



## A study of the problems between basic insurance organizations and teaching hospitals of Shiraz University of Medical Sciences as viewed by the staff of income hospitals and representative of the insurer's organization in 2013

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### ABSTRACT

**Introduction:** In Iran health insurance is a significant tool in healthcare costs, financing health care and equal access to health services for people. Problems between hospitals and insurance organizations impose extra cost to the patient, leading to financial losses they will infringe upon the rights of patients. This study aimed to determine the issues between hospitals and basic insurance organizations and proposed practical solutions to solve problems in Shiraz University of Medical Sciences.

**Method:** This research was a qualitative study (content analysis), which was conducted in 2013. The research population consisted of teaching hospitals of Shiraz University of Medical Sciences; Purposeful sampling was used and continued until data saturation. The representative of the insurers and staff of income hospitals were asked questions using a semi-structured interview. In this study, we used NVIVO for data analysis.

**Results:** The results of this study showed that the most common problems between basic insurance organizations and teaching hospitals include the lack of prompt payment of hospital bills and imposing deduction on the hospitals.

**Conclusion:** Based on the results of this study, it seems that cooperation between hospitals and insurance organizations could be improved by timely payment of hospital bills and codifying appropriate rules and regulations by basic insurance organizations and, on the other hand, with timely completion of bills and training of hospital staff by the hospital authorities.

**Keywords:** Hospitals, Insurance, deductions

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### Introduction

Health is one of the basic human rights and it represents the government's responsibility to protect the health of people in the country. In today's world, commitment and responsibility of governments besides Declaration of Human Rights, the Declaration of the World Health Organization, in the constitution of each country has been explicitly emphasized. In article 29 of the constitution of Iran, this issue has been accentuated (1) However, the rapid increase in the costs of health care services has become an important issue in health systems of different countries, even rich countries of the world (2). These high costs threaten the standards of living of poor households, especially in short-term and long-term (3). Establishing health insurance as a method to increase

efficiency and equity in developing countries is supported by international organizations, like the World Bank (4). In Iran, health insurance is an important tool in healthcare costs containment, health care financing, and equal access to health services for people (5) Hospitals, as the largest centers providing health care to the public, constitute a major part of the resources to the health sector resources (6). One of the sources of income for the hospitals, according to the law of universal coverage, is providing and selling services to individuals under insurance (7). The main basic insurance organizations include medical services insurance organization, social security organization, armed forces medical service organization, Imam Khomeini relief foundation which operates under the Ministry of Welfare, and Social Security (8). Insurance companies investigate the bills sent to hospitals, and due

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to errors in data collection and failure to comply with insurance law, they do not pay the hospital fees (that is deduction) and this is probably part of the income of the hospitals that practically cannot be implemented (9, 10). This will lead to dissatisfaction of the hospitals and also the insurance companies to avoid overpayment to hospitals in various ways to monitor hospitals so they do not suffer losses (8). In the Netherlands, focusing on consumers is a key element; insurance companies in providing services and determining premium are in strong competition and if consumers are dissatisfied, they will be able to change their insurance plans (11).

In our country, the conflicts between hospitals and insurance organizations, particularly in the deductions, impose a cost to the patients which in turn, leads to ignoring patients' right and imposing financial losses on them (12). The outstanding difference between this study and other research in this field is that in our study all problems between the hospital and the insurer had been examined. Other studies, except Rashidian's study (1389), have focused on a limited number of problems between the two organizations.

Rashidian in his study indicated that in poor communication between the hospital and the insurance organizations, more difficulty will be imposed on patients (8). Also, Vesal's study showed that the reason for the deductions were the error of the hospital personnel and the request of physicians for additional payment; he pointed out that the causes of the deductions between the hospital and the insurance organizations would lead to reduction of problems between them (7).

Karami's study suggested that in order to reduce the problems related to request for additional payment (K) and additional medical tariff which lead to financial losses of patients, the hospital should monitor the performance of doctors. (12) Also, Tavakoli indicated that the main cause of deduction in the hospital was the fact that the patients' records were incompletely recorded by the hospital staff (9).

Rashidian in his article entitled "challenges of designing basic package benefit" suggested that in designing the package, agreement between the relevant institutions should be created (13).

Kashmir found similar results in other studies in the field of insurance deductions (10). Tubbush in their study indicated that frequent tests had been prescribed for patients by specialists who had no information about cost-effectiveness of diagnosis tests; this in turn would lead to increased deductions imposed by the insurers on the hospitals (14).

The aim of this study was to examine the problems between the hospitals and insurance organizations from personal vision and proposed practical approaches to solving them at Shiraz University of Medical Sciences.

## **Methods**

The present study was a qualitative research (content analysis) conducted in 2013. The participants of the study consisted of 11 teaching hospitals of Shiraz University of Medical Sciences. Purposeful sampling was used and

continued until data saturation. In each hospital, questions were asked in an interview from representative of the insurers who were often Medical Services Insurance Organization and Social Security and the staff of income hospitals that were most relevant to the insurers, in different aspects such as problems between the hospital and the insurer, the predisposing factors for creating deductions and solutions to solving problems between them.

The representatives of the insurers were 19 individuals who had B.Sc degree in nursing, with working experience of about 10 years. In addition, the staff of income hospitals were 11 people, with average working experience of 2.15 years; 10 percent of them had M.Sc. degree, 50 percent B.Sc. degree, 10 percent had diploma, and 30 percent were under diploma.

In this study, two questionnaires were used, 1) the questionnaire related to the staff of income hospitals including 12 open questions and 2) the questionnaire related to the representatives of the insurers which included 14 open questions. The validity of this questionnaire had been evaluated by Rashidian et al., which in the first level, by literature review and based on experts' opinion, the questions were designed. Then, as a pilot an interview was done with an expert in the hospital, a representative of the insurer, and an employee of the hospital's income and after resolving the defects, the questionnaire was finalized.

In this study, we had meetings with the staff of income hospitals and representatives of the insurance organizations that were coordinated through interviews. The questionnaires were completed; one of the representatives of insurance organizations refused to participate, and some of them jointly worked in two hospitals.

In addition, NVIVO software was used for data analysis; this software is a tool for the analysis of qualitative studies. Permission was obtained for recordings the interview and the confidentiality was ensured. They were told that they can withdraw from the study whenever they want.

## **Results**

Generally, the contract between insurance company and hospitals are arranged yearly on the basis of governmental regulations through Vice Chancellery of clinical affairs of Shiraz University of Medical Sciences and central committee of the insurance organizations and then announced to the hospitals and insurance organizations for implementation.

The duties of the revenue and billing departments of hospitals include income billing, Tariff Valuation of Services based on California book and regulations, and sending documents to insurance agency for reimbursement.

The duties of insurance department include matching patients with their insurance, confirming the initial diagnosis of the disease, confirming the date of admission, confirming the patient discharge, checking and confirming whether the outpatient and inpatient services are in the commitment of the insurance or not, collecting patients'

bills, and sending them to the insurance organization.

According to revenue and billing department managers and hospital's insurance department managers, the problem between the hospitals and insurance organizations and the causes of deductions incurred to the hospitals and solutions for reducing deduction are as follows.

**Table 1.** The main topic and sub-topic of the relationship between hospitals and insurance organizations

Topic	Sub-topic
The nature of the relationship between the insurance organizations and the hospitals	-Compulsory contract -The general framework relations between the two organizations -Insurance organization and Department of Revenue duties -Link between the insurance and hospital
Insurance control duties	-Failure of control duties because of the Lack of uniformity between insurance organizations -The orientation of all control activates in insurance offices in a direction to achieve the insurance organization goals
problems between the hospitals and insurance organizations	-long period for receiving the demand -reasons of delay payment -insurance deficit
reasons of hospital deductions	-Reasons that related to the physician -Reasons that related to the defects of bills
Solutions for reducing hospital deductions	-Personnel education -coordinating between the two organizations -uniting procedure among the insurance organization

**Table 2.** Problems between the hospitals and insurance organizations from the perspective of hospital revenue and billing department managers and hospitals insurance department managers

problems between the hospitals and insurance organizations from the perspective of hospitals insurance department managers	problems between the hospitals and insurance organizations from the perspective of hospital revenue and billing department managers
1 - Lack of permanent access to insurance experts 2-Lack of uniformity between insurance organizations 3- changing insurance rules and tariffs 3 - the long process of making a new tariff that will be provided in hospitals 4- Non-alignment to the new services that provided by hospital 5- Insurance organizations delays in paying debts of hospital 6- Weakness of insurance organizations accounting system 7- problems of Hospital information system (HIS) 8- the hospital staff's error for recording the patient's bills 9-Physician's poor cooperation for sending timely the answer of diagnostic services	1-Lack of timely payment of hospital costs by insurance organizations 2 - hospital dissatisfaction with the rules and regulations of the insurance 3-hospital deduction 4 - Lack of harmonization between rules and procedures of insurance, 5- different service packages that offered by the insurance 6 - hospital Delays for sending records to insurance department 7- hospital delays for notifying insurance law to hospital staff 8 - hospital delays for notifying insurance laws for hospital staff 9 - excessive consumption of drugs and materials

**Table 3.** Reasons for hospital deductions from the perspective of hospital revenue and billing department managers and hospitals insurance department managers

reasons of Hospital deductions from the perspective of hospitals insurance department managers	reasons of Hospital deductions from the perspective of hospital revenue and billing department managers
1-not Insufficient awareness about insurance commitments 2 - mismatch of surgery operation code with description of surgery registration 4-incomplete hospital records 5 - Change the DOS system to HIS	1 - the hospital staff's error in recording hospital services 2- The lack of a consistent training system to provide appropriate training to employees 3- Physician's poor cooperation for sending timely the answer of diagnostic services 4- the lack of uniformity among insurance organizations and Lack of clarity of insurance laws 5- poor coordination between hospitals and insurance organizations

**Table 4.**Solutions for reducing hospital deductions from the perspective of hospital revenue and billing department managers and hospitals insurance department manager

Solutions for reducing hospital deductions from the perspective of hospitals insurance department managers	intersectoral solutions for reducing hospital deductions from the perspective of hospital revenue and billing department managers
1-improve insectoral coordination between hospitals and insurance organizations 2-Joint meetings between the hospitals and insurance organizations	1-Training of personnel 2-create uniformity among insurance organizations 3-create a single insurance for all persons

**Discussion**

The present study was about the difficulties among the hospitals affiliated to Shiraz University of Medical Sciences and the main insurer organizations as the point of their personnel views.

The contract among insurance organization and hospitals is mainly regulated based on the country regulations. According to the insurance experts and income authorities, the lack of legal right in revocation of the contract between these two organizations is considered as a weak point since the ability of contract revocation is a legal tool for obligation of the two parties to perform their duties and the contract contents. According to construct studies, the remedial insurance is a centralized decision making system and cannot meet the local and regional needs. Insurance high council has a quite governmental composition and the roles of different parties , i.e. the insurer, insured, and service maker, are not appropriate (15). The hospitals don't play a role in contract making. In addition, they merely perform the fixed contract contents notified by the remedial assistant of the university (8). According to the poll performed. Taking and researchers' suggestion, it is better to regulate a total frame in major policies about the relationship among the service- producer organizations and the buyer organizations. Furthermore, another separate and more detailed contract should be regulated based on the hospital needs with insurance organization party of the contract in following the major contract.

The major social insurance organizations in Iran simultaneously try to provide financial expenses of the

insured's treatment and consider the care issues. So, they both offer the insurance services to the insured person and partially play a role in providing care issues and their quality to them (16). The orientation of all control activates in insurance offices must be in a way to achieve the following goals:

- The virtue in performing the contract among the organization and the contract party institutes.
- The insured person should be assured of receiving the optimal services with appropriate quality in terms of the existing standards according to the contract contents and the present regulations as to physicians' activities and therapeutic diagnostic institutes.
- The optimal use of financial sources and avoidance from spending the unreal expenses and production of the financial losses to the organization.
- Making the insured person's satisfaction and considering their complaints.
- Determining the performances being below the expected limit in order to perform the required reformatory action (17).

The hospital's income directors believe that the insurance companies can impact the quality by permanent existence and timely account payment, and also increase obligations for new services and drugs. However, they mention that the insurer organizations are actually in a weaker position than the hospitals and they can't bargain because of their bad management and payment. Furthermore, they can't offer suitable services and control duties well because they delay in patient's and hospital's request payment. In addition, they don't have unity of procedure.

The most important problem in investigation of the problems among hospitals and the insurer organizations is the lack of on-time payment of the documents sent from hospitals through insurer companies as income director's and the insurer representative's point of view. Since the payment is very irregular, the period of demand receptions is so long; this causes disruption in the personnel's payments, drug payments, and the facilities of the centers being covered. Finally, it will have negative effects on the service delivery. Moreover, due to the growth process of the inflation rate, it will be expected to decrease the value of the incomes (18). The reasons of delay in payment include late announcement of annual tariff, lack of obligation toward the new equipment's and services in hospitals through insurance company because they asserted that these issues are not included in the tariff book, the insurance organizations act slower than the hospitals, and the accounting system of insurance organizations is very weak. Namely, the hospital documents aren't registered in their system until they are investigated and even they may be lost.

The representatives of insurance organization state that the hospital documents are incomplete and according to circulars and regulations of the insurance, the experts of this organization are obliged not to pay insurance fees.

Both of these two organizations remarked that one of the other main difficulties is insurance deficit. Insurance experts act according to their tastes. Each expert is sensitive of a special issue and acts according to his/her tastes; one of them is sensitive to hoteling and the other to ICU and it is more comfortable for them to act in accordance with their willing.

As a hospital director stated, the sum deficit is probably a part of the hospital income which is not actually received. Furthermore, as insurer organizations position, it needs more time to investigate the account bills and the documents that have more sum deficit. And the more the time of investigation of hospital documents by insurer company, the more will be the time that hospitals can receive their demands. As it results in more expenses to investigate further through insurer company, it doesn't seem to be wise (19).

The insurance experts think that the reasons for hospital sum deficit are additional registration of sums in the accounts, and the additional registration of drugs, items, and equipment by wards. They believe that registration of more operations code while the surgeons actually didn't performe them, also the registration of unperformed patient services, and the demand of irrelevant code for operation and more k by physicians will cause hospital deficits. According to the income directors, one of these deficits is caused by physicians because they don't send the diagnostic documents on time, so the documents will be incomplete for the insurer organization. In fact, the insurers are affected by their physicians and their prescriptions. They may prescribe some inessential cares so that the insurer pays more expenses (19).

Vesal investigated that the main reason for deficits of inpatient documents is additional demands. It is essential to make these deficits clear in order to decrease the

conflicts between hospitals and insurance organizations (1). Keshmiri investigated that the most important reasons for this deficit are incomplete insurance documents of inpatients and lack of attention to the insurance regulations and notified circular letter. In addition, the most deficit rate was about surgeon's operation fee (28%), the remedy fee (6%), and the drug fee (3%) in these hospitals. According to Karami's study, demandfor additional k and price, excessive consultation and drug, and time of anesthesia are the causes of these deficits. The above issues cause violation of the patient's rights. So, sufficient control on physician's performance can maintain the patient's rights and decrease the hospital deficit (12).

The policies and procedures of medical records ward especially being of well. Documented folders which should be written are the factors of deficit decrease (2).

According to the researcher investigation, the incomplete record of evidence in the hospital files by the member of the therapeutic team is the most important cause of the deficits since each of them has many carelessness and failure in this issue (9). The representative of these two organizations also emphasized the user's errors in recording the number and type of services.

According to income directors, the insurance companies don't have enough coordination with each other. Their internal regulations differ from each other and this has caused many problems for hospitals. At last, it causes in patient's disadvantage and increasing of hospital deficits. Due to lock of coterent HIS system, these problems will be increased. In addition, as the rules are frequently changed, financial personnel cannot get familiar with all of them. Moghadasi asserted that the policy of remedial assurance system is based on individuals. The directors are changed , the policy is unstable, and it doesn't have a long term programmer. There are many short term case regulations that aren't comprehensive, and have led the financial and social attendants toward consumers (15).

The guarantees of the insurer organization especially about the drug and consuming equipment aren't the same. It makes many different concepts in hospital system. According to income attendants, these problems can be solved through the united procedure among the insurance organization and making the same remedial insurance for all of the groups. It includes such issues as the formation of common committee between insurance organizations and the universities that can cause more coordination and adjustment among them.

Carrin and Rachel investigated that increasing the insurance boxes results in inconsistence among them. This, in turn, affects the low class of community. However, decreasing of these boxes declines the management expenses (20, 21).

According to the delegates of these two organizations, other problems among them are inconsistent regulations and procedures as well as the different services offered by insurer companies. The income attendants believe that the fourth regulation of organization accepts it but the other may not accept that regulation. In Iran, there are many organization work for remedial insurance system is overcoming on the present problems in order to unify all

remedial insurance organizations.

The connoisseurs cited that the constant changes in management levels of health system and remedial insurance organizations in addition to the inconsistent decision making methods have led to the lack of good outcomes of the activities. Another reason for these problems is that dependency of government hospitals to public budget of the government and that the remedial insurance companies are governmental and this sequence makes the present problems More complicated (15).

The insurance representative complained about welfare facilities; for example, they don't designate a proper place for expert observer and they don't cooperate with them. According to insurance representatives, the regulations aren't notified to the hospital personnel. So, it is one of the factors for challenge among them.

Inflexibility of HIS system is also the problem mentioned by the income attendants which includes lack of conformity in regulations and contracts. Furthermore, the insurance organizations demand that the accepted patients' information from the different parts of hospital is written on the disc. It is impossible for hospital to do that because the HIS system is not able to write this information on the disc.

According to insurance experts, the hospital personnel's don't completely know about the insurance commitment regulations and tariffs and it leads to lack of conformity among insurance company and the hospitals. Ghodoosi in his research suggested that the insurer organizations can provide a background in order to avoid lack of attention to the regulations and principles. It will be practical through informing the people about the regulations and rules, deleting the insurance notebook and substituting the electronic card of health insurance, paying the demands on time, performing congresses and seminars about the relearning of occupational morality based on canon law, and etcetra (22). Many researches showed that most of the physicians aren't informed about the service costs which they prescribe. If they are informed sufficiently, they will have an important role in the more economical use of the health and treatment section sources. They must also be informed about the drugs which are under the coverage of insurance organizations (23). Moreover, such solutions as the following can reduce many hospital deficits:

- Existence of constant learning system to train the personnel to familiarize with financial regulations, tariffs, and service code

- Increase of the motivation of personnel with financial a non-financial supports and incentives to have fixed and nonplan personnel

- Financial encouragement of ward secretaries and income staff

- Cooperation of insurer organization representatives

- Appropriate relationship of income ward with insurance representative

- Persistence of income staff

- Cooperation of other wards

More interactions and coordination among the insurer organizations and the hospital by cessions to study the documents, revise the incomplete files, and the process of

sending the documents.

Appropriate tariff service is one of the determining issues in offering the services. Without suitable price list, the suitable services aren't offered (15). According to revenue attendants and insurance representatives, the tariffs don't accord with the total price of the services. It causes many problems, such as increase in patient's payment; dissatisfaction of patient and hospital personnel, and physicians; decrease of the quality of services; and increase of physicians' bribe.

Further, the low price lists affect the hospital expense and its debts will be frequently increased, but its income will be declined. So, hospital financial level will become negative, and ultimately it leads to the hospital's debts and dependency to remedial centers and government's financial supports (20).

According to revenue attendant, hospitals cannot receive any additional money from patients; however, the insurer organization's representatives believe that if there isn't any control by experts, the hospital will receive additional sums from insurance company through making documents and recording of the services with non-performer surgery code.

The insurance attendants believe that they defend the insured rights. If they pay additional money, the insurance company will return it to them after investigating the insurer complaint by the detective unit in accordance with the legal procedure. As they said, all of our efforts are for patients' rights, we tries all patients are visited and confirmed. If outpatient departments don't have any referral code and their insurance notebooks aren't valid, we will ask all different wards to do their affairs.

### **Conclusion**

The present study suggested that the insurer company can cause the promotion of the cooperation among the health services organs and the insurance organizations by paying the hospital accounts on-time, omitting some unnecessary regulations, composing the regulations, planning and establishing the united insurance system in the country, omitting the insurance notebooks and substituting the electronic card of health insurance, promoting the insured's knowledge about their rights, forming the control teams from the incureds as the honorary observers to report the deficits of the regulations and principles and then offering appropriate rewards to them, and revising the existing system of payment in insurer organizations about the offering of health services.

The hospitals are also able to promote the cooperation among these organizations by sending the accounts on time completely and providing suitable welfare facilities for insurance experts, and training personnel of hospital appropriately.

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