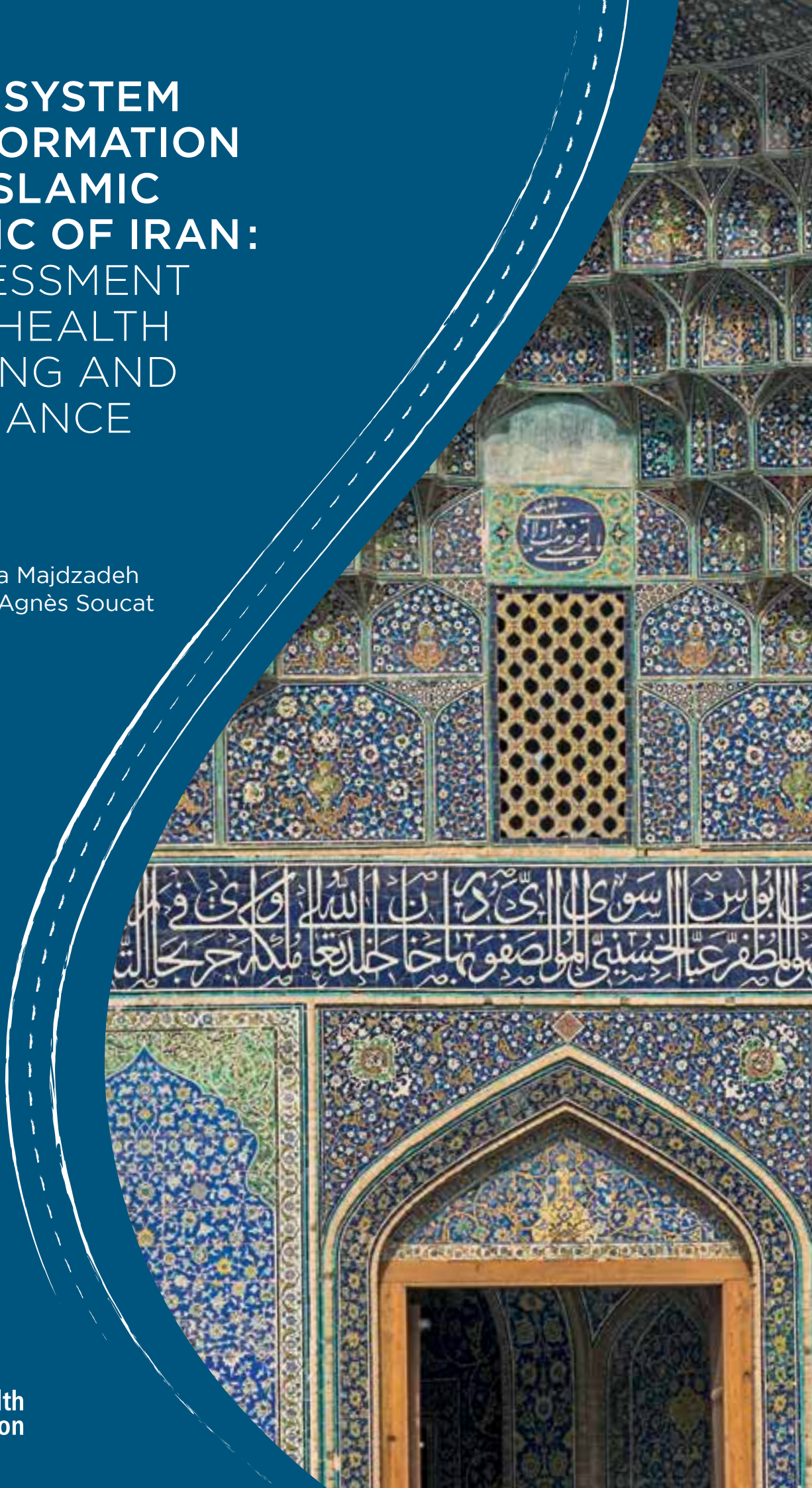
HEALTH SYSTEM TRANSFORMATION IN THE ISLAMIC REPUBLIC OF IRAN: AN ASSESSMENT OF KEY HEALTH FINANCING AND GOVERNANCE ISSUES

Edited by:
Justine Hsu, Reza Majdzadeh
Iraj Harirchi and Agnès Soucat



World Health Organization

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CONTENTS

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EXECUTIVE SUMMARY

FROM PRIMARY HEALTH CARE TO UNIVERSAL HEALTH COVERAGE: THE ROAD TO TRANSFORMATION

The health system of the Islamic Republic of Iran is in transition. The country has long been recognized for its innovative approaches to primary health care. Over the past four decades, the country's pro-poor and community-based orientation has extended access of its population to primary health care services, especially in rural areas. This has contributed significantly to improvements in maternal and child health. In the 21st century, the emerging challenges for the country are increasing urbanization, changing lifestyles and an evolving epidemiological burden. The health sector is developing rapidly with more public resources as well as a growing private sector. The expectations of the population are increasing with demands for more health services, more choice and better quality of care.

The health financing landscape of the Islamic Republic of Iran is evolving. Total current health expenditure has been increasing, representing 8.1% of gross domestic product in 2016. Moreover, since 2010, general government health expenditure has also been steadily increasing, such that its share of total expenditure has risen from 32.4% in 2010 to 54.5% in 2016. Such public investment has reversed earlier trends of rising private expenditure, much of which was out-of-pocket (OOP). While the country's investments in its health system are laudable, there is concern about the stability and sustainability of public financing. The current fiscal environment includes high inflation and limited ability to further expand the fiscal space for health, and the macro-economic outlook remains uncertain in view of the recent re-imposition of sanctions that affect the main sources of revenue for the country.

Health is a declared priority for the country's development, and President Rouhani has committed to ensuring every Iranian citizen has access to health care through his signature reform known as the Health Transformation Plan (HTP). The HTP was launched in 2014, with an additional US$ 3 billion mobilized in the first year of its implementation. Increased public financing in the health system has made possible important achievements, including the extension of insurance coverage, modernization of infrastructure and better compensation of health workers.

The Islamic Republic of Iran has extended health insurance coverage to a nearly universal level, with an estimated 95% of the population covered by a public health insurance scheme in 2017. This achievement is a direct result of a significant investment made in 2014 to the HTP, which covered an additional 6.5 million previously uninsured Iranians in the first year to reach 8 million by 2017. The achievement is also due to having extended coverage to the rural population through an insurance scheme established in 2005. The characteristics of the remaining uninsured population appear to have shifted from the rural poor to the urban poor and the near poor, reflecting both the success of the rural health service programmes and changes in Iranian society with greater urbanization, the emergence of urban poverty and an informal labour market.

Financial protection against catastrophic and impoverishing health expenditures has generally remained stable. During the period 2007–2015, total OOP payments for health remained stable in real terms; where there were slight increases, these were mostly observed in richer households. As service utilization rates increased during the same period, this suggests that the population is receiving more health services for approximately the same level of OOP payments. OOP spending on inpatient services decreased by an average of 40 439 rials per person per year during the period, indicating greater access to such care. Subsidies for medicines introduced in 2011 and 2013 also appear to have stemmed any further increase in payments for such items. Indicators of financial protection have also remained fairly stable. The national incidence rate of catastrophic health expenditures[1] was estimated to be 3.9% in 2015, with the rate stable for the poor and with increases mainly due to spending by the rich during the period 2007–2015. The percentage of the population impoverished[2] due to OOP payments was estimated at 1.4% in 2015, with an average annual percentage point decrease of –0.04 during the period 2007–2015.

Institutional reform will have to keep pace with the momentum of political commitment and increased public financing. Greater capacity to engage in strategic purchasing of health services is needed and would result in significant efficiency gains for the Iranian health system. This is particularly critical as the country's generous benefit package and the recent extension of coverage to near universal levels have raised concern about the sustainability of financing the system. Potential efficiency gains could also be made by greater pooling of resources across health insurance funds to increase their financial leverage. In addition, in view of the growing role of the private sector in financing and delivering health services, greater engagement, coordination and regulation will be important. Finally, development and strengthening of dialogue involving all stakeholders will foster consensus about necessary trade-offs in health investments.

The Islamic Republic of Iran is clearly transitioning from its success in primary health care and holds firm on its long-standing commitment to universal health coverage. A new era of transformation, with the emergence of artificial intelligence and big data and the challenges of curtailing the epidemic of noncommunicable diseases and anticipated population ageing, calls for even deeper transformation of the Iranian health system. The Islamic Republic of Iran is committed to investing in its health system for tomorrow, building modern institutions and initiating transformation of its human resources and infrastructure. In order to do so, the country must, in the short to medium term, adjust to the economic and fiscal shocks brought about by the recent re-imposition of sanctions and, in the long term, adjust to the impending cost pressures of its demographic and epidemiological transitions. Maintaining progress on the road from primary health care to universal health coverage is high on the country's development agenda.

[1] Defined as when OOP payments for health exceed 25% of total household expenditure.
[2] At the international poverty line of 2011 purchasing power parity (PPP) $5.50-a-day.

CHAPTER 1
Financial protection and equity in health spending

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KEY MESSAGES

Financial protection and equity in health spending are high on the political and development agendas of the Islamic Republic of Iran. Both health system objectives have received attention from the highest political office of the President and figure prominently in the country's 5-year National Development Plans.

During the period 2007–2015, total out-of-pocket (OOP) payments for health remained stable in real terms at approximately 2 million rials per person per year. As service utilization rates increased over the same period, this suggests that the population is receiving more health services for approximately the same level of OOP payments.

OOP spending on inpatient services decreased by an average of 40 439 rials per person per year during the period 2007–2015. This reflects prior momentum to meeting one of the key priorities of the 2014 Health Transformation Plan (HTP), which is to improve the affordability of and access to inpatient services in public hospitals.

OOP spending on medicines increased slightly, by 16 198 rials per person per year, during the period 2007–2015. Medicines comprise nearly half of all OOP payments by the poor and a quarter of all OOP payments by the rich. Subsidies for medicines introduced in 2011 and 2013 appear to have stemmed any further increase in OOP payments for such items. Continued attention should be paid to the pricing of medicines and prescription policies and practices.

The rich spend nearly 15 times more OOP than the poor, reflecting their greater willingness-to-pay and capacity-to-pay for health services. It has been suggested that such payments are for services that are not publicly covered, may be medically unnecessary or are accessed in the private sector. Policy measures to transform OOP payments by the rich into pooled prepayments could be considered, together with a proposal for entitlement to a supplemental and more generous benefit package.

OOP payments for health as a share of total household expenditure increased during 2007–2015, driven by a decrease in total overall household spending. This reflects a general decline of household living standards due to economic sanctions and very high inflation rates. Re-imposition of sanctions is a concern, and its effect on household welfare and spending on health should be monitored.

The incidence of catastrophic health expenditures, defined as when OOP payments for health exceed 25% of total household expenditure, was 3.9% in 2015. During 2007–2015, the rate increased slightly, with an average annual percentage point change of 0.1 but remained stable for the poorest.

The incidence of impoverishing health expenditures, defined as when OOP payments for health push a person below a poverty line, has remained low during 2007–2015. At the 2011 purchasing power parity (PPP) $5.50-a-day poverty line, the incidence rate was 1.4% in 2015, with an average annual percentage point decrease of –0.04 during 2007–2015.

Analysis of equity in the distribution of household contributions to the health system suggests that premiums paid to private health insurance and OOP payments paid directly to providers are progressive, with the rich paying proportionally more than the poor. This can be attributed to the generous benefit package such that the poor are protected from paying OOP for needed services. In addition, wealthier people are more likely subscribe to complementary private insurance or pay OOP for perceived better quality in the private sector. Premiums paid to public health insurance funds were either progressive or proportional, and their degree of equity will likely improve given the recent removal of caps on insurance contributions.

As part of the HTP, many policies were implemented in 2014 to reduce OOP payments for health and improve financial protection and equitable financing (e.g. banning informal payments, reducing co-payments). The data used in this analysis pre-date those initiatives. As such, results of this analysis serve as a baseline and as motivation for the Islamic Republic of Iran to ensure that it has placed itself on the right path to improving financial protection and equity in health spending.

INTRODUCTION

Financial protection and equity in health spending are key health system goals of governments worldwide. Financial protection means that people who pay out-of-pocket (OOP) to obtain the health services they need are not exposed to undue financial hardship *(1–5).* It is a key health system objective and also an important dimension of universal health coverage (UHC), an official target for health in the Sustainable Development Goals (SDGs) *(6,7).* Equity is a related health system objective, and a key principle is that health should be financed according to ability-to-pay *(8).* In the Islamic Republic of Iran, the objectives of financial protection and equity in health spending have commanded attention at the highest levels, notably in the office of the President *(9).*

The Islamic Republic of Iran has recently introduced several policy initiatives to improve financial protection and equity in health spending. These initiatives are based on objectives set out in the country's consecutive 5-year National Development Plans (NDPs) covering the period 2005–2021, which include reducing inequality in the distribution of health expenditures, reducing OOP payments to less than 30% of total health spending and reducing the incidence of catastrophic health expenditures to less than 1.0% *(10–12).* To meet these objectives, the Ministry of Health and Medical Education (MoHME) has implemented a number of health financing policy interventions,

- **2011:** Subsidization of medicines both directly to manufacturers and, from 2013, indirectly to public health insurance funds in order to increase the affordability of imported essential medicines, especially those for special, incurable and chronic conditions
- **2012:** Merger of various basic health insurance schemes under the newly constituted Iran Health Insurance Organization (previously the Medical Services Insurance Organization)
- **2013:** An increase by more than 70% in real terms of public financing for health, from 109 071 billion rials in 2010 to 186 465 billion rials in 2016
- **2014:** Introduction of legislation to eliminate informal ("under-the-table") payments
- **2014:** Reduction of co-payments for inpatient services in public hospitals from 33% to 10% in urban areas and 5% in rural areas
- **2014:** Elimination or reduction of co-payments for treatment for specific rare and/or chronically disabling diseases or conditions
- **2014:** Provision of free natural childbirth services in public hospitals
- **2014:** Introduction of policies to eliminate referral of patients in public hospitals to purchase medicines, medical supplies and diagnostic services in outpatient facilities, which required

momentum towards UHC, the country should take stock of what has been achieved to date, highlight the opportunities created by recent efforts and identify emerging challenges. This chapter addresses key questions: To what extent have levels of OOP payments for health been reduced and financial protection improved? To what degree is the system financed equitably?

The overall aim of this chapter is to assess financial protection and equity in health spending in the Islamic Republic of Iran over the period 2007–2015, relying on data obtained from the Household Income and Expenditure Survey (Box 1.1). The specific objectives of the chapter are:

- To analyse how total household OOP spending on health has evolved over time, including breakdowns by type of health service or good and by different equity stratifiers;
- To measure the impact of OOP payments on household living standards in terms of key indicators of financial protection, i.e. catastrophic health expenditures and impoverishing health expenditures;
- To assess equity in terms of the extent to which different sources of household financial contributions to the health system are related to ability-to-pay; and
- To assess the extent to which changes in financial protection correlated with the timing of key policy changes and with household characteristics.

The findings will ultimately be used to inform policy options to maximize system levers that would further improve financial protection and equity for the next phase of health reforms in the Islamic Republic of Iran.

Box 1.1: Household Income and Expenditure Survey

The analysis reported here is based on data from nine rounds of the Household Income and Expenditure Survey (HIES), which is conducted annually by the Statistical Centre of Iran and which collects information on household consumption expenditure on all items, including health. HIES is a nationally representative survey with a three-staged cluster sampling design with sample size ranging from 31 283 to 39 088 households, depending on the survey round. To adjust for the effect of inflation, we baselined expenditures to the year 2011 using annual Consumer Price Indices for all goods with rates specific to rural and urban areas to also account for spatial price differences. All analyses were carried out at the national level and sub-national level by key equity stratifiers such as area of residence (i.e. urban/rural) and socio-economic status (i.e. quintiles based on per capita expenditure).