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AN INSIGHT ON MEDICAL INSURANCE MALPRACTICES PREVAILING IN THE HEALTHCARE INDUSTRY AND ITS IMPACT ON SOCIO ECONOMIC BACKGROUND – SPECIAL REFERENCE TO UAE PRIVATE HEALTHCARE INDUSTRY

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ABSTRACT

Purpose: Examine medical insurance malpractices in the UAE's private healthcare industry and assess their impact on the socio-economic landscape, focusing on the context of a rapidly growing economy and a diverse healthcare system.

Theoretical framework: Situated within the dynamic framework of the UAE's expanding economy and healthcare sector, emphasizing the pivotal role of health insurance policies in providing medical coverage.

Design/Methodology/Approach: Employ a comprehensive research approach to uncover prevalent medical insurance malpractices within the private healthcare industry of the UAE. Analyze the effects of these practices on various socio-economic aspects.

Findings: In the backdrop of an evolving healthcare landscape, the study reveals instances of malpractices within medical insurance in the UAE's private healthcare sector. These practices have implications for access to quality healthcare and the broader socio-economic fabric.

Research, practical & social implications: The research outcomes hold significant implications for both policy makers and stakeholders within the healthcare industry. Addressing medical insurance malpractices is essential to ensure equitable access to healthcare services and to maintain a healthy socio-economic balance.

Originality/Value: This study contributes to the understanding of the interplay between medical insurance malpractices and the socio-economic backdrop of the UAE's private healthcare industry. By shedding light on exploitative practices, the research highlights the need for regulatory measures to safeguard the well-being of both individuals and the nation's socio-economic landscape.

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UMA VISÃO SOBRE AS PRÁTICAS INCORRETAS DE SEGUROS MÉDICOS PREVALECENTES NO SETOR DE SAÚDE E SEU IMPACTO NO CONTEXTO SOCIOECONÔMICO - REFERÊNCIA ESPECIAL AO SETOR DE SAÚDE PRIVADO NOS EAU

RESUMO

Objetivo: Examinar as práticas abusivas em matéria de seguros médicos no setor privado de saúde dos EAU e avaliar o seu impacto no panorama socioeconômico, centrando-se no contexto de uma economia em rápido crescimento e de um sistema de saúde diversificado.

Estrutura teórica: Situada dentro da estrutura dinâmica da economia em expansão dos Emirados Árabes Unidos e do setor de saúde, enfatizando o papel fundamental das apólices de seguro de saúde na prestação de cobertura médica.

Projeto/Metodologia/Abordagem: Empregar uma abordagem de pesquisa abrangente para descobrir práticas incorretas prevalecentes de seguro médico no setor de saúde privado dos EAU. Analisar os efeitos dessas práticas em vários aspectos socioeconômicos.

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Constatações: No contexto de um cenário de saúde em evolução, o estudo revela casos de práticas incorretas no âmbito do seguro médico no setor privado de saúde dos Emirados Árabes Unidos. Estas práticas têm implicações para o acesso a cuidados de saúde de qualidade e para o tecido socioeconômico em geral.
Investigação, implicações práticas e sociais: os resultados da investigação têm implicações significativas tanto para os decisores políticos como para as partes interessadas no setor dos cuidados de saúde. A resolução das práticas abusivas em matéria de seguros médicos é essencial para garantir o acesso equitativo aos serviços de saúde e para manter um equilíbrio socioeconômico saudável.
Originalidade/Valor: Este estudo contribui para a compreensão da interação entre as más práticas de seguro médico e o contexto socioeconômico do setor privado de saúde dos Emirados Árabes Unidos. Ao esclarecer as práticas de exploração, a pesquisa destaca a necessidade de medidas regulatórias para salvaguardar o bem-estar de ambos os indivíduos e a paisagem socioeconômica da nação.

Palavras-chave: Seguro Médico, Práticas Abusivas, Impacto Socioeconômico, EAU, Cuidados de Saúde Privados, Apólices de Seguro de Saúde, Exploração.

UNA VISIÓN DE LAS MALAS PRÁCTICAS DE SEGURO MÉDICO PREVALECIENTES EN LA INDUSTRIA DE LA SALUD Y SU IMPACTO EN EL ENTORNO SOCIOECONÓMICO - ESPECIAL REFERENCIA A LA INDUSTRIA DE LA SALUD PRIVADA DE LOS EAU

RESUMEN
Propósito: Examinar las malas prácticas de seguro médico en la industria privada de salud de los Emiratos Árabes Unidos y evaluar su impacto en el panorama socioeconómico, centrándose en el contexto de una economía de rápido crecimiento y un sistema de salud diverso.
Marco teórico: Situado en el marco dinámico de la economía en expansión de los Emiratos Árabes Unidos y el sector de la salud, haciendo hincapié en el papel fundamental de las pólizas de seguro de salud en la prestación de cobertura médica.
Diseño/Metodología/Enfoque: Emplear un enfoque de investigación integral para descubrir las malas prácticas de seguro médico prevalentes dentro de la industria de la salud privada de los EAU. Analizar los efectos de estas prácticas en diversos aspectos socioeconómicos.
Hallazgos: En el contexto de un panorama de salud en evolución, el estudio revela casos de malas prácticas dentro del seguro médico en el sector privado de salud de los EAU. Estas prácticas tienen consecuencias para el acceso a una atención sanitaria de calidad y para el tejido socioeconómico más amplio.
Investigación, implicaciones prácticas y sociales: Los resultados de la investigación tienen implicaciones significativas tanto para los responsables políticos como para las partes interesadas dentro de la industria de la salud. Abordar las malas prácticas del seguro médico es esencial para garantizar un acceso equitativo a los servicios de atención de la salud y mantener un equilibrio socioeconómico saludable.
Originalidad/Valor: Este estudio contribuye a la comprensión de la interacción entre las malas prácticas del seguro médico y el contexto socioeconómico de la industria privada de la salud de los Emiratos Árabes Unidos. Al arrojar luz sobre las prácticas de explotación, la investigación destaca la necesidad de medidas regulatorias para salvaguardar el bienestar de los individuos y el paisaje socioeconómico de la nación.

Palabras clave: Seguro Médico, Malas Prácticas, Impacto Socioeconómico, EAU, Asistencia Sanitaria Privada, Pólizas de Seguro de Salud, Explotación.

INTRODUCTION

One of the major challenges facing the industry across the world today is fraud. Blue Cross et al., (2017) estimates that in USA healthcare malpractice amounts to a whopping $ 68 billion which is almost 3% of the nation's $2.26 trillion spending on healthcare. In other countries there are evidence that this 3% of fraud might go up to 10% costing a fraud of $230 billion.

In case of UAE, this fraud figures are quite high. *Pacific Prime Dubai Blog*, (2018) reports that health insurance fraud is on a rise in UAE with an indication that the insurers are also taking notice of such fraud but with no definite preventive measures.

Medical healthcare has been on a rise. According to Hewitt, (2018) the global cost of medical insurance has been on the rise since 2017, with no definite signs of abatement. It was reported by this survey that the global cost of health insurance increased by 8.2% in 2017 as compared to 2016, which increased to 8.4% in 2018. Added to this is the problem of premium inflation. According to the 2018 report of International Private Medical Inflation report (IPMI, 2018) the global inflation of insurance in 2017 was 8.5% which is in divorce with the Cigna Global reports which found that there was a negative inflation. As per the same report, Dubai is seen as experiencing the maximum premium inflation.

One of the reasons that leads to malpractice in medical insurance is the high-cost term plans. IPMI reports that 5 of the most expensive locations for insurance has been China, Dubai, Singapore, the US and Hong Kong. It has been noted that when people spend hefty amount of money, they tend to get it back and this leads to misrepresentations in the claims which will be discussed in the later sections.

According to a recent report from Microsoft (*Microsoft*, 2018) on a global basis, health fraud accounts for a loss of $455 billion annually. To support the view, it would be suitable to cite the report of Reinsurance Group of America who reported that 3.58% of the insurance claims across the globe are falsified claims with Asia reported as the highest defaulter (4.16%). Most of these claims have been made in connection to health benefits (24%). This calls for detailed study, especially those related to prevention and the negative impact that this system will have on the economy and henceforth, the society. This acts as a motivation to the current research.

Healthcare Sector in UAE

The capacity of insurance to carry out its responsibilities as a financial middleman, as well as this COVID-19 pandemic has tested public health programs globally. The unique coronavirus SARS-CoV-2, which produces COVID-19, is one of the most severe, infectious and unique diseases the world has ever seen. The World Health Organization (WHO) has declared COVID-19 a public medical emergency of worldwide importance due to its very efficient employee transmission and high fatality rates, which prompted nations all over the world to reevaluate their public health capacities. Along with other members of the world

community, the United Arab Emirates confronted the unprecedented problem of protecting the public's safety and health while limiting the negative effects on the economy. The government of the United Arab Emirates prioritised vaccinations for its citizens, which helped it quickly map out the way to post-pandemic recovery. In December 2020, it started administering its first vaccine approved for use in emergencies, the Sinopharm vaccine from China, which was soon followed by the Pfizer-BioNTech vaccine from the United States.

The first group receiving vaccinations included Emiratis and locals over the age of 60 and older, those who have ongoing medical conditions, and the handicapped (Diehl, 2022). The vaccines were made accessible at mass vaccination sites set up by Dubai. Other health organisations in the Emirates include the Health Authority and the Abu Dhabi State Health Department after June 1st, 2021. As challenges in locating and providing personal protective equipment (PPE), testing materials, and some vaccines revealed local gaps and worldwide interdependence, the pandemic exposed weaknesses in supply chains. To increase domestic production capacity through onshoring and investment and prevent further shocks, governments have begun to recognise their role in doing so. Future demand for locally made pharmaceuticals in the GCC is projected to be driven by onshoring of pharmaceutical manufacturing for Sinopharm and other vaccines in the UAE (Al Hubaishi & Ali, 2022). A strong healthcare ecosystem should also be made possible by the growth of Abu Dhabi's Life Sciences cluster.

The governments of the UAE and Saudi Arabia place a high priority on healthcare, in part to meet the changing needs of their populations, including the rise in non-communicable diseases like diabetes and cancer. Petroleum was discovered in Saudi Arabia in 1938, and in the United Arab Emirates 20 years later. Since then, both nations have developed into modern states with high standards of living. Currently, oil and gas account for around 1 to 50% of Saudi Arabia's GDP, compared to 30% in the UAE. Both nations have worked to shift the economy from their heavy reliance on oil to get more sustainable sources. This has included developing world-class healthcare systems that will draw investors. These systems' ambitious goals include world-class research facilities, futuristic facilities, more remote care, and entire communities devoted to health and well-being. Saudi and Emirati nationals, as well as visitors from wealthy nations, anticipate top-notch medical care. People desire to be able to get specialised care without travelling abroad or back home, in the 1990s and the early 2000s. Since its inception approximately 80 years ago, the UAE's healthcare system has advanced significantly. The nation's first hospital and healthcare facility were both established in Dubai in 1943 and the

early 1950s, respectively. The Ministry of Health was founded about two decades later. A system that provides free healthcare to all UAE citizens, as well as private options for locals and foreigners, also has developed into a well-established network of players and services in the country today (Bielen, Grajzl & Marneffe, 2019). Let's examine the country's population statistics, the organisation of its healthcare system, and its most common health problems in more detail. The UAE healthcare system is expanding due to demographic changes as the population progressively ages and the incidence of chronic diseases, many of which are brought on by unhealthy lifestyle choices, rises. The high rate of cigarette consumption among the populace, the lack of exercise and poor eating habits have contributed to the increase in cardiovascular illnesses, and cancer, and the UAE has had one of the highest rates of obesity and diabetes in the world in recent years. Asthma and allergies are common, among other things. Although the federal and emirate governments are funding numerous educational programmes to raise awareness of these diseases' incidence, lifestyle adjustments, and stay high. The Emirates of Abu Dhabi and Dubai now require all employees and/or their dependents to have health insurance.

Insurance premiums received by individuals who are not otherwise qualified as employees or dependents (like self-employed people and business owners); government subsidies for a such single-payer health insurance plan for UAE citizens, as administrated by the national health authority (There is a possibility that the employee will be held responsible for paying the premiums on behalf of some of the family members, who are dependent and unemployed). Patients, who are covered by national health plans may get paid by the UAE government. Similar to other commodities, the UAE government may also provide subsidies or reimbursement for medical equipment or services (Deepa Singh. (2022). Whereas the UAE government does finance healthcare under the Ministry of Health's control. It is important to keep in mind that there is no such rule or law requiring it to do so or requiring a specific budgetary allocation to be provided annually. Every year, the annual budget is determined by trends or needs deemed to exist in the healthcare industry.

Why the Study is Relevant

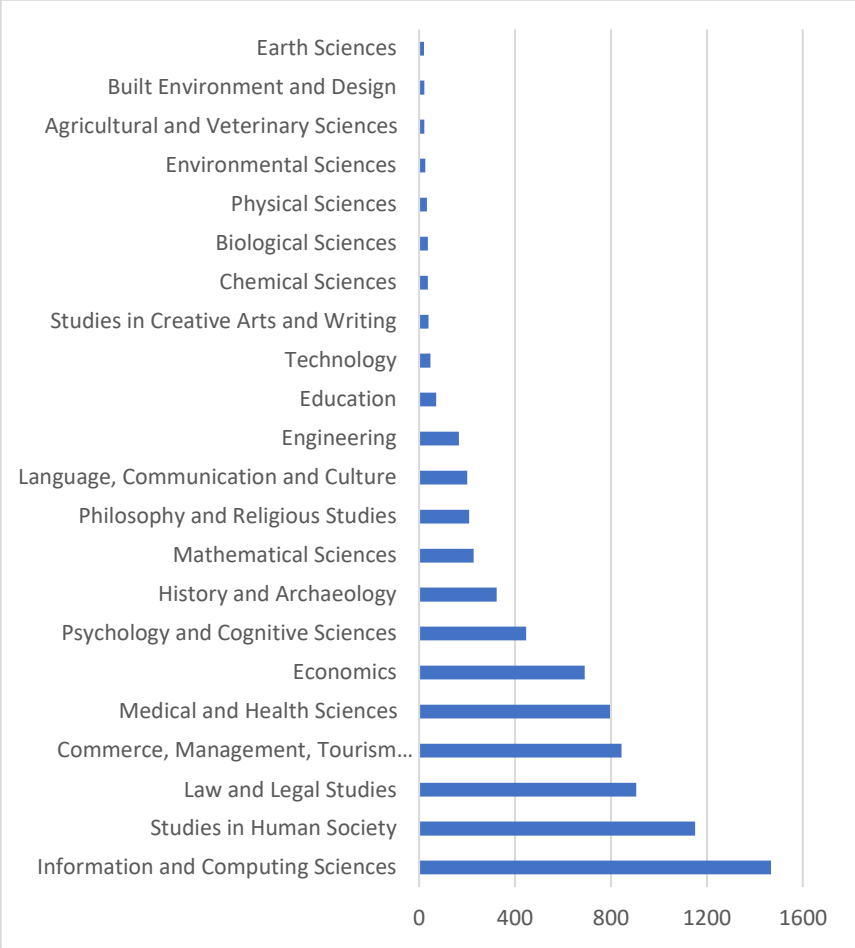
In light of the discussion made above, the current study will be done to explore the malpractices prevalent in the society and how such frauds are being done. While doing this the main discussion will be divided into two sections – the first part will discuss the general insurance frauds and the second part will focus strictly on the medical insurance malpractices.

It will also have a separate section that will discuss the negative social impact and how these can be prevented. While doing this, the current research will define the frauds and how frauds can be prevented and what can be the future researches that can be done in the said area. It will also discuss the modern mathematical models of fraud and fraud detection that will be most suitable.

This study, hence, will try to answer a few questions pertaining to the most commonly used ways of frauds. It will try to throw some light on the parties involved in giving a shape to this fraud and most importantly, will explore the reasons behind the frauds. It will try to understand the sentiment of the defaulters on the basis of sentiment analysis and will address how the underlying issues can be mitigated by the companies and will also discuss the impact of the regulations and strict rules that are hypothesized to have an effect on the occurrences of the fraud. Having concluded his discussion, the concerned research will turn to see the how the malpractices are impacting the society. It will explore how such malpractices are compounded in the society what are the driving forces of them. Consequently, the insurers side will also be studied. This included how the insurers behave to such malice and how it affects their behaviours to other consumers in general.

Researches in this area has been varied in nature and the findings have been pervasive in nature. Unfortunately, this research has been diffused in nature with financial aspects earning the maximum attention. When the academic databases were searched for insurance fraud, 8787 research papers were obtained with 2018 recording 904 research papers which is highest in the last five years. The domain-wise publication can be summarized as:

Figure 1. Major Fields of Research in Insurance Fraud



Source: Prepared by the authors (2023)

But when the focus was refined to 'insurance malpractice' and 'socio-economic impact', the number of papers were reduced to 31. For refining the results, a threshold of minimum 5 citations were selected as the minimum entry criteria for a research paper. After fishing out the important papers, there were only 9 research papers. The summary of the important papers is given below:

Table 1. Summary

Authors	Description
(Jabłonowska et al., 2018)	Application of AI for consumer law and rights.
(Cohen, 2020)	Application of law for organized crime in finance.
(Craglia & Pogorzelska, 2020)	Assessment of digital world with data mining in focus.
(Rajput, 2020)	Analysis of fraud in connection to cybercrime.
(Kindt, 2001)	Gambling and requirement of law enforcement.
(Tiwari et al., 2020)	Systematic review of money laundering cases.
(Hassani et al., 2020)	Application of Big Data in Insurance.
(Gillis, 2007)	Legal discussion of insurance related to oceanic trade.
(Costigan & Gold, 2016)	Discussion of economics in relation to terrorism background.

Source: Prepared by the authors (2023)

When the focus was turned to UAE, it was found that are only 7 researches that have studied the same area, which is almost minuscule. As such a prominent gap can be observed which requires an attention. This became a motivation for the current research, an area which is almost a virgin.

BACKGROUND OF THE STUDY

Definition of a Malpractice

Insurance malpractice is a significant problem of resource-allocation (Falabiba, 2019) and it has been asserted by the author that it is difficult to contain it by the use of traditional techniques. In this regard, two models are seen that help in insurance malpractices. According to Picard & Wang (2015) there are two types of claims- costly state verification and costly state falsification. In both the claims the insured provides false documents in support of the claim.

According to Caron and Dione (1997), insurance fraud started occurring as early as 1994 when Quebec automobile market reported a loss of $100 million which was almost 10% of the total claims. Medza (1998) reports that by 1998, Canada has seen an insurance fraud of $ 2billion in 1998 while USA at the same period witnessed a loss of $70 billion because of falsified claims.

The causes of a fraud cannot be always attributed to the fact that people have a criminal mindset. Dionne, Gibbens and St-Michel (1993) remarks that the causes of a fraud are multiple. These can a shift in morality, deteriorating financial conditions leading to poverty, change in the behaviour of doctors who are driven by financial incentives to recommend those investigations that are not required.

Model of a Fraud

The basic premise of fraud is centred on the very idea of quick economic returns. The researcher finds greed and financial strain in almost every case of a fraud. In other cases, it has been found that enjoying the delight of being a cunning person and enjoying the mastery of theft has been some of the basic causes of a fraud (Duffield & Grabosky, 2001). Hence, a fraud is the product of both motivation and opportunity.

Fraud = motivation × opportunity

In the above model of a fraud, motivation can be defined as the presence and the influence of perpetrators who motivate an individual to indulge into an act of forgery. On the

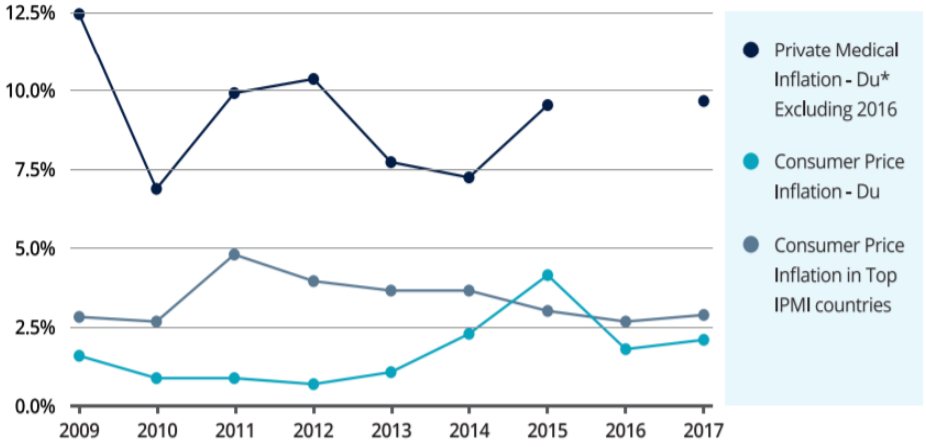
other hand, opportunity relates to the presence of suitable and vulnerable targets and also the absence of suitable gatekeeping authorities and regulations. This opportunity is multiplied by the fact that insurance fraud is a low-risk high return game. CAIF (2003) regards this 'opportunity' as safe than armed robbery and other crimes and hence there is an increasing trend observed in this particular field.

Another important reason why the researcher considered that the basic model of fraud is based on 'opportunity' is the fact that in many countries of middle east there is a lack of legislature which leads to moderate to light penalties for such crimes. Along with this, the concerned researcher observes that there is a lack of determination from the administrators to nip such crime in the early stages because the administrators in many cases have considered such soft fraud to be less expensive than hard fraud. Hence, insurance is a function of opportunity.

Causes of Insurance Malpractice in UAE

Though the middle East, especially the UAE us seen by the world as a wealthy group of nations, the problems lie deep rooted. As per the reports by International Private Medical Insurance report (IPMI, 2018), the causes of insurance fraud in this area may be attributed to the fact that medical coverage price inflation has been quite high in these areas. IPMI reports that medical price inflation has reached an all-time high in UAE. The chart below describes the major findings from Dubai:

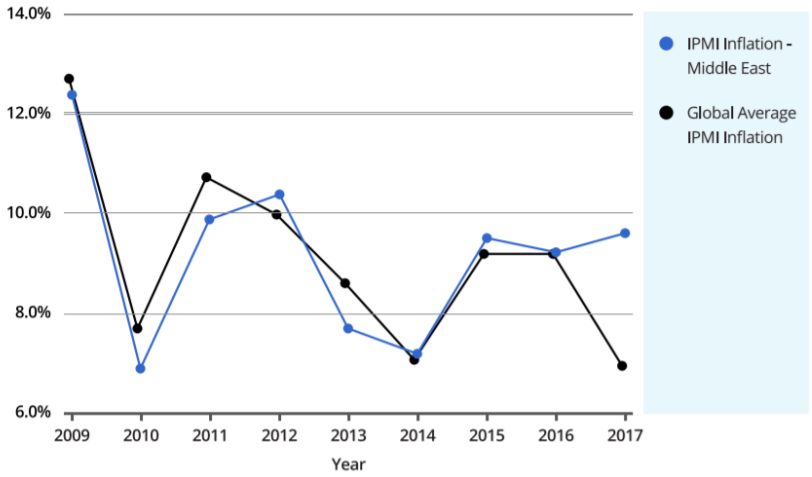
Chart 1. Major Findings from Dubai



Source: Prepared by the authors (2023)

The findings from the rest of the middle east no big difference. The IPMI reports the findings as:

Chart 2. Avarage IPMI Inflation in the Middle East: 2009 - 2017



Source: Prepared by the authors (2023)

Such situations give rise to two critical scenarios. These are:

a. Resource disparity: Diabetes has been a regular evil on the people in UAE, IPMI reports. The more the cases keep on increasing the more is the pressure on the existing systems. This poses a problem for the resources who are fighting continuously to give the best service to the patients. On the other side of the table, the costs also keep on increasing and this leads to dilated cost of the premiums. Added to these are the changes in the nature of the population which sometimes leads to a disparity of the resources.

b. Economic disparity: with the fall in the oil prices combined with lack of stability across regions has slowed the economic growth of the region. This forces many organizations to downsize the workforce or to relocate. As the workforce is downsized, the number of foreign employees who composed of the majority of the customers in the regions vanished leaving only a small number of local consumers who are faced with a burden of high premiums.

Combined with these above factors is Dionne, Gibbens and St-Michel's (1993) observation mentioned earlier that sometimes deteriorating living conditions compel the consumers to adopt unfair means of earning which sometimes takes the form of an insurance fraud.

Socio-Economic Impact

According to Tennyson, (2008) insurance fraud is a 'created' crime. In this research Tennyson observes that fraud insurance leads to two situations in the market. One of them is the inequity. By 'inequity', the author meant that the losses from the false claims are then

shifted to the other customers whose premiums become higher. Another situation arising out of these are the inefficiencies, which may arise when profiting through falsified claims lead to distortions in the purchase decisions. Apart from those, reports of such malpractice lead to lack of confidence in the insurer who stands a good risk in losing the markets. This leads to a lack of trust among the insurers and the consumers. As the thread of the trust is loosened, the chances of more frauds increase as the consumer in a bid to avenge the higher costs of premium try to extract more money from the companies.

The Economic Investigation of Fraud

Insurance fraud is a multi-faceted phenomenon which varies from various degrees in severity from build-up phase to planned criminal fraud via opportunistic fraud. Another form of fraud that occurs regularly is the suppression of the information on the side of the policyholder and deliberately creates damages to dilate his claim.

On the basis of the literature discussed earlier, it can be summed up that the current theory of insurance fraud and prevention is not a complete one (Hewitt, 2018) which creates a gap in the recent structure. This is one of the gaps that will be addressed in the next sections. Frauds affect the design of policies in several ways. It has been observed that because of the lower monitoring costs of the claims, there exists a non-verification of the pay outs.

Because of the nature of the consumers to falsify claims in many ways, the insurers are compelled to offer some kind of coinsurance depending upon the model of insurance. This leads to malady. Hewitt (2018) observes that in many cases such situations lead to overcompensation for insignificant losses and undercompensation for major ones.

Another major issue is the cooperation and understanding among the service providers. This will have a common insuring body who will be entitled with the responsibility of building larger databases that will be able to detect falsified data in better way. This is expected to have a better economic impact and, in the countries where the premium insurance inflation is going high, more people will be attracted to take better coverage plans (Da Veiga, C. R. P., Da Veiga, C. P., & Su, Z. (2023)). This will also have an impact on the insurers who will distinguish the fraudsters from the honest policy holders and will also help to bolster the credibility among the consumers. The third economic impact is the collusion between the policy holder and his agent (Jirukkakul, N., & Jirukkakul, N. (2023)). Loss-premium ratio gives rise to two main objectives to the companies. One of them is to continue the promotional efforts and the other one is to avoid any kind of understanding with the customer. As such the premiums paid to the agents

become an extra burden on the companies which ultimately affects the performance of the policy plans.

The impact of an insurance fraud on the socio-economic system has been least studied and in connection to UAE it has been omitted.

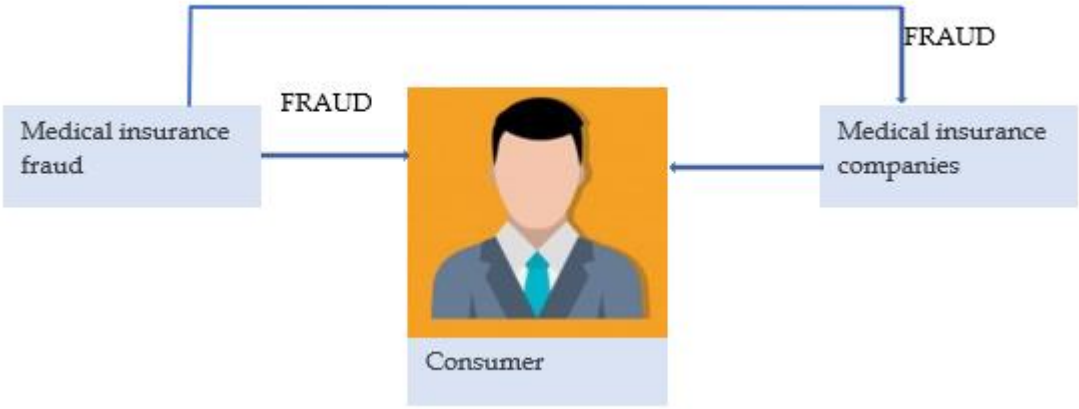
It has already been discussed that insurance fraud is one of the malice facing the industry today and many problems have been indicated in the said domain. However, the researches in UAE have been much less whereas all the leading newspapers are strongly pointing to the fact that insurance malpractices in UAE have been much more.

Sunita Menon of Gulf News, way back in 2003 reported that there are many cases of insurance frauds and these needs to be addressed. Till 2013, there have been many cases of fraud. Corporate Research and Investigation (CRI) group reported one such case in December 2020. In the said case, a person named Mr. Jack (name changed) was on a business trip to Dubai from the US when he felt nauseating and a backpain with vomiting. For this, he was charged $4000 and then discharged. When the symptoms started occurring again, he was re-admitted to another hospital who charged him $1000. When the employer of Mr. Jack approached CRI to probe the matter, it was found that the first clinic mentioned in the bill was a clinic for cosmetic surgery of women and that they never treated anyone other than female patients. When the concerned doctor was contacted, he reluctantly commented that the patient forced him to treat and give him a bill so that he can charge the company for insurance. This is an example of the collusion of patient and the doctor which has been mentioned in the earlier sections of this study. According to Alliance Insurance, Dubai, 30% of their clients are engaging in such malpractices (Menon & Sunita, n.d.).

In case of Dubai, the insurers are regularly scrutinizing the claim, but given some odd 300 claims being submitted every week, it is extremely difficult to fish out the fraud requests given the fact that there is a collusion among the doctors and the clients. (Menon & Sunita, n.d.). In view of this the researcher in this study feels that there is a need to probe the problem, especially in connection to UAE. While the insurers are fighting back in UAE with new services, there must be preventive ways so that the services can be made better.

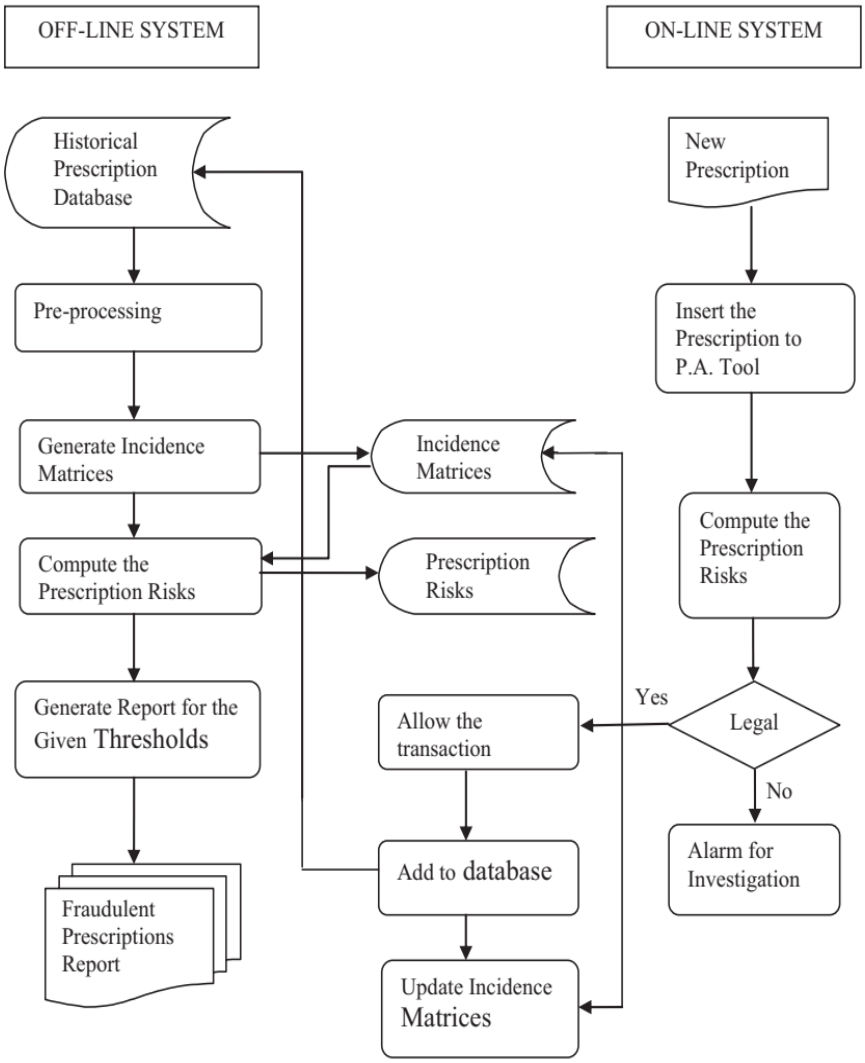
Models

Figure 2. Conceptual model



Source: Prepared by the authors (2023)

Figure 3. Algorithm Flow of Fraud Prevention



Source: Prepared by the authors (2023)

CONCLUSION

In conclusion, it can be said that there is a need to prevent such malice. This is because of two main reasons. Firstly, if such misrepresentations are not prevented and penalized, it will encourage more and more people and insurance malpractice will be looked upon as a source of annual income. This will have a negative impact on the industry as a whole. To combat such situations in future, the insurers will be compelled to make stricter regulations, which will make getting claims difficult. This will adversely affect the genuine claims whose true cases will also be seen as fraudulent ones leading to delayed disbursals. The USA regards healthcare frauds as a felony and as per Michigan's Healthcare False Claims Act, any misrepresentation in claims will be treated as a major crime leading to four years of imprisonment and a penalty of $50,000. Such strict measures are prescribed in case of UAE and implementation of strict systems are prescribed. MarketsandMarkets reports that cost of healthcare surveillance is expected to rise to $ 2.2 billion in 2022, a whooping 28.9% increase from the 2017 expenditures (Karpagavalli. (2022)).

REFERENCES

Blue Cross, Blue Shield, & Blue Care Network. (n.d.). Fraud Statistics | bcbsm.com. Retrieved September 9, 2021, from https://www.bcbsm.com/health-care-fraud/fraud-statistics.html

Cohen, M. A. (2020). The Costs of Crime and Justice. The Costs of Crime and Justice. https://doi.org/10.4324/9780429431562

Costigan, S. S., & Gold, D. (2016). Terrornomics. Terrornomics, 1–225. https://doi.org/10.4324/9781315612140

Craglia, M., & Pogorzelska, K. (2020). The Economic Value of Digital Earth. Manual of Digital Earth, 623–643. https://doi.org/10.1007/978-981-32-9915-3_19

Da Veiga, C. R. P., Da Veiga, C. P., & Su, Z. (2023). Supplementary health system in Brazil: business model not threatened by socioeconomic crisis. International Journal of Professional Business Review, 8(1), e01225. https://doi.org/10.26668/businessreview/2023.v8i1.1225

Dr. Deepa Singh. (2022). Role of Social Entrepreneurship in the Socio-Economic Development of the Developing Countries. Technoarete Transactions on Entrepreneurship and International Business (TTEIB), 1(2): 24-38. https://doi.org/10.36647/TTEIB/01.02.Art003

Duffield, G., & Grabosky, P. (2001). The psychology of fraud. Trends and Issues in Crime and Criminal Justice. https://search.informit.org/doi/abs/10.3316/agispt.20013757

Gillis, R. J. (2007). Sources, Applications, Paradigms. Navigational Servitudes: Sources, Applications, Paradigms, 1–412. https://doi.org/10.1163/EJ.9789004161559.I-412

Hassani, H., Unger, S., & Beneki, C. (2020). Big Data and Actuarial Science. Big Data and Cognitive Computing, 4(4), 1–29. https://doi.org/10.3390/BDCC4040040

Health insurance fraud in the UAE is on the rise - Pacific Prime Dubai blog. (n.d.). Retrieved September 10, 2021, from https://www.pacificprime.ae/blog/health-insurance-fraud-in-the-uae-is-on-the-rise/Hewitt, A. (2018). 2018 Global Medical Trend Rates Table of Contents. 32.IPMI. (2018). international private medical inflation report.

Jabłonowska, A., Kuziemski, M., Nowak, A. M., Micklitz, H.-W., Pałka, P., & Sartor, G. (2018). Consumer Law and Artificial Intelligence: Challenges to the EU Consumer Law and Policy Stemming from the Business' Use of Artificial Intelligence - Final report of the ARTSY project. SSRN Electronic Journal. https://doi.org/10.2139/SSRN.3228051

Jirukkakul, N., & Jirukkakul, N. (2023). The effects of economic factors and lifestyle on the healthy food consumption of the elderly in Nong Khai municipality, Thailand. International Journal of Professional Business Review, 8(2), e0587. https://doi.org/10.26668/businessreview/2023.v8i2.587

Karpagavalli. (2022). Significance of E-Healthcare for Developing the Healthcare Infrastructure. Technoarete Journal on Advances in E-Commerce and E-Business (TJAEE), 1 (1), 22-27. doi: https://doi.org/10.36647/TJAEE/01.01.A005

Kindt, J. W. (2001). The costs of addicted gamblers: should the states initiate mega-lawsuits similar to the tobacco cases? Managerial and Decision Economics, 22(1–3), 17–63. https://doi.org/10.1002/MDE.997

Menon, & Sunita. (n.d.). Warning on insurance scams | Uae – Gulf News. Retrieved September 10, 2021, from https://gulfnews.com/uae/warning-on-insurance-scams-1.360543

Microsoft Cloud for Healthcare | Microsoft. (n.d.). Retrieved September 10, 2021, from https://www.microsoft.com/en-in/industry/health/microsoft-cloud-for-healthcare?rtc=1 Ninla Elmawati Falabiba. (2019). Handbook of Insurance.

Picard, P., & Wang, K. (2015). INSURANCE FRAUD THROUGH COLLUSION BETWEEN POLICYHOLDERS AND CAR DEALERS: THEORY AND EMPIRICAL EVIDENCE Pierre PICARD. Working Papers. https://ideas.repec.org/p/hal/wpaper/hal-01140590.html

Rajput, B. (2020). Cyber Economic Crime in India, An Integrated Model for Prevention and Investigation. https://doi.org/10.1007/978-3-030-44655-0

Tennyson, S. (2008). Moral, Social, and Economic Dimensions of Insurance Claims Fraud. Social Research, 75(4), 1181–1204. http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=36934863&site=eds-live

Tiwari, M., Gepp, A., & Kumar, K. (2020). A review of money laundering literature: the state of research in key areas. Pacific Accounting Review, 32(2), 271–303. https://doi.org/10.1108/PAR-06-2019-0065

Alonazi, W. B. (2020, September 25). Fraud and Abuse in the Saudi Healthcare System: A Triangulation Analysis. Inquiry, 57. 10.1177/0046958020954624

Angima, C. B., & Omondi, M. A. (2016). Nature of Fraud and Its Effects in the Medical Insurance Sector in Kenya. DBA Africa Management Review, 6(2), 33-44.

Awofeso, N., Hamidi, S., Moussa, M., & Sergani, M. E. (2015). Preventing Healthcare Insurance Fraud in Dubai – A Risk Management Approach. International Journal of Excellence in Healthcare Management, 5(1).

Dempere, J., & Malik, S. (2021, February 26). Consumer financial fraud in the United Arab Emirates. Journal of Financial Crime. 10.1108/JFC-11-2020-0229

Flynn, K. (2016). Financial fraud in the private health insurance sector in Australia: Perspectives from the industry. Journal of Financial Crime, 23(1), 143-158.

Halbouni, S. S., Obeid, N., & Garbou, A. (2016). Corporate governance and information technology in fraud prevention and detection: Evidence from the UAE. Managerial Auditing Journal, 31(6/7), 589-628. https://doi.org/10.1108/MAJ-02-2015-1163

Hamidah, S., & Reskino. (2021, January-June). STUDY OF FRAUD TENDENCY: THE ROLE OF UNETHICAL BEHAVIORS AS MEDIATION. JEBIS: Jurnal Ekonomi dan Bisnis Islam, 7(1), 14-33. doi: 10.20473/jebis.v7i1.23554

Hyman, D. A. (2002). HIPAA and Health Care Fraud: An empirical perspective. Cato Journal, 151-178.

Jankosk, K., Milev, K., & Madjarov, G. (2020). How Simple Predictive Analysis of Health Care Claims Data can Detect Fraud, Waste and Abuse Threats in Health Care Insurance - The Case Study of United Arab Emirates. 194.149.136.10

McGinley, S. (2013, September 6). Revealed: How the Gulf is losing billions to medical insurance fraud. Retrieved 2021, from https://www.arabianbusiness.com/revealed-how-gulf-is-losing-billions-medical-insurance-fraud-516791.html

Rawashdeh, F., & Shinglawi, O. (2016). The Existence of Fraud Indicators in Insurance Industry: Case of Jordan. International Journal of Economics and Financial Issues, 6(55), 168-176.

Rawte, V., & Anuradha, G. (2015). Fraud Detection in Health Insurance using Data Mining Techniques. International Conference on Communication, Information and Computing Technology.

Skrybus, E. (2018, September 27). Health insurance fraud in the UAE is on the rise. Retrieved 2021, from https://www.pacificprime.ae/blog/health-insurance-fraud-in-the-uae-is-on-the-rise/

Stowell, N. F., Schmidt, M., & Wadlinger, N. (2018). Healthcare Fraud under the microscope; improving its prevention. Journal of Financial Crime, 1039-1061.

Sumalatha, M. R., & Prabha, M. (2019). Mediclaim Fraud Detection and Management Using Predictive Analytics. International Conference on Computational Intelligence and Knowledge Economy (ICCIKE. doi:10.1109/iccike47802.2019.9004241

Wani, G. A. & Bajeesh, B. (2022). Identification of Perspectives and Challenges of Behavioural Economics for the Next Generation. *Technoarete Transactions on Economics and Business Systems (TTEBS), 1*(2): 7–12.