CHAPTER - 3

ROLE OF THE GOVERNMENT IN HEALTHCARE MANAGEMENT

Third chapter explains the role of Government in Healthcare management – World and Indian scenarios, Public Health system in India, National Rural Health Mission, Role of Insurance in Healthcare management and ends with the unique healthcare services viz., 108 & 104 offered to the public by the Government of Andhra Pradesh.

3.1. INTRODUCTION:

The set of arrangements for the provision of healthcare in a country is usually referred to as its "Healthcare system". Systems vary considerably from one country to another, both in the extent of responsibility assumed by government for the provision of healthcare and in the administrative control of services. At one extreme its a completely free enterprise system, in which all services are bought and paid for by the consumer in an open market basis, in accordance with his perceived needs and his ability to pay. While on the other extreme its completely socialized system in which the government assumes full responsibility for the healthcare of all its citizens. In some countries the system is centrally controlled, that is, all services are administered by one central agency; in other, a multiplicity of agencies provides services. Between the extremes are a wide variety of systems.

Challenges faced by the health sector needs a review and issues, such as health sector governance and organization, burden of disease, occurrence of natural disasters, condition of women and children; as well as anticipation of issues in the future.

Burden of Diseases - Women and Children:

Reproductive health plays a major role and the Government policies and programmes have shifted from a target-oriented family planning approach to a broader comprehensive policy. Today women are safer during their pregnancies and deliveries compared to earlier years. In spite of all these number of avoidable deaths of mothers and infants in India is still high.

The norm age of marriage has been increasing in India. Yet 61% of all women are married before the age of 16. The norm age at first pregnancy is 19.2 years. Every year in India, approximately 30 million women experience pregnancy and 27 million have live births[1]. The maternal mortality ratio, an important indicator of maternal health in India, is estimated to be 301/100,000 live births[2]. India has the maximum burden of maternal mortality in the world caused due to maternal deaths in rural India and abortions.

More than 1/3rd of women in India are malnourished. Among children, 47% are starving and 74% are anemic and among adolescents 18% are malnourished. Lack of consciousness and socio-cultural taboos, only 16% of the infants are breastfed soon after birth and 37% on the first day. Only 55% of children are breastfed up to 4 months[3].

Over 2.4 million children under-five annual deaths, India accounts for a quarter of the global child mortality. In recent years, the notable rate of decline of the infant mortality rate seen in the decade of the 1980s has slowed down noticeably. There are wide inter and intra state variations in infant and child mortality. A significant proportion of child deaths (over 40% of under-five mortality and 64% of infant mortality) take place in the neonatal period.

About 1/3rd of the newborns have a birth-weight less than 2,500 grams (low birth-weight). A significant proportion of mortality occurs in low birth-weight babies. Only 47.6% of children in the age group of 12–23 months receive all the vaccinations recommended under the Universal Immunisation Programme (UIP). The three major

[1] Health Information of India, DGHS, MOHFW, 2003.
[2] Maternal Mortality in India: 1997-2003, Trends, Causes and Risk Factors, Registrar General of India, Ministry of Home Affairs, 2006.
[3] National Family Health Survey (NFHS – II), 1998-99, IIPS, Mumbai and ORC Macro, 2000.

illnesses that contribute to mortality among children are fever (30%), Acute Respiratory Infection (ARI) (19%), and diarrhea (19 %).

There are 225 million adolescents comprising nearly 1/5th (22%) of India's total population[4]. Of the total 12% belong to the 10-14 years age group and nearly 10% are in the 15-19 years age group. More than half of the uneducated at present married females have been married below the legal age of marriage. Nearly 27% of the 1.5 million girls married under the age of 15 years are already mothers. More than 70% girls in the age group of 10-19 years suffer from severe or moderate anemia[5]. Nearly 27% of married female adolescents reported unmet needs for contraception. Most sexually active adolescents are in their late adolescence. Over 35% of all reported HIV infections in India occur among young people in the age group of 15-24 years, signifying that young people are highly susceptible.

The ratio of girls to boys in the age group 0-6 years in India is becoming increasingly slanted in favor of boys. The child-sex ratio, calculated as the number of girls per 1000 boys in the 0-6 years age group, reported by the 1991 census was 945 girls per 1000 boys. It further declined to 927 girls per 1000 boys during the 2001 census. Preference to son due to cultural, social and economic factors results in neglect of female children. Pre-natal sex determination leads to abortion of female fetuses.

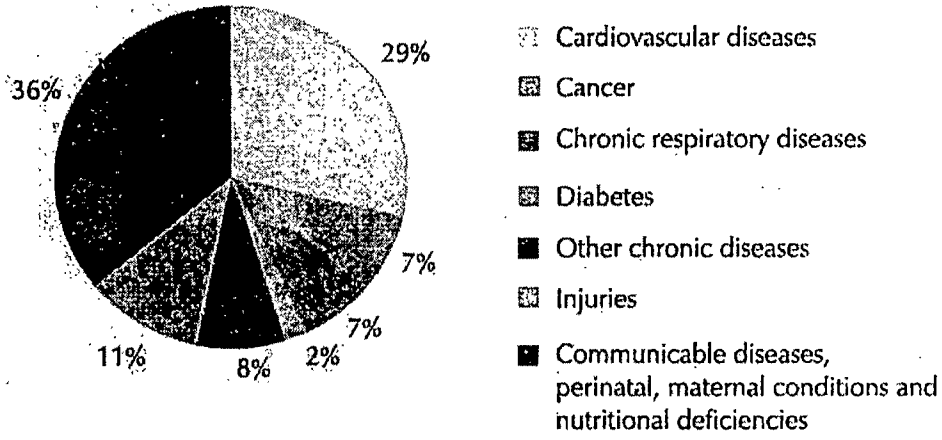
Burden of Diseases - Non Communicable Diseases:

Non Communicable Diseases (NCDs), especially Cardiovascular Diseases (CVD), diabetes mellitus, cancer, stroke and chronic lung diseases have come out as major public

[4] Census of India 2001, Provisional Population Totals: India, Registrar General of India, MOH, Govt. of India.
[5] District Level Reproductive Health Household Survey, IIPS, 2004

health problems in India, due to problems like ageing population and environmentally driven changes in behavior (Table 3.4). Grave challenge is posed to Indian society and its economy due to premature morbidity and mortality in the most productive phase of life. It is anticipated that in 2005, NCDs accounted for 5,466,000 (53%) of all deaths (10,362,000) in India. The WCOICMR study on NCDs in India has estimated that the burden of Diabetes Mellitus, Ischemic Heart Disease and Stroke are 37.8 million, 22.4 million and 0.93 million respectively. In the age group 30-59 years, NCDs account for a substantial proportion of mortality as presented in the pie diagram Graph 3.2. The disease burden for India for all age groups by major causes of death are presented in Graph 3.1.

Graph 3.1
Estimated percentage of deaths

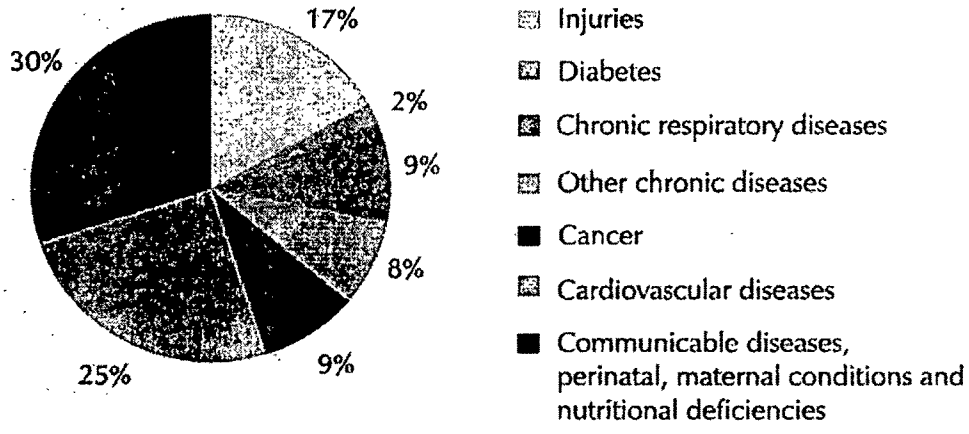


Source: http://www.who.int/chp/chronic_disease_report/en/

Table 3.1
Estimated number of deaths in India from chronic diseases

Cause of Death	**2005**	**2015**
Diabetes	1,75,000	2,36,000
Chronic Respiratory Diseases	6,74,000	8,64,000
Cancer	8,26,000	10,69,000
Cardiovascular Diseases	29,89,000	34,65,000
Total (all causes)	1,03,62,000	1,09,49,000

Graph 3.2
Estimated proportion by cause of death



Source: Preventing Chronic Diseases: A vital investment. WHO; Geneva, 2005

3.2. NEED FOR HEALTHCARE MANAGEMENT:

One of the rapid and huge growing service sectors of the world is Healthcare. Even the present health care organizations are growing by notching the hospitals with latest service areas and new-fangled institutes are inflowing with state of art equipment, most recent technology and marketing plans. As a result, struggle to win in the healthcare sector is on the mount. Until now the on hand options were restricted to health care consumers than compared with the present ones. Above all the better earnings and consciousness levels are motivating the customers to look for quality health care. Hence the Healthcare providers need to be innovative besides offering quality services at viable prices. Hence it does gradually more brazen out with the challenge to ensure cost effective quality care at reasonable prices. Moreover, India is also eyeing for universal healthcare market to materialize as one of potential ends for global patients.

The execution of the theory of Service Quality Management in the Management of healthcare sector in India would go a long way in developing its equipped competence ensuing in well-organized source allotment for best advantage, least amount of depletion of the offered resource and noteworthy development in the quality delivered, ensuring a value addition to the patient. Basically a hospital has both moral and legal responsibility so as to meet the quality of care by protecting the interests of the patients. While this kind of concern and commitment could be fulfilled by a determined effort on the part of all concerned.

The hospitals that are involved in charity should know the difference between free service and good service. The patients would turn up if and only if the service is good. On the other hand good staff is not again free staff. Eventually one should understand good service is timely delivery of quality service at reasonable cost. One should understand that the concept of quality of patient care is not fixed. It is the patients' gladness or contentment which itself is dynamic. So, they should not misunderstand or under estimate the patient's satisfaction with free service. Thus, the objectives of charitable hospitals need to do a lot to meet people's aspirations.

3.3. ROLE OF THE GOVERNMENT IN HEALTHCARE MANAGEMENT:

WORLD CASE:

Health services in various European countries have borrowed elements of reform from one another but have maintained their basic forms; with tax funded systems in UK, Scandinavia, Spain, Italy, Portugal and Greece, Switzerland, Austria and Benelux

countries. The Countries of central and south central Europe developed hybrid solutions based on a combination of employment based insurance, tax funding and private insurance. All European health systems operate with in financial limits and control the services of health providers through cost and quality defined contracts. In both tax and social insurance systems there is a division between agencies commissioning and funding health and care and the providers of the services. Social insurance agencies have been subject to reform and competition as in the case of Netherlands and Germany. This as resulted in far fewer social insurance agencies competing on the basis of the quality and cost effectiveness of the services offered. Local health commissioning agencies in tax funded systems do not compete but offer services matched to local needs. This often involves partnerships with other agencies to tackle the poverty and social exclusion of local groups.

While governments delegate health commissioning and provision to local agencies, has gained the health suppliers to exhibit that the services they tender are useful and are sustained by proof based drug. With regard to the prioritization of these health services most of the nations tagged along Norway and Netherlands which are known for paying the highest priority to services that can be shown to the cost effective and cost efficient. Where patients can reasonably be the expected to bear personal responsibility for services this is further reflected in co-payments ex: to a little extent it's associated to the smoking ailments and duty enhancement healing.

Most of the European health systems have challenged to lay down client charges at a stage that will give self-assurance in the majority cost effective use of services. This

promotes the users to use it for telephone triage and advisory services for self care. On the other hand it persuades patients seek early discharge based on low level co-payment.

Healthcare in the United States and in Canada:

It is principally in the financing of personal Health care services that differences currently exist in the American and the Canadian Healthcare Systems. Personal Health care expenditures are usually taken to include spending for services provided by hospitals and related institutions, services rendered by physicians, dentists, and other health practitioners, nursing services, drugs and drug sundries, eyeglasses, appliances such as artificial limbs and supplies and equipment used in health care.

In the United States at the present time, personal health care is paid for in a variety of ways. Government-sponsored programs include Medicare and Medicaid for senior citizens and the medically indigent, respectively. A large proportion of the remainder of the population is covered for personal health care expenses through private insurance plans. Many employers help people to meet the costs of personal health care through employer – employee cost shared insurance plans or, in some instances, through the direct provision of health services for their workers as, for example, in a company hospital. Philanthropic (charitable) organizations also finance health services, particularly for specific groups in the population, such as the Shriners' hospitals for children, and the charitable clinics and hospitals run for the poor. Finally, there is the direct payment method of financing, whereby the individual pays for services directly out of his own pocket.

An increasingly large proportion of personal health care in the United States is being financed through public monies. In 1950, it was estimated that only one fifth of the nation's expenditures for personal health care was paid for by the government. By 2005, nearly 45 per cent of these expenses were covered by government sponsored programs, chiefly Medicare and Medicaid. There has also been a considerable increase in the amount paid for by private health insurance plans from 8.5 per cent in 1950 to 35.9 per cent in 2005. It is estimated that approximately three quarters of the American public now have some form of health insurance that covers major hospital and medical-surgical expenses. The out-of-pocket expenses borne by the individual consumer have decreased proportionately with the increase in public financing of health care and the expansion of private insurance plans[6].

In Canada, the major portion of personal health care expenditures is taken care of for the consumer of health services through a system of universal prepaid health insurance. The costs are borne almost entirely by the federal and provincial governments and indirectly by the consumer. The federal government's share of the costs is derived from general tax revenues. The provinces raise their share in different ways. Some finance the program entirely out of general tax monies. Others require the individual to pay a premium. In provinces where a premium is required, it is waived for people who would have difficulty in paying it, such as senior citizens and people on low incomes, and its is waived or reduced for students.

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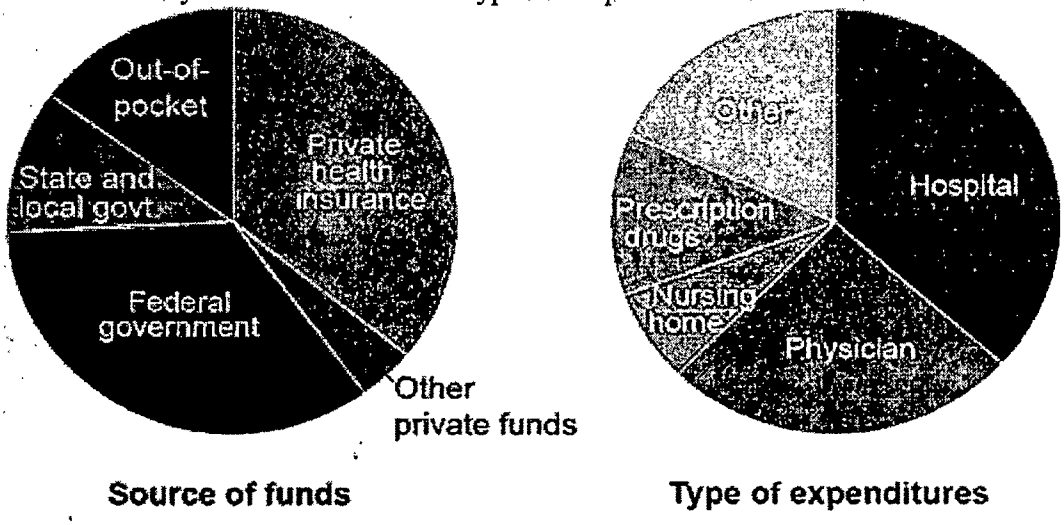
[6] Health, United States 2007 with Chart book on Trends in the Health of Americans, US Department of Health and Human Services, Centre for Disease Control and Prevention, National Centre for Health Statistics, November, 2007, DHHS Publication No. 2007 – 1232.
http://www.cdc.gov/nchs/data/hus/hus07.pdf.

Graph 3.3
Personal health care expenditure, 2005
By sources of funds and types of expenditure: United States



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Figure 8. Data from the Centers for Medicare & Medicaid Services.

Table 3.2
Personal health care expenditures, by source of funds and type of expenditures: United States, 2005

Personal health care expenditures and source of funds	*Type of expenditures*					
	Total	*Hospital care*	*Physician services*	*Nursing home*	*Prescription drugs*	*Other*
	Amount in billions					
All personal health care expenditures	$1,661.4	$611.6	$421.2	$121.9	$200.7	$306.1
	Percent distribution					
All personal health care expenditures	100.0	36.8	25.4	7.3	12.1	18.4
Source of funds	Percent distribution					
All sources of funds	100.0	100.0	100.0	100.0	100.0	100.0
Out-of-pocket payments	15.0	3.3	10.1	26.5	25.4	33.9
Private health insurance	35.9	35.5	48.3	7.5	47.4	23.5
Other private funds	4.1	4.5	6.4	3.7	0.0	3.2
Government	45.0	56.8	35.3	62.3	27.2	39.5
Medicaid	17.5	17.3	7.1	43.9	18.6	21.2
Medicare	19.9	29.5	21.2	15.7	2.0	12.6
Other government	7.5	10.0	7.0	2.7	6.6	5.6
Federal	34.2	45.7	28.9	42.7	16.4	26.9
State and local	10.7	11.1	6.3	19.6	10.8	12.5

0.0 Quantity more than zero but less than 0.05.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts.

Notes: Other expenditures includes dental services, other professional services, home health care, nonprescription drugs and other medical non durables, vision products and other medical durables, and other personal health care, not shown separately.

The range of services covered by the government-sponsored program varies from one province to another. All provincial plans must provide basic hospital and medical care services. Some include additional benefits, such as pharmaceutical services, foot care services, and eye care services. A number of people supplement the government program with private insurance plans to cover additional expenses they might incur, such as the costs for private or semiprivate accommodations in a hospital, or else to provide income security in the event of illness. In addition, industrial and commercial firms frequently offer supplementary benefits, such as dental insurance, to their employees on an employer-employee cost-shared basis. As in the United States, industrial firms also share in the financing of health clinics and hospitals in some instances[7].

HEALTHCARE IN INDIA:

India is a Democratic Republic consisting of 28 States and 7 Union Territories (directly administered by the Central Government). According to the Constitution of India, state governments have jurisdiction over public health, sanitation and hospitals while the Central Government is responsible for medical education. State and Central Governments have concurrent jurisdiction over food and drug administration, and family welfare. Even

[7] The Standard Department letter of Explanation on the Canadian Health System, Prepared in the Dept. of National Health & Welfare, Ottawa, 1978.

though health is the responsibility of the states, under the Constitution, the Central Government has been financing the national disease control, family welfare and reproductive and also the programmes that are related to child health. Each state therefore, has developed its own system of Health care delivery, independent of the Central Government.

In India, public spending on healthcare is low compared to the developed countries, having declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Government, in its National Health Policy, 2002 (NHP 2002), is targeting an increase of healthcare expenditure to 6% of GDP by 2010, with 2% of GDP being funded by public health investment[8]. Today public spending on health is a mere 1% of GDP calculated in India Budget 2011-2012. Public spending on health care as per the World Health Organization recommends should be at least 5%. The government over the last six years has not been able to move towards its own target of 3% of GDP for health. The share of the Central government in public spending for health is a mere 0.25% of GDP when as per the UPA target it should be 40% of 3% of GDP that is 1.2% of GDP or Rs. 86,400 crores at today's prices[9].

The official governing bodies of the health system at the national level consist of (a) The Ministry of Health and family Welfare (b) The Directorate General of Health Services and (c) The Central Council of Health and Family welfare. At the state level the healthcare administration comprises (a) State Ministry of Health (b) State Health Directorate and District Medical and Health Officer (DMHO) at District level.

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[8] http://www.watsonwyatt.com/europe/pubs/healthcare/render2.asp?ID=11384

[9] Right to health: Indian Budget 2011-12 – A brief comment, Saturday, March 5, 2011. http://righttohealthcare.blogspot.com/2011/03/india-budget-2011-12-brief-comment.html

3.4. PUBLIC HEALTH SYSTEM IN INDIA:

The Public Health system in India has three main links i.e. Central, State and District (Local or peripheral).

Table 3.3
Public Health System in India

	NATIONAL LEVEL Ministry of Health and Family Welfare	
	STATE & U.T.S. Department of Health Family Welfare	
	Apex Hospital	
	DISTRICTS District Hospital	

RURAL AREAS	**URBAN AREAS**
Community Health Centre	Hospital
Primary Health Centre	Dispensary
Sub-centre	
Village Health Guides and trained Dias	

At the Central: The Central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministers, so that health services cover every part of the country and know state lags behind for want of these services.

At the State: Historically, the first mile stone in State Health Administration was the year 1919, when the states obtained autonomy, under the Montague – Chelmsford reforms from the Central government in matters of public health. The Government of India act 1935 gave further autonomy to the states. The position has largely remained the same even after the new constitution of India came into force in 1950. The state is ultimate Authority responsible for all the health services operating within its jurisdiction.

At present there are 28 states in India with each state having its own health administration. In all the states the management sector comprises the State Ministry of Health and a Directorate of Health.

At the District: The principal unit of administration in India is the district under a Collector. Within each district again, there are six types of administrative areas

- Sub – divisions.
- Tehsils (Talukas).
- Community Developments Blocks.
- Municipalities and Corporations.
- Villages.
- Panchayats.

Most districts in India are divided into two or more sub-divisions, each in-charge of an Assistant Collector or Sub-Collector. Each division is again divided into tehsils (taluks), in-charge of a Tehsildar. A tehsil usually comprises from 200 to 600 villages. Community Development Block is a unit of rural planning and development, and comprises approximately 100 villages and about 80000 to 120000 population, in-charge of a Block Development Officer. Municipal Boards – in areas with population ranging between 10000 and 2 lakhs, Municipal chairman is the in-charge of Municipal Boards and Mayor is the in-charge of corporations with population above 2 lakhs and above. Finally there are the village panchayats, which are institutions of rural local self government.

3.5. NATIONAL RURAL HEALTH MISSION (NRHM):

Health care is directive under National Common Minimum Programme (NCMP) of Central Government, as it is one of the seven thrust areas of NCMP, wherein it is proposed to increase the expenditure in health sector from current 0.9 % of GDP to 2-3% of GDP over the next five years, with main focus on Primary Health Care. The Government of India has launched the National Rural Health Mission (2005-12) to carry out necessary architectural correction in the basic health care delivery system. The National Rural Health Mission (NRHM) has been theoretical and the unchanged is being equipped from April, 2005 all over the nation, with extraordinary center of attention on 18 states which consists of 8 Empowered Action Group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttaranchal, Orissa and Rajasthan), 8 North East States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura) Himachal Pradesh and Jammu & Kashmir.

- The chief aim of NRHM is to give easy to get to, reasonable, liable, successful and dependable most important health care, particularly to deprived and weak section of the populace. Besides this it also aims at over passing the gap in Rural Health Care throughout creation of a cadre of Accredited Social Health Activists (ASHA) and recovers hospital care, devolution of programme to district level to recover intra and inter-sectoral meeting and successful use of resources. Added to this the NRHM aims to provide overarching umbrella to the on hand programmes of Health and Family Welfare, including Reproductive and Child Health programme (RCH-II), Iodine Deficiency, Filaria, Kala Azar Tuberclosis, Malaria, Blindness, Leprosy and Integrated Disease Surveillance. Additionally, it tackles the issues of health also in regard to cleanliness and

hygiene, nourishment and safe drinking water as fundamental determinants of good health in order to have greater meeting among the correlated social sector sections i.e., Women and Child Development, Sanitation, Elementary Education, Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH), Panchayati Raj and Rural Development.

The task moreover seeks to put up better possession of the programme among the society through participation of Panchayati Raj Institutions, NGOs and other stakeholders staring from National to Sub district so as to accomplish the goals of National Population Policy 2000 and National Health Policy. Every year the Central Government increasing budgetary allocations to effective implementation of programmes of NRHM. Central Government increased budgets pay out for NRHM from Rs. 14,002 crore in 2009 – 2010 to Rs. 15,514 crore in 2010 – 2011.

Mission Outcome

The subsequent are expected Mission effect that could be accomplished after its execution:

- Provision of village level health provider (ASHA) in under served villages
- Intensification Sub- centers /PHCs
- Lifting CHCs to the level of IPHS
- Institutionalizing District level Management of Health (all districts)
- Hindrance and have power over of infectious and non infectious diseases together with locally widespread diseases

• Increase operation of First Referral Units from less than 20% (2002) to more than 75 % by 2010

• Decrease in infectious diseases, MMR, IMR and would assist in reaching population stabilization.

3.6. ROLE OF INSURANCE IN HEALTHCARE MANAGEMENT:

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (IRDA):

"To protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto"[10].

Insurance in India has a great role to play in Health care of the public including its major Life Insurance and General Insurance.

Insurance industry as comprised mainly two players and are given below.

1. Life Insurers

   Life Insurance Corporation of India (LIC).

2. General Insurers

   General Insurance Corporation of India (GIC).

   General Insurance Corporation of India had 4 subsidiary companies mainly[11]

   1. The Oriental Insurance Company Limited
   2. The New India Assurance Company Limited

[10] Mission statement – Insurance Regulatory and Development Authority, Govt. of India.
[11] Insurance Regulatory and Development Authority, Government of India.

3. National Insurance Company Limited
4. United Insurance Company Limited

These four have been de-linked from the parent company and made as independent companies with effect from December 2000. Private players also took place in both Life and General Insurance industry.

TPA CONCEPT AND ROLE:

The concept of TPA or the Third Party Administrator has been introduced by IRDA (Insurance Regulatory and Development Authority) for the benefit of both the insured and the insurer. While the insured is advantageous by faster and improved service, insurers are advantageous by decrease in their managerial costs, deceitful claims and eventually bringing down the claim ratios.

In brief, the job of the TPA is to maintain databases of policyholders and issue them identity cards with unique identification numbers and handle all the post policy issues including claim settlements. In terms of infrastructure, the TPA will need to run a 24-hour toll-free number, which can be accessed from anywhere in the country. And they will have full-time medical practitioners under their employment who will immediately take a decision on whether the ailment is covered under the policy.

The policy holder will have full freedom to choose the hospitals from the empanelled network and utilise the services as per his/her choice. For every hospitalisation, the policyholder will be well aware whether the treatment he/she is to undergo is covered under his policy or not. If covered, then he/she can seek cashless facility without having

to pay a single rupee at any of empanelled hospitals. During the time of Emergency Hospitalisation, the policyholder or relative can flash the Photo ID Card of the policyholder and gain admission into any of our network hospitals. Priority treatment at hospital is given without any payment to be made at the any time of admission, even at the time of discharge - no payments are to be made. Thus, it's a complete Cashless Treatment. Thus, the individual does not run around for arranging cash for paying for the hospital expenses

As on 12th May 2011 the list of T.P.As are noted below

1. United Healthcare Parekh TPA Pvt. Ltd., Mumbai
2. Medi Assist India TPA Pvt. Ltd., Bangalore
3. MD India Healthcare (TPA) Services (Pvt.) Ltd., Pune
4. Paramount Health Services (TPA) Pvt. Ltd., Mumbai
5. E Meditek (TPA) Services Ltd., Gurgaon
6. Heritage Health TPA Pvt. Ltd., Kolkata
7. Universal Medi-Aid Services Ltd., New Delhi
8. Focus Healthservices TPA Pvt. Ltd., New Delhi
9. Medicare TPA Services (I) Pvt. Ltd., Kolkata
10. Family Health Plan (TPA) Ltd., Hyderabad
11. Raksha TPA Pvt. Ltd., Haryana
12. TTK Healthcare TPA Private Ltd., Bangalore
13. Anyuta Medinet Healthcare TPA in Healthcare Pvt. Ltd., Bangalore
14. East West Assist TPA Pvt. Ltd., New Delhi
15. Med Save Health Care TPA Ltd., New Delhi

16. Genins India TPA Ltd., NOIDA

17. Alankit Health Care TPA Ltd., New Delhi

18. Health India TPA Services Private Ltd., Mumbai

19. Good Healthplan Ltd., Hyderabad

20. Vipul Med Corp TPA. Pvt. Ltd., Gurgaon

21. Park Mediclaim TPA Private Ltd., New Delhi

22. Safeway TPA Services Pvt. Ltd., New Delhi

23. Anmol Medicare TPA Ltd., Ahmedabad

24. Dedicated Healthcare Services TPA (India) Private Ltd., Mumbai

25. Grand Healthcare Services TPA Private Ltd., Kolkata

26. Rothshield Healthcare (TPA) Services Ltd., Mumbai

27. Sri Gokulam Health Services TPA (P) Ltd., Salem

28. I Care Health Maangement & TPA Services Pvt. Ltd., Secunderabad

29. Spurthi Meditech TPA Solutions Pvt. Ltd., Bengaluru

Apart from the above the following two are exclusively meant to meet health insurance of employees:

3.7. RAJIV AAROGYASRI COMMUNITY HEALTH INSURANCE SCHEME:

Apart from the regular public health care system, Government of Andhra Pradesh started unique community Health Insurance scheme on 1st April, 2007 for BPL (Below Poverty Line) families with a mission to provide quality healthcare to the poor. To monitor this Health Insurance scheme Government opened Aarogyasri Health care trust chaired by

Hon'ble Chief Minister of Andhra Pradesh and the trust is administered by IAS officer as Chief Executive Officer. The coverage of insurance per family is upto Rs. 1.50 Lakhs and an additional Rs. 0.50 Lakhs keep as buffer is allocate for deserving cases on an individual basis[12] [13]. The premium has borne by the Government of Andhra Pradesh on behalf of the beneficiary.

Table 3.4
Aarogyasri Health Insurance scheme Statistics at glance as on 05/Apr/2011

Number of Health camps	25439
Number of people screened	4329239
Number of cases registered	3694258
Number of Out patients	2430905
Number of In-patients	1109309
Number of pre-authorizations	978075
Number of Surgeries / Therapies	969873
Amount Pre-authorized for Surgeries / Therapies	Rs.2754 Cr.

3.8. 108 & 104 SERVICES IN HEALTHCARE MANAGEMENT AND ITS ROLE:

EMERGENCY MANAGEMENT AND RESEARCH INSTITUTE (EMRI):

EMRI in India is a forge in Emergency Management Services. It is a not-for-profit specialized association is been working in the Public Private (GVK) Partnership (PPP) mode, where EMRI is the only Indian Expert Emergency Service Provider.

EMRI handles medical, police force and fire emergencies throughout with "1-0-8 Emergency service". This is a free of charge service distributed through state-of-art emergency call response centres. It's available in Goa, Gujarat, Andhra Pradesh,

[12] Rajiv Aarogyasri – Surgical & Medical treatment (List of package rates for cashless treatment of BPL Population, Aarogyasri Healthcare trust, Government of Andhra Pradesh, India.
[13] www.aarogyasri.org.

Uttarakhand, Tamil Nadu, Assam, Meghalaya, Karnataka, Madhya Pradesh and Himachal Pradesh.

HEALTH MANAGEMENT AND RESEARCH INSTITUTE (HMRI):

HMRI is a not-for-profit organization paying attention on expanding public health delivery systems besides leveraging Information and Communication Technologies and Modern Management Practices.

HMRI foresees supporting public health systems that are run by government in providing improved contact and superiority of services to the weaker sections of the society. Hence, HMRI in collaboration with the Government of Andhra Pradesh joined hands under a Public Private (Piramal Healthcare) Partnership (PPP) to expand the health delivery systems in the state of Andhra Pradesh.

Under the joint venture, HMRI has executed a state of the art 24x7 Health Helpline helping the 80 million people of Andhra Pradesh.

Services of HMRI:

Health Advice: At HMRI doctors and paramedics are accessible at 24/7 basis without any holidays while giving advice on health related subjects. Here the doctors and paramedics are maintained algorithms to respond questions about illnesses, if they evaluate that the caller's situation needs instantaneous medical attention are accessed to the emergency number 108 or advice the caller to take suitable action and look for medical help.

104 – Mobile: Offers health care services for people existing in isolated areas through a well operational mobile van unit that consist of medical equipments and Auxiliary Nurse Midwife (ANM's) who will be skilled as lab assistants and registration associates.

104 – Telemedicine: Telemedicine is an innovative need based cost effective point of care technology offering comprehensive telemedicine solutions in rural India.

Disaster Relief Operations: HMRI took up swift and efficient rescue operations for the disaster affected victims.