

**A STUDY ON IMPLEMENTATION OF COMMUNITY HEALTH INSURANCE SCHEME IN THE CARDIOLOGY DEPARTMENT OF A TERTIARY CARE GOVERNMENT HOSPITAL**P. Kalyani<sup>1</sup>**HOW TO CITE THIS ARTICLE:**

P. Kalyani. "A Study on Implementation of Community Health Insurance Scheme in the Cardiology Department of a Tertiary Care Government Hospital". Journal of Evolution of Medical and Dental Sciences 2015; Vol. 4, Issue 18, March 02; Page: 3124-3133, DOI: 10.14260/jemds/2015/452

**ABSTRACT:** In many parts of the developing world, health care expenditure is largely met out of pocket, and illness can drive individuals and families into poverty and debt. India ranks third in the World Health Organization's 2012 list of "countries with highest out of pocket (OOP) expenditure on health" in the south-east Asia region with almost 60% of total health expenditure paid by the common man in 2009 (World Health Organization 2009).<sup>1</sup> The Rajiv Aarogyasri Community Health Insurance (RACHI) in Andhra Pradesh (AP) 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 is achieved **AIM OF THE STUDY:** To study implementation of Aarogyasri community health insurance scheme in the department of cardiology of a tertiary care government hospital. **MATERIAL:** A total number of 27 cases of cardiac patients recruited over a period of ten weeks from 5-9-14 to 15-11-14 in the department of cardiology K.G.H Visakhapatnam. **DISCUSSION:** Community health insurance scheme is one of the models for providing health security for the people below poverty line. The Aarogyasri scheme of Andhra Pradesh aims to ensure health care for the BPL population at the time of critical and catastrophic illness. All the cases in the study group underwent surgical treatment, PTCA with one stent and for one case an additional stent was placed. Cash less packages also covered free food and transportation charges. Medicines are given for ten days at the time of discharge. Many states, and even the central government, are believed to be looking at the scheme to see if this can be replicated across the country.<sup>6</sup> **CONCLUSION:** The case travel time from registration to final claims disposal is less than two weeks because of the organization pattern of the Aarogyasri community health insurance scheme.

**KEYWORDS:** Below poverty line, out of pocket expenditure, community health insurance, Aarogyasri.

**INTRODUCTION:** In many parts of the developing world, health care expenditure is largely met out of pocket, and illness can drive individuals and families into poverty and debt. India ranks third in the World Health Organization's 2012 list of "countries with highest out of pocket (OOP) expenditure on health" in the south-east Asia region with almost 60% of total health expenditure paid by the common man in 2009 (World Health Organization 2009).<sup>1</sup> The national commission on macroeconomics & health has pointed out that 3.3% of India's population is impoverished every year on account of health distress.(GOI,2005:23).India's low health budget is a cause for health inequity, inadequate availability and reach, unequal access, poor quality and costly health care services<sup>2</sup>. As out of pocket expenses (OOPE) cause significant economic burden on the house holder the government advocates implementing health financing mechanism that will protect the citizens from financially catastrophic effect of illness (GOI,2006).<sup>2</sup> Government provided health services only partially meet the needs of the rural and urban poor in the informal sector and making equitable and affordable

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medical care accessible to this segment remains a challenge.<sup>3</sup> It is here that community-based health insurance (CBHI) schemes could provide viable alternatives. The Rajiv Aarogyasri Community Health Insurance (RACHI) in Andhra Pradesh (AP) 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 is achieved (Nambiar 2013). There has been a substantial increase in the number of hospitals under the private sector during 1992. Health services tilted towards private sector. Health care treated as an industry with profitable margins. The behavior of private sector health care providers will depend critically on the environment within which they operate.<sup>4</sup> Big hospital set up with huge public investments and subsidies by the state in the form of tax exemptions; land subsidies, buying back services like CGHS & other insurances paying to the private sector for their services.

The 10<sup>th</sup> plan document (GOI, 2002:98) recognized that private super specialty tertiary/secondary care hospital should be given land, water, electricity etc at concessional rates and permission for duty-free import of equipment with the understanding that they will provide in-patient and out-patient services to poor patients free of charge.

To provide health security for the poor, the health insurance schemes at the national level, the Rashtriya Swasthya Bima Yojana (RSBY) was launched. Among the states, the Yeshasvini scheme in Karnataka, Kudumbasree in Kerala, and Rajiv Gandhi Aarogyasri community health insurance (RACHI), in A.P was launched to extend coverage to workers in the informal sector. Aarogyasri scheme is politically driven and it promotes the interest of tertiary corporate hospitals and tertiary public hospitals, intensifying medicalisation of society. Directed towards tertiary care with limited coverage and is run solely on state subsidies.

### **Evolution of the RACHI scheme:**

The RACHI scheme initiated with a mission to provide quality health care to the poor. The aim of the government is to achieve 'health for all' in 'Aarogyandhra Pradesh'. To facilitate the effective implementation of the scheme, the state government has set up the Aarogyasri health care trust under the chairmanship of the chief minister. This scheme provides coverage up to 2 lakhs per family per year subject to limits, in any of the network hospitals. It covered a wide range of surgical and medical treatments for serious illnesses requiring specialist healthcare resources not always available at district-level government hospitals. The key stakeholders in RACHI scheme are the state government, a private insurance company (Chennai based star health and Allied insurances) and Tata consultancy services(TCS) for ICT solutions (Aarogyasri health care Trust, 2011 b).<sup>1</sup> The RACHI scheme has ensured a key link person Aarogyamithra (Health coordinator), to connect people and the programme at the grass root level. The insurance company has appointed Aarogyamithras at all network hospitals to facilitate admission, treatment and cashless transaction of patient around the clock.<sup>1</sup> For the RACHI schemes beneficiaries are identified through the white ration cards provided as part of Annapurna & Anthyodaya Anna yojana scheme for BPL families. 80% of population has BPL ration cards and considered eligible to utilize the benefit provided by the RACHI scheme. The families, who were covered for specified diseases by other insurance schemes such as CGHS, ESIS etc. are not considered eligible for any benefits provided in the RACHI scheme.

Beneficiaries can approach through a referral from nearby PHC/Area hospitals/District hospital/network hospital.<sup>1</sup> Aarogyamithras placed in the above hospitals facilitate the contact with

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the beneficiary.<sup>5</sup> The beneficiary may also attend the health camps being conducted by the network hospitals in the villages and get the referral card based on the diagnosis.

### Criteria for selection:

1. Emergency and lifesaving in nature.
2. Requiring specialist doctors and special equipment.
3. Not ordinarily available in government hospitals (Area/CHC).
4. Verifiable diagnostic & post treatment protocols.
5. Not covered by other government schemes.

**AIM OF THE STUDY:** To study implementation of Aarogyasri community health insurance scheme in the department of cardiology of a tertiary care government hospital.

### OBJECTIVES OF THE STUDY:

1. To study community health insurance scheme- Aarogyasri.
2. To study departmental indices of cardiology department.
3. To study effectiveness of services provided by cardiology department under Aarogyasri scheme.
4. To identify the problems associated with the program and offer suggestions for effective implementation of the scheme.

### METHODOLOGY:

1. Direct observation study.
2. Indirect study from previous records.

**MATERIAL:** A total number of 27 cases of cardiac patients recruited over a period of ten weeks from 5-9-14 to 15-11-14 in the department of cardiology K.G.H Visakhapatnam. The data collected in the prescribed proforma and analyzed.

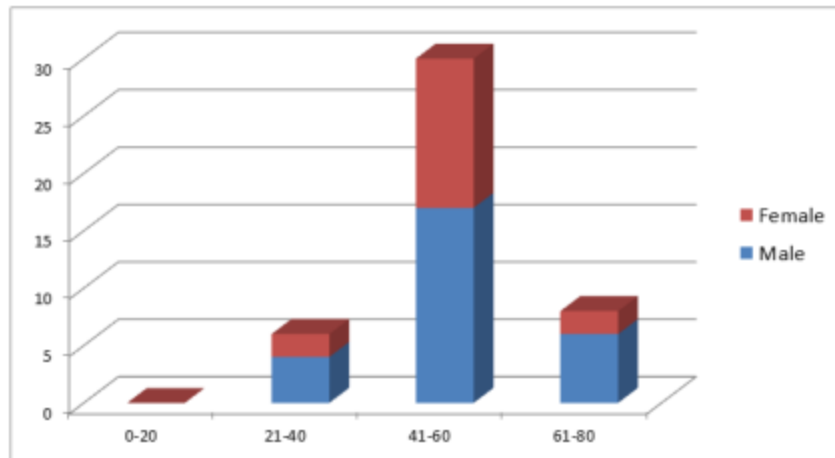
### OBSERAVATIONS:

| Age group (years) | Total | Male | Female | Total |
|-------------------|-------|------|--------|-------|
| 0-20              | 0     | 0    | 0      | 0     |
| 21-40             | 4     | 2    | 2      | 4     |
| 41-60             | 17    | 13   | 4      | 17    |
| 61-80             | 6     | 4    | 2      | 6     |

**Table 1 : DISTRIBUTION OF PUR (PERSONS UTILIZATION RATE) BY AGE-GROUP AND SEX**

Out of the total cases 14.8% are among age group 21-40 yrs, 62.96% in the age group of 41-60 yrs and 22.22% in the age group of 61-80 yrs. Out of which 70.4% are male patients and 29.6% are females.

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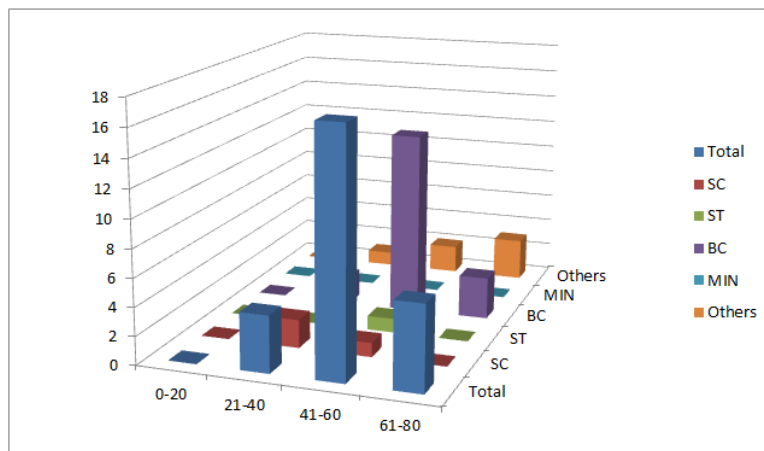


**Fig. 1: Distribution of PUR  
(persons utilization rate) by Age-group and Sex**

| Age group (years) | Total | SC | ST | BC | MIN | OTHERS | TOTAL |
|-------------------|-------|----|----|----|-----|--------|-------|
| 0-20              | -     | -  | -  | -  | -   | -      | -     |
| 21-40             | 4     | 2  | -  | 2  | -   | 1      | 4     |
| 41-60             | 17    | 1  | 1  | 13 | -   | 2      | 17    |
| 61-80             | 6     | -  | -  | 3  | -   | 3      | 6     |

**Table 2 :DISTRIBUTION OF THE PERSON BY AGE GROUP AND CASTE**

Out of the total 27 cases 11.11% cases belong to SC, 3.7% belongs to ST, 66.66% are from BC community and 22.22% belong to OC caste.



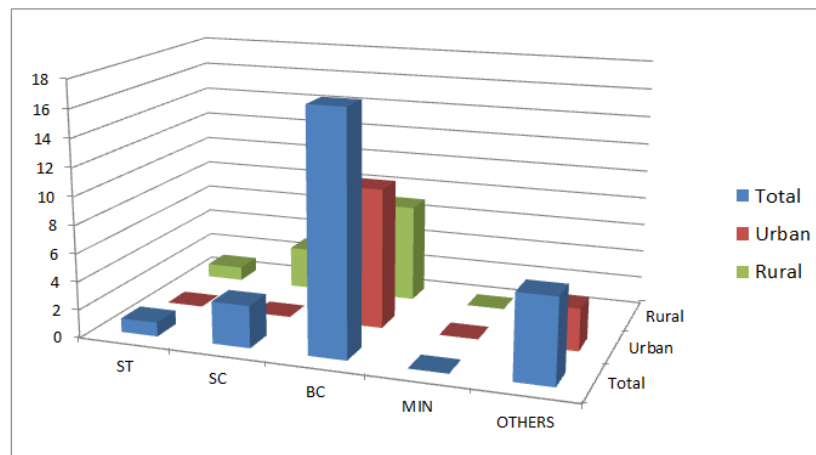
**Fig. 2: Distribution of the Person  
by Age group and Caste**

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| Community | Total | Urban | Rural | Total |
|-----------|-------|-------|-------|-------|
| ST        | 1     | -     | 1     | 1     |
| SC        | 3     | -     | 3     | 3     |
| BC        | 17    | 10    | 7     | 17    |
| MIN       | -     | -     | -     | -     |
| OTHERS    | 6     | 3     | 3     | 6     |

**Table 3 : FREQUENCY COUNT OF CARDS  
BY COMMUNITY URBAN/RURAL**

Among the ST community 3.7% are rural, 11.11% of SC community are rural, among the BC community (62.9%) 58.8% are urban and 41.17% are rural and out of the OC community (22.22%) 50% are urban and 50% are rural population.



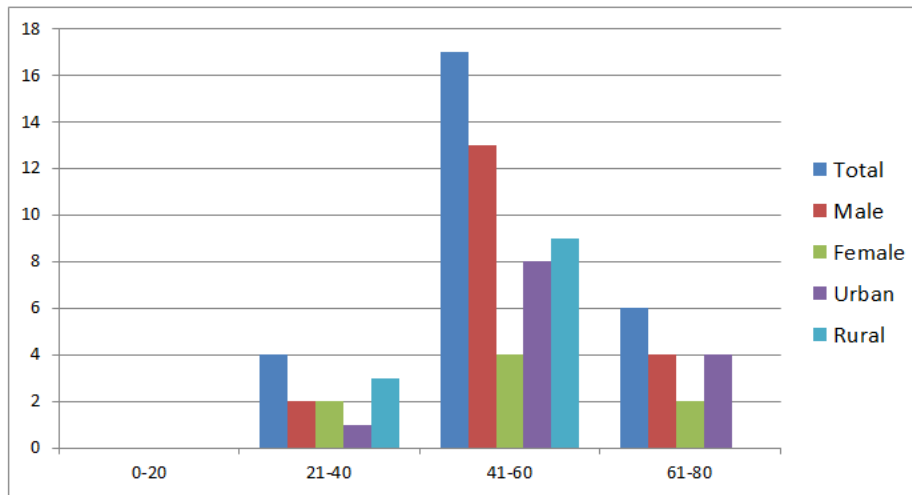
**Fig. 3: Frequency Count of Cards by  
Community Urban/Rural**

| Age Group (years) | Total | Male | Female | Total | Urban | Rural | Total |
|-------------------|-------|------|--------|-------|-------|-------|-------|
| 0-20              | 0     | 0    | 0      | 0     | 0     | 0     | 0     |
| 21-40             | 4     | 2    | 2      | 4     | 1     | 3     | 4     |
| 41-60             | 17    | 13   | 4      | 17    | 8     | 9     | 17    |
| 61-80             | 6     | 4    | 2      | 6     | 4     | 2     | 6     |

**Table 4 : FREQUENCY COUNT OF PERSONS USED BY AGE-SEX/URBAN-RURAL**

Among the study group 62.96% are from the age group of 41-60 yrs and 76.4% are male patients. 52.9% come from rural areas and 47.05% are from urban areas.

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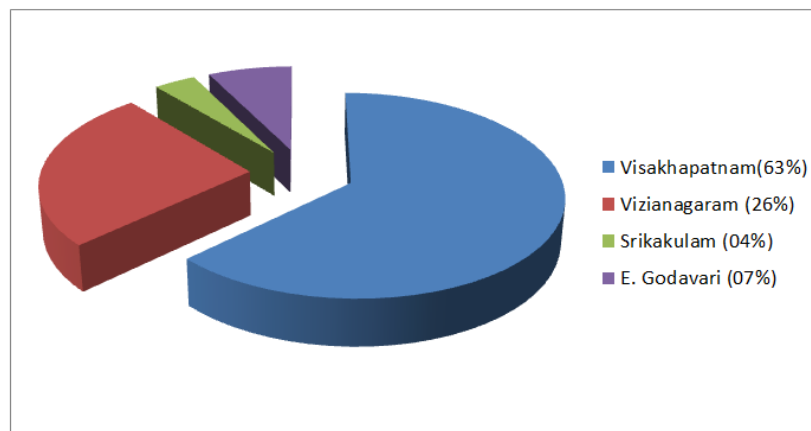


**Fig. 4: Frequency Count of Persons used by Age-Sex/Urban-Rural**

| District      | Total     | Urban     | Rural     | Total     |
|---------------|-----------|-----------|-----------|-----------|
| Visakhapatnam | 17        | 11        | 6         | 17        |
| Vizianagaram  | 7         | 2         | 5         | 7         |
| Srikakulam    | 1         | -         | 1         | 1         |
| E.Godavari    | 2         | -         | 2         | 2         |
| <b>Total</b>  | <b>27</b> | <b>13</b> | <b>14</b> | <b>27</b> |

**Table 5 : DISTRICT WISE DISTRIBUTION OF CASES**

Out of the total cases 62.96% are from Visakhapatnam district, 25.92% from Vizianagaram, 3.7% from Srikakulam and 7.40% are from East Godavari district.

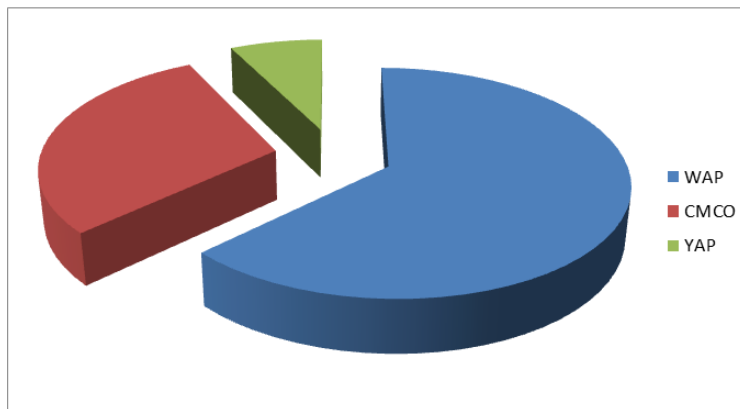


**Fig. 5: District-wise Distribution of Cases**

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| WAP         | CMCO       | YAP       | TOTAL     |
|-------------|------------|-----------|-----------|
| 17 (62.96%) | 8 (29.62%) | 2 (7.40%) | <b>27</b> |

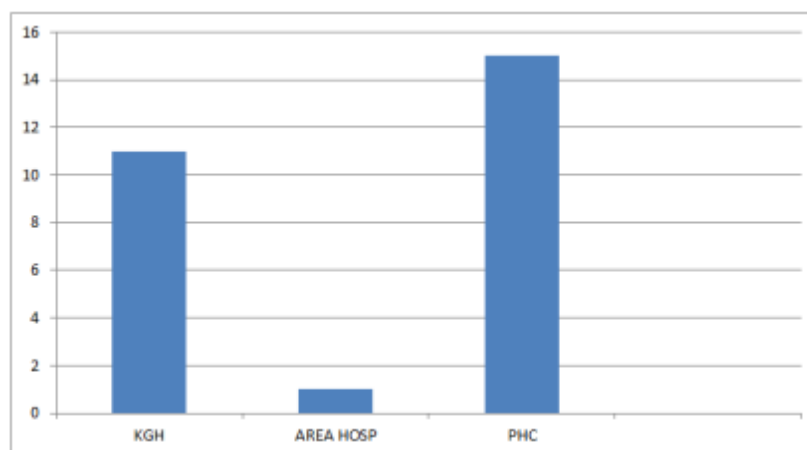
**Table 6 : HEALTH CARD UTILIZATION**



**Fig. 6: District-wise Distribution of Cases**

| K.G.H | AREA HOSPITAL | PHC | TOTAL     |
|-------|---------------|-----|-----------|
| 11    | 1             | 15  | <b>27</b> |

**Table 7 : BENEFICIARY CHOICE**

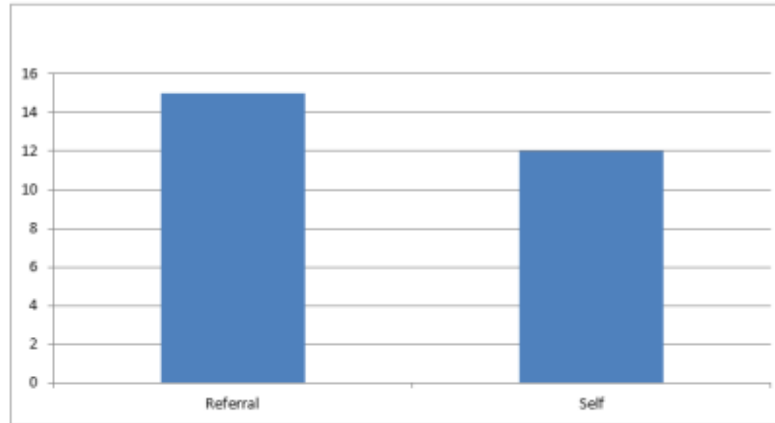


**Fig. 7: Beneficiary Choice**

| Referral | self | Total     |
|----------|------|-----------|
| 15       | 12   | <b>27</b> |

**Table 8 : REASONS FOR CHOOSING NETWORK HOSPITAL**

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**Fig. 8: Reasons for Choosing Network Hospital**

**RESULTS:** In my study out of the total cases, 14.8% are among age group 21-40yrs, 62.96% in the age group of 41-60yrs and 22.22% in the age group of 61-80yrs. Out of which 70.4% are male patients and 29.6% are females. Distribution of the person by age group and caste shows that out of the total 27 cases 11.11% cases belong to SC, 3.7% belongs to ST, 66.66% are from BC community and 22.22% belong to OC caste. Among the ST community 3.7% are rural, 11.11% of SC community are rural, among the BC community (62.9%) 58.8% are urban and 41.17% are rural and out of the OC community(22.22%) 50% are urban and 50% are rural population. Frequency count of cards by community urban/rural areas shows 62.96% are from the age group of 41-60 yrs. and 76.4% are male patients. 52.9% come from rural areas and 47.05% are from urban areas. The study shows that 40.74% of the beneficiaries approached the network hospital directly because of knowing the reputation of the hospital. (Normal rate is 20%) and 55.55% against the normal percentage of 25% attended the PHCs and were referred by the Arogyamithras to the K.G.H.

**DISCUSSION:** Community health insurance scheme is one of the models for providing health security for the people below poverty line. The Aarogyasri scheme of Andhra Pradesh aims to ensure health care for the BPL population at the time of critical and catastrophic illness.

King George Hospital –Visakhapatnam is one among the 151 government tertiary care network hospitals identified for implementation of the scheme. K.G.H renders specialty and superspeciality medical services to the urban and rural population of Visakhapatnam, and the adjacent districts like Vizianagaram, Srikakulam, etc.

In my study 63% are from Visakhapatnam, 26% from Vizianagaram, 4% from Srikakulam and 7% are from E. Godavari who attended the cardiology department.

40.74% of the beneficiaries approached the network hospital directly because of knowing the reputation of the hospital.(normal rate is 20%) and 55.55% against the normal percentage of 25% attended the PHCs and were referred by the Arogyamithras to the K.G.H. Hospitals and doctors are often chosen on the basis of previous experience and interaction, as well as distance to the facility (Narasimhan 2013).<sup>1</sup> All the cases are admitted as emergency cases and after thorough examination, necessary investigations are performed, and medical treatment started. Case sheet with provisional diagnosis and necessary documents are submitted through online portal for preauthorization. In my study preauthorization approval was given to all the cases by the arogyasri trust doctors.



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All the cases in the study group underwent surgical treatment, PTCA with one stent and for one case an additional stent was placed. Cash less packages also covered free food and transportation charges. Medicines are given for ten days at the time of discharge.

Follow up of the cases for one year with review once in a month is given for all the cases. At the time of follow up visit thorough physical examination, necessary investigations are performed. Follow up medicines provided and if required other specialty services are also advised.

Many states, and even the central government, are believed to be looking at the scheme to see if this can be replicated across the country.<sup>6</sup> To have a sustainable health care model, there is a need to strengthen the public health service systems and also use them to their optimum level and upgrade them and reduce the state subsidies to the private sector.<sup>2</sup>

### CONCLUSION:

- The case travel time from registration to final claims disposal is less than two weeks because of the organization pattern of the Arogyasri community health insurance scheme.
- Submission of the satisfaction forms (Feedback forms) by the patients helped in social auditing.
- By conducting more number of medical camps the department of cardiology can extend the services to more number of patients.
- Upgrading the infrastructure facilities in the department of cardiology – KGH, enables treatment for a variety of cardiac diseases.

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### **AUTHORS:**

1. P. Kalyani

### **PARTICULARS OF CONTRIBUTORS:**

1. Assistant Professor, Department of Physiology, Andhra Medical College, Vishakhapatnam.

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### **NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:**

Dr. P. Kalyani,  
Flat No. 4-C, R. K. Lakshmi Residency,  
Plot No. 72, Kirlampudi Layout,  
Vishakapatnam-17.  
E-mail: kalyaniparry@gmail.com

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