Chapter-I

INTRODUCTION

1.1 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 whom 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.
It shall be remembering that the well-known Sanskrit saying rendered into English, it says, a sound physical health is the first and the most important requisite for the performance on one’s duties in his life. In Latin saying ‘Men’s Aana in Corpore Sano¹ - a sound mind in a sound body, also emphasises the importance of sound physical and mental health for the full functioning of every man. These two sayings from two of the world’s classical languages suggest that from the remote past man in the advanced societies. It has realised the importance of good health towards his progress individually, towards the performance of his duties to his family and towards the fulfillment of his obligations to the society in which he lives. These tasks, well done, help the society to derive benefits from his abilities. In an industrial society, his efficiency adds to the productivity of the institution to which he belongs, thus adding to the affluence of the society and to the wealth of his country. The administrative services like police department maintaining law and order and the defence forces all needed persons, who are physically fit and mentally alert and equipped. Thus, health is not the end, but only a means for all the important human pursuits, towards his own self and in the service of the society. The nation’s prosperity and happiness lies in the health of its citizens. Good health is a fundamental human right, and each country is responsible for the provision of adequate health facilities for its population, since health and development are closely inter-twined and inseparable aspects of the government. Promotion of health is essential for national progress.² Health contributes to a better quality of life and World peace. The health of a nation is not only an essential component to the nation’s economic growth but also for internal stability. Assuring a minimal level of health care to the population is a critical constituent of the development process. Hospitals and health centres play
a vital role in protection of health of the people. Good health delivery is always associated with better capability and leadership.\textsuperscript{3}

Man and the Society in which he lives, however, are constantly on the change. In the last few centuries, man has taken great strides in the progress of science. Their pursuits have been naturally directed more towards scientific aspects, which have earned for him today, victory over nature in many fields. The impact of the development has led to the discovery of many machine tools leading to great industrial progress. The competitive of scientific and industrials developments focus the importance of efficiency arid, therefore, of good health.

The facilities for transport and communication have brought groups, societies and peoples of the world closer together, so that no group can stay in isolation in respect of economic, social and educational development. It has got to go nearer to the levels of the developed areas. The conditions of the developmentally backward areas also influence those of the advanced ones. Thus, infectious and diseases in one such area always raise the possibility of spread to other areas due to easier and quicker means of contact with and passage through these countries. International measures are necessary today for persons travelling by ship or air to prevent spread of communicable diseases from one area of the world to another. The health of the people opt the world has, therefore, to be thought of at an international level.

Most of the rural people are deprived of health and wealth. Most of the people living in rural areas and the same are the true in case of Andhra Pradesh. Still majority of the 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).

1.2 THE CONCEPT OF HEALTH

Health means the ability to lead a socially and economically productive life. The term health is defined by different organisations in different ways. According to preamble of the Constitution of World Health Organisation (WHO), health is defined as “A state of complete physical, mental and social well-being and not merely an absence of disease or infirmity”.4

Health is not only the basic to lead a happy life to an individual, but also necessary for all productive activities in the society.5

Christian Medical Commission viewed that “Health is a dynamic state of well-being of the individual and the society of physical, mental, spiritual, economic, political and social well being in harmony with environment and God”.6 Health is the state of well being whether it is of the mind, body, or soul. Physicians and others often evaluate the determinant of good health in the medical field.7

All these factors and trends have to be properly understood by any society that wishes to improve its standards of health. Any programmes for the attainment of good standards of health depend for their successful implementation, like an efficient administrative set-up, requisite financial provision, availability of sufficient medical, paramedical and technical personnel, the technical know-how and the necessary equipment and
tools. In addition to all, however, an important requirement is a public that is cooperative and capable of implementing the programmes. In the ultimate, it is the public who have to actively participate in the measure proposed and help in the achievement of the targets. This active participation can be possible only from a public, who understand the desirability or necessity of the proposed measures being in their own interest. It is this understanding, which is pre-requisite for the success of any health measures. In its absence, desired results can never come.

1.2.1 Human Health and Disease

Disease has been defined as a state, which limits life in its power, duration or enjoyment. Disease is a departure from a state of health. Specific diseases are generally diagnosed only when they produce significant changes in the internal environment of man leading to some symptoms like pain, fever, weakness etc. In such cases, deviation for health is very wide and the physical, mental, economic and social effects brought about by the disease have already made deep impressions on the affected individual and his family. However, it is interesting to note that in many cases, the changes brought about by the disease process are not big enough to produce symptoms. Naturally such a state of sub-clinical or minimal disease can’t be easily diagnosed. With the modern advances of medical sciences, especially in the field of preventive medicine, more and more diseases can now be diagnosed as a deviation from health long before the disease has produced only noticeable effects on the person.

One can easily understand that before a strong and stable building can collapse, the whole structure should either become considerably weak or be subjected to a severe blow, like the one of an explosion of a bomb. What is true of the building is true of health. Even if a weak building is standing, it is not safe. An individual, who is not actually ill, need not be
necessarily healthy. Health and disease are not sharply demarcated, but they imperceptibly merge into each other like the colours in the spectrum of light. It is, therefore, generally difficult to know when the state of health ends and the state of disease begins. In most of cases, especially in chronic diseases, the chance in the beginning is imperceptible and not noticeable. The extreme unfavourable end of the spectrum is death.

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. Most of the people living in rural areas and the same are the true in case of Andhra Pradesh. Still 75 per cent of rural population depend on Agriculture and the most of them 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 afford it. It’s a dream for the poor people whom especially Below Poverty Line. 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.

Health is one of the fundamental human rights. Unfortunately, health can’t be given or distributed, but has to be actively acquired and won. In order to know the ways of preserving and promoting health and preventing and conquering disease, it is necessary to understand the fundamentals of health and disease. It is only with such understanding that
one would be able to take proper measures and care necessary to build up health.

Health has been defined as a state of complete physical, mental, and social well being and not mere absence of disease or infirmity. This is a very broad concept of health and implies a perfect harmony of the internal environment consisting of the physical, chemical and biological surroundings. As man is so inseparable from Nature, it is not surprising that the environment in which man live, has a profound influence on him, in spite of his magnificent achievements in becoming the master of the world. All living organisms, including man, live in a highly competitive struggle for survival. Man’s internal environment, therefore, is constantly under the influence of the external forces of Nature. In this struggle, wherever a man in a perfect balance with the environment and has an upper hand over the harmful factors like the pathogenic micro-organisms, insects, physical and chemical agents etc., he is said to be healthy. There is, then normal functioning of his body and mind, and he is efficient in his personal and social duties. Whenever health is promoted to a positive level, a little disregard regarding the usual rules of health may at times not affect adversely the very stable balance established. This is because of the development of strong non-specific immunity or protection against the ordinarily harmful agents.

Health is multidimensional. The WHO definition envisages three specific dimensions. As the knowledge base grows, the number of dimensions increases. Although these dimensions function and interact with one another, each has its own nature and for descriptive purposes, it will be treated separately. The important dimensions are:
1. **Physical dimension**: The Physical dimension of health is probably the easiest to understand. The state of physical health indicates the notion of perfect functioning of the body. It conceptualises health biologically as a state in which every cell and organ function at optimum capacity and in perfect harmony with rest of the body.

2. **Mental dimension**: Good mental health is the ability to respond to many varied experiences of life with flexibility’s and a sense of purpose. It can be defined as “a state of balance between the individuals and the surrounding world, a state of harmony between self and others and that of the environment”.

3. **Social dimension**: Harmony and integration within the individual between each individual, other member of society and between individual and the world in which they live can be considered as social well-being. It also can be defined as quantity and quality of an individual’s inter-personal ties and extent of involvement with the community.

4. **Spiritual dimension**: It means the part of the individual who reaches out and strives for meaning and purpose in life. It is the intangible something that transcends physiology and psychology.

5. **Emotional dimension**: Emotional dimension and mental dimension are closely related. The research revealed the difference between both. Mental health can be seen as knowing or cognition, while emotional health relates to feelings.
6. **Vocational dimension**: This is a new dimension related to the vocational aspects of life. When work is fully adapted to human goals, capacities and limitations, work often plays a role in promoting both physical and mental health. The importance of this dimension is exposed, when individuals suddenly lose their jobs or face mandatory retirement.9

1.3 **THE HEALTH CARE SYSTEMS IN INDIA**

According to the Indian Constitution, health is a state subject, providing health services to all people is the responsibility of State Government with assistance of local health organisations. In India, the government regulates and maintains health standards, provides preventive and curative services and build-up the infrastructure for medical and health services. The Indian Medical Central Council Act (1970) that came into existence with approval of Parliament has the power to grant permission to establish any health institution in the country (Universal’s Bare Act, 2004). The health care system in India is represented by five major sectors (Figure 1.1) which differ from each other by the health technology applied, and source of funds for operation.10 These are:
Fig.1.1: Major sectors of health care systems in India

1) **Public health care Sector**: Public health care includes: (a) Primary Health Care such as - Primary Health Centers (PHC), Sub-centers, (b) Hospitals/Health Centers compressed by Community Health Centres (CHC), Rural Hospitals, District Hospitals/Health Centers, Specialist Hospitals, Teaching Hospitals, (c) Health Insurance Schemes like employee State Insurance, Central Government Health Scheme, and (d) Primary Health Care of defiance Services and Railways.

2) **Private Sector**: Corporate Hospitals, polyclinics, nursing homes, dispensaries, general practitioners and clinics are major contributors in private sector.
3) **Indigenous System of Medicine:** *Ayurveda* and *Siddha, Unani, Tibbi*, Homeopathy and unregistered practitioners are included in indigenous system of medicine.

4) **Voluntary Health agencies:** Other than government health agencies in nearly every community there are non-governmental or voluntary agencies that supplement the work of the health department. Health services in India had their beginning with voluntary groups only (Missionaries from abroad who came and established services for women, children etc). Voluntary health agencies have their own administrative body or committee which raises fund through its membership or through private sources.

5) **National Health programs:** Separate Health Structures with strong central management dedicated to the planning, management and implementation of selected interventions.

### 1.4 HEALTH POLICY IN INDIA

In India, a systematic public health administration was introduced under the British rule. The British rulers appointed several committees and enacted a number of Acts in order to develop the health system. After independence the era of scientific planning in India started with the establishment of Planning Commission in 1950. Since then, the Government of India has been giving priority to health matters and several steps have been taken through Five Year Plans. Health policy in India is formulated in each of the Five Year Plan.

**First Five Year Plan (1951-56):** Many factors like social, economic and educational have an intimate bearing on the health of a community. The First Five Year Plan gave prior importance for proper housing, water
supply; it increased the number of hospitals and dispensaries in the country.

**Second Five Year Plan (1956-61):** During the Second Five Year Plan, arrangements were made for the training of an increased number of nurses, midwives, pharmacists, sanitary inspectors and other technicians at medical colleges and larger hospitals.

**Third Five Year Plan (1961-66):** The broad objective of the Third Five Year Plan was to expand health services and family planning programmes to bring about progressive improvement in the health of people by ensuring a certain minimum physical well-being and creating conditions favorable to greater efficiency and productivity.

**Fourth Five Year Plan (1969-74):** Family planning found the highest priority in this plan. It aimed at bringing about a group acceptance of a small-sized family and personal knowledge about family planning methods. During this Plan, efforts were made to prevent communicable diseases like malaria, small pox etc. It established leprosy control units in different parts of the country.

**Fifth Five Year Plan (1974-79):** The primary objective of Fifth Five Year Plan was to increase the accessibility of self service to rural areas and quality improvement in education and training of health personnel.

**Sixth Five Year Plan (1980-85):** During this Plan, priority was given to health infrastructure, incomplete buildings and some new buildings were constructed for family planning centers. Primary Health Centers (PHCs) were upgraded as 30-beded hospitals. Medical college admission had also been increased.
**Seventh Five Year Plan (1985-90):** In the Seventh Plan, priority was assigned to medical educational facilities, training of paramedical, to meet the requirements of community health services.

**Eighth Five Year Plan (1992-97):** This Plan gave importance to human development and committed to attain “Health for all by 2000”. It initiated major efforts to expand health and educational facilities.

**Ninth Five Year Plan (1997-2002):** The approach during this Plan was to enhance the quality of primary health and promotion of human resource for health. To enable Panchayat Raj Institutions (PRIs) to Plan, monitor and improve the work environment in industrial and agricultural sectors.¹¹

**Tenth Five Year Plan (2002-2007):** The aim of this Plan was to evolve and implement a whole range of comprehensive norms for service delivery, prescribing minimum requirements of qualified staff, conditions for carrying out specialised interventions. A set of established procedures for quality assurance; promotion of rational use of diagnostics and drugs; evolving, implementing and monitoring transparent norms for quality and cost of care in different health care settings. Exploring alternative systems of health care financing including health insurance so that essential, need based and affordable healthcare is available to all; improving content and quality of education for health professionals and Para medical. So that all health personnel acquire the necessary knowledge, attitude, skills, to effectively take care of the health problems, and improve the health status of the people. The other aims of the plan are development of accurate Health Management Information System (HMIS) utilising currently available Information Technology (IT) tools; this communication link will send data on births, deaths, diseases and
request for drugs, diagnostics, equipment and status of ongoing programmers through service channels. It will also facilitate decentralised district based planning, implementation and monitoring; building up an effective system, strengthening and sustaining civil registration, sample registration system. Improving the efficiency of the existing healthcare system in the government, private and voluntary sectors, building up appropriate linkages between them; mainstreaming Indigenous System of Medicine (ISM) practitioners. So that in addition to practicing their system of care, they can help in improving the coverage of the National Disease Control Programmes and Family Welfare Programme; increasing the involvement of voluntary and private organisations. Self-help groups and social marketing organisation in improving access to health care; improving inter sectoral coordination; devolution of responsibilities and funds to Panchayati Raj institutions.12

**Eleventh Five Year Plan (2007-2012):** The objectives of this Plan are assessment of procedures for estimating mortality/morbidity in women and children, review of the functioning of family welfare infrastructure. Manpower in rural and urban areas and suggesting measures for rationalising, restructuring the infrastructure, development of an effective health system, a broad overview of the current health status and development of appropriate policy interventions is. Regulations and setting standards for measuring performance of public/private sector in health, issuing guidelines to help the states, development of partnership with non-governmental stakeholders. Developing framework for effective interventions through capacity development and decentralisation including transfer of schemes and financing in the states, where the Central Government would continue to play a role. Effective monitoring of performance, support for capacity development at all levels, sharing
the best national and international practices, providing more financial resources to drive reforms and accountability, disease surveillance, monitoring and evaluation will be the thrust of the Central Government’s interventions.13

1.5 UNION MINISTRY OF HEALTH AND FAMILY WELFARE

The Union Ministry of Health and Family Welfare is the apex executive organisation dealing with issues of health and family welfare in India. It lays the national health policy in accordance with the policy decisions of the Cabinet. “Health” is the state subject in India, so the Union Ministry of Health and Family Welfare acts as a co-coordinator between the state health departments, Planning Commission, Central Council of Health etc., besides implementing various national programmes and items under Union list and Concurrent list. In the process, it is aided by the Directorate General of Health Services. Health administration at the apex level of the Government of India consists of Secretary for Health, Secretary for Family Welfare supported by additional and joint secretaries who are recruited from the Indian Civil Service. The rest of the organisation is mostly program/project based. Ad-hoc project structures such as TB project and Malaria project etc., Since State Governments implement the projects and deliver the regular health services they have fairly well demarcated systems. Separate directorates or head offices usually exist at state capital for primary, secondary and tertiary health care, which includes medical colleges and medical education. Many states have separate structure for family welfare operations, since population control through family planning is given great importance. At district level, health administration consists of a number of officers and doctors who on average handle 10 to 15 hospitals, 30 to 60 primary health centres and 300 to 400 sub centres.
This entire complex arrangement results in a number of vertical channels of information, multiplicity of agencies and dual reporting systems etc.\textsuperscript{14}

1.6 A BRIEF EVOLUTION ON THE HEALTH INSURANCE SCHEMES

An attempt is made in this section to analyse the health insurance schemes of Government of India and the state of Andhra Pradesh. Relevance of Health Insurance for India, Taxonomy of Health Insurance in India, Health Insurance Schemes and their Target Population, Health System in Andhra Pradesh, Summary of Reform Rajiv Aarogyasri Community Health Insurance Scheme. Highlights of the health insurance scheme, Eligible BPL Families for the insurance scheme, working of Network hospitals and medical camps under the scheme, out-patients and in-patients of the network hospitals and some success stories. Perceptions of some patients at the State level also covered.

Improvement in health status is vital for the enhancement of human capabilities. Illness is an important source of deterioration to human health. Of all the risks facing poor households’ health risks pose the greatest threat to their lives and livelihoods. A health shock adds health expenditures to the burden of the poor. Even a minor health shock can cause a major impact on poor persons’ ability to work and curtail their earning capacity. Moreover, given the strong link between health and income at low income levels a health shock usually affects the poor the most.\textsuperscript{15} Non-availability of necessary finances is a major obstacle in the health care attainments of people in many developing countries including India. With the continuing resource constraints of the government and competing sectoral demands the allocation needed in the health sector may not increase to adequate level in the near future. Nonetheless, the
present trend of cut in government subsidies as a part of the ‘new economic reforms’ is likely to put more pressure on this sector.

1.6.1 Taxonomy of Health Insurance in India

The health insurance situation in India can be understood under the following headings:

I. Public/Social Health Insurance Schemes

The most prominent among the protective schemes are the Employees' State Insurance Scheme (ESIS) for workers in the organised private industrial sector and the Central Government Health Scheme (CGHS) for its employees. The beneficiaries of the above schemes are the salaried class who belongs to formal sectors. Some “Employer-managed health facilities” and the “reimbursements of health facilities” are also available in India which are limited to only a few. The Union budget proposed introduction of a universal health insurance (UHI) plan for people below the poverty line in tie-up with Insurance companies.

II. Micro-Health Insurance (MHI) Schemes

MHI schemes are based on not-for-profit principle and targeted to the underprivileged sections of the society. In India, currently there are more than 20 MHI units and many organisations are coming ahead with various proposals to introduce health insurance for getting inspiration from the successful stories of the existing MHI units.

III. Private Health Insurance (PHI) Schemes

The Private Health Insurance (PHI) schemes, often called Private Voluntary Health Insurance schemes (PVHI), are the schemes offered by insurance companies in the open market in which enrolment into the scheme is not determined by legislation. In India, the public and private sector companies provide the PHI (voluntary). The General Insurance
Corporation (GIC), which comprises of four insurance companies namely NIC, NIAC, OIC and UIC, is the largest public sector organisation of providing the PHI in India. The various policies introduced by the GICs are Mediclaim Policy (group and individual), Jan Arogya Bima, Personal Accident Policy, Nagarik Suraksha Policy and Overseas Mediclaim Policies (employment and study corporate frequent travel/business and holiday).

Among these policies, the Mediclaim policy is relatively popular. After the establishment of Insurance Regulatory and Development Authority (IRDA), many private corporate also have entered the HI market. The Bajaj Allianz, Royal Sundaram, IerCI Lombard, Cholamandalam, Tata and Reliance are the prominent private insurance companies. An important peculiarity of these corporations is the tie-up with some health care provider having super specialty facilities.

The Life Insurance Corporation (LIC) of India introduced a special insurance programme called 'Ashadeep' which covers medical expenses for four dreaded diseases namely: Cancer (malignant), Paralytic stroke resulting in permanent disability, Renal failure of both kidneys or Coronary artery diseases where by-pass surgery has been done, another policy by the LIC, called Jeevan Asha Plan, covers many surgical procedures. But these policies are a kind of savings schemes and the premium is almost equal or more than the insurance amount in short, do not follow the principle of insurance (risk pooling) in strict sense of the term.
IV. Health Insurance Schemes and their Target Population

As mentioned earlier, that there are around 20 MHI schemes operating in some specific regions of India including both rural semi-urban and urban locations. Similarly, around 11 General Insurance Companies comprising of both the public and private sectors offer different Health Insurance (HI) schemes through their branches which is operational all over India. The figure below shows the target population of both PHI and the selected MHI schemes. It is obvious from the Figure 1.2 that most of the MHI schemes aim at low-income population especially farmers and woman members of Self-Help Groups (SHGs). But both public are offering that the PHI schemes and private sectors do not put any restriction on their target population. In other words, his or her policies are open to everybody who has the ability to pay the premium.
The role and relevance of social health insurance based intervention has come to occupy central stage in recent years in several countries that are undertaking measures to reform health systems. Health insurance as a tool to finance health care has very recently gained
popularity in India. While health insurance has a long history, the upsurge in breadth of coverage can be explained by a serious effort by the Government to introduce health insurance for the poor during recent years.

This marks a major milestone in the financing of health care in the country, and Chart 1.3 provides a landscape of health insurance schemes in India. There is, however, considerable variation across states in coverage. Whether insurance is offered through employment, purchased voluntarily or sponsored by the government for select populations, all potentially contribute towards the health systems goal of providing financial risk protection and reducing the financial barriers to quality health care. By pooling funds, insurance offers the opportunity to spread costs across different stakeholders.

1.7 PROVISION OF HEALTH CARE

All the insurance schemes currently operating in India offer beneficiaries the option of seeking hospital care with either private or public sector providers. This is significant because it enables patients to take advantage of both sectors for affordable care. In particular, this is beneficial to patients in areas where the public sector is overburdened or weak and there is a credible private sector presence. Insurance schemes have little value if a strong provider network does not exist. In rural areas there are few qualified private providers and the condition of public health facilities is generally not up to the mark. Health insurance schemes may not necessarily change this situation, though they are likely to have a different effect in areas (e.g. urban) where qualified human resources are easily available.
However, evidence from various schemes suggests that private hospitals dominate the top ‘20 list’ of hospitals in terms of number of admissions. The network hospitals as shown in Chart 1.4 also point towards the fact that most schemes have private provision.
Andhra Pradesh is the eighth largest state in India and according to 2011 census, it is tenth most populous state with a population of 4.9 crores. The state has largely dependent on agriculture for revenue. The Department of Health, Medical and Family Welfare in Andhra Pradesh consists of four most important governing bodies (Fig, 1.5). They are:

1. The Directorate of Health (DOH),

2. Directorate of Health and Family Welfare,

3. Andhra Pradesh Vaidya Vidhana Parishad (APVVP),

4. Directorate of Medical Education.
The Directorate of Health (DOH) takes care of primary health care and implements the vertical programs. The Commissioner of Family Welfare is responsible for family planning, pre- and post-natal care and immunisations. The APVVP manages the secondary care hospitals in districts and hospitals at sub-district level (area hospitals and community health centers). The APVVP is an additional structure in the state level health administration and is specific in Andhra Pradesh. Conceived and implemented in the mid-1980s to give more attention to secondary level health care, the setting up of the APVVP has helped to streamline and improve infrastructure and services in secondary hospitals. The Directorate of Medical Education is the administrative authority for the smooth functioning of all medical colleges and attached teaching hospitals, nursing schools and nursing colleges. Of these four bodies, the Director of Health is the core one, and the Commissionerate of Family Welfare implements its programmes through the staff of the DOH in the districts.

Fig. 1.5 Governing Bodies of Department of Health, Medical and Family Welfare in Andhra Pradesh
The important health officials in the districts are the District Medical and Health Officer (DM&HO), who is responsible for the vertical programs (including family welfare) and the Primary Health Care Centers (PHCs). The program officers (all working under the DM&HO, and usually in charge of one vertical program); and the District Coordinator Health Services (DCHS, the main APVVP person in the district, coordinating all APVVP services). At the PHC level, it is the medical officer who is in charge.16

1.8.1 Recent Developments – Public/Private Partnerships

Collaborations between the private sector and the government in the delivery of health services are recent phenomenon in Andhra Pradesh. The collaborations effectively started during the early 1990s, the period of inception of World Bank projects – India Population Project VIII and Andhra Pradesh First Referral Health Systems Project. Many of these collaborations are continuing and take various forms: buying and selling health services, contracting out clinical and non-clinical services, facilitating and promotion of partnerships, pure business partnerships (e.g. telemedicine projects) etc. The role of each sector in partnerships differs by project.

In 2004, the Congress Party came to power in Andhra Pradesh. Dr. Rajashekar Reddy was the Chief Minister and medical doctor by training. Dr. Reddy came to power with health as one of the three main priorities in his party’s manifesto. Chief Minister Reddy, turned to P.K. Agarwal, then Principal Secretary at the Department of Health, Medical and Family Welfare (DoHMFW) for assistance to develop a strategy for how to effectively improve services for the poor. The Principal Secretary was asked to spend three days listening to the problems of the poor who were
coming to Government facilities with requests related to health. The outcome was the Aarogyasri Community Health Insurance Scheme.

1.9 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. The study results of Centre for Economic and Social Studies, Hyderabad observed that 56.1 per cent of rural are under BPL and it is 15.80 per cent in urban. At the same time, the health statistics deliberates an inequality in the both areas. 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 hospitalisation and surgery. The present Government hospitals not have requisite facility and the specialist pool of doctors to meet the state-wide requirement for the treatment of such diseases. Large proportions of people, especially below poverty line borrowing money or sells assets to pay for the treatment in 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 Sri Health Communities Health Insurance Scheme (now it is renamed as Dr. NTR Vaidya Seva on November 19, 2014) and established a trust. It has introduced a new health care insurance scheme called as Rajeev Arogya Sri. For this, Government selected the ‘Star Health and Allied Insurance Company’ for
promoting the insurance for those comes under the category of Rajeev Aarogyasri. 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 Rajeev Aarogyasri health insurance scheme especially in East Godavari District of Andhra Pradesh. Thus, present study tries to fill these gaps.

1.10 SPECIFIC OBJECTIVES OF THE STUDY

The central objective of this study is to analyse the implementation of the Rajeev Aarogyasri Community Health Insurance Scheme (RACHI) in the state of Andhra Pradesh. In effect, a brief review on the existing health insurance schemes has also made. The study will produce a road map for implementation of the scheme in future. The specific objectives of the study with respect to existing health insurance programme in the state 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.

1.11 HYPOTHESES 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.

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

1.12 METHODOLOGY OF THE STUDY

The discussion on the methodology, indicate sampling method used, how the data is ascertained, the statistical tools are used for analysis and to sort out the limitations of the study. In order to document and quantify the objectives outlined above, primary and secondary data source information is used. The procedure of the study is followed as below.

Sampling

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.
Selection of District

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 are neglected.

Table 1.1: Villages and Mandals Selected/covered the study

<table>
<thead>
<tr>
<th>S.No</th>
<th>Mandal name</th>
<th>Village</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kakinada</td>
<td>Valasapakala</td>
</tr>
<tr>
<td>2</td>
<td>Samalkot</td>
<td>Mamilladoddi</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Unduru</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Peda Brahma devam</td>
</tr>
<tr>
<td>5</td>
<td>Karapa</td>
<td>Yedamuru</td>
</tr>
<tr>
<td>6</td>
<td>TallaRevu</td>
<td>CBV Palem</td>
</tr>
<tr>
<td>7</td>
<td>Rajavammangi</td>
<td>Jeddangi</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Rajavammangi</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Yarrampudi</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Surampalem</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Lagarayi</td>
</tr>
<tr>
<td>12</td>
<td>Tuni</td>
<td>Kondavaripeta</td>
</tr>
<tr>
<td>13</td>
<td>Kotananduru</td>
<td>Kotananduru</td>
</tr>
<tr>
<td>14</td>
<td>Rampachodavaram</td>
<td>Chunabeerampalli</td>
</tr>
<tr>
<td>15</td>
<td>Ramachandrapuram</td>
<td>Ramachandrapuram</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>Bondapalli</td>
</tr>
<tr>
<td>17</td>
<td>U.Kottapalli</td>
<td>Uppada</td>
</tr>
<tr>
<td>18</td>
<td>Ambajipeta</td>
<td>Ambajipeta</td>
</tr>
<tr>
<td>19</td>
<td>Sakhinetipalli</td>
<td>Addalapalem</td>
</tr>
<tr>
<td>20</td>
<td>Gangavaram</td>
<td>Gangavaram</td>
</tr>
<tr>
<td>21</td>
<td>Rajanagaram</td>
<td>Rajanagaram</td>
</tr>
<tr>
<td>22</td>
<td>Gangavaram</td>
<td>Komaravaram</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>Mukkada</td>
</tr>
<tr>
<td>24</td>
<td>Saravakota</td>
<td>Saravakota</td>
</tr>
</tbody>
</table>
Selection of the Mandals

The second stage of sample is consisting selection of mandals. It is a fact that selection of beneficiaries is a difficult task, because, very limited people face chronic or dangerous diseases. Therefore, the researcher visited 16 mandals (Table 1.1) have been selected to find out the unambiguous information regarding the implementation of the scheme.

Selection of the Villages

The third stage of sample consists of selection of villages. About 24 villages of the selected eight mandals have randomly been selected basing on the number of beneficiaries under Rajiv Aarogyasri.

Selection of the Households

The last stage of sample consists of selection of households from four categories of Scheduled Castes, Scheduled Tribes, Backward Caste and other communities in the villages. It helps in find out that how the scheme is benefited to the different categories.

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. Trustworthy informants are picked up in every village and used them as liaison persons and used their services in the fieldwork as the local dialect spoken by the tribes is not easily understandable.

The schedule has been canvassed with 120 households to elicit information about the socio-economic characteristics and in view of the set objectives.
The secondary data has been obtained from the annual reports, action plan and other documents of the state of Andhra Pradesh. The District Handbook of Statistics of different years is obtained from the Chief Planning Officer, East Godavari. Relevant literature, information and reports have been collected from the Department of Medical and Health and Aarogyasri Trust Office, Hyderabad. The Kakinada General Hospital and referral hospital is selected to study the health facilities providing at the referral hospital.

Techniques used in the Analysis

In analysing the data apart from tabular analysis - averages and percentages are generally used. Besides, different statistical techniques like:

Measure of Knowledge index: To find out the peoples’ perceptions on the programme, comparison is made by construction of the knowledge test. Lists of practices were carefully framed with different types of questions (Optional questions, Open-end questions and Yes/No type questions). Responses were scored as follows:

Correct response 1
Wrong response 0

Total score obtained by individual was calculated, and used to find out the knowledge index (K.I.) of respondents by using following formula,

\[ K.I = \frac{\text{Actual score obtained}}{\text{Total score}} \times 100 \]

\( X^2 \) 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.

### 1.13 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. Because, the tribes who located in isolated, hilly and forest regions and some other illiterates didn’t know the diseases covered in the scheme and other benefits. They may not be provided relevant information. Thus, there may differences in actual records and the field survey results. It is further observed that the concerned secondary data provided by various authorities is unique. Therefore, even though the researcher has taken utmost care in this regard, some statistical differences may take place.

### 1.14 CHAPTERISATION OF THE THESIS

1. The present study contains six chapters. Chapter one provides a brief outline on health insurance schemes in India, specific objectives of the study and methodology adapted.

2. Review of earlier research is presented in Chapter two.

3. An overview on the Management of *Aarogyasri* Health Insurance Scheme, Andhra Pradesh is analysed in Chapter three.

4. Chapter four explains the socio-economic and health profile of the study district is discussed.

5. Fifth chapter is focused on beneficiaries’ perceptions about the implementation of *Aarogyasri* scheme. This chapter contains two sections. Section one deals the socio-economic and living
conditions of the respondents, and second section covers respondents’ perceptions on implementation and impact of Aarogyasri Scheme.

6. Summary and Conclusions is presented in the last chapter.
Chapter-I : References


