2006 | ASIAN DECENT
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International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION INITIATIVES IN SOUTH ASIA

INDIA:
STATE GOVERNMENT SPONSORED COMMUNITY HEALTH INSURANCE SCHEME
(ANDHRA PRADESH)

"EXPANDING ACCESS TO MOST EXPENSIVE HEALTH CARE SERVICES"

ILO Subregional Office for South Asia

INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach is the "rare care" health insurance scheme fully sponsored by the Government of Andhra Pradesh which extends its benefits to all poor.

BACKGROUND

There was a felt need in Andhra Pradesh to provide financial protection to poor families for the treatment of major ailments requiring hospitalization and surgery.

On the one hand, Government hospitals often do not have the requisite facility and the necessary pool of specialists to meet state wide requirements for the treatment of such diseases. On the other hand, large proportions of people cannot afford to pay for treatment in private hospitals or needed to borrow money of even sell their meagre assets to access these facilities.

Like many other states, Andhra Pradesh already set up a State Assistance Fund targeting the poorest segments of the population and aiming at meeting their hospitalization expenses for surgical procedures. Responding to individual demands, financial assistance to a tune of Rs. 10.72 crore was disbursed during the period from May 2005 to December 2006. This amount fully covered the expenditures related to surgical procedures performed for a total of 38,001 cases. From the experience gained it was felt that the time had come to institutionalize an insurance mechanism that could enhance

the operational efficiency of the scheme, extend its benefits to a broader segment of the population and improve the overall quality of health care services.

To achieve these goals, the Government of Andhra Pradesh was the first to collaborate with the Ministry of Health, Government of India, in the framework of the National Rural Health Mission (NRHM) insurance development plans. In order to operate the scheme professionally in a cost effective manner, public-private partnership had to be promoted between the State agencies, the private sector hospitals, the insurance companies and Third Party Administrators. A Public-private Trust had to be set up to assist the insurance company in establishing a network of hospitals applying pre-determined tariffs on all services covered under the scheme.

The planned partnership was to cover all issues pertaining to the preparation and implementation of the insurance scheme such as: the accreditation conditions, the fixing of treatment protocols, tariffs, treatment procedures, claims processing and scrutiny and monitoring and reporting mechanisms. This partnership also had to ensure making full use of resources available in the Government system.

Private hospitals fulfilling minimum qualifications in terms of availability of in-patient medical beds, staff, laboratory equipments, operation theatres etc, and having a track record in the treatment of specified diseases could be enlisted for providing treatment to families covered under the insurance scheme. The special Trust to be set up by Government of Andhra Pradesh should assist the insurance company / TPA / groups of beneficiaries and co-ordinate with all other actors such as Medical and Health Department, District Collectors, Civil Supplies Department etc.

Inspired by the Guidelines published in 2006 by the Ministry of Health and Family Welfare to support the NRHM venture into health insurance, the Government of Andhra Pradesh was also dedicated to collaborate actively with community based organizations, such as the Federations of Self Help Groups, which had already expressed their interest for the setting up of a health insurance scheme that could address the needs of their huge membership. The full design and preparation phase of the Rajiv Aarogyasri Community Health Insurance Scheme was completed in early 2007.

TARGET POPULATION

Like in many other states, the Government of Andhra Pradesh was first considering to cover the Below Poverty Line population. According to the Planning Commission estimates, the total Below Poverty Line population of the state amounted to 12.6 million in 2004. A major issue is the divergence in the statistics on the magnitude of BPL households between the central and sate Governments

The central government usually projects the BPL population based on the NSSO date, The state governments, on the other hand, prepare the list of BPL with the help of data collected from all the households in a locality. In 2005, while looking for a cost-sharing arrangement in relation to a first health insurance attempt, this BPL figure issue stalled the negotiations initiated with The Central Government. Based on this experience, the Government of Andhra Pradesh decided to go its own way and to rely only on State resources which allowed it to broaden the coverage of its health insurance initiative. As a result, the new planned scheme would now cover all people availing the ration card, which included both the BPL population (pink card) and the APL population (white card).

This new approach should ultimately result in covering about 70% of the entire population of the state. To this end, the Trust went on the fast track when launching the successive phases of its implementation plan.

Phase I (March 2007)

	Districts	No of BPL Families	Total BPL Population
1	Anantapur	870,616	3,134,218
2	Mahaboobnagar	781,777	2,814,397
3	Srikakulam	664,233	2,391,239
	Total	2,316,426	8,339,854

Phase II (December 2007)

	Districts	No of BPL Families	Total BPL Population
1	East Godavari		
2	West Godavari		
3	Nalgonda		
4	Ranga Reddy		
5	Chittoor		
	Total	4,813,000	16,700,000

Phase III (April 2008)

	Districts	No of BPL Families	Total BPL Population
1	Karimnagar		
2	Kadapa		
3	Medak		
4	Nellore		
5	Prakasam		
	Total	3,487,000	12,300,000

	Grand Total:	***10,616,000***	***37,339,000***

ORGANIZATION

To implement the scheme, the State Government set up the Aarogyashri Health Care Trust under the chairmanship of the Chief Minister of the State. With technical assistance from specialists in the field of insurance and health, a competitive bidding process was prepared by the Trust. As a result, a partnership was entered into with Star Alliance and Allied Insurance Company, the first stand-alone health insurance company operating in the country.

With regard to the implementation of the scheme, the role of the Trust is to serve as a regulator and assist the beneficiaries, supervise the Insurance Company and coordinate with Health and Medical Department, District Administration, Rural development Department and federations of Self Help Groups.

At the local level, each federation of Self Help Group appoints health workers (also known as Arogya Mitras) to work in close coloration with the insurance company and ensure interface with the target group. These health workers are each assigned to a specific hospital where they welcome and advise the insurance card holders and organize the registration process.

In order to inform all stakeholders as well as the common people, the Asrogyasri has established a very good online information management system. Any one can easily access the information on the progress of the scheme in several phases. They can also access disaggregated data on number of people screened in a health camp, people availing referral services, amount spent, etc. The public can also find out the health providers who are empanelled by districts and locations. All this information, updated on a day-to-day basis, would help the people to avail health care facilities

THE INSURANCE PLAN

Eligibility

The scheme is open to the whole family without any age bar. Family means head of the family, spouse, dependent children and dependent parents. Any addition of family member during the currency of the one-year policy shall not be considered. Such additions shall be included at the time of renewal of the policy.

Plan Benefits

The insurance plan only covers listed critical illnesses and major surgeries up to a sum insured of Rs. 150,000 per family per year on a floater basis. Additional amount of Rs. 50,000 is available as a buffer for excess expenses on an individual case basis and all diagnostic tests to be conducted as per standard protocols are free of cost

In addition to a list of some 270 surgical procedures, the scheme covers the following critical illnesses:

- Heart
- Lungs
- Liver
- Pancreas
- Cancer
- Burns
- Neuro-surgery
- Paediatric congenital malformations

In early 2008, the Trust decided to extend the coverage to all cases of poly-trauma and cochlear implant surgery for children below 6 years, and to provide follow-up medicines to the beneficiaries undergoing surgeries under the scheme. These medicines will be made available for free at all public Teaching / District Hospitals.

The scheme also covers pre-existing diseases and provides free transportation in case of referral from a health camp. Additional features include: simple procedures, e-authorization, packages for end-to-end-treatment and 24 hour toll free help line. Free food must also be provided by the hospital to each patient till discharge

Premium Rate

Premium was first set at Rs. 300 per family per year at no cost to the family. The premium registered a slight decline when negotiating its next expansion phases with insurance companies and stands now at Rs. 249 per family per year (Plus Service Tax) fully paid by the Government of Andhra Pradesh

General Overview	
Starting date	April 2007
Ownership profile	GoAP Trust
Target group	All ration card holders
Outreach	13 districts of Andhra Pradesh
Intervention area	Rural, semi-urban
Risks covered	Single risk: Health
Premium Insured/Y	Rs 0
Co-contribution	Rs 249 (GoAP)
Total premium	Rs 249
No of insured	36,700,000
Percentage of women	51%
Operational Mechanisms	
Type of scheme	Partner-agent
Insurance company	Private
Insurance year	Fixed year
Insured unit	Whole family
Type of enrolment	Voluntary/automatic
One-time enrolment fee	No
Premium payment	-
Waiting period	No
Scope of Health Benefits	
Tertiary health care	☺
Hospitalization	No
Deliveries	No
Access to medicines	No
Primary health care	No
Level of Health Benefits	
Surgical procedures	Rs. 150,000
Additional buffer	Rs. 50,000
Service Delivery	
Health prevent./educ. programmes	No
Prior health check-up	No
Tie-up with H.P.	Yes
Type of health prov.	Private and public HP
Type of agreement	Formal agreement
No of associated HP	74
TPA intervention	No
Access to health care services	Pre-authorization and referral
Co-payment:	No
HC payment modality	Pure cashless
Additional financial benefits	Free food, free transportation
Additional Non-financial benefits	Health camps, free screening, dedicated reception desk

Plan Distribution

Database and photographs in electronic format of BPL families were already in the ration cards issued by the Civil Supplies Department. The Trust will provide the details of each BPL family covered under the scheme electronically though the white ration card. This card will be a part of enrolment / identification for availing the health insurance facility.

Service Delivery

The scheme is presently associated with 74 hospitals spread across the State. All hospitals (whether private or public) associated with the scheme should comply with the following minimum criteria:

- Minimum of 50 in-patient medical beds
- Fully equipped and engaged in providing medical and surgical facilities along with diagnostic facilities i.e. Pathological test and X-ray, E.C.G…
- Fully equipped operation theatre
- Fully qualifies doctors should be physically in charge round the clock
- Maintaining complete record as required on day to day basis and be able to provide necessary records of the insured patient to the insurer or his representative
- Using ICD and OPQS codes for Drugs, Diagnosis, Surgical procedures, etc.
- Having sufficient experience

They should also be in a position to provide the following additional benefits to insured: substantial discounts on diagnostic tests and medical treatment and minimum of 10-12 free health camps per year

MAIN ACHIEVEMENTS

Coverage

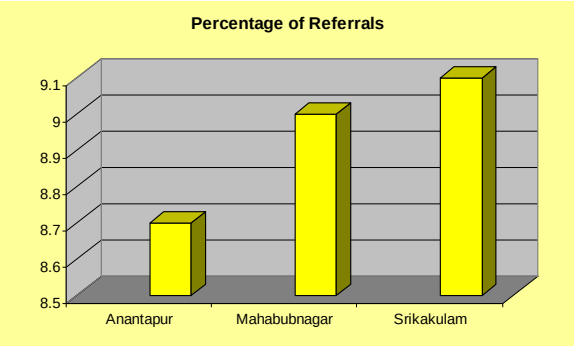
The scheme was initiated in three districts of Andhra Pradesh, covering already about 8 million people. Over a one-year period, the scheme expanded to ten new districts adding a total of 29 million people under its cover.

Services Provided

Health Camps

As mentioned in the first status report released by the scheme, 1,053 mega health camps could be organized in the three districts covered in Phase I (01/04/2007 – 31/03/2008), These camps allowed for people to be screened by medical officers before being immediately referred to network hospitals if need be. Some 175,000 people were screened with more than 15,000 being referred for pre-authorization and final approval before treatment.

During its first one-year phase, referral cases in the three districts ranged between 8.7% and 9.1% of the population screened.

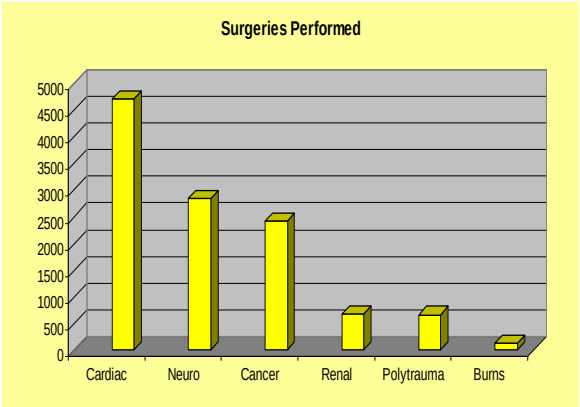


	N° Camps	N° Screen	N° Refer.
Anantapur	421	76,228	6,697
Mahabubnagar	346	47,036	4,241
Srikakulam	286	52,302	4,764
Total	1,053	175,566	15,702

Surgeries Performed

As total of 11,484 surgeries were performed during Phase I, most of these related to cardiac problems (41% of interventions). The corresponding cost for the scheme amounted to a total of Rs. 515 million, meaning an average claims cost of Rs. 44,800.

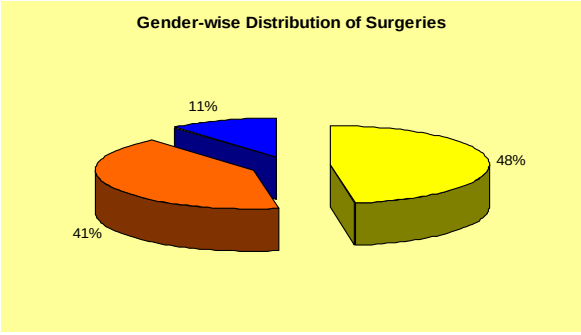
The 11,484 surgical interventions performed fell into the following categories:



	N°	% Total	Cum.%
1. Cardiac	4,712	41.0	41.0
2. Neuro	2,850	24.8	65.8
3. Cancer	2,434	21.2	87.0
4. Renal	674	5.9	92.9
5. Polytrauma	671	5.8	98,7
6. Burns	143	1.3	100.0

Gender-wise Distribution of Interventions

Only 11% of all surgical interventions were performed on children



	N° Surgeries	%
Male	5,453	47.5
Female	4,746	41.3
Children	1,285	11.2
Total	11,484	100.0

CHALLENGES

The insurance plan has still to address the following key challenges:

- The total number of beneficiaries appears to be very limited as compared to the overall figure of insured in the first three districts. This number could raise to new peaks once everyone is aware of the existence of the scheme
- A mechanism allowing for a systematic appraisal of the quality of services provided under the scheme should reach all beneficiaries
- There is still a need to strengthen the medical audit capacities and to report on all interventions covered under the scheme
- At this early stage, the long-term financial implications of the planned extension of the scheme to the whole state cannot be fully measured
- The involvement of an insurance company in the management of such a scheme may still be questioned over time

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme. Evidence also suggests that building efficient linkages between community-based initiatives and government programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages	
Financing:	
Operations:	
Service Delivery:	
Governance:	No
Policy Planning:	No
Legal Framework:	

The first partnership arrangements developed over less than a year by this ambitious health insurance initiative are still expected to expand over the years to come. However, the innovative arrangements that were already concluded with a broad network of health providers (including fixed concessional tariffs), as well as with the insurance company (with stop-loss and profit limitation provisions) deserve a special attention when comparing with other government sponsored health insurance schemes

1. Financing

The full cost of the running of the scheme is borne by the Government of Andhra Pradesh. There is no contribution coming in the form of either a yearly premium or a one-time registration fee from the insured.

2. Operations

The scheme benefits from the active support provided at all levels by the Ministry of Health. It also relies on the active support of Federations of SHGs spread across the whole state.

3. Service Delivery

The scheme has succeeded to develop efficient partnership arrangements with a broad network of private hospitals guaranteeing a high-level quality of health care services. These facilities have agreed to apply standard rates for all procedures covered under the scheme, resulting in some decrease in the treatment costs. Although still in small number, several public hospitals have been associated with the scheme.

4. Governance

The administration of the scheme is left to a Trust regrouping only public department representatives. So far, there is no direct involvement of any other key actor.

5. Policy Planning

The Government of Andhra Pradesh is keen that the scheme should rapidly extend to all other districts. This goal is now expected to be reached by the end of 2008. If this is going to happen, several years will be required before drawing the full lessons – including the financial ones - of an extension initiative of this magnitude. There is thus still a long way before developing a working model that could be replicated in other states.

It is noteworthy to mention that in the case of Rajasthan, also willing to develop a similar scheme in the NRHM framework, the original orientation has evolved over time towards an intervention that would be more along the lines of the new scheme promoted by the Ministry of Labour and Employment (targeting only the BPL population and covering hospitalization expenses).

6. Legal Framework

The scheme falls under the partner-agent model as described by the Micro-insurance Regulations issued in November 2005 by the Insurance Regulatory and Development Authority (IRDA) of India. It is therefore under regulation of the IRDA and would be considered as fulfilling Star Health & Alliance's obligations to the rural sector.

CONCLUSION

The innovative health insurance experience conducted in Andhra Pradesh has succeeded to become the largest in India in its first year of operation. Already scaling up to reach a total of 38 million, it is expected to further expand in order to cover the whole state by the end of the year. This amazing pace of development was never experienced before and many new implementation challenges will have to be addressed over the next few months. Special credit must be given to the Government of Andhra Pradesh for the transparency of all activities and the importance it set on opening wide communication channels not only with key stakeholders but also with the public at large. This particular feature should be used to develop more in-depth analysis with a focus on relations with health providers (in the absence of a Third Party Administrator) and with the self-help groups and their federations working at the grassroots level. At this still early stage, a better understanding of these relations could already prove very helpful to determine and facilitate similar initiatives in other states.

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