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Research Article

Qualitative Analysis of National Documents on the Role and Duties of Supplementary Medical Insurance in Health System: Evidence from Iran

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Abstract

Context: Supplementary medical insurance plays a key role in enhancing access to healthcare services and improving the overall quality of life for individuals. In healthcare system of Iran, these insurance companies face various legal and operational challenges that impact their effectiveness in providing adequate coverage and service delivery.

Objectives: The present study aimed to systematically investigate the roles, responsibilities, and legal framework governing supplementary medical insurance companies in Iran. The goal was to analyze how these companies operate within the health system and their interactions with service providers, as well as to identify the key policies and regulations that influence their operations.

Data Sources: A comprehensive review of all relevant documents related to supplementary insurance companies in Iran was conducted. These documents, published in Persian, included policies, laws, and guidelines governing the sector. No time limitations were applied, and the documents were sourced from governmental and regulatory bodies.

Study Selection: The study included 10 documents based on inclusion and exclusion criteria. These documents were selected for their relevance to the legal and regulatory framework of supplementary insurance in Iran, particularly those outlining the duties and responsibilities of insurance companies.

Data Extraction: Content analysis techniques were employed to extract and categorize the data from the selected documents. The analysis focused on identifying the main themes related to the operational duties of supplementary insurance companies in the Iranian health system.

Results: The study identified eight central themes regarding the legal requirements and responsibilities of supplementary insurance companies: (1) Interactions with service providers, (2) document handling processes, (3) electronic procedures, (4) contracts with healthcare providers, (5) service packages and coverage, (6) insurance premiums, (7) financial resources, and (8) monitoring and evaluation. The results revealed that the supplementary insurance landscape in Iran is highly fragmented, with a diverse range of policies and regulations. This diversity suggests a need for a more unified framework to streamline operations and ensure efficient service delivery.

Conclusions: The findings underscore the necessity of establishing a standardized, unified structure for supplementary insurance companies in Iran. Streamlining regulations and practices would not only reduce confusion but also enhance the effectiveness of supplementary insurance in improving healthcare access and quality. Further reforms in the regulatory framework are recommended to support the long-term sustainability and efficiency of supplementary insurance within healthcare system in Iran.

Keywords: Medical Insurance; Supplementary Insurance; Commercial Health Insurance; Document Analysis

1. Context

Health systems encompass all organizations, individuals, and actions that aim to promote and maintain the health of people in society. They have four main functions: Providing financial resources, delivering health and medical services, generating resources, and offering services (1). Currently, there are two main categories of insurance organizations providing health insurance services in the country: Basic insurance organizations and supplementary insurance organizations. The first category, which includes the Health Insurance Organization, Social Security Insurance Organization, and Armed Forces Insurance Organization, covers a wide range of diseases and health services (2). The second category covers the costs of other diseases and services. In addition to these two main categories, some organizations, such as the National Oil Company, municipalities, and banks,

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provide specific health and insurance services for their employees (2, 3).

Commercial medical insurance in the field of commercial insurance is relatively new, but its noticeable effect in creating satisfaction among the insured, optimizing the medical economy, and reducing pressure on the healthcare system of the country, including basic insurers and the Ministry of Health, is evident. Instead of the previous thinking based on eliminating this aspect of insurance, the focus has shifted to explaining the role of supplementary treatment insurers and redefining their overall role (1).

The limitations of financial and human resources in the basic insurers' sector and the rapid increase in costs have caused problems in expanding insurance coverage and supporting the medical expenses of the insured. This has laid the foundation for the formation of commercial insurances. In this type of insurance, in return for receiving the prescribed insurance premium, the insurer undertakes to pay the medical expenses up to the maximum amount committed in the contract if the insured becomes ill during the contract period or suffers damage to their body and health due to an accident (2-6).

In Iran, despite the wide variety of personal insurance coverage, this insurance covers less than 15% of the production insurance premium per year. It mainly accounts for about 8% of the production insurance premium and 9% of the damages paid, due to the heavy medical expenses from supplementary treatment insurance. Reasons for this include the lack of a clear boundary between the services and obligations of primary and supplementary insurers, the low quality of treatment centers covered by the primary insurer, the lack of comprehensive coverage of supplementary insurance against the wide variety of diagnostic and treatment methods, the monopoly of the insurance market, the lack of individual supplementary insurance, and most importantly, the lack of specific and clear guidelines and criteria between commercial insurance companies and service providers.

In Iran, the primary insurer and supplementary insurance cover different parts of medical expenses, and sometimes they may overlap (7, 8). The lack of a standard mechanism for training experts, the diversity and multiplicity of supplementary insurance companies, and the multitude of decision-making and influential authorities, such as the Central Insurance and the Ministry of Health, have led to inconsistency and clashes over the years. The drastic changes with the introduction of the book on relative health values and the sharp increase in tariffs have made the calendaring of medical damage documents even more difficult.

The absence of a comprehensive instruction as a reference document with a specific legal position, mandatory for all supplementary insurances, despite the competition in this field, results in complex confusions and disturbances in handling insurance documents of service providers and processes related to sending documents, introducing patients, tariff ceilings (payment methods), handling documents, and contract formats and renewals. Therefore, all upstream documents, laws, and reports in Iran were discussed and examined to address the handling of documents and the interaction between service providers, insured individuals, and supplementary insurance companies.

2. Materials and Methods

2.1. Study Design

This document analysis was carried out between December and May 2024. As a research method, document analysis provides a structured and cost-effective approach to reviewing and evaluating textual materials. It is a non-intrusive technique for data collection and is considered essential for conducting policy research, where excluding document-based evidence would be nearly impossible. Gupta believes that in performing qualitative studies, one can use some of the previous data such as documents (types of research, instructions, and governmental circulars such as official documents, programs, issued policies, and periodic reports) or other textual data (9). At the same time, Krippendorff suggests that textual materials — such as government guidelines, directives, official records, policies, and periodic reports — can be examined through a hermeneutic lens using a five-step process. This process involves gaining access to the documents and data, verifying their authenticity, thoroughly understanding their content, analyzing the information they contain, and ultimately applying the insights gained by identifying key themes (5, 10, 11).

Since national documents, laws, and legislations serve as primary sources for policymaking, their content reflects a country's key perspectives and strategic approaches in various areas. To address the current research question and identify the major challenges in procuring health care services and pharmaceuticals within Iran's health sector, this study employed qualitative document analysis as its research method (12).

2.2. Identification of Documents

To identify related documents, the study objectives were reviewed with professors and through consultation and guidance with knowledgeable and expert individuals. Related documents and reports were searched. To collect data, we first searched the above websites electronically using related keywords and phrases such as "health", "treatment", "interaction", "communication", "damage", "document handling", "deductible", "insurance premium", "entitlement", "patient introduction", "electronic prescription", "electronic", "contract", "service package", "service coverage", "financial resources" and "monitoring and evaluation".

2.3. Document Extraction and Evaluation

According to the findings from the previous step related to document identification, documents were extracted and evaluated. Initially, all related documents and laws concerning health and insurance were considered. In the next step, data and documents related to the research topic were identified, then extracted and evaluated. The documents included in the study were the highest laws and regulations in the country, as well as government approvals enforced by supplementary insurance companies.

First, by searching domestic websites such as supplementary insurance companies' documentation websites, the website of the Secretariat of the Supreme Insurance Council, the electronic portal of the Ministry of Health and Medical Education, and other relevant organizations and existing policy documents, and also by directly referring the researcher to the institution, the relevant deputy/organization collected the documents according to the data extraction table. In this regard, a total of 10 documents out of 25 were included in the study in nine main categories consisting of national plans, laws, regulations, policies, and legislations (Table 1).

Table 1. Documents Included in the Study

Documents	Number of Related Clauses
Law of the 6th five-year development plan	6
Cabinet approvals	2
Budget law 1402	5
Regulation no. 99; medical insurance regulations	3
Permanent decrees of the country's development programs	3
General "health" policies communicated by the leadership	3
Rules of regulations related to joint insurance	1
Annexation law, the law regulating part of the financial regulations of the government	1
Technical standards for determining insurance rates	2
The law on the establishment of Iran's central insurance and insurance	1

2.4. Inclusion Criteria

The inclusion criteria encompassed documents that mandated supplementary insurance policies for treatment. Documents published in the Persian language were reviewed regardless of the time limit. The lack of thematic connection of the documents with the research topic was identified as the sole criterion for exclusion from the study.

2.5. Data Collection Tool

To ensure a systematic approach and avoid overlooking important information, the research team developed a document collection and analysis form for the preliminary review of available records and documents. This form included fields such as the document title, source of retrieval, clause or article number, and the relevant legal topic. Its content validity was verified by five faculty members and subject matter experts with relevant research experience.

2.6. Validation and Reliability

A four-step Scott method was employed for data collection to evaluate the authenticity, credibility, representativeness, and meaningfulness of the documents (13). In the first step, authenticity was ensured by examining the source of each document—only those issued or approved by authoritative bodies such as the Parliament, the government, the Supreme Insurance Council, and insurance organizations were considered valid. The second step involved assessing credibility, where only documents that were accurate, unbiased, and free from errors or conflicts of interest (either personal or institutional) were accepted. Representativeness, the third criterion, ensured that the selected documents reflected broad policy directions or included specific keywords aligned with the research objectives. In the final step, the meaningfulness of each document was evaluated by verifying that its content was clear, comprehensive, and exhibited both face and content validity—meaning its format and presentation also conveyed reliability. Documents that successfully met all four of Scott's criteria were then subjected to qualitative content analysis, both explicitly and implicitly, using inductive and deductive approaches on a word-by-word basis. Any document failing to meet even one of the four criteria was excluded from the analysis (14).

2.7. Data Analysis

The conceptual framework method was used to analyze the interviews. Ritchie and Spencer (1994) stated that the analysis of qualitative data is necessary for revealing the subject, and tasks such as definition, classification, argumentation, description, review, and copying are the basic tasks of the analyst. The conceptual framework is a very useful method to perform these roles (15). At this stage, to determine the presence of certain words and concepts in the obtained text, document analysis was conducted, and content analysis was used to check their occurrence,

repetition, and connections, and to infer facts. Qualitative content analysis is a technique that systematically analyzes texts. This approach is carried out with the goals of data reduction, data organization, and facilitating theory development. In content analysis, the purpose is to classify the information obtained from the transcripts of the interviews in the form of themes, sub-themes, and issues (16).

2.8. Ethical Consideration

In terms of ethical considerations, it is important to emphasize that the analysis of all documents was conducted without referencing the names of any Iranian politicians, policymakers, or executive officials. The study focused solely on the content of the documents for qualitative analysis, ensuring that no conflicts of interest were present within the research team.

3. Results

In this research, during the first stage, 25 documents were identified and extracted. After the final evaluation and based on the relevance of the documents to the research subject, 10 documents were analyzed and examined. The steps of the screening process and search results are presented in Figure 1, and the specifications of the documents included in the study are presented in Table 1. According to the information in Table 1, it was found that the most legal clauses related to the research subject were from the 6th five-year development plan law (6 clauses and articles) and the budget law of 1402 (5 clauses and articles).

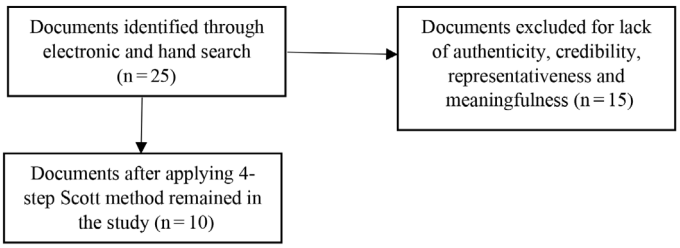


Figure 1. The process of documents acquisition

After identifying the documents related to the subject, the legal requirements and duties related to supplementary insurance interactions in Iran were extracted from the identified legal clauses and provisions. The results indicated that the most related laws and clauses were associated with document processing issues (4 laws and 5 clauses) and document processing by commercial insurance companies (4 laws and 4 clauses). Additionally, regarding the review of the interactions of commercial insurance companies, two laws and clauses were identified for introduction and eligibility assessment of patients, one law and clauses for contracts, three laws and four clauses for electronic versions, three laws and four clauses for insurance premiums, two laws and clauses for financing, two laws and clauses for competition, one law and two clauses for franchise, and one law and four clauses for miscellaneous damage.

After analyzing the content and classifying the obtained information into main themes, sub-themes, and codes, documents and reference rules were identified and extracted into 8 main themes. Relevant information is presented in Table 2. We summarized the findings into 8 main themes: Interaction between supplementary insurances and service providers, handling documents, electronic process, contract with service providers, package and coverage of services, insurance premiums, financial resources, and monitoring and evaluation. These were further categorized into 14 sub-themes: Coordination and unity, rules and guidelines, miscellaneous damages, entitlement assessment, electronic prescription, contract, service package, sources of insurance premiums, criteria for determining premium rates for group therapy, criteria for determining premium rates for family therapy, attracting capital, creating competition, financial resources, and supervision.

Table 2. Information Classification of Requirements and Legal Duties Related to Supplementary Insurance Interactions in Iran

Main Theme and Content of the Sub-theme	Codes
Interaction between supplementary insurances and service providers	
Enhanced coordination and unity	Unification of procedures among health insurance funds; coordination and coherence in the implementation of the approvals of the Supreme Council of Health Insurance of the country; unity of procedure between service providers and service buyers
Streamlined document handling	

Rules and instructions	Integration of rules and guidelines; failure to issue instructions or directives outside of the above laws and documents; creating paper instructions in the event of an emergency
Miscellaneous damage	Not paying more than the set tariff for diagnostic, health and treatment services; payment of damages within 15 working days; deducting the deductible of at least 30% in case of not using the basic insurer's medical insurance; payment of medical examinations and other diagnostic measures performed by a trusted doctor by the insurance company; payment of fees according to rules and regulations; paying for patients sent abroad
Digital transformation	
Entitlement	Requirement to use Iran Health Insurance Organization's entitlement assessment
Electronic version	Using independent and dedicated electronic systems to purchase health services; creating a patient and doctor electronic file portal; creating an online information base for the insured people of the country's treatment; insurance monitoring and electronic guidance system (Senhab) for central insurance
Contract with service centers	
Contract	Prohibition of entering into contracts with centers that receive tariffs in excess of the set tariff.
Comprehensive service package and coverage	
Service package	Service coverage outside the basic health insurance obligation; providing services beyond basic insurance within the framework of legal and transparent guidelines; implementation of the service package developed by the Ministry of Health, Treatment and Medical Education; compliance with the policy and policies of the Ministry of Health, Treatment and Medical Education; strategic purchase of services; delegating business affairs in compliance with Article (13) of the law on state service management and leveling of services; paying the package tariff for nursing services and care; obligation of additional coverages; covering possible accidents and diseases for all foreign nationals residing in the country
Insurance premium	
Sources of insurance premiums	Appropriation of 10% of premiums paid by a third party; obtaining the insurance fee based on the conditions stated in the insurance policy
Criteria for determining premium rates for group therapy	Risks covered; the amount of commitments; number of insured persons; geographical distribution of the insured; average age of the insured; tariff for diagnostic and treatment services in the concentration area of the insured; the records and behaviors of the insured and the insured; type of policyholder activity
Criteria for determining premium rates for family therapy	Age category; health status; insurance history; occupation and type of activity; risks covered; the amount of commitments; tariff for diagnostic and treatment services in the concentration area of the insured
Robust Financial Management	
Fundraising	Cooperation of foreign insurance companies with commercial insurance companies; attracting foreign capital; maintaining the health of the insurance market
Create competition	Strengthening the competitive market for the provision of health insurance services; preventing insidious and unhealthy competition; regulation of agency and insurance brokerage affairs
Financing	Providing sustainable financial resources for the health sector; quantitative and qualitative development of health insurance
Monitoring and evaluation	
Supervision	Guiding and supervising insurance institutions; supervising trust insurance affairs

3.1. Interaction between Supplementary Insurances and Service Providers

Enhanced coordination and unity were identified as a sub-theme. Due to the number of insurance funds, upstream laws and documents have required the provision of the necessary infrastructure to create unity in the implementation of insurance policies, ensuring that com-

panies and insurance funds avoid dealing with service providers and the insured.

3.2. Streamlined Document Handling

Rules and instructions and miscellaneous damages were two sub-themes identified after examining the documents. Compilation of rules and guidelines for the implementation of health system policies were identified as legal duties of supplementary insurance companies. Additionally, the rules of the general policies for paying miscellaneous damages to the insured have been mentioned.

3.3. Digital Transformation

In line with this theme, two sub-themes of entitlement measurement and electronic version were identified. Considering that the provision of electronic infrastructure in health system of Iran has been proposed and made mandatory, laws have established online entitlement assessment and electronic health records for supplementary insurance companies.

3.4. Contract with Service Centers

The contract of supplementary insurance companies with service providers does not have any special prohibition in upstream laws. Only centers that receive tariffs in excess of the annual approval of the tariff are prohibited from contracting.

3.5. Comprehensive Service Package and Coverage

In Iran, there are three types of compulsory insurance that cover people and include a package of necessary medical services. However, there are some services in excess of the mandatory insurance package, which are required to be covered according to the rules of supplementary insurance.

3.6. Insurance Premium

Determining the amount of insurance premium for additional treatment insurance coverage includes several important criteria, which are presented in detail in Table 2. Additionally, 10% of the third-party car insurance premium is allocated to the Ministry of Health, Treatment, and Medical Education for covering the treatment costs of individuals affected by accidents and incidents.

3.7. Robust Financial Management

One of the most important legal tasks of supplementary insurance companies is establishing and creating financial resources. These legal requirements are categorized into three sub-themes: Capital attraction, creating competition, and providing financial resources. Their micro-codes are presented in Table 2.

3.8. Monitoring and Evaluation

Guidance and supervision of insurance institutions, as well as oversight of insurance affairs, were among the most important legal requirements identified under the main theme of supervision and evaluation.

4. Discussion

There are many supplementary insurance companies operating in Iran that provide medical insurance coverage for people. Various requirements and rules govern the interaction and communication of supplementary insurance companies with health service providers and insured persons. Hence, the present study was conducted to investigate the role and duties of supplementary medical insurance companies in health system of Iran.

4.1. Coordination and Unity of Action

Coordination and unity of action were identified as one of the most important legal requirements for the interactions of supplementary insurance companies. The lack of unanimity in dealing with documents can lead to each company treating service providers and insured centers according to their own preferences and policies. This is clearly emphasized in the law of the sixth five-year development plan and the approval letter of the government board.

4.2. Dealing with Documents

Dealing with documents was another finding of this research. In Iran, the tariff for health care and services is reviewed annually, or policies and service packages may be compiled and notified periodically. In this regard, the existence of criteria and guidelines for handling documents in line with the notified policies is mandatory and necessary. Supplementary insurance companies must have the implementation criteria of the notified policies. This is stated in the law of the sixth five-year development plan, the approvals of the government council, the annual budget law, and regulation no. 99, which emphasize the regulation of medical insurance (8).

4.3. Electronic Processes

Moving towards electronic processes was identified as a legal requirement for supplementary insurance companies. In many supplementary insurance companies, entitlement assessment and patient introduction are still done offline and non-electronically, causing many problems and challenges for insured people. Therefore, the legal requirements extracted in the budget law, the law of the 6th five-year development plan, and the regulation of rules related to joint insurance emphasize that supplementary insurance companies provide all electronic infrastructures. Providing infrastructure and electronic platforms has also been emphasized in various studies (17-21).

4.4. Contract with Service Centers and Service Package Coverage

The contract with service centers and service package coverage were among the other findings of this study for which the laws have provided requirements and assignments. Requiring centers to have the necessary conditions and covering the package of services in addition to the package of compulsory insurance services were among the most important issues addressed by the law. In fact, the coverage of the package of services in addition to the medical services of compulsory insurance in Iran has not yet happened in many services, and it is necessary to review and discuss (2).

Results of studies showed that the supplementary insurance coverage package does not have the necessary efficiency and effectiveness, and in most cases, it does not incentivize people to buy insurance. Therefore, it is suggested to review and upgrade the supplementary insurance package, increase people's access, cover excess and out-of-package services of other funds, and respond to the needs of customers based on the needs of the insured. The diversity and increase in the quality of the service package will lead to increased satisfaction and motivation for people to buy supplementary insurance (21-24).

The insurance premium was identified as another important item mentioned in the text of the law. To avoid minimum moral risks, reverse selection, and other related issues by supplementary insurance companies, upstream laws and documents, including the technical standards for determining insurance rates and the annexation law for the regulation of part of the government's financial regulations, have outlined some of the most important cases and criteria for determining insurance premium rates. This helps ensure that a fair insurance premium is determined and received.

The results of various studies in this field have shown that the disproportion between the insurance premium rate and the risk of the disease, the lack of transparency in the factors affecting the increase in the insurance premium rate, and incomplete and ineffective strategies in financing are among the challenges and problems faced by supplementary insurances and insurance companies. It is necessary to develop and design strategies to eliminate or reduce these challenges (20, 23, 25, 26).

Attention to the dimensions of monitoring and evaluation, as well as the determination of financial resources, were among the other findings of the study mentioned by the laws. To ensure the sustainability of supplementary insurance companies, the laws have allowed for the attraction of capital and the creation of healthy competition to provide financial resources.

4.5. Conclusions

The results of the study indicated that supplementary insurance companies in Iran are highly diverse. Given the number of supplementary insurance companies, there are numerous laws and policies in this field that necessitate the creation of a unified structure to provide the infrastructure and executive regulations for supplementary insurance companies. Therefore, based on the research findings, it is suggested that guidelines and rules for handling supplementary insurance documents be developed to effectively implement the upstream policies and laws.

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