Knowledge of "Agrahara" Medical Insurance Scheme among employees of a selected public sector institution in Sri Lanka

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Abstract: The objective of this research was to assess the Knowledge of "Agrahara" Medical Insurance Scheme among selected group of policy holders in Sri Lanka and descriptive cross-sectional study design was used. Three hundred and seventeen (89.04%) were responded.

"Agrahara" was the only health insurance for 83.9% respondents. There was a statistically significant relationship (P = 0.022) between gender and knowledge on "Agrahara" insurance premium while only 32.5% knew their premium. Among respondents knowledge on benefit types vary from 10.1% to 79.2%. But overall knowledge was poor as 10.0%. Only 4.5% knew that all 10 benefit types are covered and 18.2% didn't know any type. There was statistically significant Relationship between gender and knowledge on paralysis coverage (P = 0.001), respondents' spouses employment in government sector and knowledge on childbirth coverage (P = 0.045), service period and knowledge on cancer cover (P = 0.003). There was a clear knowledge gap between groups on coverage of dependent parents and government employed spouses.

Overall knowledge on "Agrahara" was poor among public sector employees especially with regard to benefit types and benefit groups. Therefore, dynamic awareness programmes are essential to uplift the awareness and thereby to improve vertical and horizontal utilization in order to fulfill "Agrahara" objectives.

Key Words –   Medical Insurance, Alternative health financing, Out of pocket spending, Knowledge.

INTRODUCTION

Sri Lanka is a service sector dominated lower middle-income country and it accounts for 56.6% of GDP [1]. Sri Lankan population was 20,359 thousand as per last census held in 2021[2]. By the end of 2013 public servant population was 1,081,045 [3]. The Government sector as well as the private sector contributes for health care delivery and government sector dominates with 55% of GDP expenditure [4].

Although Sri Lanka is remarkably successful in delivering efficient and good quality health services health sector challenges are evolving. Increasing private health services demand, demographic and epidemiological transitions, increasing non communicable disease burden risks leading to inequalities in health care access, weak transferring of information by private sector and incorporation of common goals for both private and public sectors [5] are few of them.

Government health financing is mainly done through tax revenue collection and 83.6% of tax is collected through indirect taxation [6]. Therefore, general public has to pay more and more by way of indirect taxes to receive free health care at point of delivery. Share of health financing for government sector was Rs. 165billion [4], Rs 138.4 billion, Rs.177.8 billion [1] and Rs. 165 billion [7] in year 2013, 2014, 2015 and 2017 respectively.

Gradual decline of allocation of funds expresses the financing difficulties faced by the government and outstanding health financing feature is heavily dependent on private sector despite the free health care at the point of delivery by public sector [8]. Out of total country health financing, nearly 40% is out of pocket spending and personal health insurance also comes under it [4]. Out of the total private sector health expenditure 95.8% is out of pocket spending (OOPS) and it results in household catastrophic health expenditure with lacking financial protection [8]. A recent study has revealed that community based health insurances strongly support reducing out of pocket spending by the way of providing financial protection. Enterprise financing schemes like "Agrahara" and voluntary contributory health insurance schemes are the two main health care financing systems in Sri Lanka and which accounts for very small proportion [4].

"Agrahara" medical insurance scheme was initiated in 1997 by the government with prime objective of uplifting the living standards of public servants and it covers all the public servants and close family members except for the members of the three forces [9].

When consider the average size of the household of 3.8 [10], total coverage is approximately 3 million citizens including all the pensionable employees. It accounts for nearly one fifth of Sri Lankan population which is a quite significant amount.

Government sector inpatient admissions in 2013 were approximately 5.9 million [4] and it is 28.8% of the total population. In 2013 number of claims for "Agrahara" was 103,721 out of which government and private hospital inpatient claims were 48,912 and claims for spectacles was 52,831 [9]. Hence out of the "Agrahara" entitled population only 1.63% has utilized the benefits under inpatient category. If the numbers of inpatient claims are compared with the total government sector inpatients in 2013 it accounts to only 0.83% [4]. Despite the fact that15% of the Sri Lankan population is entitled to "Agrahara" only 0.83% of the inpatient admissions have utilized the "Agrahara" benefits.

As per the National Insurance Trust Fund (NITF) 2013 "private hospital claims for other illnesses" were 12,262 (31%) whereas government hospital claims for other illnesses were 27,162 (69%) [9].

What all those figures indicate is that the utilization of "Agrahara" medical insurance scheme is very low and out of those who utilized same, the majority received health care through government system. This is a double burden to government.

The monetary value of the private hospitals claims for other illnesses amounted to Rs.519,433,054 whereas this figure for the government hospitals was only Rs.135,187,766 [9]. Hence it is evident that 79% of the claim value has been distributed among only 31% of the total claims made in respect of private hospital treatments.

As per the National Insurance Trust Fund financial statements total contribution collected for "Agrahara" Scheme in the year 2013 was Rs.1,406,706,842 [9] and treasury contribution was 29.15%. The total insurance benefit claims for that year was Rs.1,130,123,071 [9] and it is 77% against net weighted premium without considering return from investments on treasury bonds, treasury bills and Debentures. Therefore, the return is not at the optimum level even though treasury contributes nearly 30% to the NITF. Above calculations further emphasize the double burden on government and raise the question of high claims for low admissions in private sector and weather there is any impact on seeking health care through private sector.

Therefore, study of knowledge on "Agrahara" is important in view of effective health financing together with reducing catastrophic health expenditure of public through enterprise insurance schemes.

The objectives of the present study were to assess the knowledge on "Agrahara" medical insurance scheme by employees at the Head Office of Department of Motor Traffic, Sri Lanka, with respect to 1) socio demographic characteristics, and 2) benefit categories.

RESEARCH ELABORATIONS

Methods

Descriptive cross-sectional study design was used, involving employees at the Head Office of Department of Motor Traffic, Sri Lanka. The survey was conducted in English Sinhala and Tamil languages, depending on the preference of the participants. The study protocol was approved by the Ethics Review Committee, Postgraduate Institute of Medicine, University of Colombo.

Study Populations

The study population consisted of total employees attached to the Head Office of Department of Motor Traffic Sri Lanka who are eligible for "Agrahara" medical insurance scheme. Employees who have not given consent and not completed at least two years of public service excluded for the study. Of the eligible sample of 356, yielding an 89.04% response rate.

Survey

The primary survey tool incorporated was validated and pre-tested self-administered questionnaire. Content validation was done to collect data to adequately cover all study objectives by two economic specialists in Central Bank of Sri Lanka. Questionnaire was pre-tested in two levels to improve the compliance.

Questionnaire was given to employees of 26 units of department through a unit coordinator with prior explanation of the purpose and ethical considerations. Consent forms and information sheets were distributed with the questionnaires and responded without consent were excluded from the study.

Definition of Outcome Measures

The focus of this study was to assess the knowledge on "Agrahara" medical insurance scheme by employees at the Head Office of Department of Motor Traffic, Sri Lanka. Therefore, the relevant sociodemographic and knowledge among public sector employees were assessed at the time of survey. Knowledge outcomes and utilization influencing factor outcomes were assessed for the two years. Knowledge was surveyed among policy holders.

Analysis

At the first stage all the data were entered to the original data sheet. Dummy tables were prepared according to the requirements of the objectives. Relevant frequency distributions were generated by original dataset. Data analysis was done using Statistical Package for Social Sciences version 21 (SPSS 21) software.

Statistical Methods

Age and service period was descriptively analyzed and generated mean and standard deviation as well. Cross tabulations were mainly carried out to find statistically significant relationships with outcome measures including socio demographic factors. The Pearson's Chi-square test was used to determine the significance level. P value set at 0.05 to determine significant level.

RESULTS & DISCUSSIONS

The mean age of the sample was 46.8 years while mean service duration was 21.29 years. The highest educational level of majority of the sample was G.C.E Advanced Level (43.7%) and 24.7% was educated up to degree level.

Total insurance penetration of the sample with regard to other insurances was 16.1%. Therefore majorities (83.9%) alternative health financing was "Agrahara" scheme. Even though the female male ratio of the country population is 11:9 for the own personal insurance it was 5:1. Therefore it is obvious that males were still not futuristic in health financing.

Least educated group had significantly high percentage (37.5%) of personal insurance penetration despite evidence of poor understanding of insurance concept among low educated groups [11]. Study also shows higher educated groups, higher level employees and employees with long service were not protected over health condition unless for "Agrahara" scheme.

There was a statistically significant relationship (P = 0.022) between gender and knowledge on "Agrahara" insurance premium while only 32.5% knew their premium. Among respondents knowledge on benefit types vary from 10.1% to 79.2%. But overall knowledge was poor as 10.0%. Only 4.5% knew that all 10 benefit types are covered and 18.2% didn't know any type. There was statistically significant Relationship between gender and knowledge on paralysis coverage (P = 0.001), respondents' spouses employment in government sector and knowledge on childbirth coverage (P = 0.045), service period and knowledge on cancer cover (P = 0.003). There was a clear knowledge gap between groups on coverage of dependent parents and government employed spouses.

The study researched for 12 utilization influencing factors for the "Agrahara" scheme and 4 were knowledge factors. More than 20% of never claimed respondents agreed upon three factors. Those were "I don't know about "Agrahara" benefit categories" (26.25%), "I don't know about Agrahara" (25%) and "I don't know how to claim" (22.5%) were awareness related influencing factors. Unawareness of the terms and conditions of the insurance policy [12][13], Unclear policy coverage in "Agrahara" scheme [14] and understanding of the concept of social insurance was poor in many people. Especially among the low educated group (Normand & Weber, 2009) there were supportive evidence for the less awareness. The finding of 30% of the employees who claimed for spectacles had government hospital admission and not claimed [14] for it also may be due to poor awareness of benefit types. However, the study reveals that overall knowledge on benefit types were poor as average 10.0% of benefit types were known to a respondent and 91.3% interviewers suggested conducting an awareness program to improve utilization. Also, the NITF officers were not satisfied with the public sector awareness level and they have taken initiatives to overcome knowledge barrier. They have appointed coordinator for each divisional secretary office, initiated communication tools to reduce communication and knowledge gaps.

CONCLUSIONS

The study has revealed that health insurance penetration was very low among the study group unless for the "Agrahara" Medical Insurance Scheme and overall Knowledge on benefit recipients was not satisfactory. Their knowledge was not dynamic with the policy features, new initiatives and benefit types which needing high cost medical interventions. Knowledge was good with only few benefit types including Private hospital admissions, Government hospital admissions and Spectacles cover which is not causing

catastrophic health expense. "I don't know about "Agrahara" benefit categories", "I don't know about Agrahara" and "I don't know how to claim" were the leading influencing factors for knowledge.

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