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Quality Healthcare Services: A Study of Network Hospitals under Rajiv Aarogyasri Community Health Insurance Scheme

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Abstract: *Quality healthcare service assessment in the network hospitals takes into account of committed personnel involvement including doctors, nurses, hospital staff, and sanitary employees. This has been sidelined and less studied area in the past researches in the context of healthcare delivery for insured patients. This present study focuses on personnel service in the context of health insurance delivery and is assessed with a comparison of two network hospitals in Hyderabad City -each one from public and private sector. A hundred insured patients- represented equally from both network hospitals- are selected for the study with the application of convenience non-random sampling. Though public network hospitals are enrolled into the network of insurance service, these hospitals deliver inadequate and inefficient services because of shortage of manpower, unaccountability of personnels, and lack of proper surveillance. Therefore, it is crucial for the state to make a firm attempt for enhancing the efficiency of the personnesl, rendering them to be accountable to both the patients and concerning officials. It may be a step ahead to adopt an effective mechanism that would accelerate the efficiency of personnel and avoids shortage of manpower in the hospitals.*

Keywords: *healthcare, insurance, mechanism, network hospitals,*

I. Introduction

Health never being isolated phenomenon is being influenced by a complex of social, economic, political environment and biological factors (Subrahmanyam, V. 1997). Good health is considered as wealth of the nation. A well-known fact is, with few exceptions, inadequate funding allocation to the public healthcare by the governments of developing countries causes a catastrophic medical expenditure burden among their citizens. India, a developing country is not being exception from this category of mere funding allocation to health sector and has continuously been allocating only 0.9% of GDP to its healthcare. In addition to this mere allocation, the public healthcare system has been struggling with certain loopholes in terms of institutional politicization, rampant corruption, providers' profit motive, inadequate infrastructure, unhygienic-environment, subservient authorities to ruling political bosses (Ibid, 1997). Healthcare related problems are constantly compelling people, especially the poor, bearing catastrophic medical expenditure. Whereas, the private sector healthcare services are being encouraged by the state through various forms that involves free-land allocation for the construction of the hospitals, take off fiscal charge over import equipments etc. In post-independence India, the private sector has increasingly attracted people with its efficient service delivery system. As a result of costly private services, an unexpected burden of Out of Pocket Expenditure has increased over a period of time, which is distressing the overall basic expenditure of Below Poverty Line families. For instance, a family spends in-between 5-10% of its total basic expenditure (Selvaraj and Karan 2012). It implies unfair allocation of funding to public healthcare by government has increased a financial burden over BPL families. As a result of that, about 40% of hospitalized patients per year borrow money or sell out assets in order to meet their medical needs, of whom around 20% of such patients fall into a circle of impoverishment (Devadasan, et al 2004). In this context, a middle-way has come up into the existent system in the form of insurance to cover medical expenditure of the patients. The insurance system covered 25% (302 million) of people by the year 2009-10. Out of this 25%, there are 82% of such people exclusively covered by the government's rolling health insurance schemes (Yellaiah, 2013). Its coverage is likely to increase at different levels in days to come.

II. Rajiv Aarogyasri Community Health Insurance (RACHI)

One of the governments' sponsored health insurance schemes for people belong to the Below Poverty Line at state level is Rajiv Aarogyasri Community Health Insurance Scheme (RACHI) in erstwhile Andhra Pradesh. This was initiated in three of the economically backward districts of the state in 2007 as a pilot project. The main aim was to rescue the poor from meeting expensive medical expenditures. The World Health Organization (WHO) even has suggested to other developing countries to pursue this insurance model to meet medical needs of their people. The insurance coverage of state's total population by the year 2013 is 85%

(Yellaiah, 2013). Under this insurance, each insured family is secured with Rs.2 lakh coverage per year. Insured people are allowed direct access to the network hospitals of both public and private sectors enrolled into this service for treatment of their enlisted diseases at free of cost. The premium to insurance company is completely borne by the state government alone in order to achieve its intension of bringing advanced healthcare service to the doorstep of the poor families. Some of previous studies and insurance index concerning this insurance service stated that a large proportion of poor patients are benefited by this insurance coverage. Few others highlighted the inadequate service delivery of this insurance including enhanced premium rates that would be burden unto state exchequer (Sunitha and marry 2013), inadequately affected over catastrophic medical expenditure of insured patients (selvaraj and karan 2012), and so on.

III. Indentations and EQUATIONS

In this paper an attempt is made to address where problems of healthcare providers lie and how personnel of hospitals deliver the services through a process perspective. Personnel of the hospitals including hospital staffs, sanitary employees, doctors and nurses are analyzed in detail by a comparison of two network-hospitals pertained to both the sectors. This study is anthropological in approach and deals with wider issues that play part in health care related problems. The study was carried out in two network hospitals- Care Banjara Private Network Hospital (CBH) and Gandhi Medical College Public Network Hospital (GPH) by the mid-2013.

A. Admission Process

The process of admission for insured patients varies in accordance with category of hospital is considered as one of the prominent elements for the comparison between the network hospitals. The empirical data has proven that about 28% patients have rendered more than one of the outpatient visits prior to admission for inpatient service. Their delay is caused by two reasons, personal reasons as well as hospital related reasons. Personal reasons concerning handling certain family related issues are about assigned responsibility to oversee their small piece of land to neighbors, handling over the responsibility of taking care of their children to relatives or to neighbors, and borrowing a small amount of money from moneylenders and relatives in order to meet their medical and non-medical needs. Most of such patients, even after doctors referred them, are delayed their admission into the hospital for inpatient care due to certain unavoidable commitments. Hospital related reasons are of absence of concerning doctors, preferred more outpatient visits by doctors, shortage of beds, and delay of diagnostic tests. Of 28% of such patients, about 16% patients get delayed admissions into the CBH even after doctors referred them for inpatient treatment due to shortage of beds (see Table-1). They are called up by the hospital administrative staff, when beds are vacant, to obtain inpatient treatment. Sometimes, even after their arrival to the hospital they had to wait for few days in process of seeking admission due to shortage of beds. For such patients, the hospital staff provides accommodation at free of cost called 'Aarogyasri Patients Room' until they have obtained beds in the general patients' room in the hospital. During the stay in this Aarogyasri patients' room, patients must bear expenditures regarding the food and the medicines. The hospital related problems such as delayed admission for the patients is associated with more than a single reason. Reasons include irregularity of doctors attendance to their duties, often postponed schedule time and so on. Some of them are laid down on the floor in the patients' room until beds are vacated after arrival into the hospital. In such cases, hospital staff provides such patients admissions very lately. Hence, the determent factors for admission into the hospital are similar related to personal related issues and dissimilar regarding to hospital related reasons because only one reason caused for patients seeking service of the private network hospital and multi-factors for patients of the GPH. In addition, in both hospitals the service of the admission staff is appropriately similar to each other.

B. Sanitary Employees Service:

Quality sanitary environment enhances healthy healthcare delivery to the patients by the doctors. Sanitary conditions are considered as one of the prominent measures to comprehend quality standard healthcare delivery. In the process of maintaining quality sanitary conditions, sanitary employees have prominent role to play. For assessing every day service delivery by sanitary employees, there are three sub-measurements such as how many times sanitary employees sweep the rooms of the patients per day, providing bed-sheets and pillow covers to patients, and cleaning of bathroom and latrine. In general, the public hospitals are complained of having insanitary conditions. However, there are changes in sanitary service of the public network hospitals after their collaboration with the insurance service. The empirical data shows (see Table-2) that all patients, majority in the CBH, have agreed that they availed these employees service between 2-4 times for sweeping each room of the patients per a day. In the CBH, more than three-fourth of them are accessed to this service in-between three-four times. In contrary, sanitary employees in the GPH delivered their services of one-two times to 90% of sampled patients of this hospital. In case of the secondary element of measurement of the service,

probably all patients in the CBH agreed that they all acquired bed-sheets and pillow covers every day from sanitary employees, except 2% patients who used own-bed-sheets out of their self-desire. In the GPH, only 28% patients availed this service but only obtained bed-sheets irregularly (non-daily). These sanitary employees provided them bed-sheets in different interval that 22% patients obtained bed-sheets once in two days, followed by 5% once in 5-10 days, and 1% once in 10-15 days respectively. This pattern of service delivery implies inadequate supply of bed-sheets, unaccountable administration, and irregular service delivery of sanitary employees. Final measurement element discussed is cleaning of bathrooms and latrines of the patients. None of the patients in CBH has complained against insanitary conditions in their bathrooms and latrines. They also expressed their complete satisfaction with sanitary conditions and, service of sanitary employees. Generally, quality sanitary conditions in bathroom and latrine resist transfer of diseases from one to another. One-third of total sampled patients in the GPH have complained against inefficient service delivery of sanitary employees for insanitary conditions of the hospital including overused limited facilities by patients, and stinking of toilets due to unhygienic cleaning, as well as electricity and water shortages. Overall, sanitary employees' service in the GPH as compared to that in the CBH is inefficient, result of absence of monitoring, accountability of these employees, and shortage of required facilities to provide this service efficiently.

C. Services of Doctors:

Doctors' service is prominent service among all the services of the hospital, and always been the backbone of the hospitals. It is considered as key measurement to compare one hospital with another. This comparison between two hospitals for assessing efficiency of this service has done by three sub-measures such as number of visits of the doctors to patients per a day, the time doctor allocated in each visit, and expectations of patients from the doctors. Around 49% patients in the CBH stated that they are completely satisfied with this personnel service whereas 18% patients in the GPH have same opinion. The Table-3 shows that about three-fourth of sampled patients in the CBH and exactly a half of sampled patients in the GMH have had access to this service for twice a day. In addition, the remaining patients of both hospitals could avail this service for one time only. In fact, doctors in the CBH spend more proportion of time in each visit to their patients. For instance, around half of sampled patients in the CBH and one-third of sampled patients in the GPH have accessed this service in-between 5 to 15 minutes in each time. There are patients who availed this service for less than 5 minutes are 1% in the CBH and 10% in the GPH. In a sense, the insured patients in the CBH as compared to those in the GPH have been accessing the better services of doctors in terms of more number of visits and considerable duration of service of the doctors in each visit. On the other side, the inadequate and unsatisfactory services of the doctors are found in the GPH and a considerable proportion of patients have desired for extra-service of their concerning doctors. The empirical data shows that 23% patients overall in total sample have desired for extra-service of their doctors, of whom 19% of such patients are pertained to the GPH. It implies that five-times higher proportion of patients in the GPH as compared to those in the CBH have desired extra service of their doctors. Thus, service of doctors in the CBH is highly satisfactory. Whereas, about half of patients in the GPH are unsatisfied with this service that is because of doctors' unaccountability, non-concern towards patients, along with lack of proper monitoring over the service delivery.

D. Service of Nurse:

Service of nurses is another essential contributor in complete hospital services that usually renders accomplishment of assignment of doctors for patients' treatment. This service is as important as the service of doctor in the hospital. But, there is a difference that doctor's visit to patients in particular time in a day but nurses stay back with the patients round the clock. This service is taken into account to measure the efficiency of the hospital' service by measurements such as when nurses started delivering the service to the patients after admission, maintaining friendly relations with the patients, and what kind of service they delivered when doctors are absent for treating minor diseases. The empirical data (see Table-4) depicts that almost all patients in the CBH and all patients in the GMH agreed of accessing to this service from the day of their admission. However, a noticed difference is that nurses in the GPH provided medicine to some of the patients during the time of doctors' absence to the duty and nurses in the CBH accomplished the assigned task of doctors regarding treating the patients. Very few patients (about 3%) complained against unfriendly treatment of the nurses in the network hospitals. Finally, there are also few patients who stated that their nurses provided peripheral service to the patients when they are suffering of minor diseases. In such situations, overall 70% of patients availed this service for treating of their minor diseases such as fever, headache and minor pains. By policy, the insurance does not cover such minor diseases. Out of 70%, there are 33% patients only pertained to the GPH, of whom around 31% patients are given only medicine by nurses. About one-fourth (i.e.37%) of the total such patients in the CBH availed service beyond medication like special care by nurses, doctors' service, and timely injections. Hence nurses in the GPH have provided their service from the first day of their admission, restricted solely to

medication due to absence of concerning doctors, whereas nurses in CBH followed the pattern of completion of assigned work of the doctors.

IV. Tables

Table-1, Number of time outpatient visits of the patients prior to admission into the hospital

Reasons	Private Hospital (%)	Public Hospital (%)	
Not delayed	34	38	72
2-4 days later	11	9	20
5-8 days later	5	3	8
Total	50	50	100

Table-2, sanitary employees service delivery

	Private	Public	
Sweeping the rooms			
One time		2	2
Two times	12	43	55
Three times	33	5	38
Four times	5		5
	50	50	100
Changing of bed sheets and pillow covers			
Daily	48		48
2 days later		22	22
Once in 5-10 days		5	5
Once in 10-15 days		1	1
Used their own bed-sheet	2		2
Did not get		22	22
Total	50	50	100

Table-3, Doctors' service delivery to the patients

	Private (%)	Public (%)	Total
Number of visits doctors made to the patients			
One time	13	25	38
Two times	37	25	62
Total	50	50	100
Doctors spending time in each visit			
2-4 times	1	10	11
5 minutes	23	22	45
6-10 minutes	19	14	33
11-15 minutes	6	4	10
Did not start this service yet			
Total	50	50	100
Expecting excess time from their doctors			
Extra time for examining patient		12	12
Quick and Quality Service		4	4
Listing to patients' complaints		2	2
Including minor diseases under the insurance		1	1
Assurance from the doctor	4		4
Total	4	19	23

Table-4, Nurses service delivery to the patients

Treatment	Private (%)	Public (%)
Not yet faced such health problem in the hospitals	13	17
Medicine provided by nurses	28	32
Check-up and injection and show more care	4	-
Intimate to the doctors	5	1
Total	50	50

V. Conclusion

The service of personnel in the network hospitals is acknowledged as a vital mechanism in delivering efficient and quality healthcare service to the patients. Study reveals that the personnel of the public network

hospital (GPH), even after being part of the network of the insurance, still struggle to be efficient service providers due to multiple-reasons and institutional drawbacks. Patient's perceptions bring forth multiple problems such as admission process in to the hospital, shortage of required sanitary equipments, inefficient service of sanitary employees, non-commitment and irregularity of doctors with regard to attending to duties, unfriendly behaviour of nurses, and insurance coverage of diseases. These all are indication of an inefficient system that exists in the public network hospitals. Therefore, an immediate task for the state is to improve further personnel efficiency and overall quality in the public hospitals along with increasing associated infrastructural facilities. In this way only, the purpose of medical insurance service would be accomplished.

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