ISSN : 0973-5976

Health Insurance : Penetration and Awareness in Punjab

*Ms. Tishey Rakshita
**Ms. Payal Arora

ABSTRACT

Indian insurance markets are among the fastest growing markets in the world. Health insurance is one of the world's fastest growing insurance products. Thus health insurance is having the highest growth potential in India with 1.15 bn population. But the growth potential of health insurance has always remained untapped in India for many reasons. Health care is financed through general tax revenue, community financing, out of pocket payment and social and private health insurance schemes. India spends about 4.9% of GDP on health *(WHR, 2002)*. The per capita total expenditure on health in India is US$ 23, of which the per capita Government expenditure on health is US$ 4. Hence, it is seen that the total health expenditure is around 4.9% of GDP, with breakdown of public expenditure (0.9%); private expenditure (4.0%). The private expenditure can be further classified as out-of-pocket (OOP) expenditure (3.6%) and employees/community financing (0.4%). It is thus evident that public health investment has been comparatively low. This paper attempts to analyse awareness of health insurance and various reasons of low penetration in Punjab like less promotional measures, high claim ratio, increasing litigation with customers, dissatisfaction among the insuring public for loading of premium as well as rejection of claims, delay by the TPA's to process cashless hospitalisation, delay by insurers in payments to TPA's and overcharging by hospitals to insureds.

Keywords: *Reasons of low penetration of health insurance, promotional measures, litigation with customers*

INTRODUCTION

Health insurance in India developed quite late as compared to developed countries. Voluntary health insurance, also called mediclaim insurance started in 1986. These policies were sold by subsidiaries of General Insurance Corporation (GIC). The potential for life insurance is very large in India. Currently less than 15 percent of the Indian population has some kind of health insurance cover. This includes those covered under the central government health scheme (four million beneficiaries), the railways health scheme (1.2 million) and the employees state insurance scheme (0.3 million). Further, a study states that out of 312 million insurable people only 65 million people are insured. It is noteworthy that more than 40 percent of individual who are hospitalized in India every year either borrow money or sell assets to cover the cost of health care. The above discussion clearly reveals that health insurance has low penetration in India. Therefore, there is a need to create awareness about the immense benefit of health insurance in India.

With the opening of the insurance sector , it was estimated that health insurance will improve significantly, with a population of over a billion , its rather sad that health insurance has not penetrated much in India, although it offers huge potential for health insurance products. This study aims at analyzing reasons for low penetration of health insurance sector in spite of the economic growth of 7-8 percent which has brought relative prosperity in the lower middle income groups of people with increased consciousness for better health care.

This article will address the issues of low penetration of health insurance in Punjab and how it can be overcome so that both the demand side (consumer) and the supply side (companies) can contribute towards the deep penetration of health insurance products in Punjab. This study will also determine the causes for its low penetration in India in general.

REVIEW OF LITERATURE

Both macro and micro studies on the use of health care services show that the poor and disadvantaged sections are forced to spend a higher proportion of their income on health care than the better off. The burden of treatment is particularly unduly large on them when seeking inpatient care (Visaria and Gumber 1994; Gumber 1997).

Estimates based on a large-scale health care utilization survey of 1993 suggest that overall about six per cent of the household income is spent on curative care which amounts to Rs. 250 per capita per annum (Shariff et al. 1999).One analysis suggests that the existing voluntary health insurance plans cover only 55–67 per cent of the total hospitalisation cost and in all just 10–20 per cent of the total outpatient care burden on households (Gumber 2000a).

Gender bias in health care use continues to persist with men having better access to facility as compared to women due to various socio-economic and cultural reasons. More specifically, poor women are most vulnerable to diseases and ill-health due to living in unhygienic conditions, heavy burden of child bearing, low emphasis on their own health care needs, and severe constraints in seeking health care for

* *Research Scholar in Deptt. of Commerce, Singhania University, Rajasthan*
** *Assistant Professor in Deptt. of Commerce and Management, Apeejay College of Fine Arts, Jalandhar*

themselves. Institutional arrangements have so far been lacking in correcting these gender differentials. A pioneer study undertaken by Gumber and Kulkarni (2000) has carefully looked into issues related to the availability and needs of health insurance coverage for the poor, especially the women, and the likely constraints in extending current health insurance benefits to workers of the informal sector.

Around 24% of all people hospitalized in India in a single year fall below the poverty line due to hospitalization. An analysis of financing of hospitalization shows that large proportion of people; especially those in the bottom four income quintiles borrow money or sell assets to pay for hospitalization (World Bank, 2002).

Given that insurance companies are large and almost monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this create confusion and disputes. (Shah M 1999)

Health Insurance schemes are increasingly recognized as preferable mechanism to finance health care provision. Other alternative3 such as cost recovery strategies and user fees have been criticized (Gilson 1998, Sauerborn , Nougtara et al. 1994) on grounds that it affects access to care. The option insurance seems to be a promising alternative as it pools and transfers risk of unforeseeable health care cost for a pre-determined fixed premium (Griffin 1992)

Studies have found a very strong link between health and income(for low-income levels) poor are the most susceptible to a health shock(CMH 2001, Morrisson 2002)

The literature review suggests that income is one of the important determinant of purchase of health insurance (Scotton 1969, Cameron, Trivedi et al. 1988, Savage and Wright 1999)

In India knowledge and awareness about health insurance could be important factor for health insurance purchase decision. Very few studies have tried to analyze reason for low penetration of health insurance in India (Wadhwan 1987, Ellis 2000, Bhat and Mavlankar 2001)

The view of role of education in health decision-making has been well documented by Grossman(1972) and Muurinen (1982). The implication is that not only is a better educated person likely to be healthier which would lower the probability of insurance , but also he/she likely to be better informed about both the services available in the public hospital system and the benefits of joining a private health insurance fund.

Another set of factors which are found important in the literature of the health insurance are demographic and economic variables. These variables are employment, age, marital status and gender. The available evidences suggests that socioeconomic variables act on the choice in the expected ways. Those who are employed and are on executive positions are likely to purchase insurance(Butler 1999; Savage and Wright 1999). Married Respondents are more likely to take out coverage (Cameron & McCallum 1995), though family size apperntly has been a little influence on the purchase decision(Cameron and Trivedi 1991). Age has also been shown to have a significant influence on insurance choice. Age has also been found having positive and significant impact on the probability of having insurance cover(Cameron. Trivedi et al. 1988, Ngui, Burrows et al. 1989, Savage and Wright1999).

The public expenditure on health is less than 1 percent of GDP(Bhat and Jain2005). Also more than 80 percent of total health care expenditure is out of pocket expenditure. Reliance on out of pocket payments is inefficient and it is also unfair for the poor on whom the burden of disease fall more than proportionately (Ahuja 2005). Channeling these high private expenditures through insurance system is real challenge in Indian context.(Gumber and Kulkarni2000).

Sujatha Rao(2004) discusses the issues and challenges for health insurance sector in India. She found financing to be the most important component to improve health system in India and advocated that the health insurance should be given very high priority by the government as a financing mechanism.

RESEARCH METHODOLOGY

The research design is partially exploratory and partially descriptive in nature. The sampling process is random sampling. The data is collected from both primary and secondary sources. The primary data is gathered through a survey conducted with a aid of self administered questionnaire with a view to get information from the demand side i.e. consumers. The sample size comprises of 150 respondents who have to fulfil two criterions which are as follows

- One must be above 25 years of age.
- One must be earning.

Objectives

- A detailed study of the background gives the following feasible objectives:
- To determine the various causes of low penetration of health insurance in Punjab State.
- To determine the awareness of health insurance among the population of Punjab State.
- To recommend various measures to the insurance companies to improve their penetration in Punjab State.

Limitations of the study

- The research faced several limitations. The findings were suggestive and could not be treated as generalization due to several reasons which are as follows:
- The respondents were selected randomly, so all limitations pertaining to random sampling are applicable.
- Sample was convenience sampling, so it may not be a true representative of the actual population.

- Sample size was not evenly distributed, so could not give a very clear picture about the findings in the different strata.
- Since this product was not very famous in the market much data is not available.

ANALYSIS AND INTERPRETATION

Vast amount of scattered and undifferentiated data is transformed into valuable information database with the help of analysis using some statistical tools The following information was gathered from the analysis of data:.

Respondents in the age group of 25 to 35 were having the maximum (45.4%) of the total number of health insurance covers while the age groups of 55 and above were having the minimum number of health insurance policies. This shows that young people are more aware of health insurance (Table1&2).The Male gender dominates the health insurance market. Out of the general male – female ratio of 62:38, male - female ratio holding health insurance was 81:19. It can, therefore be deduced that health insurance is more popular among males.

(Table3&4).It was also observed that health insurance is more popular amongst more qualified respondents. It was found that out of all respondents having health insurance policies, 63.7% were graduates and above(Table5)

Health insurance was more common among married respondents as compared to singles. It was observed that 82% of respondents having health insurance were married (Table6). It was observed that from the total of 22 respondents who were covered under health insurance, 15 had dependents also. But out of that 15, only 3 respondents have covered dependents under health insurance(Table7). So, it can be concluded that covering dependents under health insurance is not popular.

The majority of the respondents who are covered under health insurance belong to government sector companies. This may be due to the fact that most government authorities cover their employees under one or the other health insurance scheme. Results also showed that out of the total respondents covered under health insurance, 63.6% were employed in the public sector(Table8). There is an inverse relationship between increasing income and health insurance. This can be concluded because the results have shown that 54.5% of respondents having health insurance belong to income level of less than 3 lakhs a year, 31.8% of the respondents having health insurance falls in the bracket of 3 to 6 lakhs per year. Further, a mere 13.7% of the respondents having health insurance are from the income bracket of 6 lakhs an above(Table9). So, it can be concluded that if a person's income is increasing, the need for health insurance falls. This is exactly what Sethi (2005) has mentioned in his book.

Respondents have ranked the importance of health insurance in the following hierarchy :

1. Contingencies
2. Tax benefits
3. Statutory requirement

The results showed that respondents who were having hospitalization expenses less than 25000 Rs were having maximum number of health insurance policies i.e. 72,7%. Out of 26 respondents having hospitalization expenses between 25000 Rs to 50000 Rs, only 6 respondents were covered under health insurance. Further, 6 respondents who showed their hospitalization expenditure between 50000 Rs to 100000 Rs do not have any health cover(Table10). 28% of the respondents were found to be confused between life and health insurance as they did not know the difference between the two(Table11).Out of respondents who had health insurance policies, most motivating factor was tax benefit followed by safety and security and elimination of dependence.(Table 12).

Even out of non holders only 46% want to purchase a policy. This shows lack of awareness and interest. The respondents who had health insurance in their past ranked the reasons for non -renewal of their health insurance schemes as follows(Table 14):

1. Lack of promotional activities 2. Same old products 3. Claim settlement 4. Stringent policies 5. Inefficiencies of insurance companies 6. High cost of the policies 7. Poor distribution reach.

It was observed that 80 respondents (i.e. 53.3%) were not even aware of health insurance schemes and policies; whereas 23 respondents (i.e. 22.3%), who did not have health insurance cover were aware about health insurance schemes and policies (Table15). The remaining had health insurance, so the question of awareness did not arise.

The respondents who were not having health insurance, but were aware of it, had ranked various options which had made them so aware as follows(Table16):

1. Media (Television, Radio, Newspaper, Magazines etc) 2. Insurance Agents 3. Doctors 4. Friends/Relatives 5. Internet

Further 43.5% of respondents say that the products are not innovative and that's why they do not buy health insurance products; 21.7% don't feel the need to buy any. 17.4% have said that they find it costly while the same percentage of respondents expressed that they do not know from where to buy(Table17).

RECOMMENDATIONS

The capital requirement for health insurance companies should be reduced to Rs 25 crore from the current Rs 100 crore. This is because the. present Rs 100-crore requirement is a deterrent since a larger capital requirement will bring in additional cost associated with such capital like interest, etc. Various studies also show that insurance companies are reluctant to enter the Indian insurance market with the stated capital requirement.

- Complete statistical database must be available to each and every insurance company. This will help them to understand the market conditions and come up with new innovative products which are low in price and yet satisfy the needs of the customers.

- The foreign direct investment (FDI) limit should be raised to 51 per cent from the existing 26 per cent. This would attract global health insurance players and encourage them to take a long-term perspective of their investments in the country. With the arrival of global companies the standard of operations will improve, giving rise to healthy competition in the Indian insurance industry. The customer will enjoy the benefits in terms of price and quality of service.

- Grading and accreditation of hospitals and health providers should be done. The parameters used to evaluate the hospitals would include medical specialties (evaluated on the availability of equipment, and qualification adequacy of medical personnel). This will help in standardizing the treatment for the customer, which will result in less of claim rejections and, in turn lead to a healthy relationship between insurer and insured which is missing in the current scenario.

- Insurance companies should start advertising health insurance on a large scale so that they can reach those people who are still unaware about health insurance schemes and policies. This will also help the insurance companies to sell their products and penetrate the market more effectively

CONCLUSION

In the course of carrying out the research study, some very important aspects have emerged which justify why in spite of having a great potential, there is low penetration of health insurance in Punjab. Majority of the respondents who are covered under health insurance belong to government sector companies. This may be due to the fact that most government organizations cover their employees under some health insurance scheme or the other. Further, it was found some of the respondents did not know the difference between the life insurance and health insurance. Hence it can be concluded that inadequate knowledge and information about health insurance has also led to its low penetration. More over a huge number of people, who do not have health insurance, have no intention of buying it. It was also concluded that the people who were holding health insurance in the past, do not buy it these days because they feel that health insurance schemes are not well promoted, there is no new offering from· the insurance companies, they had serious problems in getting claims passed, (d) policies are not user friendly insurance companies are inefficient and cost of insurance covers are beyond their reach and the poor distribution reach of these policies/schemes. The study also concludes that the ·low penetration of health insurance is also because of high claim ratios which the insurance companies are facing in this segment of insurance, because of which they are not paying attention towards this loss making segment. It is also concluded that the poor statistical database has hit the health insurance sector, and because of this, companies do not have necessary information which is required to make new, friendly and comprehensive policies. It has also been shown that inefficiencies of the health insurance companies have resulted in low penetration of health insurance. Inspite of settling the claims faster, and coming out with new products, insurance companies have cross subsidized health insurance with other general insurance products. They are selling 'fire' and 'property insurance' to the public along with huge discounts on health insurance, and ultimately hampering the growth of health insurance segment. In the end it can be safely concluded health insurance, despite its great potential, has not come out well in Punjab.

ANNEXURES :

Table 1

Age –wise breakup of the sample size

Age group	Number of respondents	percentage
25-35 years	69	46%
35-45 years	34	22.7%
45-55 years	25	16.7%
55 years and above	22	14.7%
Total	150	100%

Source: According to author's calculations

Table 2

Age group with Maximum Number of Health Insurance policies

Age group	Number of respondents having health insurance	Percentage
25-35	10	45.4%
35-45	4	18.2%
45-55	6	27.3%
55 years and above	2	9.1%
Total	22	100%

Table 3

Gender - wise Break up of the Sample Size

Gender	Number of Respondents	Percentage
Males	93	62%
Females	57	38%
Total	150	100%

Table 4

Gender with Maximum Number of Health Insurance policies

Gender	Number of respondents having Health Insurance	Percentage
Males	18	81.8%
Females	4	18.2%
Total	22	100%

Table 5

Qualifications of the respondents having health insurance policy

Qualifications	Number of respondents	Percentage
Matric	3	13.6%
Higher Secondary	5	22.7%
Graduates and above	14	63.7%
Total	22	100%

Table 6

The Married vis-a-vis the Single holding Number of Health Insurance Policies

Marital Status	Number of Respondents holding health insurance	Percentage
Married	18	81.1%
Single	4	18.2%
Total	22	100%

Table 7

Number of Dependents of the Respondents.

Number of Dependents	Number of respondents	Percentage
No dependent	7	31.8%
1-3 dependent	13	59.1%
3-6 dependent	2	9.1%
Total	22	100%

Table 8

Occupational background and number of Health Insurance policies

Occupation	Number of respondents	Percentage
Self Employed	4	18.2%
Employed in Public Sector	14	63.6%
Employed in Private sector	4	18.2%
Total	22	100%

Table 9

Category of Respondents, Income wise, holding Health Insurance

Annual income	Number of respondents	Percentage
Less than 3 lakhs	12	54.5%
3-6 lakhs	7	31.8%
6 lakhs and above	3	13.7%
Total	22	100%

Table 10

Hospitalization Expenses and number of Health Insurance policies

Hospitalization expenses	Number of respondents	Percentage
Less than 25000 Rs	16	72.7%
25000 Rs-50000 Rs	6	27.3%
50000 Rs-100000 Rs	0	0%
100000 Rs and above	0	0%
Total	22	100%

Table 11

Knowledge of Difference between Life Insurance and Health Insurance

Particulars	Number of respondents	Percentage
Yes	108	72%
No	42	28%
Total	150	100%

Table 12

Most important factor motivating Respondents to buy Health Insurance

Factors motivated to buy Health insurance	Number of respondents
Tax benefits	12
Safety & security	9
Eliminates dependence	12
Total	22

Table 13

Intentions of non-insured for buying Health Insurance

Intention of buying health insurance	Number of respondents who do not have health insurance	Percentage
Yes	59	46.1%
No	69	53.9%
Total	128	100%

Table 14

Reasons of non renewal of health insurance policies by those insured in the past

Reasons	Ranks
Lack of promotional activities	Rank 1
Same old products	Rank 2
Claim settlement	Rank 3
Stringent policies	Rank 4
Inefficiencies of insurance companies	Rank 5
High cost of policy	Rank 6
Poor distribution reach	Rank 7

Table 15

Awareness of health insurance amongst non- insured

Aware of health insurance	Number of respondents who neither have nor had health insurance in past	percentage
Yes	23	22.3%
No	80	77.7%
Sample size	103	100%

Table 16

Ranking of options through which non-insured got awareness

Reasons	Ranks
Media	Rank 1
Agents	Rank 2
Doctors	Rank 3
Friends/Relatives	Rank 4
Internet	Rank 5

Table 17

Reasons for not buying health insurance though awareness is there	Number of respondents who neither have nor had health insurance in past	percentage
Don't feel the need	5	21.7%
Find it costly	4	17.4%
Non-innovative products	10	43.5%
Don't know from where to buy	4	17.4%
Sample size	23	100%

REFERENCES

Ahuja,R. (2005). " Health Insurance for Poor: An analytical study." Indian Council for Research on International Economic Relations Working paper no. 161.

Bhat Ramesh & Mavlankar Dileep (2000), 'Health Insurance in India: Opportunities, Challenges and Concerns', Indian Institute of Management, Ahmedabad.

Bhat, R. and D. Mavlankar (2001). Health insurance in India: Opportunities , challenges and concerns in Indian Insurance Industry: Transition and Prospects by Srivastava D C and Srivastava S(eds). New Century Publications, New Delhi.

Bhat R. Public private partnerships in the health sector: Issues and prospects, May 1999, W.P No. 99 – 05-06 Ahmedabad: IIM.

Butler. J (1999) Estimating Elasticities of Demand for Private Health Insurance in Australia. National Center for Epidemiology and Population Health. Canberra, ANU.

Cameron, C. A. and P.K. Trivedi (1991) The Role of Income And Health Risk In the Choice Of Health Insurance. Journal of Public Economics. 45: 1-28.

CMH(2001). " Macro Economics and Health : Investing in Health for Economic Development." Report of the commission on Macro Economics and Health Geneva: WHO

Gilson, L. (1998). " In Defense and Pursuit of Equity." Social Science and medicine 47 (12):1891- 1896.

Griffin, C. (1992). Health Care In Asia : a Comparative study of Cost and Financing. Washington , D.C. , World Bank Original and Sectoral Studies.

Grossman, M. (1972). " On the Concept of Health Capital and the Demand for Health." Journal of Political Economy 80 (2) : 223.

Gumber, Anil (1997): 'Burden of Disease and Cost of Ill Health in India: Setting Priorities for Health Interventions During the Ninth Plan', Margin, Vol. 29, No. 2, pp. 133–72.

Gumber, Anil (1998): 'Facets of Indian Healthcare Market-Some Issues', Saket Industrial Digest, Vol. 4, Issue 12, December.

Gumber, Anil (2000a): 'Health Care Burden on Households in the Informal Sector: Implications for Social Security Assistance', Indian Journal of Labour Economics, Vol. 43, No. 2, pp. 277–91.

Gumber, Anil (2000b): 'Structure of the Indian Health Care Market: Implications for Health Insurance Sector', WHO Regional Health Forum, Vol. 4, Nos. 1&2, pp. 26–34.

Gumber, A. and V. Kulkarni(2000). " Health Insurance for Workers in the Informal Sector, deatailed results , Pilot Study." National Council of Applied Economic Research , New Delhi.

Gumber, Anil and Veena Kulkarni (2000): Health Insurance for Workers in the Informal Sector: Detail Results from a Pilot Study, National Council of Applied Economic Research, New Delhi.

Gupta, D. B. and Anil Gumber (1999): 'Decentralisation: Some Initiatives in Health Sector', Economic and Political Weekly, Vol. 34, No. 6, 6–12 February, pp. 356–62.

Ngui, M , C. Burrows , et al. (1989). Health Insurance Choice: An Econometyric analysis of A. B. S. Health and Health Insurance surveys , Economics and health. Proceeding of the Australian Conference of Health Economists.

Rao Sujatha, Selvaraju S, Nagpal S, Sakthivel S. Financing of health in India. In: Rao Sujatha, editor. Financing and delivery of health care services in India. New Delhi: Ministry of Health and Family welfare, 2005: 239-317

Shah M. 1999. Consumer perspective on health insurance. Presentation at One day workshop on 'Health Insurance in India'. Indian Institute of Management, Ahmedabad. Oct. 30, 1999.

Shariff, Abusaleh (1994): 'Employees' State Insurance Scheme in Gujarat: Key Results of a Survey', Gujarat Institute of Development Research (mimeo), Ahmedabad.

Shariff, Abusaleh, Anil Gumber, Ravi Duggal and Moneer Alam (1999): 'Health Care Financing and Insurance Perspective for the Ninth Plan (1997-2002)', Margin, Vol. 31, No. 2, January–March, pp. 38–68.

Visaria, Pravin and Anil Gumber (1994): 'Utilization of and Expenditure on Health Care in India, 1986–87', Gujarat Institute of Development Research, Ahmedabad

World Health Organization (2002), 'World Health Report 2002: Reducing risks, promoting healthy life', WHO: Geneva

Reference # Envision - C -13

❑❑❑

GUIDELINES FOR AUTHORS

1. Authors should submit two copies of their manuscripts, clearly typed with double spacing on A4 Size paper; verbatim inset quotations should be single-placed.
2. **Electronic Copy.** Authors are required to submit an electronic copy (soft copy) of the paper in MS Word Format (DOC format) in a 3.5 inch (1.44 mb) floppy diskette or CD-ROM & via email to ruchitrehan2006@gmail.com
3. The cover page shall contain the title of the manuscript, the author's name and affiliation including, acknowledgement if any. This page will be removed before the manuscript is sent to a referee. The first page of the text should show the title but NOT the author's name.
4. Each manuscript should include an abstract of about 100-150 words.
5. The introduction section must have no heading or number. Subsequent headings should be given numerals. Subsection headings should be lettered A,B,C etc.
6. The article should end with a non-technical summary statement of the main conclusions. Lengthy mathematical proofs and very extensive detailed tables should be placed in appendix. The author should make every effort to explain the meaning of mathematical proofs.
7. **Footnotes.** Footnotes in the text must be numbered consecutively and typed on a separate page, double-spaced, following the reference section. Footnotes to the table must also be double-spaced and typed at the bottom of the page with the table.
8. **Tables.** Tables must be numbered consecutively with Roman numerals. Please check that your text contains a reference to each table. Type each table on a separate page. Authors must check tables to make sure that amounts add up to the Totals shown and that the titles, column headings, captions etc. are clear and to the point.
9. **Figures.** Figures must be titled and numbered consecutively with numerals.
10. **Equations.** All but very short mathematical expressions should be displayed on a separate line and centred. Equations must be numbered consecutively on the right margin, using numerals in parenthesis.
11. **References.** References must be typed on a separate page and double-spaced at the end of the paper.
12. Please check your manuscript for clarity, grammar, spellings, punctuation and consistency of references to minimize editorial changes.
13. As the submitted papers will undergo a double-blind review process, the name, affiliation and contact information of the author(s) should be provided on the cover page only.
14. The declaration certificate should also be provided that it is an original article and not published in any other journal.

Address of Correspondence:

Dr. Ruchi Trehan

Editor-in-chief- Envision

Apeejay College of Fine Arts, Mahavir Marg, New Jawahar Nagar, Jalandhar.

Tel. No.0181-2458547, 2452181 Fax. 91-181-2225204

E-mail : ruchitrehan2006@gmail.com, ruchitrehan@rediffmail.com

website : www.acfa.apeejay.edu

® **2009, All rights reserved.**

- No part of this publication may be reproduced or copied in any form by any means without prior written permission.
- APJCFA holds the copyright to all articles contributed to its publications. In case of reprinted articles, APJCFA holds the copyright for the selection, sequence, introduction material, summaries and other value additions.
- The views expressed in this publication are purely personal judgments of the authors and do not reflect the views of APJCFA. The views expressed by external authors represent their personal views and not necessarily the views of the organizations they represent.
- All efforts are made to ensure that the published information is correct. APJCFA is not responsible for any errors caused due to oversight or otherwise.