ORIGINAL RESEARCH

Role of private healthcare providers while facilitating Mediclaim services for their patients: A cross-sectional study in selected private hospitals of Delhi

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Received: 15 January, 2019 Accepted: 04 February, 2019 Published: 16 March, 2019

Abstract
Mediclaim is a cost-effective option for health risk transfer offered by public and private sector insurers. Of late, it is emerging as a big industry wherein patients, insurers and providers may have their unique positions to influence outcomes, especially the private healthcare providers (hospitals/doctors) controlling treatment at insurers' costs. This study assessed the role of private healthcare providers while facilitating mediclaim services for their patients. The study was conducted in a cross-section of in-patients in four selected tertiary-level private hospitals of Delhi, who had availed mediclaim facility for treatment during the Indian Financial Year 2011-12. The sample comprised 120 patients, 30 from each hospital. Confidential in-depth interview method was used to collect data from the sample respondents. It was observed that all 120 patients in the sample had been facilitated by their private healthcare providers in availing mediclaim services. However, on probing further to find out any practice of influence/deception by the providers, the respondents revealed various tactics used by the providers during such facilitations. The authors conclude that many private healthcare providers resort to various tactics of influence/deception while facilitating mediclaim services for their patients. Introduction of corrective regulations and measures for their strict compliance are recommended.

Keywords: Mediclaim, Health insurance, Private healthcare provider, Private hospital, Influence, Deception, Tactics.

Introduction

Day by day, health is becoming all the more valuable and disease all the more expensive. As a method of risk transfer, many people plan and opt for mediclaim (also called as private health insurance) which is the insurance against the risk of incurring medical expenses.[1] It is seen as a cost-effective way of supporting financial resources available for medical care[2]. Of late, in India too,mediclaim is emerging as a big industry in both public and private sectors which have witnessed tremendous changes and wider coverage over past few years[3,4].

Mediclaim generally covers the insured person's hospitalisation expenses and provides medical reimbursement facility for expenses incurred due to sickness. However, patients are generally required to share the costs, because some of the cost components are non-coverable under any given mediclaim policy[1,5]. In order to avail cashless facility under mediclaim for treatment in a private healthcare institution, an authorization from the concerned insurer, or its third party administrator (TPA), is required. The procedural formalities for this purpose are generally done by the concerned private healthcare provider who also gets the payment from the insurer directly for such a treatment[1]. After the insurer issues the final authorisation for cashless treatment, the patient does not need to pay anything to the provider (except any bill difference arising over and above the amount thus authorized).

An unfavourable effect on any of the stakeholders of mediclaim may jeopardize the inherent philosophy of risk transfer and can potentially detriment its utility and significance[6].Under the present scenario of mediclaim services, patients, insurers and providers may have their unique positions to influence outcomes, especially the providers (hospitals/doctors) controlling treatment at insurers' costs. Several case reports have indicated that many mediclaim schemes suffer from high claim ratios, over-utilization and false claims, particularly due to moral hazard and a practice of influence/deception by theprivate healthcare providers[7-10]. This is a serious issue. However, studies assessing the role of private healthcare providers from this perspective are hard to find, particularly in Indian context.

OBJECTIVE

The objective of this study was to assess the role of private healthcare providers while facilitating mediclaim services for their patients.

METHODOLOGY

Type of study

The present study is a descriptive, cross-sectional, hospital-based study that aimed to gather an in-depth understanding of the role of private healthcare providers while facilitating mediclaim services for their patients. It focused on the tertiary-level hospitals of Delhi for in-patients with mediclaim facility.

Place of study

The study was conducted in four selected, registered, tertiary-level, private hospitals located in Delhi and empanelled with mediclaim facilities. Due to practical constraints of the private hospitals' own concerns and acceptability for such kind of study, convenience sampling technique was used and the first four eligible hospitals, which agreed for participation and gave written permissions for conducting this study in their hospitals, were selected and included in this study. In order to maintain privacy and confidentiality inidentification of these private hospitals, the study hospitals were coded (as SH_1, SH_2, SH_3 and SH_4) and their precise identification data (such as hospital's name, complete address, absolute bed strength etc) have not been disclosed here intentionally.

Period of study

The study pertained to the Indian Financial Year (FY) 2011-12 (that is, a period of one year starting April 1, 2011 and ending March 31, 2012). This period was chosen as it was the year immediately preceding that in which the process of actual data collection was done.

Study subjects

The sample comprised 120 in-patients (30 from each of the four study hospitals) who had availed mediclaim facility for treatment during the period of study. Inclusion criteria for selection of patients were: a) the hospitalisation period falling within the period of study; b) complete hospitalised treatment followed by discharge on improvement (as per the medical advice); and c) availing of individual mediclaim facility for the hospitalised treatment. Exclusion criteria were: a) hospitalisation period extending beyond the period of study; b) expired, brought dead, left against medical advice, discharged on request, or referred/transferred out patients; c) hospitalisation for a period less than 24 hours; d) treatment under fixed-cost package deals; e) treatment under social health insurance facility or any other subsidised scheme; f) treatment rendered on complimentary basis; and g) destitute patients. Based on these criteria, a discrete list of patients who were found eligible for inclusion was prepared (arranged in a chronological order from the latest to the oldest time of discharge from the hospital) for each study hospital, from which 30 patients were selected by using systematic sampling technique and included in the study. Informed consents were obtained from the sample subjects for participation in this study.

Tools and techniques for data collection

Suitable pretested checklists and semi-structured schedules were used as tools for the present study. Data were collected in a single cross-section during the period from June through October of 2012. Profile data on the study subjects and their hospitalisation details were collected from the concerned hospitals. Confidential in-depth interview method was used to collect data from the sample respondents, which involved focused, conversational, two-way communication on their experiences regarding the role of their private healthcare providers in facilitating mediclaim services for them. The subjects were probed further to find out any practice of influence/deception by the

providers during such facilitations; and in case of affirmation, further details of their pertinent experiences were gathered from the respondents.

Data analysis

The collected data were analysed by using appropriate statistical techniques and software packages (the Microsoft Office Excel 2013 and the IBM SPSS Statistics version 21.0).

FINDINGS AND DISCUSSION

Profile of the study hospitals

Table 1. Profile Of The Study Hospitals

Particulars	Study Hospitals (Codes only)*				Total
	SH_1	SH_2	SH_3	SH_4	
Address (location only)*	West	North	North-West	North-West	
Type of hospital (public or private)	Private	Private	Private	Private	
Level of healthcare services available	Tertiary	Tertiary	Tertiary	Tertiary	
Whether registered with DHS	Yes	Yes	Yes	Yes	
Accreditations: • By NABH • By others [If "Yes", name of accrediting/certifying body]	 No Yes [ISO 9001]	 No Yes [ISO 9001]	 No Yes [ISO 9001]	 No Yes [ISO 9001]	
Bed strength*	>250	101-250	101-250	≤100	627
Whether processes mediclaim cases	Yes	Yes	Yes	Yes	

DHS, Directorate of Health Services; ISO, International Organisation for Standardisation; NABH, National Accreditation Board for Hospitals.

* Precise identification data of these private hospitals viz. their names, complete addresses and absolute bed strengths have not been disclosed here intentionally in order to maintain privacy and confidentiality in their identification.

General profile of the study hospitals is shown in TABLE 1. Each hospital was a tertiary-level hospital; registered with the Directorate of Health Services, Government of National capital Territory of Delhi; and processing mediclaim cases also.

Listing of in-patients and selection of the study subjects

Table 2. Listing Of In-Patients And Selection Of The Study Subjects*

Study hospitals (Codes only)*	Number of in-patients**			
	Total patients hospitalised	Patients availing mediclaim facility	Patients eligible for inclusion	Patients included in the study
SH_1	18518	3584	1753	30
SH_2	14019	2335	1170	30
SH_3	11294	1043	649	30
SH_4	4479	1377	690	30
Total	48310	8339	4262	120

* Names of these private hospitals have not been disclosed here intentionally in order to maintain privacy and confidentiality in their identification.

** During the Indian Financial Year 2011-12.

In total, 48310 patients were hospitalised in the four study hospitals during FY 2011-12 (TABLE 2). About one-sixth of them, that is, 8339 in-patients had availed mediclaim facility for treatment, which is an observation in support of the fact that the mediclaim is becoming increasingly popular in India, particularly in the urban areas[3,4,11,12]. About half of the patients with mediclaim facility fulfilled the eligibly criteria for inclusion in the study; and out of them, 30 patients were selected systematically from each of the four study hospitals thereby making a total of 120 subjects in the sample.

Demographic profile of the study subjects

The mean age of the study subjects was 41.5 ± 19.9 years (mean ± SD). There were 82 males and 38 females, making a male-to-female ratio of 2:1. Overall, they had good educational levels (with more than half of them being intermediate or higher qualified), mostly belonged to business- and service-class families, and had good socio-economic status (71% and 14% of them belonging to the upper-middle and the middle socio-economic classes respectively). Based on these observations, the authors consider the respondents reliable enough for the purpose of the present study.

Details of hospitalised treatment of the study subjects

The study subjects had remained hospitalised for a mean period of 4.6 ± 2.3 days. During such periods, they had received hospitalised treatment for various current illnesses (including acute infections, medical emergencies and other diseases). Some of them had more than one disease (which included the pre-existing diseases and those diagnosed for the first time during their current hospitalisations) and most of these diseases had also needed treatment simultaneously. Coverage of pre-existing diseases under mediclaim has remained an issue worldwide with several surveys showing a very strong opposition to their exclusion whereas others advocating for their inclusion under mediclaimcover for more equitable service delivery[13,14].

Mediclaim-related details

Each of the study subjects stated that their private healthcare providers had performed the needful procedural formalities to enable them to avail cashless facility under mediclaim for their hospitalised treatments. During these processes, a denial of cashless facility was observed in 2 patients while an approval of the final authorisation for cashless facility was observed in the remaining 118 patients. Many of the study subjects also stated that their insurers (or TPAs) had posed one or other queries to which their providers (hospitals and/or doctors) had then responded to; and after such replies to the queries, their insurers/TPAs had issued the final authorizations for cashless facility. So, all 120 patients in the sample recognised that they had been facilitated by their private healthcare providers in availing mediclaim services.

However, apparently these providers (hospitals and their doctors) had an authoritarian role while doing such procedural formalities and a possibility of its misuse to facilitate mediclaim services for the ineligible patients in an improper manner could never be ruled out. Few other studies and reports have raised this issue[7-9,13,15].

Table 3. Experience Of The Study Subjects Regarding Practice Of Influence/ Deception And The Tactics Used By Their Private Healthcare Providers While Facilitating Mediclaim Services For Them (*n*=120)

Tactics of influence/deception used by the private healthcare providers (hospitals/doctors)	**Experience of the study subjects regarding use of these tactics by their private healthcare providerswhile facilitating mediclaim services for them**		
	Number of responses in affirmation	Number of responses in denial	Proportion of affirmative respondents
1. Showing duration of the hospital stay longer than the actual	7	17	**29.2%**
2. Exaggerating/distorting the clinical presentation	30	75	**28.6%**
3. Hiking charges for the services availed	16	42	**27.6%**
4. Adding charges for the services not actually availed	18	57	**24.0%**
5. Keeping patient hospitalized for longer duration	25	88	**22.1%**
6. Offering extra services coverable under mediclaim	23	89	**20.5%**
7. Taking payment of non-coverable charges separately and not showing under mediclaim	10	44	**18.5%**
8. Concealing undesirable facts coming across during hospital stay	15	68	**18.1%**

9. Hiding undesirable charges	7	38	**15.6%**
10. Hiding undesirable investigation reports	6	40	**13.0%**
11. Hiding pre-existing diseases	12	85	**12.4%**
12. Concealing correct durations of pre-existing diseases	10	88	**10.2%**
13. Cooking-up clinical presentation	1	35	**2.8%**
14. Colluding with third party administrators	1	43	**2.3%**

* Some patients refrained from commenting on practices and/or tactics used by their private healthcare providers.

When the study subjects were probed further to find out any practice of influence/deception by their providers, 112 (93.3%) respondents affirmed, 1 (0.8%) denied completely and 7 (5.8%) refrained from commenting on their experiences. The respondents revealed varioustactics that had been used by their private healthcare providers in facilitating mediclaim services for them and further disclosed that one or more of such tactics had been used in their cases (TABLE 3). Broadly, the tactics used by these private healthcare providers were certain manipulations through which they had attempted to project a favourable fact, hide an adverse fact, and/or fabricate a desired situation, thereby making their patients' cases suitable for authorisation of mediclaim facility by their concerned insurers/TPAs.

In some cases, a given private healthcare provider had shown the duration of its patient's hospital stay longer than the actual, which could not have been done without conniving with the concerned patient. Similarly, cooking-up, exaggeration or distortion of clinical presentation and hiding facts about any pre-existing disease (or its duration) would also have involved the concerned patient actively. Some of the patients in this study had been kept hospitalised for longer durations, which would have benefitted either their providers (who made more money out of it) or the patients themselves (who otherwise had to bear the costs of their post-hospitalization expenses). A patient availing cashless facility under mediclaim is generally less bothered about the various charges being levied for his/her treatment because these charges are not to be paid by him/her directly. This factor could have prompted some providers to offer extra services unnecessarily, hike charges for the services provided, and/or add charges for the services not even provided to their mediclaim patients in this study. Some providers had concealed those facts, reports and even charge-heads about their mediclaim patients, revelation of which could otherwise have led to denial of cashless facility to them; and even further, they had either not levied any charges on such accounts or had taken such charges separately (without showing them in the medical expenses being billed under mediclaim). Instance of a provider colluding with the TPA was a rarity in this study.

It was inferred from these observations that, apart from doing procedural formalities, many private healthcare providers had resorted to various tactics of influence/deception while facilitating mediclaim services for their patients in this study. Although some providers may be able to sell some extra services (or rather waste them) or make some extra money by using such tactics, these practices (or malpractices) tend to put undue burden on the insurers and affect the financial resources available for care in future. In the long run, it would impinge upon the linkage between health demands and provision of services, and increase the cost of treatment under mediclaim[6]. So, there is an urgent need to address this crucial issue and prevent such practice of using tactics by the providers.

Insurers (or their TPAs) have so far neither monitored mediclaim cases adequately from this perspective nor devoted enough attention to the appropriateness of such claims by the large private healthcare institutions, both of which indirectly encourage expensive corporate hospital treatment[13]. Exclusions under mediclaim coverage (such as pre-existing diseases and other specified conditions) are not being regulated sufficiently in India, which are generally left to the decision of the insurers at present[13,14]. To ensure quality services and check malpractices in private healthcare institutions, the Clinical Establishments (Registration and Regulation) Act, 2010 has a promising role; however it is yet to be adopted by many state governments[16]. Moreover, the problems of private health system need attention at the very core[17,18]. In particular, the objective of profit maximization tends to embolden some of the private healthcare

providers to resort to unfair practices and tactics in mediclaim cases. The current delicate situation of these providers requires measures of social development, increased awareness, self-restraint and stringent regulations for punitive actions. Introduction of appropriate corrective regulations for mediclaim in India and measures for their strict compliance are recommended for prevention of such unfair practices and tactics.

CONCLUSION AND RECOMMENDATION

The present study has shown that many private healthcare providers resort to various tactics of influence/deception while facilitating mediclaim services for their patients. Although these providers may benefit temporarily by doing such malpractices, it would have deleterious effects in the long run as it would result in an escalation in the cost of treatment under mediclaim. To address this crucial issue and prevent such practice of using tactics by the providers, there is an urgent need for measures of social development, increased awareness, self-restraint and stringent regulations for punitive actions. Introduction of corrective regulations and measures for their strict compliance may be more practical, feasible and implementable on short-term basis and are highly recommended for prevention of such unfair practices and tactics.

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