In the Name of God the Compassionate the Merciful

The Necessities of Executing Iran Health Insurance Organization Bylaw

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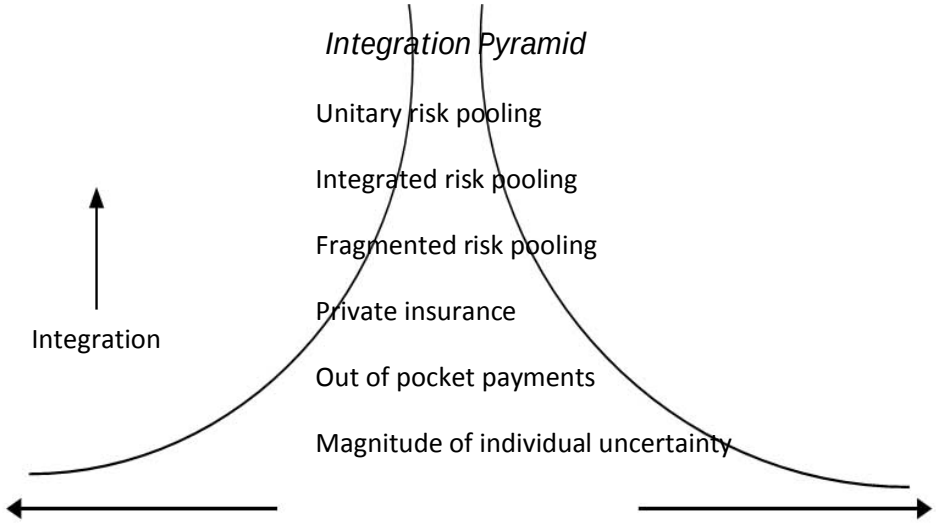
The government approved and assigned Iran Health Insurance organization bylaw, according to clause "B" of the 38th article of law, the 5th Social, Economic and Cultural Development Program of the country, so that this organization officially announce existence in 2012/9/18 and integrate the medical sectors of all funds subjected to the 5th article of the state services management law and the general state calculations law. In this ground, the general overview of the global literature manifests two identified health insurance systems: Single payer and multiple payer systems. Presently, Iran is stated in multiple payer system stage, and is going towards the single payer system, based upon the law and bylaw. Evidently, analysis of the current situation is essential to write the passing stages, and in this ground, through the "integration pyramid" of health insurance system viewpoint, on one hand, and risk coverage view, on the other hand, the country is located in the multiple payer stage, and in order to get the single payer stage, three important steps should be taken.

It is worth mentioning that in order to confront the uncertainty of disease risk happening, bringing into the mind that in the past, there were just the direct out of pocket payments, the first solutions of risk confrontation in Europe were risk pooling establishment, and in Renaissance, it took the form of private insurances (like Guilders in Switzerland). Through progression of insurance systems and aiming at greater risk pooling, private insurances came to the fore, and through development of insurance culture, and increase in their number, the multiple payer system was created. To gain the greatest risk pooling in a country, the single payer systems were created. This structure is referred to as "integration pyramid". The embedded principle is that to obtain the efficiency of health insurances, the movement direction from the lowest level of the pyramid (out of pocket or private insurances) toward the highest level (single-payer system), needs the least of expenditures, while the movement from multiple payer system level (in which Iran is stated now) is necessitated by three phenomena: the necessity of unification in the financial provisionary system, which is taking place by the approval of the parliament as the first step, the unification of the basic package (commitments) as the second, and the last step would be inevitably structural integration.



On the other hand, studies manifest that there exists four major models of single payer systems in the world, each of them having characteristics that essentialize the necessity of their location and establishment before accessing this system. Hence, responding to some questions before deciding to move towards this system becomes indispensable.

1) In what state are we from the view of collecting resources, risk pooling, service purchasing and social solidarity, and what is the optimal state?
2) Which model will be the single payer system based on? regional/ private-regional/ public-central/private- central/public
3) Since in single payer system the competition between the public funds would be lost, will the private commercial insurances be allowed to compete with these funds? (Note that in no model, the commercial private insurances are allowed to enter into public services. (this competition exists in our country at the present and has caused the incredibility of the basic health insurance)
4) According to the experiences of the countries, the fundamental term and condition for the shift from the multiple to the single payer system, is universal coverage for the public. Although this subject has been observed in clause "A" of the 38th article of the development law, what is the essential prerequisite for its establishment?
5) In countries having a single payer system, most of the resources are provided through progressive financing systems, and the consumer franchise is very low or even zero. In establishing this organization, would the 30% franchise of outpatient services and 10% franchise of hospitalization services exist? What would be done for the nearly two-time difference of the private and state tariffs?
6) The physicians providing services in this system should have one-job. What will be done for all our multi-job physicians, observing the evidence of note "2", clause "D" of the 32nd article of the development law?
7) In the single-payer system, to strengthen the integrity, the private sector is forbidden to create a double layer health system; hence it is not permitted to have overlaps with the public coverage. Therefore, the physicians who have accepted to treat the patients of the private sector are

omitted from the public payments. Will this subject matter be observed in the established organization?

8) In the single payer systems, a single organization might have the responsibility of managing the financial provisions, pooling, and service provisions; and on the other side, the policy holding sector, including service purchase and provision, does not have any kind of incumbency, in a way that inside the integrated systems, the major part of the regulation developing responsibility is of the central government, but in non-concentrated systems, the regional authorities have the most responsibilities, and the central government exerts the public principles via consuming powers. However, the countries having this system are more and more apt to execute amendments and separate the purchase process from the service provision, in order to improve efficiency and response. For this reason, the public purchasers and providers are administered exactly like private institutions, even though they are under the public sector ownership. At the present, the service provision and purchase systems are separate and have two diverse ministries in Iran. Considering the current situation of the country, what are the proper solutions?
9) In the single payer system, the public contribution, conditioned to the kinds of financial provisions (income taxes, wage contribution, asset taxes) is a progressive and comprehensive system. In today's condi on of the country, the premiums equal 5% (in the 1st 3 years of the program) and 6% (in the last two years) with a twice of the salary limit, being determined, according to the 1st and 2nd clauses of the 38th ar cle. While in the very ar cle, the 3rd clause, the Social Security beneficiaries have been determined (medical share: 9/27, equals: 9%, with the 7 time salary) limit, what decisions would be made? (Although the solutions have been predicted)
10) Of the characteristics (properties) of the single-payer system is the monopsony power, which is obtained via debates by the service providers. In the current condition of the tariffs in Iran, and considering the two-time difference of the private and state tariffs, no solution has been observed. Wouldn't it be necessary, noticing the establishment of this organization?
    The optimal condition in answering the above questions is the patients' interest to be considered as the orient and center of focus for the authorities of the health market (service providers, policy holders and the organizations) whereas these principles are practically located outside the patients' interest realm. Three major happenings are the perquisites of the movement in this direction:
    1) Purchaser provider split
    2) Splitting the governance of the funding agency from stewardship function of government (decentralization and agency formation)
    3) 3) Using direct out of pocket payments as the lost sharing in order to defeat behavioral problems and adopting policies to face adverse selections.

According to world Health Report year 2000, WHO considers the final executive responsibility of the country health system as governments duties, which is done through playing a stewardship role by the health system, which is consisted of a collective, and not an individual responsibility, and social welfare would be elevated in this way. Public protection, ensuring health improvement of the people, ensuring

fulfillment of the social demands, and perusing equity goals are executed following the elevation of welfare.

Although integration of the policy making, purchasing, supervising, and health service delivery is an unacceptable hypothesis in the developed countries, firstly, it should be clarified that what is the current financial organizational, and ownership of healthcare providers system in Iran, and how the stewardship of health system is directed, for stewardship is consisted of a process through which the government takes the responsibility of directing and guidance of healthcare system, rather than direct service delivery. Unfortunately, the experiences in the countries manifest that when governments dispatch policy making management from delivering services, because of the lack of policy holding and skill capacities, they understand that they are incapable of directing, and practically they enter the delivering services sector. It's when the benefit contradictions happen and unconditional defending of health service production along with inefficient governmental management, cause the incapability of the health insurance system in accomplishing the responsibility of protecting people from disease causing financial risks.

It is worth mentioning that health system is a collaboration of functions and outcomes (chart2). In functions sector, financing supports as one of the three principal sectors, in common sense, is considered as the health insurance duties. However, in outcome sector, two sectors of responding to the non-medical expectations of the people and fairness of financial contribution of the people are of the functional duties of health insurances leading to social health. Financial protection, in this perspective, means that individuals and families:

1) Take healthcares, when needed, and high prices do not prevent their access.
2) Access to healthcare, do not cause prevention of life essentialities accessibilities such as food, education, and life shelter.
3) People do not lose their income and fall to poverty trap because of the burden of high healthcare expenditures.

Differences between health services delivered by Health Ministry, and the services purchased by social Health Insurance Organization, is that in the first group the services are dependant to the resources, whereas according to the obligatory and nature of the second system, the determining factor is the "demand", for law has bestowed the right of using medical and health services quid pro quo collecting insurance per capita from his income, and obliges insurance organizations to be cost conscious, attempting in maintaining balance between resources and demands, along with attempts in responding to the insured.

Viewing the approved bylaw by the board of ministers, manifests the matter of evidence that this organization is supposed to be the center of holding and executing the single payer insurance system policies in the country and to obtain this goal, the following activities are essential:

1) Determining and suggesting the premium according to the committed services (defined benefits approach) or the basic package according to the received per capita (defined contribution approach) for each family per month based upon the 1st article of the bylaw. For as much as the

regulator has determined the amount and the way of receiving per capita according to clause 1-4, note "d" of the 38th article of the 5th development program law. Therefore the "defined contribution approach" would be the touchstone of planning

2) Execution and designing health insurance services plan in an integrated form based upon IT, and in collaboration with the health electronic file according to the 1st article of bylaw, and clauses "A" and "B" of 35th article. Evidently, according to the very clause, Health Ministry has the responsibility of execution and designing health electronic file, with the priority of initiating from Referral system, in cooperation with Iran Statistics Center and Civil Registration
3) In order to get released from the incumbency, the necessity of identification and determination of the brokers of the health insurance organization, according to the 1st article of the bylaw, and clause "A" and "B" of the 6th article and note of the structure law, and the approval necessity of rules and regulations by the high welfare council according to clause "4" of the 1st note of the 12th article of structure law
4) The necessity of designing service delivery system according to the 1st article of the bylaw, and clauses "G" and "D" of the 32nd article of the 5th development program law, and accomplishment of activities such as redesigning the comprehensive public health services system based on the primary cares, family physician and referral system orientation, staging the services, etc … in the first year of the program by Health Ministry and the approval of the executive plan in the Health and Food Safety High Council, and necessity of executing it in the 2nd year of the program Through providing the country medical system program in the basic medical insurance integration frame work, family physician and referral system medical guideline, etc … and the approval of the board of ministers in the 1st year of the program
5) Designing the blueprints of the provision of all health level services, according to the basic and complementary insurance regulations, and delivering an executive plan, alongside obliging the commercial insurances to observe the relevant rules and regulations, and the approvals of Insurance High Council, and developing the way of having supervision on execution according to the 1st article of the bylaw
6) Developing and approval of the executive bylaw of purchasing guideline, amendment in payment system and the committed services list by the welfare ministry, health and medical ministry, and the chancellor, and also the approval of the board of ministers in the 1st year of the program, aiming at forming the basic health insurance, according to the 1st article of the bylaw, and clause "Z" of the 38th article of the program law
7) Developing the complementary insurances regulations, according to the 1st article, and 2nd clause of the note of clause "A" of the 2nd article of the structure law
8) Accomplishment of Family Physician and Referral System Program, according to the 1st article of the bylaw, and clauses "G" and "D" of the 32nd article of the program law
9) The suggestion of the integration of the members, duties, responsibilities and authorities, and also secretariat of the Insurance High Council to the board of ministers for confirmation, and approval of the parliament, according to the 1st article of the bylaw, and 3rd note of the 38th article of the program law
10) The necessity of identifying the ministers, state institutions, non-governmental public centers and institutions, state companies, and all other organizations like Oil Company, Industrial

Development, and Innovation Organization of Iran, Central Bank, all banks and state insurances, and developing the regulations and processes regarding their integration with Iran Health Insurance Organiza on, according to the 2nd ar cle of the bylaw, and clause "B" of the 38th article of the program law

11) Developing the regulations and process of adjoining the exempted organizations to Iran Health Insurance Organization, such as Armed Forces, Social Security Fund and Intelligent Ministry and the necessity of developing direct medical purchasing regulations (from social security organization)
12) The necessity of the approval of regulations of the agencies by the High Welfare Council
13) Identifying the capitals, asset, and commitments of all integrating funds and adding them to the capital of the organization
14) Developing the regulations of contracting and dissolution of the contracts of delivering basic health insurance services, and also developing the regulations of receiving per capita as the subject matter of the executive method of the 38th article following note of the program law, explaining the responsibility of the executive organizations in liquidation of the clerks' per capita in a month, according to clause "A" of the 7th article of the law
15) The necessity of developing supervisory regulations on the quality and quantity of delivery services directly or indirectly
16) The necessity of developing standards and production of the relevant software to organize delivering health insurance services in cooperation with electronic health file, according to the 7th article of the bylaw
17) The necessity of developing standards, protocols, and clinical guides, and the way of their execu on in the contracted units according to clause "Z" of the 7th article of the bylaw
18) The necessity of the approval of regulations of the agencies in the High Welfare Council, according to clause "H" of the 7th article of the bylaw
19) Developing the necessary regulations in collecting premium, and legal confrontation with the delayed payments
20) Developing the regulations related to the complementary insurance delivering services, and gaining the premiums according to the 7th article
21) Doing the actuary calculations to parallel supplies, sources and demands
22) Developing the contraction and dissolution regulations for the board of trustee's approval
23) Developing medical documents audit for the board of trustee's approval
24) Developing regulations of gaining qualification for the medical centers
25) Developing the policies and executive plans for the board of trustee's approval
26) Developing the official, employment, financial and transaction statutes for the board of trustee's approval
27) Developing the top chart and detailed structure for the approval of the relevant referents
28) Developing the contraction and dissolution of the basic and complimentary services for the approval of the board of trustee
29) Developing the documents audit regulations
30) Extracting other authorities, not of the board of trustee's duties, according to a part of trade law

31) The necessity of identification of the relevant resources of clauses “B”, “G”, “D”, “V”, “Z”, “H”, and “T”, and developing the process of gaining these resources according to the 16th article of the bylaw