HEALTH SERVICE DELIVERY SYSTEM IN ARUNACHAL PRADESH

Submitted by:

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INTRODUCTION

Health is a human right. Its accessibility and affordability has to be ensured by a welfare Government. The escalating cost of medical treatment is now beyond the reach of common man. The Government and people have started exploring various health financing options to manage problem arising out of increasing cost of care, out of pocket (OOP) expenses and changing epidemiological pattern of diseases.

Arunachal Pradesh is the largest among the North Eastern states in terms of geographical area and has the least population density of just 17 persons /sq.km. As per the 2011 census, Arunachal Pradesh has a total population of 13, 83, 727 persons living in 5545 villages, 17 census towns and 9 urban towns. With such sparsely distributed population, Arunachal faces **unique challenge in providing equitable and quality healthcare** to its citizens.

Though health is a State subject, Arunachal Pradesh is hugely dependent on central funding for providing universal health coverage to its people. The **Central funding pattern is based on population** due to which Arunachal Pradesh loses out as a result of population based criteria. Because of the geographical vastness and sparsely distributed habitation, hostile terrain and poor surface communication the issue of **providing easily accessible and quality healthcare has been a mammoth task for the policy makers and health care providers**. All policy makers in the past had sought solution for this problem. Thus many health facilities were created. As of date, Arunachal Pradesh has one State Hospital (TRIHMS), 6 General Hospitals, 14 District Hospitals, 63 Community Health Centre, 144 Primary Health Centre and 584 Sub-Centre. But it has not solved the problem. With limited resources, Arunachal could not provide the required manpower for deployment, create all the necessary infrastructures and maintain the many facilities that were created. Moreover, till date patients have to travel outside the State to avail tertiary level care as it is not available within the state.

➢ Key health indicators of Arunacal Pradesh

Indicators	State	National
Infant Mortality Rate (SRS 2017)	36	34
Maternal Mortality Rate (SRS 2017)	-	167
Total Fertility Rate (NFHS-4)	2.1	2.2
Immunization Coverage(Children Age-2 to 23 months) (NFHS-4)	38.2	62

There is a growing demand of well-equipped and quality healthcare services in the State of Arunachal Pradesh. The state has an extremely difficult terrain and hence service delivery of any kind is a challenge. There is lack of economic resources, poor environmental condition, overcrowding in few areas and environmental pollution which further contribute to poor health status in the State. There are no systematic investments and efforts to improve health care in the State.Public Health Network in both urban and rural areas is inadequate and functions sub optimally. The population base of the State is also increasing

due to various factors such as migrants, expansion of the city boundaries and rise in slum populations and urban poverty.

The healthcare services are provided both by the public, Govt. aided and private institutions. **There is no PPP mode of healthcare services system in the State till date.** The availability of services ranges from primary to secondary level. There is an upcoming Medical College in the Naharlagun town but the facilities available are not up to the level of tertiary care till now.

Situation in the State Capital

The primary healthcare services in the Capital complex region are provided through the Public Health Centers at Banderdewa, Chimpu, Itafort, Raj Bhawan Dispensary and the Sub Centers covered under these PHCs. The secondary level healthcare facilities are being provided through the TRIHMS Hospital at Naharlagun and the Govt. aided RK Mission Hospital at Itanagar run by the RK Mission, Belur Math (NGO). There is also a Govt. aided Homeopathy College in Itanagar run through an NGO. There are various private nursing homes in the Capital complex area providing secondary level of healthcare facilities. However, affordability of medicines and services is an issue where the out of pocket expenditure is high in the city. There are three GNM and one BSc. nursing colleges in the city. One of the GNM School is being run by the State Govt.

- **Population distribution of Itanagar capital region**

Area name	Households			Population		
	Total	Rural	Urban	Total	Rural	Urban
Itanagar	14489	1024	13465	65301	5811	59490
Naharlagun	10344	2609	7735	49106	12948	36158
Banderdewa	1625	1625	-	8523	8523	-
Total	26458	5258	21200	122930	27282	95648

Source: Census 2011

The population break-up of localities where health care institutions are located:

Sl. No	Town	Locality	Total population	Rural Population	Urban Population	No. of Health Institutions
1.	Itanagar		65,301	3,455	59,490	4 (Rajbhavan, Itafort, RKMH & Heema Hospital)
		Chimpu		1,469		1(PHC)
		Jollang		379		1(SC)
		Ganga		508		1(SC)
2.	Naharlagun		49,106	6,750	36,158	5 (ASH, Niba, BTMH, SASH & Hormin)
		Pachin				1 SC
		Papu-I		423		1 (SC)
		Papu-II		322		
		Nirjuli		5,453		2 (SC+Tago)
3.	Banderdewa		8,523			
		Karsingsa		2,552		1(U-PHC Karsingsa)
		Banderdewa		5,971		1(PTC Dispensary)
Total			1,22,930	27,282	95,648	18

The public healthcare facilities provide all three types of services- preventive, promotive and curative aspects as envisaged in the National Health Mission (NHM) program. AYUSH system of medicines is also being promoted now days.

➢ Expectation of the citizens

1. Overall quality of healthcare should be improved.
2. Free diagnostic and free medicine (Generic) should be made available in public health facilities as per National Health Mission Program to reduce the out of pocket expenditure.
3. Schemes like Dulari Kanya, Janani Suraksha Yojna, Janani Shishu Suraksha Karyakarm, APCMUHIS etc. should be properly implemented.
4. All Govt. health facilities should be as per IPHS standards- Infrastructure, Manpower and equipment.
5. There should be proper referral mechanism and call center with adequate no. of ambulances

A lot needs to be done in the Health Sector to meet these bonafide and justified expectations of the citizens. In this paper, we will examine the following areas of healthcare service delivery in State-

- **Current Status of Healthcare Delivery (Infrastructure, Manpower etc.) – Problems and Possible Solutions**
- **Improving Healthcare service delivery using PPP**
- **Experience of Universal Health Insurance Scheme and the way forward.**

Current status of healthcare delivery in the State (Infrastructure, manpower etc)

As mentioned earlier, the State of Arunachal Pradesh is characterised by complex topography, difficult inaccessible terrains, social structure and very low population with density of 13, which is the lowest in the country. These factors together pose several formidable problems for implementation of health delivery schemes.

The Infant Mortality Rate (IMR) declined from 63/1000 live births in 1998-99 (NFHS-2) to 32 per 1,000 live births in SRS-2011). In this sensitive key indicator, the goal of 60 fixed in the 1983 National Health Policy has been reached. in 2005. The Total Fertility Rate from 4.07 in 1992 has declined to 2.5 in 2009(SRS-2009). The incidence of polio cases has been reduced to zero and the status is being maintained through AFP-Surveillance and weekly reporting. The state is now ready for polio-free certification by the WHO in 2013..

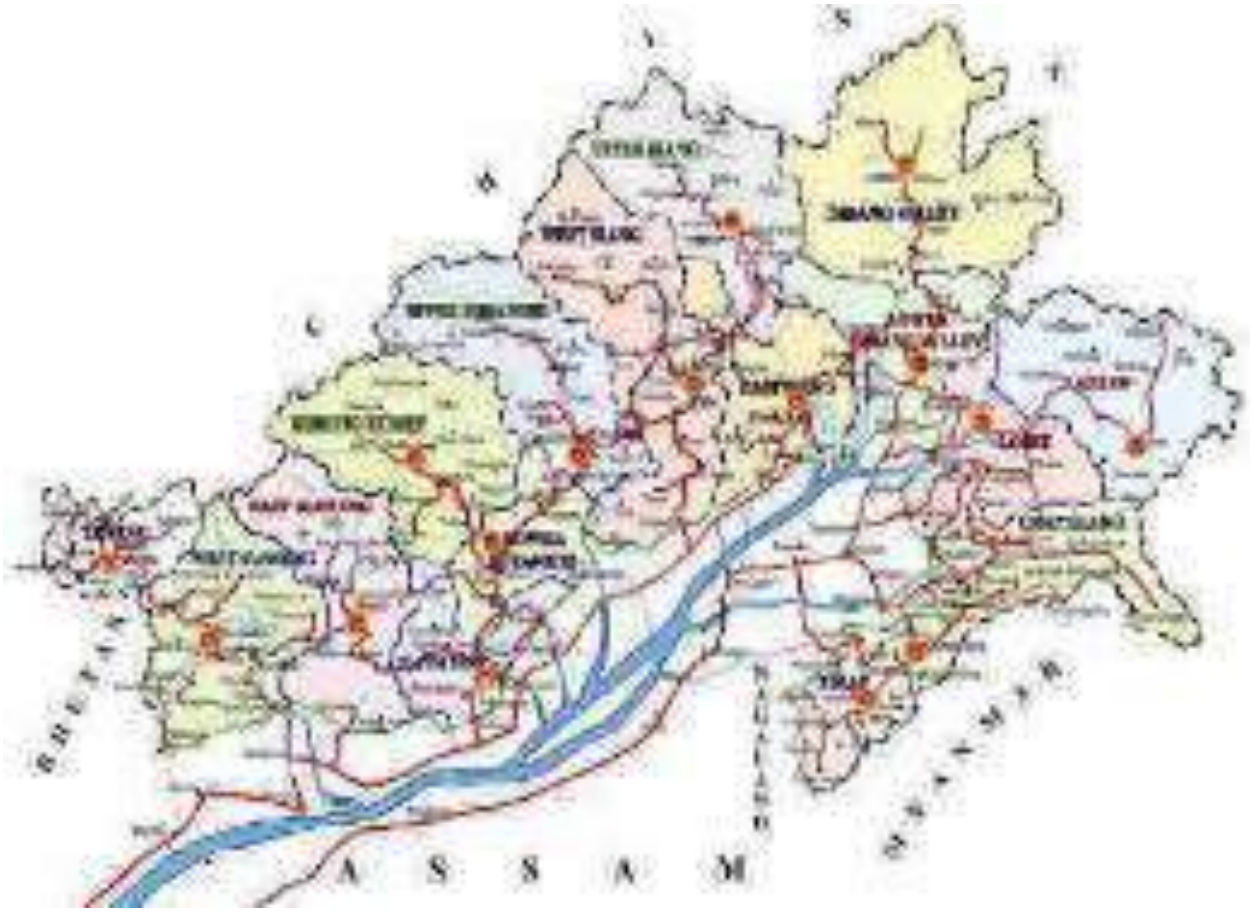
The *infant mortality rate* in Arunachal Pradesh has declined marginally, from 61 in NFHS-3 (2005-06) to 32 per 1,000 live births in SRS-2011.

Girls in Arunachal Pradesh face a lower mortality risk than boys in the first five years of life. Children born to mothers under age 20 years are 54 percent more likely to die in infancy than children born to mothers in the prime childbearing ages. Infant mortality is 90 per 1,000 live births for teenage mothers, compared with 59 per 1000 live births for mothers age 20-29.

However, despite the best of efforts, Government is not in a position to provide ideal health care facilities to people specially, living in rural areas up to their satisfaction.

Geographical spread of Health Institutions in the State

PHC/CHCs in the respective districts



Human resource required and available as per IPHS norms in Health Department, Arunachal Pradesh

Sl. No.	Descipline	Requirement as per IPHS per Institution						Total as per IPHS	Existing	Shortfall	Remark
		ASH, Naharlagu	GH, Pasighat	District Hospital 13	CHC 54 Nos.	PHC 129 Nos	SC 472 Nos.				
1.	Medicine	3	2	2	1	0	0	85	7	78	
2.	Surgery	3	2	2	1	0	0	85	8	77	
3.	Obs. & Gynae	4	3	2	1	0	0	87	1	76	
4.	Paediatric	4	3	2	1	0	0	87	7	80	
5.	Anaesthesiolo	3	2	2	1	0	0	85	7	78	
6.	Opthalmology	2	1	1	1	0	0	70	1	58	
7.	Orthopaedic	2	1	1	0	0	0	16	5	11	
8.	Pathology	3	2	1	0	0	0	18	5	13	
9.	ENT	2	1	1	0	0	0	16	3	13	

10.	Psychiatric	1	1	1	0	0	0	15	2	13	
11.	Dermatology	1	1	1	0	0	0	15	1	14	
12.	Forensic	1	1	1	0	0	0	15	1	14	
13.	Microbiology	1	1	1	0	0	0	15	1	14	
14.	GDMO (Allo)	1	1	1	6	2	0	75	4	33	
15.	MO (AYUSH)	1	1	1	1	1	0	19	6	13	
16.	Dental	2	1	1	1	0	0	70	3	31	
17.	Staff Nurse/										
19.	Lab. Tech	1	9	6	3	0	0	26	9	16	
20.	Radiographer	5	3	2	2	0	0	14	2	11	
21.	Opthal. Asstt.	2	1	1	1	0	0	70	2	44	
22.	ECG. Tech.	3	2	1	0	0	0	18	5	13	
23.	OT Tech.	8	6	4	1	1	0	24	2	24	
24.	Pharmacist	9	7	5	1	1	0	26	2	63	
25.	Dental Tech.	2	1	1	1	0	0	70	2	49	
26.	Blood Bank										
28.	ANM	0	0	0	1	2	1	78	4	36	
29.	HA	0	0	0	0	1	1	60	3	28	

N.B. Manpower required for Administration and other paramedics works have not been entered here
Above list of discipline is of skilled manpower only.

Health facilities in the state

Sl. No.	Category	No of notified Health Facilities	Functional
1.	Arunachal State Hospital (TRIHMS)	01	01
2.	General Hospital (GH)	06	06
3.	District Hospital (DH)	14	09
4.	Community Health Centre (CHC)	63	63
5.	Primary Health Centre (PHC)	143	86
6.	Sub-Health Centre (SHC)	584	232

Total Beds – 2092 *Total Personnel - 8817*

➢ Glimpses of few Health facilities in the State

Sub Center Mopit, Siang District

Sub Center Tarak, Siang District

Sub Center Bogne, West Siang District

Sub Center Tama Chung, U/Subansiri

PHC, Giba, Upper Subansiri District

PHC, Taksing, Upper Subansiri District

General Hospital, Passighat, East Siang District

Tomo Riba State Hospital, Naharlagun

A brief description of the present status of Infrastructure and manpower in the various Health Establishments of Capital Complex is reproduced below:

Sl. No	**Name of Health Facility**	**IPHS status**	**Hospital building availability (Infrastructure)**	**Manpower (Present Status)**
1	Raj Bhawan Dispensary	No	Yes	MO-4,Dentist-1 GNM-5, Pharmacist-1, LT-1, senior Attendant-1, Nursing Asistant-1, HA-1, SFW-1, MPW-1, RFW-2, Sanitary Assistant-1, Stretcher Bearer-1, Driver- 1
2	Itafort U-PHC	No	Yes	MO-7, GNM-2, ANM-4,LT-2, MPW-4, Pharmacist-2, HA-4, Peon-1, Chowidar-1

3	Chimpu PHC	No	Yes	MO-4, SN-3, ANM-3, LT-3,HA-4, Pharmacist-1, MPW-3
4	Jollang SC	No	Yes	ANM-3, HA-1, Pharmacist-1
5	Ganga SC	No		ANM-2, Pharmacist-1
6	TRIHMS Hospital	NA	Yes	On process
7	Pachin SC	No	Yes	ANM-4, HA-1, Pharmacist-1, DHV-2,SFW-2, RFW-4, MPW-4
8	Papu-I+ II SC	No	Yes	ANM-6, HA-1, Pharmacist-2, FA-4, DHV-1, SFW-2, RFW-5, MPW-3, FW-1
9	Nirjuli SC	No	Yes	ANM-3, HA-3, Pharmacist-1, MPW-6, SFW-4, RFW-3, FA-2, Peon-2
10	Banderdewa PTC Dispensary	No	Yes	SMO-1, GNM-2,ANM-1, RFW-4, SFW-1, FW-1, MPW-1, SN-1
11	Karsingsa U-PHC	No	Yes	MO-4, staff nurse-3, ANM-4, LT-2, Pharmacist-1, DHV-2, MPW-5, SFW-1, RFW-5, F/W-2, F/A-3, N/C-2, S/A-1
12	Lobi	No	Yes	ANM-2, HA-1

In addition, there are another 6 state government run health institutions around Itanagar capital region which fall under the rural Itanagar but is controlled by DMO, Yupia, Papum Pare district. These are:

i. Nirjuli Sub-Centre
ii. Papu I+II Sub-Centre
iii. Pachin Sub-centre
iv. Chimpu PHC
v. Ganga SC

vi. Jullang SC

It is well-known that the health care system is plagued by multiple problems and radical thinking and solutions are required to uplift the quality of service delivery. Some challenges in the healthcare service delivery of the State and their possible solutions are discussed below:

➢ *Challenge: Optimal Utilization of available manpower*

In many health establishments in ICC, there is an acute mismatch between the facilities and equipment and the available manpower. Mostly the transfers of Doctors and other paramedical staff is done on extraneous considerations without first assessing the requirement of the establishment. There is a tendency to stick in and around the Capital rather than serve in remote areas.

• *Possible Solution*

A major reform in this area shall be the introduction of the e-HRMS system. With this system, the Health Department will be able to get a clear picture of its manpower and optimally utilize it. The e-HRMS system has the following benefits-

1. Gives a clear summary of the available manpower
2. Can be used to take preferences of postings transparently from the staff
3. Optimal utilization of available manpower

The Health Department in collaboration with the IT Department is currently in the process of rolling out e-HRMS for Doctors.

Further, the Health Department also needs a **robust and clear Transfer/Posting Policy which can incentivize serving in hard areas and can also link career progression to minimum tenure in remote areas.**

➢ *Challenge: Maintenance of equipment*

Very often the Health establishments have dysfunctional equipment. Medical equipment such as dental chairs, X-Ray machines etc. are procured but not maintained/repaired. This not only leads to unsatisfactory health service delivery but also causes frustration for the doctors who can't treat patients despite having the skills and knowledge to do so.

- ***Possible Solution***

  First and foremost, the Health Department needs to map its existing equipment at each PHC/CHC/SC etc. It needs to create an inventory of the existing assets and their current status of functionality. Thereafter, it is suggested that the entire task of maintenance of these assets is outsourced to a competent service provider. The service provider should have strict service level agreements with the Health Department so as to ensure minimum turnaround time for repairing any equipment.

  It is pertinent to note that as part of the National Health Mission, GoI has adopted this same model for maintaining the assets under NHM. The work of maintenance has been outsourced to different firms for each State. The same firm can also be co-opted by the State Government to maintain its own assets.

➢ ***Challenge: Maintenance of buildings***

It is observed that in many cases the buildings that house the various Health establishments such as CHC/PHC etc. are in an extremely dilapidated condition. This is mainly because of want of funding for maintenance. This problem is further exacerbated by the fact that most of these establishments don't have adequate manpower.

- ***Possible Solution***

  The Health Department first needs to map its existing health units and close down the unnecessary health establishments. This will not only help in better utilization of the available manpower, but will also reduce the burden of maintenance on the Department.

  The Department needs to allocate sufficient funds for maintenance of these health units. These funds can also be augmented by levy of User charges.

  The main priority areas, constraints and the actionable points in each area are enlisted in the table below:

Priorities	**Constraints**	**Action**
Functional facilities - **Establishing fully**	• Dilapidated or absent • physical infrastructure • Non-availability of • doctors/paramedics, Drugs/	• Infrastructure/equipment • Management support

functional Sub Health Centres / PHCs/ CHCs/Sub Divisional/District Hospitals.	vaccines shortages • Dysfunctional equipment • Untimely procurements • Chocked fund flows • Lack of accountability framework • Inflexible financial resources. • No minimum mandatory service provision standards for every facility in place which makes full use of available human and physical resources and no road map to how desirable levels can be achieved	• Streamlined fund flows • Contractual appointment and support for capacity development • Pooling of staff/optimal utilization • Improved MIS • Streamlined procurement • Local level flexibility • Community /PRI/RKS for accountability / M&E • Adopt standard treatment guidelines for each facility and different levels of staffing, and develop road maps to reach desirable levels in a five to seven year period.
Increasing and improving human resources in rural areas	• Non-availability of doctors • Non-availability of paramedics • Shortage of ANMs/MPWs. • Large jurisdiction and poor monitoring. • No accountability • Lack of any plan for career advancement or for systematic skill upgradation. • No system of appraisal with incentives/disincentives for good/poor performance and	• Local preference • Contractual appointment to a facility for filling short term gaps. • Train and develop local residents of remote areas with appropriate cadre structure and incentives. • Multi-skilling of doctors /

	governance related problems.	paramedics and continuous skill upgradation • Convergence with AYUSH • Partnership with non- State Stakeholders.
Reducing maternal **and child deaths and** **population** **stabilization**	• Lack of 24X7 facilities for safe deliveries. • Lack of facilities with for emergency obstetric care. • Unsatisfactory access and utilization of skilled assistance at birth • Lack of equity/sensitivity in family welfare services/ counseling. • Non-availability of Specialists for anaesthesia, obstetric care, paediatric care, etc. • No system of new born care with adequate referral support. • Lack of referral transport systems. • Need for universalization of ICDS services and universal access to good quality antenatal care. • Need for linkage with parallel improvement efforts in social and gender equity dimensions. • Lack of linkages with other dimensions of women's health and women friendliness of public health facilities.	• Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluk/District Hospital • Trained ANM locally recruited • Institutional delivery • Quality services at facility • Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs. • Thrust on Skilled Birth Attendants/local appointment and training • Training of ASHA • New born care for • reducing neo natal mortality; • Active Village Health and

		Sanitation Committee; • Training of Panchayat members. • Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas. • Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees. • Linkage of all above to the Panchayat committee on health.
Action for preventive and promotive health	• Poor emphasis on locally and culturally appropriate health communication efforts. • No community action & household surveys • No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc. • Weak school health	• Untied funds for local action • Convergence with other departments/institutions • IEC Training and capability building • Working together with ICDS/TSC/CRSP/SSA/

	programmes • Absence of Health counseling/early detection. • Compartmentalized IEC of every scheme.	MDM • Improved School Health Programmes • Common approach to IEC for health • Involvement of PRIs in health. • Oral hygiene movement
Disease Surveillance	• Improperly managed Vertical programmes for communicable diseases • No integrated / coordinated action for disease surveillance at various levels in place yet. • No periodic data collection and analysis and no district and block specific epidemiological data available	• Horizontal integration of programmes through VH&SC,SHC,PHC,CHC. • Initiation and Integration of IDSP at all levels. • Building district / Sub-district Level epidemiological capabilities.
Health Information System	• Absence of a Health Information System facilitating smooth flow of information. • Not possible to make informed choices	• A fully functional two-way communication system leading to effective decision making. • Publication of State and District Public Reports on Health.
Planning and	• No local planning, no household surveys, no Village	• Habitation/village based

monitoring with community ownership	Health Registers. • Lack of involvement of local community, PRI, RKS, NGOs in monitoring of public health institutions like SHC/PHC/CHC/Taluk/DistrictHospitals.	household surveys and Facility Surveys as the basis for local action. Untied resources for planning and monitoring. Management of health facilities by the PRIs. • Thrust on community monitoring, NGO involvement, PRI action, etc. • Ensure Equity & Health. • Promote education of women SC/ST & other vulnerable groups.
Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water etc. with community	• Vertical implementation of • programme. • Only curative care. • Inadequate service delivery. • Non-involvement of community.	• Convergence of programmes. • Preventive care. • Health & Education • Empowering Communities. • Providing functional health facility [SHC], PHC • [CHC] for effective intervention.

support.		
Social security to poor to cover for ill health linked impoverishment and bankruptcy.	• Large out of pocket expenditures even while attending free public health facilities- food transport, escort, livelihood loss etc. • Economically catastrophic illness events like accidents, surgeries need coverage for everyone especially the poor.	• Innovations for risk pooling mechanisms that either cross subsidize the poor or are forms of more efficient demand side financing so that the economic burden of disease on the poor decreases. • Guaranteeing hospitalization at functional facilities

Having explored various challenges and their possible solutions, it is important to note that all solutions rely heavily on government funding and support. Even though the government does pump in a lot of funds for the Health Sector, however the outcomes are not forthcoming. This is mainly because of heavy leakages prevalent in the system and also because of imbalanced budget allocations.

Hence, in the context of Arunachal Pradesh, it may be fruitful to explore the model of promoting PPP in Health Services which is discussed in the next section.

PROMOTING PPP IN HEALTH SERVICES

The National Urban Health Mission (NUHM), a subset of National Health Mission covers two towns of state namely Itanagar and Pasighat whereas the National Rural Health Mission covers the other areas. Both NUHM and NRHM have been combined under the umbrella program of NHM (National Health Mission).

NUHM program was launched during 2013 in the State to improve the health status of the urban population in general, but particularly of the poor and disadvantaged sections of the two towns of Itanagar and Pasighat. Under the NUHM programme there are two Urban-PHCs at present- Urban-PHC Karsingsa and Urban-PHC Itafort. One more U-PHC is under construction at Rakap Colony, Naharlagun and almost completed now.

PPP in NHRM

The Government of Arunachal Pradesh, in order to overcome the shortcomings in the health care delivery system in the remote health facilities in the state and to further improve the health facilities, implemented Public Private Partnership (PPP) in 2005 in which some Primary Health Centers (PHC)/Community Health Centers (CHC) in the State are managed and operated through a selected Non-Government Organization (NGO); and the project is successfully sustaining till date. The strategic objective of the project is to provide quality clinical and preventive health services to the people residing in the Primary Health Centre area and at the same time effectively implementing National Rural Health Mission (NRHM) and other National programs including IEC activities, and promotion of community based disaster preparedness. Under the project, the management of 16 Health Facilities is handed over to selected 5 Non-Government Organization (NGO) for a period of 1 (one) year and extendable subject to the approval of Government of India.

Sl. No.	Name of the NGO	No. of Health Facilities managed by the NGO	Annual budget/ facility
1	Karuna Trust	11	3752000
2	Future Generations Arunachal	2	3752000

3	JAC Prayas	1	3752000
4	N.N. Charitable Society	1	3752000
5	M.M Charitable Trust	1	3752000

The funds made available per annum, to the Agency for operating and managing the PHC/CHC are as follows.

ANNUAL BUDGET FOR MANAGEMENT OF ONE HEALTH FACILITY					
	Budget Head	Unit	Monthly Budget	Annual Budget	Head wise annual budget
A	Medicines, Healthcare consumables				
1	Medicines	1	25000	300000	438000
2	Surgical Items	1	5000	60000	
3	Laboratory Items & diagnostic kits	1	3500	42000	
5	Hospital Materials & supplies	1	3000	36000	
B	Maintenance, Furniture, equipments				
1	Repairs & Maintenance of PHC/SCs	1	5000	60000	120000
2	Equipments & Furniture	1	5000	60000	
C	Administrative Expenses				
1	Water & Electricity	1	2000	24000	302000
2	Talephone, internet, postage	1	1000	12000	
3	Vehicle Repairing	1	5000	60000	
4	Vehicle fuel	1	5000	60000	
5	Travelling expenses	1	3000	36000	
6	Transportation cost	1	2500	30000	
7	Outreach Health camp expenses	1	2167	26000	
8	Printing, Stationeries & IEC	1	2500	30000	
9	Staff Training & orientation	1	2000	24000	
D	Personnel Cost				
1	Medical Officer	2	35000	840000	2892000
2	Pharmacist	1	12000	144000	
3	Staff Nurse	2	12000	288000	
4	Lab Tech	1	10000	120000	
5	ANM, (3 in SCs, 2 in PHC)	8	10000	960000	

6	Health Assistant (male)	2	10000	240000	
7	Driver	1	7000	84000	
8	Group D(Including SCs)	4	4500	216000	
TOTAL					3752000
Budget Summary					
A	Medicines & Healthcare consumables				438000
B	Maintenance, Furniture				120000
C	Administrative Expenses				302000
D	Personal Cost				2892000
TOTAL Rs					3752000

Rupees Thirty-Seven lakhs Fifty Thousand only per health facility per annum. The Agency contributes 10 percent from its own sources towards the project cost.

Health facilities Managed under PPP

NGO	Name of the district	Name of the PHC/CHCs	Sub Centres under the PHC				
Karuna Trust	Anjaw	PHC Walong	Yasong	Kibitho			
	Changlang	PHC Khimiyong	Yanam	Jongi Havi			
	Dibang Valley	PHC Etalin	Arzoo	Anelih			
	Kurung Kumey	CHC Sangram	Pagba	Leel	o Point		
	Tawang	PHC Dungdugarh		Phongleng			
	Papum Pare	PHC Tarrasso					
	Upper Siang	PHC Jeying	Bine	Sibuk	Pongging		
	Papum Pare	PHC Mengio	Kamrung	Nyopang	Pilla		
	Tirap	PHC Wakka	Nginu	Khanu			
	East Kameng	PHC Bameng	Lada	Paksa camp	Marjingla	Pakke	
	Lower Dibang Valley	PHC Anpum	Keba	Paglam	Bizari		
Future Generations,	East Siang	PHC Sille	Sika-Bamin	Mangnang			

AP	West Kameng	PHC Thrizino	Palizi	Subu			
J.A.C PRAYAS	Lohit	PHC Wakro	SC Medo				
N.N Charitable Society	Lower Subansiri	PHC DEED Neelam	SC Dem	SC Miya	SC Sito	SC Pania	
M.M. Charitable Trust	Upper Subansiri	PHC Siyum	Page Nalloh	Bogia Siyum	Eru	Laklam	Jingbarai

Under the umbrella NHM Programme there is immense scope for PPP mode of healthcare delivery system. This could be replicated in facilities not covered under NHM programme also. Let us look at various options of PPP for healthcare service delivery.

➢ Options for Primary Care PPPs under NHM are:

1. *Clinical Services*
   - *Engaging with private clinics- Capitation Model –*
     Various healthcare institutions and services in the State that are mostly dysfunctional and non-performing can be provided by a competent private player who levies minimal user charges and is subsidized by the Government.
     For instance, a PHC/CHC/District Hospital can be completely handed over to a private service provider for a fixed time period to provide specified services at fixed rates. Since the costs of the service delivery by a private service provider is likely to be high, hence the remaining costs will have to be borne by the government. However, this cost can either be met by government funding or by tapping into CSR funds.
   - *Contracting "in" Specialists for OPD*
     At various health centres where there is shortage of good specialists, the government can also think of hiring specialists on contract basis for fixed time periods. However, it needs to be borne in mind that good specialists shall be keen to opt for such contracts only if the infrastructure and other medical equipment is in order and functional.
2. *Diagnostics-*

- *NHM Free Diagnostics Scheme*

  The State also lacks good diagnostic services. CT Scan, MRI or even X-Ray machines or ultrasound machines are unavailable at many places and thus the service delivery deteriorates further despite availability of good health specialists. The PPP mode can thus also be opted for diagnostics wherein a private diagnostic lab can be directly linked to health institutions for all kinds of diagnostic tests.

3. *Outreach*
   - *Special outreach camps*– These can be conducted by good NGOs or other PR agencies who can inform the masses about the benefits available to them under various government health schemes. They can also generate awareness about benefits of institutional delivery, sterilization programs etc.

     It has been observed that ASHAs in the State are mostly not well-trained and ill-equipped to conduct such outreach programs. In fact, the whole approach has become more procedural and oriented towards documentation and statistics generation rather than being focused towards outcomes.

4. *Drugs*
   - NHM Free Drugs Scheme

     Most of the health institutions don't have adequate supply of the requisite drugs. In most of the areas of the State there are no private medical shops and citizens rely exclusively on the drugs available at the PHCs/CHCs etc. Thus it becomes extremely important to have sufficient quantity of medicines available at these institutions at all times.

     This can be achieved by opting for privately run medical shops that can stock the requisite medicines and disburse them to patients on the basis of prescriptions by government doctors free of cost. The cost can be claimed from the government. Thus, the government need not get into the business of logistics of arranging the medicines and can rather focus on the final outcome of ensuring that medicines are available to the citizens.

A **Franchisee model can be opted for such dispensaries.**

5. *Sanitation, House-keeping and Security*

Most of the government health institutions are unkempt and unclean and also face regular thefts or vandalism. This is primarily because of little or no staff to look after sanitation, house-keeping or security. Hence, these services can be outsourced to the private sector which has more expertise in professional management and delivery of these services.

➢ Challenges in PPP:

1. Limited presence of established private providers in primary care – market largely unorganised. The State of Arunachal due its difficult terrain and remoteness is not a preferred destination for may private providers.
2. Another challenge in attracting a good private player in the State of Arunachal is extremely low volumes and population base thus impacting the profit margins and operational costs.
3. Payment mechanisms do not incentivize better performance. It has been observed that payment models in most PPP contracts do not promote better outcomes rather they are more focused on adherence to procedures. This needs to be factored in all PPP contracts
4. Delays in payment to the private service provider. Any delays in payments will certainly discourage the private service providers from forging partnerships with the government.
5. Lack of specific and measurable performance parameters
6. Lack of robust monitoring mechanism
7. Inadequate capacities for managing the PPP contracts

➢ Pillars of successful PPPs

1. **Access** to Healthcare services
2. **Quality** of care to Beneficiaries
3. **Feasible** to private partner within budgetary constraint of Government

4. **Efficient** delivery system & scalable
5. **Robust** Monitoring framework and clearly specified and measurable performance indicators

➢ Case Studies of PPP being used by other States

✓ *Integrated hospital sanitation monitoring system dash- board (Andhra Pradesh)*

❖ Problem Statement

The erstwhile Sanitation Policy in the State of Andhra Pradesh had two major lacunae:

1. Policy: A single service provider was selected to provide three services- Sanitation, Security and Pest & Rodent control and often quality in the services was optimal.
2. Monitoring: Monitoring of such diverse services by a single nodal officer was prone to allegation to personal biases.

❖ Program Description

To address the issue, GoAP formulated New Scientific Sanitation Policy 2015, which was largely based on Swacchta Guidelines and Kayakalp parameters by decentralizing all 3 services to different service providers. It resulted into quality improvement and enhanced patient satisfaction.

For effective monitoring, a web based application named Hospital Sanitation Monitoring System was developed with Dynamic checklists and Assessment sheets duly linking to a Dash Board. It captures following critical data element for all the three services:

Name of services	**No. of Monitoring Items**	**No. of Measurable Elements**	**No. of Check points**
Sanitation	9	53	53

Security	6	5	54
Pest Rodent Control	7	39	48

- **Implementing Partners**

  Dept. of Health &FW, GoAP & NHM, AP.

- **Progress Outcome**

  Visible impact is noticed with patient satisfaction and public perception about the hospital services. The transparency, accountability and integrity of the program is maintained through dynamic process, which is displayed on public domain.

- **Financial Implications**

  The HSMS too has been developed with one-time implementation cost with no recurring costs/additional financial burden.

- **Scalability**

  The Monitoring too has been developed for improving the efficacy and efficiency of the services and objective monitoring. This is scalable at other institutions & health facilities.

✓ ***SWACCHTA MISSION AUDIT' - Infection control in public health care institutions (Gujarat)***

- **Problem Statement**

  There are 1700 health facilities in Gujarat. The culture of monitoring & supervision of cleanliness as per the laid standard was lacking in all the health facilities. Moreover, the Medical Officer busy with clinical work

always has limited time to monitor and supervise the cleanliness in the hospital including infection control practices.

❖ **Program Description**

The 'Swacchta Audit' is conducted on 6th of every month in all the Public Health Care Institutions since 2014. The audit aims to provide inter-departmental convergence for the monitoring & supervision of standards of cleanliness aiming to reduce nosocomial infections. The facilities are rated based on 25 questionnaires, each comprising of 5 scores, hence a total of 125 scores for 25 questionnaires in the tool. The facilities are graded based on the scores achieved as per below rating:

- 90% = A Grade
- 80- 90 % = B Grade
- 70-80 % = C Grade
- More than 40-50% = D Grade

❖ **Program Outcome**

Reduction in Hospital Acquired Infections & improvement in Patient Satisfaction

❖ **Implementing Partners**

- Health & FW Department
- PRI Members
- Local leaders
- Members of VHSNC
- NGOs

❖ **Financial Implications**

There is zero cost incurred in the initiative as it is conducted by involved stakeholders.

❖ **Scalability**

The 'Swacchta Audit' initiative is convergent initiative with concerned stakeholders which is implemented in all the health care facilities of Gujarat from District Hospital to Sub Centres

✓ ***Striving for excellence in quality of lab services- A case study of district hospital laboratory (RAJASTHAN)***

❖ **Problem Statement**

Laboratory services are critical in health care services provision. The Labs for Life laboratory services have been initiated in 20 Public Health institutions across 10 Districts and 6 States in India. This case study aims to present the effectiveness of the initiative in Paota District Hospital Laboratory, Jodhpur (Rajasthan).

❖ **Program Description**

The Labs for Life Project (L4L) is a pilot partnership initiative between MoHFW, US Centre for Disease Control and Prevention (CDC), BD and Christian Medical Association of India (CMAI):

- Implementation: After baseline assessment and closure of the gaps, following interventions were undertaken for implementation of Quality Management System (QMS)
- Safe collection practices for infection control and sample integrity.
- Safety: Safety audits, Fire Safety drills, Disaster management drills, Vaccination of staff.
- Equipment management: Daily maintenance, Calibrations, Downtime monitoring.
- Quality controls: Initiation of internal controls with monitoring, Registration with External Quality Assurance Scheme (EQAS).

- Documentation: Formats to record activities, SOPs, Quality Manual and Quality System Procedures.

Above initiatives were supported under NHM, L4L Project and the State.

❖ **Program Outcome**

The overall Quality score increased significantly from 27.25% at baseline to 59.7% at midterm (increase of 119%). It also resulted into all- round improvement in knowledge and skills, ability to adapt, responsiveness to changing requirements, team work, communication, staff attitude, motivation and morale of employees.

❖ **Implementing Partners**

MoHFW, CDC CMAI, Govt. of Rajasthan, DH Jodhpur.

❖ **Financial Implications**

Initial- Rs.8.0 Lakh PA, Recurring- Rs.4.0 Lakh PA (Cost of control)

❖ **Scalability**

Can be replicated at District Hospitals

Even though there are many benefits of PPP model in health care service delivery, however; it needs to be remembered that the private sector will primarily be always driven by profit motive while the state is mostly concerned with the welfare of its citizens. There is thus a need to align these aims and objectives for better service delivery.

Further, citizens will also look outside the government sector for quality health care and for services that are not available within the government health care

set-up. Thus, a universal health insurance scheme is a sine-qua-non for any State that seeks to promote well-being of its citizens. In the next section, we take a look at the experience of the Universal Health Insurance scheme till now and also discuss the broad contours of a better, robust and outcome driven revamped Universal Health Assurance Scheme.

Experience of Universal Health insurance and Way Forward

Arunachal Pradesh Chief Minister's Universal Health Insurance scheme (APCMUHIS) is a modest attempt by the Government of Arunachal Pradesh to provide universal health care services to all the citizens of the state in a cashless manner through a network of empaneled hospitals located all over India. The original objective of the scheme was to reduce catastrophic out of pocket expenses of its citizen. The scheme was new with unique operational modalities but activated in September 2014. It had lot of teething problems. Initially the scheme operated smoothly but subsequently during 2nd year the problems started to surface which now needs immediate correction. The Government of Arunachal Pradesh did not have direct agreement with the empaneled hospitals and the service agreement was between the insurance company and the hospitals for a period of 5years.

At the beginning of the scheme, 66 hospitals were empaneled of which 24 were within the state and 42 were spread across other cities in India. Later, problems began to crop up while implementing the scheme. As the service agreement was between the insurance company and hospitals, due to payment related dispute between them, most of the hospitals withdrew from the scheme. The crux of the problem has been delayed and non-transparent claim processing by the TPA (Third Party Administrator) of the scheme.

A number of short term and long term steps need to be taken by the Government for improvement of the scheme. Vital steps that need to be taken include putting in place a robust IT platform so that scheme is easily accessible to all and strengthening the Program Management component of the scheme.

The Government ought to plan for immediately putting in place a standalone Program Management Unit (PMU) with domain experts.

➢ Scheme Outline

The Arunachal Pradesh Chief Minister's Universal Health Insurance Scheme (APCMUHIS) is one of the flagship programs of the State Government which envisages providing Universal and Cashless health benefit up to Rs.2 lakhs as insurance coverage on floater sum basis per household per annum. Through a tender process New India Assurance Co. Ltd (NIACL) was selected as the insurer for the scheme. NIACL works through its subsidiary- the Dedicated Health Care Services- Third Party Administrator (DHS-TPA), Mumbai. The scheme was officially launched on 20th February'2014 and became operational on 17th September 2014. Memorandum of Understanding (MoU) is signed with NIACL for period of 5 years. The scheme is now implemented through a registered Government Society by name "Arunachal Pradesh Chief Minister's Universal Health Insurance Society" (APCMUHI Society) whose Chairman is the Hon'ble Chief Minister. The main objective of the scheme is to provide free medical and surgical treatment in government and private empaneled hospitals in cashless manner to the bona fide families of Arunachal Pradesh. The scheme is universal in nature because it includes all sections of people viz. Above Poverty Line, Below Poverty Line, Arunachal Pradesh Scheduled Tribe/Non-Tribal, Transgender and all State Government employees.

The scheme covers 1346 surgical / medical procedures requiring hospitalization that covers most procedures under cancer, gynecology and obstetrics, ophthalmology, cardiac illnesses, pediatric ailments, as well as day care procedures in dental, ENT and minor surgical procedures which are done in OPD setting. Each of these procedures is made into a benefit package and the rates of these packages include-

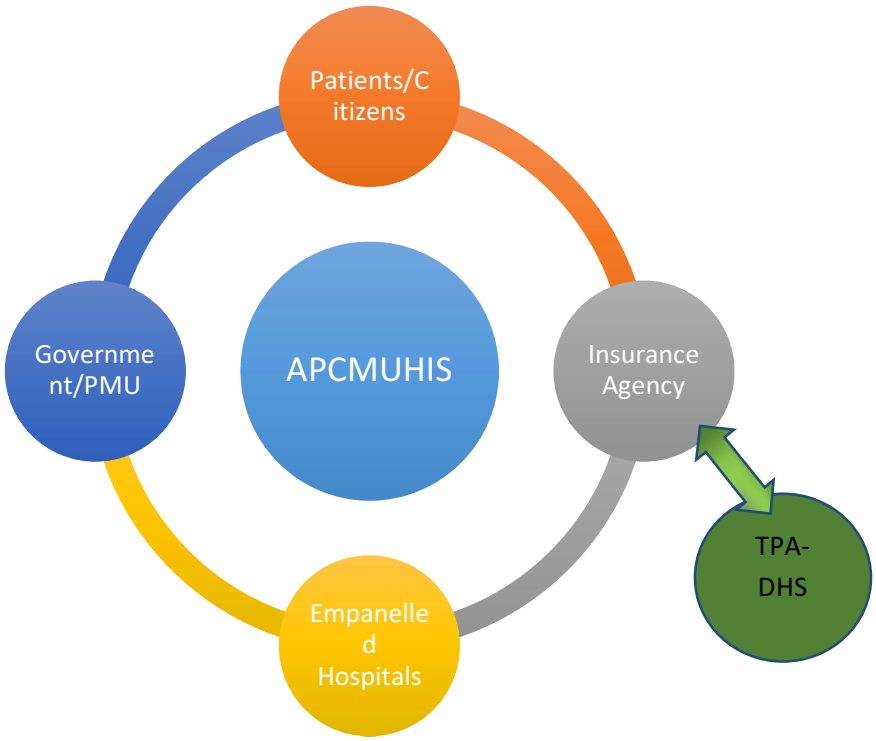
- Registration charges
- Bed charges (General Ward)
- Nursing and Boarding charges
- Surgeons charges
- Anesthetists charges
- Medical Practitioner fees
- Consultants fees Anesthesia
- Blood, Oxygen & O.T. charges
- Cost of Surgical Appliances
- Diagnostic tests (Including radiological) from the reporting to discharge
- Medicines from the day of reporting to up to 10 days of the discharge from the hospital for the same ailment/surgery
- Cost of Prosthetic Devices & implants
- It also covers pre-existing disease conditions of the beneficiary.
- Transportation allowance within the state by Government rate and outside state by Sleeper class berth in train is included in the overall package.
- Head of the family allowance of Rs.100 is paid up to a maximum of 7 days on hospitalization of the head of the household to compensate for bread earner.
- Further, in case of death of head of family due to accident a sum of Rs.50,000/- shall be paid within the overall insured amount.
- Also carriage charge of mortal remains of Rs. 5000 within Arunachal Pradesh and Rs. 10,000 outside the state is also provided under this scheme.

➢ Brief Performance of the Scheme

- 29,583 persons/families have availed the benefit of the scheme since the launch of the scheme with a reported claim amount of Rs. 64,54,15,409/- as per data provided by the insurance company (as on 21st Nov'2016).
- The insurance company has settled Rs. 39,9277816/- as claim settlement to the claims raised by various empaneled hospital spent on free treatment to the APCMUHIS beneficiaries.
- Data further shows that claims amounting to Rs 16,86,76,986/- have been rejected by the insurance company.
- The company data shows that their outstanding dues to the hospitals is Rs 6,08,82,685/-

- Meanwhile an amount of Rs 40.07 crores has been paid as premium to the insurance company by the state Government till date.
- The cumulative performance of the scheme as on 21/11/2016 may be seen at **Annexure- I**

➢ Stakeholders in the Scheme



➢ Formation of APCMUHIS Review Committee

In view of the problems being faced in operationalization of the APCMUHIS, the Government vide order No-Commr H&FW-02/2016 dated 29th September 2016 constituted a committee to **study the functioning of APCMUHIS** and **recommend modification for better and comprehensive coverage (refer Annexure-II).** The constitution of the Committee was as follows:

- Dr. Mohesh Chai, MLA, 44, Tezu Legislative Assembly
- Sh. Prince Dhawan, IAS, Spl Secretary (H&FW)
- Dr. Tana Takum, Nodal Officer, APCMUHIS
- Dr. Nabam Peter, Health Research Scientist
- V. Chello, F&AO, Health & FW Department

The committee went for field visits to various locations to study the functioning of the scheme at the ground level and to identify the problems being faced in the implementation of the Scheme. The members also visited Hyderabad to study the *Aarogyashree* Health Insurance scheme of Govt. of Telangana with the objective to learn the best practices.

Details of the field visits may be seen at ***Annexure III***

Interaction was held with all stakeholders namely the empaneled Hospitals, NIACL & DHS-TPA and beneficiaries.

- ✓ Empaneled Hospitals- Interaction with the Empaneled Hospitals was held as a part of visits to some of the empaneled Hospitals as at **Annexure III.**
- ✓ NIACL & DHS-TPA: Discussed all outstanding issues with the insurer & DHS-TPA officials team based on feedback from other stakeholders and beneficiaries during a meeting held on 10th November 2016 under Chairmanship of Commissioner (Health &FW).
- ✓ Beneficiaries/public leaders/officials: Open feedback was taken from all possible stakeholders through official letters, social media, etc. Few feedbacks may be seen at **Annexure-IV**

➢ Problems identified in the Scheme

Based on the feedback collected during the field visits and interaction with all the Stakeholders, the problems being faced in the implementation of the Scheme were identified.

The ensuing sections enlists the observations and the problems from the point of view of each Stakeholder that threaten to derail the scheme.

- *From Patient point of view*
  - Most of the patients who have availed the scheme feel that this is one of the best schemes by the state Government but it needs to be made hassle free.
  - Difficulty in getting new enrolment / updating family details / replacement of old cards & damaged cards
  - In some instances, after reaching the empaneled hospitals, beneficiaries were shocked to find that empaneled hospitals were not honoring the APCMUHIS smart cards. As per feedback from various sources, this trend started especially with the onset of 2nd year of the scheme.
  - Beneficiaries face difficulty in resolving technical issues at the APCMUHIS kiosks located in the empaneled hospitals and feel lost regarding facilities available under the scheme specifically regarding inclusions & exclusions, etc.
  - Still lot of confusion regarding benefits under the scheme among the beneficiaries especially in the rural areas.
  - Though the scheme is supposed to be cashless it is not so in many places. In some hospitals they charge the difference amount of the hospital rates of a procedure and the package rate given by the insurer from the patient. In some, the patients are charged the full cost of treatment and the hospital pays back the claim settlement amount only after they receive it from the insurer.

- *From Empaneled Hospitals point of view*
  - Empaneled hospitals complain that Insurance company is deliberately rejecting the claims in spite of providing all necessary documents. This problem started from the onset of 2nd year onwards.
  - There is no proper communication from the DHS-TPA side / insurance company regarding the rejection of cases and off late insurance company/ TPA officials have stopped communicating with the hospitals.
  - Further renewal of MoU could not happen as the package rates offered by the insurance company is lower than that was given during the 1st year of the

policy year and also Insurance Agency and TPA have started insisting on reimbursement based on actual expenditure rather than package.

- *From Insurance Company point of view*
  - Insurance company claims that it is running at huge loss due to excessive claims
  - State Government not paying premium in time leading to delay in payment to empaneled hospitals
  - State Government also not paying the service Tax component of the scheme which is an additional burden for the company
  - Empaneled hospitals not providing adequate supporting documents for settling of claims
  - Empaneled hospitals resorting to fraudulent means in raising claims

- *From the Department's/Program Management Unit(PMU) point of view*
  - *Lack of a dedicated PMU adversely affecting the implementation of the scheme at the field level. No dedicated PMU for the scheme leads to poor outcomes as a result of inadequate monitoring.*
  - *Due to lack of website/portal real time data about the system does not reach the program Managers/Govt. in time for taking immediate action. The department is at the mercy of insurer for real time data.*
  - *Difficulty in receiving timely grants in aid from the state Government leading to delay in premium payment to the insurance company.*
  - *Insurance company exploiting the situation of getting delayed premiums to not release outstanding claims to the empaneled hospitals and also not complying with other conditions under the Letter of Agreement.*
  - *Percentage of rejection was 15 % in the 1st year policy period. This rose to 51% in the 2nd year which is whooping and unacceptable. At this rate of rejection, no hospital will be able to sustain its operation and back out from the scheme. The statistics shows a trend of increasing rejection of claims in the 2nd policy year indicating a deliberate attempt by the insurer/TPA to reduce its claim settlement outflow/loss under the garb of document inadequacies and some or other silly observations. Statement of rejected claim details given in* ***Annexure-I****.*
  - *The Government is usually caught in an embarrassing situation when Empaneled hospitals without any prior notice suddenly discontinue APCMUHIS services unilaterally citing non-payment of dues by insurance company. Neither the empaneled hospitals nor the insurance company gives any prior information to the Government / PMU regarding the impending closure / discontinuation. Ultimately patients are the worst sufferer's in such a situation and PMU remains clueless about the matter.*
  - *The tripartite sub MoU between the Insurance Company, TPA and Empaneled hospitals does not clearly specify the documents to be submitted for each procedure/package to authenticate the claims leading to regular disputes and sudden disruption of services.*

- *There is a trust deficit between the hospitals (including Govt. hospitals) and insurer which more often lead to hot unpleasant exchanges in meetings. Insurer/TPA does not comply with their assurances given to government as well as hospitals.*
- *Differences in agreeing to package rates between the TPA and hospitals is leading to reluctance of many hospitals to sign/renew MOU forcing many to back out from the scheme.*
- *There is no time limit for claim settlement. Some of the claims of 1st year of policy period are still under process whereas the scheme is now in the mid of 3rd year.*
- *No proper grievance redressal mechanism for the scheme and hence felt need for a dedicated call center within the state.*
- *No proper information about the scheme among the beneficiaries and the responsibility for IEC of the scheme lies with the insurer as per the MoU whereas it should have been a joint activity*
- *Issues with Medical Reimbursement (MR) of State Government Employees as MR is now temporarily closed due to APCMUHIS and in some instances patients are referred to hospitals which are not empaneled under APCMUHIS due to specific expertise of that particular hospital.*
- *Issues related to critical illness like cancer, Liver transplant, Kidney transplant, etc. wherein the cost of treatment is more than Rs. 2 lacs and there are many representations to the health department including from the Finance Department for framing of a Govt. policy in this regard.*

➢ Present Process Flow in the Scheme

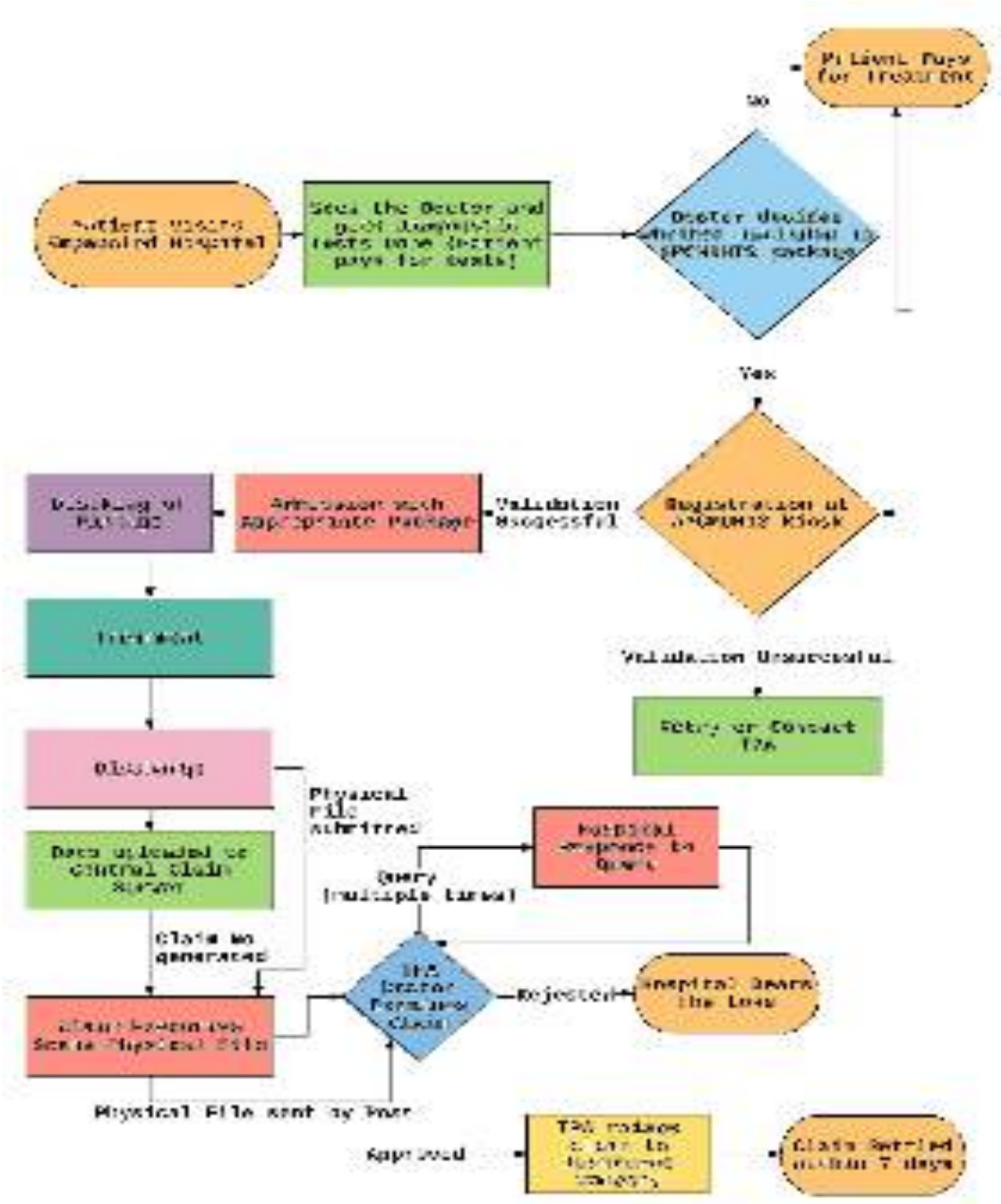
- Beneficiary Enrolled Under APCMUHIS will visit Empaneled Hospital for treatment
- Patient will be checked by the doctor and then according to diagnosis, if any, of the disease mentioned under the package, he/she or accompanying family member will be sent to APCMUHIS help desk for verification and blocking of procedure of the amount on the card.

- If the patient is suffering from any disease which is not mentioned under package procedure, the treatment of the same has to be carried out under "unspecified" in Govt. empaneled hospitals only @ Rs 9000/- for cases needing 3-5 days hospitalization and Rs 12000/- for cases needing hospitalization more than 5 days.
- If finger print verification is unsuccessful then modification of finger print will be done at Kiosk with identification of beneficiary.
- After the blocking and Registration process of the beneficiary is complete, the treatment process shall be started and all expenses during the treatment including expenses outside the hospital shall be borne by the hospital itself as it will be coming under package rate.
- One way travelling expenses as per actual state transport rates (within the state) & sleeper class rates(outside the state) will be part of sum insured and will be paid to the patient by hospital (to be later reimbursed by the insurance company).
- Head of Family(HOF) allowance @ Rs 100 for maximum 7 days would be paid by the hospital to be reimbursed by the insurance company.
- After completion of treatment when patient is about to be discharged he/she will go to the APCMUHIS help desk for final transaction.
- The amount that had been blocked before the treatment will be deducted from his or her total insurance coverage and the remaining value will be shown in the e-receipt given to the patient and one copy of that receipt will be given to the medical official who will be in-charge of the scheme.
- In case of death of HOF in hospital due to accident a flat sum of Rs. 50,000/- will be made to Director of Health Services(DHS), Govt of Arunachal Pradesh after receipt of documents related to legal heir, death certificate, and DHS will disburse the amount to the legal heir after verification.
- The Mortal carriage charge @ Rs 5,000/- inside Arunachal and Rs 10,000/- outside Arunachal will be paid by hospital which would be reimbursed by the insurance company.
- After discharge of the patient the hospital will submit physical files containing system generated admission slip, discharge slip. Discharge summary and all

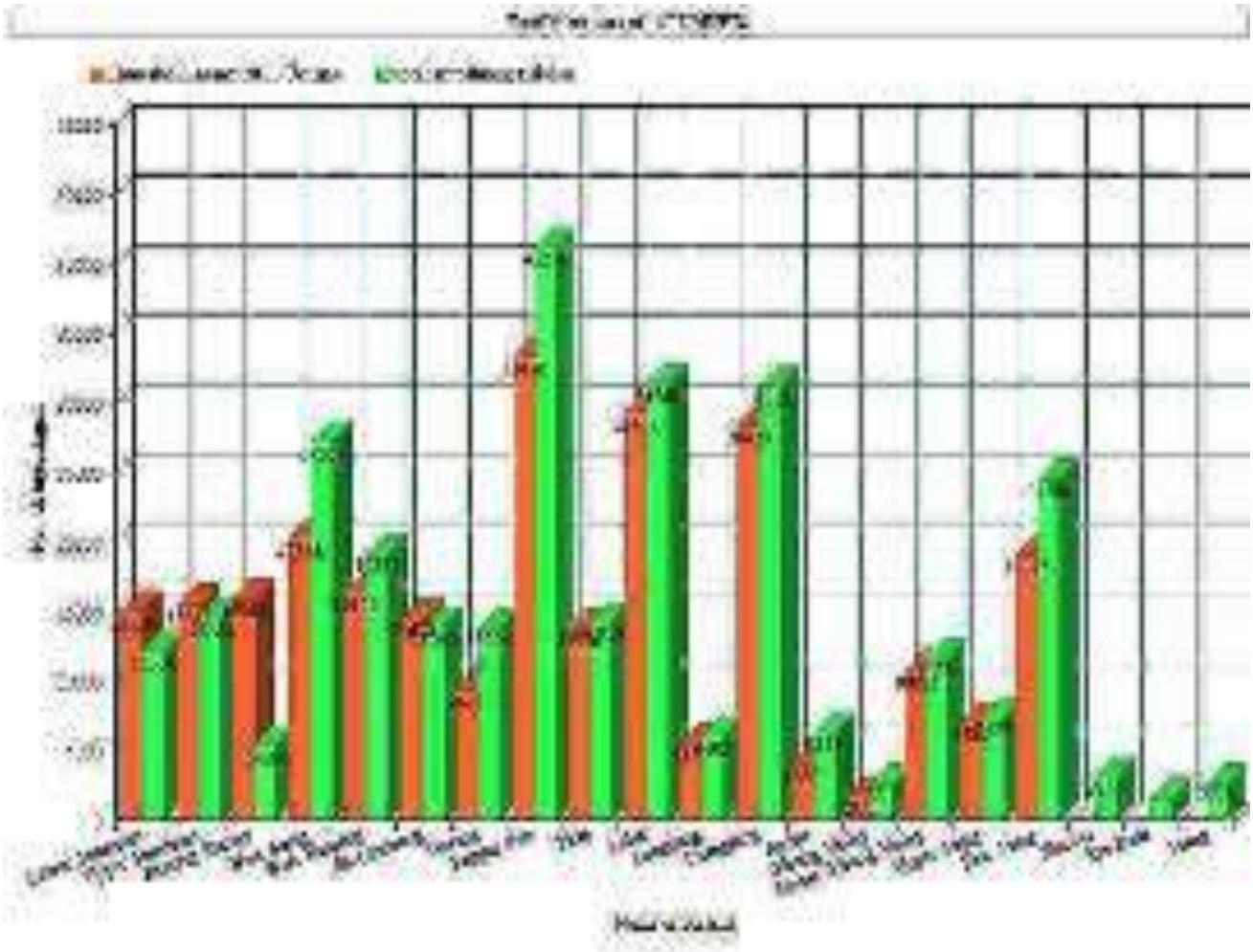
other documents related to the treatment of the patient to the insurance company/TPA for further processing of the claims.

- After receipt of the physical files with all necessary documents the claim will be settled within 7 days
- The claim settlement amount is transferred to hospitals account via NEFT transactions
- There is also provision for cancellation of admission if patient does not want to proceed with the treatment. The cancellation of admission can be done on the same day of admission.
- In case if any field problem needs resolution the escalation matrix is as follows:
    - *Level I: District Level TPA coordinator*
    - *Level II: Cluster In Charge(TPA)*
    - *Level III: State In charge (TPA)*
    - *Level IV: Head Office Representative(TPA)*
    - *Level V: Chief Admin Officer(TPA)*
    - *Level VI: CEO(TPA), New India Assurance Co. Ltd. and Govt. of A.P.*

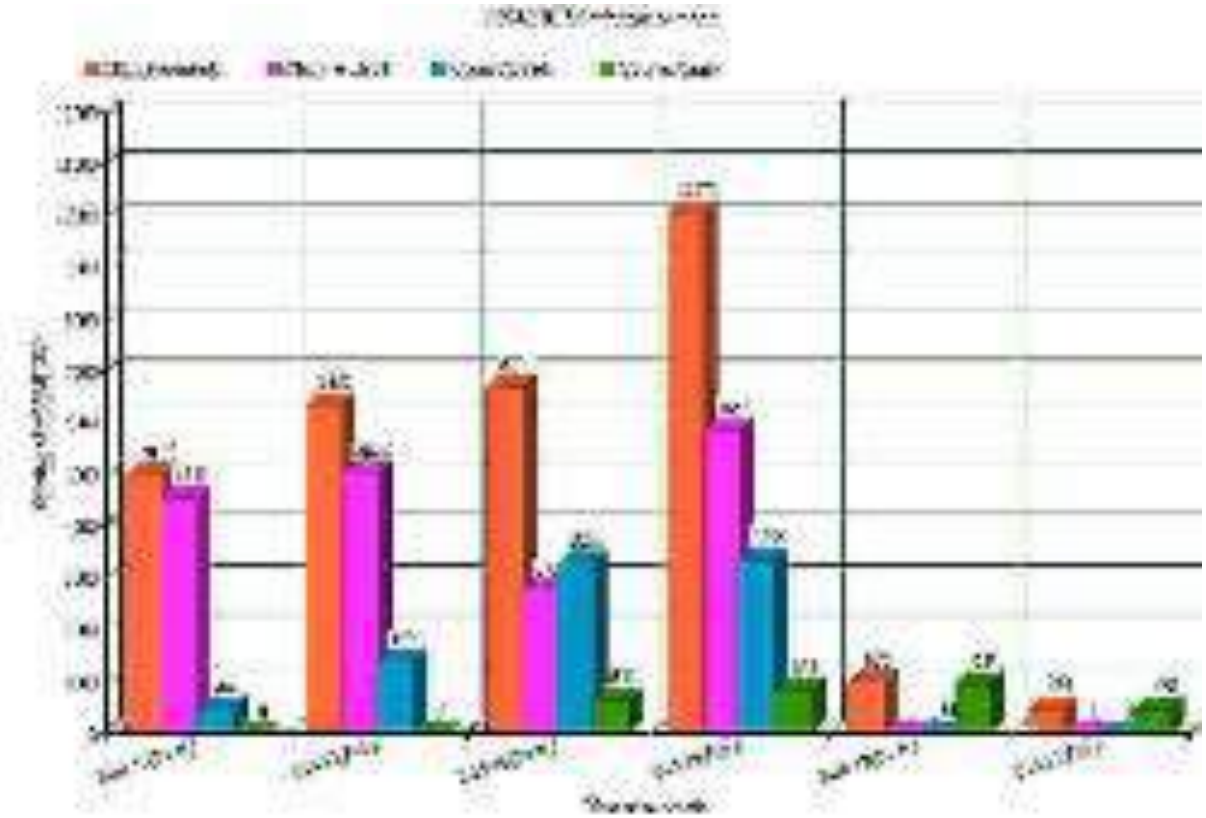
The above process flow is captured schematically in the Diagram below:


Yes
Yes
Physical file arrives
Query (multiple times)
Rejected
Approved

District wise population and enrollment status in the old APCMUHIS



Year wise claims filed by various hospitals with TPA and the number of claims accepted /rejected or sent for queries



➢ Proposed Revamped model of Health Assurance

The State Government has now decided to re- launch the scheme in Assurance Model wherein there is no concept of premium or insurance, rather a Management Support Provider (MSP) would be engaged to support the Government in implementing the scheme.

- The earlier scheme failed due to various reasons like lack of in house institutional knowledge on Insurance, quoting of low premium by the Insurer, lack of defined guidelines for adjudication (claim settlement), delayed/non-payment to empanelled hospitals by the Insurance Company and lack of trigger based medical audits.

- Re-launching the scheme again in Insurance model may not be viable proposition, as the expected premium (based on claim analysis of the APCMUHIS) will be too high for the State to afford.

- Because of collapse of earlier scheme many patients which included Indigenous population and Govt. Employees had to undergo untold suffering in the absence of some form of financial risk coverage like insurance.

- By re-launching the scheme in ASSURANCE Mode, the Govt will self-administer the scheme utilizing the services as well as expertise of a Management Support Provider (MSP) which will enable the Government to closely monitor/nurture the scheme apart from serving financial risk coverage for healthcare of the needy patients.

- In ASSURANCE model there is room for more flexibility Vis-Vis INSURANCE model. Since it would be self-administered scheme, the performance, effectiveness and outcomes will depend on having robust guidelines which will be reviewed from time to time.

- Tables showing main differences between Assurance Vs Insurance models; experience with Insurance model in the previous scheme & by other states and pros and cons of the Assurance model may be seen below:

DIFFERENCES BETWEEN INSURANCE AND ASSURANCE MODE

Particulars	**Assurance**	**Insurance**
Enrolment Criteria	Automatic – All individuals having APST/PRC/Employee ID plus Aaadhar card	Separate Smart Cards – Many families may get left out as enrolment only few episodes
Enrolment Rate	Automatic - 100 %	Only those having Smart Cards
Scheme Administrator	Directly by Assurance Society through Management Support Provider (MSP)	By Insurance company through Third Party administrators (TPAs)
Premium	No premium – Govt. releases funds to Society	Advance premium to be paid to insurance company
Avg. Unit Cost	Rs. 353/- per life per year	>Rs. 1000/- per family
Administrative Cost	6 – 7 % included in unit cost	20 % included in unit cost
Provider Payment	Case based	Case based
OOP & Co payment	No	Yes
Gate Keeping	APCMUHA Society – By doctors of MSP and also Govt. Doctors	By Insurance Cos. Through TPAs.
Flexibility of making changes in the scheme (Eg. Adding new procedures or group of	Can be done & implemented with immediate effect	Time consuming plus additional premium is to be paid to Insurance Cos.

people)		
Financial Security	Cashless Treatment	Unpredictable
Motive	Service – Welfare of people	Profit – Tendency towards less utilization, more profit

INSURANCE MODEL - APCMUHIS EXPERIENCE / EXPERIENCE OF OTHER STATES

- Due to competitive bidding involved, insurance companies may quote very low thereby compromising on the quality of service to the insured people whereas in assurance model this is avoided.
- If total payout is more than 70 % of the premium collected, insurance companies will slow down utilization to reduce losses compromising the health security of the needy people.
- Good hospitals are deliberately kept out of empanelment
- Active Hospitals will be targetted and continuation of empanellment will be very subjective
- All approvals and servicing of claims is at the discretion of Insurance Cos. & TPAs. The government does not have control over TPAs to ensure proper & full utilization.
- There will be no effort to increase awareness among beneficiaries by Insurance Cos. as it increases outgo
- Denial of claims would be higher on the slightest pretext
- Due to the profit motive of the insurance companies, the tendency is to ensure less utilization of the scheme defeating the very purpose of the health schemes.

- Under tertiary, there is no empirical evidence as to the incidence / prevalence rate. The insurance cos. will assume incidence to be between 0.8 % to 1.2 % & charge very high premium, which may or may not be utilized.
- Under Assurance, there is conscious effort to increase participation of Government / Public Hospitals and maximum utilisation of benefits by beneficiaries

ASSURANCE MODEL- PROS AND CONS

PROS	CONS
No Budgetary limit/ Increase cash flow	The Project can lead to catastrophic losses with no risk sharing
Policy design can be changed as required over time	In house administration may be interfered with by political pressures
A Self-Funded health plan can allocate more of each dollar toward payment of medical claims through eliminating commissions, risk charges and insurer profit	May have high level of interference of providers and hence less control over the outgo
Better Reserves	Self Insurers are not able to be reinsured
No Margins to be kept for Adverse claim ratio	Legal Liability is inhouse too
Administration Cost may be less with Self Insurers to a max of 5%	Catastrophic losses lead to non sustainable programs
Administration cost does not remain low, since inhouse administration still required manpower intensive project management	Software needs to be bought/cost incurred
Not subject to IRDA regulations	Requires more time to design, implement & monitor

➢ Coverage- Population and Benefits extended

✓ Family floater to individual coverage:

- Due to lack of proper data on family size and number, no checks could be built on individual posing as the single beneficiary for the family floater
- Variation in traditional practices posed difficulty in identifying the head of the family and the number of individuals in a family thus proving hindrance for equal benefits.
- To overcome the above practical problems, the scheme should be designed to cover individual.

✓ Enhancement in Sum Assured

- Move from erstwhile Sum insured of Rs. 2 lakhs to sum assured of Rs. 2 lakhs with enhanced coverage for critical illness up Rs. Rs 4 lakhs and Rs. 5 lakhs for General public and State Government employees respectively:
- Most of the secondary and tertiary packages identified are done outside Arunachal Pradesh. Once the beneficiaries go outside the State, they expect good facilities. There is no scope for provision of transport expense and other travel expenses for the bystander/attendant of the patient. Enhancement will give relief in minimising out of pocket expenses during hospitalization.
- During the previous scheme there was no provision for persons afflicted by critical illness beyond Rs 2 lakhs.
- The load on Chief Minister's Relief Fund (CMRF) will drastically reduce as most cases seeking assistance under CMRF can be directed to take benefit under this scheme. Further, genuine patients afflicted by high cost critical illness who have exhausted their top up amount can approach the CMRF or Government may devise a mechanism to fund such cases through buffer or corpus fund within the scheme.

✓ Use of Aadhaar number:

This is a welfare scheme where benefit must be weighted carefully with the outgoings of the State exchequer. We cannot afford to allow anyone to pilfer the Government fund by means of cheating and other fraudulent activity. Aadhaar is unique identification for an individual and is robust enough to check duplicate and fake identities which can be easily verified and authenticated.

✓ Inclusion of Government Hospitals

The Government hospitals are mandated to offer free / subsidized services to the public & one of the thoughts was not to include the Government hospitals in the assurance scheme, however if the Government hospitals are excluded from the scheme, the following effects would be observed :

- Utilisation of the scheme would be 100% only in Private hospitals which is contradictory to the objective of the scheme to strengthen the government health system
- As a best practice all other state schemes encourage government hospital participation since the equity of care is higher in Government hospitals
- Geographic spread of government hospitals are better compared to private hospitals within the State. They are usually the first point of contact.
- A Cashless scheme will minimise the out of pocket expenses which are incurred by patients in current scenario in government hospitals.
- Since the scheme is incentivising the government health machinery, better outcomes & infrastructure is envisaged with the inclusion of Government hospitals

➢ Financial Projections

Based on the data available as per the previous APCMUHIS, the following financial projections have been worked out for the Assurance model:

- Total Packages – **1346**
- Utilized Packages - **848**
- Non - Utilized Packages - **498**
- Total Number of Claims in 36 months – **30,697**
- Total Liability over 36 months – **INR 670,350, 189/- (This is as per the historical data given by PMU)**
- Average Liability Amount per claim – **INR 21838/- = (670350189/30697)**
- Though the previous schemes was for 3 years, however the first 12 - 14 months had minimum claims and the scheme practically worked completely for about 24 months
- Based on the above fact, the assumption is that the maximum claims were reported in the last 24 months & hence the projections are as follows –
    - Incidence rate for 36 months on a population of 12 lac lives – **1.28% per life per year = (30697/1200000/2)×100**
    - Cost per life per year – **INR 279/- = (670350189/2/1200000)**

Historical Data as per the PMU for the previous scheme :

	# packages	# claims	Claims / Year	Reported amt	per yr outgo
Total Packages	***1346***	***30697***	***15349***	***670350189***	***335175095***
To be retained	634	15755	***7878***	430697510	***215348755***
To be excluded	712	14942	***7471***	230122315	***115061158***

- Changes as per the newly designed policy –
    a. **Family floater changed to Single Sum Insured**
    - Factor for conversion of 1.31 is defined below -
        - Total Number of Unique Chip Numbers – 2,49,783
        - Since the policy was a family Floater, the number of Unique SMART card chips utilized –**19207**
        - Cards Utilized only once – **13216**
        - Cards Utilized more than once – **5991**
    - Factor for utilization of card from Family Floater to Single Sum Insured – **0.31 = (5991/19207)**
    - The total conversion factor hence for converting from Family floater to Single Sum Insured – **1.31**
        - Card utilized once = 1
        - Card utilized more than once is 0.31
        - Hence the factor has been calculated as 1.31
    - **So cost per life post conversion to Single Sum Insured – INR 366/- = (279×1.31)**

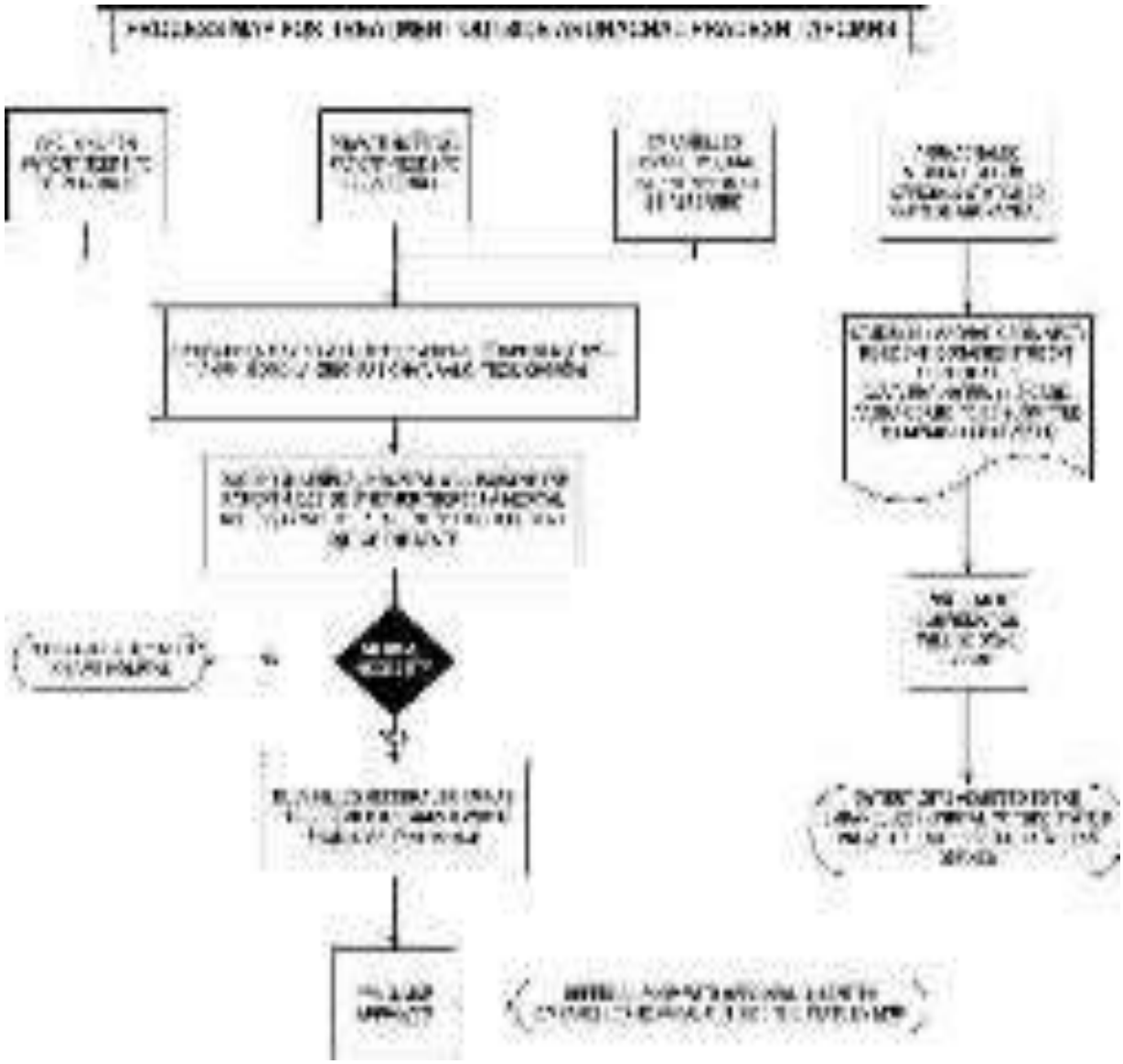
    b. **Number of Procedures have reduced from 1346 to 634 (No new procedures have been added)**
        - Number of claims proposed for the 634, based on the Incidence ratio per life – **7878**
          (This is the number which has been reported for the previous Insurance Scheme where the procedures have been utilized & have been decided to be retained)
        - The total outgo for the above claims per year = INR 21.53 Crore
        - Proposed yearly outgo with Single Sum Insured – **INR 28.21 Crore = (21.53×1.31)**
        - Proposed Cost per life – **INR 235/-** = (28.21 Cr/ 12 lacs)
        - Proposed Cost per Life with 50% increment is due to
            - Increased Cost per package
            - Increase in the incidence rate
            - Top Up Benefit

– **INR 353/- = (235×1.50)**

- Total Proposed Liability – **INR 42.38 Crore = (353×1200000)**
- Administrative Fee of PMU + MSP – INR **33.27 /- Per life / Year**
  - Per Year cost for PMU = INR 1.5 Crore
  - Per Year cost for PMU per life = INR 12.50/-
  - Per Year cost for MSP = INR 2.49 Crore
  - Per Year cost for MSP per life = INR 20.77/-
  - Total Administrative Cost Per Life Per Year = INR 12.50 + 20.77 = INR 33.27/-
  - Total amount for administration per year = INR 3.99 Cr
- Total project Cost – **INR 46.37 Crore per year = (42.38 + 3.99)**

➢ Proposed Process of Claim Processing in the Assurance Model

1. **Benefits**
   - Individual Sum Assured
   - For Non critical ailments Individual Sum Assured is maximum of Rs 2 Lacs per year per member
   - For Critical ailments:
     i. Sum Assured for APST Members is Rs. 4 Lacs per year per member
     ii. Sum Assured for Government Employees & their dependents is Rs. 5 lacs per year per member
2. **SOP for Referral out of State –**
   - For Predefined illness & procedures which are not available within state
   - Mandatory Referral from defined General Hospitals for referral
   - **Process for above –**



Evidences for pre- authorization and claim settlement In order to streamline pre-authorization and claim settlement evidences, the following evidences are prescribed.

S.No.	Evidence	Requirement	Reason
1	On bed photo	Mandatory	To ensure the patient is admitted
2	Video recording of procedure	Mandatory in all endoscopic procedure/Angiography/ Laparoscopy procedures	To ensure procedure is performed as per the claim

3	Intra-op photo 1. One photograph of the patient with face while on the operation table. 2. Photographs showing the critical steps of the procedure. 3. One photograph of the suture line at the end of the procedure.	Mandatory Surgeries under CVTS surgery, Oncosurgery, genitourinary surgery are exempt from during the procedure photos at (2) & (3).However, Govt.hospital may be exempted from Photographs showing the critical steps of the procedure. Procedures involving private parts are exempt from photos.	To ensure procedure is performed as per the claim.
4	Scar/ suture photo	Mandatory	To ensure procedure is performed.
5	Discharge photo	Mandatory (photo with MCO/Duty doctor/ARM in front of Kiosk/Banner/Poster)	To ensure complete recovery of the patient
6	Case sheet, Operative notes for surgical procedures	Mandatory	Required for proper evaluation & audit
7	Investigations- Pre & post Therapy/Surgery	Mandatory	Required as they are vital for proof of standard diagnosis and treatment.
8.	Death certificate in	Mandatory.	To confirm outcome

The Govt. will self-administer the scheme utilizing the services as well as expertise of MSP which will enable the Govt. to closely monitor/ nurture the scheme apart from serving financial risk coverage for healthcare of the needy patients. The scheme is designed to cover mainly secondary and tertiary care.

Home-Grown Success Stories

Some of the initiatives taken by the district administration capital complex to improve health care service delivery

a) Inauguration of Minor OT / Laboratory at U-PHC at Itafort Dispensary from DC's Untied Fund

b) Clean Hospital Campaign as a part of Swachh Bharat Mission

c) Intensified Mission Indradhanush within Capital Complex

Conclusion

The Government needs to work upon the following key priority areas to improve Health Service Delivery in the State:

- Infrastructure development and rational staffing as per Indian Public Health Standards(IPHS)norms.
- Converting all PHCs/U-PHCs into delivery points.
- Quality care to be improved including less waiting time for patients.
- IT enabled services (ITES) and e-governance for effective tracking, monitoring and timely intervention for the urban poor.
- Capacity building of stakeholders (Human Resource Development)
- Proper referral system from Primary Care health facility level to secondary/tertiary care.
- To improve the social determinants of health there should be a good intra and inter sectoral convergence between the departments of Health, ICDS, Education, Municipal Councils/Panchayats, UD & Housing, PHE, PWD, Police, General Administration, and etc.
- Strengthen the Primary Healthcare services to extend the services to underserved areas
- Incentives may be provided to doctors/ staffs posted to remote areas (hard posting).
- Community level healthcare activities to be improved with active participation of ANMs, U-ASHAs, MAS, AWWs and SHGs through community outreach activities.
- Awareness about the Government services like JSY, JSSK and others. Mobile campaigns may be launched.
- IEC s on health education, hygiene, preventive health care improvement etc should be conducted regularly.

- Recruitment of specialist to cater to the needs of district as per IPHS norms.
- Generic medicines should be made available to increase affordability and continuous monitoring should be done.
- Well-functioning Health Assurance Scheme
- Most importantly, public demand generation should be accelerated.

There is a need for radical shift in the thinking process within the Government policy making and new service delivery models need to be adopted. Activating PPP and operationalizing a new and working Health Assurance Scheme shall certainly go a long way in improving health service delivery within the State. It needs to be also borne in mind that for any initiative to be replicable and sustainable, it must be backed by a robust IT system which can help the administrators to track the progress of a scheme and monitor the outcomes. The government needs to commit a significant portion of its budget towards Health Sector for substantial improvements and it needs to do this urgently.

ANNEXURES

- *Annexure-I*

Cumulative APCMUHIS Hospital Wise Claim Analysis, 2014-15, 2015-16 & 2016-17 (as on 21-11-16)

Hospital Name	No of Reported Claims	Reported Claim Amount	No of Settled Claims	Settled Claim Amt	No of Closed / Rejected Claims	Closed/ Rejected Amt	No of O/s Claims	O/s Claim Amt
Tomo Riba State Hospital	7,124	15,30,94,148	4,489	9,20,15,582	1,467	3,10,31,514	1,168	2,64,54,746
District Hospital, Aalo	169	39,66,776	57	11,26,195	101	24,72,816	11	2,67,195
District Hospita,l Anini	2	204	1	100	1	102	0	0
District Hospital, Bomdila	607	1,03,74,307	244	37,27,658	323	58,19,489	40	6,96,730
District Hospital, Changlang	142	26,42,200	89	15,17,350	53	11,11,180	-	-
District Hospital, Daporijo	974	1,77,19,944	265	39,72,815	692	1,30,30,684	17	3,15,470
District Hospital, Khonsa	236	48,88,201	89	16,89,600	147	30,59,286	-	-
District Hospital, Koloriang	5	50,550	5	50,000			-	-
District Hospital, Roing,	17	74,280	13	57,000	4	17,150	-	-
District Hospital, Seppa	172	32,27,991	90	12,20,000	82	14,06,042	-	-
District Hospital, Tawang	331	9,35,020	188	6,44,900	83	1,90,709	60	98,296
District Hospital, Tezu	18	3,42,733	10	2,01,200	8	1,29,815	-	-
District Hospital, Yingkiong	44	4,89,340	28	3,18,650	12	1,26,800	4	40,400

District Hospital, Ziro	778	42,03,863	367	16,43,997	262	19,12,864	149	6,20,505
General Hospital, Pasighat	1,125	2,70,08,585	547	1,20,32,732	423	1,04,92,855	155	35,30,838
CHC, Sagalee	942	9,61,542	826	8,80,610	112	65,020	4	2,070
CHC Longding, Longding	-	-	-	-	-	-	-	-
CHC Hayuliang, Anjaw	-	-	-	-	-	-	-	-
ADITYA DIAGNOSTICS & HOSPITALS	1,949	4,25,36,022	979	2,83,72,060	969	1,07,91,411	1	51,001
Apollo Gleneagles Hospital LTd.	4	3,32,700	4	3,31,900	-	-	-	-
Apollo Hospital	73	35,59,270	46	26,88,032	13	3,76,611	14	4,47,402
Apollo Hospital - Jubilee Hills	1	74,900	1	74,900	-	-	-	-
Assa Diagnostics & Nursing Home	1,712	3,19,40,619	1,169	2,25,33,619	412	61,05,193	131	25,69,498
B J Nursing Home	1,880	5,99,45,330	1,362	4,36,80,543	511	1,51,92,443	7	1,99,509
Baptist Christian Hospital	761	70,42,109	592	40,47,407	122	22,74,630	47	6,78,612
BTM Hospital, PappuNala (NLG)	39	10,33,248	15	3,56,504	24	6,62,502	-	-
CMC Vellore	3	1,92,800	3	1,58,400	-	-	-	-
Sanjivini Diagnostics and Hospital	126	22,56,859	69	15,21,027	52	7,07,472	5	27,190
Divjoni medicare & diagnostic Centre	2,121	3,24,09,900	1,493	2,29,50,157	556	79,56,786	72	13,21,988
Down Town Hospital	401	2,14,33,825	227	1,10,55,232	147	77,97,852	27	18,75,221

Dr B Boraah Cancer Institute	413	36,70,413	117	11,82,212	39	2,51,019	257	22,25,580
GNRC Hospital	492	3,66,61,051	428	3,13,18,559	56	40,55,910	8	6,44,600
Hayat Hospital	235	85,50,336	84	32,80,495	106	33,62,467	45	16,74,361
Heema Hospital	1,561	4,38,38,525	927	2,54,36,849	327	90,05,550	307	87,41,452
Indraprastha Apollo Hospitals	175	98,83,705	122	78,14,889	22	9,59,678	31	8,66,468
JJ MEMORIAL HOSPITAL	589	1,27,33,053	316	67,76,963	266	55,31,548	7	1,78,513
Malpani Hospital and research institute	1	8,510	1	8,500	-	-	-	-
Ratan DIAGNOSTICS AND Nursing Home	120	9,51,280	-	-	-	-	120	9,51,280
Narayan Hrudalaya	1	1,25,200	-	-	1	1,25,200	-	-
Narayan Super Seciality Hospital	2	3,21,998	2	3,21,998	-	-	-	-
MEDICARE DIAGNOSTICS & HOSPITAL	836	1,70,94,991	583	1,13,57,608	250	50,50,444	3	53,581
Ruby General Hospital	5	3,63,720	3	1,30,000	1	55,000	1	1,78,700
Samaritan Hormin Hospital	2,032	4,92,64,381	1,367	3,24,75,800	435	1,00,36,342	230	53,29,499
Sevenhills Healthcare Pvt. Ltd.	14	2,98,817	14	2,63,800	-	-	-	-
Shivalik Medical Centre Pvt Lmt	1	30,010	1	30,000	-	-	-	-
Sri Shankardeva Nethralaya	35	9,15,691	22	5,48,113	13	3,64,869	-	-
Srishti	1,091	2,36,92,197	783	1,73,34,479	307	58,52,849	1	25,520

Hospital								
Tago Memorial Hospital	82	14,56,098	49	7,74,451	33	6,63,337	-	-
Sri Ramachandra Medical Centre	6	3,38,610	5	2,99,300	1	39,110	-	-
Max Super Speciality East Blook	13	7,89,120	10	6,73,800	**3**	**1,15,050**	-	-
Max Super Speciality Haspital (W/Blook)	1	38,200	1	38,000	-	-	-	-
Medanta Hospital	10	8,76,461	-	-	1	60,001	9	8,16,460
Max Super Spciality Hospital Vaishali	1	68,200	-	-	1	68,200	-	-
Manipal Hospital	1	1,25,320	1	1,25,320	-	-	-	-
EMM Hospital	109	5,69,856	38	2,06,310	71	3,49,186	-	-
Currae Spciality Hospital	1	12,400	1	12,200	-	-	-	-
	16,897	**41,54,35,725**	**10,835**	**27,81,79,427**	**4,739**	**9,78,10,660**	**1,323**	**2,88,56,435**
GRAND TOTAL(Govt + Pvt)	**29,583**	**64,54,15,409**	**18,143**	**39,92,77,816**	**8,509**	**16,86,76,986**	**2,931**	**6,08,82,685**

- *Annexure-II*

- *Annexure III*

Field Visit Experiences/Feedbacks

TRSH, Naharlagun-Team visited the hospital on 30th September'16:

- Met the Chief Medical superintendent (CMS) and also interacted with the Kiosk operators regarding the process followed in detail.
- Scheme was operational in the hospital at the time of the visit.
- CMS informed that around Rs 2 Crore was pending for payment to the hospital by insurance company
- CMS also alleged that the insurance company had raised unnecessary / silly queries to all the valid claims of the hospital.

DHS-TPA office, Naharlagun- Visited on 30th September'16

- Interacted with the DHS-TPA doctor and other staffs
- TPA doctor informed that claims are now processed in Naharlagun but it is again scrutinized at Mumbai TPA office for 2nd time.
- The staffs informed that they do not have access to central database of the beneficiaries and so it is not possible to check for name of beneficiary before issuing new card/replacing old card
- Staffs also informed that cards can't be printed here in Naharlagun and needs to be sent to Mumbai and from there it is again sent back

Medicare Hospital, Dibrugarh-

- Met MD of the hospital Dr. Damani and interacted with kiosk operator.
- APCMUHI Scheme is non-operational at the time of visit.
- Closure due to non-payment of claims raised to the insurance (approx. outstanding dues Rs. 50.0 Lacs)
- During recent times more number of rejection of cases seen.
- The practical steps followed by the hospital right from reporting of the patient to hospital till discharge was inquired.
- MoU expired more than a year back and has not been renewed till date

- Renewal could not happen due to disagreement in package rates. Hospital was offered with condition that either actual expense or package rate would be offered whichever is lower which was not agreeable/accepted by the hospital leading to delay in renewal.
- The hospital has been offered with package rates, which are lower than that was offered/agreed earlier, which is not in tune with cost escalation in the market.
- The hospital is implementing RSBY by National Insurance Corporation through Emeditech (TPA) and bills have been settled regularly.
- Hospital authority revealed that reimbursement for diagnostic procedures are done once case is found admissible.
- Transaction application in the hospital was inspected and mock demonstration with actual card was tried. However, transaction was not successful as application was not updated and screenshot showed "Insurance Company Code does not exist in DB"
- Later the team visited the hospital to see the available facilities.
- Documents requested from the hospital authorities were: Copies of queries related to claims, Copy of MoU, hospital profile, hospital rates of procedures(actual), copy of payment detail by Insurance Company to the hospital.


Shristi Hospital, Dibrugarh- Visited by the team on 7th October 2016

- Service discontinued since March 2016

- MoU expired in April 2016
- Rejection of claims started in December 2015 and no opportunity was given to explain or support claims.
- Instances of rejection on flimsy ground noted ones being seeking for physical X-Ray films and post-operative Ultrasound(USG) for cases such as appendectomy where such tests are usually not necessary

- If two operation are performed on the same day, only 50% of second operation is payable.
- If two procedures are blocked only one is cleared and other always queried or rejected without explanation.
- There are no operational guidelines in place.
- Successfully implementing other insurance policy without any instances of rejection where pre-authorization procedure is followed and final settlement comes to 99%.
- Communication gap widened later ultimately resulting in no response from TPA.
- Instances of "File not received" increased later and there is no acknowledgement procedure in the system.

Aditya Hospital, Dibrugarh- Visited by team on 7th October 2016

- Met Managing Director, Dr. N. K Sahewalla, Rajendra Bhagat- Manager (Corporate Relations) and Satish Modi- Manager (Commercial)

- Was informed that the services of APCMUHIS ceased more than 6 months ago.
- Was also informed that it was verbally conveyed to them that delay in settlement of claims was due to non-payment of premium by State Government.
- Differences over actual and package rate are collected from the patients.
- When two packages are blocked, lower packages are approved.
- Does not pay even when pre-authorization was done.
- Biometric does not match in many instances.
- Offline authorization given in few instances but payment not approved.
- TPA is not responding to any communication.

Arogyasri Health Care Trust(AHCT), Hyderabad- Team members visited AHCT office on 13th& 14th Octotober 2016

- Meeting with CEO & Officials of AHCT
- Visit to Data processing center
- Visit to Call centre- 24x7 online queries apart from aarogyasri health insurance for all medical conditions under single roof

- Visit to NIMS-Government hospital
- Visit to Continental Hospital(Pvt hospital
- **Overview of the scheme:** Aarogyasri Health scheme is a unique Community Health insurance scheme being implemented from 1st April 2007 by earstwhile Government of Andhra Pradesh. The scheme is the flagship of all health initiatives of the state Government with a mission to provide quality health care to the poor as defined by civil supplies Department of the Government of the state. The scheme is run in PPP model in field of Health insurance, tailor made to health needs of poor patients and providing end to end cashless medical services for identified diseases through a network of service providers from Government and private sector. The scheme started with launch of

Aarogyasri –I(AS-I) scheme in 2007 initially with 3 pilot districts and subsequently in 2008 the Aarogyasri-II(AS-II) covered the entire state to cover 233 lakh families. The identity of the beneficiaries and family size is based on the socio-economic data, digital photographs and biometrics available in ration card/PDS card for BPL families/Health card. Government further extended the scheme to the other persons suffering from serious ailments, (i.e. who are not having ration card and who are not covered under AS-I & II) under Chief Minister's Camp Office Referral Letter(CMCO) scheme. The scheme was extended to working journalists and their families in 2009. In order to facilitate the effective implementation of the scheme the state Government set up the Aarogyasri Health Care trust under Chairmanship of Chief Minister. The scheme is now run in "trust mode" wherein role of insurance company and TPA is performed by the Trust. The trust is administered by a Chief Executive Officer. The trust in consultation with the specialists in the field of insurance and health care runs the scheme.

- The scheme is designed in such a way that the benefit in the primary care is addressed through free screening and outpatient consultation both in the health camps and the network hospitals as part of scheme implementation. The IEC activity during health camps, screening, counseling and treatment of common ailments in the health camps and outpatient services in network hospitals is supplementing the government health care system in preventive and primary care. The entire process from the time of conduct of health camps to the screening, diagnosing, treatment, follow up and claim payment is made transparent through online web based processing to prevent any misuse and fraud. The scheme is complementary to facilities available in Government hospitals and put together fully meets the medical requirements of the BPL population including prevention and primary care. All the Primary Health Centres(PHCs) which are the first contact point, District Hospitals and Network Hospitals are provided with Help Desks manned by *Aarogya Mithra* to facilitate the illiterate patients.
- It was pointed out that some of the critical learning points of the scheme which were responsible for success of the scheme was-1) Important role

played by the Aarogya Mithra and Medco of the network hospital 2) Robust IT platform through which all activities are carried out 3) System of preauthorization so that claims based on evidence and also prevent the frauds 3) Grievance Redressal through the same web portal.

- Departments under the Aarogyasree Health care trust:
  - Programme Management Unit
  - Planning & Coordination
  - Operations
  - Finance, Budget & Administration
  - Field Operation support services
  - Grievance
  - Health camps
  - 104 Call Centre
- **Eligibility** for benefit under the scheme
  - WAP Card (White Card)
  - AAP Card (Annapoorna Card)
  - YAP Card (Anthyodaya Anna Yojana Card)
  - Health Card (Aarogyasri Bheema Health Card)
  - Journalist Card
  - TAP Card (Temporary Card)
  - RAP Card (Rachhabanda Card)
  - CMCO letter(Chief Minister's camp office referral letter)
  - Pediatric Cases-Beneficiary Copy / Birth certificate / Delivery certificate / Self declaration by parents.
- **Role of Arogya Mitra**:
  - Receive the patient at the Network Hospital.
  - Verify the non technical documents of the patients like health card/ration card/ beneficiary copy/Birth certificate/delivery certificate in case of child etc.
  - Facilitates the Patient for consultation with concerned specialist and for admission.
  - Facilitates NWH to send proper pre-authorization as follows.
    - In patient Case registration and handovers the pt. to MEDCO
    - Preauth updation by MEDCO of Network Hospital(NWH)
- **Pre-authorisation process:**

- Beneficiaries approach NWH from various sources
- Aarogya Mithra examines the referral card / BPL card and will do the Registration of the Beneficiary.
- Network Hospital, basing on the Diagnosis, admits and sends Preauthorization Request through E-Preauthorisation by MEDCO.
- Pre-auth Executive(PEX) will verify homepage,WAP number, details of the Pt. and all other non-medical documents like Pre-auth forms, consent, counseling, DTRS forms, Health card/White card etc., and forward to the Panel doctor (Specialist) with remarks.
- Panel doctor (Specialist) examines, verifies and approves if all the technical Documents/Evidences are as per AHCT guidelines or will keep pending for want of clarification on remarks from NWH and PPD will reject if pending remarks are not updated by NWH.
- After Panel doctor, The Trust doctor examines , re-verifies all documents and Approve / Pending / Reject the case.
- After Trust approval the NWH extends Cashless Treatment and provides Cashless Surgery/Therapy.

- **Claims processing:**
  - Aarogyasri Claims processing (claim initiation, collection of documents, scrutiny of claim documents) shall be carried out electronically through the Trust Portal.
  - The Network Hospital will raise the claim 11 day onwards after satisfactory discharge of the patient upon the performance of the listed therapy(Some identified packages have exemption for the same MHDs, Chemotherapy).
  - The claim shall be settled by verifying the identity, listed therapy, evidence of treatment, amount of the submitted claim.
  - Claims will be processed through a designated work flow of First In First Out [FIFO] at all levels.
  - The Claim shall be settled and payment made to the NWH within 7 days.
  - The Claims Payments will be credited directly to the Hospital Bank Account through Online Bank Transfer.
  - Erroneous Claims(if discrepancy in approved claim amount, NWH can raise the erroneous claim after claim paid).

- **Documents for claims**
  - Clinical Photographs(On bed photo):
    - A photograph with lesion and patient face taken for clinical purpose.
  - Stages of Photographs (in the operation theatre):
    - Pre-Operative photograph Showing the lesion with face on table(Just before the operation).
    - Intra-Operative photograph: 2-3 photographs showing the critical steps of the surgical procedure while being operated with patient face.
    - Photograph of the suture line at the end of the procedure wherever external sutures are applied with patient face.
    - Post-Operative Scar photograph with patient face.
  - Endoscopic Procedures:

- All endoscopic procedures must be video recorded and uploaded.
- (Pre & post procedure CD in WebEx Recording, Fluoroscopic WebEx recording)
- Starting with face and position of the patient in the theatre to the revival of the patient from anesthesia or completion of the procedure.

- Recording of Procedure for all Lap Procedures showing the patient face & continues to ports.
- One photo showing the port insertion of the endoscope with surgeon and patient face with monitor in a single shot.

- Investigation Reports:
  - All the biochemistry, pathology, micro biology and imageology pre & post investigations for management of the patient.
- Case Sheet:
  - A medical record that the complete therapy has been performed as per procedure.
  - Case sheet should be submitted from the date of admission to date of discharge i.e. day to day medical/treatment record followed by nurses chart.
  - There should not be any manipulations regarding name, date, procedure/therapy in the case sheet.
  - The name and signature of the treating doctor on each page of the case sheet of the case sheet.
  - PAC forms and Anesthesia notes required for every surgical procedure.
  - Complete discharge details recording in case sheet.
  - ICU /IABP Chart/Ventilator photos/RT chart etc(if any).
  - Implants, stickers, pouches & pre and post operative X-rays.
  - Evidence of Functional Improvement.
  - Discharge photo with MEDCO & Aarogya Mithra showing discharge summary along with medicines and Transport charges at Aarogyasri kiosk.

- System generated Discharge summary, Satisfaction letter & Transport money acknowledgement.

- **Grievances Redressal**

- Grievances from 104:Attending 104 Grievances which were forwarded by the 104 Call Center.
- Phone Calls – Handling phone calls through CUG/Land Line and Registering the Grievances in Grievance from the Patients/Attendant and any representatives.
- Walk Ins: Attending /Registering in Grievance Module the Grievances Received through Walk In's.
- .CM Feedback Letters - Generating /Writing/Packing/Pasting/Dispatching CM Letter Scanning& Uploading of feedback letters received from beneficiaries and Registering in Grievance Module.
- News Articles - Surfing/Downloading/Translating News Articles Content related to treatment and other adverse articles and Registering in Grievance Module.
- CTT Communication To Trust: Receiving Petition from the Tappal Section and follow-up/Registering the grievances in grievance module
- District Grievances: Attending District Grievances which were forwarded by the Field Team through Online/Offline.
- Online updation of portals: Uploading CM Feedback Letters/ News Articles/Paper Clippings in online on daily basis.

- **Other features/information regarding Aarogyashree scheme:**
  - Arogyasree scheme budget(2015-16)-684 crore, admin cost- 30 crore, manpower-around 4000.
  - Trust empaneled specialist decides on going ahead with the treatment(preauth) within 12 hrs in normal cases.fees to free lance doctors on case to case patient,
  - Emergency case authorization over phone
  - 133 procedures reserved for Government Hospitals,
  - Break up of amount received by Government Hospital: 35% incentive goes as incentive to treatment team in Government hospitals, 45% to Hospital Development Committee(HDC) for recurring expense of hospital, 20% to revolving fund account of hospital,
  - IT support by Tata Consultancy Services (TCS) who also provide similar support to Maharastra
  - Online claim settlement
  - NABH accredited hospitals- paid rates 2% extra over the package rate.
  - Separate Health Insurance scheme for Govt Employees/ opt for MR runs parallel
  - Journalist health scheme on the same platform

- **Visit to Operations/Data processing centre:**They process700-800 claims a day. Fuctions of this section includes processing of:
  - Preauthorisations
  - Claims
  - Follow-up Claims
  - Enhancements of package
  - Change Requests
  - Erroneous Claims
  - Telephonic Intimations/Enquiries
  - Specialist Opinions
  - Process of the Panel Doctors Payments and Cases.
  - Disallowances
- **Visit to Call center**- 24x7 online queries apart from aarogyasri health insurance for all medical conditions under a single roof in collaboration with 104 call service center under National Health Mission(NHM).Their objective is
  - To provide Non-Emergency Services
  - Healthcare & Guidance Services
  - Counselling Services.
  - Medical Advice
  - To provide directory information
  - Healthcare Institutions.
  - Blood Banks.
  - To register the complaints related to
    - Implementation of AarogyasriScheme.
    - Implementation of Employee Health Scheme.
    - Service deficiencies, negligence, and money collection in Govt Medical & Health Services.
    - Food facilities as per the Food Standard Acts.
    - Report on outbreak of diseases.
    - To Monitor Major schemes
    - 108 Services.

- Aarogyasri.
- Other Health Schemes.


- **Visit to NIMS, Hyderabad-Government hospital**

- **Visit to Continental Hospital (Pvt hospital)- package rate felt inadequate**

- **Meeting with Consultants of Tata Consultancy Services(TCS):**
  - TCS has been providing the IT platform required for running the software/Hardware component of the scheme in Telangana. They also provide support to Andhra Pradesh Government and Maharastra Government in similar schemes.
  - During the discussion a request was made to TCS consultants to visit Arunachal Pradesh and provide necessary advice on improving IT system under APCMUHIS.
  - Accordingly, the consultants visited Itanagar on 10th November 2016 and gave a demo of the software to the Govt officials, officials of NIACL & DHS-TPA.

- *Annexure IV*

Some feedback from various other stakeholders/beneficiaries/ etc.

Copies of opinion given by a group of doctors including dentists of Pasighat side on Whatsapp group:

- Regarding APCM's health insurance ...
- I feel that this policy is not cost effective so far... Reasons:
  - The purpose of health insurance was to give free treatment to all arunachalees , for that all the govt hospitals were supposed to be included in APCM's insurance in phase wise , but so far only few hospitals are included.
  - All the diseases are not included in package ...so far patients get benefits for those diseases included in the package only
  - More than 90% of patients attending OPD do not comes under this policy .
  - Amount sanction for those diseases that come under APCM's package are not enough. Especially for Orthopedic and dental. e.g...for plaster application fractures is rs 1200/- where cost of plaster itself is more than 2000 , reduction of disloction under GA is again 1200 only ....where anaesthetist take 1500 to 3000 for giving GA.
  - Patients need to stay in hospital for minimum of three days to get benefits....where as many big surgery can be done in day-care surgery.
- Remedies ....as per my opinion.
  - Inclusion of all the diseases in package and
  - All the district hosp plus FRU ruksin be included
  - Sanctioned money per package to be revised .
- Many of the diseases indeed r not included. And as pointed out by Dr ... some pt have to stay back for 2-3 days whereas there is something call Day care procedure wherein certain surgeries can b performed under local anesthesia, regional anesthesia and even GA, and pt can leave the hospital after few hours of observation
- Most of the surgical interventions for Trauma both Orthopedic and Maxillofacial have such low coverage that it is impossible to give free treatment in a fair way

  [28/09, 22:31]

- And company are very slow in payment even for those patients rightly treated under package

  [28/09, 22:35]
- Example- Open Reduction and Internal Fixation of Jaw fracture is arnd 8000/- if done under General anesthesia and 2000/- under Local anesthesia. Which I feel is quite low. Anesthetist charge arnd 3500/- to 5000/- depending on length of surgery (open reduction and fixation in bone fracture are usually more time taking). Now consider OT charge, charge of the Maim Surgeon, Assistant surgeon, Medicines, Lab investigations, hospital room charges, nursing care charges....

  [28/09, 22:38]
- The Additional charges r borne by the pts in such cases and then they complain that it was suppose to b free or almost free and that there is balance of 2,00,000/- for a yr..

  [28/09, 22:39]
- Interestingly, in General Medicine cases the package amount are so huge ..I did few operations in Assa lab ....when I did it on self payment ..I get 4000 to 7000 thousands depending on cases ....but when I did the same operation under smart card ...they give 2000 to 3000 that also after 4 to 6 months naturally I prefer to do without it ...
- Best thing will be to instruct all empaneled hospitals to furnish the approximate estimated cost for each procedure. Collect all the furnish data from the hospitals and then rearrange the packages according to the average or least values.

  [28/09, 22:52]
- When we do same operation in gen hosp we do not get any thing . And still patient has to buy many things in extra from their own pocket.
- almost all the shortcomings have been pointed out by dr ..... and dr ..... about APCMUHIS...1. all the diseases are not covered under the scheme. 2. surgical packages are disproportionately low. 2. In cases of polytrauma or multiple disorders only one is covered in the full package, rest are in

descending order or some percentage of the package given for particular disorder/ injury when used in isolation, whereas in other insurance schemes all the diseases/ injuries are covered cent percent.. 4. needs frequent scrutiny of the empaneled hospitals and also the insuring company by govt. have seen some cases of of cholecystectomy where the pt party are told that the cost of treatment is around 50,000/- and the package is around 25,000/-and the balance amount has to be borne by the party, whereas if done without the scheme it cost around 20000/- to 25000/-. so double mazaa for hospital.. 4. patients party needed to be given awareness or do's n don'ts told while handing over the cards.

[29/09, 06:12]

- Good morning all.Reg.APCMUHIS.members hav express n short coming.but it is vry good scheme all shud appriciate n appulase for it.The intention of govt is vry good.At present the problem is with insurence company for not paying attitude,n 100% business policy.like a pt.of stroke need ct scan of head to confirm bleed in brain,we don't hav at general hospital pasighat company refuse to pay without ct scan report.a pt of febrile illness shud admitted in ICU then only they will pay. we don't hav ICU at ghp.inspite of fulfill all requirements company take any forms of excuse to pay. now according to company only few numbers of case will entitle place like pasighat.or we r bound to tell benificeries that inspite of disease is under apcmhis you can't get it because we hav no facilities like ct scan, ICU, ecocardiography ect. Remedies-if the company can v convinced then people will get real taste of benifit of scheme.at ghp we have the amount not paid is tune of rs 50 lakh.

1. Coverage of Procedures:

2. Diagnostic Procedures:

3. Service Charges: