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A study on health insurance and its impact on The operations of hospitals

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Abstract
In today's world of chaos and uncertainties, the most unignorably important constituent of human life is to have sound health without any health related problems. There is growing concern for major ailments attacking us without any intimation. In such a scenario humongous amounts of insurance companies both public and private are offering health insurance services to their customers. Health insurance has become the latest trend in insurance sector in the present generation. Even in the developing countries like India also has a great potential and prospective to sustain a business domain for long years. Whenever we talk about health insurance, certainly hospitals have to play a major role in giving the benefits to the insurer as per the terms and conditions of the policy that the companies have agreed upon. It was obvious that a common man cannot afford all the charges levied by the corporate hospitals in the name of better treatment. But with advent of the health insurance policies, now a day everyone wants to consult the physician without fear of what will the medical expenses. In the light of this, this paper aims to study how the health insurance can play its role in the changing occupancy rate in hospitals.
Key Words: *Human life, Health insurance, insurance companies, corporate hospitals, medical expenses Good health is real wealth of society.*

Introduction

Health insurance is fast emerging as an important mechanism to finance health care needs of the people. The need for an insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging premium from a wider population base of the same community.

To put it more simply, in a health insurance programme, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g. hospitalisation).

Today many countries are shifting over to health insurance as a mechanism of financing their healthcare programme. India is also not exempted from this. People (insured) identify health insurance is a fine solution to their health problems because:

- An insured patient can walk into a health facility without the fear of financial burden
- Health insurance protects the patient from the burden of raising funds at the time of illness;
- Insurance through its risk pooling mechanism is more equitable; and
- Health insurance programme can negotiate for better quality care.

In hospital markets the complicating factor has been the presence of conventional health insurance. It has mean that patient-consumers have been shielded from the cost consequences of their choice. When the decision to use care is based on the services, amenities, and quality of the provider, one should expect that hospitals will compete for patients based on these factors. This has the effect of standing traditional economics on its head. Instead of more competition leading to prices driven closer to marginal costs, more competition in a hospital market leads to increased service, amenity, and quality rivalry-and higher prices.

Objectives of the study

- To know health insurance
- To understand the implications of privatization on health insurance in India
- To know government fund allocation and utilisation for the development of hospital services
- To know the impact of health insurance on hospital services.

Methodology

It is a secondary database study; gathered information from various articles published in referred journals and magazines. And websites are refereed based on the study demand. The study is based on the historical data of the relevance for the last five years.

Review of Literature

The earlier researchers have made an attempt to access the impact of health insurance services on hospitals. As we stated earlier people need good hospital services. Most of the middle class and upper medical class and upper class people of India have been showing their interest to get the corporate hospital services rather than government hospital services (low income group of people have been utilizing the government hospital services under various health insurance schemes given by the government, like 'Aarogyasri Health Care Trust' in Andhra Pradesh) to come over from their health disorders. However peoples have scared to meet the hospital expenditure from their pocket, here the health insurance coverage is bridging the gap and providing assurance to the insured for good treatment and assurance of business to hospitals (both for the private and government)

Mudgal (2005) has examined that whether consumption expenditure of households in rural India was insured against medical ailments. This study found that the villagers were not able to perfectly share the risk of all shocks. Indirani Gupta (2002) in her study found a wide disparity across selections on willingness to participate. The challenges for the new system would be to pool individuals across risk and economic status categories, setup a multi-tier system to meet objectives of equity and efficiency in health care delivery and for planners and regulators, to keep health insurance separate from other non-health insurance.

B. Reshmi et al. (2007),in their study they found that the awareness of health insurance was found to be 64.0 per cent. Around 45.0 per cent of the respondents came to know about health insurance from the media which played an important role in the dissemination of information. The middle and low socio-economic groups favoured government

health insurance compared to private health insurance. They suggested that government should come out with a policy, where the public can be made to contribute to a health insurance scheme to ensure unnecessary out-of-pocket expenditures and also better utilization of health care facilities.

Gumber and kulkarani (2000), has found that there was strongly expressed need for health insurance among low income households in both rural and urban areas. This need has arisen primarily because of heavy burden of out of-pocket expenditure on them while seeking health care. The need for education for rural and urban populations alike on the concept of insurance and information on health insurance is a crucial aspect in extending health insurance coverage on large scale. Ahuja (2004) in his study explained that health insurance was emerging as an important financing tool in meeting the health care needs of the poor. Households which have higher health expenditure and income have higher probability of renewing health insurance policy.

D. Mavalankar and R. Bhat (2000) in their article, "Health Insurance in India Opportunities, challenges and concerns" reviews health insurance situation in India, opportunities it provide, the challenges it face and concerns it raises. The author discuss several imperative for opening of the health insurance sector in India for private investment, some of them are: government is unable to provide more resources for healthcare and institute cost recovery, Need for long-term financial resource on sustainable basis for the development of infrastructure sector etc.

R. P. Ellis et al., (2000) in their article, "Health insurance in India-Prognosis and Prospects" attempts to review a variety of health insurance system in India, their limitation and role of the general insurance corporation as an important insurance agency. They highlighted the need for a competitive environment. This paper recommends improvement in delivery of health care and its financing, efficient functioning of the ESIS and CGHS and amending the mediclaim system and alteration in exclusion clause.

Ramesh Bhat and Falan Reuben (2001) in their article, "Analysis of claim and reimbursements made under mediclaim policy of general insurance corporation of India" analyses 621 claims and reimbursements data pertaining to policy initiation year 1997-98 and 1998-99 of Ahmedabad. They found that number of policies and premium collected have grown 30 percent during 1998-1999 and 50 percent during 1999-2000. It was found that the number of claims increased by about 93 percent during 1998-99 1/3rd of reimbursement is made towards doctors' fees. Diagnostic charges are 30 percent. Insurance company took on an average 121 days to settle the claim. IRDA's proposal to ensure payment settlement within 7 days is highly ambitious.

Evolution of Health Insurance

The concept of Health Insurance was proposed in the year 1694 by Hugh the elder Chamberlen from Peter Chamberlen family. In 19th Century "Accident Assurance" began to be available which operated much like modern disability insurance. This

payment model continued until the start of 20th century. During the middle to late 20th century traditional disability insurance evolved in to modern health insurance programmes. Today, most comprehensive health insurance programmes cover the cost of routine, preventive and emergency health care procedures and also most prescription drugs. But this is not always the case.

Healthcare in India is in a state of enormous transition: increased income and health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy, and the introduction of private healthcare financing drive the change.

The new economic policy and liberalization process followed by the Government of India since 1991 paved the way for privatization of insurance sector in the country. Health insurance, which remained highly underdeveloped and a less significant segment of the product portfolios of the nationalized insurance companies in India, is now poised for a fundamental change in its approach and management. The Insurance Regulatory and Development Authority (IRDA) Bill, recently passed in the Indian Parliament, is important beginning of changes having significant implications for the health sector.

India has limited experience of health insurance. Given that government has liberalized the insurance industry, health insurance is going to develop rapidly in future. The challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without the negative aspects of cost increase and over use of procedures and technology in provision of health care. The experience from other places suggest that if health insurance is left to the private market it will only cover those which have substantial ability to pay leaving out the poor and making them more vulnerable.

Implications of privatization on health insurance

The privatization of insurance sector and constitution of IRDA envisage improving the performance of state insurance sector in the country by increasing benefits from competition in terms of lowered costs and increased level of consumer satisfaction. However, the implications of the entry of private insurance companies in health sector are not very clear. There are several contentious issues pertaining to development in this sector and these need critical examination. Role of private insurance varies depending on the economic, social and institutional settings in a country or a region.

Some of the areas of concern which the regulator has to look into are:

- Many times the insurance claims are rejected due to small technical reasons. This leads to disputes
- Various conditions included in the insurance policy contract is not negotiable and these are binding on consumer
- There no analysis on what is fair practice and what is unfair practice
- The most important area of dispute and unfair treatment is the knowledge and implications of pre-existing conditions.
- The main danger in the health insurance business is that the private companies will cover the risk of middle class who can afford to pay

high premiums. Unregulated reimbursement of medical costs by the insurance companies will push up the prices of private care. So large section of India's population who are not insured will be at a relatively disadvantage as they will, in future, have to pay more for the private care.

Health insurance is like a knife. In the surgeon's hand it can save the patient, while in the hands of the quack, it can kill. Health insurance is going to develop rapidly in future. The main challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without negative aspects of cost increase and overuse of procedures and technology in provision of health care.

Health insurance policies are available from a sum insured of Rs 5000 in micro-insurance policies to even a sum insured of Rs 50 lakhs or more in certain critical illness plans. Most insurers offer policies between 1 lakh to 5 lakh sum insured. As the room rents and other expenses payable by insurers are increasingly being linked to the sum insured opted for, it is advisable to take adequate cover from an early age, particularly because it may not be easy to increase the sum insured after a claim occurs. Also, while most non-life insurance companies offer health insurance policies for a duration of one year, there are policies that are issued for two, three, four and five years duration also. Life insurance companies have plans which could extend even longer in the duration.

A Hospitalization policy covers, fully or partly, the actual cost of the treatment for hospital admissions during the policy period. This is a 6 7 wider form of coverage applicable for various hospitalization expenses, including expenses before and after hospitalization for some specified period. Such policies may be available on individual sum insured basis, or on a family floater basis where the sum insured is shared across the family members.

Another type of product, the Hospital Daily Cash Benefit policy, provides a fixed daily sum insured for each day of hospitalization. There may also be coverage for a higher daily benefit in case of Intensive Care Unit (ICU) admissions or for specified illnesses or injuries.

A Critical Illness benefit policy provides a fixed lumpsum amount to the insured in case of diagnosis of a specified illness or on undergoing a specified procedure. This amount is helpful in mitigating various direct and indirect financial consequences of a critical illness. Usually, once this lump sum is paid, the plan ceases to remain in force. There are also other types of products, which offer lumpsum payment on undergoing a specified surgery (Surgical Cash Benefit), and others catering to the needs of specified target audience like senior citizens.

Many a times the insurance claims are rejected due to some small technical reasons.

This leads to disputes.

Most of the time the conditions and various points included in insurance policy contracts is not negotiable and these are binding on consumers. There is no analysis on what fair practice is and what unfair practice is. Given that insurance companies are large and almost

monopoly setting the consumers is treated as secondary and they do not have opportunity to negotiate the terms and conditions of a contract. Many times insurance companies do not strictly follow the conditions in all cases and this create confusion and disputes. (Shah M 1999)

The most important area of dispute and unfair treatment is the knowledge and implications of pre-exiting conditions. A number of cases of litigation are disagreement on these pre-existing conditions. These problems also arise because of lack of specification of number of areas and properly spelling out the conditions. This is also because some chronic conditions such as high blood pressure and diabetes can increase the risk of many other disease of organs such as heart, kidney, vascular and eyes diseases. The patients with these pre-existing conditions are denied claims for treatment of complications. This is not fair and leads to disputes. Health insurance is typically annual and has to be renewed yearly.

Policy, which is not renewed in time lapses and a new policy has to be taken out. Medical conditions detected during the interim period are treated as pre-existing condition for the new policy, which is not fair. This is seen as major issue as it changes the conditionalities about what constitutes pre- exiting conditions. Courts, however, have ruled that even if there is delay in renewing the policies it should be considered as renewed policy.

In case two doctors give different reports one favouring consumer and other insurance company, the insurance company generally follows the later opinion. There are several such consumer-related issues, which need to be addressed in health insurance. One of the planks on which the insurance has been deregulated is the gain in efficiency and passing on these benefits to the consumers. It is very unrealistic to assume that insurance companies will be able to gain efficiency, which helps them to reduce the price of schemes. At least one should not be expecting this thing happening in the short-run. But providing full information to the consumer and dealing with claims in a just and expeditious manner is the minimum expected outcome of the deregulation process. Consumer organizations have to play very active role in future development of the health insurance sector in India.

Government Allocation on Utilization

The below table has revealed a study on government allocation of funds for the development of hospitals and their utilization during the period from 1st January, 2012 to 10th January, 2015. It was a good sing to note that even though the government has sanctioned equally in every year during the period of study (Rs.750 crores), where as utilization of funds by both the government and the private hospital has been increased year by year. In 2012-13 the government hospitals have utilized on Rs.148.85 crores, whereas in 2014-15 it was Rs.239.4 cores. Coming the private hospitals the funds utilization growth rate during the period is from 44 percent to 59 percent.

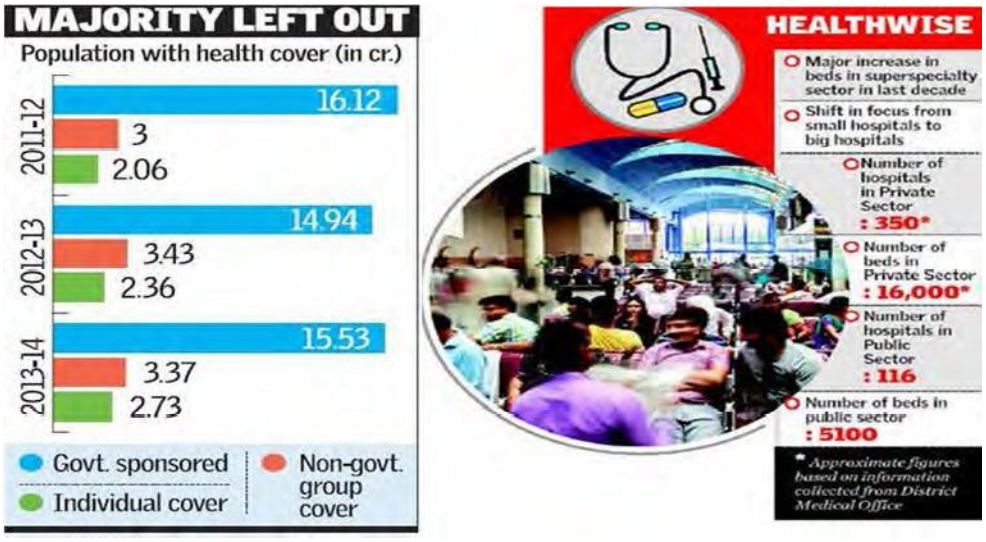
HOW THE MONEY WAS SPENT

Year	Allocation	Utilisation by hospitals		Total
		Government	Private	
2012 (January 1, 2012 to January 10, 2013)	Rs. 750 crore	Rs. 148.85 crore (19.8 per cent)	Rs. 330.46 crore (44.2 per cent)	Rs. 479.31 crore
2013 (January 11, 2013 to January 10, 2014)	Rs. 750 crore	Rs. 245.46 crore (32.6 per cent)	Rs. 434.51 crore (57.9 per cent)	Rs. 679.97 crore
2014 (January 11, 2014 to January 10, 2015)	Rs. 750 crore	Rs. 239.4 crore	Rs. 438. 65 crore	Rs. 678.05 crore

Source: The Hindu, June 26, 2015

Over the last few decades, there has been a tremendous improvement in the quality of healthcare services in India. This is illustrated by the significant improvement in healthcare indicators such as life expectancy at birth, infant mortality rates, maternal mortality rate, etc. over this period.

The sector has problems due to low level of public private partnership (PPP) ventures and therefore, availability of capital at a reasonable cost remains a key challenge for the sector. However, opening up of foreign direct investment in medical devices may provide some relief for the sector as it will reduce the cost of equipment and thereby reduce the maintenance and upgradation cost.



Source: Official figures, the hindu.com

Source: www.pwc.com

Impact of health insurance on hospitals services:

The health care market is characterized by information irregularities between the patient and physician, resulting in a principal–agent relationship. This often misleads the potentially simple monotonic relationship between socio economic status and usage of health services. For instance, researchers have argued that the demand for medical care is an induced preference (Feldstein, 1977), where physicians' interest, peer pressure and ethical concern play an important role in shaping the usage of health care. Hence, there is a possibility that, guided by physicians, the patients end up in purchasing services more than they actually require or can afford. This may result in moral hazard.

One of the most important determinants of hospitalisation is socio economic status of the individual. A high socio economic status has two counteracting forces on the demand for health (Grossman, 1972b; Grossman, 2000). On the one hand, it increases the value of available healthy time and, hence, the incentive to maintain health capital. On the other hand, it increases personal cost of gross investments in health, thereby reducing the demand for health. The net effect is to make the demand for health positively correlated with individuals' socio economic status. With an increase in third-party insurance coverage, however, the importance of socio economic status in determining medical care demand has diminished (Becker, 1964; Mincer, 1974; Somers, 1986; Pappas et al., 1993; Guralnik et al., 1993).

In recent years, schemes like the *Rashtriya Swasthya Bima Yojana*, *Yeshaswini* and *Aarogyasri* have been introduced, but with little impact (Aggarwal, 2010).[1] The recent report of the High Level Expert Group (HLEG) on Universal Health Coverage for India

(GoI, 2011) too calls upon the state to provide 'affordable, accountable, appropriate health services of assured quality with the government being the guarantor and enabler, although not necessarily the only provider ...' (GoI, 2011: 9).

Fast growing population with increasing lifestyle related disease India is the second most populated country with over 1.2 bn population and according to few industry reports it is expected to surpass China over the next 10-15 years in terms of population. Along with this India's working population is also increasing which will help Indian economy to grow at a much faster rate than the other emerging economies. The working population in India was at 58% (age group of 15-60 years) in 2001 and expected to be close to 64% in 2026. However, with the increase in young working population and change in lifestyle of this young population, there has Sources: Apollo Hospitals' Investor Presentation HDFC Bank Investment Advisory Group March 11, 2015 Demographic shift in India (% of population by age group) been an increase in lifestyle related diseases like obesity, cancer and cardiovascular illness.

It is believed that going forward the growth in sector will be mainly driven by the factors like 1) Fast growing population with increasing lifestyle related disease, 2) Improvement in poor healthcare infrastructure, 3) Low healthcare spending, 4) Improvement in medical insurance penetration and 5) Rising medical tourism.

However, the introduction of compliances may also have an adverse impact on the outcome. The presence of compliances means that the patient too is participating in the 'production' of health. The literature on principal–agent relations shows that in such cases, a double moral hazard may emerge (Bhattacharya and Lafontaine, 1995; Cooper and Ross, 1985; Demski and Sappington, 1991). Specifically, in the health market, this may lead insured patients to seek treatment even when such treatment is not essential. This tendency may be encouraged by physicians (the moral hazard problem discussed earlier), so that we get a double moral hazard effect.

Thus the hospital services are been effected by the influence of health insurance interventions.

Conclusion:

In the present scenario health care expenditure is consistently increasing ,in this situation more money are required to paid hospital bill or expenses, most of the people use out of pocket for the health care expenses or in some cases also sell his or her personal assets. Low-income households are more vulnerable to risks and economic shocks. One way for the poor to protect their health is through insurance. By helping low-income households to manage their health risks, health-insurance can assist them to maintain a sense of financial confidence even in the phase of significant vulnerability. Insurance reduce a person's uncertainty concerning the time and amount of possible future expenses that may incur. In the process hospitals also have to play major role in extending support to the mankind in the light of health insurance.

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