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Stakeholders Analysis of Health Insurance Benefit Package Policy in Iran

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Abstract

Background: Formulation of cost efficiency of health insurance benefit package requires an evidence-based policy making, with efficient management of stakeholders, therefore, identifying the stakeholders and considering their characteristics and interests and also the position and power of the main actors involved in policies seems to be necessary. For this purpose, this study aimed at analyzing the stakeholders of health insurance benefit package in Iran to specify their position in the assessed policy.
Methods: This was done on a qualitative basis during years 2015 and 2016. Data was collected from semi-structured interviews, document analysis, and participation in decision-making meetings of the Supreme Council of Health Insurance, to identify the stakeholders, and their power, situation, interests, opportunities, and challenges. The data was analyzed with the content analysis approach using the MAXQDA software.
Results: Overall, 23 stakeholders were identified and categorized in 6 groups, including policy makers, service providers, payers, suppliers of medicines and equipment, service recipients, and others. Sixteen stakeholders were at the national level, 3 stakeholders of regional, and 4 stakeholders of local level, however most stakeholders were owned by the public sector. Furthermore, 78% of stakeholders supported the policies of health insurance benefit package, and 48% had moderate power. Stakeholders had different interests and various opportunities and challenges to health insurance benefit package.
Conclusions: The findings show that multiple stakeholders directly and indirectly affect the formulation and implementation of HIBP policies. Meanwhile, the members of supreme council of health insurance, legally being authorized to apply for entry of service and drug into the HIBP, have the most important role in decision making related to HIBP. Establishment of a systematic approach, considering the role of all stakeholders and alignment of their interests leads to a positive outcome of the stakeholders' power and finally effective formulation and implementation of policies, and facilitates the ultimate goal of this policy, which promotes public health.

Keywords: Stakeholder Analysis, Health Benefit Package, Health Insurance, Health System of Iran

1. Background

In the health surveillance systems with public financing, optimal resources allocation based on health requirements of the society reflects relative priorities associated with the choice among interventions. These priorities may be known and official or not so clear and specified, and depend on the procedure of policy-making and prioritization of health services (1, 2). Due to various reasons, such as demographic and epidemiological changes, increased awareness, education and training, new technologies, increasing of family income and consequently high demand for health services and inability of countries to increase health resources with the same speed, no country could provide all health costs. Therefore, these choices and decisions about the inclusion of services and drugs in the health insurance package and financing thereof, is inevitable and unavoidable (3).

One of the main problems in developing countries is the lack of proportion between allocation and distribution of resources (resources expended) with the burden of diseases and health problems (4, 5). The resources supply pro-

cess in these countries doesn't show any appropriate trend and public budgets have not been increased significantly compared to the trend of cost changes. For this reason, most countries are trying to use new policy making tools for efficient prioritization of health services, in addition to continuous use of traditional approaches to set priorities (such as waiting lists, etc.) and formulation of a health insurance benefit package (HIBP) (6, 7).

The HIBP was non-integrated and different in health insurance organizations in Iran up to year 2008. This package was systematically compiled and documented for the first time in 2008. The HIBP was designed by health insurance supreme council of the islamic republic of Iran, as stewards of health insurance policies formulation in the country. The greatest coverage of health services by organizations was applied as a basis for formulation of the health insurance benefit package. This package includes services approved in 1984 and services approved in the next years by a committee categorized in 9 service groups. This procedure is not an evidence-based process, and prioritization doesn't actually exist. In fact, services were generally announced and prioritization was made based on the ability of payment of health insurance organizations, and typically was a defined contribution approach (8-10).

Since that time, decision-making for inclusion of service/drug in the HIBP begins upon request of authorized legal and real entities. These requests are considered during meetings and negotiations made by the experts. To implement this process, stakeholders of HIBP policies are involved directly and indirectly, which could affect the depth and content of the package very significantly, so that the efficiency cost of its composition may be affected. Policy-makers, developers, performers, supporters, and opponents, as policy-making actors, each have their own values, interests, and views and they determine the outcome of the policy by their actions. These actors may be an individual, an organization, a group, a scientific association or a social institute. For this purpose, the position of main actors involved in the policy to the policy, their strength compared to other actors and such issues are ought to be analyzed (11).

Whereas formulation of efficient cost of HIBP requires evidence-based policy making with proper management of stakeholders in the public and private sectors, identification of stakeholders and their characteristics and interests is necessary to achieve its goals. Stakeholder analysis is used as an important tool for establishment of programs and executive instructions to increase the protection of political reforms and agreement and participation in political reforms (12). This study aimed at analyzing the HIBP stakeholders based on the opinions of policy makers, experts, and executors of rules related to health insurance package and relative subjects, upon making qualitative interviews and also analysis of upstream documents and rules in order to determine their position to the reviewing policy.

2. Methods

The present paper was an applied study that was conducted qualitatively during years 2015 and 2016. In this study, the multi-triangulation approach was used as a strategy to ensure full investigation and confirmation of the findings. At first, the aspects of analysis of HIBP stakeholders and their definition was specified based on the stockholder analysis framework in policy maker software and research objectives (Table 1) (13). Later, the study was implemented as follows:

2.1. Data Collection

Data was collected from 06/22/2015 to 03/05/2016. This data was collected through in-depth interviews with 25 experts in the field of health insurance and economics, analysis of relative upstream documents, and rules and observation (attending meetings of supreme council of health insurance secretary). Experts participating in interviews in 2 executive and academic areas consisted of senior managers involved in ministry of health (MOH) and ministry of cooperatives labour and social welfare (MCLSW), senior managers of health insurance organizations, and university professors, who had been selected and sampled based on reputational case sampling.

2.1.1. Document Analysis

analyzing the content of laws, bylaws, and articles related to HIBP policies was an important reference for data collection. Access to this information was possible by reading the upstream documents available in books, reports, and related formal and governmental websites. To collect and categorize the rules, in addition to using qualitative analysis MAXQDA software, the informational worksheet of documents (including position (title), type of document, date of document, author (creator), and targeted audience, and text of document) was prepared and data summarization was conducted by the research team. During review and analysis of documents as the first step of executive process of research, 15 policies and rules related to the HIBP were analyzed and examined to identify the stakeholders.

Table 1. Schemer's Definition and Ratings of Domains in Stakeholder Analysis[a]

Aspect	Definition and Rating
Identifying Player	This table identifies all the players that might be affected by or might affect policy, and assesses their power and their position on the policy. This table includes information on who is for and who is against policy, and who has yet to take a position.
Level	Identify the level of the player. The selection is between national, regional, and local options.
Sector	A sector which the player belongs, consist of government, international, media, local non-government, political, private, social, religious, professional …
Position	Two questions are considered to determine the actors position:
	How strong is the player's commitment to the policy?
	What percentages of the player's total resources have been committed to working on this policy?
	The players support, oppose or have no position on the questions.
Power	Four questions were considered to determine power of actors:
	Does the player have substantial financial resources that could be used to influence the policy?
	Does the player have significant organizational resources that could be used to influence the policy?
	Does the player have significant symbolic resources that could be used to influence the policy?
	Does the player have easy and direct access to the decision making on the policy?
	The players power is categorized to low, medium and high.
Interest	The Interests table explains why a player has taken a particular position. This analysis is important because it helps explain the motives behind the positions taken.
	The Interests table involves three qualitative assessments about the players:
	Type of Interest: What does the player seek to gain from its position on the policy? (Financial, ideological, organizational, humanitarian, self-interest, political, and religious)
	Priority of Interest: How important (high, medium, or low) is this interest for the player? The level of priority could be expressed in various ways: the degree of involvement of leaders, the level of resources committed for promoting the player's position, or explicit statements about the priority (interviews or documents).
	Interest (Description): Describes briefly the player's interest. What do you think motivates the player to take a particular position? This assessment of "motives" may rely on ambiguous data and could be subjective. This field could be used to explain the evidence needed to reach a conclusion about the motives for a player. Both the selected types of interest and the priority of each interest could be explained.
Opportunity	Provide a brief description of the opportunity. For example, the opportunity may involve a change in leadership, or a new source of financial support, or a loss of high-level political support. Also, in this box, briefly describe an action that could take advantage of the opportunity, to influence the policymaking process and create support for policy.
Obstacle	Provide a brief description of the obstacle. Also, in the box, briefly describe an action that could overcome this obstacle, to influence the policymaking process and enhance the feasibility of your policy.

[a] Source: Policy Maker 4 Software/ Buse, Kent, Nicholas Mays, and Gillian Walt. Making health policy. McGraw-Hill Education (UK), 2012.

2.1.2. Interview

semi-structured interviews, assumed as the most important collection instrument, were used in this study. Interviews were saturated with 25 participants. The data required for this step was collected using an interview guide. The guide questions were as follows: who are evident and hidden actors involved in formulation of HIBP policies? What is their role? How much is the power of each one? What are their interests? What is the position of stakeholder groups? Who are involved in formulation of country's fifth development Act and the general leadership policies (referred to HIBP policy)? Who is the winner and who is the loser in this policy? And who participated in these counseling meetings?

2.1.3. Observation

Researchers participated in the meetings of the supreme council of health insurance with the subject of health benefit package, and were directly informed of decision-making process and the relationship between stakeholders and propounded topics. Interview and observation data was recorded through recording the conversations.

2.2. Data Analysis

2.2.1. Analysis of Interviews and Documents

To analyze the documents and interviews, which were analyzed as text, qualitative content analysis was used. The objective was to investigate the contents of the text. Cat-

egorization system was the main tool for content analysis. Every unit was encoded in the analysis and categorized in one or several categories. Each category was extracted clearly, completely, and properly. In order to perform this analysis, the Maxqda software was used at first and the texts were classified and analyzed preliminarily and general themes were identified. Later, the researchers analyzed interview transcripts and documents again, manually, by studying and analyzing the output codes of the software. Two individuals independently examined the extracted themes to increase the reliability of the conducted analysis.

Scott's four-step method was used to assess the validity and reliability of documents.

2.2.2. Analysis of Observations

Observations of the study are the result of participation of the researcher team in meetings of the supreme council of health that were analyzed in a thematic manner. Finally, the data was extracted from analysis and summarized in tables and the stakeholder map.

3. Results

The aim of the policies related to HIBP in the country includes financial protection and public access to health services in order to reduce the burden of disease and increase life expectancy. The HIBP coverage along with population coverage and cost coverage by health insurance organizations acts as public health coverage. These policies intend to promote community health using mechanisms, such as fair contribution, access and justice in payment, optimal use of resources, and effectiveness in rendering health system services.

Upon qualitative analysis of documents and conducting interviews, altogether 23 stakeholders were identified, who were categorized to 6 groups including policy makers, service providers, payers, suppliers of medicines and equipment, service recipients, and others.

Sixteen stakeholders had national level, 3 stakeholders regional level and 4 stakeholders had local level, and most of them (12 stakeholders) were owned by the public sector. Overall, 78% of stakeholders protected the HIBP policies, and 48% of them had moderate power (Table 2). The findings show that MOH and the food and drug organization (FDO) had the highest direct impact on the policies of HIBP with the most support and power. High support position and high power of specialized medical associations also demonstrate the deep influence of physicians on this subject.

The findings show that most interests of the stakeholders (30%) were related to financial matters and the lowest were related to religious issues.

The interest of MOH as the steward of health systems is achieving better response and accessibility to health services, whilst MCLSW takes the balance of resources and expenditures into consideration. Interest of Medical council, specialized associations and materials and equipment supplier companies, is increasing the volume of health services. Other policy-making institutions, such as the health commission parliament of Islamic republic of Iran (HCPI), Supreme council of health insurance and management planning organization (MPO), consider all aspects related to available upstream resources and the viewpoints of stakeholders. The importance of HIBP for leader of midday congregational Friday prayers, mayors, and governors is majorly public consent and non-objection to the government and regime policies (Table 3).

Identification of opportunities and challenges of stakeholders was another factor that was considered for identification and analysis of HIBP stakeholders. The findings indicate that health insurance organizations, board of medical specialties, suppliers of medicines and equipment and the Islamic republic of Iran Medical council, have the greatest opportunities to apply the direct and indirect effects on the HIBP policies (Table 4).

This section provides the findings obtained from content analysis of the interviews. In addition to analysis of stakeholders' table, interests, opportunities and challenges of stakeholders, the researchers identified 2 themes including "characteristics of stakeholders" and "interaction and conflict of interests", 4 categories, including "Influence", "power", "conflict of interests" and "stakeholder interactions", and 44 sub-categories in qualitative content analysis of the interviews (Table 5).

4. Discussion

The findings show that multiple stakeholders directly and indirectly affect the formulation and implementation of HIBP policies. Meanwhile, the members of supreme council of health insurance, legally being authorized to apply for entry of service and drug into the HIBP, have the most important role in decision-making related to HIBP.

The MOH has considerable power due to final response to the public health and legal obligations (general leadership policies). Although this Ministry is in charge of health policy making, service delivery and in some cases financing, seems to have a conflict of interest in formulation and implementation of these policies; this process is not systematic and these decisions are made majorly by consen-

Table 2. Health Insurance Benefit Package Stakeholder Characteristics

Group Name	Player Name	Level	Sector	Position	Power
Policy makers	Management planning organization (MPO)	National	Governmental	Medium support	High
	Supreme council of health insurance	National	Governmental	Medium support	High
	Iran Expediency Council	National	Political	Low support	High
	The government cabinet	National	Governmental	Low support	High
	The Islamic republic of Iran Medical council	National	Local non-governmental	High support	Medium
	Health commission parliament of Islamic republic of Iran (HCPI)	National	Political	Medium support	Medium
	MCLSW	National	Governmental	Non-mobilized	Medium
	FDO	National	Governmental	High support	High
	MOH	National	Governmental	High support	High
Providers	Physicians and other health service providers	Local	Private	High support	Medium
	Universities of Medical Sciences	Regional	Governmental	High support	Medium
	State welfare organization of Iran	National	Donor	Low support	Medium
	Board of Medical Specialties	Regional	Professional	High support	High
Recipients	Patient protection associations	National	International NGO	Medium support	Medium
	Community members	Local	Social	Non-mobilized	Low
Suppliers of medicines and equipment	Suppliers of medicines and equipment	Regional	Private	High support	Medium
Payers	Armed forces health insurance organization	National	Governmental	Non-mobilized	High
	Health insurance organization	National	Governmental	Low support	High
	Social security organization	National	Governmental	Low opposition	High
	Central insurance of I.R. Iran	National	Local Non-Governmental	Medium support	Medium
	The Imam Khomeini relief committee	National	Governmental	Non-mobilized	Medium
Other	Governors / mayors /district governors	Local	Governmental	Low support	Medium
	Leader of mid-day congregational Friday prayers	Local	Religious	Low support	Low

sus of experts, who have the greatest influence in covering a service or drug by HIBP.

Approach of health insurance organizations to HIBP is resistive and they believe that within these years, the package has been developed expansively, without being revised, which resulted in inconsistency between funding and per capita of insurance, and HIBP financing. Right of vote of 4 health insurance organizations separately in the supreme council of health insurance, has provided a considerable power to effect HIBP policies. Medical council, as a member of the supreme council of health insurance, is involved in the policy making of HIBP, yet this organization has a supporting role for health service providers at the meetings so that it seems to have missed its policy-making role.

Health service providers and suppliers are the most influential stakeholders, who indirectly effect the content and volume of HIBP. They apply pressure on insurance organizations upon creating demand in the health market and public need to the new services and drugs, to cover the services.

Interest of MOH, as a steward of health system, is providing better response and accessibility to health services, whilst MCLSW takes the balance of resources and expenditure of health insurance organizations into consideration. Whereas the interest of Medical council, specialized associations, and suppliers is to increase the volume of HIBP, the executive process of service entry and exit into/from HIBP and list of authorized persons requesting entry into the package service must be revised to minimize the con-

flict of interest in this relation.

Due to the interest of health insurance organizations and MCLSW that majorly take financial aspects in account, determination of the overall approach in macro policies, on how to finance the HIBP (Defined contribution or Defined benefit) seems to be necessary. Under a defined contribution (DC), benefit levels depend on the total contributions and investment earnings of the accumulation in the account. Defined benefit (DB) healthcare is the traditional way for health insurance; a company provides a defined healthcare benefit (14).

Reviewing the experiences of other countries shows the different composition and power of stakeholders in the design process of HIBP. The formulation process of benefit package in Germany is specified by the physicians federal committee and disease funds that is ought to define the emergency, pharmaceutical and outpatient services, and the hospital committee that is ought to define the hospital services. Selection of services is mainly conducted based on HTA reports, with each one taking an average period of 18 months. In this process, public preferences are taken into account (15).

A study from Afghanistan investigated and analyzed the stakeholders of health benefit package. The findings of this study indicated that the Ministry of finance had the most power and MOH had the lowest power in formulation of financial policies of health insurance benefit package. The position of MOH is very supportive and Ministry of finance is neutral. This study demonstrated that financial resources from international organizations have great impact on the content of the health insurance package (16).

Ibrahimipour et al. reported a study titled "A qualitative study of the difficulties in reaching sustainable universal health insurance coverage in Iran" in 2009. Based on the results of this study, determining the basic health insurance package in Iran requires a systematic and comprehensive approach to this issue and is a long-term plan (17).

The NICE is the name of a community in the UK that deals with formulation of clinical guidelines. These guidelines are formulated based on an assessment of drugs, medical services, diagnostic technologies, surgical procedures, and prevention services. This association enters the information to the guidelines, which is then used in proposals and by physicians. In this case, RHA that is responsible for health of every region in the country, finances for the services provided by physicians. The NICE, physicians, and RHA are the most effective stakeholders of the health benefit package (15). Stakeholder analysis of this study also identified physicians and specialized medical associations as the most influential groups.

Taking the public preferences into account, as the most influenced stakeholder by the health benefit package policy in the Netherlands, is an important factor in this policy-making. In the present study, the demand and needs of people indirectly and applying pressure through the patient protection community was effective on the service package (18). In this study, the population members were the most influenced group and had the lowest direct effect on the policy-making of HIBP.

Limitations and weaknesses of this study include limited access to some key experts, lack of evidence-informed policies in the field of health service package and how to develop it, there being no single definition of health service package in the scientific literature and different countries, and the difficulty of collecting evidence from different organizations because of the lack of a comprehensive system documentation.

Comprehensive analysis of stakeholders in such a way that all aspects of stakeholder analysis were included, the use of multiple sources of data gathering, documentation analysis and data analysis with manual methods and software, were the strengths of this study.

4.1. Conclusion

Briefly, in Iran, whatever the influential groups are approaching to the pyramid of power, their influence on policy formulation is increased. Therefore, HIBP policy approaches and procedure of their execution varies at different periods.

Considering the necessity of controlling entry of services and drugs into the HIBP and minimizing the conflicts of interest, it is recommended to develop a systematic process to enter services and medicines to HIBP, and to appoint authorized people with the permission to apply for entry of services into the package.

Health insurance organizations are assumed as stakeholders that due to having the information of health services use burden and public need, and could have a positive impact on the policies and decisions of HIBP, through effective interaction with the MOH.

In general, establishment of a systematic approach, considering the role of all stakeholders and alignment of their interests leads to a positive outcome of the stakeholders' power and ultimately effective formulation and implementation of policies, and facilitates the ultimate goal of this policy, which is promoting public health.

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Table 3. Interests of Health Insurance Benefit Package Stakeholders

Stakeholders	Interest	Type	Priority
MCLSW	Protection against financial risk	Financial	Medium
	Consistency between resources and expenditures of HIBP		
MOH	Expanding the health insurance benefit package	Organizational	High
	Meeting the needs and demands		
	Providing access to services for the community		
The government cabinet	Trying to make balance and lack of complaints by different groups of stakeholders	Organizational	Medium
	Respond to requests of suppliers and service providers for entrance of services/drugs in the package		
Iran expediency council	Adopted policies matching the upstream documents and rules	Political	Medium
HCPI	Approving the rules in accordance with upstream documents and public demands	Political	Medium
Governors / Mayors /District	Responding to case requests of material providers and suppliers	Political	Medium
Supreme council of health insurance	Making decisions acceptable for all stakeholders of the council	Organizational	High
The Islamic republic of Iran medical council	Extending HIBP	Self-Interest	High
	Orientation of the package toward entry of specialized services and drugs		
	Responding and applying the interests of service providers and private sector		
MPO	Balancing the resources and expenditures	Financial	High
	Formulation of relevant executive guidelines and instructions		
The Imam Khomeini relief committee	Balancing resources and expenditure	Financial	Medium
	Resisting to HIBP coverage extension		
FDO	Addition of pharmacopoeia drugs to HIBP	Organizational	High
Social security organization	Balancing resources and expenditure	Financial	High
	Resisting to HIBP coverage extension		
Health insurance organization	Balancing resources and expenditure	Financial	High
	Resisting HIBP coverage extension		
State welfare organization of Iran	Entrance of services and drugs required for vulnerable groups into the HIBP	Financial	Medium
Universities of Medical Sciences	Adding services / packages to the package as much as possible to reduce complaints of the public	Organizational	High
	Responding to the requests of the service providers about the coverage of services/drugs		
Suppliers of medicines and equipment	Expanding the coverage of services/drugs and equipment in the HIBP	Financial	High
Physicians and other health service providers	Entrance of specialized services and drugs into the HIBP	Self-Interest	Medium
Armed forces health insurance organization	Balancing resources and expenditure	Financial	Medium
	Resisting HIBP coverage extension		
Central Insurance of Iran	Extending of HIBP	Financial	High
leader of mid-day congregational Friday prayers	Lowering financial pressure and access to the health service by increasing coverage	Religious	
	Respond to the public needs	Political	Medium
	Respond to requests of providers		
Patient advocacy associations	Financing the health services and drugs for specific patients	Humanitarian	Medium
	Inattention to the services and drugs financing sources		
Board of Medical Specialties	Specializing the HIBP	Self-Interest	High
Community members	Paying less money upon receiving services	Self-Interest	Medium

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Table 4. Opportunities and Challenges of Health Insurance Benefit Package Stakeholders[a]

Stakeholders	Opportunities	Challenges
MCLSW	Management of Supreme Council of Health Insurance secretary in the MCLSW	Inattention to the resources in formulation of package; Inattention to the catastrophic costs for formulation of package; Responsibility interference due to extensive work areas, such as employment, cooperatives, etc. Lack of academic infrastructures in MCLSW
MOH	Existence of legal leverages for protection of HIBP policies organizing by MOH	Interference of the governing and procuring role and forgetting the stewardship role; Lack of unified strategic plan in the deputies of the MOH; Lack of priority
The government cabinet	The power of affecting formulation of package rules and policies; The ability of notifying the upstream policies to the downstream; Power of management on financial resources allocated for the content of service coverage	The huge volume of issues to be dealt in the Cabinet; Inattention to implementing policies related to the HIBP in the upstream rules
Iran expediency council	Developer of strategic direction and macro policies in the country; The power to decide about the policies and roles	The huge volume of issues to be dealt
HCPI	Having lever of enacting laws and regulations	Micro perspective instead of macro perspective; Political considerations due to attract votes
Governors / mayors /district governors	Having political power	Lack of direct influence on the HIBP policies; Lack of specialized power in the fields of HIBP
Supreme council of health insurance	Existence of key and affective individuals in the composition of council; Having legal leverage to reform HIBP policy making	Influenced by providers and the guild sector; Political decisions without regard to their effectiveness cost
The Islamic republic of Iran Medical council	The right to participate in meetings of the Supreme Council of Health Insurance secretary and commenting in relation to HIBP policies; Having a vote in supreme council of health insurance; The right to apply for entry of medicine and service into the HIBP	Having a guild perspective and not only a national perspective
MPO	Having political and financial power; Effectiveness on HIBP policies in the country's development plans	Political considerations in decision-making; Controlling the balance between resources and consumption of insurance organizations
The Imam Khomeini relief committee	Funding by the government; The right to participate in meetings of the Supreme Council of Health Insurance secretary and submit comments related to HIBP policies; Having a vote in supreme council of health insurance; The right to request entry of medicine and service into the HIBP	Lack of effective role due to the low population covered; Lack of academic and executive mechanisms related to health insurance
FDO	Funding by the government; The right to participate in meetings of the Supreme Council of Health Insurance secretary and commenting on HIBP policies; Having a vote in Supreme Council of Health Insurance; The right to apply for entry of medicine and service into the HIBP	Existence of pressure from manufacturing and importing companies; Pressure from the needs and public demands; Pressure from the request of service providers
Social security organization	The right to participate in meetings of the Supreme Council of Health Insurance secretary and commenting on HIBP policies; Having a vote in supreme council of health insurance; The right to apply for entry of medicine and service into the HIBP; Having specific financial resources	Establishment of organization with the purpose of social security coverage but trying to maintain the organization and forgetting the insured; Reducing illegal service obligations in the HIBP providing centers
Health insurance organization	Funding by the government The right to participate in meetings of the supreme council of health insurance secretary and commenting on HIBP policies; Having a vote in supreme council of health insurance; The right to apply for entry of medicine and service into the HIBP	Ignoring cost containment because of governmental management; Lack of application of rules and regulations permitting them to make a strategic purchase; Reducing illegal service obligations in the HIBP providing centers

State welfare organization of Iran	Having information related to the needs of vulnerable groups; Having proprietary financial resources	Lack of effective relationship between MOH and State Welfare Organization; Ignoring the third level services in the HIBP' priority
Universities of Medical Sciences	Direct subordination of universities by service providers; Having health information of under converge population; The right to apply for entry of medicine and service into the HIBP	Lower and direct influence on the HIBP policies; Applying the requirements of definite population and not the entire community
Suppliers of medicines and equipment	Having proprietary financial resources; Closeness to the pyramid of power; The dependence of service providers; Exclusivity in specialized and expensive equipment / drugs; The right to apply for entry of medicine and service into the HIBP	Lack of formal financial support from the government; Spending on marketing and attracting the provider; Risks in the supply of equipment and drugs in the health market
Physicians and other health service providers	Closeness to the pyramid of power; Having specialty power; Having high indirect impact and power on the HIBP policies; The right to apply for entry of medicine and service into the HIBP	Having specialized and not health-based perspective; Inability of direct impact on the HIBP policies
Armed forces health insurance organization	Funding by the government; The right to participate in meetings of the Supreme Council of Health Insurance secretary and commenting on HIBP policies; Having vote in supreme council of health insurance; The right to apply for entry of medicine and service into the HIBP	Lack of having a significant role in the HIBP because of having specific financial resources for complementary insurance
Central insurance of Iran	Creation of financial capacity to extend service and drug coverage; Creating mechanisms for implementation of policies related to the benefit package in the supplemental health insurance	Follow up supplementary health insurance companies' benefit rather than having the role of community members' support; Nonbinding the complementary insurance companies to implementation laws and policies related to the type of covering services; Lack of force for direct respond to MOH
Leader of mid-day congregational Friday prayers	Having political power; Having charismatic power; Having direct contact with the people and awareness of their demands and needs	Lack of direct influence on the HIBP policies; Lack of specialized power in the field of HIBP and health and drug services
Patient protection associations	The right to apply for entry of medicine and service into the HIBP; The ability to attract proprietary financial resources to respond to special patients	Creating parallel packages and island resources to cover health services; Inadequacy of financial resources for full coverage of services and drugs for special patients
Board of Medical specialties	Having specialty power; Closeness to the pyramid of power; Having managerial positions at various levels of MOH, MCLSW and health insurance organizations; The right to apply for entry of medicine and service into the HIBP	Having the guild and not inter-sectional and national perspective; Lack of applying academic methods in proposals for entry into the health services package
Community members	Having direct contact with health service providers	Lack of patient voice; Lack of applying the real needs of the society in the content of HIBP; Lack of mechanisms for applying public preference in the HIBP

[a] Stakeholder analysis based on the defined aspects in Table 2 and qualitative content analysis of the interviews.

Table 5. Themes Identified Through Qualitative Content Analysis of Interviews

Theme/Subject	Categories	Sub-Categories
Characteristics of the stakeholders	Influence	High impact and influence of clinical professors and specialized field experts on formulation of the content of HIBP; High impact of the MOH because of stewardship role; Indirect influence of drug and equipment companies through health service providers; Belonging of most demands of entry from suppliers; Effectiveness and multi-faceted pressures from suppliers on relative institutions and governmental organizations; Indirect impact on HIBP' policies, by stakeholders with the ability to directly influence due to personal interests; The impact of political elites on macro policies and laws related to HIBP; Affecting the government and insurance organizations due to expending the public resources; Creating need in the community by the provider; The impact of providers and suppliers on public demand and eventually HIBP; Public impact through creating demand in the health market; Influential stakeholder groups by approaching the pyramid of power; Introducing physicians and other health service providers as the most influential actor in the HIBP; The high effectiveness of HIBP' policies on the public
	Power	High power of the MOH in formulation of the content of HIBP policies; Low Power of MOH in the implementation of HIBP policies; Having the highest power and most prominent role in accordance with the macro health policies for formulation of a package by MOH; Responsibility of health insurance organization for formulation of the benefit package and strategic purchase in accordance with the country's fifth development plan; High power of the cabinet in notification of non-assessed policies (from up to down); Low power of people due to lack of representative and patient voice; Different behavior of insurance organizations and providers from formulated policies by policy makers; Obedience of MOH by MCLSW experts; Periodic force and power of MOH and MCLSW; Change of stakeholders' power with respect to the change of government, people and positions; Passive attitude of insurance organizations encountering the offers to enter services and medicines into the benefit package; Low option and power of insurance organizations to carry out the strategic purchase; Greater weight of insurance organizations (4 rights to vote + secretariat of the council) in the Supreme Council of Insurance
Interaction and conflict of interests	Interaction and conflict of interests	The 4-factor role of MOH in policy making, health service providing, monitoring, and financing; The role of providers in two specialized/technical aspects and role of stewardship; 2-factor role of MPO; planning and financing; Having the positions in management and responsibility of experts, and clinical professors; The impact of specialty type of officials of policy making organizations on the type of drug and service entered into HIBP; Concerns about financial resources in insurance organizations only because of being a financer; Formation of supreme council of health insurance, with the purpose of minimizing the conflict of interests
	Stakeholder interactions	Major difference between stakeholders in position and not the perspective; Requests of entering the service into the package by physicians through insurance organizations, MOH and MCLSW; Requests of entering the service into the HIBP by MPs through the insurance organizations, MOH and MCLSW; Resistance approach of insurance organizations and MCLSW in relation to HIBP expansion; Reference role of MCLSW for health insurance organizations; Applying HTA studies by insurance organizations, pharmaceutical companies, the FDO or MOH; Coverage of specific health services by MOH; Existence of stakeholders and factors effective on various fronts; Low priority of health because of different aspects and duties in the MCLSW; Unfamiliarity of public with their rights as the most influenced stakeholder