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Health Administration in Andhra Pradesh: a Comparative Study on Rajiv Aarogyasri and Community Health Insurance Scheme

KEYWORDS: Health Administration, History, Professional Organizations, Rajiv Aarogyasri, History, Included Treatments, Excluded Treatments, Community Health Insurance (CHI)

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ABSTRACT *Health Administration describes the leadership and general management of hospitals, hospital networks, and /or health care systems. In international use, the term refers to management at all levels. It is important to Health Administration ensures that specific outcomes are attained, that departments within a health facility are running smoothly, that the right people are in the right jobs that people know what is expected of them, that resources are used efficiently and that all departments are working towards a common goal. Concluding, Rajiv Aarogyasri is the flagship scheme of all health initiatives of the State Government with a mission to provide quality healthcare to the poor. Study on the performance of Indian CHI schemes. The effect of CHI was assessed on quality of care using patient satisfaction as a proxy*

Introduction

Health Administration or Healthcare Administration is the field relating to leadership, management, and administration of public health systems, health care systems, hospitals, and hospital networks. Health care administrators are considered health care professionals.

Health systems management or health care systems management describes the leadership and general management of hospitals, hospital networks, and/or health care systems. In international use, the term refers to management at all levels. In the United States, management of a single institution (e.g. a hospital) is also referred to as "Medical and health services management", «Healthcare management» or Health Administration.

Health systems management ensures that specific outcomes are attained, that departments within a health facility are running smoothly, that the right people are in the right jobs that people know what is expected of them, that resources are used efficiently and that all departments are working towards a common goal.

Professional Organizations

There are a variety of different professional associations related to health systems management, which can be subcategorized as either personal or institutional membership groups. Personal membership groups are joined by individuals, and typically have individual skills and career development as their focus. Larger personal membership groups include the American College of Healthcare Executives, the Healthcare Financial Management Association, and the Healthcare Information and Management Systems Society. Institutional membership groups are joined by organizations; whereas they typically focus on organizational effectiveness, and may also include data-sharing agreements and other medical related or administrative practice sharing vehicles for member organizations. Prominent examples include the American Hospital Association and the University Health systems Consortium.

History

Early hospital administrators were called patient directors or superintendents. At the time, many were nurses who had taken on administrative responsibilities. Over half of the members of the Association were graduate nurses in 1916. Other superintendents were medical doctors, laymen and members of the clergy. In the United States, the first degree granting program in the United States was established at Marquette University in Milwaukee, Wisconsin. By 1927, the first two students received their degrees. The original idea is credited to Father Moulinier, associated with the Catholic Hospital Association. The first modern health systems management program was established in 1934 at the University of Chicago. At the time, programs were completed in two years – one year of formal graduate study and one year of practicing internship. In 1958, the Sloan program at Cornell University began offering a special program requiring two years of formal study, which remains the dominant structure in the United States and Canada today (see also «Academic Preparation»).

Health systems management has been described as a "hidden" health profession because of the relatively low-profile role managers take in health systems, in comparison to direct-care professions such as nursing and medicine. However the visibility of the management profession within healthcare has been rising in recent years, due largely to the widespread problems developed countries are having in balancing cost, access, and quality in their hospitals and health systems.

RAJIV AAROGYASRI SCHEME

Rajiv Aarogyasri or Aarogyasri is a program of the Government of Andhra Pradesh. It covers those below the poverty line. The government issues an Aarogyasri card and the beneficiary can use it at government and private hospitals and get services free of cost.

History

The unique program was started in mahabubnager dist on 1 April 2007 by the then Chief Minister of Andhra Pradesh, Y. S. Rajasekhara Reddy. The government created Aarogyasri Health Care Trust and allocated Rs.5000 crores in the first year.

Rajiv Aarogyasri is the flagship scheme of all health initiatives of the State Government with a mission to provide quality healthcare to the poor. The aim of the Government is to achieve "Health for all". In order to facilitate

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the effective implementation of the scheme, the State Government set up the Aarogyasri Health Care Trust under the chairmanship of the Chief Minister. The Trust is administered by a Chief Executive Officer, an IAS Officer. The trust, in consultation with the specialists in the field of healthcare, runs the scheme.

Included Treatments
The scheme provides financial protection to families living below poverty line up to Rs. 2 lakhs in a year for the treatment of serious ailments requiring hospitalization and surgery.

938 treatments are covered under the scheme in order 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. The scheme provides coverage for the systems like Heart, Lung, Liver, Pancreas, Kidney, Neuro-Surgery, Pediatric Congenital Malformations, Burns, Post -Burn Contracture Surgeries for Functional Improvement, Prostheses (Artificial limbs), Cancer treatment (Surgery, Chemo Therapy, Radio Therapy), Polytrauma (including cases covered under MV Act) and Cochlear Implant Surgery with Auditory-Verbal Therapy for Children below 6 years (costs reimbursed by the Trust on case to case basis). All the pre-existing cases of the above mentioned diseases are covered under the scheme.

Excluded Treatments
The diseases specifically excluded from the list are high end diseases such as hip and knee replacement, bone morrow, cardiac and liver transplantations, gamma-knife procedures in neuro surgery, assisted devices for cardiac failures etc; and diseases covered by national programmes viz., TB, HIV/AIDS, Leprosy, Infectious diseases, Malaria, Filaria, Gastroenteritis, Jaundice etc.

To the extended RAS covers the treatments, it would no longer be permissible for the BPL holders to apply for relief for medical purposes under Chief Minister Relief Fund (CMRF).

There is a widespread discrepancy in the implementation of the Programme with misuse by hospitals.

COMMUNITY HEALTH INSURANCE SCHEMES IN INDIA
Quality of care is one of many important determinants of health service utilization. Various studies show that health services' utilization is sensitive to the perception of quality by the users. While many articles concentrate on the technical aspects, studies are increasingly looking at quality from the patient's perspective.

The quality of healthcare in India in both the private and public health sector is unsatisfactory. The problems include non-availability of staff and medicines as well as the rude behaviour of the staff. Studies in the private sector have shown that practitioners tend to prescribe unnecessary and even harmful medicines. Recent policy documents also acknowledge the lack of quality in the Indian health services. One of the recommended strategies is to introduce demand-side financing, specifically community health insurance (CHI).

There are three possible mechanisms whereby CHI can improve the quality of care. One of the mechanisms is when the organizer of the CHI scheme strategically purchases health care from the provider14. Strategic purchasing includes among other facets, a mandate to set quality standards of care. This could include the following activities: gate keeping, contracting out with specific providers, maintaining a provider profile and monitoring the quality and financial performance, conducting utilization reviews, quality assurance, introducing generic medicines and implementing standard treatment protocols. To summarize, the organizer of the scheme can negotiate with the provider for 'better quality of care' because they control the funds and are ultimately responsible for paying the provider. Yet another mechanism is by empowering the community. In any health insurance scheme, there is an element of 'service guarantee' i.e. once the insured pays the premium, the insurer has to guarantee the promised services. This can then give the insured patient the authority to 'demand' the services from the provider. Thus, ideally the insured patient can access the care that is required. A third mechanism is from the provider side. Especially in the Indian milieu where the private practitioners compete with each other for patients, providers would be happy to empanel themselves with a CHI scheme and have a captive community of patients who would use their services. This would ensure that they receive a steady income over time. They would thus be willing to improve their standard of care, to ensure that they remain empanelled with the CHI scheme. Thus insured patients should hypothetically receive better quality of care from these providers.

However, there is very little evidence that this relationship between CHI schemes and improved quality of care actually exists. Some insured women at self Employed Women's Association (SEWA) were exposed to 'dangerous' hospital conditions while undergoing hysterectomy. A study in China also documented that insured patients under the New Comprehensive Medical Scheme were exposed to over prescribing compared to uninsured patients19. This suggests that community health insurance could potentially lead to patients using facilities that provide poor quality care.

This study is part of a larger study on the performance of Indian CHI schemes. The effect of CHI was assessed on quality of care using patient satisfaction as a proxy. Patient satisfaction is an important but little studied aspect of quality of care in the Indian context. Satisfaction is defined as the "overall level of contentment with a service experience". Two CHI schemes were studied between 2004 and 2005, one with a single provider and the other with multiple empanelled providers. The objective was to see whether insured patients have higher satisfaction levels as compared to the uninsured patients. Also the reasons for this satisfaction / dissatisfaction were explored. The underlying hypothesis was that insured patients would be more satisfied as they receive 'better quality of care'.

Conclusion
In conclusion, Health Administration describes the leadership and general management of hospitals, hospital networks, and /or health care systems. In international use, the term refers to management at all levels. It is important to Health Administration ensures that specific outcomes are attained, that departments within a health facility are running smoothly, that the right people are in the right jobs that people know what is expected of them, that resources are used efficiently and that all departments are working towards a common goal. Concluding, Rajiv Aarogyasri is the flagship scheme of all health initiatives of the State Government with a mission to provide quality healthcare to the poor. Study on the performance of Indian CHI

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