Health economics perspectives of nursing services tariff setting in Islamic Republic of Iran

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Background

In 1996, the Iranian Government set the cost of ancillary and nursing services at 6% of the hoteling tariff, and the insurer and the insured were obliged to pay it (*1,2*). The nursing community and its related trade unions followed up on this pronouncement and the "tariffs setting for nursing services and adjusting nursing fees" law of 2007 and the "improving the productivity of clinical staff in the health system" act of 2009 were approved by the Islamic Council Parliament (*3,4*). On 24 April 2022, after more than a decade and some changes, the Council of Ministers approved the law (*5*).

The budget law 1402 recommends that nursing tariffs should be included in the per capita health insurance package with a certain budget line and insurance companies are required to apply the tariff, just as other diagnostic and treatment service tariffs, in settling invoices sent by diagnostic and treatment centres and hospitals. This action serves as a permanent and sustainable means of providing resources and supporting implementation of the tariff-setting act (*6*).

Most countries base their wage systems on the prevailing conditions in their countries instead of instituting separate payment systems for nurses (*7*). Although nurses make significant contribution to care, there is no valid method for determining the actual costs of their services (*8*), because of the differences between the functions of the nursing units and the other income-generating units (*9*). There is no evidence that nursing services are reimbursed purely through the fee for service method in any country's health systems except in the United States, where a study reported that fee for service was used for nursing services by some service providers that are not covered by the Federal Payment Legislation Act in Wisconsin (*10*). In some health systems, reimbursement is implemented in the form of bonuses, to increase motivation among nurses to provide quality care (*11*).

The Council of Ministers of the Islamic Republic of Iran approved the relative value of nursing services and care, and ultimately its impact on insurance bills, hospitals and patients became visible (*5*). The monetary coefficient of the nursing care package for all service delivery sectors (public, public non-government, private, and charitable) was estimated to be the equivalent of the monetary coefficient for the professional component of other licensed experts (such as nutritionist, midwife, audiometrist, and other similar experts) in the public sector (equivalent to 201 000 Iranian Rials, ≈US$ 5, based on government-subsidized exchange rate in 2021).

Departments in the Ministry of Health, including management development and resources, nursing and treatment, with the participation of the nursing trade union and the country's emergency institution, are obliged to ensure a balance between the number of nurses working in emergency and those in the hospitals. The basic insurance package was estimated at 90% for inpatient and emergency medical hospitalization (emergency) and 70% for emergency medical outpatient and outpatient wards. To make the nursing services tariff operational, an item entitled "nursing services and care package" was added on the billing form and approved by the Council of ministers, and calculation of the amount is based on the notification tariff (*5*). Budgets are allocated to the medical universities, hospitals and health centres through the insurance companies and payments to nurses are made by the centres.

Challenges with the tariffs on nursing services from the health economics perspective

Increase in out-of-pocket payments

Based on the law, 10% nursing tariff, like other tariffs, should be paid on inpatient wards by the population in the form of co-insurance (*6*). On the other hand, basic health insurance companies do not cover the nursing tariff for starred codes (payments not included in the basic benefit package), and patients accessing these services must pay the full amount of the nursing tariff. Therefore, patients pay more than they were paying before implementation of the plan, which is contrary to the goal of reducing out-of-pocket payments in the Iranian health system.

Patients using the private and military hospitals, who do not have contracts with basic insurance companies

will bear the cost of nursing service fees, in addition to the other healthcare costs. For example, based on the nursing tariff 1402, an average of 562 800 Iranian Rials (≈US$ 13.5 based on government-subsidized exchange rate in 2021) for nursing services is recorded in the patient's bill per case (if we consider the average hospital rate to be 3.5 days), and it is paid by the patient.

After about a year of implementation, some centres do not have the software capability to register nursing services for payments by insurance companies, therefore, patients are forced to pay.

In 1996, the cost of ancillary and nursing services was set at 6% of the hoteling tariff (2). However, with the implementation of the nursing tariff law, responsibility for payment of this cost item, which is included in patient bills, has not been determined. This double calculation will likely increase out-of-pocket payments.

Inequality in payments to nurses

The codes being used in the outpatient department can be interpreted, and for similar cases different codes may be used. Based on the existing regulation, coding was not done for some nursing services such as injections or routine services provided by departments such as the echocardiography in the heart wards. This may cause inequality in payments to nurses serving in different centres or an undervaluation of nursing services.

Payment for many surgical procedures are made in the form of global tariff or payment. However, the global payment system (12) does not specify the micro-tariff for services such as nursing services, and as a result, services provided by nurses are not specified, therefore, there may be no payments for nursing services in the inpatient department, or payments may be based on the opinion of health centre managers, which may be unfair.

The monetary coefficient approved for the public, charitable, non-government public, and private sectors is considered the same (5). However, for other medical services, the tariffs are different for the different sectors. Therefore, using the same payment for nursing services will cause inequality in payment to nurses because of the differences in structure, administration, costing, etc.

Oral evidence from nurses in some of the hospitals shows that the manner, amount and time of payment for nursing tariffs to nurses is influenced by the centre, therefore, there may be inequality in payments among hospitals or healthcare centres.

Also, some small outpatient centres are not aware of the implementation of the nursing services tariff, leading to income inequality for nurses at the different centres.

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