under government schemes of any kind have to look up to the private and public sector health insurance companies in an environment of rising health care cost and serious health concerns. The study looks in to the aspects of consumer behavior that are critical information to the health

insurance product marketers. Areas like awareness, impact of overall environment and response of the consumers on these developments are important to the agencies like government and NGOs.

Some key outcomes of the study are noted:

a) Through the study, a description of the health insurance market in Kerala is presented which gives an idea about the potential and need to promote health insurance, and areas marketers need to focus on to develop the market.

b) Major factors that influence consumers favourably and unfavourably/ negatively in purchase of health insurance purchase decision making have been identified, which suggests action areas for marketers and agencies involved in health insurance promotion.

c) Three factors - personal, marketing and social, that influence consumer purchase decision and important variables forming these factors are identified and their relative influence is ascertained.

d) Based on these three factors containing 12 variables, by conducting discriminant analysis, a model of consumer purchase decision is made that can help to differentiate a buyer and non-buyer of health insurance policy.

While accepting with humility that the model is subject to improvements, the model of consumer purchase decision making relevant to the health insurance market proposed in this paper should be of interest to academic researchers and health insurance product marketers.

10.10 Future Research

Some of the areas that can be considered for further research are:

- The impact of Rahtriya Swasthya Bhima Yojana on health care financing
- Trends in health issues affecting health insurance market behavior
- Roles of stand-alone/multi business insurance companies and joint ventures of hospitals

Studies on the factors that hinder and promote subscription to health insurance services can contribute to furtherance of health insurance concept. Considering the growing importance of health insurance coverage, deeper understanding of the subject is of relevance to marketers as well as governmental agencies to cater to the needs of various sections of the society.

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QUESTIONNAIRE ON HEALTH INSURANCE

Section A

Name : Tel No :

Area of Residence (Constituency) : Locality : Urban/Rural

1. Age Group
   a) 18-30
   b) 31-40
   c) 41-50
   d) 51-60
   e) Above 60

2. Gender
   a) Male
   b) Female

3. Educational Qualification
   a) Below Graduation
   b) Degree holder (other than professional)
   c) Post Graduate (other than professional degrees)
   d) Professional degree holder

4. Employment
   a) Agriculture
   b) Self employed/business
   c) Practicing professionals
   d) Private organization service
   e) Government service
   f) Others (eg., NRI)

5. Marital status
   a) Married
   b) Single

6. Monthly income of the family
   a) Less than Rs.5,000/-
   b) Rs.5001-10,000/-
   c) Rs.10001-25,000/-
   d) Rs.25,000-50,000/-
   e) Above Rs.50,000/-

7. No of dependent family members : Nil ☐ 1 ☐ 2 ☐ > 2 ☐

8. Average monthly medical expense of the family
   Up to 500 ☐ 501-1000 ☐ 1001- 2000 ☐ above Rs.2000/- ☐

9. Was there any case of accident/hospitalization to any family member during the last one year? **Yes/ No**

10. In case of yes, what was the total cost of hospitalization? **Rs._____**

11. Is your work environment or nature of work likely to cause health problems? **Yes/ No**
    (like working in dusty/risky/fibrous/chemical environment)

12. Is your employment covering your full medical expenditure?
    Yes/No

13. Which is the most used source of fund for meeting your medical expenses?
    a) Free medical service from government ☐
    b) Own Savings ☐
    c) Paid by employer / company ☐
    d) health Insurance ☐
    e) Others (Pls Specify) …….. ☐

14 Name three sources where you get the information on health Insurance from: (You may select from the list below)

a)	News paper Advertisements	☐	b)	TV advertisements	☐
c)	Friends & Relatives	☐	d)	Outdoor Advertisements	☐
e)	Insurance agents	☐	f)	Company brochures/ events	☐
g)	Internet	☐	h)	Hospitals	☐
i)	Others (pls specify)	☐			

15. Have you seen any advertisement of health insurance?

Yes/No

16. Which type of message from a health insurance advertisement will influence you more?

Family security / Fear of big expenditure/ Risk cover/ Well being & health

17. Do you have a health Insurance Policy ? **Yes/No**

If Yes, Does it cover: self ☐ Family ☐

Name of the Provider Company :

Name of scheme : Amount covered :

18 Have you made any health Insurance Policy claim in the last two years?

Yes/ No

19. Based on your experience of the services of the health Insurance company, will you refer health insurance of this company to other potential customers/ friends/ relatives

Yes/No/Can't say

Can you give the reason, if answer is 'NO' **:**

20. If you have a health insurance policy, do you renew your health insurance policy regularly? **Yes / No**

21. Give the most important reason, why you think you should take an HI policy?

To protect from rising cost of healthcare		Expecting health problems	
Tax benefits		Better healthcare for family	
Attractive schemes are available		Covers big expenses	

22. Give the most important reason, why people don't take a health insurance policy?

Did not feel the need		No returns for investment	
High premiums charged		Alternate sources	
Poor service provided and coverage		Shortage of disposable funds	

23. Rank (starting with 1) the three important factors which can form the basis for selecting a health insurance company, in your order of preference:

Trustworthiness of the company		Better schemes offered	
Existing insurances with the company		Personal relationships	
Easy claim settlement		More coverage of diseases	
Low premium cost		Better marketing efforts by agents	
Tax savings		Influence of advertisements	

24 If you consider purchase of a health insurance policy, which are the top two names of companies that come to your mind?

1) 2)

25. Can you rank three important health insurance companies from the following?

United India Insurance		Apollo DKV Insurance Co ltd	
Reliance health		ICICI Lombard General Insurance Co	
LIC of India		Star health and Allied Insurance Co ltd	
New India Assurance Co		Royal Sundaram Alliance Insurance Co	
Metlife India Assurance Co		Other:	

Section B

Please give the responses to the following questions on a scale of 5 to 1, where 5 =Strongly agree, 4 = Agree, 3 = Neither Agree Nor Disagree, 2 = Disagree and 1 = Strongly Disagree						
SNo	**Question**	**5**	**4**	**3**	**2**	**1**
1	I am aware of companies offering health insurance					
2	I am aware of the benefits of health insurance					
3	I am aware of schemes offered by major health insurance companies					
4	I am aware of diseases not covered in health insurance schemes					
5	I am aware of the general cost of health insurance premium					
6	I am aware of the health insurance claim procedure					
7	A health insurance policy can cover the risk of a major medical expenditure					
8	I think it is good to have a health insurance policy					
9	It is better to take a health insurance policy at a younger age					
10	The tax benefit available for health insurance premium is an important factor for me to take heath insurance					
11	A health insurance policy can provide a sense of security regarding medical care for me & my family					
12	A health insurance policy provides my family better preventive healthcare facility					
13	The experience of earlier claim settlement influences my decision to renew my policy with the service provider					
14	Irrespective of whether I have claims or not, I will continue to renew my health insurance policy					
15	The process of taking health insurance cover is relatively easy					
16	health insurance companies give good response to queries and clarifications from the customers					
17	The settlement of claims by health insurance companies are satisfactory					
18	The health insurance policy is a worth investment					

19	I am satisfied with the services provided by health insurance companies.					
20	Satisfaction with the services provided by health insurance companies influence my decision to take health insurance					
21	Attractive schemes are available under health insurance policies					
22	There are suitable covers for people of different categories					
23	Domicile treatment health insurance covers are beneficial					
24	Critical Illness cover policies are useful.					
25	Premiums charged by health insurance companies are reasonable					
26	The benefits offered for different premium charged gives good value					
27	Company personnel are available on call for queries & clarifications					
28	Agent's persuasion influences my decision making while I consider purchase of health insurance					
29	It is easy to obtain a health insurance policy					
30	Promotional offers influence my decision to purchase health insurance policy					
31	Brochures and websites of HI providers give good information about policies and schemes					
32	health insurance companies give sufficient advance information regarding policy renewal					
33	Word of Mouth communication is an important factor that can influence my purchase decision					
34	Advertisements have influence on my decision to take health insurance					
35	Brand name is an important factor for me to select health insurance provider					
36	Brand gives me an assurance about quality of service					
37	Trust in the service provider is essential while selecting a health insurance policy					
38	Marketing initiatives of health insurance companies have positive impact on purchase decision of health insurance by customers					

39	Health consciousness of people of Kerala is high					
40	Health insurance coverage can improve preventive health care					
41	Government schemes for health insurance for other social sectors motivate me to purchase a health insurance policy					
42	Rising social awareness about health care has positive influence on purchase decision of health insurance by customers					
43	Availability of preventive checkup packages can improve health care					
44	Health insurance companies have come up with attractive schemes					
45	Work related stress is causing increased health problems in society					
46	Present trends in food habits will cause more health problems					
47	The sedate life style is causing more health problems					
48	There is increase in occurrence of life style diseases					
49	The number of costly specialist medical tests advised is increasing					
50	The cost of health care is increasing rapidly					
51	I think more privatization of health sector will cause increase in health care costs					
52	I find it difficult to meet unexpected medical expenditures					
53	A health insurance policy can help in taking care of rising cost of health care					
54	I intend to cover the cost of healthcare by taking a health insurance policy					

Annexure -II

Questionnaire on Health Insurance (Marketing Executives)

Name :	
Organization & City	
Designation:	
Years of Service in Insurance field :	

1. The top three sources of information for health insurance for the consumer: please mark 1 to 3 in the order you think appropriate

News paper Advertisements		TV advertisements	
Friends & Relatives		Outdoor Advertisements	
Insurance agents		Company brochures/ events	
Internet		Any other ….	

2. The top three reasons for a person to take Health insurance with a particular company :

Trustworthiness of the company		Better schemes offered	
Existing insurances with the company		Personal relationships	
Easy Claim settlement		More coverage of diseases	
Low premium cost		Better marketing efforts by agents	
Tax Savings		Advertisements	
Any Other :			

3. Three main reasons for a person NOT taking Health insurance policy, in your opinion:

Did not feel the need		No returns for investment	
Too costly		Other sources to pay medical expense	
No health Problems		Bad experience in the past	
No effort from agents or company		Any other ….	

Please give the responses to the following questions on a scale of 5 to 1, where 5 =Strongly agree, 4 = Agree, 3 = Neither Agree Nor Disagree, 2 = Disagree and 1 = Strongly Disagree						
Sl No.	**Question**	**5**	**4**	**3**	**2**	**1**
1	The awareness level among consumers about health insurance is generally good					
2	I think advertising focusing on risk/fear factors will influence consumer's decision to opt for Health Insurance policy					
3	A health insurance policy can give a sense of security for the consumer regarding medical care					
4	A health insurance policy provides my family better preventive healthcare facility					
5	I think advertising focusing on well being/family security factors will influence consumer's decision to opt for Health Insurance policy					
6	I think agents are making good efforts to market health insurance policies					
7	Younger / healthy persons do not opt for health insurance					
8	The brochures and literature supplied by us give very relevant and adequate information to consumers					
9	Health insurance premiums charged by my company are reasonable					
10	Cashless operation is a good option for health insurance policy holders					
11	Generally, service provided by health insurance companies is good					
12	Generally, companies reject claims only for valid reasons					
13	Brand name is a very important consideration for the consumers while they select a health insurance service provider					
14	Hospitals tend to charge higher when the patient is covered under health insurance					
15	The health insurance scheme gives too little revenues to company					

Annexure -III

Questionnaire on Health Insurance (Agents)

Name :

4. How long are you working as insurance agent:

5. You are : a) Full time insurance agent ☐ b) Insurance sales is side activity ☐

6. Which company's products are you dealing with?

   LIC ☐ PSU GICs ☐ Private Companies ☐

7. How frequently do you offer health insurance as a product to potential customers:
   Most of the times ☐ Frequently ☐ Occasionally ☐ Never ☐

8. What is your opinion about many agents not promoting health insurance?
   Less customer demand ☐ Not profitable ☐ Lack of interest ☐

9. Why do you think customers opt for health insurance?
   Risk cover ☐ Expecting health problems ☐ Tax benefits ☐
   Availability of attractive schemes ☐ Better healthcare for family ☐

10. Why do you think customers do not buy health insurance?
    Did not feel the need ☐ No returns for investment ☐ Too costly ☐
    No returns for investment ☐ Other sources to pay medical expense ☐

11. Do you believe taking a health insurance policy is a worth decision for a family?
    Yes ☐ No ☐ Can't Say ☐

12. Do you think companies are promoting health insurance adequately?
    Yes ☐ No ☐

13. Do you feel entry of many players in private sector has done good for health insurance marketing?
    Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐

Annexure -IV

AVERAGE MEDICAL EXPENDITURE PER HOSPITALIZATION CASE

Type of Hospital	Rural		Urban	
	1995-96	2004	1995-96	2004
	Amount in Rupees			
Govt Hospital	2,080	3,238	2,195	3,877
Private Hospital	4,300	7,408	5,344	11,553
Any Hospital	3,202	5,695	3,921	8,851

Source : Ministry of Health Working Paper on Health and health Insurance (2006).

Annexure -V

HEALTH INSURANCE COMPANIES OPERATING IN INDIA

A	PUBLIC SECTOR	
1	New India Assurance	
2	National Insurance	
3	Oriental Insurance	
4	United India Insurance	
B	PRIVATE SECTOR	
	Insurers	**Foreign Partners**
1	Royal Sundaram	Royal Sun Alliance, UK
2	Reliance General	---
3	IFFCO-TOKIO	TOKIO Marine Asia Pte. Ltd, Japan
4	TATA AIG	American International Group (AIG), USA
5	Bajaj Allianz	Allianz, Germany
6	Cholamandalam MS	Mitsui Sumitomo, Japan
7	ICICI Lombard	Fairfax Financial Holding Ltd, Canada
8	HDFC ERGO	ERGO, Germany
9	Future Generali India	Participatie Maatschapij Graafsschap Holland NV
10	Universal Sompo	Sompo, Japan
11	Shriram General	Sanlam, South Africa
12	Bharti AXA General	AXA Holdings, France
13	Raheja QBE	QBE, Australia
14	SBI General	Insurance Australia Group Limited (IAG), Australia
15	L & T General	---
C	EXCLUSIVE HEALTH INSURERS, IN PRIVATE SECTOR	
1	Star Health & Allied Insurance	Individual Promoters, UAE
2	Apollo Munich	Munich Re
3	Max Bupa	Bupa Finance PLC, UK

Source : Insurance Regulatory and Development Authority (IRDA) of India website, Mar 2012

Annexure -VI

HEALTH INSURANCE PREMIUM COLLECTED 2005-2012

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Non-life Private Insurers	539.59	1223.99	1832.51	2266.33	2349.84	3031.48	3411.89
Non-life Public Insurers	1682.51	1973.57	3136.51	3824.04	4883.26	6912.55	8020.73
Standalone Health Insurers		11.16	155.94	535.09	1072.08	1535.77	1659.78
Total	**2222.09**	**3208.73**	**5124.95**	**6625.46**	**8305.18**	**11479.80**	**13092.40**

Source : Insurance Regulatory and Development Authority (IRDA) of India website, Mar 2012

Annexure -VII

PUBLICATIONS ARISING FROM THE THESIS

a) Journal Publications

[1] Health Insurance Marketing: Problems and Prospects, paper published in Research Journal of Social Sciences and Management (Electronic) by The International Journal's, Singapore; September 2012, Vol 2, No. 5 (2012).

[2] 'A Comparative Study of Consumer and Marketer Perceptions in the Health Insurance Market': Paper published in Journal of Marketing Management (Electronic) published by Global Strategic Inc, Michigan, USA, October 2011.

[3] 'Consumer Awareness and Marketing Activities of Health Insurance Companies': paper published in 'Focus' – Journal of IFIM Business School, Bangalore, April-Oct 2010.

b) Edited Volume Publications

[1] 'Creating Brand Preference in the Health Insurance Market', paper published in the edited volume, Brands Rising as Products Fall' published by IMT Ghaziabad and Greenwich University, UK (MacMillan Publishing) in January 2010.

[2] 'Hindrances to the Growth of Health Insurance' paper published in the edited volume, Finance and Banking: a Collection of Contemporary Research, Excel Books, 2009.

c) Conference papers presented, based on the research work

[1] 'A Comparative Study of Consumer and Marketer Perceptions in the Health Insurance Market': Paper presented at the International Conference 'BITMED 2011' organized by Global Strategic Inc, Michigan & Bangalore University at Bangalore on 21-23 Sep 2011

[2] 'Creating Brand Preference in the Health Insurance Market', paper presented at the international conference on Branding, organized by IMT Ghaziabad and Greenwich University, UK at Ghaziabad on 9,10 January 2010

[3] 'Consumer Awareness and Marketing Activities of Health Insurance Companies': paper presented at the National Conference on 'Doing Business in India', 18-19 Dec 2009

[4] Hindrances to the Growth of Health Insurance' : paper presented at the National Conference on Banking and Financial Services organized by Saintgits Institute of Management, Kottayam on 8,9 September 2008

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