Chapter-VI

SUMMARY AND CONCLUSIONS

6.1 INTRODUCTION

The concept of health is very essential ingredients of human capital development. The ancient proverb: “Health is Wealth” is true for ever and it is the correct time to say that sound minds in a sound body need to fulfill functioning of every human being. Life is for living. Without health, life is deprived not only of much of its usefulness, but also its joys and pleasures. Most of the rural people are deprived of health and wealth. Still majority of rural population depends on Agriculture and the most of them are belongs to poor and downtrodden communities. They were not in a position to bear the huge amount for the treatment of their diseases like heart problems, kidney, liver etc., and the medical facilities to treat the above diseases in rural areas of Andhra Pradesh are not yet available. The facilities not available in the government hospitals at sufficient level to treat the major diseases rather than the corporate hospitals, but the poor people can’t afford it. It’s a dream for the poor people who especially Below Poverty Line (BPL). Some can try to afford by selling their assets and afterwards they become the poorest of the poor. Ultimately it leads the health inequalities in the society and finally it creates the socio-economic problems. In India, at some extent, social health insurance schemes have been introduced and providing health facilities.

6.2 PROBLEM AND NEED FOR THE STUDY

Poverty is the common feature of the rural and urban areas in Andhra Pradesh which creates inability in meeting the expenses to chronic diseases. Thus, poor are unable to meet health expenses to the dangerous diseases. There is a need that the State to provide financial
protection to families living below poverty line for the treatment of major ailments such as cancer, kidney failure, heart and neurosurgical diseases etc., requiring hospitalization and surgery. The present Government hospitals not having requisite facility and the specialist pool of doctors to meet the state wide requirement for the treatment of such diseases. Large proportions of BPL families borrowing or sell assets to pay for the treatment in the private hospitals. Health Insurance could be a way of removing the financial barriers and improving access of poor to quality medical care, providing financial protection against high medical expenses; and negotiating with the providers for better quality care. Government of Andhra Pradesh has accordingly formulated noble scheme namely Rajeev Aarogyasri Health Communities Health Insurance Scheme (now it is renamed as Dr.NTR Vaidya on November 19, 2014) and established a trust. It has been extended to all the districts of the state and benefited a number of BPL families. Regarding, a proper and comprehensive study gives directions to further modification or change. Even though a few studies were conducted, all these were confined to secondary data. Unfortunately there is no primary source of information by field survey and the earlier research was not explained the implementation and the impact of Rajiv Aarogyasri health insurance scheme especially in East Godavari District of Andhra Pradesh. Thus, present study tries to fill these gaps.

6.3 OBJECTIVES OF THE STUDY

The central aim of this study is to analyse the implementation of the Rajeev Aarogyasri Community Health Insurance Scheme (re-named as Dr. NTR Vidya Seva) in the State of Andhra Pradesh. The objectives are:
1. To analyse the health insurance schemes currently being implementing in the country and at the state of Andhra Pradesh.

2. To discuss the management of Aarogyasri health insurance scheme at the state level.

3. To analyse the health profile and expansion of the Aarogyasri scheme in the study area (East Godavari District).

4. To study the socio-economic characteristics of the sample beneficiaries of Aarogyasri scheme.

5. To examine the implementation and the impact of Aarogyasri in the study area, and

6. To give some Policy Suggestions to effective implementation of the Scheme.

**6.4 METHODOLOGY OF THE STUDY**

In order to document and quantify the objectives outlined above, primary and secondary data source information is used.

Four stages of sampling process are carried out in the study. Multi stage stratified random sampling method is used in the present study. The first stage is selecting of district, the second stage consists of selection of mandal, the third stage consists of selection of villages and the fourth stage is of selection of households.

East Godavari District is selected due to the fact that the district has drawn country wide attention about the large population, better in implementation of the Aarogyasri scheme and another weighty reason is that studies so far undertaken in this district regarding the scheme and the socio-economic and living conditions of the Aarogyasri beneficiaries is neglected.
The researcher selected 24 villages from 16 mandals to collect accurate data from 120 beneficiaries covering various social groups.

**Data Collection**

While qualitative and quantitative information/data were obtained through a structured schedule, the investigator visited personally to conduct interviews from each of the beneficiary of the scheme. Primary data from households is collected with the help of structured schedule. The secondary data has been obtained from the annual reports, action plan and other documents of the state of Andhra Pradesh; District Handbook of Statistics of different years is obtained from the Chief Planning Officer, East Godavari.

**Techniques used in the Analysis:** In analyzing the data apart from tabular analysis - *averages* and *percentages* are generally used. Besides, different statistical techniques like:

**Measure of Knowledge index, X² test** has also applied to find out the functional relationship of various social factors of the respondents in this study.

**Cross section analysis** method is followed in the explanation of the tables in the study.

**6.5 LIMITATIONS OF THE STUDY**

The researcher has taken utmost care in collecting information from the respondents and interpreted in tables and given analysis. However, the information given by the respondents may not be absolutely accurate due to illiteracy and other social constraints. Thus, there may differences in actual records and the field survey results.
6.6 HYPOTHESIS ADOPTED IN THE STUDY

In the study, some hypothetical tests was considered.

1. \( H_0 \): There is an association between the education/literacy level of respondents and awareness of health.

2. \( H_0 \): There is an association between the burden of disease and size of the family.

\( H_0 \): There is a negative association between the size of non-workers and the family income/health status of the family.

6.7 SUMMARY, FINDINGS AND SUGGESTIONS

6.7.1 Management of Rajiv Aarogyasri in Andhra Pradesh

An attempt is made in chapter three to evaluate the management of Rajiv Aarogyasri Community Health Care Insurance Scheme in the state of Andhra Pradesh.

The scheme introduced on 01.04.2007 on pilot basis was subsequently extended to the entire state in a phased manner to cover more than 7.0 crores of population spread across the state. The scheme has been implementing directly by the Aarogyasri Health Care Trust by entering into contract agreement with network hospitals.

It has implementing into two parts. Aarogyasri-I is operated through Insurance Mode, whereas Aarogyasri-II is BPO trust mode. Encouraged by the success of Aarogyasri-I scheme, Government has launched with effect from 17\(^{th}\) July, 2008 Aarogyasri-II scheme to include a large number of additional surgical and medical diseases to enable many more BPL people who are suffering from acute ailments to lead a healthy life. Aarogyasri-II scheme is an extension of the ongoing
Health Insurance Scheme. The scheme was implemented online through an efficient IT portal.

Universal coverage of all BPL families in the state irrespective of age, sex, social status and family size is a peculiar feature of the scheme.

_Aarogyasri_ Health Insurance scheme was extended to the entire state in 5 phases. About 938 identified therapies in 31 categories and 454 network hospitals have covered under the scheme. The Scheme is being implemented through _Aarogyasri_ Health Care Trust to assist 229 lakh poor families from catastrophic health expenditure in the State. The scheme provides end-to-end cashless services for identified diseases through a network of hospitals from Government and private sector. Under the scheme, each BPL family is provided health coverage to the extent of Rs.2.5 lakhs.

The entire scheme is funded by the Government and budget is provided through green channel to facilitate unhindered access to required funds. About 36,394 Medical camps were held by the network hospitals in rural areas and 62.98 lakh patients screened in these health camps since inception of the scheme (01.04.2007) until December, 2013.

The progress of cochlear implantation therapies count was recorded by 5,641 in Government Hospitals and 12,278 in corporate hospitals during by 2011-12. The percentage share of Government Hospitals was 31.48 per cent and the remaining 68.52 per cent in case of corporate hospitals.

About 30,855 health camps were conducted. Patients screened campus was made at 52,33,503 and 2,39,709 patients referred campus conducted.
To optimise benefit of surgery/therapy taken under the treatment, the scheme provides packages for one year cashless follow-up services (consultation, testing and treatment) to beneficiary in 125 identified procedures.

About 5,59,884 patients were treated as out-patients and 23,19,669 patients treated as in-patients in 454 network hospitals under the scheme so far. Preauthorized therapies count by Government hospitals was recorded by 12,280 (15.27%) in 2008-09 and increased to 51,213 (39.93%) during 2008-09 to 2011-12. It was recorded by 68,112 (84.73%) and 77,036 (60.07%) in case of corporate hospitals. Thus, about 2,86,621 therapies were preauthorised at the cost of Rs.4,050.64 crores.

The aggregate expenditure on all the items incurred by Aarogyasri trust till December was Rs 4,805.57 crores. Of which Rs.1,066.39 crores (22.19%) occupied by Government Hospitals and 3,739.18 (77.81%) by Private corporate hospitals.

Crores of rupees have been paid to the corporate hospitals for treatment. It may be misused. Thus, a treatment facility-wise mapping of Government Hospitals can help route Aarogyasri patients to those hospitals for specific medical conditions. Only those cases which cannot be treated in these hospitals (for either lack of bed space or lack of required facilities) should be referred to private hospitals. Simultaneously, there should be a vigorous campaign to improve service delivery standards in secondary and tertiary hospitals.

Everyday burning issue in the news and studies shows that many of the corporate hospitals exploiting the insurance companies as well the Government in demanding money through fraud enrolment of patients. Sometimes, they are submitting bills for more days as giving treatment.
So, introduction of **biometric** attendance from patient every day can reduce fraud billing and cancel the hospitals, if they followed the same.

The cost benefit ratio of insurance mode during the study period was varied from 71.0 per cent in 2007-08 to 91 per cent in 2011-12. In case of trust mode, it was 96.94 per cent in 2007-08 and increased to 98.39 per cent in 2010-11. It was fallen to 84.13 per cent in 2011-12. The aggregate Cost Benefit Ratio was recorded by 936.38 per cent during 2007-2012 respectively.

The Government of Andhra Pradesh has taken some initiatives to strengthening this scheme. To strengthen and enhance participation of Government Hospitals, the Trust reserved 133 identified procedures for Government Hospitals across the state to improve performance of Aarogyasri scheme.

*Aarogyasri* Health Care Trust introduced **biometric** registration for *Aarogyasri* patients in the network hospitals to strengthen implementation of the scheme and avoid fraud.

Mega health camps are currently being conducted at Revenue Divisional Level by NWHs instead of regular health camps through PHCs and are conducting multi specialties camps through NWHs. Medical camps are being organised under the *Aarogyasri* programme across the district to screen persons for various ailments, including heart disease, weakness of bones, problems of ear, nose, and throat, brain and nervous system and diseases prevalent among women and children.

But, these are confined to limited areas and working times. Hence, medical camps should be arranged in remote areas and non-working hours of rural and urban areas.
The success stories of the *Aarogyasri* beneficiaries deliberating the performance of the scheme. They believed that the scheme is *Apara Sanjeevini* (supreme savior).

However, as two sides of coin, the scheme has some administrative problems. There are certain ‘management failures’ in proper implementation of this scheme. The enrolment of beneficiaries is on higher side and the facilities and service available to them is not up to their level of expectations. The proper examination of the data provided by the hospital reveals that nearly 5-7 per cent of claims and false due to misuse of the scheme in collusion with hospital management and insurer.

A problem with such health insurance schemes, though welcome, was that they did not cover primary healthcare. Families still faced high health-related costs to access clinics. Backed with qualitative evidence the ‘Young Lives Report’ demonstrated that healthcare costs contribute to debt and proved to be a barrier to effective primary healthcare. Poor access to such services meant that parents often had to either take their child to district hospitals or opt for expensive private medical care. Thus, primary health should also undertake in this regard.

It is the right to establish equipment at Government Hospitals which can recover while giving treatment and recover it from insurance companies rather than push profits to private hospitals. The incentive system for Government Doctors provided for under the *Aarogyasri* scheme has to be either dismantled or be made more nuanced. If the latter is preferred, the incentives should kick-in only after a certain performance benchmark is breached.

Health department should be at the forefront to conduct awareness camps, and participate in a big way in the scheme. Some mechanism to facilitate the access the health insurance scheme among the poor, along
the lines of the pilot-project implemented by the Labour Department may be thought of.

There should a need of coordination of health schemes of rural and urban areas to simplify the implementation of health programmes and reduce costs and divert fund to the Aarogyasri scheme, if it is possible.

6.7.2 Health profile and expansion of Aarogyasri in the study area

Chapter four explains the socio-economic and health profile of the study area. East Godavari District has 5 Revenue Divisions and comprising with 60 mandals. In 2011, East Godavari had population of 5,154,296. Sex Ratio stood at 1,006 per 1,000 male. Average literacy rate was 70.99. The per capita annual income of Andhra Pradesh was Rs.41,593. About 51.33 percentage of households below poverty, about 40.36 lakhs of BPL families have 12.21 lakhs of BPL Cards and Aarogyasri cards.

The district has Rangaraya Medical College at Kakinada. There are 807 sub-centers includes 2 urban sub-centers, 80 PHCs, 6 CHCs, 2 CHCs (other hospitals) and three area hospitals. Nearly 42 private hospitals and one government General (referral) hospital treatment under Aarogyasri scheme and nearly 25 varieties of Specialty/Categories treatments covered under the scheme. About 1,34,251 (7.60%) therapies preauthorised to the total of Andhra Pradesh under Aarogyasri scheme.

One must keep in mind that the Government scheme involving a large amount of funds is always susceptible to misappropriation and corruption. One issue that stands in the way of effective implementation is the issuance of BPL cards; this process is still to be streamlined, and often families who rightly deserve the card are deprived of it.
Therefore, this issue needs to be seriously addressed. That said, in a country where quality and technologically superior healthcare facilities are the privilege of a select few, Aarogyasri can go a long way in establishing a health welfare framework for the underprivileged.

6.7.3 Socio-economic profile of the beneficiaries

Fifth chapter contains two sections. Section one deal with the Socio-economic conditions of the respondents.

It is observed that large consecration of the respondents held in the age group 25-45 years in all the categories in four social groups, 84 per cent of all respondents are Hindu, 3 per cent are Muslim, and 13 per cent are Christian.

Married have secured first place registered by 75 per cent among all categories, separate family respondents registered by 58.33 percent, followed by 18.33 per cent by unmarried and widowed secured of 10.01 per cent respectively. It is said that the insurance is more useful and benefit to the separate and widowed head of the families because they may be economically low status.

Highest percentage of respondents has primary education by 40.83 per cent followed by illiterates with 19.17 per cent. The Chi-square values explained that there is an association between the education/literacy level of respondents and awareness of health.

Majority of the family members are in the age group of 15-55 years. The number of dependency population (below 14 years and above 55 years) is higher (54.60%) than the working population. The average size of the total respondents is 5.1 members. But the size of the family of Scheduled Tribes (STs) is 5.6 members as highest as the others.
6.7.4 Respondents’ perceptions on the implementation of *Aarogyasri* scheme

Respondents were believed that the scheme is the *Apara Sanjeevini* (supreme savior) to the poor. The main source of knowledge regarding the Rajeev *Aarogyasri* Community Health Insurance Scheme (RACHI) is private hospitals while they went to take treatment. But, very limited members have awareness about the issues like diseases covered, medical camps of network hospitals, providing snacks and medicines while network hospitals medical camps, traveling expenses, post-operative care for specific diseases.

It is found that about 43.56 per cent of the SCs, 56.80 per cent of STs, 42.25 per cent of BCs and OCs by 44.29 per cent were faced ill-health in the last year. The figures show the demand for health facilities in the study area.

One to two members were benefitted in each family under the scheme. Of the total beneficiaries, about 44.53 per cent were belonging to male, 32.81 per cent were female and 22.66 were children. BC community people were benefited more by taking costly treatment followed by STs, OCs and STS respectively.

Out of the 128 beneficiaries, nearly 13 cases were related to cancer, kidney (12), heart surgery (13), eye operations (22), and appendicitis (14) etc., is recorded.

The priorities of this scheme have been criticised about the benefit package that focuses on alleviating the financial distress associated with catastrophic illness and ignores health problems faced by the majority of the poor such as fever and gastro-intestinal disorders. The two main reasons for the chosen focus of *Aarogyasri* are: (1) the purpose of
addressing indebtedness due to health care costs; and (2) the challenges with monitoring treatment of ailments without hospitalisation.

It is observed in the field survey that the poor patients continue to spend significantly on conditions that are not covered by the Aarogyasri at both government and private facilities. Their findings show that Aarogyasri alone is not likely to reduce the financial burden of illness on the BPL population.

It is suggested that strong referral system and fundamental changes to the health system are needed to meet goals of financial risk protection.

About 77.5 per cent of the beneficiaries were taken treatment in the private hospitals.

The curried persons are participating in daily activities as evidence that the number of working days has been increased and varied from 60 to 85 days. The percentage share of money earnings to the annual income is also increased.

Interestingly, all the respondents are willing to contribute to health insurance scheme by Rs 50-250.

The respondents about 25 per cent felt that they were faced problem at the time of testing, 27.50 per cent were faced problem during post-operation days. Meanwhile, 73.33 percent were faced the problem of getting proper information at both government and private hospitals.

Thus, there should be a need of proper mechanism to provide information and arrange friendly treatment with the patients.

The patients were satisfied about the scheme and providing costly medicine in time, doctors visiting and testing etc. But, patients who were admitted in Government Hospitals said that, air conditioners not functioning even in emergency words and surgical wards also. Bad smell
is common in the Government Hospital even though the management applying bleaching powder and other precautionary chemicals.

Thus, proper mechanism in this regard is very essential. The government should increase revolving fund under the scheme to the Government Hospitals towards maintenance.

It is further found that majority of the beneficiaries were fallen in debt due medical expenses before joining Aarogyasri. They have to come out from debt trap. Otherwise, poverty cannot eradicate from the mass.

In this regard, the grass root organisations like self-help groups should provide loans to income generation activities with proper supervision.

It is further said that proper civic amenities like shelter, safe drinking water, first aid, time to time health checkup can control spreading of diseases. Thus, the concerned administrative body should provide such facilities to the poor.

Under the scheme, only the BPL families have been getting benefits. But, why the middle class people are neglected. They are also unable to meet the costly treatment in the inflationary economic conditions.

Thus, they are humbly requesting the government to extend the scheme to the middle class also. The government should extend the scheme to the middle class by acclimate unique insurance policy.

It is concluded that there is no doubt to say that the RASCHI has been an Apara Sanjeevini (supreme saver) of poor from dangerous chronic diseases. The Aarogyasri scheme has been revolutionary in placing health on the political map in the state. It is a major landmark in
India’s administrative approach to health and has emerged as a popular scheme among the masses. It has given hope to multitudes where none existed.

6.8 FURTHER RESEARCH

The present study is confined to management of *Aarogyasri* with reference to East Godavari only. There is a scope to conduct studies at the state level and comparative study with other districts.