A STUDY ON IMPACT OF GOVERNMENT SOCIAL SCHEMES IN THE HEALTH CARE SECTOR IN INDIA –FINDINGS, CONCLUSION, AND SUGGESTIONS

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ABSTRACT
According to agency research, there is a huge market opportunity in the Indian healthcare industry. They have drawn attention to the fact that despite India having one of the lowest health insurance costs, a sizable portion of the population remains uninsured. There is no denying that, especially in rural and semi-urban areas, the current awareness level and penetrations are quite low. A study was conducted to examine the macro and micro effects of several government social programmes on the Indian health care industry. It was necessary to evaluate the impact on market penetration overall, customer segmentation, consumer behaviour, supply-side considerations including prices, and issues with the current goods and services. Maharashtra and Karnataka each had 400 beneficiaries surveyed. This essay offers the study's findings, conclusions, and recommendations.
Keywords: Healthcare, Social inequality, Government schemes, Marketing

Introduction

According to agency research, the Indian healthcare industry offers a humongous marketing opportunity. Despite the fact that health insurance in India is among the most affordable, they have drawn attention to the fact that a sizable portion of the population remains uninsured. Everyone agrees that the existing penetrations and awareness levels are quite low, especially in rural and semi-urban areas. An analysis of the macro and micro effects of several government social programmes on the Indian health care sector was conducted. Assessments were to be made of the impact on overall market penetration, customer segmentation, consumer behaviour, supply-side considerations including prices, and issues with the current products/services. Surveys were given to 400 recipients each from Maharashtra and Karnataka. The study's findings, recommendations, and conclusions are presented in this essay.

The research was carried to study the macroeconomic impact of social healthcare schemes of Central and State Government, to study the microeconomic impact of social healthcare schemes of Central and State Government, to evaluate the overall market penetration and the reach of social healthcare schemes of Central and State Government, to analyze the customer satisfaction of the social healthcare schemes of Central and State Government, to critically evaluate the health care offerings of the social healthcare schemes to the customers, and to study the management of social healthcare schemes of central and state government.

CSAT, or customer satisfaction, is a marketing word that is frequently employed. It is a gauge of how well an organization's goods and services live up to or surpass consumer expectations. Customer satisfaction is described as "the number of customers, or percentage of all customers, whose quantified experience with a firm, its products, or its services (evaluations) surpasses stated satisfaction objectives."

It is vital that the government and network together rise to the occasion and address these difficulties concurrently, inclusively, and sensibly in this changing environment with unique concerns that loom over the public's health and well-being. Universalism, justice, poise, security, and human rights are ethical concepts that must be dispensed with in order to address social concerns affecting health and economic issues. In achieving the ideal of the Right to Health, this strategy will be of great benefit to humanity. The ultimate test of success might be whether every Indian, from a small village in Bihar to the metropolis of Mumbai, has experienced the transformation.

Literature Review

Based on patient data, the investigation was conducted from April 2007 to December 2013. Simple measures like frequency counts, ratios, percentages, averages, and others were used to evaluate the scheme's presentation

and understand the effectiveness of the insurance mode. According to a brief analysis of the programme based on publicly accessible information and media reports, 87% of Andhra Pradesh's population was covered by the programme. Males used the method 40% more frequently than females, according to the sample analysis. When compared to 91% for Trust mode, the cost-benefit ratio for the insurance option was 81%. The scheme's insurance-based implementation is very inefficient financially. Patients' opinions on the programme revealed that the majority of them were satisfied with it; none of them had a negative opinion of the flagship project of the Government of Andhra Pradesh. The plan has already helped it spread successfully throughout the state. In order to achieve "Health for All," it wants to support the replication of similar programmes elsewhere. This will allow the most disadvantaged segments of society to assert their "right to life." She assumed that Andhra Pradesh's Rajiv Aarogyasri Community Health Insurance, a well-known social insurance programme with a private public partnership approach, would be able to handle the problem of catastrophic medical costs for tertiary care for low-income households (Shreedevi, 2014).

A model was investigated that is an all-encompassing approach to healthcare that provides free health checks through the network's hospitals and 24-hour helpline, which is staffed by 100 doctors and 1,600 paramedics and receives roughly 53,000 calls every day. With only a quick phone call, patients will always have access to the 108 and 104 Ambulance services right at their doorsteps. He claimed that even though Aarogyasri's disease coverage was limited, many patients still turned to the Chief Minister's Relief Fund for assistance in treating their various afflictions. The State Government's misaligned priorities are supported by the Aarogyasri Health Scheme. Only 500 of the 20,000+ patients who are admitted to the Network Hospitals each day from the public and private sectors of the state receive assistance from it. The remaining patients must pay out of pocket expenses. The opposition political parties claimed that Aarogyasri, with its emphasis on super speciality care, has merely assisted corporate hospitals in treating public hospitals like their stepmothers. The goal is to move 40% of the Aarogyasri operations back to government hospitals in order to fix the flaws in this programme. Government hospitals would benefit from more advanced equipment, better-equipped doctors, and the ability to receive incentives under this programme. The Andhra Pradesh government has stopped paying corporate hospitals and instituted penal measures against 66 hospitals in the state for making errors when providing care to patients covered by the Arogyasri Health Insurance Scheme (Mallikarjuna, 2014).

Health insurance is swiftly developing into a significant way of meeting individualised health care demands. The exam was given in the Rohtak region of Haryana and was based on primary information that was collected using a questionnaire technique from a sample of 150 respondents. Many statistical techniques have been used to examine the results. The findings showed that awareness of and desire in purchasing health insurance were low. The various benefits and risks of a policy were subject to much overlap among the responders, therefore health insurance providers should give precise policy details. Since they are prepared to pay an affordable premium each year rather than high medical bills in the event of a sickness, people in the middle and lower socioeconomic levels constitute a market that may be taken advantage of. Because government health insurance programmes provide capital certainty, which was why the majority of respondents preferred them, private insurance providers should make an effort to earn the trust of the public if they must enter the market. For a health insurance plan to be successful, it is essential to comprehend how people think and to design a package that is accessible, inexpensive, and agreeable to all social groups. The majority of respondents believed that in order to reduce unnecessary out-of-pocket costs and promote better use of healthcare resources, the government should develop a clear policy requiring everyone to enrol in a health insurance scheme (Goel, 2014).

Dealing with health insurance portability it is stated that it is a rule established by IRDA that allows a person to transfer insurers at their discretion without worrying about their no claim bonus and pre-existing conditions coverage. The purpose of the inquiry is to draw attention to portability, a mechanism that enables the policyholder to move the policy from one insurance provider to another. You can switch to a different product that might be offered elsewhere in the health insurance services if you are unhappy with the existing policy or services. The majority of the Indian health insurance industry is made up of the Social Health Insurance (SHI), Community Based Health Insurance (CBHI), and Private Health Insurance sectors. Health insurance is a small player in the Indian healthcare system. The study is supported by secondary information obtained from IRDA and research publications from different journals. Although health insurance portability has been legal for more than two years, the investigation found that it isn't widely known among companies that offer health insurance services because of its complexity, insurance agents' lack of interest, inappropriate correspondence, and lack of customer awareness (Yadav et al., 2014).

A study was carried in Andhra Pradesh, a state in southern India, which is putting into practise the popular Aarogyasri (health services) plan. Corporate hospitals handle the majority of cases in this system of providing healthcare. Unfortunately, there is no plan in place for ongoing (outpatient) care, which in fact could have made

this programme complete. The majority of people's requirements are less likely to be met by the current medical care model as a result of the emphasis on tertiary healthcare and the rejection of all other forms of medical help. A debate of the program's healthcare and techno-commercial performance is necessary, especially if other states and even the federal government want to adopt it in order to implement universal healthcare as part of the National Rural Health Mission. The programme seeks to provide tertiary surgical and medical treatment for serious illnesses for BPL households up to a value of 0.2 million (Indian National Rupees) per year, protecting them from excessive private borrowing. The Aarogyasri Health Care Trust, a public-private cooperation between Star Health & Allied Insurance, the corporate hospitals, and governmental authorities, oversees the scheme. In any case, this cooperation has ended as of the beginning of March 2013. Obstetrics is the only major area of speciality in the private sector's unregulated medical and healthcare industry. The current study is experimental in nature and will make an effort to evaluate the PPPs' features in the health sector, where public funding is typically subpar. In the state of Andhra Pradesh, where the function of the government has essentially vanished, it will also be explained how collaboration affects the general accessibility of health services (Kumar et al., 2013).

Offering all-inclusive, superior general healthcare services, such as primary care, screening, tertiary care, and rehabilitative care, in conjunction with network health insurance plans like RACHIS, could motivate people to band together for their health. The long-term viability of such expansive open sector schemes for the poor and impoverished must be ensured if the expense of protection, which is presently exclusively handled by the State Government, is shared or contributed in nature. RACHIS can increase access to healthcare for those who most need it, including vulnerable and underserved communities. More control over how services are delivered and utilised is beneficial for the general public. The Area Cancer Control Programme should be extended with accountability in mind and a strong sense of purpose. Building institutional and field-based cancer vaults will be important to find the crucial supporting data for a fruitful intervention. Encourage the use of evidence-based practises in the treatment of malignant growth in order to deliver efficient and suitable care. Finally, they argued that, in the age of globalisation, privatisation, or state corporatization, many Indian regions that are favoured by private medical organisations or have corporate health part infiltration can also support the viability of programmes like RACHIS by improving or offering top-notch oncology care. The Health Insurance Scheme must continue for people who face starvation. PAP smears provide for the early diagnosis of cervical disease (26.2%), and women over 40 should now undergo routine screenings while taking multiparity into consideration. A thorough breast cancer control scheme should exist to lessen the doom and mortality by early identification (Dudala et al., 2013).

A study identified the origins of medical insurance in India and other countries as well as to examine the growth trends and patterns of public and private health insurance in the post-advancement era. The study looks at how the medical insurance market is represented in relation to GDP, how the health insurance market as a whole shares non-disaster protection, and how well-informed family and friends are about public and private health insurance backup plans. According to the analysis, the market structure and entry level for the medical insurance industry are evolving over an ambiguous period of time. The better degree and number of people who are aware of the benefits of medical insurance have been steadily growing. Due to the growing number of private health insurance backup plans, competitive pressures, and the inclusion of rural areas with innovative new products, the growth rate and share of the overall industry of private medical insurance has been increasing while the number of general health safety net providers has been decreasing (Shahi, Gill, 2013).

Respondents' familiarity with and trust in medical insurance was good. Additional study demonstrates that while knowledge of medical care's accessibility is acceptable, inclination is typical. The majority of respondents take medical insurance into account, while others do not have a plan because they are unaware of or lack knowledge about health insurance. According to studies, there are clear implications for both the public and private medical insurance firms, as well as the Indian medical insurance industry. Most people think that the wages of respondents assume that they must work in order to have health insurance (Panchal, 2013).

A study was conducted to assess the guaranteed population's level of attentiveness and attitude towards treatment costs. The next section examines a few cost variables before addressing the role of TPAs and the impact of cashless services on treatment costs. It seeks to look at some of the evidence of both legitimate dangers and phoney moves in addition to the supplier's observations. According to the findings, few people who are covered by insurance are aware of the terms and conditions of their coverage, and the majority of them don't give a damn about the cost of their medical care. The suppliers frequently raise their prices and lean towards the middle pay group in exchange for greater cashless benefits. Although the TPA model has not been successful in lowering case costs, it has aided in providing impartial administrations, including cashless benefits. The classification of room leases is linked to the value structure of social insurance administrations, and as protected

patients are generally more demanding, they choose to stay in rooms of higher classifications. Cost-sharing by the protected will assist deal with this problem in some measure. There is a requirement to develop various methods to deal with supply-side good risks and fraudulent workouts because they pose a threat to the Indian medical insurance market. There is a chance for insurance companies to build long-lasting relationships with the preferred providers of medical services by using innovation and understanding how each other contributes to the needs of the average client (Kumar, Divi, 2013).

The study attempts to look at the business practises of speculators regarding medical insurance in the Salem district of Tamil Nadu state. Tthe important data collection was done by planned polling. For the examination, the opinions of 200 respondents were taken into account. Through this inquiry, it was found that the general population of the Salem area is unaware of medical coverage, and their salary level does not support expensive premium arrangements (Priyadarsini, 2013).

An online survey was conducted including a personal information form, a mistrust of the health care system scale, a vaccine hesitancy scale, and a health literacy scale was administered to 620 participants (Turhan et al., 2022).

An assessment was made of assessed the impact of the COVID-19 pandemic on household incomes and government policy responses in April 2020 in four large and hard-hit EU countries: Belgium, Italy, Spain and the United Kingdom (Canto et al., 2022).

Objective of the study

Following were the objectives set for the research:

1. To study the macroeconomic impact of social healthcare schemes of Central and State Government.
2. To study the microeconomic impact of social healthcare schemes of Central and State Government.
3. To evaluate the overall market penetration and the reach of social healthcare schemes of Central and State Government
4. To analyze the customer satisfaction of the social healthcare schemes of Central and State Government
5. To critically evaluate the health care offerings of the social healthcare schemes to the customers
6. To study the management of social healthcare schemes of central and state government.

Hypotheses of the study

Ho1 - There is a significant macroeconomic impact of social healthcare schemes of Central and State Government

Ha1 - There is no significant macroeconomic impact of social healthcare schemes of Central and State Government

Ho2 - There is a significant microeconomic impact of social healthcare schemes of Central and State Government

Ha2 - There is no significant microeconomic impact of social healthcare schemes of Central and State Government

Ho3 - The overall market penetration is deep in terms of the reach of social healthcare schemes of Central and State Government

Ha3 - The overall market penetration is not deep in terms of the reach of social healthcare schemes of Central and State Government

Ho4 - Customers are satisfied with social healthcare schemes of Central and State Government

Ha4 - Customers are not satisfied with social healthcare schemes of the Central and State Government

Ho5 - The health care offerings of the social healthcare schemes to the customers have been effective.

Ha5 - The health care offerings of the social healthcare schemes to the customers have not been effective.

Ho6 - The management of social healthcare schemes of central and state government is effective

Ha6 - The management of social healthcare schemes of central and state government is not effective

Materials and Methods

A survey questionnaire was used to collect primary data from 800 respondents from Maharashtra and Karnataka. The hypotheses were tested using a t-test by comparing the sample means with hypothesized population mean of agreement/disagreement of 50 per cent (connoting an event by chance). The hypotheses were tested at a 95 per cent confidence level. Convenience sampling methods was used. A t-test was preferred over the Z-test as the standard deviation of the population was not known. Sample size was calculated assuming that the population of beneficiaries in both the states is a large population, that is in excess of 20,000. At a 95% confidence level and a 5% interval, the sample size was estimated to 377 and was rounded off to 400 each to take care of sampling errors and ease of calculation.

Data analysis and interpretation

a. Testing of hypotheses

Summary of responses to main sections of the questionnaire are given in Table 1.

Question	1.1#	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	1.10	Average
Disagree %	85%	86%	83%	84%	88%	84%	83%	85%	87%	84%	**85%**
Question	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	Average
Disagree %	76%	70%	68%	69%	74%	73%	67%	74%	73%	71%	**71%**
Question	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	3.10	Average
Disagree %	72%	72%	72%	64%	74%	73%	67%	69%	71%	77%	**71%**
Question	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	4.10	Average
Dissatisfied %	75%	76%	81%	77%	76%	77%	75%	76%	76%	77%	**77%**
Question	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10	Average
Agree %	76%	77%	81%	78%	77%	78%	76%	78%	77%	78%	**78%**
Question	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9	6.10	Average
Disagree%	72%	74%	76%	75%	74%	75%	72%	74%	73%	74%	**74%**

Table 1: Summary of responses to main sections of the questionnaire
(Source: Primary data)

1.1 indicates sub question 1 of section 1, 1.2 indicates sub question 2 of section 2. These details are given below by way of a table.

1.1	Social schemes have led to increased awareness about health care
1.2	Schemes of the Government have given wide publicity to the concept
1.3	They have led to inclusion of classes like women, rural people etc.
1.4	Major portion of middle class and working class have been included
1.5	Schemes have eased overall access to health care
1.6	Government intervention has made health care protection more affordable
1.7	The divide between classes and masses has been considerably reduced
1.8	People today have recognized that health care expenditure is a risk and needs protection
1.9	Governments active participation has prompted an active participation from the private sector
1.10	Areas like medical tourism are taking off
2.1	Family health care expenditure has come down
2.2	As a result of lower health care expenditure savings have gone up
2.3	Tax benefits like 80 D have increased
2.4	Cost of insurance premium has reduced
2.5	Reimbursement of claims has speeded
2.6	Cashless coverage has increased
2.7	Coverage now extends to entire family
2.8	Despite being from BPL family, health care is now affordable for my family
2.9	Personal level anxiety of health care expenditure has reduced
2.10	Feeling of being financially secured has increased
3.1	Health insurance schemes like Ayushman Bharat have helped big penetration
3.2	Cost of insurance has come down

3.3	Number of health care organizations have increased substantially
3.4	A new service channel in the form of Public Private Partnership (PPP) has emerged due to Government schemes
3.5	Number of health care products have increased substantially
3.6	Coverage to BPL families has widely increased
3.7	Affordable options in products have increased
3.8	Number of private trust hospitals have widely increased
3.9	Systems are becoming more transparent thanks to technology
3.10	Technology has also helped in improving quality and efficiency
4.1	Doctor Qualification & Medicine Updating
4.2	Speed in Completing Medical Examination
4.3	Expertise Service Providers
4.4	Accuracy & Timely Report
4.5	Cost Feasibility
4.6	Modern Equipment for Diagnosis
4.7	Environment & Toilet Cleanliness
4.8	Care of Nursing
4.9	Friendliness & Courtesy of Staff Members
4.10	Treatment Outcome Level
5.1	Quality is far off from desirable levels
5.2	Price remains on the higher side
5.3	Delivery chains are poorly managed
5.4	Products are not customized to the extent required
5.5	Generic medicines (available at low cost) are not readily accessible
5.6	Duplicates affect quality
5.7	Costly diagnostic tests are often unnecessarily prescribed
5.8	"Cut practice" is rampant
5.9	Insurance procedures are cumbersome
5.10	Insurance procedures involve sizable manipulations
6.1	Management is effective in terms of the objectives stated
6.2	Management is efficient and no wastage of resources is seen
6.3	Schemes have been well-planned
6.4	Communication of schemes is quite clear
6.5	Directions for implementation are clear and effective
6.6	Control over schemes is strong
6.7	Schemes reflect strategic thinking
6.8	Implementation at operational level is well coordinated
6.9	Central and State schemes complement each other well
6.10	Schemes are comprehensive and cater to high inclusion

Table 2: Details of questions
(Source: Author)

All the six averages were tested for statistical significance against hypothesized mean of 50% agreement/disagreement level of the population. Results are given in Table 2.

Sr. No.	Parameter	H1	H2	H3	H4	H5	H6
1	Sample mean	85%	71%	71%	77%	78%	74%
2	Standard deviation of sample	0.90814	1.01374	1.0085	0.99248	0.984871	0.90021
3	H1	50%	50%	50%	50%	50%	50%
4	Ho	0.85	0.71	0.71	0.77	0.78	0.74
5	N (sample size)	800	800	800	800	800	800
6	t-value	10.84	5.99	5.86	7.58	7.94	7.49
7	p-value	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001
8	Decision	Reject Null	Reject Null	Reject Null	Reject Null	Reject Null	Reject Null

Table 3: Hypotheses testing @ 95% confidence level
(Source: Primary data analysis)
Going by the p-values of <0.05, all the six null hypotheses were rejected.

b. Finer data analysis

While in case of Macro-impact, micro-impact and market penetration, the responses from the two states of Maharashtra and Karnataka are not significantly different, in case of customer satisfaction, critical evaluation and management effectiveness, the responses are significantly different.

Findings

a. Findings related to profile

i) The distribution of respondents State was 400 of Maharashtra group; and 400 for Karnataka group.

ii) The division of respondents Category was 400 of Urban group; and 400 for Rural group.

iii) The age distribution was as follows: 224 for the 20-29 year group, 158 for the 30-39 year group, 208 for the 40-49 year group, and 210 for the group older than 50 years.

iv) The spread of respondents Gender was 378 of Male group; and 422 for Female group.

v) The distribution of respondents Type was 541 of Beneficiary group; and 259 for Hospital employee group.

vi) The division of Experience of dealing with Government Health Schemes was 424 of <3 years group; 158 for 3-5 years group; and 218 for >5 years group.

vii) The spread of respondents predominant experience with Government Schemes types was 308 of Insurance group; 258 for Non-insurance group; and 234 for Both group.

b. Inferential analysis

i) Findings show that for the variable macroeconomic and microeconomic impact of different social schemes the disagreement for sizable positive impact by the sample was 85% for macro-impact and 71% for micro-impact.

ii) For the variable impact on overall market penetration, customer segmentation and supply side factors the disagreement for success by the respondents is 71%.

iii) It was found that for the variable customer satisfaction the dissatisfaction was expressed by majority of the respondents, 77%.

iv) In case of the variable critical evaluation of service offerings the agreement to problems with the schemes by the respondents is 78%.

v) For the variable management of social healthcare schemes the disagreement of the sample is 74% for effectiveness of the management.

vi) Neither the central nor state governments' social healthcare programmes have a large macroeconomic impact.

vii)Similarly there is no significant micro impact of the central nor state governments' social healthcare programmes.

viii) That the overall market penetration is deep in terms of reach of social healthcare schemes of Central and State Government has been summarily rejected.

ix) The programmes received negative feedback from the clients.

x) The health-care offerings have been ineffective on a number of fronts.

xi) Management of the schemes has been grossly ineffective.

Conclusion

Neither the central nor state governments' social healthcare programmes have a large macroeconomic impact. There is strong disagreement with the first 10 points, including: Social programmes have raised public knowledge of health care; and others. Similar is the case with micro-impact. Wide disagreement to the ten statements, namely, family health care expenditure has come down and others show that respondents just do not agree for a microeconomic impact of the government social schemes in healthcare. That the overall market penetration is deep in terms of reach of social healthcare schemes of Central and State Government has been summarily rejected. Strong disagreement to statements, namely, Health insurance schemes like Ayushman Bharat have helped big penetration, cost of insurance has come down, and others were recorded. The programmes received zero positive feedback from the clients. The open expression of dissatisfaction on a number of different parameters, such as doctor qualification and medication updating, and others demonstrates the high level of customer dissatisfaction with the schemes. The health-care offerings have been ineffective on a number of fronts. Wide agreement to statements, namely, quality is far off from desirable levels, price remains on the higher side and others clearly prove the ineffectiveness of the offerings. Management of the schemes has been grossly ineffective.

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