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Critique of Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh

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Contents

Abbreviations

AP- Andhra Pradesh
AHCT- Aarogyasri Health Care Trust
APNA- Andhra Pradesh Nursing Homes Association
APVVP- Andhra Pradesh Vaidya Vidhan Parishad
ASHA- Andhra Pradesh Specialty Hospitals Association
BPL- Below Poverty Line
CEO- Chief Executive Officer
CHC- Community Health Centre
CGHS- Central Government Health Scheme
CM- Chief Minister
DALY- Daily Adjusted Life Years
DME- Department of Medical Education
ESI- Employee's State Insurance scheme
EU- European Union
GO- Government Order
HLEG- High Level Expert Group
IAS- Indian Administrative Service
ICU- Intensive Care Unit
IMA- Indian Medical Association
IPD- In Patient Care
IIPH- Indian Institute of Public Health
MoU- Memorandum of Understanding
OECD-Organisation for Economic Co-operation and Development
OPD- Out Patient Care
PDS- Public Distribution System
PHC- Primary Health Centre
PHFI- Public Health Foundation of India
PPP- Public-Private Partnership
RAS- Rajiv Aarogyasri Community Health Insurance Scheme
RSBY- Rashtriya Swasthya Bima Yojana
STP- Standard Treatment Protocol
UHC- Universal Health Care
WHO- World Health Organisation
WHR- World Health Report

Opening remarks

Rajiv Aarogyasri Community Health Insurance Scheme (RAS) was started by the Andhra Pradesh state government, in 2007, to assist poor families from catastrophic health expenditure. It is a PPP (public-private partnership) model which provides 938 tertiary care procedures (from angiographies to various laparoscopic surgeries) in a cashless manner through a network of government and private hospitals to card-holder families with annual income less than one lac rupees. Inclusion of majority of the families in a scheme to provide some tertiary care services free of charge is a welcome step. From many points of view, RAS has proved to be a game changer and trend setter health insurance scheme in India. However this scheme is quite at variance with the recommendations of the Planning Commission's High Level Expert Group (HLEG) on Universal Health Coverage (UHC) and has become an obstacle in achieving the goal of UHC.

RAS has firmly put healthcare on the electoral political agenda in Andhra Pradesh. Its immense popularity contributed to the electoral victory of Dr. YSR Reddy (then Chief Minister of Andhra Pradesh) in 2009. The kind of popularity and electoral success achieved by the scheme makes it the hot- selling political agenda for ruling parties from other states in India. It has created a 'ripple effect'. Delegations from 21 states from India have already visited Andhra Pradesh to study this scheme. More numbers of state governments are coming up with similar kind of schemes. Tamil Nadu state government launched 'Kalaignar Insurance Scheme for Life Saving Diseases' on 23rd June 2009. After state assembly election, new state government replaced this scheme with another similar scheme named as 'Chief Minister's Elaborate Medical Insurance Scheme'. Karnataka state government started 'Vajpayee Aarogyasri' on 1st February 2010 while Delhi government started 'Aapka Swasthya Bima Trust' in December 2010. Maharashtra state government launched 'Rajiv Gandhi Jeevandayee Arogya Yojana' in 2012. It is more likely that more state governments would go in the same direction. It is clear that schemes like RAS have created their space in populist electoral politics in India.

Improving health of chronically starved, weakened public health system has been perennial concern of people oriented health activists and organisations. RAS kind of neoliberal health insurance schemes pose a challenge for people oriented health activists and people's health movement in terms of how to deal with such a populist scheme. Rapidly increasing influence of such public-private partnership based, publicly financed but corporate hospital biased healthcare insurance model might prove to be a death knell for deteriorated public health system.

Success of RAS and its replication in many other states has a grave potential to significantly alter the ongoing discourse on Universal Health Care in the country in favour of some kind of insurance based model, in variance with the recommendations of High Level Expert Group(HLEG) on Universal Health Care. Hence, RAS needs close scrutiny. There is an urgent need to analyse it critically and come up with its robust criticism. This paper is an attempt towards this objective.

Brief introduction to the scheme

The Rajiv Gandhi Community Health Insurance Scheme was introduced on 1st April 2007 in three backward districts of Mahboobnagar, Ananthapur and Srikakulam in Andhra Pradesh on pilot basis with the objective to reduce catastrophic health expenditure for BPL families by providing end-to-end cashless services for identified 938 procedures and therapies through a network of service providers from Government and private sector.

It is a public-private partnership between multiple stakeholders which includes insurance company (Star Health and Allied Insurance Company) for risk coverage, MD India company as pre-authorisation human resource provider, empaneled network of public and private hospitals as service providers, and a regulatory public body in the form of Aarogyasri Health Care Trust (AHCT) with the Chief Minister of Andhra Pradesh as its chairperson and designated IAS officer as Chief Executive Officer. Arogyamitras are health workers affiliated to the insurance company which serve as a bridge between the empaneled network hospitals and RAS beneficiary patients.

The scheme which was initiated with coverage to 163 identified procedures and therapies in 6 systems was gradually extended to 330 procedures and therapies in 13 systems under Aarogyasri- phase I. Later on it was further extended to whole Andhra Pradesh state to cover 2.03 Crore BPL families (more than 20 million) in 23 districts with addition of 612 procedures and therapies through Aarogyasri-phase ll from July 2008. Thus total 938 procedures and therapies are being covered under Rajiv Aarogyasri scheme. Procedures and therapies which are life- saving in nature, which are required in emergency, which need specialist doctors and special equipment, which have verifiable diagnostic and post-treatment protocols, which are not ordinarily available in Government Hospitals and not covered by other government schemes are included in the scheme. Thus, Aarogyasri scheme was rationalized by the state government as a complementary arrangement to existing primary, secondary and tertiary care given through public health system. Follow-up treatment is provided for 125 procedures for one year. There is no differentiation by pre-existing health conditions.

The Identity of the scheme beneficiaries and the family size is based on the socio - economic data, digital photographs and biometrics available in the white card (PDS Card for BPL families) / Health Card. Sum insured per family per year is Rs.1,50,000/- and benefit are on floater basis, can be availed by individual or family. There is provision of additional sum of Rs.50,000/- in case of need from buffer amount. For each case of cochlear implantation for children up to 12 yrs age, insurance cover up to a maximum of Rs. 6.50 lakh is provided. The only exclusion criteria is coverage under any other central or state government financed scheme such as CGHS, ESI and State government employees; and families which do not have white card (non-BPL families).

Network hospitals include both public and private sectors. These hospitals are empanelled on the basis of set criteria (like minimum 50 beds and other infrastructure criteria like ICU with 2 Ventilators) and willingness to provide cashless treatment at the point of service delivery for a set of predefined treatment packages including out patient services. In RAS, there are total 340 hospitals out of which 38 are super specialty hospitals

affiliated to 'AP Specialty Hospitals Association' (ASHA), 220 hospitals affiliated to 'AP Nursing Homes Association' (APNA) and the remaining 80 are public sector hospitals.

RAS has been flagship programme of Andhra Pradesh Government. Massive popularity of the scheme and politico-administrative support for the scheme has resulted in high priority financial allocation for the scheme. As then Finance Minister and Ex- Chief Minister K. Rosaiah gave budget speech in AP assembly on 24th July 2009; and in that speech he said that average amount claimed by the Aarogyasri beneficiaries per day was about 3.5 Crores! Budgetary allocation for Aarogyasri, during years April 2007 to March 2012, was as follows- -

- April 2007 to March 2009 -990 Crores
- 2009-2010 -925 crores r
- 2010-2011 -925 crores
- 2011- 2012- 925 crores

Budget for RAS was 23% of Andhra Pradesh's health budget and almost 50% of State Non Plan Health Budget, in financial year 2011-12. [1]

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[1] Ref.- Aarogyasri HI- The AP Experience by Dr Rajan Shukla and Dr Veena Shatrugna

Executive summary

Critique of Rajiv Aarogyasri Community Health Insurance Scheme(RAS), Andhra Pradesh

The commitment of the political leadership in Andhra Pradesh to extend the benefits of the Aarogyasri scheme to wider sections of the society is a welcome step. People definitely need quality and affordable tertiary healthcare serivices and RAS is an attempt in this direction. Benefits of free provision of costly tertiary care procedures and therapies under RAS are definitely reaching to the population in the state of Andhra Pradesh. However, basic design of RAS is questionable from the point of view of improving health outcomes and achieving health equity.

Andhra Pradesh as a state is spending more than half of entire healthcare expenditure on tertiary care through RAS, ESIS,CGHS, private health insurance etc. One of the characteristic features of RAS is its over thrust on selective tertiary care procedures at the cost of primary and secondary care. During post RAS launching period, proportionate spending by AP state government on primary care has been drastically reduced from 69% to 48% while spending on tertiary care has been increased from 16% to 39%. This is an alarming sign. This disproportionately increased thrust on tertiary care through RAS kind of scheme and neglect of primary, secondary level healthcare available throgh public health system may lead to serious problems like over medicalisation, healthcare consumerism, healthcare inflation, finacial insustainability of the healthcare expenditure, weakening of primary health centres and collapse of secondary care system. This kind of system would have limited capacity to improve health outcomes and achieve health equity. The idea of preventive and promotive care, primary care has been pushed behind by bringing forward narrow, bio-medical and techno-centric view of healthcare as envisioned in RAS.

The scheme is mainly procedure and therapy oriented. There is ample of scope for the healthcare providers to resort to unnecessary technological interventions to maximise their profit margins without giving any consideration for improving healthcare effectiveness and there is no incentive to take into consideration efficiency of simple, primary or conservative approaches.

RAS has an important but very limited role in reducing overall catastrophic healthcare expenditure for BPL families in Andhra Pradesh as it does not cover all kinds of hospitalisations (but very few), any kind of OPD care (except screening in health camps and network hospitals), cost of medicines (except conditions covered under RAS). Since inception of Aarogyasri (April 2007) to Jan 2012, total 13, 05,617 procedures were performed, which means that in last five years (2007-2012), benefits of RAS reached only about 1.86% of BPL population in Andhra Pradesh. If we take into consideration the entire population of AP then the reach is just 1.45 %. Even the beneficieries of RAS have to spend some money while availing services under the scheme. Study conducted by Indian Institute of Public Health(Hyderabad) in year 2008-2009 revealed that nearly 58.5% of beneficiaries spent additional money before, during or after the treatment at network hospitals. The median amount of money spent was Rs. 3600. Medicine, diagnostic tests and transport were the main reasons for out of pocket expenditures by the beneficiaries.

Implementation of this scheme through the insurance company is characterised by risk free insurance, high administrative cost and no incentive for cost containment resulting in draining out of valuable public resources. There is no risk bearing for the insurance company as claims payment have been capped after which Aarogyasri trust pays the difference. It is a risk free insurance. Expenditure never crossed the premium amount in a single year since the inception of the scheme. On the contrary, if claims amount is unspent, insurance agency keeps 10% of unspent amount and returns the rest. In various countries administrative costs of insurance schemes ranged from 5 to 17% including the premium collection cost. Premium collection is quite a tedious task and major contributor for upscaling of the administrative cost. Under RAS the government ofAndhra Pradesh is paying premiums on behalf of the BPL families, so there is no cost attached to premium collection as a part of the administration cost for insurance company. Administration cost charged by Star Health and Allied Insurance Company was initially 20% of entire premium amount. Later on, it was increased to 30%. By international comparison, it is a very high administrative cost. In RAS design, there is no incentive for insurance company to monitor inefficiencies, wastage, inflation of the system or reduce supply side moral hazard.

In the design of RAS, there are no Standard Treatment Protocols. In the absence of STPs and their implementation, the design of RAS incentivises network hospitals to perform unnecessary procedures and therapies, which may lead to gradual cost escalation. Network hospitals have lobbied time and again in last five years of RAS implementation to increase the package rates. This hike in package rates have no effect on the insurance company as it simply passed on the burden to the Arogyasri Health Care Trust(AHCT) while renewing the contracts.

Existence of inadequate monitoring mechanisms to block operational loopholes in case management, no adequate cross verification, over reliance on data from service providers led to many instances where network hospitals misused the scheme in clear violation of MoU with the AHCT. Unnecessary hysterectomies performed by some network hospitals under RAS was reported by many newpapers prominently.

In unequal competition under RAS scheme, between resources starved public health system and ‘fit-n-fine’ private corporate hospitals- obviously government hospitals are lagging behind. Only reputed Govt Medical Institutions like NIMS, SVIMS, MNJ Hospital are able to compete with corporate hospitals. There is no earmarked funding for strengthening of public hospitals. Since the inception of the scheme till 30th May 2012, in total 14, 70,571 surgeries were performed out of which 3,46,118 (23.54%) were performed in government hospitals while 11,24,453(76.46%) were performed in private hospitals. For all these procedures total 4023 crores were spent. Out of which 3159 crores (78.52%) were received by Private Hospitals while Government hospitals got barely 864 crores (21.48%).

RAS structure was created as a stand alone separate structure and is functining without adequate integration with existing public health system. Even, within the public hospitals- the RAS is implemented separately and not as an integral part of public

hospital. There are separate systems for RAS patients and other patients in the same government hospital (RAS system and non- RAS system). The hospital staff is getting more incentives for RAS patient care. To get maximum revenue for hospital and incentive to hospital staff, it is very natural for hospital management to focus on RAS procedures and patients. This is leading to neglect of other tertiary care services that are not included in the scheme. Non-Aarogyasri patients are questioning the discrimination towards them in government hospitals. The logic of per patient and per procedure incentive to public hospital staff under RAS can create distortions in the public health system. In the long run, it has the potential to weaken the public character of government hospitals and pave way for semi-privatization or even privatization of public hospitals.

There is no role for patients as a stakeholder. There are no patient's rights, no community oversight and no participative governance.

Financial sustainability of scheme is one major issue and AP Government is battling with it. It tried to cut down the expenses. Gradually, Arogyasri Health Care Trust has assumed more responsibilities and reduced role of insurance company. The trust decided to reserve commonly performed 133 procedures to public hospitals only in order to minimise their misuse in private network hospitals. Recently, Arogyasri Health Care Trust has taken over the rein of running the entire scheme on its own and shunted out insurance company from the scheme.

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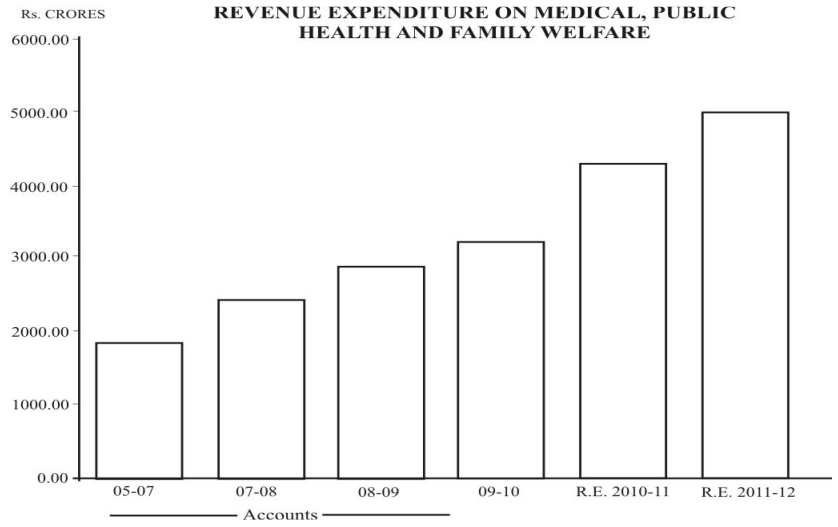
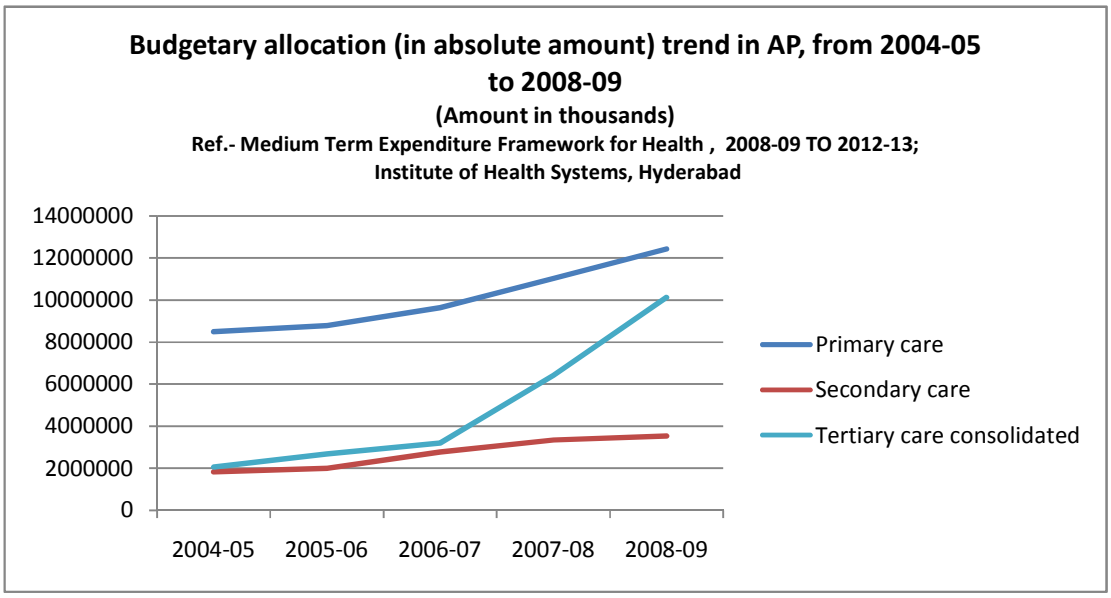
Critical analysis of the scheme

1) Diversion of funds for tertiary care while proportion of primary care expenditure falling down

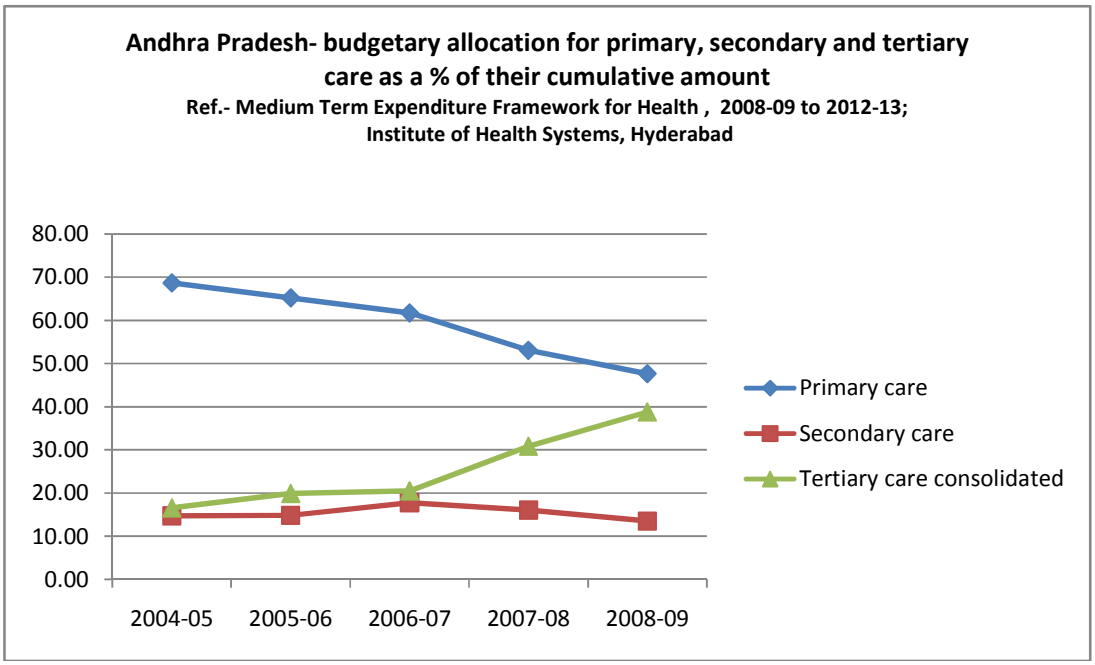
Andhra Pradesh state government's expenditure on healthcare has seen continuous increase in last six years(2006-2012), as shown in the following chart. Expenditure on RAS constitutes one of the major chunk in this increased expenditure.



The break-up of this expenditure(for period 2004-05 to 2008-09), as seen in the graph below shows that In terms of absolute amount, there is a sharp rise in tertiary care spending in year 2007-08 and 2008-09 (i.e. post RAS), compared to marginally increased expenditure on secondary care and primary care.



In terms of proportionate spending on primary, secondary and tertiary care, as shown in the following graph, proportionate spending on primary care has drastically reduced from 69% to 48% while spending on tertiary care has been increased from 16% to 39%. This is alarming sign and it raises several questions.



Contributions of Health Insurance and Tertiary Care Spending

(In percent)

State	Contribution of Social to Health Insurance (ESIS+CGHS)	Contribution of RSBY/State Scheme to Health Insurance	Health Insurance to health Expenditure	Tertiary Care to Health Expenditure	Tertiary Care + Health Insurance to Health Expenditure
Andhra Pradesh	16%	84%	37%	16%	53%

[2]

Above table shows that Andhra Pradesh as a state is spending more than half of entire healthcare expenditure on tertiary care through RAS, ESIS,CGHS, private health insurance etc.

This disproportionately increased thrust on tertiary care at the cost of primary and secondary care may lead to serious problems like over medicalisation, healthcare consumerism,healthcare inflation, finacial insustainability of the healthcare expenditure, weakening of primary health centres and collapse of secondary care system. This kind of system would have limited capacity to improve health outcomes and achieve health equity.

[2] Ref.- 'Critical Assessment of Health Insurance Models in India' by PHFI; figures were for the financial year 2009-2010

Health care systems contribute most to improving health and health equity where the institutions and services are organised around the principle of universal coverage and where the system as a whole is organised around Primary Health Care. [3]

This has been vindicated by experience of several countries. Several middle-income countries such as Chile, Brazil, Thailand have witnessed transition from the earlier hospital-centric thrust to primary care, on its way towards achieving universal coverage.[4]

2) Wider reach of the Scheme but exclusion of some really needy sections of the society -

One important and good aspect of the Aarogyasri Scheme is that about 85% of the population of the Andhra Pradesh is eligible to benefit from this scheme. By 2010, 22.4 million families were enrolled as beneficiaries. (Ref.-'Critical Assessment of Health Insurance Models in India' by PHFI) Andhra Pradesh Government has its own BPL assessment method and it does not follow the one prescribed by the Planning Commission. This is because the catastrophic healthcare expenditure affects not only poor but also people who are not 'poor' as per planning commission defined poverty line.

In the era when whole discourse on social welfare scheme is focused on narrow targeting, the commitment of the political leadership in Andhra Pradesh to extend the benefits of the Aarogyasri scheme to such wider sections of the society is a welcome sign.

However, as per the report 'A Rapid Evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme, Andhra Pradesh (2009)' by Indian Institute of Public Health (Hyderabad)-

'The evaluation revealed that the scheme may exclude marginalised communities and the destitute such as street dwellers and migrant labourers with no residential address who were not even eligible for inclusion in the BPL population'.

3) Services are defined in terms of procedures and therapies rather than disease conditions

The scheme is mainly procedure and therapy oriented. Services are defined in terms of procedures and therapies rather than disease conditions. Network hospital under RAS gets money for the procedures performed and it does not have any relationship with rational treatment option for f the disease . Hospitals will get money for the procedures performed irrespective of whether or not the procedure was the best option from the point of view of rational treatment.

[3] Ref-Commission on Social Determinants of Health, 2008

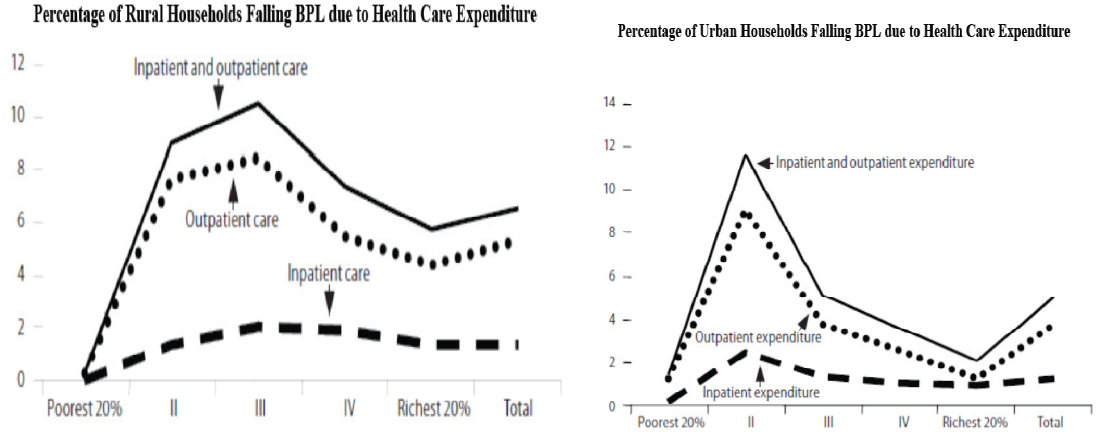
[4] Ref- WHR, WHO 2008

In RAS, there are no standard treatment protocols according to diseases but there are protocols for procedures. There is ample of scope for the healthcare providers to resort to unnecessary technological interventions to maximise their profit margins without giving any consideration for improving healthcare effectiveness. There is no incentive to take into consideration efficiency of simple, primary or conservative approaches. Thus, RAS is based upon techno-centric model of healthcare.

E.g. A hospital would not get reimbursement from the govt. for treating a case of Ischaemic Heart Disease with medicines alone, or for treating a case of spinal problem with non-surgical measures. However there is reimbursement to treat such conditions with surgery. Thus there is incentive to use procedures even when not necessary.

4) Failure to significantly lower catastrophic expenditure for BPL families

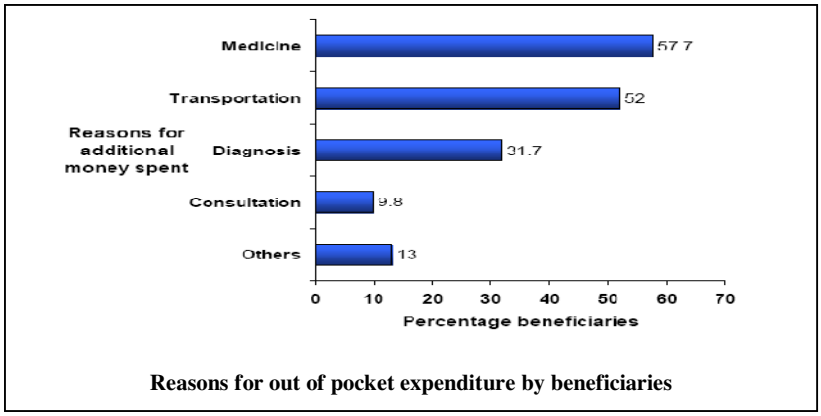
RAS aims to reduce catastrophic out-of-pocket healthcare expenditure for BPL families in Andhra Pradesh. However, package covers only some high cost, low frequency procedures and therapies. It means people have to spend significant amount on OPD care medicines and hospitalisation on conditions other than the procedures covered in RAS.. It is the low cost but high frequency out-patient care constitutes major chunk of the out-of-pocket expenditure and is a major reason for households falling below poverty line due to healthcare expenditure(See diagrams below). In both in-patient and out-patient healthcare expenditure, significant amount is spent on purchasing medicines.



(Source: Peter Berman, Rajeev Ahuja, Laveesh Bhandari, The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings, Economic & Political Weekly, April 17, 2010 vol xlv no 16, p. 67)

RAS does not cover all kinds of hospitalisations(but very few), OPD care(except screening in health camps and network hospitals) and cost of medicines (except conditions covered under RAS). To eliminate all catastrophic healthcare expenditure for BPL families, the service package of RAS should be much more broad based and in tandem with the epidemiological profile; along with the strengthening of service delivery in all levels of public healthcare system and provision of affordable medicines.

Even Aarogyasri beneficieries have to spend some amount out-of-pocket largely due to implementation loop-holes like non-adherence to MoU by network hospitals. Study conducted by Indian Institute of Public Health(Hyderabad) in year 2008-2009 revealed that nearly 58.5% of beneficiaries spent additional money before, during or after the treatment at network hospitals. The median amount of money spent was Rs. 3600. Medicine, diagnostic tests and transport were the main reasons for out of pocket expenditures by the beneficiaries.(See diagram below)



Reasons for out of pocket expenditure by beneficiaries

There were some media reports coroborative to this finding. These reports revealed that the official investigating agency had found that instead of providing cashless treatment to the poor, many network hospitals in some district were collecting consultation and diagnosis fee, besides admission charges in clear violation of the MoU entered into with Aarogyasri Trust. In some instances, patients who went for follow-up examination were charged consultation fee and made to buy medicines. The patients were also not provided free of cost the required medicines and post-operative treatment. For instance, one hospital in Karimnagar town made the patients to undergo ultrasonography tests at a specified scanning centre and buy the medicines in cases relating to appendix surgery, casting a financial burden up to Rs.4,000 in one incident.[5]

5) Draining public resources to Insurance Company- risk free insurance, high administrative cost and no incentive for cost containment

AP Government selected The Star health and Allied Insurance Company, a private for profit organisation, through an open bidding process. Under Aarogyasri I, network hospitals both public and private signed the MOU with the insurance company and as per MoU, this insurance company is a risk bearer. Under Aarogyasri II, the network hospitals signed the MOUs directly with the Trust. However, the insurance company is only a third party administrator for Aarogyasri II. Aarogyasri-I is typically a high-cost, low frequency scheme, whereas Aarogyasri II covers relatively higher frequency conditions.[6]

[5] The Hindu, Hyderabad, 4th November 20009

[6] Ref.- 'A Rapid Evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme- Andhra Pradesh Report (2009)' by Indian Institute of Public Health

a) Risk free insurance –

Though the agreements between the Aarogyasri Health Care Trust and Star Health Insurance Co and all AHCT documents mention that the insurance company will bear the entitre risk, if one looks into details of the agreement then it becomes clear that actually the entire risk of the scheme is borne by the Rajiv Aarogyasri Trust and not by the insurance company.

This scheme is operationalised by the insurance company under the guidance and supervision by the trust. All important decisions are taken by the trust. Insurance company just enrolls the hospitals, enters into MoUs with them(that too for RAS-Phase I) and place arogyamitras. Content of the package and rate of the packaged services are fixed by the trust. Pre-authorization is a joint task of the trust and insurance company.

Table- Role and responsibilities of various stakeholders in RAS[7]

	Aarogyasri Trust	Insurer	Network Hospitals	Aarogya Mithras
Over-sight of scheme	Y	-	-	-
Financing scheme	Y	-	-	-
Setting parameters(benefit package, empanelment criteria etc)	Y	Y	-	-
Hardware specifications (systems, cards etc)	Y	Y	-	-
Contract management with insurer	Y	-	-	-
Accreditation or Empanelment of providers	Y	Y	-	-
Enrollment	-	Y	Y	Y
Financial management/planning	Y	-	-	-
Acturial analysis	Y	Y	-	-
Setting rate schedules for services/ reimbursement rates	Y	-	-	-
Claim processing and payment	Y	Y	-	-
Outreach and marketing to beneficiaries	-	Y	Y	Y
Service delivery	-	-	Y	-
Developing clinical information system for monitoring/evaluation	Y	Y	-	-
Monitoring utilization and other patient information	Y	Y	-	-
Customer service	Y	Y	-	Y

[7] http://www.resultsfordevelopment.org/sites/resultsfordevelopment.org/files/RSBY%20Case%20Study.pdf

It is evident from the table given above, the insurance company is more of co-implemeter of the scheme along with the AHCT. Contrary to the MoU with insurance company, information got from note files on Aarogyasri- it is evident that the AP government decided to involve the insurance company for the following reasons-

1. The Aarogyasri Trust was a nascent organisation and it needed to establish itself in the field of insurance.
2. Trust did not have necessary mechanism and manpower with expertise in the field of health insurance.
3. It was considered safe to go through the professional service providers like insurance company in the initial stages of such a huge venture, till necessary expertise is acquired.

Kindly note that, in these rationales, there was no mention of risk bearing.

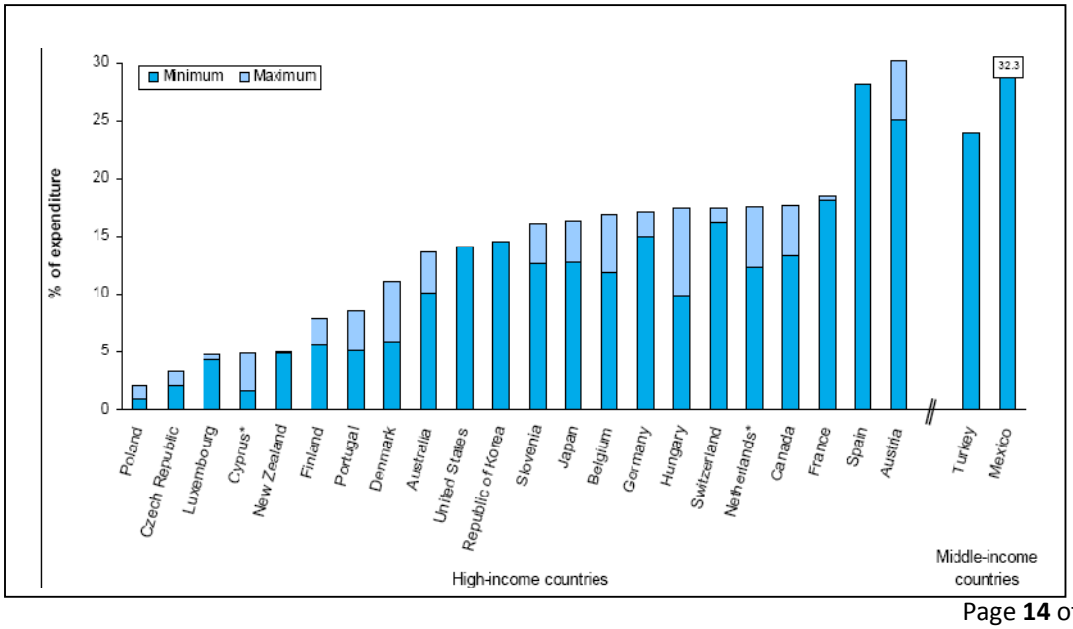
The Insurance agency has assured profit as claims payment have been capped at 150% by agreement, after this Aarogyasri trust pays the difference. So, where is risk bearing?

Expenditure never crossed the premium amount in not a single year since the inception of the scheme. On the contrary, if claims amount is unspent, insurance agency keeps 10% of unspent amount and returns the rest.

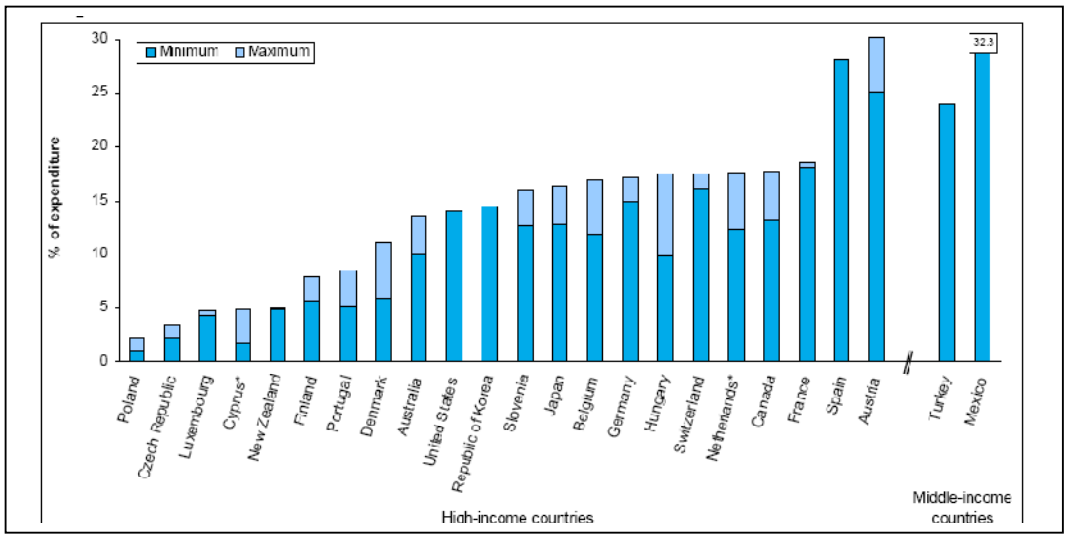
b) High administrative cost

Administration cost of any health insurance scheme involves resource mobilisation, pooling and transferring resources, purchasing the service from healthcare providers and overall management with stewardship. The administrative efficiency of the scheme is understood as the ratio of administrative costs of insurance administrative activities over their outputs and wider benefits.In OECD & EU countries, for Social Security Schemes, the average administrative costs was 4.7% of scheme expenditure, over years 2000-2007; with a minimum of 1.4% (Poland) and a maximum of 16.9% (Mexico).(See chart below)

Public insurance administrative costs over 1999-2007 in OECD & EU countries



Private insurance administrative costs over 1999-2007 in OECD & EU countries



(Source.- Administrative costs of health insurance schemes: Exploring the reasons for their variability by Emmanuelle Nicolle and Inke Mathauer; WHO,2010)

Bennett et. al (1998) in a WHO study of 82 different health insurance schemes reported that the administrative costs ranged from 5 to 17% including the premium collection cost. Premium collection is quite a tedious task and major contributor for upscaling of the administrative cost. Under RAS the government ofAndhra Pradesh is paying premiums on behalf of the BPL families, so there is no cost attached to premium collection as part of the administration cost. Administration cost charged by Star Health and Allied Insurance Company was initially 20% of entire premium amount. Later on, it was increased to 30%. By international comparison, it is a high administrative cost.

c) No incentive for cost containment-

In RAS design, there is no incentive for insurance company to monitor inefficiencies, wastage, inflation of the system or reduce supply side moral hazard. On one hand company gets administrative cost as a % of the entire premium amount while on the other hand it has been successful in capping the claim payment amount by agreement with the AHCT. Thus, there is no incentive for the company to reduce the overall cost. Similarly, there there is no incentive for network hospitals, too, reduce the expenditure. Network hospitals have lobbied time and again in last five years of RAS implementation to increase the package rates. This hike in package rates have no effect on the insurance company as it simply passes on the burden to the AHCT while renewing the contacts.

6) Unequal competition between private corporate hospitals and public hospitals for the RAS fund kitty – advantage to private hospitals while public hospitals are struggling to attract patients

The private sector has been playing a dominant role in the delivery of health services in Andhra Pradesh. It accounted for over 72 percent of inpatient admissions and over 85

percent of outpatient contacts – both significantly above national averages, before launching of RAS. This already dominating position favoured the private hospitals while competing with the weaker public health sector for the same kitty of resources in RAS.

Table provided below shows that the private hospitals provide large share of services and getting benefited for the same. Since the inception of the scheme till 30th May 2012, in total 14, 70,571 surgeries were performed out of which 3,46,118 (23.54%) were performed in government hospitals while 11,24,453(76.46%) were performed in private hospitals. For all these procedures total 4023 crores were spent. Out of which 3159 crores (78.52%) were received by Private Hospitals while Government hospitals got barely 864 crores (21.48%).

	Government Hospitals	**Private Hospitals**	**Total**
Surgeries/Therapies till 30th May 2012	346118 **(23.54%)**	1124453**(76.46%)**	1470571
Amount Preauthorized in Crores till 30th May 2012	864 **(21.48%)**	3159 **(78.52%)**	4023

(Source- Aarogyasri website)

In this open competition between resources starved public health system and 'fit-n-fine' private corporate hospitals, obviously government hospitals are lagging behind. There is no earmarked funding for strengthening of public hospitals. Since public hospitals do not have enough resources, equipments and specialists, they are not able to attract Aarogyasri patients. Less number of Aarogyasri patient means there will be less financial resources for development of the hospital which again means there will be less number of Aarogyasri patients. Thus, the vicious cycle continues.

Many government hospitals have shown apathy towards taking up RAS patients. Government hospitals cited non-availability of specialists and equipment as the reason for not providing proper treatment. Even attempts to provide targets (in terms of number procedures under RAS) to public hospitals did not give good results.

'For various reasons especially due to lack of interest, government sector hospitals are not taking up Arogyasri cases in Warangal. In four years, both Jangaon Area Hospital and Mahbubabad Area Hospital, which are the major government hospitals in Jangaon and Mahbubabad revenue divisions have collectively performed only five Arogyasri operations. As per latest data released by Rajiv Arogyasri Health Scheme, Warangal, during March 2010 to March 2011, these two hospitals have not performed a single operation under Arogyasri scheme. Collectively, barring MGM hospital (the largest government sector hospital under Arogyasri in Warangal), all the four government sector hospitals had performed `97 lakh worth of operations on Arogyasri patients during March-2007 to March-2011. These include Jangaon Area hospital (`30,000), Mahbubabad Area Hospital (`88,000), CKM hospital (Rs 82,10,000) and Government Maternity hospital, Hanamkonda (Rs 13,85,000). In contrast, thanks largely to part-time service by Kakatiya Medical College (KMC) teaching staff, during

the four years of the existence of Arogyasri scheme in Warangal, 12 private sector Arogyasri empanelled hospitals crossed the Rs 3crore mark each."[8]*.....*

In Andhra Pradesh, there three categories of Government Hospitals and their performance in RAS can be analysed from the following table.

Hospital Type	**Surgeries/ Therapies till 29-07-2011**	**%**	**Preauthorized Amount (Rs Crs) till 29-07-2011**	**%**
Corporate Hospitals	807552	79.03	2328.08	80.61
Govt .Institutions (NIMS, SVIMS & M.N.J)	73978	7.24	196.29	6.80
Govt. APVVP Hospitals	9990	0.98	26.35	0.91
Govt. DME Hospitals	130366	12.76	337.50	11.69
Total	**1115834**	**100.00**	**3128.04**	**100.00**

(Source- Presentation by N Shrikanth, CEO- AHCT and Aarogyasri website)

1) The district and area hospitals providing secondary care are managed by Andhra Pradesh Vaidya Vidhan Parishad(APVVP). The majority of the network hospitals under APVVP are facing shortage of infrastructure, resources and specialists. As a result most are providing very few services under the RAS scheme.They are the weakest link of government hospitals under RAS.
2) Teaching hospitals under Department of Medical Education(DME) are contributing significantly in the RAS. They have quite adequate resources and specialists to attract RAS patients. However, they are also facing problems regarding billing, claim processing and technical issues including standard treatment protocols.
3) Govt Medical Institutions like NIMS, SVIMS, MNJ Hospital are reputed institutions and are able to compete with corporate hospitals.

7) Weak regulation of the scheme leading to misuse of the scheme by private network hospitals : Unnecessary hysterectomies as an example

Existence of inadequate monitoring mechanisms to block operational loopholes (in case management), no adequate cross verification, over reliance on data from service providers lead to many instances where network hospitals misused the scheme in clear violation of MoU with the AHCT. Some examples of misuse by network hospitals[9]-

- collecting fees and performing unwanted operations
- collecting consultation, admission fee and not providing follow-up medicines free of cost
- not admitting serious poly-trauma cases and referring them to government hospitals
- conducting hysterectomy operations against norms

[8] Deccan Chronicle, 10 April,2011

[9] source- various media reports

- In one instance, one hospital in Karimnagar town made the patients to undergo ultra-sonography tests at a specified scanning centre and buy the medicines in cases relating to appendix surgery, casting a financial burden up to Rs.4, 000.
- In another case, one hospital collected a huge deposit amount and did not reimburse it to the patient and yet collected the bill from RAS.

a) Unnecessary hysterectomies- scheme induced procedures??

Many media reports have highlighted the instances of unnecessary hysterectomies performed by the network hospitals under RAS. This is a serious ethical issue. Some media reports were like these-

- *'The probe revealed that a hospital in Hanamkonda conducted five per cent of the hysterectomy operations without first trying medical treatment. Similarly, 68 per cent of the patients who underwent hysterectomy operations in three hospitals in Guntur district were between 21 and 40 years. Generally the procedure would not be performed in women below 40 years unless there is a specific indication requiring the procedure.'*
- *'Some doctors and hospitals were exploiting gullible village women by instilling fear among them that they would die unless uterus was removed.'*
- *'An inquiry has been ordered by the government against six empanelled hospitals of Arogyasri scheme in the State for allegedly performing hysterectomy (uterus removal) on women aged below 30, thus depriving them of the chances to bear children. These hospitals have been removed from the empanelled list of Arogyasri Health Care Trust forthwith and blacklisted.'*

These instances reveal ongoing misuse and grave side effects of the scheme. Though the government has taken action in above-mentioned cases, there are chances of many more such cases which might had gone unnoticed.

There is need for strong regulatory framework for implementation of such kind of schemes. There is also question about how these unwanted hysterectomies got pre-authorization? There must be some loopholes in pre- authorization process. Over reliance on hospital provided data without adequate cross- verification is one possible loophole. Many a times, clinical audit is performed on some number of random hospitals but this is a post facto exercise. There is no other real time cross verification mechanism than hospital provided online data that could be manipulated in certain ways. There is no gate keeping mechanism.

In July 2011, AHCT took a decision to reserve all kind of hysterectomies to public hospitals as a response to large number of unnecessary hysterectomies performed by private hospitals. According to then CEO of the trust- N. Shrikanth, the ratio of allocation of *budget* to Government Hospitals and Private Hospitals was 13:87 in year 2010. However, the Trust had mandated in July 2011 that some 133 procedures such as appendicitis, hysterectomy should be attended by public hospitals only. Within a few months, the budget ratio improved to 27:73.[10]

[10] Business Line, The Hindu- 28th Sept 2011

b) Aarogyasri Trust started cracking whip: De-listing of network hospitals

Till 15th May 2012, 9 hospitals were de-empanelled while 101 hospitals were delisted from the scheme by the trust. Some of the common reasons for delisting were–

- defaulting to conduct health camps
- no response to show cause notice issued by the trust
- infrastructure gap
- unavailability of necessary equipments
- inadequate skilled manpower and unqualified doctors
- not updating information as per the scheme
- non-cooperation with the field staff of trust and insurance company
- submitting false and duplicate documents to get false pre-authorisation
- complacency in managing the cases
- referring patients to imaging centres or path-labs which are not empanelled in the scheme

c) Inadequate cost containment mechanisms and regulatory framework-

In RAS, there are some mechanisms for cost-containment like- pre-authorisation, MIS monitoring, package rates, surveillance and medical vigilance teams, arogyamithras in network hospitals.

Pre-authorisation- In RAS, every procedure and therapy has to be authorized beforehand by appropriate authorities at respective levels. The pre-authorization is scrutinized at four levels before being approved with definite timeliness.

- Scrutiny by Aarogyamithra in the hospital before submission.
- Scrutiny of socio-economic parameters and availability of required attachments by pre-auth executive.
- Scrutiny by Insurance doctor/Panel doctor (a specialist) with regard to diagnostic evidence, other clinical parameters and appropriateness of treatment and package.
- Scrutiny by Trust doctors for final approval.

However, study conducted by Indian Institute of Public Health mentions that there is a suggestion that some Aarogyamitras are acting as agents for certain private network hospitals and get benefits for referring patients to them. There is a perception that some of the Aarogyamitras are promoting the interest of the private hospitals rather than those of the patients.

Now, let us look at the number of pre-authorisations in one day[11] -

Last 24 hours- 19/4/2012	Pre-authorisation count	Pre-authorisation cost
All Hospitals	1627	44222700
Government Hospitals	568	13532400
Private Hospitals	1059	30690300

[11] Source- Aarogyasri website- Dash board real time data

There were 1627 pre-authorisations in 24 hours which means almost 68 pre-autharisations every hour- i.e. more than one per minute!

How many doctors are involved in pre-authorisation procedure? As per one report, implementing agency has total number of 117 personnel but staff information in AHCT website shows that there are only 19 persons in Preauthorization, Claims & Follow Up department of Operations Wing. There is a need to look in detail in this aspect to rule out the compromise on scrutiny of information under sheer load of number of pre-authorisation. This is important because the claim ratio in RAS is pretty high – 89%.

Out-sourcing the pre-authorisation??- In 2011, AHCT outsourced some key functions to private company MD-India for Rs.1.67 crore. It is supposed to provide manpower to attend to the claims, pre-authorisation, MIS, co-ordination for the patients seeking treatment for procedures listed under the Trust.[12]

Reliance on multi-stakeholders (AHCT, Star Health, MD India, network hospitals and arogyamithras) for pre-authorisation and cost-containment may not give any fruitful results.

Surveillance and vigilance teams- There are surveillance and vigilance teams for cross-verification and clinical audits. But, there is hardly any information available on working of this unit. Though the trust has de-listed 110 hospitals for various reasons, majority of them were concerned with inadequate infrastructure. There is need to shift focus on actual case management, quality of care etc.

Over-reliance on MIS monitoring- There is visible tendency in the functioning of AHCT to rely on the electronic-data provided by the network hospitals. To check misuse of the scheme, it should be complemented by robust regulatory framework with actual cross-verifications.

Lack of standard treatment protocol- In the design of RAS, there are no Standard Treatment Protocols. Study conducted by Indian Institute of Public Health clearly recommends immediate formation and use of Standard Treatment Protocols (STPs). In the absence of STPs and their implementation, the design of RAS incentivises network hospitals to perform unnecessary procedures and therapies, which in turn lead to cost escalation.

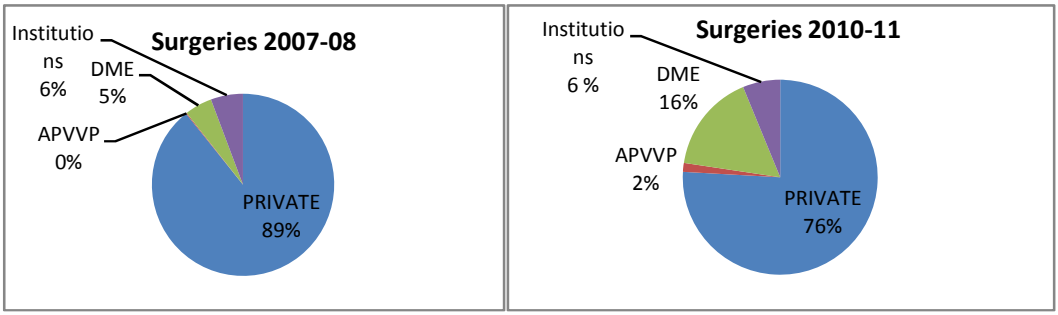
Weak regulatory framework- There are numerous instances where network hospitals clearly violated MoU with the AHCT, did not provide follow-up care or medicines or investigations at free cost as per the scheme. The average out-of-pocket expenditure by RAS beneficiary is Rs.3600/-. This implies that there are still loopholes in the implementation framework of the scheme leading to OOP for BPL families even at network hospitals. There has to be an appropriate regulatory framework to take care of all these issues. There has to be a monitoring mechanism in network hospitals to ensure free outpatient services.

[12] The Hindu, Hyderabad, July 18-2011

Accountability gap- Despite of such a huge increase in public spending for privately provided care, there is no increase in quality of accountability of private providers. There is no participation of patients in decision making process. There is no role for patients as a stakeholder. There are no patient's rights, no community oversight and no participative governance. There is no mechanism for protection of patient's rights. Patients have no say in the implementation of the scheme. They are just beneficiaries.

8) Distortions in public health system- Formation of a dual system in Government Hospitals under RAS

As shown in the diagrams below, Government Hospitals participation in RAS has increased from 11% to 24% during 2007-08 to 2010-2011.



(Source- Aarogyasri HI- The AP Experience by Dr Rajan Shukla and Dr Veena Shatrugna)

This increased revenue in public hospitals was partially used to develop hospital infrastructure and partially distributed as incentive for hospital staff on per RAS patient/procedure basis. This performance based incentive for RAS implementation has lead to distortion in public hospital system.

The AP governmet as per government memo. No.8350/K2/2009, dated 25.06.2009, set up a four member professional team to recommend the norms and guidelines for uniform billing of Aarogyasri cases and apportionment of Aarogyasri funds towards incentives to the concerned. As per recommendations of this team, the Aarogyasri funds for Government Hospitals under the control of Director of Medical Education and A.P.Vaidya Vidhana Parishad would be spent as follows[13]-

- 20% of the package amount is deducted at source by the Aarogyasri Health Care Trust for common revolving fund (except in the case of packages relating to Double-valve replacement, Cochlear Implantation, Hemodialysis and Kidney Transplantation)

[13] Source- Health, Medical and Family Welfare Department, G.O. Rt. No. 134,Dated: 1st February, 2010

- Out of the balance 80%, 45% is earmarked for expenditure related to patient care and the rest of 35% shall be utilized for payment of incentives to the staff responsible to provide service to the beneficiaries under the scheme.
- 45% shall be spent on purchase of consumables, disposables, implants, medicines, blood and blood products etc. for the care of the Aarogyasri patients involved (other than those available in hospital under regular budget), cost of data entry operators for RAS, transportation charges for RAS patients, special diet etc.
- The Superintendent of the hospital and other administrative staff of the hospital involved in the implementation of scheme will be paid an incentive for their indirect involvement in patient care. 1% of the balance after meeting the expenditure for Aarogyasri patient care will be paid to the Superintendent and 1% to the administrative staff of the hospital.
- The balance (45%- expenditure- incentive) after meeting the above expenditure is deposited into the hospital account for the development of hospital infrastructure and facilities as suggested in earlier circulars of DME.
- The 35% incentive amount shall be apportioned among the Surgical/ Medical,Investigative, Nursing and Class IV staff, who were actually involved in care giving, as per the following ratio:
- Surgical/ Medical Team … 75%
- Investigative … 10%
- Nursing Staff … 10%
- Class IV … 5%
- The 75% share of the Professional Team managing the patient shall be apportioned as follows:
- In Surgical cases- 50% to surgical team of doctors and 25% to Anesthetist team of doctors
- In Medical cases- Entire 75% to the team – (In case where Anesthetist services are utilized up to 25% to be provided to Anesthetist)
- Further distribution among the above Surgical and Medical teams shall be on the following ratio for teaching/ APVVP hospitals.
- Professors /CSS … 35%
- Associate Professors/ Dy.CS … 30%
- Assistant Professor/ CAS … 25%
- Residents (Sr./Jr.) … 9%
- RAMCO … 1%

There are provisions of separate wards for Aarogyasri patients. Hospitals are supposed to maintain separate indenting system, separate inventory and stock register for purchase of medicines, equipment, instruments, implants etc procured from Aarogyasri funds. For that matter, hospitals are supposed to have a separate account. The medicines, equipment, furniture, computers etc. procured under Aarogyasri funds shall be utilized only for the Aarogyasri programme in the concerned department.

From above, it becomes clear that- there is different provisioning and human resource allocation towards RAS implementation in government hospitals. This bias towards RAS is leading to formation of dual system within public health system. There are separate systems for RAS patients and other patients in the same government hospital (RAS system

and non- RAS system). The hospital staff is getting more incentives for RAS patient care. To get maximum revenue for hospital and incentive to hospital staff, it is very natural for hospital management to focus on RAS procedures and patients. This is leading to neglect of other tertiary care services that are not included in the scheme. Non-Aarogyasri patients are questioning the discrimination meted out to them in government hospitals.[14]

RAS framework implies a system of competition between public and private hospitals for the same kitty. There are instances where some government hospitals have earned substantial revenues through better performance and improved inftrastructure. However, competition for more revenue may lead towards increase in irrational and unnecessary surgeries etc in government hospitals, if proper vigilance is not kept. The logic of per patient and per procedure incentive can create distortions in the public health system. In the long run, it has the potential to weaken the public character of government hospitals and pave way for semi-privatization or even privatization of public hospitals.

9) Lobby of private hospitals- a challenge for the AHCT

Of the 340 Aarogyasri empanelled hospitals in the state, 38 are super specialty hospitals affiliated to 'AP Specialty Hospitals Association' (ASHA), 220 hospitals affiliated to 'AP Nursing Homes Association' (APNA) and the remaining 80 are public sector hospitals. Time and again, they had flexed their muscles to increase package rates. Let us see one example of it- how these associations formed their special interest lobbies and held the entire scheme for ransom.[15]

In July 2011, AHCT reserved 133 procedures to only public hospitals from 10 districts (phase IV and V). These procedures include-

- common general surgery procedures like- appendicectomy, hernia, gall bladder surgery (cholecystectomy) , thyroidectomy, splenectomy, gastrectomy, gastro-jejunostomy, other common gastro-intestinal surgeries
- other common procedures like- hysterectomy, laminectomy, cleft palate, cleft lip
- genito-urinary surgeries, kidney- and pancreas-related ailments
- all laparoscopies

Procedures that would be reserved for government hospitals were identified by a committee, formed by AHCT, for better administration and strengthening of government hospitals. These identified procedures were those where there was scope for misuse or supply side moral hazard and the rationale was that if thse procedures entrusted to government hospitals, their misuse would not occur.

The payout on account of these procedures amount to about 20 per cent of the total expenditure on Aarogyasri. Thus, according to the estimates of one official (as appeared in a newspaper)- about Rs 190 crore of business will now go entirely to government hospitals. This move would significantly damage revenues of many relatively small (or B grade)

[14] TOI, Hyderabad- 10th August 2010

[15] Source- various media reports

hospitals that were set up post -RAS and those were mainly dependent on these procedures covered under RAS.

This decision was not likely to damage revenues of big corporate hospitals but; small hospitals and nursing homes, which depended upon general surgeries, pediatric surgeries, orthopedic surgeries, genitor-urinary surgeries, laparoscopies and gynaecological procedures as their main source of income could be badly affected.

As immediate reaction to this decision, the AP chapter of the Indian Medical Association (IMA) and Andhra Pradesh Nursing Homes Association (APNA) had declared that private nursing homes in 10 districts would no longer admit Aarogyasri patients needing any treatment and went on to protest. They boycotted on RAS and refused to see any patients under RAS. They demanded increase in package rates. AP Specialty Hospitals Association (ASHA), which uphold the interests of 38 super-speciality hospitals, also demanded hike in package rates but, notably, did not participate in the boycott.

Government initially took tough stand but later on gave in and agreed to review the package rates in next round of MoUs and requested the IMA and APNA to call off the protest.
This kind of lobbying is a serious challenge for the AHCT and if unchecked, the package rates would keep going to north in coming years.

10) Stand alone RAS system and AHCT ; no integration with the health system

The claim by the AHCT that RAS will act as a complementary scheme to existing public health services has not been fulfilled. Instead it is drawing more political-administrative-financial- social support towards this PPP model to such an extent that RAS has become 'something like core ' while public health system remained on the periphery especially PHCs, CHCs and area hospitals. At one point of time, RAS had a separate 'Minister for Aarogyasri' and public health system had 'Health Minister'. RAS is implemented by AHCT which has a CEO and functions under the direct supervision of the Chief Minister.

RAS structure was created as a separate structure. Arogyamitras which are health workers function independent of the public health system and have no answerability to public health system. They are answerable to insurance company. Even, within the government hospitals- the RAS is implemented separately and not as an integral part of public hospital. Thus the scheme is functioning vertically irrespective of existing public health system.

Then Minister for Medical and Health D.L.Ravindra Reddy gave way to his frustration while talking to the media. He said, "Health department does not mean just 108, 104 or Aarogyasri. In fact, Aarogyasri supports only 1 percent of the state's 8.5-crore population. And, 104 service is not a Sanjeevani….Unfortunately, Primary Health Centres have been neglected.''[16]

[16] Express News Service, 31 May 2011

The idea of preventive and promotive care, primary care has been pushed behind. The kind of buzz created around Rajiv Aarogyasri Scheme, huge amount spent on the scheme, political and administrative support to this scheme along with the massive propaganda had been successful in pushing the narrow, bio-medical and techno-centric view of healthcare (as envisioned in RAS) at front stage. From the point of view of obtaining optimum health outcomes from any healthcare delivery system, RAS kind of tertiary care schemes under PPP should be integrated with primary, secondary and tertiary care given through the public health system.

Health camps- *A camp is proved as an effective medium to generate awareness about RAS. However, network hospitals are reluctant to conduct camps. Patients are being referred to the RAS through a number of routes of which attendance at the camp is only one channel. Consequently, hospitals perceive camps are waste of time and money. There is declining interest among specialists in attending the camps. The camps are not sufficiently equipped to undertake preliminary diagnostic tests. There is no standard list of diagnostic procedures and facilities for the camp. It is overall difficult to inform the public of the specific nature (e.g. super specialties) of camps. All camps should cater for all conditions. Health Camps are unsustainable and it would be best if preliminary diagnosis can be offered through improved PHCs. In some hard to reach areas health camps can be of immense value if planned and implemented according to local needs and sensitivities.*[17]

11) Financial un-sustainability of the scheme-

"Healthcare and administrative costs have gone up in recent years, and it would be difficult to sustain the scheme with the budget", Srikanth, CEO of the Rajiv Aarogyasri Trust said. He further said that, "the state government has proposals to rope in the Administrative Staff College of India or the Public Health Foundation of India to do the feasible study and come up with a sustainable report to reduce costs."[18]

All three Chief Ministers of Andhra Pradesh (after introduction of RAS) viz. YSR Raj Shekhar Reddy, K Rosaiah and N Kiran Kumar Reddy made requests to Central Government and Union Health Minister to share the burden of the scheme. Centre refused it on the recommendation of Planning Commission. Apparently and interestingly, PC refused to support RAS by citing that 'such schemes are nothing but cash cow for corporate hospitals'[19]. It is little paradoxical since PC Deputy Chairman is openly in favour of some form of health insurance model for UHC / essential health package in India. From this, it could be concluded that even supporters of private health insurance model for UHC in Planning Commission are skeptical about fiscal prudence of RAS model.

17 Ref.-'A Rapid Evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme- Andhra Pradesh Report (2009)' by Indian Institute of Public Health
18 Business Standard Reporter / Hyderabad Oct 03, 2011
19 Times of India, Hyderabad, Jul 11-2011

a) Taking up the prices rather than dictating the prices by the trust lead to higher package rates-

A Rapid Evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme-Andhra Pradesh Report (2009) by Indian Institute of Public Health (Hyderabad) states that-

'In RAS, the maximum package rates for individual procedures have been fixed based on average fee for service rates in a few network hospitals. The insurer and the trust have not yet used their strategic position to negotiate value for money. The claims are settled based on fee for service guided by the defined maximum package rates. This payment mechanism may promote over utilisation of diagnostic investigations and other hospital services as is shown to be the case in similar health systems elsewhere.'

Variation in Package Rates for Similar Procedures, 2009-10 (in Rs.)

Procedures	CGHS & ESIS	Rajiv Aarogyasri Scheme (AP)	Kalaignar (TN)	Yeshasvini (KN)	Vajapayee Arogyasri Scheme (KN)	RSBY
Coronary bypass surgery	130,000	95,000	90,000	60,000	95,000	Up to 30,000
Coronary Angioplasty	85,000	60,000	60,000	25,000	60,000	
Transurethral Resection on prostate	16,200	30,000	25,000	12,000	20,000	14,250
Nephrolithotomy	14,100	10,000	25,000	14,000	10,000	10,000
Nepherectomy	NA	40,000	40,000	14,000	10,000	10,000
Appendectomy	12,000	18,000	NA	9,000	NA	6,000
Cholecystectomy	10,200	20,000	25,000	9,000	NA	10,000
Hysterectomy	13,000	20,000	25,000	6,000	NA	10,000
Tympanoplasty	7,050	15,000	NA	3,500	NA	7,000
Normal Delivery	6,500	NA	NA	NA	NA	2,500

NA: Not Applicable, Service Not Covered; Source: Scheme documents and websites of various schemes
(Ref.- 'Critical Assessment of Health Insurance Models in India' by PHFI)

Package rates between CGHS and Rajiv Aarogyasri appear to be much higher than other schemes. Substantial variation in inter-schemes can be explained by the negotiating power of states /schemes.

There is a need for the AHCT to dictate prices rather than take them.

b) Wide variation in claims paid under the RAS

As per 'A Rapid Evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme-Andhra Pradesh Report (2009)' by Indian Institute of Public Health- *there is wide variation in claims paid for some treatment packages and individual medical and surgical procedures conducted under the RAS. Following figure shows the variations in claims paid for a sample of procedures*.

This wide variation in claims paid for same procedure denotes that there is urgent need for standardisation of care including finances in RAS.

c) Finding ways for cost-containment-

The AP government is finding it difficult to sustain the RAS despite of surplus budget and desperately trying to cut down the expenses by different ways. On 14th August 2011, the Chief Minister Mr. N.Kiran Kumar Reddy made important policy announcement that the AP government would bring back about 40 per cent operations under 'Aarogyasri' to the government hospitals by providing them modern infrastructure and facilities on par with corporate hospitals in next 3-4 years[20]. Currently barely 23% procedures are performed in government hospitals.

Aarogyasri Health Care Trust is working hard on cost curtailments and series of steps have been taken in that direction. Some of those are as follows-

1. Fine-tuning of treatment packages to check misuse of the scheme
2. Attempts for tighter control on "case management" at hospitals
3. Checking out unnecessary pre-authorizations
4. Re-survey of Aarogyasri cards had been carried out to weed out fake cards
5. Initially, Star Health and Allied Insurance Company was handling 352 procedures (at a premium of Rs. 330/ per family per year) while trust was handling 586 procedures. In 2011, trust started handling 746 procedures while Star Health's role was restricted to 192 procedures (at a premium of Rs. 279/ per family per year) out of total 938 procedures. Thus, Government tried to cut down the expenses and trust assumed more responsibilities. However, private hospitals were apprehensive of this move, as they feared delay in releasing the payment by the trust vis-à-vis the insurance company.
6. Trust reserved 133 procedures to public hospitals that include common procedures like hysterectomies, appendectomy, hernia, gall bladder operations, kidney- and pancreas-related ailments and all laparoscopies. The payout on account of these procedures amount to about 20 per cent of the total expenditure on Aarogyasri. Thus, about Rs 190 crore of business will now go entirely to government hospitals in stepwise manner.

According to then CEO of the trust- N. Shrikanth, the ratio of allocation of budget to Government Hospitals and Private Hospitals was 13:87 in year 2010. However, the Trust had mandated in July 2011 that some 133 procedures such as appendicitis should be attended to by public hospitals. Within a few months, the ratio improved to 27:73.[21]

Recently, AHCT has eliminated the Star Health and Allied Insurance Company from implementation of Aarogyasri scheme to reduce the cost. AHCT has taken over the rein of running the entire scheme on its own.[22]

[20] Ref.-The Siasat Daily, Hyderabad, 14 August 2011

[21] The Hindu, Business Line, 28th Sept 2011

[22] Ref- "Aarogyasri axes private insurer to cut costs", Times of India, Hyderabad, 25th August 2012

Concluding remarks

Thus overall, this Rajiv Aarogyasri Scheme (RAS) has enrolled majority of families in AP and partially fulfilled some tertiary care needs of the people free of charge. It has firmly put healthcare on the agenda of electoral politics in this country. However, RAS kind of high-tech, procedure driven and high-cost schemes are merely populist ones. It's too costly and unsustainable. The administrative costs are too high. Hence, it cannot be and should not be scaled up for UHC, in its existing format. RAS has not only eroded the much needed strengthening of the primary and secondary care, but also created distortions in the tertiary care Public Hospitals by catering more to the RAS patients at the expense of other patients. Role of insurance company is highly questionable. Stand-alone nature of RAS independent of existing public health system, handing over valuable public resources to the private healthcare providers in the absence of robust regulatory framework, unequal competition between public and private hospitals, and evidence of irrational, unnecessary surgeries performed under the scheme are highly worrisome issues. This scheme which is quite at variance with the recommendations of the Planning Commission's High Level Expert Group (HLEG) on Universal Health Coverage (UHC) has become an obstacle in achieving the goal UHC and should not be replicated in other states. There is an urgent need to develop strong evidence based arguments against these kinds of schemes while continuing advocacy for Universal Health Care at the national level.

However, there is also a need to engage with these kinds of schemes in various states where they are in force and strive to bring out appropriate modifications like eliminating role of insurance company and asking the state governments to allocate more funds, resources for strengthening of Public Health System, take over the administration of the scheme, demanding enforcement of Standard Treatment Protocols (STPs), developing regulatory framework within the scheme, integrating the scheme with the public health system, strengthening public health system with focus on primary and secondary care while providing tertiary care etc. These schemes can be viewed as an opportunity for demanding regulation of private healthcare providers in the concerned states as handing over public resources to private providers create favourable conditions and strong rationale for social regulation of such providers.
