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The Study of the Possibility of Eliminating Franchise in Selected Medical Centers under Insurance Contract Affiliated to Medical Sciences Universities and Other Centers Regarding Service Grading

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Abstract

Competitive atmosphere of organizations is struggling against major challenges in the present decade. Due to increasingly developments in activity environments of organizations, rapid changes in markets, and promotion of competitiveness culture, it is felt the need using the patterns which not only have the ability of evaluating the current condition of the organization, recognizing the deeply-rooted issues and organizational harms (disadvantages), and identifying improvable areas, but also building an accurate basis in order to plan strategic planning. The present study aimed to investigate the possibility of eliminating franchise in selected Medical Centers under insurance contract in Social Security, and it is done in collaboration with managers and experts of healthcare managements of Social Security of Elam, Ardabil, South Khorasan province, Khuzestan, Semnan, Kurdistan, Kohkilooyeh and Boyer Ahmad cities, and Tehran. The results indicated that, in present conditions, the elimination of franchise cannot meet the interests of insurer. Because the management method of franchise as a major and efficient tool in the field of health economy reduces indiscriminate increase of unnecessary costs, therefore its elimination is not on the benefit of Healthcare Services providers of the country.

Keywords: Franchise, Hospitalized Centers under (Insurance) Contract, Services' Grading

Introduction

In different countries, Social Insurance Funds have been formed to reach the human, social, and economic noble goals, to provide an appropriate level of livelihood, to give a warranty to workforce and finally to create a suitable background for the realization of sustainable development which makes both economic, social, political, cultural peace and security and social justice(Nikpur, 2008).

In Iran, citizens are also supported by Social Security which guarantees the minimum needs of life fitted with the dignity of man which is manifested according to its assigned missions mandated by the law (Mozafari, 1998) in the form of retirement pensions, medical aid costs, compensations, and finally as preventive measures (Ebrahimiali, 2006).

Since the health and access to health services is an inalienable right of any person (n.n, 1998) and the society is obliged to provide the minimum health services for all citizens (Evans, nd.), to reach this goal, the (insurance) Fund is in charge of providing medical care for the insured while delivering care services in medical centers under insurance services (direct treatment) through signing a contract with independent medical- care centers(indirect treatment) (Statistics Journal of Social Security, 2010). In addition, to deliver the presented services, it pays all or part of the costs, so the insured can choose doctor, clinic and hospital on their own ideas. In this approach, parts of costs as a franchise are usually the insured's duty (Talebe, 1991). The French word "franchir" is pronounced "frænshiz" in Persian while in English it is pronounced / frænt∫aiz/. The stem of this word is Latin and means "immunity and connivance" (http:// www.iraninsurance.ir). This is one of the most important aspects of risk management (http:// www.bih.ir). Since the formation and development of care insurances had a large effect on treatment

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method and on patients' health coverage in different countries over the past decade, the risk reduction for providers and demanders of health services has always been in demand (Kermani,2005). It seems that according to the rapid developments in health sector of the country, the need for preparedness of health and care section of Social Security fund especially indirect healthcare is felt in order to keep up with these developments and meeting the new requirements (Mozafari,2005.) .

Review of literature

The authorities of each country in insurance system that deliver health services are responsible to choose the best approach for their country and experience the approaches practically after they became fully aware of public and economic status of the considered country. Furthermore, after analyzing the outcomes of approaches, they may need to study some approaches experimentally as a sample in a part of the region (Inter-American Conference of Social Security, 2005). In a study carried out by Medical Document Office of Semnan province about hospital fees in 2005)= and the hospitals of center of province compared with Imam Hossein hospital of Shahrud city which is granted to Medical University of Shahrud city where the insured served without giving franchise, it was seen that although Semnan and Shahrud are at the same socially and economically level and also at the level of having the facilities of care recognition, lack of franchise in Imam Hossein hospital has caused an increase in the amount of patients that resulted in increasing hospital costs in Shahrud town compared to Semnan (Audit Office of Medical Records of Semnan province,2005).

Statistics derived from the entire hospitalization deeds and documents of Semnan province in 2009 and comparing Imam Hossein hospital (without franchise) with other Medical centers of the province are shown below as well as the method of making costs in related towns.

Table1. Comparing statistics of hospitals that are under the control of Medical Universities of Semnan and Shahrud towns in 2009

Title	Insured number	File number	Patients' reference	Cost	Active number of bed	Number of bed in every 1000 people
Imam Hossein Shahroud		10571	079/0		351	63/2
Fatemiye Shahroud		3586	027/0		90	67/0
Khatamolanbiay Shahroud	133664	2756	021/0	327189	122	91/0
All medical science hospitals in Shahroud	133664	16913	127/0	327189	563	21/4
Fatemiye Semnan		2817	017/0		96	60/0
Emdade Semnan		2053	013/0		53	33/0
Amir Almomenin Semnan		3227	020/0		88	55/0
15 khordade Semnan	161304	1055	007/0	158441	41	25/0
Rezaei Semnan		3089	053/0		116	01/2
11 Moharram Semnan		1271	022/0		30	52/0
Imam Garmsar	57852 64086	2781	043/0	161878 83988	82	28/1
All medical science hospitals in Semnan	283242	16293	058/0	142297	506	79/1
Total	416906	33206	080/0	201575	1069	56/2

Also, according to the following table, the average costs and the statistics of non-indigenous patients do not show significant differences.

Table 2. The average costs of each file (record) in 2009

University	Mean cost for every file in a year (Rials)	Nonnative patients
Shahroud Medical Sciences	183/684/2	6
Semnan Medical Sciences	056/383/2	5

*Note that as there are two Medical Universities in the province, the statistics of the two places have been listed both individually and totally.

Therefore, with regard to the obtained information from the above mentioned tables, it is obvious that numbers of the insured who were hospitalized have significantly grown in Shahrud town compared to other towns of the province, which are under the coverage of Semnan University of Medical Sciences. Equally the costs of annual hospitalization of each insured in this town is 2/3 more, in comparison to other towns of the province; however, 70% of the related costs has been spend in Imam Hossein hospital that is out of grading level determination and lacks franchise. Another point of these two universities of Medical Sciences relates to the number of beds. Shahrud university of Medical Sciences with 4/21 beds per 1000 people had two times more patients than Semnn University of Medical sciences with 2/56 beds. This can be considered as a factor for increasing the related costs.

To explain more, the average cost of each case (file) and the statistics of non-indigenous patients in both areas do not show significant differences (Audit Office of Medical Records of Semnan province, 2007).

Meanwhile, a study on the costs of hospitalization of the first six month of (2010) of Tehran hospitals with or without franchise (without taking into consideration the costs of Milad and Sadr hospitals) implies that in case of eliminating 10 % hospitalization section franchise, care costs will be indirectly added about 11/1% and about 42/85% in outpatient section in case of eliminating 30% of franchise in outpatient section (table 3).

Regarding the growth process of the population under the coverage of the organization(fig 1)and also considerable increasing in numbers and costs of investigated prescriptions of hospitalization in medical centers that are under the insurance organization (table 4), it is predicted that in case of eliminating franchise and because of intendancy of the insured to getting services from under insurance contracts organizations, the health and care costs has increased significantly, providing an opportunity for drawing up contracts with more Medical centers.

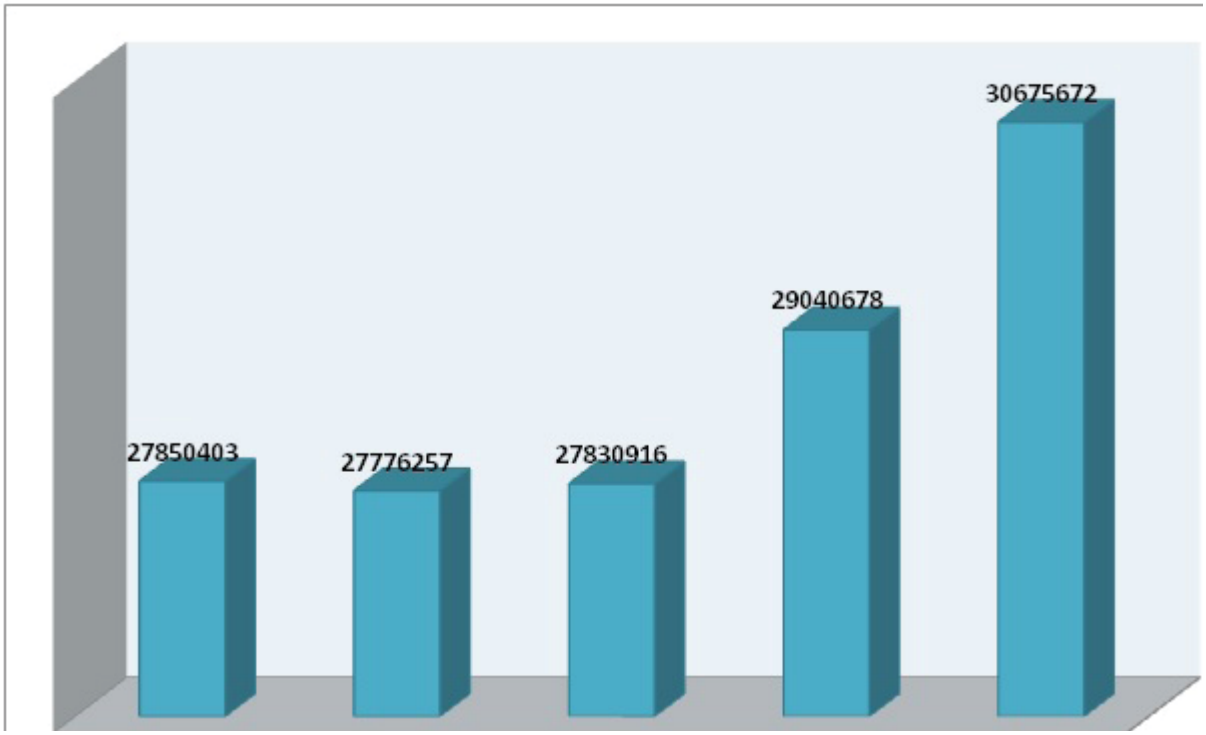

Figure 1. The population under Iran health and care coverage (2005-2009)

Table 3. Number and increasing rate of costs for the investigated prescriptions of hospitalization in Medical centers of insurance during the year (2005-2009)

Year	Studied prescriptions	Mean cost
2005	1548584	1393162
2006	1626051	1600420
2007	1895422	1731302
2008	2035538	4137502
2009	2013415	2419640

Advantages of the plan

The plans of healthcare insurance, in one hand, includes an insuring structure that pay the costs for curing which are mentioned in the contract and on the other hand, it includes the insured population. In addition to these two items, there is another item that is called suppliers (providers) of services (Gold Marsha, 1995). According to this, the advantages of the plan in three dimensions of the insured, Social Security Fund, and agencies under contract include the followings:

1-The insured

-Increasing the level of satisfaction

-Increase in the power of patients over their decisions

-Justice in using healthcare advantages of the organization (at the present time, a limited percent of the insured use the advantages of direct care and there is no equal distribution in different locational centers in all towns)

-A speed-up in admitting and releasing the patients

-Reduction in expenses paid by patients (out of pocket)

-Reduction in expectancy time (reduction in the time of long shifts for surgical operations in direct care)

-Helping to protect family economically that consequently leads to a rise in health and its survival (it is a help to provide social justice for the insured)

2- Social Security Fund

-Reduction in referrals to direct care centers because of doing some specialized and sub-specialized services in the university hospitals

-Reduction in the amount of patients' references to centers with crowded locations

-Promotion of the image of social security fund among other insurance organizations and in of people's view and authorities'

-More practical and easier approach in order to boost the implementation of the referral system

-The reduction probability in the number of patients who go from towns and smaller cities to large cities like Tehran

-No need to increase medical centers in towns

-More control and monitoring on hospitals

-To create a competitive atmosphere between locational centers and non-locational centers

-Outsourcing treatment

-To play a real role by insurance organization

3-Providers of service (agencies under contract)

-An increase in the extent of bed occupation

-An increase in the number of references (visitors) of the selected centers

-To facilitate the setting up of documents' registration in regard to integrating in paying the share of organization

-To make transparency and to increase the predicted and proven rates of earnings (to decrease the financial rebate for the sake of destitute patients of Social Security)

-To highlight the role of the University of Medical Sciences in selected centers

Disadvantages of the plan

The disadvantages of the mentioned plan for the insured, Social Security Fund, and the providers of the services (agencies under contract) are as follow:

1- The insured

-Increase in induction demands and its related costs like the costs of services of an expensive Para clinic before hospitalization (admission)

-Promoting the bribery in selected academic centers with respect to non-payment of franchise

-Increase in risks due to the failure in observing hospitalization and surgical Indications

-Probability of increasing in patients' references over the capacity of selected institutions that can lead to waiting time

-Imposing limitations on the choice of under-insurance- coverage centers by the insured as they are induced that the costs will decreas in selected centers but without paying attention to the quality of services

-To criticize the selected and common centers where the patients attend and pay different fee due to inconsistency

-Dissatisfaction of the insured in case of likely increase of insurance premium

2- Social Security Fund

-Increase in misusing of medical books

-Providing manpower for the sake of monitoring the quality of services in non-locational centers

-Making unpredictable costs because some of the services become free -in –charge, such as chemotherapy

-Increasing the costs of Fund and imposing financial pressure as a result of at least ten percent rise in hospitalization costs because of removal of franchise (theoretically)

-More obligations in paying the costs to the selected centers on time, because of more dependent on sources of the Fund

-Increasing induction demand and the related costs such as rise in hospitalization without Indication, rise in the average length of staying in hospital, and etc.

-Not using all capacity of direct treatment and care section and a fall in locational hospitals due to reduction in bed occupancy

-Causing duplicity in the behavior of Fund against the insured and centers and institutions under insurance coverage from the viewpoint of public

-Shifting costs particularly in outpatient sectors of hospitals (it is predicted that if this plan is going to be carried out in outpatient sectors of hospitals that are under the coverage of insurance contract, there will be an increase in payment; that is, 50% more than franchise)

-The willingness of the centers under-insurance-contract toward services which increase revenue and sometimes cause costs and expenses for insurance like, Echo, physiotherapy, etc. without caring the patients who should pay franchise

-Encouraging the patient to use Social Security Insurance rather than other insurances (those who have different insurance book)

-Lack of financial budget coverage of 9 to 27 in direct and indirect treatment and healthcare

-An increase in unnecessary references to the selected centers

-Creating likely expectations by the insured trade unions to publicize the issue to all of the capitals of provinces

-Uncertain prospect and incoordination of all effective organs (such as financiers, project managers, selected centers, and the insured)

-Doubt about economic and insurance logic of franchise

-Failure to maintain and develop the reserves of the insured

-Imperfect monitoring power of insurers' organizations against the institutions and centers that are under-insurance-contract

-Unknown state and condition of real per capita treatment, the extent of the insurance premium, etc.

-Interference in indices and criteria of measuring performances of treatment units (such action in provinces like Kashan and Semnan led to descending of desirability of treatment indices of these units)

-To carry out the pilot project, with regard to hospitals which are assigned to the Ministry of Health and Medical Education by the insurance organization (out of level) and with a review of existing records (a review of Semnan and Shahrud universities),it is clear that the plan is illogical.

-If the plan is in hospitalization sector and does not include outpatient sector, most of outpatient cases turn to hospitalization ones, causing an increase in the cost of day beds

-Finally, if the plan only covers emergency section, most of the elective surgeries will be operated in the case of emergency

Regarding Clause 2 of Article 38 of Health Insurance of the Fifth Development Plan, hospitals and locational centers of Social Security Fund also need to sell their services according to law pertaining to Iran Health Insurance Organization. Therefore, turning the centers under-insurance-contract, like locational hospitals, is inconsistent with the objectives of the Fifth Plan.

3-Service providers (agencies under contract)

-Increasing economic dependence to the Social Security Fund and to be influenced by existing fluctuations of the Fund

-Reduction in liquidity of the selected centers

-Increased expectations of the insured of the selected centers

-Dependence of Medical Science University on in- cash revenues because of receiving franchise from patients

-Dissatisfaction of other centers because of the insured visits such centers fewer

- Likely lack of cooperation of doctors of other unselected centers whenever it seems crucial

-Reduction in quality services of the selected centers due to increasing the number of references

-Contradiction in objectives of the plan with the viewpoints of the aimed hospital that results from non-receiving 10% franchise for hospitalization and 30% franchise for outpatient services

Conclusion

To look carefully at the current condition of the country and at the process of handling the audit in office of medical records, it seems that in current situation, removal of franchise will not meet the interests of the insurer organization. Regarding the reasons, we can claim that management process of franchise as an important and effective tool in health economy field prevents indiscriminate increases in unnecessary costs and its removal is not beneficial to providers of healthcare services.

Recommendations of the study

The results of Social Security Fund as the first buyer of services and as the second organization that presents medical services are strongly influenced by macro-economic and social policies of the country. To do this, the effective interaction between authorities and policymakers of the Fund in political and social fields play an important role for maintaining its position. Hence, to replace the mentioned plan, the following solutions are suggested.

- Rapid implementation of the plan of referral system and family physician (GP) in order to adjust distribution of resources of the healthcare sector and reduce wasting of related costs, and to improve quality of diagnostic and therapeutic procedures and its desired outcomes
- Moving toward purchasing of a particular service and grading them in the selected centers (abolishing law of all or nothing in contracts of medical documentary books)
- Identifying particular services like poisoning and burns sections
- To investigate the possibility of making specific surgical operation with practical and scientific controls free in charge like subspecialized operations of pediatric surgery and Expansion of insurance undertakings as follows:

a- In form of increasing in undertakings such as ICU patients and death files

b- Insurance coverage for pensioners up to 100%

c- Expanding and increasing obligations scope of the Fund from now specific diseases to other certain diseases such as cancer, etc

d- Making free the emergency services

- Grading and purchasing services fitted with the quality of the presented services (qualitative and quantitative)

-Further restriction on the issuing of medical insurance books and replacing such costs in other needed sectors like restoring employment checkups and increasing the pensioners' services and the insured with over 10 years insurance

-Dividing the plan into outpatient and hospitalization sectors and to withdraw from providing services in outpatient sector gratis due to probable false and uncontrollable costs

-Systematic monitoring using scientific and practical methods

-Exact implementation of the plan and evaluating it in a determined period of time

-To boost the controlling scope of indirect treatment regarding numbers of supervisor, time and quality of monitoring, and other parameters

-To strength specialized scientific councils

-To assess the provincial needs

- To study the type of required services of provinces such as

A- Lack of specialized facilities

B- Need to make some services

C- Encourage some services

D- Eliminating of some services

-To carry out pilot project in smaller cities and to increase the undertakings stage by stage whenever necessary

-To provide the necessary resources for the implementation of the project or plan

- To use the facilities of other secondary insurance and university in order to make some of the services free of charge

-To consider special facilities for paying payments to the selected centers in time (priority in payment, allocating separate budget, and etc.)

-To grade the referrals to solve the main problem of the insured; for example, presenting free services like ERCP and surgical sub-specialized services (the possibility of increasing authority of healthcare managers in provinces)

-Increasing credibility in deprived regions and areas where there is no lacational center

-To provide step (steeped) franchise for healthcare services in a case that costly hospitalization services have less franchise, and the reduction in franchise along with increase in treatment cost be gradually raised and be free for necessary costly services

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