

The Integration of Health Insurance Funds as a Reform Approach in Iran

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Dear Editor,

Integration of insurance funds means the identical use of equal coverage by all people and receiving the same benefits; therefore, it is not referred to the integration of the insurance organizations into each other. The insurance industry especially social insurance, like any other field, has proven scientific principles such as the risk pooling, financial resource pooling, cross-subsidies, strategic purchasing, information redundancy, etc. Dispersion of insurance funds results in the lack of risk pooling and resource pooling, eliminating the possibility of insurance organizations' strategic purchasing and decreasing their bargaining power. In addition, the lack of information redundancy causes some problems, including the insured overlaps and the lack of coverage of the needy (1, 2).

Some Problems of Health Insurance Industry in Iran

Most important problems of the health insurance industry in Iran include:

The existence of multiple and dispersed insurance funds, the decentralized and uncoordinated decision-making system for financing the health care system, especially in the health insurance organizations, the lack of horizontal and vertical equity, the lack of comprehensive depth of coverage in terms of payment, the definition and separation of the population based on the different criteria, including jobs, housing, income, and social status, which has resulted in the overlaps in statistics and therefore, the provision of incorrect and inappropriate information, the existence of numerous insurance organizations in the treatment section with the same methods and criteria and without competition, which has resulted in the repetition of costs and activities related to purchasing the medical services, the unfair financing and the inefficient allocation mechanisms and financial resource absorption in the health insurance organizations, the unfair calculation

method of per capita to get the premium and the inappropriateness of the process of determining insurance premium per capita, the reliance of health insurance organizations on the government in terms of financial resources due to the weakness of resource pooling, the parallel activities and the lack of comprehensive and coordinated information system of the insured, which has created many problems and has made it difficult to achieve basic insurance coverage in the country, the lack of proper management evaluation system in the insurance industry, the lack of service levels and packages defined based on the priorities due to the absence of a single policy-making system, nearly half of the population of the country (the villagers and urban self-employed) do not have the universal and continuous social insurance coverage because of the lack of a single policy-making system, not-specified duty of the insurer to choose the type of insurance in the law and therefore, due to the incorporation of the principles of social insurance with group and individual insurance, the inconsistent regulations and rules have been applied, the lack of compliance of executive decisions and programs with the results of applied studies because of the lack of unities of purpose and procedures, the consumers and providers' rights, demands on and satisfaction with the health insurance system are not transparent, and there is not any appropriate strategy for improving the service consumption model, which has been created through induced demand (3-5).

Health Insurance Regulations in Iran

According to what mentioned above and in order to improve the interaction of insurance organizations with other parts of the health system, the paragraph (b) of article 36 of the fifth development plan has focused the importance of this interaction, and has stated that the policymaking, planning and monitoring of the health sector

should be centralized in the ministry of health and medical education. In other words, the stewardship function of ministry of health has priority over its service providing function. With regard to this legal obligation and according to the types of the governance model mentioned and the successful experiences of the stewardship model in different countries, the results demonstrate that stewardship function should be centralized and unified. According to paragraph (b) of Article 38 of the fifth five-year development plan of the Islamic Republic of Iran to integrate insurance funds, as well as the statute of the health insurance organization of Iran approved by the Cabinet at the meeting of 2012.01.29, this aggregation is essential because in the current system of health insurance, there is no coordination among the insurance funds in the country in providing services, and the problems resulting from the multiple health insurance funds are as follows:

The lack of clear information, the lack of ability to do proper planning due to the multiplicity of insurance funds, the differences in the levels and types of liabilities and services accepted and committed by the health insurance organizations, the waste of resources due to the lack of clarity about the insurance sector's contribution, the impossibility of monitoring services provided by the supplementary and complementary health insurance organizations and, the multiplicity in the provision of health care and the differences in the types of services provided (4, 6).

The Solution

The studies of the status quo of basic health insurance organizations in recent years indicate their obvious differences in the population covered the premium, the costs per capita, etc. For example, the results of a study on the performance of the social security organization, Iran health insurance organization, and Imam Khomeini relief foundation in 2013 showed that:

The social security organization had covered 48.7% of the country's population with the premium of 7% of salary, and per capita costs of 1,545,000 Rials; the Iran health insurance organization had covered 18% of the country's population with the premium of 5% of salary, and per capita costs of 1,201,240 Rials; and the Imam Khomeini relief foundation had covered 1520000 persons with the premium of 5% of salary, and per capita costs of 99,000 Rials.

Therefore, the efficiency of available health insurance organizations can be increased by aggregating the insurance funds as one of the strategies of organizational growth, which means uniting two or more organizations or parts of them that have similar, complementary, or related activities. This can be done to gain more abilities and achieve improvements in the status quo. It should be noted that the integration of health insurance organizations does not mean possessing or owning the health in-

surance organizations or their structural integration.

The Most Important Outcomes of the Aggregation of Health Insurance Funds

Some of the advantages of aggregating health insurance funds in Iran can be as follows: Increasing responsiveness to the insured's real needs, controlling the health costs through reducing overhead costs, integrating the hospital observers with others, strengthening the supervision and monitoring, decentralization, improving the stewardship and policy making in the field of insurance, having all people an equal share of governmental resources and subsidies, strengthening the strategic purchasing, improving the payment system, equalizing the participation of health insurance organizations in the health costs and reducing the challenges among hospitals, medical community and health insurance organization, improving health insurance coverage to the highest liabilities of the health insurance organizations based on the approvals of the health insurance supreme council and the Cabinet, reducing the organizations' overhead costs and increasing the coverage of more health services, reducing patients' confusion resulting from the lack of unities of purpose and procedures among the country's health insurance organizations, improving the delivery of hospitals and health centers' services to the patients due to improved interaction with the health insurance organizations, increasing the efficiency of health insurance funds based on the experiences of other countries, increasing the productivity of health insurance funds on the basis of scientific and economic principles, and promoting the health equity in the health service utilization and increasing the people's participation (7).

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Hereby, we would like to express our gratitude to Journal.

Footnote

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