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EVALUATION OF RAJIV AAROGYASRI SCHEME IN ANDHRA PRADESH AND SURVEY OF PATIENTS OPINION

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ABSTRACT

Poverty is undoubtedly one of the greatest challenges facing India. Given the large proportion of its underprivileged population, the delivery of basic universal services seems almost unattainable. This issue is exemplified in public health service delivery. It is very common for poor Indians to use their life savings to access quality treatment for themselves and their loved ones. To address this problem of indebtedness of the poor due to overwhelming health costs, the Government of Andhra Pradesh launched the Rajiv Aarogyasri Healthcare Insurance Scheme in 2007 under which free tertiary healthcare services are provided to holders of below poverty line(BPL) ration cards. BPL families can avail benefits of this healthcare insurance policy without having to pay any premium. This study captures the objective, functioning, achievements and impact of Aarogyasri. The study was conducted for the period April 2007 to December 2013 based on patient data. Simple tools such as frequency counts, percentages, ratios, averages, and so on were used to understand efficiency of insurance mode, and measure the performance of the scheme. A brief analysis of the scheme based on officially available data and media reports from a public health perspective revealed that 87% of population of AP was covered under the scheme. From the sample study, it was found that males had 40% higher utilization than females under the scheme. The cost benefit ratio of insurance mode was 81% when compared to 91% for Trust mode. Implementation of the scheme through the insurance mode is highly inefficient in terms of cost. Patients' opinion regarding the scheme revealed that majority of them were happy with the scheme, none of them had a poor opinion about the flagship project of Government of Andhra Pradesh. The scheme has already contributed to its successful replication throughout the state. It aims to support the replication of such a scheme elsewhere in order to achieve 'Health for All', ensuring that the most underprivileged sections of society are able to claim their 'right to live'.

KEYWORDS

Aarogyamithras, AHCT, BPL, PPPs, Preauthorised therapies, RACHI.

INTRODUCTION

Health care in India often faces heavy criticism. Serious shortcomings in quality of and access to services, quantity of personnel and equipment, and levels of funding haunt the public health care system. Moreover, government hospitals face a myriad of problems, exposing the poorest sectors of society to insufficient and low quality treatment. With diseases and the numbers of affected on the rise, it is crucial to develop a sound and effective health care delivery process. In such circumstances, a public private partnership may offer a solution.

Subsequently, the Government of Andhra Pradesh developed an innovative scheme for quality health service delivery to the underprivileged in 2007. The Rajiv Aarogyasri Community Health Insurance Scheme (RACHI) is a state funded health insurance scheme for the 2.03 crore BPL families in Andhra Pradesh. The scheme aims to achieve 'Health for all' by assisting poor families in their struggle out of indebtedness through the provision of free insurance through a unique Public Private Partnership (PPP) model.

ABOUT THE SCHEME

In the year 2007, the scheme was introduced on a pilot basis in three districts. It has subsequently been extended through five phases to the remaining 20 districts. The scheme is implemented in two streams:

INSURANCE SCHEME: The scheme implemented through an identified insurer on payment of premium.

AAROGYASRI TRUST SCHEME: The scheme implemented directly by the Trust by entering into contract agreement with network hospitals.

Aarogyasri-I is operated through Insurance Mode, whereas Aarogyasri-II is BPO mode. Encouraged by the success of Aarogyasri-I scheme, Government has launched with effect from 17th 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.

Together, Aarogyasri I and II cover 942 medical procedures. The scheme provides coverage for meeting expenses of up to Rs. 1.50 lakhs per family per year for hospitalization and surgical procedures in any of the network hospitals. The insurance coverage is for a period of one year from its commencement date. Primary health care is also provided in the network hospital through free screening, outpatient consultation and health camps. Rajiv Aarogyasri Community Health Insurance Scheme seeks to improve access of BPL families to quality medical care and treatment for identified diseases through a network of healthcare providers. All transactions are cashless for covered procedures. This is a state government scheme privately operated. Under this, hospital bills of the insured persons are paid by the insurance company. The premium for insurance company is paid by the government. People do not have to pay anything under this scheme.

ADMINISTRATIVE STRUCTURE

The administrative structure of Aarogyasri is comprised of the following organizations:

1. Aarogyasri Healthcare Trust - The Trust is administered by a Chief Executive Officer who has administrative functions such as formulating packages and pricing, managing contracts with insurer(s) and network hospital providers, approving claims, and monitoring.

2. The Insurance Company - The insurance company is selected through an open bidding process. After selection, the company signs a MoU with the Trust and then goes on to sign MoUs with network hospitals and the Zilla Samkhyas. The insurer manages all frontend and backend insurance administration, including empanelment (registration) of hospitals, hiring of staff for scheme facilitation, claims processing, reimbursements to providers, oversight of hospitals, monitoring and feedback mechanisms.

3. Network Hospitals - Network hospitals offer healthcare facilities and treatment to Aarogyasri beneficiaries.

4. District Administration - The district collector is the chairman of the district level monitoring committee. These committees are largely responsible for mobilization and spreading awareness about the scheme through health camps and campaigns. They review the implementation of the scheme through regular review meetings and oversee the functioning of the field staff. They work in close association with local self help groups and other field functionaries.

5. Aarogyamithras - Aarogyamithras, 'Friends of Health', are the health coordinators who assist the patients in registration, admission, evaluation, preauthorization, treatment, discharge and post-discharge follow-up.

6. Software Company - The entire scheme is processed online - registration of the patient and their details, to empanelment of hospitals, health camp details, preauthorization, treatment and other services at the hospital, discharge and post-treatment follow up services, claim settlements, and payments, An online monitoring system and the e-office tool are used for effective tracking of patients and administration.

KEY SUCCESS FACTORS

Some key innovations and success factors in Aarogyasri were:

- **Not collecting a premium** - the cost of the premium would have prevented many of the poorest from enrolling even if the amount were nominal
- **A collaborative private sector** – The private sector in Andhra Pradesh agreed to low reimbursement rates for services provided and agreed to conduct compulsory health camps where thousands of rural people would be screened every day
- "**White Cards**" – White Cards, or ration cards, were an existing targeting mechanism utilized by the state to identify the poorest.
- **The use of technology** – The technology utilized by Aarogyasri facilitates end-to-end cashless claims processing, from pre-authorization to provider payment; the technology also facilitates a robust monitoring mechanism
- **Health camps** – All empaneled hospitals are required to conduct free health camps in rural areas to screen patients, identify undetected illness, and refer patients to in-network hospitals as needed
- **Community representation** – Aarogya Mithras are patient advocates employed by Aarogyasri to oversee each in-network hospital and serve as representatives of the insured to help them navigate the system of care, receive quality care, prevent fraud, and conduct reviews and evaluations of service provision

REVIEW OF LITERATURE

Health is one of the key determinants of the poverty levels of a household. Households using inpatient services, especially at private hospitals, were more likely to face catastrophic expenditures and impoverishment from out-of-pocket payments (Limwattananon, Tangcharoensathien, & Prakongsai, 2007). Reducing the prevalence of catastrophic health expenditure is a policy objective of government, which can be achieved by focusing on increased financial protection offered to poor and expanding government financed benefits for poor and chronically ill by including and expanding inpatient coverage and adding drug benefits (George, Akaki, & Natia, 2009). Xu et al., 2003 identified three key preconditions for catastrophic payments: the availability of health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance.

Rao et al, conducted a rapid evaluation of the scheme and found that. 111 beneficiaries per 100,000 BPL populations had utilised the scheme until the end of September 2008. Cardiac, cancer and neurological interventions made up 65% of all treatments administered by the scheme. The evaluation has revealed that there is scope for the scheme to improve strategic purchasing, quality of care, integration, continuous audit and in-built evaluation. The evaluation has emphasised on developing more coherent, cohesive and integrated health system with convergence of preventive, promotive and curative services taking into account the wider determinants of health. Sunitha in her article critically analyses the procedures and the cost incurred in private and public hospitals and finds that Aarogyasri is skewed towards curative tertiary care and is a big drain on the state exchequer with questions of sustainability. Yellaiah had discussed the coverage and features of major health insurance schemes in India and also examined the role of Rajiv aarogyasri scheme in AP. He attempted to measure the performance of the scheme by providing various statistics.

IMPORTANCE/NEED FOR THE STUDY

Health risks probably pose the greatest threat to lives and livelihoods of poor households. The low income and high medical expenses can lead to debt, sale of assets, and removal of children from school in the poorest families. Thus, a short- term health shock can contribute to long-term poverty. The study assumes importance on the above backdrop to evaluate whether the scheme is performing well so that it can be implemented in other states of the nation to benefit the poor and help them to avail the healthcare services.

OBJECTIVES OF THE STUDY

- To evaluate the performance, successful implementation of Rajiv Aarogyasri Scheme based on certain indicators.
- To find out the patients opinion about the scheme among sample patients

RESEARCH METHODOLOGY

SCOPE

The scope of the study includes the beneficiaries who are enrolled in Aarogyasri Scheme

SAMPLE DESIGN AND SIZE

100 Samples are randomly selected from those enrolled in Aarogyasri scheme in network hospitals, in Hyderabad.

SOURCES OF DATA

Patients opinion was collected through primary data i.e., through questionnaire, direct interaction and observation. Secondary data is collected from journals, websites, hospital records, and AHCT annual reports.

TOOLS OF ANALYSIS

Simple tools such as frequency counts, percentages, ratios, averages, medians and so on are used for analysis

ANALYSIS AND INTERPRETATION OF THE DATA

The data has been analysed into two sections. Section- A deals with the Evaluation of the scheme on the basis of certain indicators. Section – B deals with the patient opinion about the scheme from the respondents who have enrolled under the scheme.

SECTION – A EVALUATION OF THE SCHEME

The scheme is evaluated on the basis of performance in terms of certain indicators, implementation mechanism and hospital network.

The performance of the scheme was looked at in terms of the trends in therapies preauthorized by the Trust. Pre-authorization is a prior sanction given to the hospital by the Trust for an in-patient treatment. The RACHI scheme has achieved its intended objective to improve access to health care by the poor. The progress of the programme in terms of quantitative indicators is presented as follows. The following table shows certain vital health statistics regarding the scheme.

TABLE 1: VITAL STATISTICS OF THE AAROGYASRI SCHEME SINCE INCEPTION IN APRIL 2007 TILL DECEMBER 2013

Vital Statistics	Provisioning – private/public	Number of Cases
Health Camps		36,394
BPL Cards Covered		223 Lakhs
Therapies reserved for Govt. Hospitals		133
Population Covered		777 Lakhs
Cards utilized		11.25 Lakhs
Therapies Covered		938
Preauthorization	Government	556,108
	Private	1,548,260
	Total	**2,104,368**
Outpatients	Government	559,884
	Private	4,009,203
	Total	**4,569,087**
Inpatients	Government	660,468
	Private	1,659,201
	Total	**2,319,669**
Patients	Screened	7,090,728
	Registered	7,390,739
Surgeries/Therapies	Government	549,173
	Private	1,537,836
	Total	**2,087,009**
Amount preauthorized	Government	Rs. 1322 Crore
	Private	Rs. 4256 Crore
	Total	**Rs. 5579 Crore**

Source: AHCT Annual Reports and website

Since the inception of the programme from April 2007 to December 2013, 36,394 health camps had been held at villages in 23 districts. A total of 7,090,728 people have been screened and of those 4,569,087 treated as outpatients and 2,319,669 treated as inpatients. Till date, 2,087,009 surgeries/therapies have been conducted for the patients. In this only 549,173 underwent surgeries in government hospitals and 1,537,836 underwent surgeries in private hospitals. The pre authorized amount is Rs. 5579 Crore with an annual budget of around 1,000 crore.

I) SCHEME PERFORMANCE

Indicators	Data Needed and Calculation	Purpose
Therapies Preauthorized (TP)	Frequency of Therapies and their Costs	To assess the absolute volumes under the scheme
Expenditure Incurred	Expenditure by Aarogyasri Health Care Trust (AHCT)	To assess the expenditures by AHCT
Person Utilization Rate (PUR)	Number of TP/ Number of Beneficiaries Covered	This gives the number of therapies being, preauthorized for a given procedure if one lakh persons are covered under the scheme for one year.

Based on count, 80% of cases preauthorized are surgical and 20% are medical cases. Based on cost, of all therapies preauthorized 85% are surgical cases and 15% are medical cases.

TABLE 2: EXPENDITURE INCURRED BY AAROGYASRI TRUST TILL DECEMBER – 2013

Year	Government Hospitals (Rs. Crores)	Private Hospitals (Rs. Crores)	Total (Rs. Crores)
2008	3.11	52.29	55.40
2009	77.16	429.51	506.67
2010	168.86	737.87	906.73
2011	221.63	790.20	1011.83
2012	270.70	843.59	1114.29
2013	324.93	885.72	1210.65
Total	**1066.39**	**3739.18**	**4805.57**

Source: AHCT Annual Reports

TABLE 3: PERSON UTILIZATION RATE FROM 2009 - 2013

Year	2009	2010	2011	2012	2013
Person Utilization Rate in terms of numbers	5337	7766	9236	9410	9850

Source: AHCT Annual Reports

Person Utilization Rate has been gradually increasing from 2009 to 2013 i.e., the number of therapies being preauthorized has been increased

II) IMPLEMENTATION MECHANISM

Indicators	Data needed and calculation	Purpose
Cost Benefit Ratio (CBR)	Total Claim amount paid to Hospitals/Total Expenditure incurred by Trust	To compare the efficiency between the two modes of implementation (i.e., trust mode and insurance mode)
Claim Denial Ratio (CDR)	Total Cost Claim amount paid to Hospitals for Claims Raised/ Total Cost of Claims Raised	To compare the level of deductions made between the two modes

EXPENDITURE THROUGH INSURANCE AND TRUST MODES

TABLE 4: COST BENEFIT RATIO – INSURANCE VS TRUST MODES (Rs. in Crores)

	2008 – 09	2009 - 10	2010 - 11	2011 - 12	2012 - 13	Total
(A) Insurance Premium Expenditure	133.1	478.9	747.6	831.8	915.0	3106.4
Insurer Claim Paid	94.4	390.8	540.7	714.2	788.3	2528.4
CBR	70.9	81.6	72.3	85.9	86.1	81.4
(B) Total Trust Expenditure	9.9	127.5	266.7	299.6	311.0	1014.8
Trust Claim Paid	0.0	112.3	257.4	289.4	263.0	922.1
Administrative Expenses	9.9	15.3	9.3	10.2	48.0	92.7
CBR	--	88.0	96.5	96.6	84.6	90.9

Source: AHCT Annual Reports

TABLE 5: CLAIM DENIAL RATIOS

CDR%	2008	2009	2010	2011	2012	2013
SCHEME						
Overall CDR	0.1	5.7	8.2	7.0	8.5	8.4
CDR in Private NWH	0.1	4.7	7.1	5.7	6.7	7.0
CDR in Govt. NWH	1.3	12.2	13.8	12.2	14.6	13.1
INSURANCE MODE						
Overall CDR	0.1	5.9	8.6	7.2	8.7	8.4
CDR in Private NWH	0.1	4.7	7.3	5.8	6.9	6.9
CDR in Govt. NWH	1.3	12.8	15.1	13.5	15.6	16.2
TRUST MODE						
Overall CDR	5.4	7.5	6.5	7.8	8.5	7.6
CDR in Private NWH	4.7	6.6	5.2	5.8	7.0	6.2
CDR in Govt. NWH	10.7	11.7	10.1	12.4	12.5	11.8

Source: AHCT Annual Reports

CDR in Government network hospitals is more in insurance mode when compared with trust mode from the year 2009 onwards.

III) NET WORK HOSPITALS

Indicators	Data needed and calculation	Purpose
Empanelled Hospitals or Beds	Number of active Net work hospitals or Beds on a given date	To know the number of hospitals or beds available
Average Claim Size	Total cost of Claims paid/number of Claims Settled	This gives the average size of the claims in rupees

TABLE 6 EMPANELLED HOSPITALS EXISTING ON THE BEGIN OF CALENDAR YEAR AND THERAPIES PREAUTHORIZED DURING THE YEAR

Empanelment	2007	2008	2009	2010	2011	2012	2013
All Hospitals	0	105	348	360	346	364	425
All Beds	0	29000	62093	64552	64264	66349	70931
TP (Overall)	**11251**	**156168**	**320885**	**376452**	**434693**	**445858**	**534986**
Private NWH	0	105	254	262	248	260	275
Pvt Beds	0	29000	36472	38731	38443	40298	41410
TP (Pvt Hosp.)	**10557**	**130562**	**258571**	**288319**	**319205**	**299318**	**359152**
Government NWH	0	94	98	98	98	104	150
Govt. Beds	0	NA	25621	25821	25821	26221	29521
TP (Govt. Hosp.)	**694**	**25606**	**62314**	**88133**	**115488**	**146540**	**175834**

Source: AHCT Annual Reports

Presently there are in total 425 empanelled hospitals with 70931 Beds available

TABLE 7: CALENDAR YEAR WISE CLAIM SIZES (in thousands)

	Calendar Year	2008	2009	2010	2011	2012	2013
Total Scheme	Mean (ACS)	53336	33193	27530	26121	24441	23560
	Standard Deviation	41158	34496	27104	25136	25039	24289
	Median	40000	25000	22000	20000	20000	20000
	Q Range (IQR)	55000	25000	17000	20000	20000	20000
Insurance	Mean	53336	34612	28589	27434	25852	30165
	Standard Deviation	41158	33473	27129	24792	23489	25179
	Median	40000	25000	22000	22000	20000	22000
	Q Range (IQR)	55000	39500	23000	20000	20000	18000
Trust	Mean	0	30366	25853	23333	20380	21941
	Standard Deviation	0	36283	26981	26177	28655	23788
	Median	0	25000	21508	20000	15000	15000
	Q Range (IQR)	0	10000	15000	19341	15000	17000

Source: AHCT Annual Reports

ACHEIVEMENTS AND FEW INSIGHTS

While Aarogyasri has yet to be fully evaluated, some results to date include:

- The scheme currently covers 85% of below-the-poverty line households in the state- which totals 65 million people
  - The scheme started with 330 procedures covered and has been gradually extended to 938 procedures.
  - The majority of beneficiaries utilizing the scheme are illiterate and have a rural address
  - Cardiac, cancer, and neurological interventions make up 65% of all treatments administered by the scheme.
  - Anecdotal evidence suggests that the scheme has had an impact on reducing the financial barriers to accessing care and utilization of services has increased.
- Patients are satisfied with the Aarogya Sri Scheme and have very good opinion about the scheme.
- Majority of the patients avail the surgeries at low or no cost, which will help them by covering the cost of care after a health shock.
- Camps are conducted by only few hospitals and hence awareness of people regarding the scheme is comparatively less than those hospitals who conduct camps.
- Majority of the farmers with low income group are benefited with the scheme.
- Public hospitals do not comply with most of the protocol guidelines designed by the Aarogyasri trust.

SECTION – B PATIENTS OPINION

One hundred samples are randomly selected from those enrolled in Aarogyasri scheme in network hospitals, Hyderabad and their opinions about the scheme have been analyzed. There are eighteen questions are included in the questionnaire to know the background of the beneficiary and at the same time to know the opinion. Out of 100 beneficiaries enrolled in the scheme, who are chosen for the study 49% are females and 51% are males. Among the beneficiaries 46% lie between age group of 41-60 years, 29% lie between 21-40 years, 18% lie between 61-80 years, and 7% lie between 0-20 years.

Among the beneficiaries of the AarogyaSri scheme, 58% of them are farmers, 24% work in private sector or have their own business. 10% are retired and 8% are students. Majority of farmers are benefited from the scheme. 38% of the beneficiaries are uneducated, 34% of them have finished their primary education. 18%

have finished their secondary education (intermediate). Only 10% are graduates. 62% of beneficiary's income level lies between Rs. 1000-5000 per month. 33% of beneficiaries' income level lies between Rs. 6000-10,000.4% of them are between Rs.11,000-15,000. 1% of beneficiaries' income lies between Rs.16,000-20,000 per month. Lower income group are benefited from this scheme. 70% of the beneficiaries are Unique Healthcare Identification number (UHID) card holders. Balance 30% are not UHID card holders.

49% of beneficiaries are aware of the Aarogyasri scheme through their relatives .31 % are aware by friends, 15% are aware of the scheme by pamphlets and only 5% are aware by camps. Network hospitals should show more involvement in conducting camps and distributing pamphlets to bring awareness among the people regarding Aarogyasri scheme. 54% of patients are beneficiaries of the Aarogyasri scheme from past 3-4 years, 25% from past 1-2 years and 21% from past 5-6years. This shows that people are interested to enroll in the scheme to avail services. Among beneficiaries 84% have undergone surgeries, 13 % are out patients and only 3% have availed medical emergencies. Most of the beneficiaries are availing surgical treatment and getting benefited. 35% of beneficiaries underwent eye surgeries.17% underwent surgeries in obstetrics.14% underwent surgeries in cardiac and general surgery.2% surgeries were orthopaedic and genitourinary.3% were medical emergencies. 97% of the beneficiaries said that they did not pay extra amount other than the fixed tariff. Only 3% said they paid extra amount. 95% of the beneficiaries have chosen as they are not affordable. Only 3% have chosen based on the quality of treatment and 2% have chosen based on distance of the hospital. Majority of the beneficiaries got enrolled as they are not affordable to pay. 94% of the beneficiaries are satisfied with the treatment given. Only 6% are not satisfied. 69% of beneficiaries have very good opinion about the scheme. 21% have Good opinion about the scheme. Only 10% have average opinion about the scheme. 68% of beneficiaries had an annual amount coverage of Rs. 1000-50,000, 26% had annual amount of coverage between Rs.51,000-1,00,000, 4% had an annual amount of coverage of Rs.1,01,000-1,50,000, 2% had amount coverage of 1,51,000-2,00,000. 74% of the family members had taken treatment during the past one year. About 26% of them have not availed the treatment. These are the major findings from the survey of sample patients.

RECOMMENTDATIONS

- Since most of the people with lower income group are getting benefited by this scheme, hence it can be positively implemented in other states also.
- We can create awareness about the scheme among people through camps, by distributing pamphlets, puppet shows and by educating about the benefits of the scheme.
- Regular auditing by the higher authority can be conducted to check whether hospitals are complying with the protocol guidelines.
- Training the hospital staff regarding the scheme for its effective functioning.

CONCLUSIONS

The Rajiv Aarogyasri Community Health Insurance in Andhra Pradesh has been very popular social insurance scheme with a private public partnership model to deal with the problems of catastrophic medical expenditures at tertiary level care for the poor households.

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