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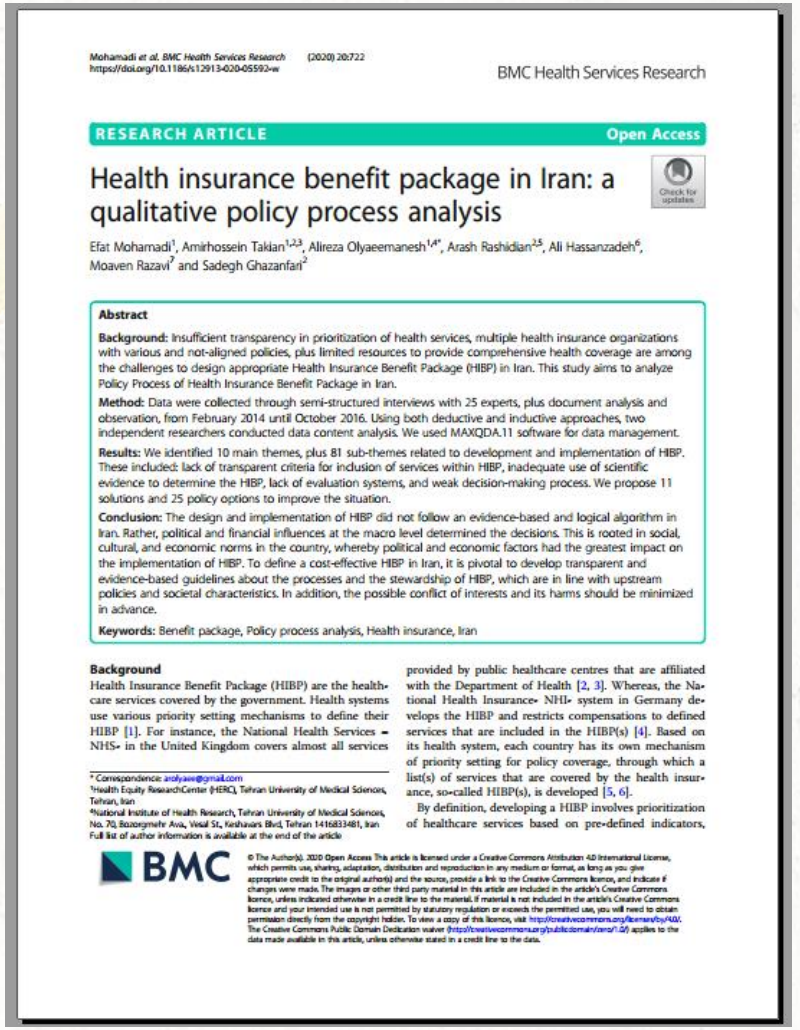
Discussing the paper:

Health insurance benefit package in Iran: a qualitative policy process analysis



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Health insurance benefit package in Iran: a qualitative policy process analysis

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Abstract

Background: Insufficient transparency in prioritization of health services, multiple health insurance organizations with various and not-aligned policies, plus limited resources to provide comprehensive health coverage are among the challenges to design appropriate Health Insurance Benefit Package (HIBP) in Iran. This study aims to analyze Policy Process of Health Insurance Benefit Package in Iran.

Method: Data were collected through semi-structured interviews with 25 experts, plus document analysis and observation, from February 2014 until October 2016. Using both deductive and inductive approaches, two independent researchers conducted data content analysis. We used MAXQDA.11 software for data management.

Results: We identified 10 main themes, plus 81 sub-themes related to development and implementation of HIBP. These included: lack of transparent criteria for inclusion of services within HIBP, inadequate use of scientific evidence to determine the HIBP, lack of evaluation systems, and weak decision-making process. We propose 11 solutions and 25 policy options to improve the situation.

Conclusion: The design and implementation of HIBP did not follow an evidence-based and logical algorithm in Iran. Rather, political and financial influences at the macro level determined the decisions. This is rooted in social, cultural, and economic norms in the country, whereby political and economic factors had the greatest impact on the implementation of HIBP. To define a cost-effective HIBP in Iran, it is pivotal to develop transparent and evidence-based guidelines about the processes and the stewardship of HIBP, which are in line with upstream policies and societal characteristics. In addition, the possible conflict of interests and its harms should be minimized in advance.

Keywords: Benefit package, Policy process analysis, Health insurance, Iran

Background

Health Insurance Benefit Package (HIBP) are the healthcare services covered by the government. Health systems use various priority setting mechanisms to define their HIBP [1]. For instance, the National Health Services – NHS- in the United Kingdom covers almost all services provided by public healthcare centres that are affiliated with the Department of Health [2, 3]. Whereas, the National Health Insurance- NHI- system in Germany develops the HIBP and restricts compensations to defined services that are included in the HIBP(s) [4]. Based on its health system, each country has its own mechanism of priority setting for policy coverage, through which a list(s) of services that are covered by the health insurance, so-called HIBP(s), is developed [5, 6].

By definition, developing a HIBP involves prioritization of healthcare services based on pre-defined indicators,

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We hope that you found our study of interest and value

No let us begin todays discussion…

Introduction

What is the aim of the study?

This study aims to analyze **Policy Process** of Health Insurance Benefit Package in Iran. We found that:

1. Insufficient transparency in prioritization of health services
2. Multiple health insurance organizations with various and not-aligned policies
3. Limited resources to provide comprehensive health coverage

are among the challenges to design appropriate Health Insurance Benefit Package (HIBP) in Iran.

Background & setting

Health Insurance Benefit Package (HIBP) are the healthcare services covered by the government. Health systems use various priority setting mechanisms to define their HIBP.

For instance:

a. NHS
b. NHI

Discuss:

1. How is a health insurance benefit package developed?
2. What are the challenges faced in the process of designing a package in Iran?
3. who is in charge of decision making and how do they arrive at it?
4. Could a universal method for HIBP implementation exist? Elaborate.

Methods

This is a qualitative research. We used both approaches:

- Retrospective (policy analysis)
- Prospective (analysis for policy)

How was the data collected?

Data collection and analysis were conducted for 18 months.

Data were collected through semi-structured interviews with 25 experts, plus document analysis and observation, from February 2014 until October 2016. Using both deductive and inductive approaches, two independent researchers conducted data content analysis. We used MAXQDA.11 software for data management.

Process analysis of HIBP

Policy Analysis (Retrospective)

Agenda Setting:	**Policy Development:**	**Policy Implementation:**	**Policy Evaluation**
-Problem Stream -Policy Stream -Politics Stream	- Decision making -Technical discussions -Political support -Internal pressures	-Review the implementation strategies - Implementation at in the Health Insurance Organizations - Implementation in the Supreme Council of Insurance	

Policy option Analysis (Analysis for Policy; Prospective)

1	**Problem Identification**
2	**Evidence collection**
3	**Prioritizing and policy options evaluation**
4	**Proposing final solutions to achieve evidence-informed policy options**

Phase 1: Retrospective policy process analysis of HIBP

We investigated four dimensions of the policy process:

A. agenda-setting
B. policy development
C. policy implementation
D. evaluation

Our main method for data collection was **face-to-face semi-structured interviews** with purposefully identified experts. We used a **literature-based** interview guide.

Interviews were continued until we reached data saturation, when 25 expert were interviewed. No one refused to participate or dropped out from interviews and we did not repeat any interviews.

Phase 1: Retrospective policy process analysis of HIBP

The following issues were investigated during the interviews:

- how development of a HIBP was included in the MOHME agenda?
- How HIBP -related policies were developed (or are being developed)?
- The extent to which the HIBP development was evidence-based?
- What mechanisms were used to attract policy-makers' attention to the HIBP -related problems?
- How HIBP -related policies are being implemented?
- Is there an evaluation and revision process for the HIBP?
- What instruments and solutions were used for revising the HIBP?

An inductive thematic content analysis approach was used to analyze the data (Eloo 2007) and to categorize themes, MAXQDA.11 software was used to assist data management.

Phase 2: Prospective policy-options analysis

We followed a **four steps policy analysis model** to draw evidence-informed policy options about the issues and challenges of developing the HIBP:

1. Problem identification
2. Evidence collection
3. Prioritizing and evaluating policy options
4. proposed solutions to achieve evidence-informed and prioritized policy options

Phase 2: Prospective policy-options analysis

1. **Problem identification:** The finding of phase one were used to identify and list the issues and challenges of each dimension.
2. **Evidence collection:** We collected scientific evidence for each identified issue:
   - comprehensive review of valid databases;
   - experts' opinions that were extracted from interviews;
   - rationales extracted from investigating process;
   - document review.

Phase 2: Prospective policy-options analysis

3. **Prioritizing and evaluating policy options**: a panel of professionals was convened to prioritize the policy options. A checklist which contained policy options (in the rows) and criteria (in the columns) was developed to obtain experts' opinions.

All identified options were evaluated in terms of feasibility and necessity . The participants were asked to rate each option on a Likert scale ranged from 1 (the worst) to 10 (the best).

Phase 2: Prospective policy-options analysis

4. **Final proposed solutions to achieve evidence-informed and prioritized policy options:** Experts' opinions were analyzed based on specified criteria.

   The data from the previous phase were analyzed using the Simple Additive Weighting (SAW) method.

The total score of each policy option was calculated by multiplying the comparable rating for each criterion by the weight assigned to the criteria and then summing these values for all criteria.

Data were analyzed using the Microsoft Excel software. Finally, we developed a summary of final solutions in the form of policy options.

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? E.g. PhD, MD
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic

http://cdn.elsevier.com/promis_misc/ISSM_COREQ_Checklist.pdf

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
Participant selection		
10.	Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball
11.	Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.g. home, clinic, workplace
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?
16.	Description of sample	What are the important characteristics of the sample? e.g. demographic data, date
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

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Discuss:

1. What are the methods used in this article?
2. How are the main phases of the study conducted?
3. What tools were used in this article?
4. How did the research team come to choose this particular method?
5. Did you find any inconsistencies in their methods and analysis?
6. Could the research team have used a better method to conduct their study? Elaborate.

Findings

What was found?

We identified **10 main themes**, plus **81 sub-themes** related to development and implementation of HIBP. These included:

a) lack of transparent criteria for inclusion of services within HIBP,
b) inadequate use of scientific evidence to determine the HIBP,
c) lack of evaluation systems,
d) and weak decision-making process.

We propose **11 solutions** and **25 policy options** to improve the situation.

Issues	Themes	Sub-themes
Agenda setting	**Problem stream**	1. Increasing the number of services that can be provided 2. Soaring health expenditures 3. Unavailability of information about inequality within insured populations 4. Inadequacy of resources 5. 5. Parallel budgets (insurances, hygiene, special programs, etc.)
	Policies stream	1. Managing services that can be provided 2. Deficiencies in legislation and decision-making process that are related to the HIBP 3. Lack of clear criteria for including services in the HIBP 4. Not using professional and related staffs (not only those who are experienced) in implementation and support of the HIBP
	Politics stream	1. Prioritizing health, and therefore its related policies, in the twelfth government 2. Increasing health sector budget in the 11th government 3. 13. Notifying OHP and making decision about the HIBP
Policy development	**Stewardship of the policy making**	1. Developing the article 29 of the constitution 2. Developing policy's draft by the MoHME and MoCLSW 3. HCHI as the steward of developing and notifying the HIBP's strategies 4. Confirming policies by the National Expediency Council 5. Enacting policies by the Parliament 6. Final approval and notifying OHP by the supreme leader’s office 7. The MoHME is the steward of developing the HIBP based on the OHP
	Method and trend of decision-making	1. Endorsing the HIBP by the third NDP for the first time 2. Lack of a defined methodology to include/exclude services into/from the HIBP 3. Drafted policies are different from notified policies, up to 70% 4. The ISCHI makes decision about the strategic policies of the HIBP 5. Developing polices according to the available resources 6. A defined contribution approach in developing HIBP-related policies 7. Inadequate attention to people's preference/demand

Issues	Themes	Sub-themes	
Policy implementation	**Policy implementation timeline**	Before 1993	1. Article 29 of the constitution, requires the government to cover all necessary services 2. Lack of a clear distinction between service provision in public and private sectors 3. Lack of defined criteria to cover services by health insurance organizations 4. 33. Considering the availability of services when deciding to provide a service
		Between 1993 to 2003	1. Developing the UHI Act in 1993 and notifying it in 1994 2. Establishing the HCHI within the MoHME 3. HCHI became responsible about the HIBP 4. Experts debating in joint meetings 5. Commitment to provide all services that can be provided 6. Determining the covered services by the health insurance organizations 7. Political top-down decisions, without expert debates 8. Stakeholders or head of the meeting have greater influence
		2004 to 2006	1. Transferring the ISCHI from the MoHME to the MoCLSW 2. Insurance-related stakeholders had more influence 3. Services/medicines were included based on the frequency and compensation patterns 4. Including Services/medicines based on the reviewing less expensive services and equipment 5. Top-down political decisions, without expert debates 6. Introducing complementary insurance to cover services that were not covered by the basic insurance
		2007 to 2014	1. Developing the first comprehensive package 2. Using the most frequent services criterion to develop the HIBP 3. It takes a long time to decide whether to include a service/medicine or not 4. HCHI decides based on the consensus criteria 5. Special packages or separate resources/stewards (e.g. special diseases) 6. In 2010, the MoHME and the MoCLSW started strategic purchasing 7. New mandatory criteria were introduced (i.e. safety studies, effectiveness, cost-effectiveness) to include new medicines to the national formulary 8. In 2012, new RVU Book was developed
		Since 2014	1. In 2014, the OHP were notified by the Supreme Leader's office 2. In 2014, the MoHME was mandated to develop the new HIBP 3. The MoCLSW was selected as the steward of financing and implementing the HIBP 4. In 2014, health transformation plan was started 5. The new HIBP was defined in the form of the RVU Book 6. Services that are not included in the HIBP were clearly mentioned in the new RVU Book 7. Defining and providing services that were not previously covered in the HIBP, as a part of the HTP

Issues	Themes	Sub-themes
	Process of HIBP implementation	1. Sending a request to the ISCHI 2. Expert review of the request 3. Deciding about the request 4. If it has low financial burden, notifying its inclusion to the HIBP 5. If it has high financial burden, the cabinet confirmation is required
Evaluation	**HIBP Revision**	1. Lack of fundamental and purposive revision(s) 2. Before 2014, there was no significant change occurred in the HIBP 3. Due to changes in the treatment methods, some services/drugs are automatically excluded 4. Mandating the ISCHI to annually revise the HIBP 5. Temporary and non-methodological changes (three times, in 2007, 2012, and 2014) 6. Unorganized revision of the OTC drugs 7. In 2003, some performance-enhancing drugs were excluded
	Revising the methods and decisions	1. Process and criteria for including/excluding services are not revised 2. No evaluation has been performed, and laws and regulations are not revised 3. In 2013, service prioritizing program was begun, without clear outcomes
	Evaluating the aims of HIBP-related policies	1. The impact of HIBP-related policies on achieving universal health insurance coverage 2. The impact of HIBP-related policies on developing basic and complementary HIBPs 3. The impact of HIBP-related policies on unifying the HIBP among all health insurance organizations

Limitations and issues that can be investigated

- Lack of clear criteria to include services into the HIBP
- Not considering the epidemiological transitions to increase the effectiveness of included services.
- Scientific evidences were not adequately used
- Health Technology Assessment (HTA) studies were not used
- Bargaining power had an important role in the ISCHI decisions
- The extensive HIBP list regardless of the priorities and costs
- Policies on HIBP and the strategic purchasing were not implemented
- Cultural, social and economic issues were not considered
- Passive performance of health insurance organizations to include new proposed services within the HIBP
- Lack of revision and evaluation systems
- OTC drugs are included in the HIBP
- Unproportioned percentage of the health expenditures are created by a small percentage of patients
- Development and implementation of programs and policies are not permanent
- Inadequate resources

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Differentiating between HIBP(s) from services that can be provided	Defining necessary services benefit package and financing it by government and defining the higher level package that its financing is elective	Creating elective options for patients/ people and financial savings for the government	Establishing limitations on access to higher level services	7.8 ± 1
	Defining “necessary primary services HIBP” and financing it by the MoHME and also a “ HIBP for secondary and tertiary necessary services” and financing it by insurance organizations	Ensure easy and free access to primary services, more effective management of curative services with stewardship of health insurance organizations	Inadequate attention of insurance organizations to the importance of preventive and screening services	5 ± 2.55
	Developing a HIBP that can be provided in all levels and financing it by health insurance organizations	Matching the HIBP with society's health needs	Probability of increasing the number of covered services without considering available resources of health insurance organizations has increased	5.3±2.3

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Using scientific evidences to make HIBP-related decisions	Collecting and reviewing demographic information	Prioritizing services and evidence-based decision-making, indeed the HIBP should be targeted	Lack of precise information systems to determine the burden and pattern of diseases, by age groups	7.6±1.5
	Conducting HTA studies	Developing a cost effective HIBP based on the comprehensive needs	These studies are cost driven and adequate experts to conduct them are not available	6.9±1.6
	Considering cultural problems and needs in developing the HIBP (i.e. religious beliefs and cultural behaviors)	Increasing the acceptability of services for targeted populations, increasing equity in health	Increasing the probability of health expenditure soaring for the health system	4.6±1.7
	Considering intervention's QALY and DALY (analyzing the epidemiologic profile, and determining interventions based on it)	Prioritizing services that have more influence on life expectancy and quality of life	Ethical and social criteria are neglected	6.7±1

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Estimating the financial burden of diseases	Direct, indirect and intangible costs	Creating a systemic view or considering costs carried out by patients and avoiding catastrophic expenditures	Ignoring the necessity of covering some services that based on economic terms should not be covered	6.6±1.6
Employing multi-criteria decision-making methods to develop the HIBP	Considering criteria that are related to economic aspects of services (cost effectiveness, budget impact, reducing poverty, quality and quantity of evidences and equity in better access to health-care services	More economic mix of services and avoiding exorbitant costs; transparency of definitions and prioritizing economic criteria	Some decision have unethical economic consequences	7.6±1.1
	Mixing cost and effectiveness and economic and socio-economic criteria in related decisions (using multi-criteria decisions)	Creating a comprehensive view or considering all criteria that affects the decisions; increasing cost-effectiveness of the HIBP	Collecting information is time-consuming, and such decisions are costly	7.9±1

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Controlling inclusion of drugs, services and equipment that their effectiveness is not proved	The MoHME's intervention in licensing new drugs and technologies or developing and implementing laws and regulations to restrict and control them	Increasing the control over services that can be provided, and, therefore, preventing the inclusion of services that are not cost effectiveness	A prolonged period is required to update health services of the country	**8±1.1**
Organizing services/ drugs list that are covered or not covered	Developing a waiting list to include/exclude services/drugs (due to technological changes, policy change, new diseases patterns)	More efficient management of decisions to include/exclude services/drugs and facilitating annual revisions	More health human resources as well as continuous monitoring are required	8±0.7
Creating a decision-making framework based on mathematical models and defined criteria	Weighting predetermined criteria and determining how to mix them by mathematical models	Transparency of method and process of decision-making and determining weights of criteria to make decisions	Possibility of conflict with ethical values in decision's outcomes	6.7±1
Expanding the package of services that can be provided	Expanding the HIBP by providing extra resources	Increasing access to health-care services	Services utilization is out of control and is creating exorbitant costs	5.8±1.3
	Expanding the HIBP along with developing guidelines and standards for services provision	Increasing cost-effectiveness of services, reducing induced demand	Access to services can potentially be decreased	7±1.2

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Policies should be based on study's findings and expert's opinions	Macro decisions be made at higher levels and following that performing expert studies to increase efficacy of implementation	Clear tasks of middle and lower levels, converging tasks at lower levels	Environmental problems and issues are not reflected in macro decisions	7±1.2
	Proposing policies by expert level and following that developing and notifying policies at macro level	Developing evidence-based policies	Prolonging decision-making process	7.3±1.2
	Determining macro-level decisions orientation and following that developing expert-based policies	Transparency of overall strategies and finally making evidence-based decisions	Possibility of different interpretations that may be different from macro policies	7.9±1.3
Organizing ISCHI meeting on including/excluding a service/drug/ equipment	Developing specialized forms which contain key criteria such as cost-effectiveness	Increasing efficacy of decisions through systematic process and defined participation of stakeholders	Challenges may arise in exceptional cases	8.3±1

Solutions	Policy options/description	Pros	Cons	Average Necessity and feasibility (+_) standard deviation (1-10)
Revision and evaluation of the HIBP, both services-and- drugs related	Categorizing services/ drugs in three different lists (i.e. must be under coverage, can be covered, and must not be covered). Then, conducting cost-effectiveness studies for those services that can be covered	Making the HIBP cost-effective by spending minimum time and cost	HTA studies are not performed for all services; categorization may be biased	7.9±1.3
	Conducting HTA studies for all services/drugs that can be provided, then revising the HIBP	Having a HIBP with cost-effective services, as much as possible	HTA studies are highly time and cost consuming; social criteria may be neglected	6.1±1.6
	Perform the first method for the services in the package and the requirement for the HTA to include the new services / drug into the package	The HIBP will be cost-effective; these studies will be institutionalized in deciding about including services/ drugs	HTA studies are not performed for all services; categorization may be biased	7.5±1.1
	Conducting second method and mandating HTA studies	Having a HIBP with highest possible of cost-effective services/drugs; these studies will be institutionalized in deciding about including services/ drugs	HTA studies are highly time and cost consuming; social criteria may be neglected	6.6±1.8
	Determining the minimum expected level of health with measurable indicators to identify the situation or measuring the gap between coverage level and defined standards	Developing the HIBP based on the country's needs	Lack of scientific evidences and field studies; conducing required studies require extra resources	5.8±1.7

Discuss:

1. Did the paper find what it set out to discover?
2. What were the main findings?
3. How accurate do you believe the findings to be?
4. How much do you agree with the proposed solutions?
5. Can you think of any other solutions?
6. How similar/different are their findings to similar papers?

Conclusion

What are the take aways of this study?

The design and implementation of HIBP did not follow an **evidence-based** and **logical algorithm** in Iran. Rather, political and financial influences at the macro level determined the decisions. This is rooted in social, cultural, and economic norms in the country, whereby political and economic factors had the greatest impact on the implementation of HIBP.

To define a cost-effective HIBP in Iran, it is pivotal to develop transparent and evidence-based guidelines about the processes and the stewardship of HIBP, which are in line with upstream policies and societal characteristics. In addition, the possible conflict of interests and its harms should be minimized in advance.

Discuss:

1. What was found to be the main obstacle for inclusion or exclusion of services?
2. What was done to address this issue?
3. Why did we find that structural modifications are of great need?
4. What solutions were other countries using?
5. What are some of the problems of the current benefit package?
6. What service evaluating system are other countries using?

Policy recommendations

- Creating different packaged based on the type of disease
- Evidence-based decisions for the content of HIBP
- Periodical Revision of the HIBP

Discuss:

1. How effective do you believe these recommendations to be?
2. Can these changes cover the whole issue? Or they fix it partially?
3. How long can these policy changes stay effective?
4. Can you think of any other effective policy changes? Elaborate.

Strengths and limitations

To the best of our knowledge, this is the first deep and extensive study for analyzing the HIBP policies in Iran, whose findings can respond to long-waiting questions of health policy-makers in this regard. The final solutions presented in this study are based on scientific and objective evidence that have been approved by the experts.

However, our study had some limitations. We did not find a universal definition of a HIBP, and encountered discrepancies between scientific literature and the experience of different countries. We also faced some challenges in obtaining some documentation from different organizations, i.e. the executive instructions and the expired regulations that were not cited on the websites, due to which determining the effects of the HIBP implementation in achieving desired goals might be incomplete.

Discuss:

1. What do you think of the mentioned strengths and limitations?
2. How do they influence the study?
3. Are they significant enough to alter the accuracy of the findings?
4. Could you name any other strengths, weaknesses, or limitations of this study?

“

Any further questions?

Thank you ☺

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