Debate Article
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Health situation in Iran

Ambrogio Manenti,
WHO Representative, I.R. Iran, Email: manentia@ira.emro.who.int
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Précis
This debate article highlights the challenges of health situation in Iran and some influencing or relevant factors such as health sector, welfare system and social protection, social exclusion and civil society from the viewpoint of an international partner. Some advanced experiences in Iranian health system and the manner of system for international cooperation have also been discussed.

Keywords: Health situation, out of pocket expenditure, welfare system and social exclusion.

The economy of the Islamic Republic of Iran, with its objectives of achieving economic independence for society, uprooting poverty and deprivation, and fulfilling human needs in the process of development while preserving human liberty, is among other things based on the following criteria: provision of basic necessities for all citizens: housing food, clothing, hygiene, medical treatment, education, and the necessary facilities for the establishment of a family. (Article 43 of Iran Constitution)

The health system in Iran, reformed after the 1979 Islamic Revolution, was organized on the principles of the Conference of Alma Ata (International Conference on Primary Health Care held in Alma Ata in 1978, ex-USSR): accessibility to health services for the entire population, importance of the Primary Health Care (PHC), focus on prevention, attention to disadvantaged groups and isolated communities, development of community health workers[1].

The economic and social development of the country and the health care system centered on the PHC have resulted in improved health status (Child Mortality under 5 years fell from 73 per 1000 in 1990 to 31 per 1000 in 2009; Maternal Mortality fell from 150 per 100,000 in 1990 to 30 in 2008; life expectancy increased from 63 in 1990 at age 72 in 2008) [2].

Despite this relatively advanced situation compared to the situation in the Middle East region, since the nineties, under the influence of neo-liberal tendencies which had developed during the previous decade in various parts of the world, the private sector became increasingly important also in areas traditionally public. While the public health services in urban areas have been competing with the private services, they have been too slow in readjusting policies and strategies to changes that were, meanwhile, occurring in the country.

In fact, the demographic profile, with a wide portion of young population (a phenomenon favored by the baby boom during the Iran-Iraq war in 1980-1988) and the epidemiology, characterized predominantly by infectious diseases, have been changing over the years, foreshadowing a situation typical of middle income country with progressively more and more older population and more chronic non-communicable diseases.

However, despite these ongoing changes in the Iranian society, the public health system

1. The PHC system in Iran has gained certain notoriety since the 70's because with a vast territory and scarce resources it has ensured coverage of the rural population through the community health workers (CHW) distributed throughout the country - 2CHWs: 1 woman and 1 man working in a Health House and covering 1500 people mainly with duties of prevention. [1]

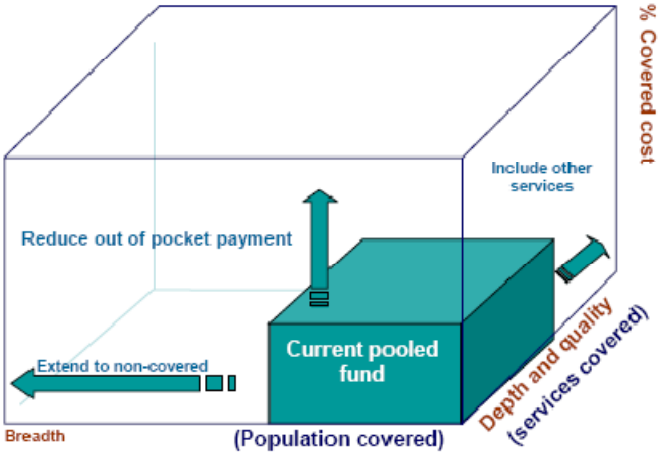

Fig. 1.Three ways of moving towards universal coverage (The World Health Report – 2008)

has not been evolving according to the population needs and the attitude that prevails in part of "people in charge" and managers is often to glorify the past (e.g. describing the achievements of PHC in rural areas) and to live on their laurels while an improvement for access and quality of health services would be necessary right away.

Main problems of the health sector

People are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations. (WHO, the World Health Report 2008)

According to estimates by the Ministry of Health and Medical Education, more than 50% of Health Expenditure is currently represented by out-of-pocket. This high percentage of direct financial contribution of users to health care costs leads to a serious situation for 2.5% of the Iranian population facing a catastrophic health expenditure[2], which makes every year 1% of the population to become poor [3]. The use of private PHC services and hospitals (especially in big cities) and the contribution to the costs for specialized out patients services and hospital care in the public sector are the main reasons for the high direct expenditure by the population. The 5th Development plan (2011-2015) includes as a goal the reduction of out of pocket expenditure but it does not indicate how to do it.

In the last 30 years, the PHC has not been equally and adequately developed throughout the country. Particularly the urban public PHC services are not able to meet the health needs of the population. In the cities, where 2/3 of the Iranian population lives, users make extensive use of private services for simple health problems. The family doctor does not exist in the urban health centers but only in rural areas where, by the way, the high number of patients per doctor (ratio is approximately 1 doctor for 4000 inhabitants) influences the quality of services for the limited time available for each patient and not allowing home visits to patients who need it.

Therefore, more doctors dedicated to family practice should be employed by the public sector to fill the gap particularly in the urban area and an overall policy to develop family medicine within PHC should be implemented.

In addition the role of nurse is weak in the health system of Iran. The number of nurses is not enough to cover the needs and the tasks of nurses are often old fashioned just

2. According to WHO, Catastrophic Health Expenditure for a family is equal to Health Expenditure of 40% (or more) of the total expenditure, excluding the cost for the food.

as support to doctors instead of having a specific public health role.[3]

The PHC should be seriously re-adapted to the demographic and epidemiological changes, but this is happening only partially. For example, community health workers "Behvarz", as the cornerstone of the PHC system in rural areas, continue to perform duties mainly related to the prevention of infectious diseases with priority given to vaccination, personal hygiene, water and sanitation rather than to also implement activities of health promotion related to the risks of non-communicable disease such as smoking, inadequate diet, sedentary lifestyle and alcohol use [5].

Health information is collected at the PHC level by ways (e.g. Vital Horoscope)[4], which, if they have represented a minimum but essential information at the beginning of the functioning of the PHC system, at present are insufficient considering the complexity of current health issues. Moreover, there are in general shortcomings in the management of information ranging from a lack of analysis of available data to a predominant use of data for bureaucratic purposes, not aimed at planning. The lack of real transparency on the data management is also a problem.

As for hospitals, there is coverage across the country with public and private facilities (the private ones representing the 15 % of total) [6]. However, the co-payment required for the users in public hospitals are high and the quality of services is sometimes poor.

Furthermore, in some health fields there is a tendency to "medicalize" needs that would require another kind of answers. A striking example is the problem of births by caesarean section that shares at least 42% of total births in the country, according to the data of 2005 [7] (The rate seems higher than this according to recent survey done by Ministry of Health and Medical Education in 2009).

Concerning patients safety, there is no established system for recording and reporting medical errors in Iran and no epidemiological survey has been conducted yet. There is a need for establishing a proper recording system and applying measures to reduce the level of risks, incidents and claims.

In general, the effort to understand people's needs should improve along the overall health system and services and should be inspired by people – centered approach.[5]

All the above mentioned problems deserve to be addressed with a proper policy for universal coverage, PHC and family practice, patient's rights, human resources development[6].

Shortcoming in the Welfare System and Social Protection

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sick-

3. "If health systems are to respond adequately to the needs of populations and communities, Member States need to address the role and status of nurses & midwives in society in general, and in the health system in a particular Without allocation of adequate resources to nursing and midwifery services, it will impossible to move the health agenda forward" said the WHO Regional Advisor for nursing in a recent visit to Iran. See below challenges and strategies that she proposed:
Current regional challenges: Disparity between supply and demand of nurses and midwives; Shortage of qualified nurses, midwives, and nursing and midwifery teachers; Poor working environments: high workload, low job satisfaction, inadequate remuneration; Status of the nursing profession; Lack of nursing workforce plans.
Proposed strategies to move forward: Scaling up nursing and midwifery capacity; Creating positive practice environments; Developing strong committed nursing leadership; Advocating for development of new roles such as family health nursing and advanced nursing practice. [4]

4 The Vital Horoscope is a health information tool adopted by the Ministry of Health and Medical Education in rural areas since 1988 with demographic and mortality data and PHC program related data collected mainly by community health workers. The data collected should be expanded (for example including the risk factors for health) and computerized. Pilot projects are being implemented for several years but without a defined plan of implementation in all country.

5 "Dealing with health problems, however, is complicated as people need to be understood holistically: their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live. Failure to deal with the whole person in their specific familial and community contexts misses out on important aspects of health that do not immediately fit into disease categories". [8]

6 Concerning the human resource development, the integration of medical education and delivery of health services in Iran under the Ministry of Health and Medical Education has not been reaching the expected results. For more details on this issue, the 2006 WHO mission report could be consulted [9].

ness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (Article 25(a) of the United Nations Universal Declaration on Human Rights, UN, 1948)

In general, Iranian institutions foster leadership ambitions in the region. The rhetoric about it is sometime redundant in official events. However, in social and health sectors, the ambitions of leadership are often backed by a situation certainly more advanced and developed than other countries in the region. The main health indicators, the rural PHC system, the production of medicines and vaccines, the health and social services for drug addicts and HIV patients are only some examples where Iran is better than others.

However it should be highlighted that if the comparison is not done exclusively between Iran and neighboring countries (such as Iraq, Afghanistan and Pakistan, where war and underdevelopment have made particularly precarious the health situation), but with countries, out of the region, with similar level of economic development and good welfare policies such as Cuba, Costa Rica, Sri Lanka and Thailand then the situation is not so advanced. See for instance the Table 1 concerning Infant Mortality Rate (IMR) and Under 5 Mortality Rate (U5MR) in these countries.

Table 1.Infant and under-5 mortality rates (IMR & U5MR) in Iran and selected countries with similar level of economic development (World Health Statistics 2010. WHO)

Country	IMR (2008)	U5MR (2008)
Cuba	5	6
Costa Rica	10	11
Sri Lanka	13	17
Thailand	13	14
Iran	27	32

In fact, the level of "human development" of Iran is not particularly good. Considering, for example Iran's position in the Human Development Index (HDI)[7], in 2007 the country is only the 88th place out of 182 countries [10]. In addition, while for the GDP per capita, which measures economic development, Iran is at the 71st place, for life expectancy, which indicates the health status, it is only at the 95th. This means that the economy in Iran has been developing more quickly than health[8] [11].

In fact, the welfare system in Iran, although relatively well-structured after the Islamic Revolution (1979) that glorified equity and social rights, has shown later precise limits on access and quality not only in health but also in education. Private schools are well developed and compete for quality with the public schools attracting large parts of the middle class and popular sectors.[9]

It is therefore important for Iran to invest more in health, education and social sectors and to reach a universal protection through a solid and generous welfare system for enabling healthy living for all across the life course.

"It is important for population of lower socioeconomic groups in particular, that social protection systems are designed such that they are universal in scope. Universality means that all citizens have equal rights to social protection. In other words, social protection is provided as a social right, rather than given to just the poor out of pity. Uni-

7. The HDI is a summary composite index that measures a country's average achievements in 3 basic aspects of human development: longevity, knowledge, and standard of living. Longevity is measured by life expectancy at birth; knowledge is measured by a combination of the adult literacy rate and the combined primary, secondary and tertiary gross enrollment ratio, and standard of living by GDP per capita.

8. In several countries the overall development approach has focused more on economic growth than human development. According to the Human Development Index 2010 there are examples of countries (e.g. Russia, China, Thailand, Turkey, South Africa and Iran) with health and education components less developed than the economic one.

9. In addition to greater emphasis on economic development, there is a gap in welfare system due to structural weaknesses in the management of public affairs (for example there is a rough planning culture, scarce attention to monitoring and evaluation, problems of responsibility and accountability, etc.).This is partially due to weak human resource development. Some reasons could be the followings: 1. Armed conflicts that have decimated entire generations; 2. Vast emigration and brain drain; 3. Management instability with high turnover of senior executives; 4. Scientific, technical and cultural isolation as consequence of political isolation.

versal approaches are important for the dignity and self-respect of those who need social protection the most. And because everybody benefits, rather than just one group that is singled out, universal social protection systems can enhance social cohesion and social inclusion, and can be politically more acceptable" [12].

Social exclusion and civil society

Integration is human and cost less than segregation. (Amartya Sen)

Social exclusion is the results of various and complex factors. The followings are some of the mechanisms recognized to facilitate people exclusion: centralism, decision making according to a strict hierarchy, sectoralism and welfarism.[10]

Although in Iran the family plays an important role in the management of the weakest groups of the society, the approach of several institutions tends towards exclusion and segregation. An adequate system of social protection is lacking. Asylums for mental ill patients and special schools for disabled children are examples of this approach which do not promote integration and inclusion of vulnerable groups within the society[11].

Considering the women's rights, situation is controversial. In fact, while on one hand, Iran has achieved unquestionable successes in education by increasing access to education of women (e.g. women university students are increased from 27%in 1990 to 50% in 2002) [14], women remain non-influential in the areas of decision-making (e.g. only 2.8% of parliamentarians are women) [2]. In addition, the legal framework is controversial (e.g. Iran has not signed the Convention on the Rights of Women: United Nations convention on the Elimination of All Forms of Discrimination against Women but it has adopted the charter: "Law of women's rights and responsibilities in I. R. Iran" in 2007).

Complex and problematic is the situation of young people. For instance, there is an evident gap between level of education (high rates of schooling) and opportunity of work (high levels of unemployment). Drug addiction, marginalization and violence are some of the problems arising from the lack of promising perspectives for the future. Specific measures of reduction of vulnerability and increasing protection should be taken.[12]

A proper managerial approach to the problems of vulnerable groups would require a collective effort involving all sectors of society particularly public institutions and non-profit area. Unfortunately, NGOs and civil society associations are sometimes negatively perceived by public institutions and the role of non-profit sector is limited both in the management of services and in the support to marginal people. [13]

10. *Centralism* is the fact that all the most important decisions that concern a great number of persons that live in different and far away areas are taken in few central seats. Centralism could be corrected with decentralization that allows public and private actors at the local levels to take a large amount of decisions on matters that can be solved locally and to be active in processes that imply central decisions.
Decision making according to strict hierarchy is the fact that many decisions are taken without any consultation with the parties concerned, with the idea that it is better to respond, although in an imperfect way, rather than leaving matters unsolved. It could be corrected with the participation of the social parties concerned, adopting participatory mechanisms.
Sectoralism is the fact that every aspect of economic and social life is treated separately, fragmented in watertight compartments, in a simplified and non communicative way. It could be corrected with an integrated approach, according to which, the different sector can be treated as a whole with a people-centered approach.
Welfarism is the fact that subsidies and aids are given to people in difficulty, increasing their dependence and passivity, incurring into high costs. The welfarism mentality is common to whoever thinks of poor, handicapped, weak and excluded groups as a dead weight for development and that their survival must be assured for pure humanitarian duties. It could be corrected by adopting working methods that stimulate and favor the empowerment and the active role of the disadvantaged people, considering that, each person, in spite the difficulties he/she faces, could a resource for development and can be viewed as an occasion for improving human relations. [13]

11. There are exceptions represented by pilot projects which promote integration of vulnerable groups. These should be strengthened and extended to wider scale. The Community Based Rehabilitation programme in rural area should be also mentioned as good example of integration policy, although it is not implemented in the cities.

12. "Reduction of vulnerabilities include providing social security for the unemployed or disabled, developing social networks at community level, introducing social inclusion policies and policies that protect mothers while working or studying, offering cash benefits or transfers, protecting particularly the disadvantaged, against exposure to health hazards, e.g. by introducing safety regulations for the physical and social environment, providing safe water and sanitations, promoting healthy lifestyles, establishing healthy housing policies, etc." [8]

13. An important role is played by religious foundations, particularly the Imam Khomeini Relief Foundation which assists millions of

A "welfare system mix" with a specific role of the non-profit sector (which is no private and no public) would allow dealing effectively with the complex problems of the most vulnerable sectors of population (elderly, disabled, chronically ill, marginalized youth, etc.) applying approaches more human-centered, more flexible, less expensive and contributing to reduce inequity and social exclusion.

Advanced experiences

The mentally ill person needs not only cure for the illness but also a human relation. The ill person is not only an ill person, but a person with all its own needs. (Franco Basaglia).

In spite of the described limits, Iranian society is heterogeneous and different and contradictory experiences are present in the same context. There are in fact projects that demonstrate a clear approach of openness, inclusion and partnership. They tend to highlight the needs of the population and to overcome the stigmatization of marginal groups. We would like to mention three examples:

Family planning. The family planning initiative, started in the 1980s from professionals of health and social science, who, involving personally Imam Khomeini (Supreme Leader of the Islamic Revolution who died in 1989), created a synergy between the interests of health (promotion of family planning) and positions of the clergy. This experience, in the late 80s, with a fatwa in favor of birth control, promoting health of mother and child overcame some conservative fringes who had proposed policies to increase births. In the following decades a policy of birth control was consolidated which led to a decrease in fertility rate from 6.1 to 2.2 [15].

HIV/AIDS. The activities to fight HIV/AIDS, through advanced policies of harm reduction for drug users (such as use of methadone and, needle exchange), are spread in the country involving also prisons [16]. Similarly there are pilot activities of health promotion for vulnerable women [17].

Policy on refugees. In Iran there are 1 million of documented Afghan refugees that have access to jobs, education and health services and 2 million undocumented Afghan migrants that a recent initiative of the Iranian government seeks to regulate. This openness to refugees and recognition of their social rights is very unusual in the international scene and it is an important experience not yet well known internationally [18].

International cooperation

No man is an island. (John Donne)

International cooperation is very limited in Iran because Iran is a "middle income country", with substantial resources, and with controversial relations with the "Western World".

The World Health Organization has been developing activities, especially in areas such as Health Policy, Non-communicable Diseases and Communicable Diseases and natural disasters. In the Health Policy, the emphasis is on technical assistance to reduce the out-of-pocket and strengthen PHC with the development of family medicine. Promotion of policies to address social exclusion and protection of vulnerable groups is an ongoing commitment which will be strengthened in the next future.

There are also 15 other UN agencies that work mainly with government institutions. The approach of UN Agencies is to support Iranian institutions and promote rights through the technical and specialized projects, particularly by encouraging cooperation on poverty reduction, environment, natural disasters, drug and health

The link with UN and other international health stakeholders should be further developed, being a mean of a wider relationship with the rest of the world, which will allow

poor people and yet adopt a predominantly philanthropic and charitable approach.

Iran to both support weaker countries and mutually gain knowledge from other ones.

Conclusion

Iran achievements in the health sector during the last 30 years should represent an encouragement for the present and future challenges. All the main problems which are affecting people due to lack of access and quality of health care deserve to be addressed with a proper policy promoting universal coverage, PHC and family practice and patient's rights.

It is therefore important for Iran to invest more in health and in the sectors which are representing relevant social determinants of health such as education and social sectors and to reach a universal protection as social right through a solid and generous welfare system for enabling healthy living for all across the life course.

The welfare system should be "a welfare system mix" with a specific role of the NGOs and civil society. The non-profit sector (which is no private and no public) would allow dealing effectively with the complex problems of the most vulnerable sectors of population such as chronically ill, disabled, marginalized youth, elderly and others applying approaches more human-centered, more flexible, less expensive and contributing to reduce inequity and social exclusion.

The approach towards people should be holistic taking into account their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live.

For all this, the link between I.R. Iran and international partners should be strengthened which is a precondition for any development in an interdependent and globalized world.

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