

Health for All – A Study of State Health Insurance Scheme in Andhra Pradesh

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ABSTRACT

The State funded Health Insurance scheme for poor families launched in 2007 by Government of Andhra Pradesh, is unique with a plenty of remarkable features. A million dollar question is that when several failed attempts have been attempted, how has Andhra Pradesh managed to succeed? Hence there is a dire need for an evaluation and so this study is undertaken. The specific objective of the study is to examine the performance of the scheme by analyzing the perceptions of patients relating to the services rendered to them by the empanelled network hospitals. The scheme is highly popular with the poor and downtrodden. However, it became a 'tree of boon' in the form of money spinning to the greedy private hospitals. Out of pocket expenses for the poor still continue. In spite of critical comments here and there the scheme is undoubtedly regarded as a 'godsend' to the underprivileged. Hence there is an imminent necessity to improve its performance by plugging loopholes, in the interest of society.

Keywords: Health Insurance, Andhra Pradesh, Aarogyasri, Network Hospitals, Cashless treatment.

Introduction

Poverty is undoubtedly one of the greatest challenges facing by India. Given the large proportion of its underprivileged population, the delivery of basic universal services seems almost impossible. This issue is exemplified in public health service delivery. Health is a very significant and vital factor for the prosperity of an individual. So also, it is one of the most important indicators for socio-economic development of a country. Hence, after independence, in India, health has been given a constitutional recognition as a major factor for the national development.

But public health care in India often faces heavy criticism. Serious shortcomings in quality of and access to services, quantity of personnel and equipment, and levels of funding haunt public health care system. Moreover, government hospitals face a myriad of problems (Gopi, 2016). Diseases and the numbers of affected are on the rise. It became routine for poor Indians to use their life savings to access quality treatment for themselves and their loved ones. The financial burden on the poor escalates and illness is one of the main causes for the growing debt among the poor. Hence, it is imperative to develop a sound and effective health care delivery process.

The precarious health condition of the farmers was recognised in the report of the Jayati Ghosh Committee (2006) which was appointed by the State Government of Andhra Pradesh to study economic distress in the agricultural sector. In its chapter on health and nutrition, the Report discusses the poor health indicators, the failure of the public health system, and the cost of privatised care, that were contributory factors to farmer indebtedness, distress and suicide. This attracted the attention of the then Government of Andhra Pradesh under the leadership of Y.S.Rajasekhara Reddy, who himself a doctor. The State Government began organising health camps in 2004 providing healthcare under the Chief Minister's Relief Fund. However, the reach of them was limited and could not harvest desired results. So, the Government of Andhra Pradesh launched the 'Rajiv Aarogyasri Health Insurance'.

The Rajiv Aarogyasri Scheme is a State funded Health Insurance scheme for poor families in Andhra Pradesh. The scheme aims to achieve sustainable and comprehensive health care for people of Andhra Pradesh (Sunita Reddy, 2013) and to ensure '**Health for All**' by assisting poor families in their struggle out of indebtedness through the provision of free insurance through a unique PPP model. In 2007, the scheme was introduced on a pilot basis in three districts. It has been subsequently extended through five phases to all districts. This scheme is one of the outreach strategies of the Government of Andhra Pradesh (Mallepeddi et al., 2009).

On consequent reorganization of the State of Andhra Pradesh into the States of Telangana and Andhra Pradesh in 2014 and when the new Government under the Telugu Desam Party came to power in Andhra Pradesh, the 'Rajiv Aarogyasri Scheme' was renamed as 'NTR Vaidya Seva' (G.O.MS.No. 127, dated 27-09-2014) in the name of late Chief Minister Nandamuri Taraka Ramarao who is also the founder of Telugu Desam Party.

Conceptual frame work

Globally, both developed and developing economies recognised the importance of achieving universal health insurance coverage through either collecting premium from the citizens or as a social welfare measure or a mix of both. Although India followed a mix of these strategies since 1950s, the infiltration of health insurance into public attention remained low. However India's setting of health insurance has undergone a sea change in the last decade with the initiation of several health insurance schemes in the country launched by the governments, both at the national and state levels.

This scheme provides coverage up to 2.5 lakhs per family per year subject to limits, in any of the network hospitals (Babu, 2009). The cashless treatment in the empanelled network hospitals is provided in 1038 procedures. (www.Arogyasri.org).

The Scheme is unique which has a number of appealing features. It targets poor households. However, due to Andhra Pradesh's (AP's) high poverty line, in practice most of the population is covered. It focuses on hospital care, and largely on tertiary hospital care. It is peculiar in other respects too. All transactions are cashless where beneficiaries can go to any authorised hospital and receive care without payment for the covered procedures. The insurance is not required to pay any premium. The programme is operated by the Aarogyasri Health Care Trust and managed by a private insurance company. The Aarogyasri Trust put it in its 2011-2012 annual report that one of the scheme's objectives is "to cover catastrophic illnesses which will have the potential to wipe out a life time savings of poor families (www.aarogyasri.gov.in).

A million dollar question is that when several failed attempts have been attempted by many States, how has Andhra Pradesh managed to succeed? More over for the past ten years the Scheme has been providing assistance to Below Poverty Line. So there is a dire need to evaluate the scheme. Hence this study is undertaken.

The objectives of the study

The specific objectives are as follows:-

- I. To study the impact of the scheme on both public and private hospitals and to study the impact of the scheme on public hospitals,
- II. To analyze the perceptions of patients relating to the services rendered to them by the hospitals (both public and private); and,
- III. To examine the experiences and difficulties faced by the beneficiaries with a few case studies.

Scope and Methodology

The scope of the study is to assess the impact of Andhra Pradesh State Health Insurance scheme on the targeted group. For the purpose of the study, among the 13 districts of Andhra Pradesh, Chittoor was purposively selected due to its backwardness and the proximity of the author. It is one of the districts in the backward Rayalaseema Region of Andhra Pradesh. In 2006 the Indian government named Chittoor as one of the country's 250 (out of a total of 640) most backward districts. It is one of the thirteen districts in Andhra Pradesh currently receiving funds from the Backward Regions Grant Fund Programme (BRGF). Both primary and secondary data was used. The primary data was collected through personal interview method. Further beneficiaries were contacted through phones and mails. The Secondary data was gathered from various published and unpublished literature available on the subject.

Sampling

The Chittoor district is divided into 3 revenue divisions which are organised in 66 rural mandals. With the heterogeneity of beneficiaries hailing from the district, the Purposive and convenient sampling technique was used to select respondents. From each of the revenue division, one mandal was selected and then from each mandal 30 beneficiaries were chosen. Thus the total sample consists of 90 beneficiaries. However care was taken to include both the gender and all religions and castes.

Profile of Chittoor District

Chittoor District was formed on 1 April 1911. It has a population of 4,170,468 according to 2011 census of India. This gives it a ranking of 47th in India and 6th in its state. Chittoor district has many major temples including world famous Balaji temple, besides Vinayaka temple at Kanipakam and other temples. It is a major market centre for milk, mangoes sugarcane and peanuts. The Gross District Domestic Product (GDDP) of the district is ₹34,742 crore (US\$5.2 billion) and it contributes 6.6% to the Gross State Domestic Product (GSDP) of the district (Wikipedia).

Findings

- Nearly 90 percent of the population of the district are white card holders and so they are eligible for treatment under the scheme.
- A good majority i.e. 70 percent of the male and female patients prefers to visit private hospitals for treatment. This exposes the fact that the poorest sectors of society are not satisfied with the quality treatment in public hospitals. The scheme has no doubt created access for the rural poor for specialized health services in star hospitals. One of the beneficiary folded his hands and said that the then Chief Minister who was introduced the scheme was a 'God' to them as he provided an opportunity for them to step into the so called star hospitals.
- The cashless treatment service is one of the most important reasons for the success of the scheme. However with regards to the quality of services they are just satisfied. Only 30 percent of the respondents are satisfied with the treatment .They said that they were not treated as par with the regular paid patients .They also pointed out that health personnel in the network hospitals are often absent and waiting time is too long .
- Nearly 95 percent of the respondents said that there is no provision in the scheme for outpatient treatment of everyday illnesses that affect the working capacity of the patient.
- Mahapatra (2001) analyzed the leading causes of premature mortality and disability in rural and urban areas in AP. He found that most of the overall disease burden is constituted by conditions such as lower respiratory infections, diarrheal diseases, low birth weight (malnutrition), tuberculosis, ischemic heart disease and malaria, the leading causes of mortality. Among the cause of disability accidents due to fall and fire, depression, epilepsy, schizophrenia and protein energy malnutrition among children was among the leading causes. These are the illnesses, which curb daily functioning of the poor and have a significant impact on their economic condition. Many premature deaths and morbidity faced the vulnerable sections in the rural areas is merely due to deficient publicly provided primary care services and an ineffective referral system coupled with lack of qualified health-care providers. Hence, majority of the poor may require basic primary health-care services and access to proper referral services to reduce their disease burden and financial consequences.
- The focus on tertiary healthcare to the exclusion of all other forms of medical assistance leads to an inefficient medical care model with a low level of real impact on meeting the needs of healthcare and the health of the population (Rajan Shukla,2011)
- A great majority i.e. 90 percent of the respondents told that they continue to spend heavily on illness and medical conditions that are not covered by the Scheme at both government and private hospitals. As many as 83 percent of the respondents pointed out that network hospitals are not providing food and beverages to the patients, although there is a provision. While the scheme explicitly bars any out-of-pocket payments during an Aarogyasri-covered episode, patients in fact incurred quite high levels of out-of-pocket spending (INR 16,000 on average, around \$US 300) during inpatient episodes that they understood to be covered by the scheme (Sofi Bergkvist, 2014)
As many as sixty five percent of the select respondents ventilated that unnecessary lab tests have been conducted and thus the patents have undergone stress and strain.
- The scheme was misused by the non-poor. The private hospitals encouraged them.
- The media highlighted how the health providers, the private health hospitals, have violated the norms by collecting consultation fees, not providing medicines and performing unwanted operations like hysterectomy for the women (Mallikarjun, 2009; Vinjamuri & Vinjamuri, 2011). This is a clear violation against the MoU they signed with the Aarogyasri trust. This shows how the state led insurance scheme can be detrimental to woman's health.
- The Aarogyasri scheme was strongly criticized by a former Director of Nizam Institute of Medical Sciences (NIMS), Hyderabad. He pointed out how the scheme was feeding into the priorities of the private health-care industry enabling profit making through the soaring numbers of surgeries conducted when compared to those in Government Hospitals. He also highlighted that 59,000 surgeries were performed with the Rs. 274-crore Aarogyasri budget (mostly in the corporate sector); the Gandhi Hospital could conduct 2.56 lakhs operations with a meagre budget of Rs. 12 crore.
- Around 50 percent of the sample told that some of the Network Hospitals have limited staff, infrastructure and resources
- The huge cost paid by the State, the media is full of reports "Aarogyasri as corporate dhanasri " (God of Laxmi-money), "corporate hospitals loot Aarogyasri funds", "Aarogyasri has turned in to *anarogyasri*. Aarogyasri is a *Kalpavriksham*" (tree of boon) for corporate hospital. The whole logic of spending crores

of rupees under Aarogyasri for surgeries/tertiary care is also spoken as "gorantha labam, kondantha avinithi" meaning "for a nail size profit it is mountain size corruption".

Suggestions

Based on the above findings the suggestions made are as follows:-

- ✓ Instead of funding the heavy amounts to the private hospitals the infrastructural facilities in the public hospitals may be strengthened.
- ✓ A careful selection of the network hospitals should be done. Only those hospitals which have qualified staff and good infrastructure should be selected. Selection on whims and fancies of political functionaries and officials should be avoided.
- ✓ Fraud is one of Scheme's main challenges, and so, methods to detect and manage fraud should be developed and refined.
- ✓ Awareness on diseases may be created among the public.
- ✓ Primary health care should be given priority.
- ✓ A careful study may be done know the ground reality of disease affecting the public in rural areas and accordingly the list to be covered by the scheme should be fixed.

Conclusion

Andhra Pradesh State Health Insurance Scheme is highly popular with the poor. However, the corporate hospitals which handle the biggest share of the cases are misusing it and there is no provision for outpatient treatment of everyday illnesses that affect the working capacity of the patient capacity of the patient. Out of pocket expenses still continue.

In spite of above critical comments here and there the scheme is undoubtedly regarded as a boon to poor and downtrodden families who are otherwise vulnerable to a variety of diseases and rundown of suitable and efficient treatment due to heavy health expenditure. So, there is an imminent need to enlarge the scope of the scheme and improve delivery of health care by plugging loopholes, in the interest of society and social well being of people, especially the poor and downtrodden. Without proper health care, the economic and social development of any country becomes impossible.

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