Indian Journal of Spatial Science
Spring Issue, 11 (1) 2020 pp. 62 - 68

Indian Journal of Spatial Science
Cosmos Impact Factor 2018 : 6.521 IP Index 2019 : 2.080 Advanced Sciences Index 2019 : 1.320
Peer Reviewed and UGC Approved (Sl No. 7617)
EISSN: 2249 - 4316 Homepage: www.indiansss.org ISSN: 2249 - 3921

Utilization of Healthcare Resources and Implementation of Health Insurance Schemes: A case study of South 24 Parganas, West Bengal

Deepshikha Mutsuddi

Assistant Professor: Department of Geography, Maheshtala College, West Bengal

Article Info

Article History

Received on:
15 January 2020
Accepted in *Revised Form* on:
14 February, 2020
Available *Online* on and from:
21 March, 2020

Keywords
Healthcare Resources
Health Insurance Schemes

Abstract

Healthcare services and health insurance scheme-related problems are the reflections of the socio-economic, cultural and inherited trends of a region. The health of a population may fulfil many criteria of well-being in the long run. But unavailable and inappropriate health care service facilities of many Community Development Blocks (COB) of South 24 Parganas district are an all-time concern among the commoners. "Health is wealth" is a term which indicates overall health status, economic prosperity and human development of a country. The population of developing countries like India depends upon the internal development of health care. A healthy environment is dependent on the well-being of a population. Due to fear of high health care expenses and its impoverishment, most people take self-medication or traditional resources for healing which are very risky, mostly non-scientific and often poor quality of short-term beneficial treatment compounded to professional care. Government of developing countries are now allocating a higher percentage of their resources towards health sector and launching various Health Insurance Schemes to provide health care protection especially for the low-income group.in this study, the present scenario of the population in large scale has been observed which should come under health insurance coverage and also they should get proper health care services because healthy population makes a healthy environment which can enhance the growth of HDI and GDI of a country.

Introduction

The quality of life is determined by a healthy environment which is provided through the availability and utilization of basic services like education health care and related amenities. Adoption of a healthy lifestyle, utilization of available health care and use of protective measures depends hugely on the socio-economic and physical conditions of any region. These conditions play a significant role in the spatial variation of disease occurrence and also in health care facilities. Satisfaction level influences the individual's emotional responsibility to the illness and their coping behaviour such as the selection of health care facilities (Jannifer, et al. 2009). Perception and satisfaction level among people can improve both communications in medical consultations and also outcomes of treatment. Patient's satisfaction level is largely determined by varying socioeconomic factors and quality of life of patients (Jitske, et al. 2011, Rutten, et al. 2006).

The distribution and satisfactory utilization of health care facilities reflect the development level of my society. Planning development of the advance medical system has traditionally been dependent on the views of doctors. With changing perspective of health services, researchers, the perception and level of satisfaction among people about the existing facilities, quality of care and method of treatment become worth to be considered in providing health care facilities to society. Patients these days are much aware and have become more quality conscious than earlier days. People's perception and user's satisfaction are important aspects in the assessment of the health institutions because it is generally assumed to be a significant determinant of a repeat visit, positive word-of-mouth, and patient's loyalty (Donabedian, 1988). Besides its right shape confidence and subsequent behaviours of patients with regard to choice of health institutions (Andaleeb, 2001). Still, patients' satisfaction level about health services gets largely ignored by health care providers across developing countries (Kotler, et al. 1987).

Health care and Health Insurance Schemes providers can influence patients to make healthier lifestyle choices such as discontinue smoking, increase physical activity and making healthy dietary modifications. In the present study, a

representative sample of households in the study area has been used to explore the parameters associated with the satisfactory level of the people about the existing quality of health care facilities and also the benefits of health insurance schemes and how these two parameters are providing a healthy environment in the study area. It has been revealed that people with continuous access to a provider and health services as well as health insurance schemes are significantly more likely to report the health condition to the health care delivery system. An innovative view of health care is emerging in which patients are expected and encouraged to take a more active role in making decisions about their treatment beside these people are now conscious and aware about the benefits of different health insurance schemes. In most of the cases, the decisions are taken either on the basis of availability or on the basis of money. The present study indicates the satisfaction of the people with the existing health care features, awareness about health insurance schemes and the number of people having health insurance and getting its benefits lastly the study determines whether there is variation in people's satisfaction level which are creating a barrier in socio-economic as well as healthy environmental development.

The Study Area

South 24 Parganas an area about 9,960 Sq. Kms. has an intraspecific morphological variation which indeed made South 24 Parganas a complex district stretching from metropolitan Kolkata to the remote riverine villages of Sundarbans up to the mouth of Bay of Bengal. It is occupying the southern part of Bengal delta facing the Bay of Bengal. The district lies between 21°29'0" N to 22°33'45" N and 88°3'45" E to 89°4'50" E. I have chosen South 24 Parganas as my study area which consists of 5 Sub-divisions AliporeSadar, Baruipur, Diamond Harbour, Thakurpukur-Maheshtala, Canning and 5 sub-division consist of total 29 Community Development Blocks (CDBs). At the regional level, this area lies significant variation in demography, socio-economic status and environmental conditions. So this region requires specific studies for strengthening the existing health care facilities and its satisfactory utilization and proper implementation of Health Insurance Schemes so that people can avail the benefit of proper Health care system at a satisfactory level which will lead to developing a healthy environment of the district. My study in all the 29 Blocks has been divided into 3 parts urban, rural and rural-urban fringe area, so that disparity achieving proper benefits of the health care system and the cause for the unhealthy environment can be detected thoroughly through my work.

Objectives

Major objectives of the study area are:

1) To study the economic status of the study area.
2) To study the relative status of the sub-division and CDBs with respect to health care facilities and health insurance coverage.
3) To analyze the problems related to the health service and its impact on the mentioned area.
4) To analyze the effect of the health care system to provide a healthy environment.

Database and Methodology

The study has been conducted in two parts. The Non-Analytical part with the data of 2016-2018 includes the study of health status, economy and essentiality, implementation, the relevance of health insurance schemes and its environmental impact. The Analytical part includes economically and environmentally acceptable new and innovative technology with the help of statistical data to develop the health care status and its environmental impact on the district. Materials used were primary data tools (field visits and semi-structured interviews) and secondary data tools (data from hospitals, Census of India 2011, Human Development Report 2016, 2017, 2018, different articles, Govt. publications). The logistic regression analysis has been applied to assess the association between various socio-economic determinants and satisfaction with health care securities and health insurance schemes.

Characteristics of the Respondents

Primary data has been collected through a random sample survey of 680 households selected from 5 sub-divisions and these sub-divisions comprises of corporation areas, municipalities, Community Development Blocks (CDBs), census town, rural areas with Gram Panchayats. Total 22 hospitals including health centres have been surveyed within 29 CBDs. These 22 hospitals only a few lies in urban areas and most of the villages have health centres. So there is a wide gap in the distribution of health care facilities. District Magistrate office, different Block Development Officers (BDOs), SDOs are also surveyed while random sampling was conducted.

Availability and Utilization of Healthcare Facilities

Table 1 reveals that a high proportion of male respondents know about the availability of various health care facilities as compared to female counterparts. In the traditional rural society of the study area, womenfolk have very limited access to the sources of information; half of the female respondents do not have any knowledge of available health facilities and schemes. They depend on their male counterparts. While considering religion-wise knowledge of available health facilities and schemes, a high percentage (68.20%) of Hindu respondents have knowledge as compare to Muslim (47.70%) respondents. Above table also reveals that Educational attainment has a positive association with knowledge of health facilities. Economically sound possess different sources of information like newspaper, TV, phone etc. etc. The rich people, as well as higher-income groups, have good knowledge about health facilities as compared to their low-income groups or poorer counterpart. The social structure of the society has its direct influence on the access of information. The socio-economically well-off upper castes people have better knowledge as compared to backwards castes i.e., OBC (59.90%), SC (49.50%) and ST (30.80%). Agricultural labourers which belong to the lowest economic strata of the society have poor knowledge about health facilities as compared to respondents engaged in other occupations. Older respondents of rural areas are much aware of health facilities than their younger respondents because of lack of awareness and lack of communication facilities.

Variations in the Levels of Satisfaction

Satisfaction with government health insurance schemes/services varies according to a place of residence. In both rural and urban areas more than one-fifth of the total respondents are not satisfied with government health schemes. Interestingly the highest number of respondent reported to lack of transparency as the main reason. In rural areas, 17.10% of the respondent satisfied with these schemes due to less expensive while in urban areas only 26.70% perceived these scheme convenient. Mismanagement in the delivery system is perceived to be the main reason behind dissatisfaction in both rural and urban areas. Out of total 620 rural respondents, only 6.80% are satisfied with the quality of Government health services while 10.5%respondents said that they are satisfied because it is easily accessible (Table 2) whereas only 3.10% think these schemes are good for providing timely help. 10.00% of the respondents of the urban area accepted as good facilities and easy to access the schemes while 20.00% are accepted to mismanagement and many of them accepted lack of transparency in Government health schemes. Out of total 620 rural respondents, 4.80% respondents changed the hospital due to time-consuming for Government health schemes, while 4% from poor facilities but only 2.40% of the patients changed their first treatment hospital because they could not bear the high cost of medical care, while 10.60% wanted to quick relief from illness. Further lack of awareness is one of the reasons for the unsuccessful implementation of these schemes. Illiterate and poor rural masses are dissatisfied because of a large number of formalities related to these schemes. A small portion of respondents from the rural areas showed their dissatisfaction due to class discrimination in these schemes while selecting beneficiaries. In rural areas, a very small percentage considered these schemes as timely help, while in urban areas respondents do not perceive these scheme at all as timely help. It is found that respondents in urban areas are more satisfied as compared to their rural counterparts.

Relation between Educational Attainment and Level of Satisfaction

Table 3 shows the level of satisfaction across the education level of the respondents. Education of an individual is said to directly affect his / her perception of the facilities. Different educational background perceived Government health care schemes differently. Majority of the respondents irrespective of their educational attainment are dissatisfied with these schemes due to lack of transparency. More than two-thirds of total illiterate respondents have a low level of awareness about these health facilities therefore they are dissatisfied with the facilities. It is notable that 18% of total illiterate respondents found these schemes are good as easily accessible. A little less than one-third of respondents with primary education are satisfied with these schemes as they perceived these schemes convenient.

Relation between Occupation and Level of Satisfaction

Table 3 shows the occupation wise level of satisfaction of the respondents. More than 60% of cultivators are dissatisfied with these schemes because poor quality, lack of transparency, mismanagement and low level of awareness. It is very disheartening to note that none of the agricultural labourers who represent the weaker section of rural society is satisfied with these schemes due to the low level of awareness. Industrial workers are found that these schemes were more convenient as they generally reside in urban areas. More than half of the respondents engaged in services reported to be dissatisfied with these schemes due to lack of transparency, mismanagement, class discrimination and a high number of formalities. It is very disappointing that the educated class of society is more dissatisfied with these schemes. So it is revealed that agricultural labourer and rural people are deprived of getting health care facilities, so they are not belonging to the healthy environment with respect to the health care system.

Satisfaction with Government Health Schemes across Income Groups

The economic status of respondent largely affects his / her perception about satisfaction with government health schemes. Table 4 shows the satisfaction of respondents across different income groups with these health care schemes. Lack of transparency and low awareness are the main reasons behind dissatisfaction among respondents belonging to the income group of less than Rs. 5,000. Easy accessibility and less expensive are the reasons behind the dissatisfaction of respondents in the same income group (26.70%). A large number of respondents (63.40%) in the income group 5,000 10,000 are dissatisfied with these schemes due to lack of transparency, mismanagement and lack of awareness about services. A large number of respondents in the income group (more than 10,000) are dissatisfied with these health insurance schemes due to lack of transparency and mismanagement of these schemes. So it is found through the study that in high-income population health care facilities including health insurance schemes are satisfactorily utilized and few of them having healthy health care environment but low-income groups are not even aware of it, so they are deprived of receiving all the benefits of healthy health care environment.

Conclusion

The whole study prominently denotes that health care resources are below average in almost maximum CDBs of South 24 Parganas. Lack of healthcare-related infrastructural services is enhancing Health disaster among large scale population of the mentioned region. The awareness of respondents about availing health facilities with treatment process and problems faced due to health services is revealed that only about 14% are satisfied by health care provided by hospitals and 27% are dissatisfied while 59% of the interviewers did not give any response. Respondents of urban areas are utilizing health care resources much and are more satisfied with it than the rural areas because the availability of quality health care facilities as accessibility is better in urban areas in comparison to the rural area. Besides this as 'Health' is an important contributor to the socio-economic development of an area. Nurturing and protection of health requires insurance coverage, but health insurance addresses a major area of public comfort. It is an insurance against expensive medical expenditure met during an emergency. Health policies provide monetary protections for hospitalization, medical examinations and other expenses related to the disease within specific

guidelines written thereon. So having health insurance is important because health insurance helps people to get timely medical care and improves their lives and health. The objectives of health care insurance scheme implementation of health care services to decrease the expenditure for health care and utilization of its facilities so that equity can be achieved in the health care system. After some time different Govt. Health Insurance Scheme is provided to give financial protection against inpatient expenditure and improve utilization of inpatient services through cashless facilities especially for the low income and BPL level income groups. These schemes are targeted to give financial security and to make the inpatient less dependent on inefficient mechanism like selling of valuable households to cope with the medical expenditure.

After analyzing the data of the respondent it can be indicated that there is a large disparity in availing health care services as well as getting the benefit of the health insurance scheme among the respondent. It is clearly seen that the implementation of Govt. Health Insurance Schemes among low income and BPL level group is not done systematically and on many CDBs peoples are not even aware of such schemes. Besides this the people who have such Govt. Health Insurance Schemes they are also facing many obstruction while time of availing the benefits of the insurance scheme due to lack of knowledge, due to non-cooperation of hospital management, long time procedure, distance of their residence and hospital is far away, so people can not go several time to get the monetary benefit of the insurance scheme. From the above-mentioned reasons, many people of South 24 Parganas especially the rural and sub-urban part. The utilization of health care services are very unsatisfactory including disparities are found among health insurance schemes implementation. So the quality of life is below average, as result discrimination of people is been observed in respect of achieving a healthy environment.

References

1. Alkire, S. and Seth, S. (2008). Determining BPL Status Some Methodological Improvements. *Indian Journal of Human Development*, 2 (2): 407-424.
2. Bajpai, N., Jeffrey, D. S., Ravindra, H. D. (2010). *Improving Access and Efficiency in Public Health Services: Mid-term Evaluation of Indias National Rural Health Mission*. The Earth Institute, Columbia University, Sage Publication India Pvt. Ltd.
3. Berman, P and Ahuja R (2008). Government Health Spending in India, *Economic and Political Weekly*, 43(26): 209-216.
4. Besley, T.(1989). The Demand for Health Care and Health Insurance. *Oxford Review of Economic Policy,* 5(1):21-33.
5. Bhatia, J and Cleland, J. (1995). Determinants of maternal care in a region of South India. *Health Transition Review*, 5: 127-42.
6. Devadasan, N. et al. (2007). Indian community health insurance schemes provide partial protection against catastrophic health expenditure. *BMC Health Services Research,* 7: 43.
7. Devadasan, N. et al. (2013). Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Research Policy and Systems*, 11(29), 11-29.
8. Dilip, T. R. (2012). Why Use Consumer Expenditure Surveys for Analysis of the RSBY?.*Economic & Political Weekly*, 47(35):76.
9. Duggal, R. (2007), Poverty & health: criticality of public financing. *Indian Journal of Medical Resources*, 126(4):309-17.
10. Ekman, Bjorn. (2007). The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national household survey data, *Health Research Policy and Systems,* 5:6. (Http://www.health-policy-systems.com/content/5/1/6)
11. Government of India (2012), Report of the steering committee on health for the 12th five-year plan (http://planningcommission.nic.in/aboutus/committee/strgrp12/str_health 0203.pdf)
12. Government of India (2009). National Health Accounts India for 2004-05. New Delhi: National Health Accounts Cell, Ministry of Health and Family Welfare, Government of India.
13. Government of India, Ministry of Health and Family Welfare (2010). Annual Report to the People on Health, New Delhi.
14. Government of India, Ministry of Statistics (2001). National Sample Survey 2001. New Delhi.
15. Gupta Indrani & Purnamita Dasgupta (2002). Demand for Curative Healthcare in Rural India: Choosing Between Private, Public and No care. NCAER Working paper Series No.82, NCAER, New Delhi.
16. HLEG, (2011). Report on Universal Health Coverage for India. Submitted to the Planning Commission of India, New Delhi
17. Iyengar, S. and Dholakia, R. H. (2011). Access of the Rural Poor to Pimary Healthcare in India, W.P. No. 2011-05-03, Indian Institute of Management Ahmedabad (IIM-A), India.
18. Mohanty, S. K. and Pathak, P. K. (2009). Richpoor gap in utilization of reproductive and child health services in India, 1992-2005. *Journal of Biosocial Science*, 41(3): 381-398.
19. Morrisson, C. (2002). Health, education and poverty reduction. OECD Development Centre Policy Brief No. 19. Paris: OECD Development Centre.
20. Mukherjee, A. N. and Karmakar H (2008). Untreated Morbidity and Demand for Healthcare in India: An Analysis of National Sample Survey Data. *Economic and Political Weekly,* 43(46): 71-77.
21. Nair H and Panda R (2011) Quality of maternal healthcare in India: Has the National Rural Health Mission made a difference? *Journal of Global Health*, 1(1):79-86.
22. National Sample Survey Organization (2006). Morbidity, Health care and conditioned of the aged, NSS 60th Round, January-June, 2004. Ministry of Statistics and Programme Implementation, Government of India.
23. Public Health Foundation of India (2011). A Critical Assessment of the Existing Health Insurance Models in India. A Research Study Submitted by PHFI to the Planning Commission of India, New Delhi.
24. Purohit, B. C. (2001). Private initiatives and policy options: recent health system experience in India. Health Policy and

Planning,16 (1): 87-97.
25. Purohit, B. C. and Tasleem, A. S. (1994). Utilisation of Health Services in India. *Economic and Political Weekly*, 29 (18): 1071-1080.
26. Selvaraj, S. and Karan, A. (2012). Why Publicly-financed health insurance schemes are ineffective in providing financial risk protection. *Economy and Political Weekly*, 47: 60-69.
27. Shaban, A. and Bhole, L. M. (2000). Regional disparities in rural development in India. *Journal of Rural Development*, 19: 10317.
28. Shankar, P., Manmeet, K. and Rajesh, K. (2012). Universal Health Insurance in India:
29. Ensuring Equity, Efficiency, and Quality, *Indian Journal of Community Medicine,* 37(3): 142-149.
30. Shukla, A. (2005). National rural health mission--hope or disappointment? *Indian Journal of Public Health*, 49(3):127-132.
31. Sukumar V., Juyal, S. and Mehdi, A. (2010). Healthcare Delivery and Stakeholders Satisfaction under Social Health Insurance Schemes in India: An Evaluation of Central Government Health Scheme (CGHS) and Ex-servicemen Contributory Health Scheme (ECHS), Working Paper 252, Indian Council for Research on International Economic Relations (ICRIER), New Delhi.
32. Thakur, H. and Ghosh, S. (2009). User-fees in Indias health sector: can the poor hope for any respite? *ArthaVijnana*, 51(2): 139-158.
33. Venkat, R. A. and James, W. B. (2009). *Public-Private Partnerships in Health Care in India: Lessons for developing countries*. Routledge. Taylor and Francis Group. London & New York.
34. Wagstaff, A. (2002). Measuring equity in health care financing: reflections on and alternatives to WHOs fairness of financing index. *Health Economics*, 11(2): 103115.
35. Xu K., Evans D. B., Carrin, G., Aguilar-Rivera A. M., Musgrove, P. and Evans, T. (2007). Protecting households from catastrophic health spending. *Health Affairs*, 972-83.
36. Zeckhauser, R. (1970). Medical Insurance: A case Study of Trade-off between Risk Spreading and Appropriate Incentives, *Journal of Economic Theory*, (2):10-16.

Table -1: Availability of Healthcare Resources and Level of Satisfaction among the Respondents of Study Area

	Parametres	Number of Respondent	Availabilities of Health facilities and Schemes (%)		Satisfactory utilization of Health care resources (%)		
			Yes	No	Yes	No	DNK
Sex	Male	535	69.00	31.00	13.80	26.70	59.40
	Female	145	49.70	50.30		71.00	29.00
Age-group	< 30	174	62.60	37.40	18.40	40.80	40.80
	30 - 35	195	43.60	56.40	9.70	57.90	32.30
	35 - 40	154	76.00	24.00	14.90	23.40	61.70
	40 - 45	118	77.10	22.90		22.00	78.00
	> 45	39	100.00				100.00
Religion	Hindu	569	68.20	31.80	10.90	39.00	50.10
	Muslim	111	47.70	52.30	10.80	21.60	67.60
Residence	Rural	620	66.00	34.00	9.70	37.40	52.90
	Urban	60	53.30	46.70	23.30	23.30	53.30
Level of Income	< 5000	356	38.80	61.20	15.40	41.90	42.70
	5000 - 10000	186	88.70	11.30	9.10	24.70	66.10
	> 10000	138	100.00		1.40	37.00	61.60
Level of Education	Illiterate	50		100.00		24.00	76.00
	Primary	25		100.00		44.00	56.00
	Middle	104	5.80	94.20	26.90	42.30	30.80
	High School	188	76.10	23.90	14.40	32.40	53.20
	Intermediate	171	87.70	12.30		39.20	60.80
	Graduation +	142	100.00		13.40	35.90	50.70
Occupation	Farmer	166	45.20	54.80	9.00	68.70	22.30
	Industrial						
	Workers	17	100.00		100.00		
	Service	262	88.50	11.50	3.10	19.10	77.90
	Others	235	49.79	50.21	14.47	34.89	50.64
Social Group	General	203	85.70	14.30	5.90	39.90	54.20
	OBC	342	59.90	40.10	10.50	33.00	56.40
	SC	109	49.50	50.50	15.60	40.40	44.00
	ST	26	30.80	69.20	34.60	30.80	34.60
Total		680	64.90	35.10	10.90	36.20	52.90
Source : Primary survey and Data computed by Author							

Table-2 : Satisfaction with Government Health Insurance Schemes across Place of Residence and Religion

Factors	Place of Residence					
	Rural		Urban		Total	
Good Facility	42	(6.80)	6	(10.00)	48	(7.10)
Easy access	65	(10.50)	6	(10.00)	71	(10.40)
Less expensive	106	(17.10)			106	(15.60)
Convenient	25	(4.00)	16	(26.70)	41	(6.00)
Timely help	19	(3.10)			19	(2.80)
Poor quality	35	(5.60)			35	(5.10)
Lack of transparency	136	(21.90)	12	(20.00)	148	(21.80)
Mismanagement	79	(12.70)	12	(20.00)	91	(13.40)
Low awareness	76	(12.30)	8	(13.30)	84	(12.40)
Class discrimination	11	(1.80)			11	(1.60)
High number of formalities	26	(4.20)			26	(3.80)
Total	620	(100)	60	(100)	680	(100)
Source : Primary Survey and Data computed by Author						

Reasons	Education Level							Occupation				
	Illiterate	Primary	Middle	High School	Intermediate	Graduation and Above	Total	Farmer	Industrial Workers	Services	Other Wage Earner	Total
Good Facility			13	4		31	48			20	28	48
			(12.50)	(2.10)		(21.80)	(7.10)			(7.60)	(12.91)	(7.10)
Easy access	9		11	31	9	11	71	25		20	26	71
	(18.00)		(10.60)	(16.50)	(5.30)	(7.00)	(10.40)	(15.10)		(7.60)	(11.06)	(10.40)
Low expensive			18	58	10	20	106	35		41	30	106
			(17.30)	(30.90)	(5.80)	(14.10)	(15.60)	(21.10)		(15.60)	(12.77)	(15.60)
Convenient		8	14	17		2	41		17	10	14	41
		(32.00)	(13.50)	(9.00)		(1.40)	(6.00)		(100.00)	(3.80)	(5.96)	(6.00)
Timely help						19	19				19	19
						(13.40)	(2.80)				(8.08)	(2.80)
Poor quality				25	10		35	35				35
				(13.30)	(5.80)		(5.10)	(21.10)				(5.10)
Lack of transparency	8		24	15	88	23	158	30		101	17	148
	(16.00)		(23.10)	(2.70)	(51.50)	(16.20)	(21.80)	(18.10)		(38.50)	(7.23)	(21.80)
Mismanagement		4	8		43	36	91	25		52	14	91
		(16.00)	(7.70)		(25.10)	(25.40)	(13.40)	(15.10)		(19.80)	(5.96)	(13.40)
Low awareness	33	13	16	22			84	16			68	84
	(66.00)	(52.00)	(15.40)	(11.70)			(12.40)	(9.60)			(28.94)	(12.40)
Class discrimination					11		11			11		11
					(6.40)		(1.60)			(4.20)		(1.60)
High number of formalities				26			26			7	19	26
				(13.80)			(3.80)			(2.70)	(8.09)	(3.80)
Total	50	25	104	198	171	142	690	166	17	262	235	680
	(100)	(100)	(100)	(100)	(100)	(99)	(100)	(100)	(100)	(100)	(101)	(100)
Source : Primary survey and Data computed by Author												

Table-4 : Satisfaction with Government Health Insurance Schemes across Income Groups

Factors	Income Groups							
	< 5,000		5,000 - 10,000		> 10,000		Total	
Good Facility	17	(4.80)	17	(9.10)	14	(10.10)	48	(7.10)
Easy access	60	(16.90)			11	(8.00)	71	(10.40)
Less expensive	35	(9.80)	51	(27.40)	20	(14.50)	106	(15.60)
Convenient	39	(11.00)			2	(1.40)	41	(6.00)
Timely help					19	(13.80)	19	(2.80)
Poor quality	35	(9.80)					35	(5.10)
Lack of transparency	59	(16.60)	75	(40.30)	14	(10.10)	148	(21.80)
Mismanagement	12	(3.40)	21	(11.30)	58	(42.00)	91	(13.40)
Low awareness	62	(17.40)	22	(11.80)			84	(12.40)
Class discrimination	11	(3.10)					11	(1.60)
High number of formalities	26	(7.30)					26	(3.80)
Total	356	(100)	186	(100)	138	(100)	680	(100)
Source : Primary Survey and Data computed by Author								

Deepshikha Mutsuddi
Assistant Professor,
Department of Geography,
Maheshtala College, West Bengal
E-mail: deepsikha.geo@gmail.com