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Assessment of Health Insurance Utilization and the Associated Barriers in a Rural-to-Semi-Urban Setting in Idukki, Kerala, India: A Cross-Sectional Study

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Abstract

Introduction

Health insurance coverage in developing regions often exhibits disparities between urban and rural populations, along with a notable gap between policy enrollment and actual utilization. Local-level evaluations are essential to determine whether broad regional trends accurately reflect realities at the community level. This study aimed to assess the enrollment status, utilization patterns, and associated barriers regarding health insurance in a rural-to-semi-urban locality surrounding a municipality in Kerala, India.

Methods

A cross-sectional study was conducted across two *panchayats* near the Thodupuzha municipality, in the Idukki district of Kerala, India. Using a cluster sampling technique, a sample size of 106 households was targeted, resulting in 106 successfully selected households. Data were gathered via a structured questionnaire administered primarily to the heads of the families. The primary objective was to evaluate health insurance enrollment and utilization. Secondary parameters, including service availment, policy renewal, user satisfaction, difficulties faced, and specific concerns regarding health insurance schemes, were also documented and analyzed.

Results

Of the 106 participant households, 101 respondents (95.2%) demonstrated awareness of health insurance. Overall, 65 households (61.32%) reported prior or current enrollment, while 41 households (38.68%) had never been enrolled. Complete household coverage (all members enrolled) was observed in 28 households (26.4%), whereas only the head of the family was enrolled in 6 households (5.7%). At the time of the study, 58 (54.7% of the total 106) families had active coverage. Among the currently enrolled cohort, only 32 households (30.2% of the total sample) had successfully utilized health insurance benefits.

Conclusion

This cross-sectional study demonstrated high community awareness and moderate cumulative enrollment regarding health insurance in a semi-urban setting in Kerala. However, actual utilization remained low relative to enrollment rates, alongside variable user satisfaction. These findings highlight a critical implementation gap between having health insurance coverage and translating it into accessible healthcare utilization, emphasizing the need for targeted awareness campaigns and administrative simplification at the local governance level.

Categories: Health Policy, Public Health, Preventive Medicine

Keywords: barriers to healthcare insurance, healthcare insurance enrollment, health insurance, health insurance awareness, health insurance utilization

Introduction

Health insurance enrollment and its use help lower the financial burden of healthcare spending. It plays a crucial role in household financial stability by mitigating health expenditures, providing family members with healthcare access at lower premium payments compared to substantial out-of-pocket medical bills. According to the National Family Health Survey-5 (2019-2021; NFHS-5), approximately 41% of households in India are covered by some form of health insurance, with significantly higher coverage in urban areas compared to rural regions [1]. Persistent disparities exist not only between urban and rural coverage but also between initial insurance enrollment and actual healthcare utilization. One study which was conducted in Andhra Pradesh found that while 64% of respondents were aware of government health insurance schemes, only 56.3% had enrolled, and an even smaller proportion (37.5%) had actually utilized the benefits

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[2]. Similarly, a study in Kerala reported the coverage of publicly financed health insurance schemes to be 45.8% [3].

Despite existing regional and national data, there remains a critical need for localized studies in remote rural and semi-urban settings to thoroughly evaluate actual enrollment and utilization patterns. Adequate health insurance awareness, including comprehensive knowledge of policy benefits and coverage scopes, is a prerequisite for informed enrollment decisions. However, awareness and utilization remain persistently low in many rural areas, as demonstrated by studies in rural Karnataka, where only 65.7% of households were aware of health insurance and the utilization score was merely 45.5% [4]. Local or *panchayat*-level investigations are vital to determine whether broad state and national trends accurately reflect micro-level realities in village or semi-urban settings. A *panchayat*, specifically a *gram panchayat*, is an Indian rural administrative institution that is composed of elected representatives at the village level, who, along with the concerned state's supportive administrative staff, oversee and implement various social and economic activities inside that designated area.

This cross-sectional study was conducted to assess local health insurance enrollment, utilization rates, and associated barriers in a rural-to-semi-urban locality surrounding a local municipality in Kerala. The primary objective was to study enrollment in health insurance schemes among the families studied, regardless of the type of scheme and the number of persons covered by it; various aspects of utilization of health insurance, satisfaction, and concerns related to health insurance schemes were studied as the secondary objective.

Materials And Methods

Study design and setting

A descriptive, cross-sectional study was conducted between October and December 2025 across two selected rural-to-semi-urban *panchayats* - Kumaramangalam and Purappuzha - located in the Idukki district of Kerala, India.

Inclusion and exclusion criteria

Households with permanent residents whose primary respondents (ideally the head of the family) were willing to provide informed consent and participate in the study were included. When a selected household respondent was unavailable or unwilling to participate, the immediate next neighboring household was approached. Households living on rent and non-permanent transient populations, such as migrant workers, were excluded from the survey.

Study tool

Data were collected using a semi-structured questionnaire designed specifically for this study, which was reviewed; content and face validity were tested by subject experts in the Department of Community Medicine. The questionnaire captured information across two core domains: general sociodemographic characteristics (age, gender, education, occupation, and socioeconomic status classified using the Modified Kuppuswamy scale [5]) and specific variables concerning health insurance (awareness, knowledge of scheme concepts, enrollment status, benefits availed, user satisfaction, experienced barriers, and recommendations).

Operational definitions

Awareness was defined operationally as whether or not the respondents had heard about the concept of health insurance in their lifetime. Enrollment was defined as whether or not the family or anyone in the family had at least once in their lifetime registered for or joined any of the available insurance schemes in the country. If multiple individuals in a family were registered with multiple insurance schemes or had family coverage along with other personal coverage schemes, that family was considered a single enrolled unit. Current enrollment was defined as having an active, ready-to-use, functional insurance scheme.

Sample size calculation

The sample size was estimated using the standard formula for cross-sectional studies. Because health insurance enrollment rates vary significantly across different states and districts in India (ranging from 30% to over 70%), an anticipated population prevalence (p) of 50% was assumed to maximize sample size estimation. With an allowable relative precision of 20% and a 95% confidence interval, the target sample size was finalized at 106 households.

Sampling technique and data collection

A convenience sampling approach combined with localized contiguous selection was employed. Two wards from the Kumaramangalam *panchayat* and two wards from the Purappuzha *panchayat* were selected randomly from the list of wards in the *panchayats*. Field visits were scheduled during October and November 2025, with evening hours preferred to ensure maximum availability of respondents. Data were collected via

face-to-face interviews administered directly by the investigators using structured physical questionnaire proformas. From Kumaramangalam *panchayat*, we selected a total of 27 families from four different roadside or pocket areas using convenience sampling. Sampling was done proportionately from each of the four areas. Similarly, from each ward in the Purappuzha *panchayat*, we sampled 26 families, with a total of 54 from the Kumaramangalam *panchayat* and 52 from the Purappuzha *panchayat*, leading to a final sample size of 106 households for the study.

Statistical analysis

The collected data were manually entered into Microsoft Excel (Microsoft Corporation, Redmond, USA), thoroughly checked for errors, and cleaned before analysis. Descriptive statistical analysis was done using IBM SPSS Statistics, version 25 (IBM Corp., Armonk, USA), based on which appropriate discussions and conclusions were derived. Quantitative variables were summarized as means and standard deviations, whereas qualitative variables were expressed as frequencies and percentages (proportions).

Ethical considerations

Formal approval to conduct the study was granted by the Institutional Ethics Committee, Al-Azhar Medical College and Super-Specialty Hospital (approval no. AAMC/IEC/2023-2024/3-7). Informed consent was obtained from all participating respondents before data collection, and strict data anonymization protocols were maintained to ensure privacy and confidentiality.

Results

Demographic characteristics

A total of 106 respondents representing households across the selected *panchayats* participated in the study. The demographic profile of the study population is summarized in Table 1. Among the respondents, 60 (57.0%) were female, and 46 (43.0%) were male. Regarding family structure, the majority of households belonged to nuclear families (n=67, 63.2%), followed by three-generation families (n=23, 21.7%) and joint families (n=16, 15.1%). Monthly household income varied, with the largest proportion falling in the INR 10,000-20,000 range (n=36, 33.9%), closely followed by the INR 20,000-30,000 range (n=33, 31.1%). Only 15 households (14.15%) reported a monthly income of less than INR 10,000. Age distribution showed that the highest representation was in the 45- to 55-year age group (n=26, 24.5%) and the 55- to 65-year age group (n=25, 23.5%). In terms of educational attainment, nearly half of the respondents possessed graduate-level education (n=49, 46.2%), while 20 (18.8%) had reached the higher secondary level, and only three (2.8%) reported no formal education. Occupational classification based on the Modified Kuppuswamy scale revealed that over half of the respondents were engaged in elementary occupations (n=56, 52.8%), while 22 (20.7%) were skilled workers, and 11 (10.3%) were skilled agricultural workers.

Variable	Category	Frequency	Percentage
Gender	Male	60	57
	Female	46	43
Type of family	Nuclear family	67	63.2
	Joint family	16	15.1
	Three-generation family	23	21.7
Family income distribution (INR)	<10,000	15	14.15
	10,000-20000	36	33.9
	>20,000-30,000	33	31.1
	>30,000-40,000	12	11.3
	>40,000-50,000	7	6.6
	>50,000-60,000	2	1.88
	>60,000	1	0.94
Age (years)	15-25	3	2.83
	25-35	12	11.3
	35-45	12	11.3
	45-55	26	24.5
	55-65	25	23.5
	65-75	19	17.9
	75-85	9	8.49
Education level	Graduate level	49	46.2
	Higher secondary level	20	18.8
	Secondary level	11	10.3
	Primary level	23	21.6
	No formal education	3	2.8
Occupation	Professionals	5	4.7
	Associate professionals	4	3.7
	Clerks	2	1.8
	Skilled workers	22	20.7
	Skilled agricultural workers	11	10.3
	Trade-related work	3	2.8
	Elementary occupation	56	52.8
	Unemployed	3	2.8

TABLE 1: Demographic characteristics of the study respondents (N=106)

INR: Indian rupee

Enrollment and utilization of health insurance

Findings regarding health insurance awareness, enrollment patterns, renewal status, and service utilization

are detailed in Table 2. A vast majority of the study population (n=101, 95.2%) demonstrated awareness regarding health insurance. In 65 households (61.32%), at least one member was enrolled, whereas 41 households (38.68%) had no members enrolled. Regarding intra-household coverage, all family members were enrolled in 28 households (26.7%), some members were enrolled in 31 households (29.2%), only the head of the family was enrolled in 6 households (5.7%), and no members were enrolled in 41 households (38.7%).

Variable	Category	Frequency	Percentage
Awareness (N=106)	Aware	101	95.2
	Not aware	5	4.8
Enrolment (N=106)	At least one member enrolled	65	61.32
	No members enrolled	41	38.68
Current enrolment (N=65)	Currently enrolled member present	58	54.7
	Previously enrolled and now inactive	7	6.60
Family members enrolled (N=106)	All members enrolled	28	26.7
	Only head	6	5.7
	Some members	31	29.2
	No one	41	32
Renewal status among currently enrolled (N=58)	Active and renewed	53	50
	Not recently renewed	5	4.7
Currently enrolled and availed benefits (N=58)	Yes	32	55.17
	No	26	44.83
Satisfaction with benefits availed among current and past enrollees (N=65)	Satisfied	34	32.1
	Partially satisfied	3	2.8
	Not satisfied	1	0.9
	Not applicable	68	64.2
Satisfaction with current insurance (N=106)	Yes	49	46.2
	No	9	8.5
	Not sure	14	13.2
	Not applicable	34	32.1
Services covered	Surgeries (N=106)	73	68.8
	Hospital expenses (N=106)	71	66.9
	OPD charges (N=106)	74	69.8
	Medicines (N=106)	49	46.2
	Maternity care (N=106)	49	46.2
	Don't know (N=106)	23	21.6

TABLE 2: Enrollment, utilization, and coverage characteristics of health insurance

At the time of the study, 58 households (54.7%) held active current enrollment, while 7 households (6.60%) had previously been enrolled but let their policies lapse. Among the currently enrolled group, 53 households (50.0% of the total cohort) maintained active and renewed coverage, whereas 5 households (4.7%) had not recently renewed their policy. Of the 58 currently enrolled households, 32 (55.17% of active enrollees,

representing 30.2% of the total study sample) had successfully availed themselves of health insurance benefits.

When assessing satisfaction, 34 respondents (32.1%) were satisfied with the benefits availed, 3 (2.8%) were partially satisfied, and 1 respondent (0.9%) was dissatisfied (with the metric being non-applicable in 68 respondents who had never used benefits). Regarding overall satisfaction with their current insurance scheme, 49 respondents (46.2%) reported being satisfied, 9 (8.5%) were unsatisfied, and 14 (13.2%) were unsure. Regarding perceived scheme coverage, respondents identified insurance utility for medicines (n=74, 69.8%), surgeries (n=73, 68.8%), general hospital expenses (n=71, 66.9%), outpatient department (OPD) charges (n=49, 46.2%), and maternity care (n=49, 46.2%), while 23 respondents (21.6%) were unaware of specific service inclusions.

Attitude and barriers regarding health insurance

Participant attitudes, perceived necessity, and barriers concerning health insurance are summarized in Table 3. When asked about primary barriers and concerns, 40 respondents (37.7%) reported having no concerns, whereas cited challenges included high premium costs (n=18, 16.9%), complicated administrative procedures (n=17, 16.0%), lack of awareness (n=11, 10.3%), and poor service experiences (n=7, 6.6%). Regarding advocacy, 60 respondents (56.6%) indicated they would recommend health insurance to others, 34 (32.1%) were uncertain ("maybe"), and 12 (11.3%) would not recommend it.

Variable	Category	Frequency	Percentage
Concerns regarding health insurance	Complicated procedure	17	16
	High premium	18	16.9
	Lack of awareness	11	10.3
	Poor service	7	6.6
	No concerns	40	37.7
	Not applicable	20	18.8
Whether or not will recommend insurance to others	Yes	60	56.6
	No	12	11.3
	Maybe	34	32.1
Necessity of health insurance	Strongly agree	43	40.6
	Agree	42	39.6
	Neutral	9	8.5
	Disagree	6	5.7
	Strongly disagree	6	5.7
Believed it reduced out-of-pocket expenditure	Yes	82	77.4
	No	8	7.5
	Unsure	16	15.1

TABLE 3: Participant attitudes, perceived necessity, and barriers regarding health insurance (N=106)

When evaluating perceived necessity, 43 respondents (40.6%) strongly agreed that health insurance is essential, 42 (39.6%) agreed, 9 (8.5%) remained neutral, 6 (5.7%) disagreed, and 6 (5.7%) strongly disagreed. Furthermore, the majority of the study population (n=82, 77.4%) believed that health insurance effectively reduces out-of-pocket healthcare expenditures, while 8 (7.5%) disagreed and 16 (15.1%) were unsure.

Discussion

This cross-sectional study evaluated the awareness, enrollment patterns, utilization rates, and associated barriers regarding health insurance among households in two semi-urban *panchayats* of the Idukki district,

Kerala. Our findings revealed a high level of community awareness paired with moderate cumulative enrollment, while highlighting a persistent gap between health insurance possession and actual benefit utilization.

Sociodemographic profile

The study population was predominantly female (57%), with diverse age groups (32.8% aged 15–25 years), education levels (46.2% graduates or above), and occupations (54.7% professionals). These characteristics align with the objective to contextualize insurance metrics against socioeconomic factors, as higher education and professional occupations often correlate with better scheme uptake.

Awareness levels

Awareness of health insurance was high at 95.2%, supporting the objective to gauge knowledge gaps in local settings. This exceeds national rural averages (e.g., NFHS-5's 41% coverage) and matches Kerala's higher baseline, like one of the studies reporting 70% awareness of the Karunya scheme [3]. Another study conducted in Delhi highlighted that 18% of study subjects were insured and there was very low awareness among study subjects (only 19%) [6]. Thus, Idukki's near-universal awareness reflects Kerala's stronger public health outreach but underscores the need to convert it to action.

Enrollment status

Family enrollment stood at 61.3%, with over 50% currently active, addressing the aim to evaluate penetration in *panchayat* areas. This is higher than rural Karnataka's 45.5% [4] and another study conducted in Dharwad, Karnataka, which reported a family enrollment of 30%–33% [7]. A study on Kerala's Comprehensive Health Insurance Scheme (CHIS) in the Kollam district showed demand-side barriers, such as socioeconomic status, limiting uptake, mirroring Idukki, where 45% were unenrolled, possibly due to similar access issues in hilly terrains [8].

Satisfaction and perceptions

Satisfaction with schemes was positive (46.2% satisfied), with 77.4% believing it reduces out-of-pocket expenses and 56.6% recommending it, aligning with user experience objectives. Concerns included complicated procedures (16%) and high premiums (16.9%), aligning with the CHIS study citing inadequate coverage and poor public facilities [8]. However, 37.7% with no concerns related to health insurance matters could indicate their limited concerns about out-of-pocket spending on healthcare.

Utilization of benefits

Only 30.2% availed benefits, with 32.1% satisfied among users, fulfilling the objective to measure actual scheme usage. This low rate echoes previous studies in Kerala, such as the study on the Karunya scheme (45% utilization in Kerala) [3], and national trends where awareness exceeded use, as seen in Karnataka's 45.5% enrollment compared to 65.7% awareness [4]. A systematic review noted the highest utilization in Karnataka (78.8%) but the lowest in Odisha (12.6%), attributing gaps to exclusions like OPD; Idukki's figures suggest persistent supply-side issues, such as limited provider choice, despite high perceived coverage for hospitalizations (69.8%–73%) [9].

Barriers and recommendations

Key barriers were procedural complexity and premiums, with 40.6% strongly agreeing on the necessity of health insurance schemes, aligning with the study's objectives to address financial hardships and inform future policy recommendations. This mirrors demand-side factors in Kerala studies (procedural complexity, limited OPD coverage) and national calls for Information, Education, and Communication (IEC) campaigns [10]. Unlike lower rural awareness elsewhere, Idukki's high baseline awareness implies that focusing on process simplification could elevate enrollment/utilization beyond state averages (70% awareness; 45% use) [3].

Global comparison

On a global scale, countries striving toward universal health coverage (UHC) frequently encounter similar demand- and supply-side obstacles, including administrative friction, premium affordability, and incomplete service baskets. World Health Organization reports consistently indicate that insured populations often continue to face out-of-pocket spending for pharmaceuticals and diagnostic investigations, underscoring the universal need for refined policy frameworks that enhance both financial risk protection and service accessibility [11].

Limitations

Several limitations should be considered when interpreting the findings of this study. First, the cross-sectional design captures data at a single point in time, precluding causal inferences. Second, the study was conducted with a sample size of 106 households across two specific *panchayats* in the Idukki district, which

may limit the generalizability of the findings to broader urban environments or remote tribal terrains. Finally, reliance on self-reported data introduces potential recall and social desirability biases. Despite these constraints, the study's methodological strength lies in its direct, face-to-face household data collection conducted on the ground, offering granular micro-level insights that can serve as a foundation for larger, multi-centric investigations.

Conclusions

This cross-sectional study demonstrates that while health insurance awareness and cumulative enrollment are robust in the semi-urban *panchayats* of Idukki, Kerala, a substantial gap persists between policy possession and actual benefit utilization. Despite high community awareness and active enrollment rates, only a minor proportion of households successfully availed themselves of scheme benefits, hindered by procedural complexities, premium costs, and operational barriers. These findings emphasize that achieving effective financial risk protection requires more than simply expanding baseline coverage; it necessitates targeted administrative simplification, localized educational campaigns, and enhanced healthcare access. Future large-scale investigations are warranted to further explore these implementation bottlenecks and optimize health insurance uptake across diverse rural and semi-urban settings.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Pranav V. Vasisht, Sandhya G. I

Acquisition, analysis, or interpretation of data: Pranav V. Vasisht, Sandhya G. I

Drafting of the manuscript: Pranav V. Vasisht, Sandhya G. I

Critical review of the manuscript for important intellectual content: Pranav V. Vasisht, Sandhya G. I

Supervision: Pranav V. Vasisht, Sandhya G. I

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Institutional Ethics Committee, Al-Azhar Medical College and Super-Specialty Hospital issued approval AAMC/IEC/2023-2024/3-7. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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