

Healthcare Programme (Rajiv Aarogyasri Insurance Scheme) For Poor People: A Qualitative Study

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Abstract: Majority samples are in the age group of 35 years to 50 years. Nearly 50 per cent of respondents are illiterates. 62.3 per cent (187 respondents) are male. Mostly samples are married people; their percentage is 84 (252 respondents). The respondents from both the selected districts are drastically high from the OBC community, with 48 per cent (144 respondents). The respondents with agriculture, agricultural allied activities and agricultural labourers as the primary occupation, is 60 per cent (182 respondents). Nearly 60 percent families are landless and from below poverty line. The study shows that Ortho-related diseases dominated by 33.3 per cent (103 respondents). This is followed by paralysis at 16 per cent (48 respondents). Uterus related disease is an account for 27 respondents (9 per cent), pulmonary diseases are account for 25 respondents (8.3 per cent). It can be found that there is a high positive correlation between age, education, occupation, possession of land, health problems.

Keywords: Health programme, Diseases, Insurance, BPL families.

1. INTRODUCTION:

Health is a fundamental human right and a worldwide social goal. Health is necessary for the realization of basic human needs and to attain the status of a better quality of life, WHO (1979). Health is a common theme in most cultures. All communities have their concepts of health as part of their culture. Among definitions still used; probably the oldest is that health is the Absence of Disease. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" according to the World Health Organization WHO (1948). Health is a human right, and enhanced health care should make available universally Rural Healthcare (2009). Healthcare is the diagnosis, treatment and prevention of disease, illness, injury and other physical and mental impairments in human beings, WHO (1948).

The World Health Organization (WHO) has done an excellent service to humanity by ushering in an era of international co-operation in the field of health and promoting the concept of "Health for All" by the year 2000. The constitution of WHO, which was drafted and signed in 1946, stated that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity Lal(2020). The studies try to establish common health problems to factors such as morbidity and mortality, wide-spread poverty, illiteracy, malnutrition hostile environment, insanitation living conditions, ignorance of causes of diseases, lack of health services, etc. among the tribal population. The study of health status and health practices among tribals deserves special attention in the situation of poverty Lal(2006). Alcohol misuse is associated with a large range of personal, social, and health problems. Personal and societal costs include reduced vocational and educational performance, family and social disruption, and contact with the criminal justice system. Individuals are also negatively affected by other's drinking. In addition, alcohol misuse has negative economic impacts such as lost productivity, law enforcement costs, and direct health care costs Naik (2013a)

The Rajiv Aarogyasri is the flagship of all health initiatives of the State Government with a mission to provide quality healthcare to the poor and needy rural families. In order to facilitate the effective implementation of the scheme, the State Government has set up the Aarogyasri Health Care Trust under the chairmanship of the Chief Minister. There is a felt need in the State to provide medical support to the families living below poverty line for the major ailments. Government hospitals lack the requisite facility and the specialist pool of doctors to meet the statewide requirement for the treatment of the health problems, Kumar (2017).

2. REVIEW OF LITERATURE:

Few important related earlier studies have been reviewed and mentioned here. Wong (2009), the study discusses how to deliver primary healthcare (PHC) services and increase their accessibility from the patient's perspective. The authors conducted seven focus groups with people living in rural communities, in British Columbia, Canada, as they reflected on priorities for the use of PHC. Sonia (2007), the study explains the severe inequalities in healthcare in the world. Developing countries spend a much smaller share of their national income on health expenditure than do richer countries.

After 64 years of Independence, several public and growth-orientated developmental programs have been implemented; nearly 716 million rural people (72% of the total population), half of which are below the poverty line (BPL), continue to fight a hopeless and continually losing battle for survival and health. The policies implemented so far, which concentrate only on the growth of the economy, not on equity and equality, have widened the gap between 'urban and rural' and 'haves and have-nots.' Nearly 70% of all deaths, and 92% of deaths from infectious diseases, occurred among the most deficient 20% of the population Lal(2020).

Kavitha(2013), focuses that majority of rural households are facing various health problems of sanitation-related. A research study conducted in Warangal district in two village emphasis that 94 per cent of the women are facing the problems of abdominal pain, 86 % uterus related, 85% urine burn and 42% water burn disease air and water combined 30%. The sanitation service ladder parameters reveal that open defecation is rampant and access to sanitation facilities is far from within reach for many households. Sekher (2011), the delivery of health services in India remains low, particularly in rural areas, due to lack of infrastructure and personnel, financial constraints, lack of awareness, low accountability and transparency. Though the networks of the department have spread to almost every village, the availability and utilization of the services continue to be very poor and grossly inadequate.

Large proportions of people, especially below poverty line borrow money or sell assets to pay for the treatment in private hospitals. Rajiv Aarogyasri scheme is a boon for the below poverty line (BPL) families particularly SCs and STs living in rural areas by removing the financial barriers and improving access of poor to quality medical care of providing financial protection against high medical expenses; and negotiating with the providers for better quality health care Kumar(2017).

India is pitted against Thailand, Singapore and Some other Asian countries, which have good hospitals, salubrious climate and tourist destinations to attract patients from Europe, USA and other affluent nations. While, Thailand and Singapore, with their advanced medical facilities and built-in medical tourism options, have been drawing lakhs of foreign patients per annum, the rapidly expanding Indian corporate hospital sector has been able to get a few thousand for treatment Naik (2013).

Lal conducted a study (2015), examined that Water-borne communicable diseases like gastrointestinal disorders including acute diarrhoea are responsible for higher morbidity and mortality due to poor sanitation, unhygienic conditions and lack of safe drinking water in the banjara's thandas. The acute diarrheal problem was basically due to the poor environmental hygiene, lack of safe drinking water, improper disposal of human excreta which was further aggravated by low literacy, indiscriminate defecation in the open field, barefoot walking and lack of health awareness and hygiene, low socio-economic status coupled with blind cultural belief, lack of access to medical facilities leading to a severe public health problem.

In India, Sri Lanka, Thailand, and Malaysia, drinking patterns illustrate how the per capita consumption figures of a country do not necessarily give the real picture of consumption patterns of Asian countries. Parallel with the international and more expensive alcoholic beverages, there exist the local, cheap, potent brews, both legal and illicit, which are not computed into the national statistics Naik (2013a). Safe water and sanitation are the two essential components of hygiene, which have a robust cultural determination and a key influence on people's health, perhaps comparable only to food, Lal(2010).

Personal hygiene is significant issues for adolescent students. As hands are an essential mode of transmission of infectious disease among school-aged children, simple hand washing with soap helps to protect children from the two common global paediatric killers- diarrhoea and lower respiratory infection. The study observed that the majority of school-going boys is practising personal hygiene. More than 90% of children are adolescents. 37% of children are pursuing class VII, and 44% of parents are illiterates. 100% of boys do a regular bath, and 91% brush their teeth daily. 100% of students practising hand wash, and 48% used soap for hand wash. 66% of students replied that they wash hands after toilet. 85% of students are maintaining their clothes clean and neat. It is also observed that 64% of students share their combs with other students. 84% of students trim their nails regularly, and 58% per cent of students used handkerchief at the time of cough and sneezing. 56% of students get awareness on personal hygiene issues from their teachers Lal(2016).

The study reveals that a hundred per cent of students practising hand wash. The material used for hand wash is a soap for 48% and only water 52%- the hundred per cent of students practising hand wash before eating. A question was asked as to hand wash after toilet. 66% of students replied that yes, and the remaining 34% said no. About the maintenance of clothes neat and clean, 85% of students replied yes, and 15% said no, Lal(2016). The study provides information on awareness of personal hygiene practice of school-going children. Cent per cent of children is doing a bath regularly. 43 % of children do head bath between 2-4 days, 36% of children do between 4-6 days, and the remaining 21% of children do daily. 91% of children brush their teeth daily morning and remaining nine per cent brush their teeth morning and night. Majority students replied that they do not have any bad smell from their mouth, Lal(2016).

The study shows the family discrimination of the respondents. Out of 300 respondents, about 73% of the respondents are living with their families, and 27% of the respondents are separated or driven away by their families. This shows the awareness and suitable emotional attachments among families, and it is one of the causes to be attached

to remain with their families. Notably, female respondents face much discrimination than males after having suffered these diseases. As most of the males are earning something, they are treated well in society or the family, but the females are facing problems Lal(2010).

The health impact of alcohol consumption in term of injuries, illness, disorders, including liver cirrhosis, mental illness, and several types of cancer, pancreatitis, and damage to the fetus among pregnant women and loss of economy. It also focuses there is a strong correlation between alcohol consumption and smoker Naik (2013a).

3. OBJECTIVES AND METHODOLOGY

- To study the demographic profile of the selected sample respondents, the beneficiaries of the health schemes.
- To study the performance of Rajiv Aarogyasri Health Insurance Scheme in providing health service to the below poverty line people.
- To analyse the economic impact of the health scheme on beneficiaries.

3.1 . HYPOTHESES:

- Rajiv Aarogyasri Health insurance scheme protects low-income households' health.
- Health insurance status affects healthcare utilization behaviour of more outpatient & inpatient visits to choose private over public facilities.

3.2 . SAMPLE DESIGN

The sample design was chosen based on the Stratified random sampling method. Data has been collected from two districts, i.e., Warangal and Karimnagar in Telangana State India. A total sample of (300) households is split-up in Warangal and Karimnagar Districts with (150) households in each district by taking (50) sample households from each of the mandals namely, Warangal, Hanamkonda and Hasanparthy in Warangal District and similarly in Karimnagar District (150) Households are selected from Huzurabad, Elkaturthy and Kamalapur mandals.

3.3 5. SOURCE OF DATA

The study will base on primary and secondary data. For the collection of Primary required data, the questionnaire was served to the sample respondents of selected villages. The questionnaire comprises of several dimensions and factors related directly / indirectly discussions with the beneficiaries in that study area. This information has been supplemented by conducting informal interviews & discussions with a cross-section of society in the respected mandals.

3.4 . TOOLS OF ANALYSIS

The data had been analyzed, keeping in view the objectives of the study by applying statistical tools like Frequency Counts, Averages, Correlation, and Chi-square analysis.

4. RESULTS AND DISCUSSION:

Rajiv Aarogyasri Scheme is unique unparalleled in the country with a private, public partnership model to deal with the problems of catastrophic medical expenditures at tertiary curative, largely surgeries and therapies care for the low households. Despite policies to make healthcare accessible to all, it is not universally accessible. Frequent evaluation of barriers to accessibility of healthcare services paves the path for movement. Hence the present study is undertaken to evaluate the factors and public health policies influencing healthcare access to the rural/urban people in fast-growing cities of Warangal & Karimnagar Districts in the Telangana State of India.

Table-1. Highlights the age group particulars of all the respondents in the survey taken up to analyze the healthcare services provided by the State Government under the Arogyasri scheme. Out of the 300 respondents from two districts of Telangana, namely Warangal and Karimnagar, 150 from each district have been selected. The study revealed that 13 per cent (39 respondents) belong to the age group between 15-25 years in Warangal and Karimnagar. There is 12.6 per cent (38 respondents) in the age group of 26-35 years, while it is 25 per cent (75 respondents) in the age group of 36-45 years. In the age group of 46-50 years, it was 20.7 per cent (62 respondents) who participated in the survey. The respondents participated in the analysis under the age group of 51-60 years is 14 per cent (42 respondents). Finally, in the age group of 60 years and above represent 14.7 per cent (44 respondents).

Education plays a vital role in people's lives and decides their lifestyle, habits as well as their healthy behaviour. It shows that most of the respondents in the two districts are illiterate, while the next maximum respondents have just primary education. It is 48 per cent (144 respondents) are illiterate. Those who have primary education among the respondents is 21 per cent (63 respondents). In Warangal and Karimnagar, it is 21.3 per cent (64 respondents) who have completed Secondary education. Those who have attended college is just 7.3 per cent (22 respondents). Among the responded, two per cent (6 respondents) have done theirs under graduation.

Table-1 depicts that sex ratio of the respondents in the selected study areas with 62.3 per cent (187 respondents) are male and Female are the rest 37.7 per cent (113 respondents) from Warangal and Karimnagar districts respectively. The table indicates that large numbers of respondents in this survey, in two districts, have been mostly married people, their percentages are 84 (252 respondents) and 12 (36 respondents) are unmarried, rest of four per cent (12 respondents) are widows in the study area.

Variables	Parameters	Frequency	Percentage
Age Group (in years)	15–25	39	13.0
	26 – 35	38	12.6
	36 – 45	75	25.0
	46 – 50	62	20.7
	51 – 60	42	14.0
	Above 60	44	14.7
	Total	300	100
Education Status	Illiterate	144	48.0
	Primary	63	21.0
	Secondary	64	21.3
	College	22	7.3
	Degree	6	2.0
	Technical	1	0.4
	Total	300	100.00
Gender	Male	187	62.3
	Female	113	37.7
	Total	300	100.00
Marital status	Married	252	84.0
	Unmarried	36	12.0
	Others	12	04.0
	Total	300	100
Community	FC	32	10.7
	SC	83	27.7
	ST	41	13.7
	OBC	144	48.0
	Total	300	100.00

TABLE – 1 DEMOGRAPHIC PARTICULAR OF SAMPLE RESPONDENTS

Source: Field Study

Table-1 shows that the respondents from both the selected districts are drastically high from the OBC community with 48 per cent (144 respondents) and 27.7 per cent (83 respondents) are SC community. ST community represents 13.7 per cent (41 respondents) and while Forward Caste represent 10.7 per cent (32 respondents) in the study area.

Table-2 brings forward different occupations that the respondents in the two selected districts are mostly working upon. It is clear from the table that both the selected districts are dominated by people with agriculture, allied agricultural activities and agricultural labourers as the primary occupation with 60 per cent (182 respondents). Private employees are 5.7 per cent (17 respondents), and wage earners are 11 per cent (33 respondents). Moreover, the rest of the sample respondents are running a little business in the study areas. The table indicates that landless respondents in the selected districts are nearly 60 per cent (179 respondents). Another 29 per cent (87 respondents) are having the only less than two areas of land. 8.3 per cent of respondents have 3 to 4 areas of land they account for 25 samples. Rests of 9 sample respondents are having more than four areas of land in the study area.

Table-2 shows that around half of the respondents in the selected districts are earning about Rs 3000-3500 per month are 37.7 per cent (113 respondent) in this category. Another 14.7 per cent (44 respondents) are earning between rupees 4000 to 5000. 9.3 per cent sample respondents are earning monthly below Rs. 1500, it is shown that people are extreme poverty. Eighty respondents (26.7 per cent) are earning between Rs. 1500 to 2500, the category people are below poverty line (BPL) families. Income indicates the quality of life.

Table -2 Occupation and Income Particulars

Variables	Parameters	Frequency	Percentage
Occupation	Agriculture	99	33.0
	Agriculture allied	12	4.0
	Agri. Labor	71	23.7
	Employee (private)	17	5.7
	Daily-wage Earner	33	11.0
	Petty Business	68	22.7
	Total	300	100
Particulars of Land (Size in Acres)	Below 2 Acres	87	29.0
	3-4 Acres	25	8.3
	5-7 Acres	5	1.7
	8- 10 Acres	3	1.0
	Above 10 Acres	1	0.3
	Land fewer People	179	59.7
	Total	300	100
The income per Month in Rupees	Below Rs. 1500	28	9.3
	1500 – 2000	50	16.7
	2000 – 2500	30	10.0
	3000 -3500	113	37.7
	4000 -5000	44	14.7
	Above 5000	3	1.0
	No Work	32	10.7
Total	300	100	

Source: Field Study

Table- 3 Name of the Diseases of Sample Respondents

Variables	Parameters	Frequency	Percentage
Name of the Diseases	Cardiology	14	4.7
	Cancer	14	4.7
	Neurological	24	8.0
	Kidney	22	7.3
	Paralysis	48	16.0
	ENT	23	7.7
	Ortho	103	34.3
	Pulmonary diseases	25	8.3
	Uterus related	27	9.0
	Total	300	100

Source: Field Study

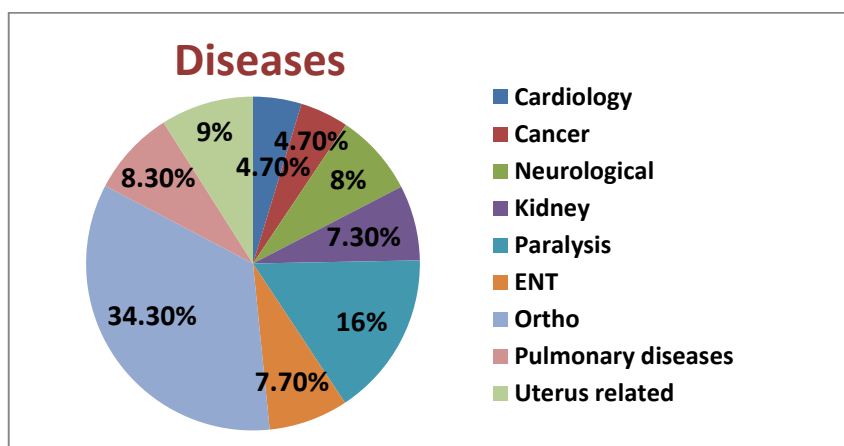


Table-3 establishes the fact that it is not just a few types of diseases that are prevalent in the selected districts. However, many significant diseases are affecting the lives of sample respondents. Importantly, it has been mentioned in the table that Ortho-related diseases dominated by 33.3 per cent (103 respondents). This is followed by paralysis at

16 per cent (48 respondents). Uterus related disease is an account for 27 respondents (9 per cent), pulmonary diseases are account for 25 respondents (8.3 per cent). Eight per cent of respondents (24) are suffering from neurological diseases. ENT and Kidney related diseases are account 7.7. & 7.3 per cent, respectively. Cardiological and Cancer-related diseases are account four per cent each in the study areas.

Table-4. Test of Hypothesis

Chi-Square Tests			
	Value	Df	Sig. (2-sided)
Pearson Chi-Square	80.145 ^a	30	.000
Likelihood Ratio	85.732	30	.000
Linear-by-Linear Association	20.410	1	.000
N of Valid Cases	300		
Df=30, Chi-square (0.05)=43.8			

Source: Field Study

Does the Rajiv Aarogyasri Health insurance scheme protect low-income households' health? To find out the null hypothesis Chi-square test was performed. After testing the null hypothesis, it is finding that the calculated chi-square value is less than the table value of chi-square. Hence the Null hypothesis is accepted.

Table-5. Correlation Analysis

Variables		Age	Education	Occupation	Possession of land	Insurance Coverage
Age	Pearson Correlation	1	.645(**)	.342(**)	.286(**)	.062(**)
	Sig. (2-tailed)	.	.000	.000	.000	.283
	N	300	300	300	300	300
Education	Pearson Correlation	.645(**)	1	.365(**)	.187(**)	.110(**)
	Sig. (2-tailed)	.000	.	.000	.001	.058
	N	300	300	300	300	300
Occupation	Pearson Correlation	.342(**)	.365(**)	1	.542(**)	.342(**)
	Sig. (2-tailed)	.000	.000	.	.000	.000
	N	300	300	300	300	300
Possession of land	Pearson Correlation	.286(**)	.187(**)	.542(**)	1(**)	1(**)
	Sig. (2-tailed)	.000	.001	.000	.	.
	N	300	300	300	300	300
Insurance Coverage	Pearson Correlation	.062(**)	.110(**)	.342(**)	.077	.077
	Sig. (2-tailed)	.283	.058	.000	.181	.181
	N	300	300	300	300	300

** Correlation is significant at the 0.01 level (2-tailed). Source: Field Study

(i) From the above table it can be found that there is a high positive correlation between Age, Education, Occupation, Possession of Land, Health Problems, Earnings per month, Diseases & Insurance Coverage. Further, it can be seen that age and education are positively correlated with an r-value of .645. The analysis also observes that age and occupation have moderate Correlation (r values.342) among the variables. Also, age and possession of land has relative less Correlation when compared to the possession of land and occupation, with an r-value of .542

(ii) Education Vs Occupation & Possession of Land: The Correlation between educations occupation is 0.365. This shows that there is a relationship between education and occupation. It can be observed from the above table that there is a moderate correlation with r value being 0.365 between education and occupation. From this, it can be understood that if people are educated, occupation will be high earning to some extent.

(iii) Earn per Month and Insurance Coverage: Income and coverage of insurance have positive Correlation at

Correlation is significant at the 0.01 level (2-tailed), hence higher the income-earning extensive coverage of insurance among sample respondents.

Hence this study concludes that age and education influence to earn more money and opt for insurance coverage.

5. CONCLUSION AND SUGGESTIONS:

India is one of the few countries which have public health spending of less than 1% of GDP, resulting in three-quarters of the expense being met from out of pocket spending by individuals. The National Commission on Macro Economics and Health (NCMEH) has pointed out that 3.3% of India's population is impoverished every year on account of health distress. India's meagre health budget is a cause of and exacerbating factor in the challenges of health inequity, inadequate availability and reach, unequal access, low quality and costly healthcare services. The Aarogyasri experience showed that the commitment to equity and healthcare access to poor people was visible as it covered over 85 per cent of the state's population. Despite several structural and institutional constraints, Aarogyasri was a unique healthcare system which comprehensively addressed the high-end, low-frequency medical needs of the poor.

A robust referral system and fundamental changes to the health system are needed to meet the goals of financial risk protection. Most of the people were affected by the common disease(s) /any, which could be controlled by disinfections water, air and food used by the people.

To create awareness about the scheme among the people shall be driven through camps, by distributions pamphlets, puppet shows and by educating about the benefits of the scheme. Hospital staff has to be trained for the effective functioning of the scheme. Furthermore, the income of the population will have to be raised through better employment opportunities in order to ensure better health standard.

REFERENCES:

1. Kavitha G & Lal B.Suresh (2013). "Economic Impact of Inadequate Sanitation on Women's Health: A Study in Warangal District". International Journal of Environment and Development: Vol. 10, No. 2, (July-December): 209-220.
2. Kavitha G & Lal B. Suresh, (2016); Assessment of Personal Hygiene Knowledge and Practices: An Empirical Study of Schooling Children in Warangal, International Journal of Science and Research (IJSR), Volume 5 Issue 8, August. "Retrieved from <https://www.researchgate.net/publication/311562391>"
3. Kumar Praveen, R & Lal B. Suresh (2017). Economic Analysis of the `Rajiv Aarogyasri (Health Care) Scheme: An Empirical Study in Warangal District, International Journal of Academic Research, Vol.4, Issue-1(10), January.
4. Lal B. Suresh (2015). Socio-Economic and Health Issues of Banjaras in the Era of Globalization: A Study in Telangana Tribal Villages, International Journal of Physical and Social Sciences (IJPSS), Vol-5, Issue-6, June, ISSN: 2249-5894, pp. 207. "Retrieved from <https://www.researchgate.net/publication/277534999>"
5. Lal B. Suresh (2010). The Economic Impact of HIV/AIDS: A Study in Tribal Areas in Andhra Pradesh, Indian Journal of Millennium Development Studies: An International Journal, 5(1-2), January & June, pp. 139-146. <https://www.researchgate.net/publication/276866184>
6. Lal B. Suresh, (2020); Essays on Health Economics, Akhand Publishing House, New Delhi.
7. Lal B.Suresh, (2006): Health Status and Health Practices among the Tribals: A Case Study in AP, Journal of Social Anthropology, vol-3, No.2 Dec, Serials, New Delhi.
8. Naik NTK & Lal B. Suresh (2013). Economic Analysis of Indian Medical Tourism (International Healthcare Destination), International Journal of Business Management Economics and Information Technology, Vol-5, Number-2, July-December, pp.259-277. from <https://www.researchgate.net/publication/276868151>"
9. Naik NTK & Lal B. Suresh (2013a). Impact of Alcohol Consumption on Health and Economy (A Focus on Mc Dowellization of World); IOSR Journal of Nursing and Health Science (IOSR-JNHS), Volume-1, Issue-5, Jul-Aug. pp.18-23. "Retrieved from <https://www.researchgate.net/publication/340091042>"
10. Rural Health Care (2009), Towards a Healthy Rural India, Gramavaani (Voice of the village).
11. Sekher TV (2011). Health Care for the Rural Poor: Decentralization of Health Services in Karnataka, India. Institute for Social and Economic Change, Bangalore.
12. World Health Organisation(1948). Definition of Health, Geneva- Switzerland. Retrieved from <http://www.who.int/about/definition/en/print.html>
13. Wong S, S Regan (2009). Patient Perspectives on Primary Healthcare in Rural Communities: Effects of Geography on Access, Continuity and Efficiency. Retrieved from <http://www.rrh.org.au>