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Performance of Rajiv Aarogyasri on Rural Health Care in Telangana – A Study

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Abstract

The present paper deals with the performance of Rajiv Aarogyasri on rural health care in Telangana with special reference to Warangal district. The present paper is divided into three sections. Section-I deals with the conceptualisation of the Rajiv Aarogyasri and its essential features. Section-II deals with the objectives and methodology. Findings and conclusions of the study had been presented in Section-III. The study is based on the following objectives: to analyse the importance of Rajiv Aarogyasri Scheme in general and the study area in particular; and to assess the performance of Rajiv Aarogyasri on rural health care in the study area. The present paper is primarily based the data gathered from primary and secondary sources.

Keywords: Rajiv Aarogyasri, Rural Healthcare

I. Introduction

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity". In other words, Health is not a static. But it oscillates on a scale, which ranges between 'optimum health' as defined by WHO to 'complete lack of health'. Hence, it is not only curative but also includes preventive, promotive and rehabilitative services. As per the preamble to the WHO Constitution, enjoyment of the highest attainable standard of health is a fundamental right of every human being and the governments are responsible for the health of their people and can fulfill that responsibility by taking appropriate health and social welfare measures.

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized by the Alma-Ata Declaration signatories, who noted that Health for All would contribute both to a better quality of life and also to global peace and security (WHO, 2010). It is known fact that the better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more of public expenditure on health so that resources may be transferred to other attendant public service delivery.

The rural health sector in India, if not non-existent, is still at the very least, in shambles. Originally conceived to be

an integrated system of providing access to both traditional and modern means of medicine to individuals, it remains nearly sixty decades after independence a hollow promise. Its urban counterpart on the other hand, though hardly in the pink of health, has fared relatively better. The urban-rural divide has been the main plank on which many of the policies of the Government to meet rural health needs have been built. The Compulsory Rural Medical Service Scheme (CRMS), where, medical students are expected to spend an extra year after their fifth year internship.

The Rajiv Aarogyasri Community Health Insurance Scheme (RAS) was established with the aim of breaking a vicious cycle of ill health, poverty, indebtedness and bankruptcy among the families living below the poverty line (BPL) in Andhra Pradesh in the year 2007. The purpose of the scheme was to improve access of BPL families to treatment of identified medical and surgical conditions through a network of health care providers. Indian Institute of Public Health (IIPH), Hyderabad did a rapid evaluation of Rajiv Aarogyasri Community Health Insurance Scheme. The purpose of the evaluation was to provide insights into the current performance of the scheme, to examine whether it is meeting the overall objectives and to suggest ways by which it may be further strengthened.

The Rajiv Aarogya Sri Health Insurance Scheme, to serve people of poor from the serious ailments is now attracting the nation, as this programme highly successful. This scheme provides financial support to families of BPL upto 2 lakhs per annum for treating serious ailments. It is proposed to cover the entire State by 2nd October, 2008 with the government paying the insurance premium for all the beneficiaries. An amount of Rs.450 crores is provided to implement the scheme during 2008-09. The main objective is to improve access of BPL families to quality medical care for treatment of identified diseases involving hospitalization, surgeries and therapies, through an identified network of health care providers.

Hospitals play an integral part in healthcare system in India. They perform various functions like In-patient, Out-patient services, Research and Development, Training etc. Indian hospitals can be categorized into Public hospitals (Government), Private and not-for-profit (Missionary/Trust owned) hospitals. The Public hospitals are run by the Central and State Governments and Missionary hospitals by charitable trusts which endows with free services or at subsidized rates to the needy (ILO, India). The changes in economical empowerment of the rural people due to which there has been a boost in the number of corporate hospitals and private hospitals that provide health care services in towns and cities.

Revenue expenditure on Health and Family Welfare at Central level by the Govt. of India and Medical, Public Health and Family Welfare at the State level by the Government of Andhra Pradesh. While looking at the Table, it can be said that an increasing trend can be discerned even in both the Union budget and the State budget as well. The Union budget was more than doubled within a span of five years i.e. from 2006-

07 to 2011-12 whereas in the case of State budget, nearly the five fold increase can be found from 2006-07 to 2011-12. Therefore, it can be surmised that both the Central and State governments are evincing much interest to create more physical health facilities and also make the facilities to access the public.

In this regard, the present study is being carried out to assess Government and Private hospitals service quality and to analyze service gaps between perceptions and expectations of patients. If quality of services provided by health care sector is not up to the expectations, the public will be at a very heavy loss in the form of ill health and low working ability leading to low economic development. Many studies at macro level have been conducted to measure quality of care in hospitals. Area specific and agency specific studies are also necessary to have a clear picture about the quality maintenance of health care services by hospitals. Researcher is of the opinion that the present study has thrown some light to the administration of Government, Private and Corporation hospitals on service quality provided by them i.e., patient's expectations and perceptions on health care services and patients' satisfaction levels to service quality with special reference to the Warangal mandal, Warangal District of Telangana.

II: The **objectivities** of the study are mentioned hereunder:

i. to analyse the importance of Rajiv Aarogyasri Scheme in general and the study area in particular; and

ii. to assess the performance of Rajiv Aarogyasri on rural health care in the study area

Methodology:

The research design adopted for the study is to examine the Rajiv Aarogyasri programme in general and the performance of Rajiv Aarogyasri in Warangal district in particular. For this study, the research design adopted in the study is an analytical one where both data from primary as well as secondary sources had been collected. The district of Warangal having two revenue divisions is located in Telangana state is selected. The stratified random sampling method had been adopted for the selection of villages.

As a part of the study two different Health Centres had been chosen at random. A sample of 40 respondents from Public Hospitals and 40 respondents from Private Hospitals have been selected purposively from the Warangal division of Warangal district. The researcher had also collected data in terms of overall allocation/spending over the years policies covered, premium claims and settlement, utilisation of facilities, cost data by diseases and other socio-economic determinants from Rajiv Aarogya Sri Health Insurance Programmes.

III: Findings of the Study:

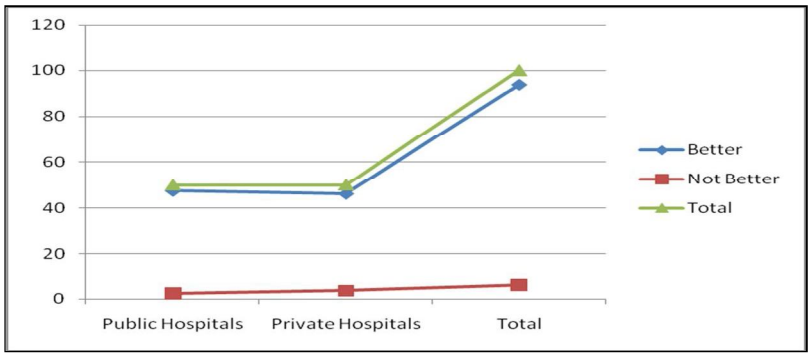
The present section had been devoted to an empirical analysis of Rajiv Aarogyasri on rural healthcare in Telangana.

Opinion of the sample beneficiaries about the launching of the Rajiv Arogyasri programme has shown in Table-1. While looking at the Table, it can be said that irrespective of the type of hospital an overwhelming majority of the sample beneficiaries (93.75 per cent) opined that the launching of the scheme is better and only the remaining households i.e. 6.25 per cent stated that the introduction of the scheme is not so better. During the field work, the researcher had also been observed that the introduction of the scheme is welcoming sign in general and the study area in particular as it provides better medical facilities especially for the poorest of the poor.

Table – 1: Opinion of the Sample Beneficiaries about the Launching of Rajiv Arogyasri Programme

Opinion of Beneficiaries	Public Hospitals	Private Hospitals	Total
Better	76 (47.50)	74 (46.25)	150 (93.75)
Not Better	4 (2.50)	6 (3.75)	10 (6.25)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study



Distribution of the sample beneficiaries' opinion about the Arogyasri Helpline and Helpdesk has presented in Table-2. Of the total sample beneficiaries, an overwhelming majority (93.75 per cent) of them were of the view that they satisfied with the Arogyasri helpline desk these in both the public and private hospitals. The percentage of households those who stated the opinion of satisfied in private hospitals preponderates over the same opinion stated by the households in public hospitals. And the remaining neglible 6.25 percentage of sample beneficiaries were of the opinion that they have not satisfied. During the field investigation, the researcher had also observed that the helpline and helpdesk in both the public and private hospitals are performing their duties according to their norms.

Table – 2: Distribution of the Sample Beneficiaries Opinion about the Arogyasri Helpline & Helpdesk

Nature of Beneficiaries	Public Hospitals	Private Hospitals	Total
Satisfied	72 (45.00)	78 (48.75)	150 (93.75)
Not Satisfied	8 (5.00)	2 (1.25)	10 (6.25)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

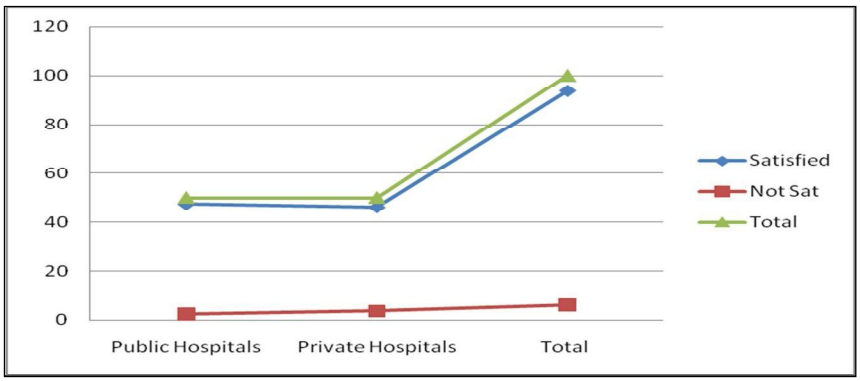


Table – 3: Opinion of the Sample Beneficiaries with the Functioning of Rajiv Arogyasri Programme

Functioning of R.A. Programme	Public Hospitals	Private Hospitals	Total
Good	70 (43.75)	66 (41.25)	136 (85.00)
Bad	2 (1.25)	2 (1.25)	4 (2.50)
Average	6 (3.75)	8 (5.00)	14 (8.75)
No Response	2 (1.25)	4 (2.50)	6 (3.75)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

Table-3 shows about the opinion of the sample beneficiaries with the functioning of Rajiv Arogyasri Programme in selected area. Of the total sample beneficiaries, a majority of them (85 per cent) said that the functioning of the

programme is good and its percentage is relatively higher in public hospitals that 43.75 per cent and in the case of private hospitals its percentage is 41.25. 8.75 percentage of the sample beneficiaries viewed that its functioning is by and large is neither good nor bad or it is average. The percentage of households who stated that it's functioning average private hospitals are relatively higher as compared with that of public hospitals. During the field investigation, it had also been observed that its functioning is up to the expectations of the people in general and the selected sample beneficiaries in particular.

Table – 4: Opinion of Patients Post- Treatment in Arogyasri Scheme

Opinion of patients	Public Hospitals	Private Hospitals	Total
Good	4 (2.50)	2 (1.25)	6 (3.75)
Better	6 (3.75)	10 (6.25)	16 (10.00)
Best	60 (37.50)	66 (41.25)	126 (78.75)
No Response	10 (6.25)	2 (1.25)	12 (7.50)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

The Table -4 shows about the opinion of patients as regards the post treatment in Arogyasri Scheme. While looking at the Table, a majority (i.e. 78.75 per cent) of the sample beneficiaries were of the view that post-treatment in Arogyasri Scheme is the best. As regards this there is no much difference between public hospitals and private hospitals but there is a marginal difference. 10 per cent of the sample beneficiaries opined that the post-treatment is better followed by good with 3.75 per cent. Thus, from the analysis it can be inferred that post-treatment is the best one with few exceptions.

Table – 5: Opinion of the Sample Beneficiaries about Arogyasri Scheme Strengthens Health Facilities in Rural Areas

Opinion Health Facilities	Public Hospitals	Private Hospitals	Total
Strengthen Health Facilities	78 (48.75)	72 (45.00)	150 (93.75)
Do Not Strengthen Health Facilities	2 (1.25)	8 (5.00)	10 (6.25)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

Table-5 deals with the opinion of the sample beneficiaries about the Arogyasri Scheme which strengthens health facilities in rural areas. While looking at the Table, it can be said that an overwhelming majority (i.e. 93.75 per

cent) of the sample beneficiaries opined that the introduction of the sample strengthens the health facilities in rural areas and of the 75 beneficiaries, 48.75 per cent of beneficiaries and 45 per cent beneficiaries are belong to the public hospitals and private hospitals respectively. And the remaining 6.25 per cent of sample beneficiaries said that in no way the introduction of the scheme strengthens the health facilities in the rural areas. Therefore, from the analysis, it can be said that the onslaught of the programme improves and strengthens the health facilities in general and the rural areas in particulars. During the field investigation, the researcher had also been observed that the introduction of the scheme is a welcoming sign in the sphere of health facilities because this scheme covers the people hither to excluded people from the health policy especially in the rural areas.

Table – 6: Information about the Referral Hospitals at the Sample Beneficiaries Village

Information about Referral Hospital	Public Hospitals	Private Hospitals	Total
Having Referral Hospital	12 (7.50)	16 (10.00)	28 (17.50)
Not Having Referral Hospital	68 (42.50)	64 (40.00)	132 (82.50)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

Information about the referral hospital at the sample beneficiaries village has shown in Table- 6. Of the 80 sample beneficiaries, 66 of them accounting for 82.50 per cent said that these are no referral hospitals at their villages and the remaining 17.50 per cent of household said that there are referral hospitals at their villages. During the field work and discussions held with the cross-section of the people, the researcher had also been observed that not having the referral hospitals is a serious limitation of the implementation of the scheme in general and rural areas in particular. Thus, there is an imminent need to establish/have referral hospitals at least near by the villages.

Table – 7: Opinion of the Sample Beneficiaries about the Quality of Life

Opinion about the quality of life	Public Hospitals	Private Hospitals	Total
Improved	76 (47.50)	74 (46.25)	150 (93.75)
Not Improved	4 (2.50)	6 (3.75)	10 (6.25)
Total	80 (50.00)	80 (50.00)	160 (100.00)

Source: Field Study

Opinion of the sample beneficiaries about the quality of life is documented in Table-7. This Table is corollary to the Table-5.17 and 5.18. Of the total sample beneficiaries, an overwhelming majority (i.e. 93.75 per cent) of them stated the quality of life had improved after the introduction of the Arogyasri Scheme. And the remaining 6.25 per cent of the sample beneficiaries were of the opinion that the quality of life has not improved owing to the introduction of the scheme and this might be due to the fact that these households may not have the awareness of the function of the scheme. By and large, from the analysis, it can be inferred that the quality of life especially poorest of the poor in general and the rural areas in particular had improved due to the function of the scheme. During the field investigation and discussion held with the cross-section of the beneficiaries, the researcher had also observed the similar tendency.

By and large, from the analysis, it can be inferred that the quality of life especially poorest of the poor in general and the rural areas in particular had improved due to the functioning of the scheme. The researcher had also observed that the researcher identified the prime reasons for the debacle of the scheme in the rural areas is government authorities, no proper communication, and lack of awareness. Further, the preceding analysis contained in the earlier analyses lead the researcher to conclude that in principle, while this is a desirable scheme but practical implementation and the associated problems of enforcing medicine reimbursement to patients would be a stupendous task and could fiscally strain the coffers of the government. Outpatient care and drug reimbursement must be kept out of the health insurance programme while strengthening the public health institutions and sprucing the medicine procurement and distribution. Besides, as the large part of the medicine purchased by the households occurs at the private chemists. Therefore, it can be said that the need of the hour is to strengthen the drug price control by bringing all the essential drugs under the one umbrella of price control.

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