Challenges of a Large Health Insurance Organization in Iran: A Qualitative Study

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ABSTRACT

Introduction: The importance of health insurance coverage can be considered from two viewpoints: protecting people against the costs of providing health; and providing universal coverage of health services so that people have access to affordable and adequate health services. Overview of insurance organizations' performance in Iran indicates that they are faced with various problems such as increasing costs, the lack of comprehensiveness and adequacy of services, the lack of clear boundaries between basic and supplementary health insurance packages, as well as, the problems on determining the scientific and fact-based tariffs. This research aimed to study the problems of health insurance coverage in a large insurance organization from the perspective of its managers.

Methods: This study is an applied and qualitative research conducted in Iran in 2011. The participants in this study were 11 senior managers of one of the largest health insurance organizations selected using purposive method. Data was collected using structured interviews. Framework analysis using Atlas-Ti software was used to analyze the collected data.

Results: Available challenges were categorized into 4 themes including structure and organization, policy making, the management of providing services, and culture and public education which were identified as the effective factors in health insurance coverage, and 69 sub-themes.

Conclusion: Stated challenges can be largely met through making comprehensive and integrated policies by insurance organization, developing an updated and health-oriented structure,

purposeful outsourcing of services, the application of modern and mechanized systems in providing services, as well as, providing the insured with information by electronic systems.

Key words: Challenges, the insurance organization, qualitative research, Iran

Introduction

Governments have undertaken to run some programs for financing health care by governmental or NGOs' resources to promote public health. Providing health services through supportive mechanisms and public participation in the social insurance schemes have been among these key programs in the past two decades (1-3).

The importance of health insurance coverage can be considered from two viewpoints: protecting people against the costs of providing health; and providing universal coverage of health services so that people have access to affordable and adequate health services.

Therefore, the most valuable way to protect people against the high cost of health services, which are growing increasingly today more than ever, is to create a insurance partnership among government, insurance organizations and the public (4-10).

Generally, in many countries, including Iran, there are two health packages which are funded by the health systems and insurance organizations: basic and supplementary packages. The first package includes basic health services whose identification is one of the serious challenges that insurance organizations are faced with and about 30 to 35 percent of the costs of the health sector are being allocated to these services and the government finances the major part of these costs. The second package includes medical care services which are funded by insurance organizations (6, 9, 11-12).

The largest insurance organizations in Iran are social security insurance organization, social security organization of the armed forces, medical services insurance organization, Imam Khomeini Relief Committee and the micro-insurance funds (6, 9, 13).

In many developing countries, only a small part of the population is protected against the financial risks of the health costs because of the lack of government commitment, the scarcity of financial resources to cover the entire population and the lack of administrative capacity for managing the insurance funds (9).

In Iran, the poor performance of the health system and insurance organizations to finance health costs has resulted in the lack of any insurance coverage and no proper protection against the financial risks of the health costs for many households. Therefore, out of pocket payments are growing increasingly. The results of a few studies conducted in Iran show that 3 percent of population is confronted with catastrophic payments. Thus, decreasing gray payments in the health system of Iran is very important and should be taken into consideration (6).

Though Iran has a 100-year history in health insurance, it has no organizational and structural maturity in its insurance organizations. Therefore, they can't play an appropriate and effective role in covering health services (14).

Few studies have been conducted on the issues and problems related to health insurance in Iran. Overview of insurance organizations' performance in Iran indicates that they are faced with various problems such as increasing costs, financial constraints, the lack of comprehensiveness, adequacy and quality of services, the lack of clear boundaries between basic and supplementary health insurance packages, the lack of actual tariffs which do not fit with the diagnostic and treatment centers' costs, and also, the lack of clarity in the level of commitments and covered services in basic package (7, 12, 14).Dehnavieh and et al. (2010 and 2011) have studied the information criteria for basic health insurance package from health insurance organization's view and in another study, the challenges of determining basic health insurance package in Iran (11-12). Also, a study has been conducted in Iran in 2010 on the challenges of sustainable universal health insurance coverage by Ibrahimipour and et al. (6).

The results of studies conducted in Iran show that health insurance problems are one of the major challenges that exists in the health care system. Therefore, considering the importance of service coverage in the health insurance and the challenges which insurance organizations are faced with, this research has been conducted to study the problems of health insurance coverage in a large insurance organization from the perspective of its managers to provide an effective and appropriate coverage of insurance services to the insured.

Methods

This study is an applied and qualitative research conducted in Iran in 2011. The participants in this study were 11 senior managers of one of the largest insurance organizations selected using purposive method. Data was collected using structured interviews. In order to define the right interview questions, having reviewed the data collected and related references by researchers, the initial categories of questions were determined. Finally, in order to raise the main research questions, four deep interviews were conducted with the experts and policy makers and 18 questions in three categories - descriptive, structural and distinguishing questions - were defined.

All interviews were recorded and then written down. The average interview time was 60 to 80 minutes. Interview questions were designed to take the views and beliefs of the people interviewed on the considered topic. The validity of data was ensured using obtaining supplement expert opinions and reviewing manuscripts written by participants. Getting informed consents from each interviewee to record their voices, being confidential their personal information and not being mandatory to participate in the interview were considered as ethical considerations in this study.

Framework analysis was used to analyze the collected data. Framework analysis is a method for data analysis in qualitative studies which at first was developed to analyze the social studies' data (5, 15-17). It consists of 5 stages of familiarization, identifying the conceptual framework, coding, drawing tables and data interpretation (6, 9, 13, 18-19).

During the familiarization phase, a form containing interviewees' personal information and a summary of the contents of each interview were developed. For developing initial conceptual framework guide, frequent meetings and discussions were held among the researchers.

Then, this conceptual framework was reviewed using frequent studies of each interview (familiarization phase). Each of the interviews was coded separately and a list of these codes along with their relationships with the conceptual framework was extracted from these interviews.

At this stage, each of the sections of interviews contained related information was given a code. Then, these codes were reviewed in meetings with other researchers and revised if necessary. This process was frequently used for each of the interviews. Afterward, the tables were drawn to compare the interviewees' comments about each of the main themes and identify the relationships between each of the main themes and sub-themes. Each components of the conceptual model were interpreted in the same process as coding step and, finally, this conceptual framework was revised repeatedly resulted in making several changes in themes and sub-themes. All of mentioned phases were completed using Atlas-Ti software which is used for data analysis of qualitative studies (4).

Results

Having frequently revised the conceptual framework, the identified problems of the studied insurance organization were categorized into 4 themes and 69 sub-themes (Tables1 and 2).

Theme 1: Structure and Organization

Twenty-three sub-themes were identified on this theme including the lack of prevention center in the current organizational structure, entry of new health services, many structural changes, the shortage of skilled manpower, the mismatch between skilled human resources and organizational missions, developing the system of stakeholder participation and lack of a comprehensive and updated mechanized system for recording statistics. We explain some of these sub-themes below.

The lack of prevention center in the current organizational structure: Unfortunately, the current organizational structure is not based on today's health system status and conditions and does not have the flexibility to suit the organizational missions. The current structure is treatment-oriented in which treatment deputy is the most important pillar. While today because of the increasing attention to prevention and the necessity to address this issue as one of the most important factors in future costs containment, establishing the prevention center in the organization seems inevitable.

"One of the principles of being health-oriented is prevention. It means that as we spend money on treatment, we should also spend on prevention" (P1). "The current structure was suitable in 1990s and is not harmonized with the current organizational missions" (P2). "The general policy

of the organization is being health-oriented not treatment-oriented, and this approach is good. If we can do the best in this field, we have taken a big step. If all available resources spend in treatment, we do not achieve a suitable outcome. However, by health- and prevention-oriented approach, we will have the possibility of control" (P6). "There are diseases that are really costly and harmful for insurance organization, such as diabetes, hypertension, obesity, stress, addiction and smoking which tend to empty insurance fund severely. If we act in the field of prevention, it will make great savings in our fund in the near future by which we can provide very good services" (P10).

Shortage of skilled manpower: What the majority of participants stated in the field of human resource was the shortage of skilled manpower, especially in some branches of the insurance organization. Interviewees acknowledged that the services provided by the insurance organization, particularly in recent years, have had a growing trend. However, unfortunately, the organization has not been able to recruit the required human resources according to this trend. "Throughout the country, we have 1200 personnel, 38000 centers under contract with the insurance organization and about 5 million insured. Please judge how we can provide services to 5 million insured and 38000 centers under contract with the insurance organization, and supervise them only by 1200 personnel while the most of our supervision is observational in that the location and process of providing services must be carefully supervised" (P 1)."Shortage of manpower causes that not all services be provided with the desirable quality" (P 4).

Theme 2: Policy making

Twenty-nine sub-themes were identified on this theme including reduced service commitments due to growing costs, the need for integration and standardization of Health Ministry's insurance policies, the medical community's influences on policy and decision making in the health system, lack of Health Ministry's domination on factors affecting health, and the necessity of policy-making integration in the health system, some of which are explained below.

Decreased commitments to services due to growing costs: There is an increasing growth in health care services throughout the world and in our country accordingly, and the expectations of service consumers are also growing progressively, and on the other hand, the lack of the governmental budget and not meeting governmental commitments have resulted in decreasing in the studied insurance organization's commitments in some cases. "An important issue we are faced with in our insurance organization is that our income does not have any compliance with our costs. The money we spend on treatment section is much more than that we receive as capitation because the capitation is fixed but our costs are growing increasingly. For example, the pricing of medicines is not controlled by the organization and their prices are growing increasingly, so our services become inevitably less" (P 6).

The medical community's influences on policy and decision making in the health system: People in today's world are aware of the science and art of management as the only solution to organizational development so that those countries and organizations have been more successful in their industry, services and business which have been able to use the findings, tools and management knowledge to solve their problems. All experiences show that managing the health systems and organizations which are providing health services, considering the serious organizational complexities and problems which they have been faced with, today more than any other time requires a combination of managerial and clinical knowledge and skills. "Making policies on health issues has been entrusted only to the Ministry of Health and in this ministry primarily to the physicians and less attention has been paid to the role of other health professionals while health is not only a medical issue. Medicine helps to screen and treat patients. Whatever medical system and physicians perform well and in a health-based manner, other sectors that are important and are affecting the health will be ignored. For example, do not have municipalities any role in the health of the Iranian people? What about Welfare Organizations? When you talk about health, it should be noted that health is a pervasive discussion and all sectors which can maintain or improve the population health should be considered, while the Health Ministry has no dominion over them and many of these sectors have no obedience from the Health Ministry" (P1).

Theme 3: The management of providing services

Thirteen sub-themes were identified on this theme including taking a long time to receive required services in the pay-day branches, difficult access to the pay-day services for patients, overcrowding in the pay-day branches, a lengthy process for paying in the pay-day branches, the small number of pay-day branches in Tehran, as well as the shortage of manpower in the pay-day branches. We explain some of these sub-themes below.

Taking a long time to receive the required services in the pay-day branches: The review of the interview notes shows that receiving the required services in the pay-day branches, in some cases, takes a long time due to the high volume of services provided, as well as, the shortage of manpower. "The number of personnel we have in a branch doesn't really fit with the volume of work that they do. Therefore, a large load of work is imposed on everyone who works there. So, providing the services for clients takes a long time." (P8)

The small number of pay-day branches in Tehran: "The insured must refer to one of our branches which are not more than 4 in Tehran. It means that the insured may travel a long distance and when they reach our branch, they may wait for a long time which unfortunately is inevitable because of overcrowding, and having delivered their documents, they may be faced with delay in payment (even 1 month). So, our branches' service delivery in the city is low." (P8)

Theme 4: Culture and public education

Twenty sub-themes were identified on this theme including low level of the insured's medical information, the lack of the insured's information about the insurance organization's commitments in the private sector, the necessity of giving insurance information to the insured through national media, and being wrong to receive services for free. Some of these sub-themes are explained below.

The necessity of giving insurance information to the insured: "We provide better services than other insurance organizations, however sometimes the insured tend to go to the other insurers. This means that we couldn't give sufficient notice and the insured isn't aware of services that can enjoy. In giving notice, the insured should be familiar with his/her real demands. The most essential step to respect the insured is that he/she should be informed of his/her real demands. Of course the organizations refrain from addressing this issue because they think if the insured becomes familiar with the real demands, the organizations' costs will grow and the insured's referrals and demands will increase" (P10).

Being wrong to receive services for free: From the viewpoint of the most participants in this study, unfortunately, some of the insured visits to the medical centers of this organization as well as some of the repetitive referrals to different physicians in centers under contract with the insurance organization, which are made because of providing free health care services in these centers, are unnecessary. From the interviewees' perspective, in some cases, the lack of any rule to receive the costs of treatment has been resulted in a physicians' waste of time, as well as causing several managerial problems. "Not receiving the treatment costs is wrong and will increase the costs of the organization. The culture of living for free is wrong because living without any payment is never possible and one should eventually pay these costs. How should he/she pay these costs? Removing and not receiving the treatment costs is something completely foolish and wrong. You should always take care to maintain the insured's contribution at the point of service because it is one of the important tools to control costs" (P1).

Discussion

Considering the importance and role of the health insurance coverage, in this study we tried to identify the available challenges and problems of health services coverage which one of the largest insurance organizations in Iran is faced with using a qualitative research. The findings show that these problems can be categorized into four themes.

On the structure and organization theme, the most important sub-theme was the organization's old structure and its mismatch with the current organizational missions (14). Therefore, the available structure cannot fulfill the managers' expectations which are based on the current organizational goals. Currently, there is a view that the organizational structure should promote

the insured's health and quality of life, as well as, provide desirable health services. Ibrahimipour and his colleagues in their study showed that one of the major problems of the health insurance system in Iran was its disjointed structure which confirms our study findings (6-7). Also, the findings of another study conducted in Mexico showed that one of the required reforms to achieve universal health insurance coverage was structural reform (20). It seems that the current structure needs to be reviewed so that it can provide the best services according to its situation. One of the most important issues which should be considered in this review is developing an updated and health-oriented structure that includes a prevention center based on utilizing modern and mechanized information systems, as well as, employing appropriate and sufficient skilled manpower.

The findings about policy making theme show that the treatment costs today are growing increasingly because of the diversity of services provided, the increasing number of patients visit the health care centers, and the rapid advancements in the medical technologies (2, 6, 14, 21). Therefore, the insurance organizations should, on the one hand, improve the quality of services provided continuously and, on the other hand, prepare appropriate occasion for receiving services using cost containment (7). Hence the commitments are increased and consequently, in some cases, meeting these commitments has decreased. Also, the lack of government commitments, the lack of financial resources to cover the entire population and the lack of administrative capacity for management of insurance funds have also resulted in not being able to well protect the insured against financial risks arising from the increasing costs (9). The lack of a suitable system for determining the commitments of the insurance package in the Iranian insurance organizations is one of the major problems of the insurance system (22).

The findings of the initial studies on the health insurance system in Iran show that this system is currently faced with major challenges which one of the most important one is the lack of clarity in the insurance commitments (23). In such circumstances, making comprehensive and integrated policies by the health system and insurance organizations is inevitable.

The problems stated on the management of providing services theme were more about the lack of appropriate physical space and skilled manpower in the pay-day branches which have resulted in overcrowding and taking a long time to provide suitable services for the insured in the pay-day branches. It seems that the appropriate solutions to solve these problems are the purposeful outsourcing of services, as well as, the application of modern and mechanized systems (9).

Finally, the most important sub-theme on the culture and public education theme was the low level of insured's information on insurance organization services. It seems that this problem can be solved by making appropriate policies such as providing the insured with information by electronic systems and all branches of the insurance organization throughout Iran. The findings of a study conducted in Iran showed that the awareness, expectations and attitudes of people towards the health insurance is not in a good condition which confirms the current study findings (24).

Conclusion

In summary, the findings of this study indicate the fundamental problems of service coverage in the fields of structure and organization, policy making, the management of providing services, as well as, culture and public education which can be solved through making comprehensive and integrated policies by studied insurance organization, developing an updated and health-oriented structure, purposeful outsourcing of services, the application of modern and mechanized systems in providing services, as well as, providing the insured with information by electronic systems.

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Table 1: The sub-themes of structure, organization and policy-making on the health insurance coverage

Themes	Sub-themes
Structure and organization	Lack of a prevention center in the current organizational structure
	The mismatch between the organizational structure and updated information technology systems
	Lack of an appropriate control system in entry of new services to the organization
	Many structural changes
	Structural barriers in establishing financial communication with and giving notice to centers through network
	Organization's inability to achieve its missions
	Shortage of skilled manpower at the headquarters
	The mismatch between skilled human resources and organizational missions
	Developing a system for participating people, centers under contract with the insurance organization, and stakeholders
	Lack of a comprehensive and updated mechanized systems for recording insured-related statistics
	Failure of information systems related to the insured
	Shortage of skilled manpower in the field of prevention
	Shortage of skilled manpower in the field of treatment
	The mismatch between the structure and organizational missions
	Entry of the new drugs to the supplementary services package without any expert working
	Lack of access to desirable situation using available resources
	Lack of appropriate training and instructions for the newcomers to the organization on arrival
	Weaknesses in resource management
	Weaknesses in the patient information system
	Performance evaluation of managers regardless of their expert decisions
Policy-making	Making appropriate policies on outsourcing as a solution to the problems of overcrowding in the pay day branches
	The problems of the implementation methods of outsourcing
	The contradictions in the simultaneity of developing the insurance ID and the health smart card
	Decreased commitments to services due to growing costs
	Lack of any indicator for grading health service centers and putting all of them at the same level
	The necessity for grading health service centers and giving the insured sufficient notice of this grading
	Working in parallel and the lack of integration in the insurance data
	The need for integration and standardization of the Ministry of Health policies on health insurance
	Completing supplementary insurance package and strengthening supportive insurance
	Appropriate expansion of health services in border areas
	The weak performance of Supreme Council of Insurance
	Absence of obligation for physicians to contract with insurance organizations
	Lack of coordination between Ministry of Health and insurance organizations
	Lack of any measure which is necessary for leading physicians' performance
	Improper use patterns in the health sector
	Insufficient service coverage in basic health insurance package
	Lack of health services to purchase in some disadvantaged areas
	The medical community's influences on policy and decision making in the health system
	Lack of Health Ministry's domination on factors affecting health
	The necessity of policy-making integration in the health system
	Lack of coordination among decisions about health made by Parliament, Ministry of Welfare and Social Security, and the Ministry of Health
	People's freedom to refer to the physicians
	Problems relating to setting tariffs and using unlicensed services in the country

Table 2: The sub-themes of the management of providing services, and culture and public education on the health insurance coverage

Themes	Sub-themes
The management of providing services	Reluctance of some private centers for contracting
	Taking a long time to receive required services in the pay-day branches
	Overcrowding in the pay-day branches
	A lengthy process for paying in the pay-day branches
	The small number of pay-day branches in some provinces
	The shortage of manpower in the pay-day branches
	Lack of physical space to develop pay-day human resources
	Poor physical design of pay-day centers
	The mismatch between employees' performance in the pay-day branches and their predetermined job descriptions and duties
	The mismatch between the development of insurance groups and the expansion of pay-day branches' facilities
	People's reluctance to substitute their old insurance ID by telephone due to delays in the post delivery
Culture and Public Education	Low level of the insured's information about the insurance organization services and the necessity of giving them appropriate notice
	Lack of the insured's information about the similarity of services in the centers under contract with the private centers
	Lack of the insured's information about the difficulty of the process of receiving costs
	Lack of the insured's information about the insurance organization's commitments in the private sector
	Lack of effectiveness of giving information to the insured using booklets
	The necessity of creating a culture of the insurance organization control over physicians
	Lack of patients' awareness of how to use insurance ID accurately
	Patients' indifference to detach the insurance ID's sheets
	The necessity of creating a culture of appropriate financial relationships among the insured, physicians and the insurance organization
	The necessity of creating a culture of supervision in the organization between managers and employees
	Being wrong to receive services for free.
	The necessity of information and interaction of insurance deductions for health care centers
	Lack of appropriate culture of visiting a doctor in the community
	The insured's dissatisfaction due to the growth of their unrealistic expectations
	Increased expectations and referring to centers which are not under contract with supplementary insurance organizations.