Research Article
Volume 5:1,2020
DOI: 10.37421/ijphs.2020.5.178

International Journal of Public Health and Safety

Open Access

A Comparative Study on Health Sector in South Asia and Middle East Countries (Health Insurance)

Said AK* **and Rakesh KJ**

Institute of Pharmacy, Shri Jagdishprasad Jhabarmal Tibrewala University Vidya Nagari, Chudela Jhunjhunu, India

Abstract

Background: Economic impact widely considered on a number of successive health policy by the international as well as national bodies It gives elaborated data, as a remedial method on to solve such problems which affected state's revenues, it needs to discuss the indirect cost borne in health care cost, factors like misdiagnosis, it not only leads to wastage of money but also periled quality of life.

Methods: Primarily noted custom practices followed health insurance policy, as one found mandatory in middle east region (Saudi, UAE, Oman) and tendency found in up growing private health insurers' targeted specific class of people in south Asia, neglected lion share of people those working unorganized sector, Secondarily it considered expert opinion on needs for public health insurance scheme and implementation programs low and middle-income countries.

Results: A total of 463 experts' opinion validated matters related health insurance scheme, fraudulent activities meted their clinical practices both internally and externally. Which were often noted health insurance scheme run by private sector, Here the health insurers' to serve the common man efficient manner not reached at all, even paradigm shows not reproduced any desirable results to achieve national goals, (universal health coverage system). It also discussed similar temptation if the health insurance scheme brought under public health scheme, suggested to resolve such type of fraudulent activities by introducing co-payment system.

Conclusion: This study enabled us to find extent of utility in health insurance services, if once brings under public health programs, it needs vigilant on exploitation both extreme in consumer as well as health care providers. This study enabled us to find extent of utility in health insurance services, if once brings under public health programs, it needs vigilant on exploitation both extreme in consumer as well as health care providers. The public health care system improved significantly by supplying additional human resources and on by retained infrastructural facilities, for developing countries, it is an alternative option by integrating other national scheme like vehicle insurance for raising funds on this generally utilized services.

Keywords: Health insurance • Out of pocket expenditure • Fraudulent activities • Co-payment

Introduction

The concept of health insurance evolved based on social security system, in which certain organisation intakes duties and responsibilities and guarded risks involving all members of society, it is not merely a contract between an insurance provider and an individual but may be contributed by the employer or any organizational bodies to the concerned employee. In some countries, health insurance policy becomes mandatory for all citizens who are enlisted in national plans. However underdeveloped and developing countries are far away from this concept and implementing this procedure. Insurance density in India is stealthily growing compared to Asian and global economies [found in emerging Asian (USD 360) and global economies (USD 650)] and the insurance penetration seen 3.69% in India, 5.62% in emerging Asian economies and 6.13% globally (IRDAI Annual report). However the concept of health insurance in developing countries still needs to be matured.

The liberalization policy on health insurance scheme attracted more investors in to developing countries like India, it becomes rapidly prospered in near future, but health insurance providers undervalued majority of the people who were working in unorganized sector [1]. A decade ago, health insurance program introduced in Pakistan, "The Benazir income support program"; largest ever met program, to meet weaker section of the society and their health needs, allocated fund was 0.3 percentage of GDP. However the system failed on allocating funds and to achieve target goal fully in later periods [2], Generally found private health sector tendency in self-managed health care system, initially made decision to reduce overall cost in an effective manner and in the best possible way, the selection of hospitals based on their infrastructure and services carried out by them for the target population, and reached an agreement by mutual understanding between this parties, primarily focused on awareness amongst the people needs to be created, vigilant on the claims they have made, and other monitoring measures while settling concerned parties. It was found somewhat difficult to carry out entire procedure by single dictator for running this system efficiently and to solve all this problems, it needs fully fledged labour forces and more expensive one [3].

Factors like over charging and pre-selection or selective recommendation made by them which often precluded obtaining desired health services to the patient in equity terms. The limitation on coverage of illness and failure to give alternative treatment option is the major drawbacks in private health insurance scheme. It failed to address all problems related financing, for preventive cares, and for outreach campaigns for promoting health coverage

***Address for Correspondence:** Said Alavi Kolambil, Institute of Pharmacy, Shri Jagdishprasad Jhabarmal Tibrewala University Vidya Nagari, Chudela Jhunjhunu, India, Tel: +919744974723; E-mail: admaero2000@gmail.com*

Received: December 24, 2019; **Accepted:** January 16, 2020; **Published:** January 23, 2019

[4]. The integration of health insurance schemes in existing public health system has great utilities.

While implementing social health insurance programs at national level, primarily following intricacies succeeded like to raise funds in national budget, needs to build up enough human resource and infrastructural capacities [5]. Now the scenario faced in developing counties (The Egyptian studies) health services limited only for employment base health insurance scheme, it neglected vulnerable section of the society, however, it expected universal health coverage system will grow near future and needs to take significant effort to improve this condition [6]. In Indian studies emphasized health insurance targeted on special section of the society instead of concerning epidemiological and demographic status of the people, clearly shows that delivery of health services neglected vulnerable section of the society [7]. The studies also shows in Indian scenario while implementing policies, once introduced micro financing in existing health insurance system, the people withdrawn at rate of 16 percentages to come forward within one year [8]. And the policy holders hesitated to come forward due to less hospital covered in nearby location, affordability to pay off premium, poor response on part of concerned agent when claiming, more formalities when claiming, delay on sanctioning, expected amount not refunded at all. We can't deny the ambiguous statement made by the insurer's representative while canvassing initially. Here the thing valued based on south Indian population [9], the facts on health insurance scheme, often insurer becomes handy on claimed charge sheet, explaining that on limits and sublimit or restrictions which were not being previously advised one, even the entry of private insurer declined growth of public sector [10]. The improvement in health care field by introducing community health insurance scheme, beneficial for 70 percentage of working population in Yemen, however it needs legal framework for successive planning. In another extreme, not need to say, instead of public health insurance scheme, encouraging private health insurance scheme guided in to catastrophic events [11,12].

Health insurance found significant improvement to meet health care cost, countries like Saudi Arabia policy attracted private investment in to this field, it considered as part of reduction of cost burden in health care, definitely it promoted national economy. However, it failed to discuss problems of needy population like migrants (more than one-third of population) [13]. it needed awareness programs in migrant workers, the research studies partly suggested relatively low knowledge on co-payment system, the patient does not approached health care system for their health needs due to either any one of the reasons, suspicious in mind on to get proper health services, also on by frightened cost of co-payment yielded (want to pay in the private sector). Most of the private health insurers attracted due to contribution of healthy migrant workers, even private health insurers not at all considered free check up on senior citizen during their life time, more prone to diseases and disorder states [14].

Empanelment of hospital is another concern especially in public health system, because lack of networking system on tertiary care settings in public utilities and failed easy to access this services for the common man, it should be assigned subjectively, the selection of hospital based on comparing utility services provided both in public and private hospital, noted in specialist concern, infrastructural setup, human resources, nearest location to access services to the patient, however payment through packages found varied price on same surgical procedures in different hospital, here diagnose related payment schedule should under consideration, however it is difficult to calculate fixed price on all surgical procedures, because of patient referred in to hospital with different stages of complication, and varied in technology used (space maker, prosthetics), as well as quality of service provided. Here needs to advocate for social health insurance system, poorest one needs to be considered through subsidy, however in developing countries like Indian subcontinents voluntary insurance encouraged instead of focusing on social health insurance scheme.

By introducing public health insurance scheme useful one for low and middle income countries to reduce out of pocket expenditure, it can avail funds in existing public utility services by enrolling large section of society on to provide better quality services. It needs public awareness program amongst the population [15]. Lot of articles exposed the fact that people not aware on the concept of health insurance, in developing countries the penniless man don't have money even to pay off premium, for enrolling health insurance scheme found luxurious one, government should take responsibility to support on miserable section of this society. The information technology has great utility in the field of health insurance; it provides transparent view, facilitated speedy measures to detect fraudulent activities encountered in this field, eased for paper less work. While implementing policies, lack of awareness amongst the people rested on RSBY, failure of this policies previously enacted one in India, however in later period, post card issuance strategy adopted by the state government little bit improved this condition to create awareness amongst the people. We learned from past experience, needs to take conscious attempt to improve this condition, by the utilization of field staff to convey messages amongst the society on the importance of benefits for individual as well as whole community[16-18]. As far discussed drawbacks on private health insurance, and anomalies presented in existing public health insurance scheme, which also directed the importance of public health insurance scheme, needs to be strengthened.

Research Methodology

As the studies focused on health care providers, professional commitment, attitudes towards practicing, people concerned expectations as well as contributing factors in ethical dilemma, and dialectical peculiarities were noticed. The research was based on direct personal contact and also online reply made by the respondents. For the justification, it used specific research tools, "questionnaire and interview guide" to study on this survey parts, in fact questionnaire at large and interview guide to a lesser extent to gather exhaustively bigger information in all 463 samples (physician – 179, Dentist 43, pharmacist 66, nurses 45, Researcher 52, professors-66) considered on this part of studies.

In the survey design, the most important facts to design standardized questionnaire, make it free from personal bias, initially data collection done by observing on consumer's attitude, concerned general perception whole community in health care system, the researcher spend time in Dubai, (UAE), Sohar, Muscat (Oman), in which large amount of international migrant met from the region of south Asia and middle east, and in south India, it takes four years and takes maximum efforts to reach in a conclusion. Here author not only closely inspected on attitude, and perception of people related on health promoting activities but also behaviour of shoppers, and health care providers and other intermediate agencies (representatives, consultant agencies). A systematic approach done throughout the study to carry out functioning on this research studies which attributed in quantitative and in qualitative terms.

Data Analysis

Demographic data profile almost research data interpreted, in certain extent it have a crucial role to play based on subject studies, the analysis of diagram represented a total of 463 participant in which 296 participants were found male, and remaining 167 respondents were found female, the weightage given almost same for both sex (male/female).

The subjects related to health care, almost all section of the societies who served in clinical field considered, here priority is given to the physician because of all role on this relevant field subjugated (accustomed in their clinical practice), by them (Figure 1).

Even the study considered education of participants, which reflected on many factors like quality of participants, behaviour of respondents, research competencies, and innovative capabilities.

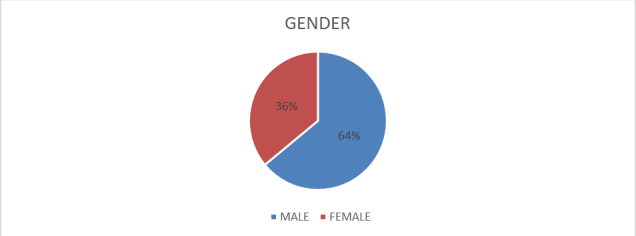

Figure 1. Analysis classification of data (Demographic profiles).

The analysis of Figure 2 data represented different stake holders in health care field like physician, dentist, professors, researcher, pharmacist, nurses.

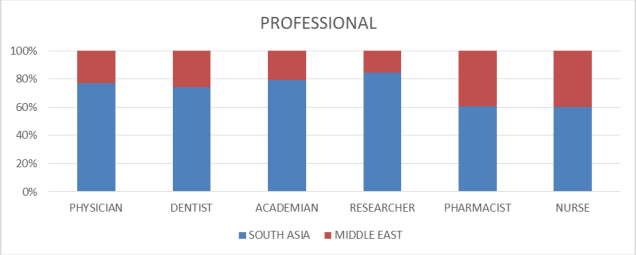

Figure 2. Analysis classifications of data (Profession).

In which overall 179 physician in the region of South Asia (138) and counterpart Middle East countries (41). Dentist being participated on this research studies a total of 43 from south Asian region (32), and eleven from Middle East. And a total of 78 highly experienced medical professors worked in familiar institutes around the globe, from the south Asian region (62), and counterpart from Middle East countries (16), and a total of 62 well expert researchers practicing in clinical field, from South Asian countries (44), from Middle East countries (8), and pharmacists who had good clinical exposure, a total of 66 pharmacist participated on this study from south Asian region (40) and Middle East (26), one of the major mediator in clinical field like 45 nurses participated on this studies from the region of south Asia (27), counterpart from Middle East countries (18).

The above figure illustrated on experience of health care providers in their clinical practices. Initially a total of 520 participants responded on this research studies, through online survey conducted by using Google forms (admaero2017@gmail.com;admaero2000@gmail.com; admaero2018@gmail.com) and by offline service through personal approach. However 57 participants rejected due to incomplete data and because of less than three years of experiences. Subjects considered based on least three years of experience in clinical fields.

Finally selected a total of 463 participants those who had experience between 3 to 6 years (201+43.19%), between 7 to 10 years (93+20.08%), between to 11 to 14 (59+12.74%), between 15 to 19(52+11.23%), between 20 and above (58+12.52%) (Figure 3).

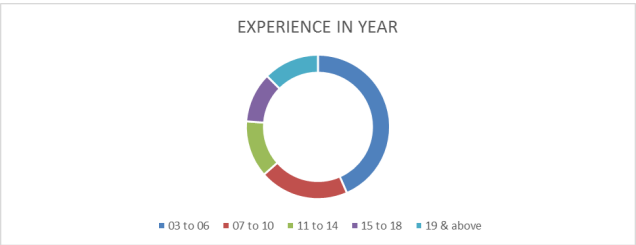

Figure 3. Analysis classification of data (Professional experience).

How would you rate the following statements "Health insurance which encourages more medication through hospital visit?"

Figure 4 diagram illustrated view on fully free cost in health insurance scheme encourages more medication through hospital visit, interpreted by using rating scale, strongly agreed 33 participants (7.2 valid percentages), out of 463 health care professionals 204 agreed (valid percentages 44.3), almost one fourth of the participants kept silent on this data, two them not commented at all, on disagreed terms 70 participants (valid percentage 15.2) and strongly disagreed by 15 participants (3.3%), ignorance of participants on this terms found 35 (7.6%), especially in counterpart south Asian countries still needs to be advocated on beneficiary effect of health insurance through national schemes.

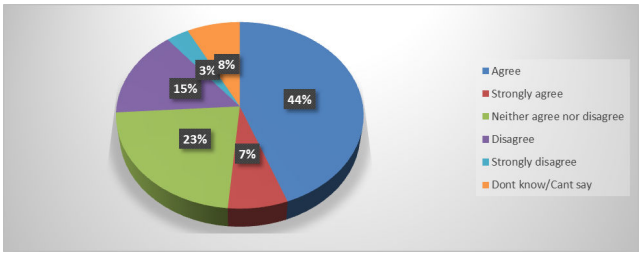

Figure 4. Analysis of classification of data (Health insurance policy – co-payment).

Figure 5 illustrated on fraudulent activities met in internal sector, responsible by the health care providers, sometimes patient pressurized on to the physician.

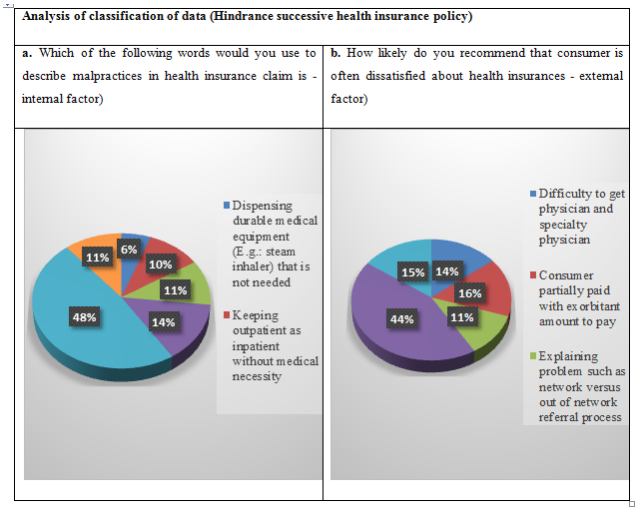

Figure 5. Analysis of classification of data (Hindrance successive health insurance policy).

Here often failed to implement health insurance policy in successive way, intricacies faced such as durable medical equipment dispensed that not needed one (26+5.6 valid percentage), keeping outpatient as in patient without medical necessity (48+10.4 valid percentage), falsifying patient diagnosis to justify tests, investigation and other procedures (65+14 valid percentage), and on by branded medicines dispensed with more profitable ones (65+14 valid percentage), here nearly half of the participants on above all fraudulent activities (223+48.2 valid percentage), 51 participants withdrawn (Valid percentage 11) to comment on this statement. From the above description it can be concluded that statement, juxtaposed Health insurance as a knife in the surgeon's hand saves patient's life, but in the hands of quack, it can murder [19].

The second graphical representation provides information regarding challenges faced by the consumer while approaching on health care providers, difficulty to get physician and specialty physician near the location (66+14.3%), and for claim settlement consumer partially paid with exorbitant amount to pay, (72+15.7%), problem explaining such as network versus out of network referral process (52+11.3%), on the above all problems opted nearly half of the participants (200+43.5%), and remaining 70 participants not

commented on it, three of them not at all made responses on the above statement.

Results

The current study indicates that health insurance which encourages more medication through hospital visit, in which highly weighed on the statement strongly agreed by the expert's opinion, as one found previously, in the analysis five scale rating scale were used for this measurement. It observed fully free cost services on health insurance scheme exploited, needs to be addressed. This problem could be curtailed by introducing co-payment system. There is a significant difference on to implement successive, smooth running health insurance policy in a cost effective manner like social health insurance scheme in public health sector. So it should consider financial liabilities in public health insurance scheme, and it needs to take precautionary measures on the following facts which hurdled health insurance schemes both externally and internally. External factors, here nearly half of the participants agreed on all parameters, it gives more realistic picture on dispensing medicines branded one with more profitable, followed keeping outpatient as in patient without medical necessity.

The internal factors agreed nearly half of the participants on all parameters, difficulty to get physician and specialty physician highlighted on sixth of the participants, partially suggested government should consider setting up highly infrastructural tertiary care hospitals with supply of efficient human resources on this concerned sector. No one can afford to entrust public utilities if not getting proper services provided by them. In the case of health insurance, utility can avail entire society which were built by on trusteeship, here rational people who comes forward, the role of both health care providers as well as policy makers have great concern, because of their attitude, commitment, and overall competencies expected by the community in each and every situation, studies shows that present scenario, public drastically changed on part of confidential movement in generally utilized survival programs. The present studies focused on various roles of a healthcare providers, role and commitment levels; in turn people concerned expectation to avail quality of health service system.

Discussion

Prolificacy of health insurance widely acknowledged things at the cost of entire population can save needy life. We want to learn from past experiences, it needs to integrate in different state health insurance programs through centralised programs and to raise the funds by enrolling mass population on to this scheme, promoted through active enrolment programs by issuing health insurance cards to the individual family, here to enrol health insurance scheme become mandatory to everyone the premium should counted based on they have to pay (based on their savings). It is also found in undeveloped countries majority of people don't have money to pay off even premium [20]. It should be considered by the national bodies to covers whole or part of the risked person subjected to medical expenses. Health insurance initially advocated for the nation as a budget allocation to meet expense on health, it benefited on large number of people. However, later it counterfeited malpractices on both extreme, internally and externally.

The fully free cost of treatment exploited certain section of society, it gives concise note on fraudulent activities such as hiding pre-existing disease or disorder, forged results to meet policy terms conditions, staged accidents, overemphasize clinical facts, duplicate bills so on. The introduction of co-payment in health insurance scheme can avoided such anomalies [21,22] like to purchase branded one, indirectly leaded in to costly treatment, here the brand loyalties created by the pharmaceutical companies on by providing free sample to the consumer as well as physician, or by direct to consumer advertising [23]. A systematic review & research done by "WHO" on subject "The alliance for health policy and systems", for cost sharing mechanisms in health insurance scheme, the author emphasized the importance of health insurance system in public health sector, and also discussed barriers found in successive planning health insurance system in middle east as well as in south Asia. However this system needs to be matured in Middle East region like Iran, Iraq, Egypt, Yemen, and counterpart south Asia. It needs proper monitoring system for even-tempered health insurance system currently practiced. It needed special intelligent wings for the presentation of such data subjected anomalies.

Conclusion

Information Technology based monitoring system have remarkable contribution for smooth facilitation of health insurance scheme, it gives transparent view one for accountable data, facilitated to detect malpractices like conversion of outpatient on to inpatient, conducting unnecessary test and other investigational ways so on, common hindrance found (budgetary deficit) in efficient running of health insurance policies.

References

1. Mavalankar, Dileep, and Ramesh Bhat. "Health insurance in India: opportunities, challenges and concerns." *Ahmedabad: Indian Institute of Management* (2000): 1-16.
2. Jooma, Rashid, and Sabeena Jalal. "Designing the first ever health insurance for the poor in Pakistan–a pilot project." *J Pak Med Assoc* 61, no. 1 (2012): 56.
3. Jian N, and Stewart S. Role of government-funded and community based health insurance scheme in moving toward universal health coverage in India USAID (2014).
4. Purohit, Bhaskar. "Community based health Insurance in India: prospects and challenges." *Health* 2014 (2014).
5. Abrejo, Farina G., and Babar Tasneem Shaikh. "Social Health Insurance: can we ever make a case for Pakistan." *J Pak Med Assoc* 58 (2008): 267.
6. Abbas, Y. M., E. Abul-Magd, A. Elmekkawy, and S. Abaza. "The Evolution Of Private Health Insurance In Egypt Within The Implementation Of Universal Health Coverage." *Value in Health* 19 (2016): A291.
7. Mathur, Vineesh. "Ethical questions regarding health insurance in India." *GEORGE THOMAS* 8 (2010).
8. Banerjee, Abhijit, Esther Duflo, and Richard Hornbeck. "Bundling health insurance and microfinance in India: There cannot be adverse selection if there is no demand." *Am Econ Rev* 104 (2014): 291-97.
9. Priya, A., and R. Srinivasan. "A study on customer awareness towards health insurance with special reference to Coimbatore city." *IOSR J Business Mgmt* 17 (2015): 50-54.
10. Sujatha R. "Health insurance concepts and challenges." *Economic and political weakly* 1 (2014): 2.
11. Arora CRS. "Life insurance sector in India: a study of post reform period." *Int Res J Mgmt Socio Humanities* 6 (2015): 265-280.
12. Fuss, Matthew. "Increasing health care access in Yemen through community-based health insurance." *Indiana J Glob Legal Studies* 23 (2016): 795-818.
13. Albejaidi Fahad. "Emerging role cooperative health insurance in achieving health system goals under Saudi Vision 2030." *J Bio Agri Healthcare* 8 (2018): 1-8.
14. Alkhamis, Abdulwahab. "Knowledge of health insurance benefits among male expatriates in Saudi Arabia." *Saudi Med J* 38 (2017): 642.
15. Shet N, and Quadiri GJ. "Impact out of pocket health care financing and health insurance among the population: A systematic review utilization." *Int J Health Sci Res* 8 (2018): 249-255.

16. Madhukumar, Suwarna, D. Sudeepa, and Vaishali Gaikwad. "Awareness and perception regarding health insurance in Bangalore rural population." *Int J Med Public Health* 2 (2012).

17. Prinja, Shankar, Akashdeep Singh Chauhan, Anup Karan, and Gunjeet Kaur, et al. "Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India: a systematic review." *PloS one* 12 (2017).

18. Makwana, Naresh R., and Sudha B. Yadav. "AWARENESS OF HEALTH INSURANCE AND ITS RELATED ISSUES IN RURAL AREAS OF JAMNAGAR DISTRICT." *Hindu* 362 (2016): 90-50.

19. https: //accessh.org/evolution-health-insurance-India/

20. Perera, Susie, Olivia Nieveras, Padmal de Silva, and Chatura Wijesundara. "Accelerating reforms of primary health care towards universal health coverage in Sri Lanka." *WHO South-East Asia J Public Health* 8 (2019): 21-25.

21. Morley, Nicola J., Linden J. Ball, and Thomas C. Ormerod. "How the detection of insurance fraud succeeds and fails." *Psychology, Crime & Law* 12 (2006): 163-180.

22. Hidayat, Budi, Hasbullah Thabrany, Hengjin Dong, and Rainer Sauerborn. "The effects of mandatory health insurance on equity in access to outpatient care in Indonesia." *Health Policy and Planning* 19 (2004): 322-335.

23. McManus, Peter, Neil Donnelly, David Henry, and Wayne Hall, et al. "Prescription drug utilization following patient co - payment changes in Australia." *Pharmacoepidem Drug Safe* 5 (1996): 385-392.

How to cite this article: Said AK and Rakesh KJ. "A Comparative Study on Health Sector in South Asia and Middle East Countries (Health Insurance)". Int J Pub Health Safe 5 (2020) doi: 10.37421/ijphs.2020.5.178