AAROGYA SRI - PUBLIC PRIVATE PARTNERSHIP
AAROGYA SREE- PUBLIC PRIVATE PARTNERSHIP (PPP)

Introduction:

The concept of Public-Private Partnership (PPP) in India is as old as the human history. Government in olden days used to take private contribution for innumerable development and other activities (Singhvi N.M and Srivastava R. C, 2007:22). When India opted for a mixed economy after the independence, the state played a prominent role in the economy as well as welfare services in key areas like education, health and other social services.

While the state played an important role in the provision and administration of social services. Private interests were also accommodated and over the years these interests have grown and entrenched themselves in the system. In mixed economy, the health care services also are based on the principle of a simultaneous operation of the private sector although the state has played a central role in providing medical care in India and private interests were never curbed and discouraged as a result, private sector has grown over the years. In recent years the health care has commodified and the private sector is the dominant provider of health care globally as well as in India. New medical technology has aided such a development and the character of the health care as a service is being eroded rapidly. India has the large health private sector in the world. It became a major provider of curative care services in nation due to various issues, inadequacies in medical administration in Government hospitals, such as improper planning, inadequate resources and poor organization (Rama V. Baru, 1998:43).

Partnership with private sector has emerged as a new avenue of reforms. Due to resource constraints in the public sector and the governments across the world collaboration with private sector and a partnership for providing health care services to the undeserved sections of the society. By reviewing the health sector in India the World Bank and the National Commission on Macro Economics in health strongly advocated harnessing the private sector energy and countering public sector failures by making both
public and private sectors more accountable. The 10th five year plan (2002-2007) envisioned in detail the need for private sector participation in the delivery of health services (India Health Report, 2008:43).

**Definitions of Public/private/partnership:**

There are several definitions of the terms public, private and partnership.

In general the public sector includes organizations or institutions that are financed by the state revenue and function under government control.

The private sector comprises of those organizations and individuals working outside the direct control of the state. Broadly, the private sector seeks profits and some operating on a not-for-profit basis. Those operating for-profit are called private enterprise and not-for-profit are called as Non Governmental Organizations (NGO). (Venkat Raman.A and James Warner Bjorkman, 2007:73).

The term partnership can be defined in the following terms:

As per World Health Organisation partnership means “to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles” (World Health Organization, 1999).

According to Blagescue and Young partnership means “two parties have agreed to work together implementing a program and each party has a clear role and say in how that implementation happens. In all partnerships the principal public partner is the department of health and family welfare, either directly or through health facility level committees (Blagescue. M and Young. J, 2005:225).

**Features of public private partnership are:**

1. Common goals and objectives
2. Commonly used strategies for operation
3. Usual and transparent fund flow
4. Decentralizing authority to local health agencies
5. Public sector to play lead role in defining the framework and sustaining partnership

6. Management plan for PPP initiative at district, state and at national levels.

**Conditions for the success of partnership:**

- A clear understanding between the partners about mutual benefits
- A clear understanding of the responsibilities and obligations between the partners
- Strong community support
- Stability of the political (government) and legal climate (laws).
- Regulatory framework that is followed and enforced
- Capacity and expertise of the government at different levels in designing and managing contracts (partnership).
- Appropriate organizational and management systems for partnerships
- Strong management information system
- Clarity on incentives and penalties (Venkat Raman.A and James Warner Bjorkman, 2007:80).

**Types of Partnership:**

Public private partnership in health care sector is of different types. They are

- **a)** Contracting
- **b)** Franchising
- **c)** Social marketing
- **d)** Joint ventures
- **e)** Subsidies and tax incentives
- **f)** Vouchers (or) service purchase coupons
- **g)** Hospital autonomy
- **h)** Leasing and
- **i)** Social health insurance.
These models are useful under different circumstances. Among all the partnership models, contracting has been the most common form.

The following are some of the schemes working under PPP in various states in India:

During the last few years, several private partnership initiatives are under implementation in various states of India. The Centre and state governments have initiated a wide variety of public private partnership arrangements to meet peoples growing health care needs. Services like cleaning, building maintenance, security, waste management, laundry, diet etc., have been contracted out to the private sector. These are all simple contracts. Some other are more complex, involving many stake holders with their respective responsibility such as Yeshaswini health insurance scheme in Karnataka, Chiranjeevi scheme in Gujarat and Aarogya Sree in Andhra Pradesh are good examples for a corporate third party administrator (Planning Commission of India 11th Plan, 2008:82).

There are number of initiatives in India regarding PPP initiatives for urban health services. These include covering a wide range of services for contracting the management of the urban health centers to NGOs, contracting in specialists for public sector facilities, providing outreach services in the areas which are not served. Currently several private partnership initiatives are under implementation in India. The scope of initiatives span disease surveillance, purchase and distribution of drugs in bulk, contracting specialists for high risk pregnancies, national disease control programs, social marketing, adoption and management of primary health centers, co-location of private facilities (blood banks, pharmacy), subsidies and duty exemptions, joint ventures, contracting out, medical education and training, engaging private sector consultants, pay clinics, discount vouchers, self-regulation, R and D investments, telemedicine, health cooperatives and accreditation.

- Arpana Swastya Kendra (ASK) in New Delhi, under the partnership between the municipal corporation of Delhi and Arpana trust.
In Tamil Nadu, Uttaranchal, and West Bengal mobile health services like, diagnostic and general health care services are being provided. Other partnership initiatives are telemedicine and tele-health project in Karnataka and contracting-out cleaning, kitchen and laundry services in West Bengal. Rogi Kalyan Samiti, or hospital autonomy in a decentralized context by local self government in Bhopal, Madhya Pradesh.

Urban health program. This project is implemented since April 2003 with the partnership of five NGOs in Indore. (Venkat Raman A and James Warner Bjorkman, 2007:82).

**Public Private Partnership Activities in Andhra Pradesh:** The following activities are being implemented under PPP in Andhra Pradesh.

**Emergency Health Transportation Scheme -108:**
- To meet the emergency management 108 services, a non-profit joint venture launched on August 2nd, 2005, by A.P state government and Satyam foundation.
- The Government of A.P initiated the scheme mainly to enable the rural poor to have easy access to the hospital health care services free of cost in times of emergency particularly in respect of maternal and neonatal / infant health emergencies.
- The Emergency Management Research Institute (EMRI), an NGO set up by the Satyam foundation is identified as nodal agency by the Government of Andhra Pradesh.
- A common toll-free telephone number 108 is provided for 24 hours and 365 days for accessing ambulance services.
- An operational cost of Rs.1, 12,499/- per month per ambulance is being paid by the Government.
- Every ambulance is provided with trained technical staff.
• Total 502 Ambulances are covering the entire state of Andhra Pradesh. Each ambulance is covering 50 kms. per trip approximately for both ways of transport covering 400 kms per day and approximately 5.93 lakh cases are attended per year by this scheme.

**Emergency Health Transportation - 108 Ambulance**

![Image of an ambulance]

**Figure 5.1**

**Health Information Helpline (HIHL) 104:**

This scheme was started during the year 2007. It is a public private partnership with Health Management Research Institute by Government of Andhra Pradesh. The objective of the scheme is to provide health information advise, counseling to the people on toll free No.104. On average 36,000 calls are being attended by HIHL.
Urban Slum Health Care Project

The state government of Andhra Pradesh operating urban slum health care project on PPP mode with selected NGOs in slums. Under this project 192 health centers are established in different municipalities of 21 different districts.

Rajiv Arogya Sri- Community Health Insurance Scheme:

This scheme meant for below poverty line people of Andhra Pradesh, Rajiv Arogya Sri (RAS) is a unique community health insurance scheme being implemented in Andhra Pradesh from 1st April, 2007. The scheme provides financial protection to families living below poverty line up to Rs. 1.50 lakhs in a year for the treatment of serious ailments requiring hospitalization and surgery, about 938 treatments are covered under the scheme. (www.aponline.gov.in: retrieved 2012-12-22)

What is Insurance?

Humans have always sought security. Today we are more vulnerable than our ancestors. So we are motivated to take health insurance policies which cover the cost of injuries or sickness. We rely on groups for financial stability. The group may be our employer, the government or an insurance company (Kenneth Black and Harold.D , 2000:19)

Coverage of health insurance in India is pathetically limited. Current health insurance in government and private sector covers around 11% of population and nearly 89% of India’s population and almost all its poor have no health insurance coverage. They primarily meet health care needs through direct expenditure on services provided by the public and private sector. The 60th round of National Sample Survey (NSS) on health care services (2004-05) show the facts that in rural areas, an out of pocket expenditure of more than Rs3000/- is made during hospitalization in government hospitals. In rural private hospitals it is more than Rs7000/-. The expenditure in urban areas in private hospital is more than Rs11000/- and above 3 times higher than the public hospitals. Today this
expenditure would have increased substantially. Private out-of-pocket expenditure can be reduced through comprehensive health insurance (Planning Commission of India 11th 5 Year Plan, 2008:82)

Poor and other disadvantage groups are forced to spend a higher proportion of their income on health care than better off groups. For the disadvantaged the burden of treatment especially inpatient care is disproportionately heavy. In addition this group of people suffers a high incidence of morbidity, which adversely affects their household budget in two ways. They have to spend the large amount of money and resources on medical care and they have to forego the earnings during periods of illness. Thus they often have to borrow funds at very high interest rates to meet both medical and household consumption needs (Saket Industrial Digest, 1998:11-17).

In India only 9% of employees are covered by some form of health insurance such as CGHS, ESIS, Ex-service men contributory scheme provides services to industrial workers, government employees and their families most of them are from organized groups. Med claim covers mainly upper middle income groups (Thaneswar Bir, 2006:470-550). Health insurance coverage is so sparse because the government policy has been to provide free health services through public hospitals, dispensaries and clinics. Public sector providers charge patients for various services and the outreach is also poor. According to estimates based on the NSS 1986-87, nationally 40% of inpatients and 30% of outpatients using public sector facilities had paid for the various services. The percentages vary substantially between rural and urban areas and among states. Furthermore health care costs have increased enormously. A comparison of NSS data for 1986-87 and 1995-96 suggests that the cost of inpatient care and outpatient care grow annually at 26%-31% and 15%-16% respectively, putting strains on efforts to achieve equality in health care (Gumber. A and Kulakarni V, 2000:1-3).

The public insurance companies of India so far have paid very little attention to voluntary medical insurance because of low profitability, high risk and lack of demand from consumer point of view. Insurance coverage is low because consumers lack
information about private insurance plan and the mechanism used by the health insurance providers are not suitable for consumers. Further more, compared with ESIS and with the community based schemes, the private plans offer a modicum of benefits. One analysis suggests that the existing voluntary health insurance plan cover between 55 and 67% of total hospitalization cost and on average only 10%-20% of the total annual, out of pocket expenditure on health care (Visaria. P and Gumber. A, 2002:4).

**Micro insurance:** Micro insurance is a key element in the financial services package for people at the bottom of the pyramid. The poor face more risks than well-off. They are more vulnerable to the risks. Micro insurance provide great economic and psychological security to the poor. Through the grameen model of Bangladesh has covered 17.7 lakhs lives, in Sri Lanka micro products including funeral expenses also. In Kenya Micro insurance is operated through co-operatives. In Indonesia micro insurance is sold through banks. In India micro insurance is reaching the poor and socially disadvantaged populations in recent years (Vijaya Bharathi .G etal, 2008:19).

When the Life Insurance Corporation (LIC) of India was formed in September, 1956, the then Union Finance Minister gave a call to take life insurance to every nook and corner of this vast country. When the insurance industry was decentralized in 1999-2000 and was opened to the private sector once again. The Insurance Regulatory and Development Authority (IRDA) was formed, the situation of reaching every insurable person was a far cry and it was one of the reasons for government to take this crucial decision. IRDA issued special guidelines called micro insurance regulation-2005. Since that was the only way to compel the life and non life insurer to turn towards the down trodden and lonely or the people at the bottom of the pyramid. India with the world’s second largest population and a largely untapped insurance market provides a huge opportunity for national and foreign investors. The impressive growth of this industry driven by liberalization has seen new players enter into the Indian market (Pravartak,
After IRDA issued the micro insurance regulations-2005 the life insurance companies have rolled out a few products. They are:

- LIC Jeevan Mathur
- Three products from Bajaj Allianz Company
- Three plans from Birla Insurance Company,
- Two plans from National Insurance Company,
- Swam Sakthi Suraksha-A micro insurance group product by Bajaj Allianz,
- Max Newyork LIC tied up with NGO’s and with Peerless for rural poor to sell these plans,
- State Bank of India(SBI) Life insurance company has a plan called Gramin Sakthi focusing on Self Help Group(SHG) women members,
- Kotak Life Insurance,
- ICICI Life insurance Company,
- IDBI Life Insurance and
- Star Union ,and

**RAJIV AAROGYA SREE- COMMUNITY HEALTH INSURANCE SCHEME FOR BELOW POVERTY LINE PEPOLE OF ANDHRA PRADESH:**

The main aim of Vision 2020 for Andhra Pradesh is to provide responsive basic health care services to the poor and vulnerable groups. Its intention is to provide basic and specialized services accessible to these sections through health insurance. Health insurance could be a way of removing the financial barriers and improving access of poor to quality medical care; of providing financial protection against high medical expenses; and negotiating with the providers for better quality care. Government of Andhra Pradesh (under the leadership of Dr.Rajasekhar Reddy the late Chief Minister) has accordingly implemented a community health insurance scheme by name Rajiv Aarogya Sri in the
three districts namely Mahabubnagar, Anantapur and Srikakulam from 01-04-07 on pilot basis and later extended to the entire state by 2008. (Ram Murthy R. S., 2008:4-7).

In order to operate the scheme professionally in a cost effective manner, public private partnership is envisaged between the insurance company, the private sector hospitals and the state agencies. State Government/Trust will guide the insurance company in establishing network of hospitals, fixing of treatment protocol and costs, treatment authorization, claims scrutiny and any other related work, such that the cost of administering the scheme is kept at the lowest, while making full use of the resources available in the government system. Private hospitals fulfilling minimum qualifications in terms of availability of inpatient medical beds, laboratory, equipments, operation theatres etc. and a track record in the treatment of the specified diseases can be enlisted for providing treatment to the Below Poverty Line (BPL) families under the scheme. All eligible families in state are provided with RAS Bhima health cards. These health cards will be the basis for identification of beneficiary under the scheme. Members are enumerated and photographed on the RAS Health Card. The photograph in the health card/ BPL ration Card will be taken as the proof for determining the eligibility of the beneficiary. GOAP/Trust will provide the details of each BPL family covered under the scheme through the health card. This health card will be a part of enrollment / identification for availing the health insurance facility.

The scheme is being implemented in the state through insurance firm called Star Health Allied Insurance from March, 2007 to the BPL families from Chief Minister’s Relief Fund. A total of 184 hospitals both from the government and private sector are included in this scheme. More than 1452 health camps were held with participation of network hospitals. A total of 17923 patients have been treated as out patients and 18828 patients as inpatients by recognized hospitals.

The scheme shall provide coverage for meeting expenses of hospitalization and surgical procedures of beneficiary members up to Rs.1.50 lakhs per family per year subject to limits, in any of the network hospitals. The benefit on family will be on floater basis i.e.
the total reimbursement of Rs.1.50 lakhs can be availed of individually or collectively by members of the family. The package includes consultation, medicines, diagnostics, specialist services, implants, grafts, prosthetics, food, cost of transportation, hospital charges etc., In other words, the package should cover the entire cost of treatment of the patient from date of reporting to his discharge from hospital and 10 days after discharge and any complications while in hospital, making the transaction truly cashless to the patient. The post-operative hospital stay in all surgical procedures shall be a minimum of 10 days except in case of interventions and chemotherapy for cancers. (Yadagiri Rao.T and Seetharama Rao. K, 2010)

Hospital shall conduct all diagnostic tests as per standard protocols free of cost. Hospital shall provide 10 days post discharge free medicines to the patient within package. Hospital shall provide reasonably good food to the patient, and shall make alternate arrangement for food wherever in-house pantry is not available. The hospital shall not give money as an alternative to food. Hospital shall pay return fare from mandal headquarters to the town where hospital is situated based on Road Transport Corporation fare. Hospital shall use standard prosthetics and implants for surgical procedures and shall not charge extra cost from the patient since the entire scheme is intended to be implemented as cashless

The insurer is required to enter into Memorandum of Understanding (MOU) for implementation of the scheme with Government of Andhra Pradesh/Aarogya Sree Trust. Insurer may propose a draft MOU from their end. GoAP/Trust is not bound to accept the same. The trust will pay the premium in instalments. If there is a surplus after the actual claims experience on the premium (excluding Service Tax) at the end of the policy period, after providing 20% of the premium paid towards the company’s administrative cost, in the balance 80% after providing for claims payment and outstanding claims, 90% of the left over surplus will be refunded to the Government/Trust with in 30 days after the expiry of the policy period.
Period of Agreement: The agreement will be for one year from the effective date. The trust shall be having the right to accord the contract to other insurer in case of finding the unsatisfactory service track of the insurer.

Capacity Building: The insurer will arrange a workshop for the capacity building of the insured, their representatives and other stakeholders in respect of specific field of insurance at each district on the convenience of the insured. Empanelled medical institutions are supposed to extend medical aids to the beneficiary under the scheme. A provision is to be made in MOU of non-compliance clause while signing them. Such matter shall be looked into by an empowered committee constituted by the government of AP/Trust.

Process Flow of the Beneficiary-Treatment in the Network Hospital: There are several steps through which the treatment to the patient under the RAS scheme takes place. The following are the details:

Step 1: Patients approach to the nearby Primary Health Center/Area hospitals/District hospital/Network hospital. Arogya Mithras placed in the above hospitals facilitate the beneficiary. If beneficiary visits any other PHC/Government hospital other than the network hospital, the doctors will give him a referral card to the network hospital after preliminary diagnosis. The beneficiary may also attend the health camps being conducted by the network hospital in the villages and can get the referral card based on the diagnosis.

Step 2: The Arogya Mithras at the network hospital examines the referral card and BPL ration card and facilitates the beneficiary to undergo preliminary diagnosis and basic tests.

Step 3: The network hospital, based on the diagnosis, admits the patient and sends pre authorization request to the insurance company and the Aarogya Sri Health Care Trust.

Step 4: Specialists of the insurance company and the trust examine the pre authorization request and approve pre authorization if all the conditions are satisfied.
Step 5: The network hospital extends cashless treatment and surgery to the beneficiary.

Step 6: Network hospital after discharge forwards the original bill, discharge summary with signature of the patient and other relevant documents to insurance company for settlement of the claim.

Step 7: Insurance company scrutinize the bills and gives approval for the sanction of the bill.

Step 8: Network hospital will provide follow-up free consultation and medicines supplied by the trust for the patients undergoing treatment under the scheme for a period of up to one year from eleventh day of discharge. (www.saakshi.com: accessed on 1st August, 2009)

Arogya Mithras:

The unique nature of the scheme is the insurance company to appoint Arogya mithras in consultation with the trust in all PHCs, CHCs, Area Hospitals and District Hospitals for propagating the scheme, mobilizing people for health camps, counseling beneficiaries, facilitating the referral/treatment of these patients and follow-up. Arogya mithra acts as facilitator for the patients. Arogya mithras are selected by the stakeholders of Self Help Group (SHG) movement/ Indira Kranthi Patham (IKP) from local area of each PHC / government hospital in order to ensure performance efficiency and acceptability among local communities. The following qualifications are prescribed for Arogya mithra:

i) Graduate
ii) Native and resident of the same PHC area
iii) Good communication skills
iv) Prefers to move around the villages, and
v) Functional knowledge of computers
Role of Arogya Mithras: The role of Arogya mithra’s is dual. One role is within the hospital and other one is outside the hospital.

a) In the hospital

- Publicity and awareness.
- Maintain helpdesk at hospital.
- Receive the beneficiary.
- Verify the beneficiary criteria, (Eligibility criteria)
- Facilitate consultation with doctor (PHC Doctor/nearest government hospital doctor)
- Fill up the referral card.
- Guide the patient to the next center.
- To counsel the patients who may require any one of the listed surgeries.
- To facilitate either to a government hospital for further tests or to a network hospital depending upon the advice of the doctor.
- To guide the patient to network hospital.
- Follow-up the referred cases.
- In effect to act as, a guide and friend for the prospective beneficiaries under the Aarogya Sri scheme.

b) Outside the hospital

- To bring the awareness of the scheme in the villages.
- To bring the awareness about the scheduled camps by network hospitals in the villages.
- To coordinate with network hospitals and help conduct camps.
- Mobilize the patients for camps
- Follow up the patients identified in the camp to report to network hospital.
➢ Coordinate with local Panchayati Raj bodies, village organizations (VOs), Samakhyas, Auxiliary Nursing and Midwifery’s (ANMs), Women Health Volunteers and SHGs for effective implementation of the scheme.

➢ Move around the villages and encourage patients to come to avail the benefits of the scheme.

➢ Educate villagers about the scheme and distribute brochures and other material.

➢ Keep in touch with the district coordinator

➢ Follow up the beneficiaries before and after surgery.

Apart from the duties enlisted above the Arogya Mithras in area hospital and district hospitals will:

- Facilitate the Patient for specialist consultation and tests
- Fill up the referral card (part-B) properly
- Counsel the patient

The mandal and zilla samakhya are the nodal agencies that select the health coordinators. Insurance company has to enter into an MOU with the zilla samakhya to hire the services of local persons in each PHC/CHC/Area Hospital/Government Hospital. The insurance company will make a consolidated payment for the health coordinators through the zilla samakhya. The working of the Arogya mithras will be monitored on a daily basis by the regional coordinators and district coordinators of the Insurance Company in coordination with the Zilla/mandal samakhyas, District Rural Development Agency, DM&HO, district administration etc. All the Arogya mithras are to be provided with cell phones by the insurance company for instant communication and networking. The insurance company shall also provide uniforms, aprons for all Arogya mithras.
### Board of Trustees of Rajiv Arogya Sri

**Chairman**  
Chief Minister

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**Figure 5.2**

**Source:** Arogya Sri trust.
Monitoring Mechanism of RAS

Regular review meetings on performance or administration of the scheme would be held between the state government /trust and the insurer.

The state level monitoring committee consists of the following members.

- Chairman: Chief Minister
- Principle secretary health and finance as vice chairman of Aarogya sri health care trust.
- CEO, Aarogya sri health care trust
- State co-ordinator/ zonal manager insurer
- Any member of trust board, and
- Technical committee member nominated by the trust

The district level committee includes:

- District collector as the chairman
- Project director of DRDA
- District Medical and Health Officer
- District Co-Ordinator of insurer
- Representative of Zilla samakhya,

The chairman of the district committee may invite any member of the legislative Assembly whose constituency falls in the 3 districts/ elected members of Panchayati raj institutions for the meetings. Fortnightly meetings shall be organized at both district and state level preferably on alternative mondays. The minutes of the meetings at district level and state level will be forwarded to the Government of AP trust.

Grievance mechanism:

District collector as the chairman with following members will form the grievance cell at the district level. Members of the committee is:

- District co-ordinator(DCHS)
- Superintendent of district hospitals
- Member from the technical committee (nominated by the trust)
Central committee:

Committee chaired by chief executive officer of the trust will entertain all the appeals on the decision taken by the district committee. The decision taken by the committee will be final and binding on the both parties. This committee consists of the following members.

- Representative of the trust
- Technical committee members
- Representative from insurance firm

A toll free number will be made available at Hyderabad where any complaint can be registered. The insurance shall keep track of the complaint and report on the action taken to central committee. The beneficiaries can also send telegrams to CEO of the trust/CMD’s secretariat/zonal office of insurer (www.Rajivarogyasri.org:accessed 10-11-2010).

Conclusion:

A new institutional arrangement that has come into operation through public-private partnership is Rajiv Aarogya sri. The idea behind this scheme is to promote greater efficiency. It is widely accepted that the deficiencies in public sector health system can only be overcome by significant reforms. The need for reforms in India’s health sector has been emphasized by successive plan documents since 8th five year plan (1992) and by the national health policy (2002). The Andhra Pradesh model of health initiative Aarogya Sri has drawn the attention of many states and they are exploring the possibility of introduction of the scheme in their states. The Union government recognized health care as one of the crucial sector among the service sectors. Hence, the Union government has taken initiative to improve rural health care with the participation of public and private agencies. Partnerships are more useful when the net benefits of partnership exceed those of independent activities when the joint efforts result in more efficient or effective services than independent actions.
References:

- Government of India, Planning Commission, 11th Five Year Plan (2007-12), P.82.
- Rama V. Baru (1998), Public Private Health Care in India, Sage, New Delhi, P43.


