

How to integrate social care services into primary health care? An experience from Iran

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Abstract

Background: Social issues have prominent effects on the peoples' physical and mental health and on the health risk factors. In Iran, many organizations provide social care services to their target population. This study aimed to explore the roles and functions of Primary Health Care (PHC) system in providing social care services in Iran.

Methods: This was a qualitative study, for which data were collected via three sources: A review of the literature, in-depth interviews and focus group discussions with experts and stakeholders. The main objective was to find a way to integrate social care into the Iranian PHC system. A conventional content analysis was performed to explore the data.

Results: Overall, 20 experts were interviewed and the acquired data were classified into four major categories including priorities, implementation, requirements and stewardship. The main challenges were the existing controversies in the definition of social care, social service unit disintegration, multiple stewards for social care services, weaknesses of rules and regulations and low financing of the public budget. Social care services can be divided into two categories: Basic and advanced. Urban and rural health centers, as the first level of PHC, could potentially provide basic social care services for their defined population and catchment areas such as detecting social harms in high risk individuals and families and providing counseling for people in need. They can also refer the individuals to receive advanced services.

Conclusion: Iran has a successful history of establishing the PHC System especially in rural areas. This network has an invaluable capacity to provide social health services. Establishing these services needs some prerequisites such as a reform PHC structure, macro support and technical intersectoral collaboration. They should also be piloted and evaluated before they could be implemented in the whole country.

Keywords: Social Harms, Primary Health Care, Social Care Services, Iran.

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Introduction

Social problems have prominent effects on peoples' physical and mental health and the health related risk factors (1). The ultimate goal of social care services is to help people live financially independent and do their ordinary life without receiving help from others. Provision of social care services varies in different countries with respect to the structure of healthcare systems, social support services and financing (2,3).

The subject of integrating social care services into the health care systems in differ-

ent countries is in dispute. The most prominent controversies include concerns related to connections between primary and secondary care services, collaborative services, coordinated unique intersectional services and integration of prevention and health care services (4,5). Yet, it is suggested that integration has several benefits including cost reduction, admission rate, length of hospitalization and waiting time (6).

In Iran, social care services are fragmented or disintegrated in terms of policy and structure. The Social Council within the

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Ministry of Home Affairs is in charge of centralized policies, but the Cultural Revolutionary Supreme Council and many other organizations play a role in the policymaking process for social care and for receiving government budget (7).

Articles 2,3,29 and 43 of the 1979 Iranian constitution describe justice and social cohesion as the goal of Islamic republic of Iran (8). Those articles consider health as one of the nation's basic needs. Moreover, these articles mandate the government to use all the capacities to establish a proper and fair economy based on Islamic teachings to decrease nutrition deficiency, housing problems, unemployment and health care. The government must provide the basic needs such as social security including health services and medical care for everyone in the country. Furthermore, improving physical, mental, social and spiritual health has also been emphasized in other Iranian legal documents. Article 32 of the 5th development plan law has obligated the government to design a 'comprehensive and universal healthcare system' based on primary health care focusing, with a focus on family physician and referral system, decentralization of services, strategic purchasing of services and stressing on pay for performance (9). In addition, article 39 of this law has requested a regionalized system of support services and empowering local and regional conditions and target groups (9).

The Iranian Ministry of Health and Medical Education (MOH & ME) tried to reform the health care services delivered by public, private and charity sectors since a long time ago. In March 1985, the parliament passed the district health networks' expansion law using national and international experiences (10). Accordingly, different services including vaccination, mother and child health, nutrition, family planning, essential medicine and treatment for common diseases and environmental and occupational health were provided (11). These services are delivered in each Health Center's catchment area both in rural and urban are-

as. In Rural Health Houses, the Behvarz (a female health worker who has received a two year training after high school education) and in Urban Health Posts, the health technicians are responsible for delivering these basic service packages. Patients who needed more advanced services were referred to Rural or Urban Health Centers (R/UHC) located in larger villages or cities (12). The coverage of health networks is more than 95 percent in rural areas and about 30 percent in urban areas (13). A family physician model (General Practitioner and the health team) was developed since 2005 based on a mixed payments system, mainly capitation, in rural health centers (14). Health Insurance Organization (HIO) is the purchaser of services, funded by government revenues, from health care centers and hospitals affiliated to medical universities. On the other hand, at the same time, there are other fragmented medical service providers that deliver healthcare services in the form of governmental (Ministry of Defense, Ministry of Education, Ministry of Oil), public (Social Security and Municipality), private and charity institutions, but they do not have an effective well-known referral system.

Many units provide social care services in governmental, private and charity organizations under the supervision of supportive intuitions such as Welfare Organization (WO), Imam Khomeini Relief Foundation (IKRF) governed by Ministry of Cooperatives, Labor and Social Welfare (MOCLSW). The budget is provided by public funds and community donations.

There is a mixture of problems in the health care system of Iran including diversity in providing health care services and structural arrangements in offering such services. It is argued that the existing health inequalities, in terms of accessibility to basic services and public's health in different parts of the country, might be attributed to such diversities (15,16).

Thus, the aim of this study was to explore the roles and functions of primary health care system (PHC) in providing so-

cial care services in Iran to introduce a unified and integrated model for PHC with respect to Iran’s legal structure for people’s accessibility to social care services.

Methods

This was a qualitative study carried out in three consequent phases.

Phase 1: Review of the Literature

A review of the literature using key words listed in Table 1 was carried out to collect data on experiences in implementing social care services in Iran. We were especially interested to retrieve information on institutions involved and interventions applied.

By reviewing the documents, a checklist was devised to identify social services that had to be prioritized. Then social care providers were listed to perform organizational analysis. Finally, a framework was designed, and a questionnaire was developed to collect stakeholders’ opinions.

Phase 2: In-depth Interview with Experts and Stakeholders

A) Stakeholders: They were selected according to their power and influence, using a stakeholder analysis. B) Experts: Intentional sampling method was used to recruit experienced experts from different disciplines including public health, health care

Table 1. Key words & Search Engine

Key words		Search engines & Data bases
Social care	Healthcare, Primary healthcare, Primary care	Google scholar
Social care services		Google
Social care system		Pubmed.org
Social history taking		rc.majlis.ir (Iranian Parliament Research Center)
Social service		Irando.com
Social work		Magiran.com
Social support		SID.ir
Social planning		Iranmedex.com
Social program		
Social welfare		
Social work		
Social worker		
Community service		
Social Health and social services		

Table 2. Distribution of stakeholders for interview and holding discussion group

Ministry or Institution	Representative	Number of representatives
Ministry of Health and Medical Education (MOH&ME)	1. Head of health network management (head of family physician’s program)	2
	2. Deputy for Health and head of provincial health center, Qazvin UMS&HS	
Ministry of Cooperatives, Labor and Social Welfare (MOCLSW)	1. Deputy and social advisor of Welfare Organization	4
	2. Director in central office of Imam Khomeini Relief Foundation	
	3. Head of Social Workers Association	
	4. Advisor of Health Insurance Organization	
Tehran Municipality	1. Deputy of Social affairs	1
Ministry of Interior	1. Coordinator expert with MOHME	1
Judiciary power, Prison Organization and Police Department	1. Head of Prisons organization and Security Affairs	2
	2. Researcher in Prison organization	
Ministry of Education	1. Head of Counseling Center of Ministry of Education	1
Ministry of Sport & Youth		
Ministry of Culture & Islamic Guidance		
Parliament Research Center	1. Social deputy of Parliament Research Center	1
	1. Health Network Designer (2 person)	8
2. Sociologist		
Experts	3. Social Care Researchers (3 persons)	
	4. Head of scientific association of Social Workers	
	5. Head of Medical Sociology of Sociology Association	
Total		20

management and social work (Table 2).

Semi-structured interviews were conducted using a set of open-ended questions. The interview questions were sent to the interviewees by email and then a face-to-face interview was arranged. All interviews were recorded on a digital audio recorder with the permission of the interviewees. The interviewer was a trained researcher and familiar with the in-depth interview method. The four major questions were as follows:

1) What types of social care services does your institution deliver to ordinary people or your particular audience? (A question for the organizations)

2) In your opinion, what are the priorities in social care services?

3) What are the roles and functions of the Primary Health Care (PHC) in providing social care services? In other words, what type of services could be provided by the Ministry of Health and Medical Education (MOH & ME) in different national programs, especially in the context of 'family physician' and 'referral system' programs?

4) What are the obligations or requirements for implementing social care services through the PHC networks?

Phase 3: Focus Group Discussions

A draft report on how to integrate social care services into the PHC network (the Blue report) was developed by the research team based on the information gathered by the previous phases. Then the report was reviewed and criticized by experts in two focus group discussions (FGD). A facilitator raised the questions in each session; and we collected ideas and opinions by assign-

ing a member as the session manager. The discussions were recorded with the group's consent.

Finally, a table consisting of a brief overview on the role of health networks for providing social care services in three levels of PHC was indicated and then the requirements of implementation were defined. The collected data were reviewed by the steering committee and a consensus was reached on how to implement the services.

Results

Findings from the Literature: An Overview of Social Care Deliverers in the Country

Reviewing the literature revealed that multiple organizations are providing social care services in the country including Imam Khomeini Relief Committee, Ministry of Cooperatives, Labor and Social Welfare (MoCLSW), Police Forces, Municipalities, Ministry of Justice, Ministry of Interior, Islamic Propagation Organization, Government Suspended Organization, Prisons and Security-Corrective Measures Organization, Ministry of Education, Ministry of Health and insurance companies. These organizations have different duties and deliver variant services (Table 3). Little information existed on the evaluation of these interventions in the literature and their websites.

Findings from In-depth Interviews and FGDs

A) Priorities: According to the interviewees, although the priorities in social health services could not be determined without a comprehensive needs assessment, all the

Table 3. Categorized priorities of Social Health according to the interviewees' opinions

- Early detection of those at risk of social harms and providing consultancy services
- Social health services provision to vulnerable groups such as: households with mentally-ill or other chronic communicable or no-communicable disease patient, households with addicted persons, families of prisoners, female-headed households (including divorced or widow women), households covered by Imam Khomeini Relief Foundation and welfare organization, households with suicide person, sub-urban citizens, households living in vulnerable neighborhoods (including city outskirts and border towns), Children with educational failure and their families, runaway girls and boys, sex workers, homeless
- Increasing the social management role of the family physicians
- Improving social and mental service packages in the health system

interviewees have addressed a wide range of priorities. These priorities have been summarized in three main themes and 18 subthemes.

It was also mentioned that provision of social care services should be designed and delivered in the form of social policies. In past years, these policies were formulated in the form of Five-year economic development plan, and the parliament has passed those social policy bills. Due to the lack of monitoring and evaluation, there was no feedback on the successes and failures of these policies. The interviewees believed that there are lessons learned in the success of PHC, especially in rural areas. They also reasoned that a referral system should be defined for social services and that fragmented social services should be integrated.

B) Implementation: There were different opinions in response to the role and functions of PHC for delivering social care services. Most believed that due to the different needs of various regions and population groups, services should be delivered according to their necessities.

However, there were two different general viewpoints about the role and functions of PHC in delivering social health services:

The first group believed that PHC should not interfere with the social care services delivery. "At the present time we are facing a service gap in providing physical and mental health services." The PHC coverage is insufficient in the urban areas, which comprises about 70% of the population. Moreover, the services merely cover the communicable diseases prevention, mother and child health and environmental health and non-communicable diseases, and mental health care services are mostly neglected. Therefore, adding the burden of social services into the current healthcare system would increase the problems. "In the existing cultural and economical and physical infrastructures, social care services could not be delivered by the health network."

"Social care services need a welfare state and it is beyond the jurisdictions of MOH & ME." "The MOH & ME is not responsi-

ble for reducing social harms or providing social care services. The intervention of MOH & ME would 'medicalize' the social issues and could be dangerous. Although it does not mean that the MOH & ME would not observe the social conditions, it does not create valid evidences on the impact of social issues on health and does not advocate the role of a social leader in reducing peoples' social problems."

The second group believed that health is a comprehensive issue. In other words, due to the syndemics effects of physical and mental health with the social issues, people's physical and mental problems could hardly be dealt with without addressing their social problems. They daresay that the physical, social and mental services should be provided together as an integrated service. In this regard, the PHC could be redesigned to provide social care services. "The PHC infrastructures (health houses, health posts and health centers) should act as the gatekeepers for social services." These centers primarily assess the risk factors of social harms or identify the people in need (first level). Then the centers refer them to the appropriate social care providers (second level). Some believed that in addition to the gatekeeping role, preventive training services for social care (including citizen's rights and duties, life skills and consultancy for the vulnerable and at risk population) should be provided at the first level of the PHC network. In addition, community participation interventions such as creating community councils, following up community's legal and right-based claims for more social care using community's capacities such as schools, universities and cultural centers should be facilitated. A list of proposed social care services in primary health care in three types of prevention is presented in Table 4.

C) Requirements: The interviewees have different opinions about the requirements for establishing social care services in PHC. With respect to the entry point of social care services into the PHC, the interviewees believed that first the cost-

Table 4. Primary Health Care Network capacities and priorities in providing social care services according to the interviewees' opinions

Themes	Subthemes
Prevention	<ol style="list-style-type: none"> 1. Promoting healthy social behaviors (including social self-care in targeted groups and public education) and prevent social harms to families 2. Promoting public participation in order to develop indigenous communities especially formation of neighborhoods councils in the catchment areas of Health Centers and participation of health center representatives in the council as well as in the City and Village Islamic Councils 3. Contribute to the national days (e.g. arboriculture day) in appropriate ways 4. Advocacy for creating an encouraging environment of healthy social behaviors including: <ul style="list-style-type: none"> • Securing civil rights and citizenship education in cooperation with municipalities • Promoting NGO's and other form of community participation • Promoting national identity and brotherhood • Attract investors to build recreation centers and develop tourism • Creating consultancy centers to promote citizens' income, employment, housing, legal counsel and insurances <ul style="list-style-type: none"> • interventions to increasing per capita reading time • Improving kindergartens and other educational centers
Screening	<ol style="list-style-type: none"> 5. Active screening for families at risk of social harms. The major risk factors are as follows: Poverty, unemployment, drug addiction, crimes, domestic violence (children, women, the elder), dropouts, divorce, runaways girls and boys, child labor, teenage pregnancy,
Rehabilitation	<ol style="list-style-type: none"> 6. Advocacy for support and provide counseling services to empower at risk individuals and households. [the service package for each social harm should be devised] 7. Providing substance abuse services 8. Formation of self-help groups for individuals and households affected by social harms

effectiveness of health sector contribution should be documented to win the senior managers' support. Then the packages for each level of social care services should be defined. Based on the updated valid evidences, the social issues that affect health should be considered as the priorities. The existing social services delivered by institutions are defined as the second level of services. The current structure of welfare services in urban and rural areas could be used as a backbone for regionalization of social care services.

Complementary packages should be considered for the regions and population groups with specific needs. For example, community-based crime prevention packages should be provided for those in the areas with a high crime rate, Implementation of these packages needs the permission of authorized institutions like the Country's Social Council. "A memorandum of understanding for collaboration, as well as approvals should be exchanged at the national level."

Moreover, it was recommended that provision of basic social services' packages be designed and piloted with the participation of specialists from the following fields: So-

ciology, psychology, community medicine, epidemiology and social working.

D) Stewardship: The overseer of this integration should also be defined. According to most interviewees, a suitable choice is the Supreme Council of Health and Food Security (SCHFS). Thirteen ministers are members of the SCHFS. The President is the chair, and the Minister of Health and Medical Education is the secretary. Furthermore, a structure similar to SCHFS exists at each province chaired by the governors. Some believed that the overseer should be the ministry of Cooperatives, Labor and Social Welfare, and Ministry of Health and Medical Education, Welfare Organization, Imam Khomeini Relief Foundation, municipalities and Non-Governmental Organizations (NGOs), should do the implementation. Others believed that according to the Social Council, MOH & ME is one of its members, should be in charge. A summary of different stated opinions are listed in Table 5.

To integrate these services into the PHC, the social care attitude should be entered into the health networks. "Empowering and training the health care providers and PHC team is necessary." Enlisting the graduates

Table 5. Social Health care division of labor in the view of the interviewees

Stewardship	Basic and advanced social care services provision	
	Social care services integrated in the PHC system	Social care services not integrated in the PHC system
Supreme Council of Health and Food Security Iranian Social Council Supreme Council of Welfare and Social Security	<ul style="list-style-type: none"> • Basic services are provided by the PHC system • Advanced services are provided by organizations in the Social Council and Supreme Council of Welfare and Social Security, and NGO's 	<ul style="list-style-type: none"> • Basic services provided by the municipalities • Advanced services are provided by organizations in the Social Council and Supreme Council of Welfare and Social Security, and NGO's

of social work and related social sciences disciplines in the PHC network is required.

Iran PHC has good experiences with the community health workers (Behvarz) (12).

To provide social care services, a similar person should be defined in health centers. S/he would be in charge of communicating with families, providing preventive basic education and assessing risk factors for physical, mental health as well as social issues. In cases in which social support and mental consultancy is needed, s/he would refer them to the social workers or the psychologists in the health center, respectively.

Curriculum of the related disciplines should be changed so that the graduates could do these new tasks. Managers, decision makers and policy makers' attitudes should be changed from a medical approach to a social one. Social training of the medical teams and family physicians are necessary. The legal obstacles should be investigated, and hiring and outsourcing social services should be facilitated by law. The priorities in social care research should be defined. Permanent monitoring of social care and situational reports are necessary for authorities' awareness.

All tasks allocation and signing of memorandum of understandings could be done at the national level. Training, propagation, raising public awareness and changing people beliefs about preventing social harms are of prime importance. In addition, social marketing should be done to create demands in people to use the services.

E) Resources: The financing routines should be defined considering the potential resources such as added-value taxes, municipality taxes, taxes on harmful goods and services, donations, social insurance

premiums, NGOs volunteering services and the government budget. It is better to create an intersectoral mutual fund to pool the resources.

Using all regional capacities at the primary level of services is very important. At first, an asset assessment should be done and the capitals should be used. Establishing a monitoring system, using other countries' successful experiences taking into account Iran's differences is essential. The role of intersectional collaboration and people's participation should not be ignored. In the meantime, service delivery structure should be defined at both the district and provincial health centers.

The second level social care services should be clearly defined. For example, the role and function of the centers to provide care for vulnerable groups, such as female-headed households, mentally disabled, psychotic patients, working kids, shelters and prisons, should be clarified.

Discussion

In summary, according to the interviewees' points of view, the PHC could participate in delivering social care services and reducing the growth trend of social issues by acting as a gatekeeper. The integration of social services is part of the WHO's recommendations; The WHO has emphasized comprehensiveness as a main characteristic that should be considered in the reforms in PHC (17).

The suggested basic social care services for targeted populations are as follows: Identifying at risk individuals and families, and referring them to social care services. Establishing these services needs some prerequisites such as a reformed PHC struc-

ture, macro support and technical intersectoral collaboration. These service packages should be piloted and evaluated before they could be implemented in the whole country.

Other challenges facing the integration of these services into the PHC harden the situation. Some of these problems include fragmented social care services in Iran, unclear institutional trusteeship, weaknesses of laws related to social care interventions as well as social services financing and shortage of trained human resources for social working (18).

Other countries have some experiences in providing social care services through PHC. The experience of Northern Ireland shows that the integration of social care into the healthcare was very beneficial. The Irish have also proposed a strategic framework for further improvements (19,20).

There are also some experiences on the collaboration of social workers with PHC in Canada. The Canadians believe that because one of the characteristics of social workers is to consider each person in her/his living context, and as social status, employment, work environment, culture, gender and physical environment are all important to the social workers, they could be helpful companions for the physicians (21). In Finland, Sweden and Norway, providing social care services as well as mental and physical health services are assigned to the municipalities (22,23).

The advantages of this suggested model are as follows: 1) Increasing people's access to social care services; 2) Accessing the second level of social services by cost reduction and orderly entering.

This model is also in accordance with the article 32 of The Country's 5th Plan emphasizing on creation of universal health services. In this article, there is a law focusing on provision of services at three levels of physical, mental and social dimensions (24).

One criticism on PHC during the past decade was its lack of sufficient attention to social issues (25). Even though definitions

and concepts of social care were different among Iranian policymakers, it seems that the integration of social care services into the primary health care is an excellent opportunity in dealing with social harms such as poverty, illiteracy, unemployment, homelessness, addiction and insecurity. Intersectional collaboration and people participation are essential for effective social care.

Conclusion

To use the results of this study, we recommend that the results should be documented an advocacy paper for the policy makers such as Iranian Social Council, Supreme Council of Cultural Revolution, Social and Cultural Committee of Parliament, Social and Prevention Deputy of Judiciary, municipalities and district levels. The proposed service packages should be implemented as a pilot program in a region (Preferably in a province). To obtain credible evidences, the appropriate indices should be measured before and after the intervention and compared with the control regions. The suggested indexes could be the reduction in social harms, the quantity and quality of access to services, and people's satisfaction with the services. In addition, conducting further researches on the technical aspects of the services including planning and budget allocation is crucial.

Ethics

Ethical issues (including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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