СЕКЦІЯ 7

ФІНАНСИ

FINANCES

SESSION 7

Аналіз руху коштів в системі охорони здоров'я Ірану

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За визначенням всесвітньої організації охорони здоров'я витрати вважаються катастрофічними, якщо домашні фінансові внески в систему охорони здоров'я перевищують 40 % від прибутку, що залишається після задоволення основних потреб. Тому таким важливим є аналіз фінансування системи охорони здоров'я.

На практиці система громадської первинної медичної допомоги контролюється Міністерством Охорони Здоров'я, в той час як вторинний і третинний рівні медичної допомоги фінансуються обов'язково Організацією соціального захисту, Медичною службою збройних сил і Організацією медичного страхування. Окрім цього, Фонд Імама Хомейні надає страхове забезпечення для бідних. Індивідуальне страхування є, як правило, додатковим до цих державних програм.

Слаборозвинуті країни в більшій мірі покладаються на готівкові оплати. В системі охорони здоров'я Ірану приватні джерела становлять найбільшу долю загальних ресурсів (61%), а готівкові оплати відіграють важливу роль в цьому контексті (96.6% від цієї цифри). Тому метою даної роботи є аналіз системи охорони здоров'я Ірану, як країни, що розвивається.

Незважаючи на те, що понад 90 % населення застраховане різними організаціями, існує і паралельне покриття.

Витрати на медичну допомогу дають хороші результати в плані ефективності заходів по охороні здоров'я, але поступлення, що використовуються для фінансування системи охорони здоров'я є складними, непрозорими і можуть бути недостатніми. Більше того, дана система використовує численні системи страхування, що призводить до затрат в плані менеджменту, управління прибутками, відповідальності тощо.

Беручи до уваги той факт, що 10 % населення не мають офіційного страхового захисту, враховуючи значні майбутні витрати, пов'язані із змінами в системі охорони здоров'я та новинки в медичних технологіях, серйозні проблеми пов'язані з ефективністю, якістю та доступом для певних груп і браком прозорості, платоспроможності та стабільного розвитку сучасних заходів щодо фінансування охорони здоров'я, комплексна реформа є необхідною.

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Analyzing flow of funds in Iranian health care

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This paper first describes Iranian Health Care system, then counts the strengths and weakpoints if the system and finally analyzing flow of fund in Iranian Health Care system, highlights some of the areas which demand more consideration.

Keywords – Delivery System, Finance, Flow of funds, Healthcare, Social security.

I. Introduction

Equity financing in Iranian health care has been the focus of some scholarly researches [1] yet, flow of funds for Iranian health care resources has not been systematically analyzed. World Health Organization (WHO) defined expenditure as being catastrophic if a household's financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met [2].

For public sources, it is assumed that all contributions are pooled to fund the public health system, from which everyone is entitled to receive care. For private sources, expenditure is directly linked with consumption or entitlement to services. A low proportion of private expenditure at low incomes (i.e. progressive) can be an indicator of non-affordability of a given good or service. High expenditure by higher income groups could indicate purchase of non-essential health care services.

In many developed countries, including European ones, private resources account for a relatively small proportion of total health care financing [3] and it is assumed that utilization of health care is not largely contingent on payment for healthcare [4]. On the other hand, under developed and less developed states rely to a larger extent on out-of-pocket payments (e.g. 30–82% in a selection of low-income Asian countries [5], and the direct linkage between payments and utilization cannot be ignored in these countries.

The Iranian health care financing system relies on highly complicated combination of both public and private financing. Using a flow of funds framework this paper attempts to provide a more in-depth understanding of how the current Iranian health system finances.

II. The quality of health care

The right of all citizens to health care is embodied in the Constitution of Iran which recognizes the rights of all citizens to health as well as an equitable distribution of health services based on Islamic religious principles. In practice this has resulted in a strong focus on basic public health financed from the public budget and delivered to all Iranians through a public primary health care (PHC) delivery system run by the Ministry of Health and Medical Education (MOHME), while secondary and tertiary level curative care is financed (and sometimes directly provided) through the compulsory Social Security Organization (SSO) for formal sector employees and their dependents, the Armed Forces Medical Service Organization for members of the military and their dependents, and the Medical Service Insurance Organization (MSIO) for government employees, rural households, the self-employed, and "others" (e.g., students). Members of the armed forces and their dependents are covered through the Armed Forces Medical Service Organization. In addition, there is the Imam Khomeini Foundation that provides insurance coverage for the poor. Private insurance generally is supplemental to these public programs. The MOHME is responsible for overall management of the public health system, regulates the provision of private health services as well as NGOs [6].

All formal sector workers and dependents have mandatory coverage for curative services through the SSO. The network effectively reaches about 90 percent of the population and is particularly extensive in rural areas. Members of the armed forces and their dependents are covered through the Armed Forces Medical Service Organization. The rest of the population is eligible to enroll in the MSIO, which has four separate funds covering distinct groups: government employees, rural households, the self-employed, and "others" (e.g., students). The MSIO is compulsory for the government employees and voluntary for the other groups.

The Imam Khomeini Relief Foundation finances health services for the poor.

In other words:

- Government health sector employees are salaried and Government facilities are reimbursed
- based on budgets and/or fee for service payments from Government, MSIO and SSO.
- Private providers are paid on a fee-for-service basis.
- MSIO, the Imam Khomeini Foundation, and SSO reimburse providers on a fee-for-service basis with no overall budget caps or other cost control mechanisms.
- Fees are established by the High Council composed of a number of Ministers and Managing Directors, and these fees apply to MSIO, the Imam Khomeini Foundation, and SSO.

III. Finance system

Fig. 1 outlines the flow of funds in the Iranian health care system. Resource flows are traced from individuals to public and private.

Financial intermediaries, from there to health care providers, and from there distributed to individuals.

Total health care expenditure in 2009, according to the WHO definition of health care, are estimated to be $20bn. In 2009, Iran spent an estimated 5.5 percent of its GDP on. some 269US$ per capita in exchange rate-based dollars (US$685 in purchasing power parity-adjusted dollars). Health spending accounts for some 8.7 percent of Government spending.

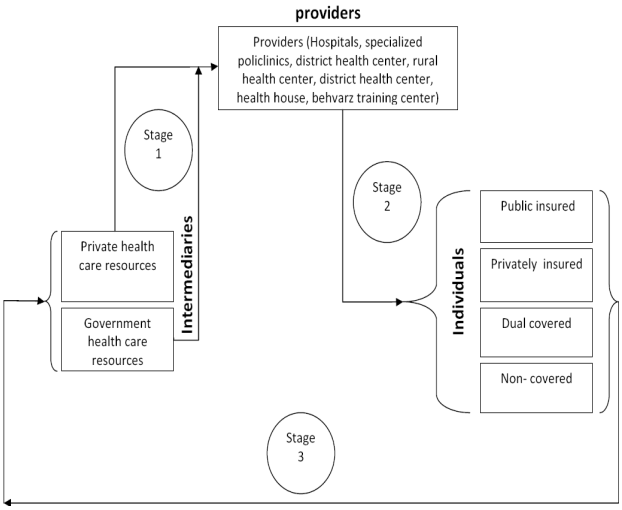

Fig. 1. Flow of funds in Iranian health system

At stage I in the resource flow, private sources account for the largest proportion of resources (61%). In this part out-of-pocket payments play essential role (96.6% of that), followed by social security funds and public resource (respectively 26.1% and 12.8%). Of health expenditure per capita $269, $105 is paid by the government the rest is funded by private sector [7].

Iran's per capita GDP is above the regional average excluding the Persian Gulf States (4860 US$ in 2009). But Iran's public share of total health spending is below the regional average. The public share is estimated to be 2.1 percent of GDP or some 39 percent of total health spending.

SSO contributions are earnings related and account for 30 percent of earnings for a wide range of social security and health benefits. Seven percentage points of the contributions are paid by employees, 20 percentage points by employers, and 3 percentage points by government. Health accounts for some 9 percentage points of the 30.

The actual share of the premium for MSIO paid by the individual depends on which fund the individual is covered through:

- Government employees: They pay 30 percent of the premium and the Government the remaining 70 percent.
- Rural households: The Government pays the total amount of the premium.
- "Others" (e.g., students, clergies, etc.): They pay between 20 and 30 percent of the premium. The remaining 70 to 80 percent is paid by the relevant institution the individual is a member of.
- Self-employed: They pay the full amount of their premium.

The government budget covers MSIO deficits.

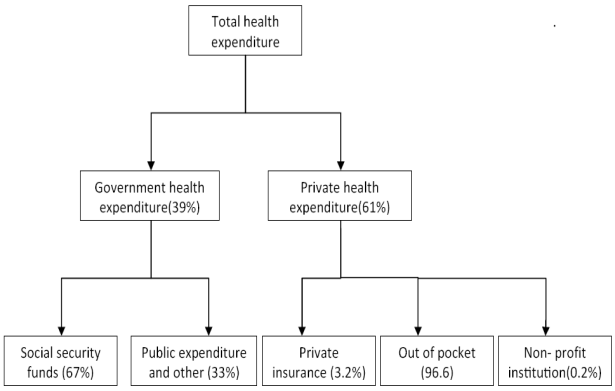

Fig. 2. Health ecpenditure composision

At stage II, health care providers are financed by public and private resources to deliver services to the population. The allocation of resources is uneven across the entitlement groups.

At stage III, ultimate contributors to health care resources are identified. The largest mean contributions are made by the privately insured and non-covered groups.

In 2009, the insurance coverage among the various financing agencies was shown as Fig. 3.

- 30.67 million covered through SSO, mostly in urban areas.
- 33.67 million covered through MSIO, mostly government employees, farmers, students, etc.
- 4.6 million covered by other institutions like the Imam Khomeini Foundation for the poor.
- Nearly 6.1 million not covered by any form of insurance.

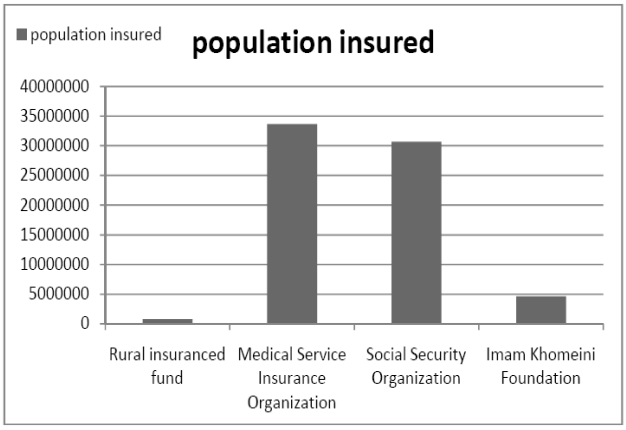

Fig. 3. Population insured by funds

IV. Strengths and Weak points

The three finance sources have quite different distributional consequences. Theoretically the progressivity of the fund schedule will alternatively be improved by a progressive rate schedule, rather than a uniform flat rate.

Equity can be improved by changing the financing mix as well as improving the progressivity of the finance sources. Financing strategies with a shift towards increased reliance on the extension of progressive EPF to encompass public employees, the abolishment of upper income limit of SSO members, and the promotion of progressive private insurance and out-of-pocket payments as complementary finance sources, can improve equity in health care financing.

Table 1

Health finance scheme

	Financing
primary health care (PHC)	fully paid through budget allocations
Medical Service Insurance Organization (MSIO)	– co-payments are set at 25 percent for outpatient and 10 percent for urban inpatient care services; and of 25 percent for rural inpatient care.
Social Security Organization (SSO)	- no cost-sharing for services provided in SSO facilities - face cost-sharing of 10 percent for inpatient care and 20 percent for outpatient care for services provided in non-SSO contracted facilities. - for care in private non-contractually-related facilities individuals face a coinsurance amount equal to the difference between the facilities charge and SSO's normal payment level.

There are strengths and weaknesses in the Iranian health care system. In this section we briefly address the main strengths and weaknesses of this system.

A. Strengths:

In Iranian health system about 90 percent of population has insurance coverage and the health care expending has good health outcomes. In this system, villagers and other poor groups not only have some kind of insurance, but also receive a primary health care services. Furthermore, financing the primary care by government due to easy access in primary care has been successful.

B. Weakness:

The revenue used to finance Medical Service Insurance Organization and Social Security Organization are complex, opaque and may be unfair. Existence of the fee-for-service in Health finance system leads to providing the unnecessary services by providers.

By the risk pooling concerns, the voluntary nature of Iranian health insurances and immediate benefits, leads to cost rising for Insurer. Furthermore using the option of compulsory public insurance limits risk pooling of MSIO and SSO.

Another weakness of health finance system in Iran is using multiple insurance systems that lead to some costs in management, revenue, liability and other areas.

- Cooperation between GPs – hospitals- diagnostic test laboratories;
- Prevalence of fee splitting;
- The households' share from national health care expenditures is high, about 60 percent and it has been increasing.
- The households' contributions through the existing insurance organizations are very low, less than 6 percent.
- The referral systems at SSO and MSIO have caused the shift of resources away from specialists and toward general practitioners.
- PHC expenditures are only 7 percent of national health care expenditures.

- Despite of that over 90 percent of the population is covered by different insurance organizations, there is parallel coverage by different insurance organizations.
- The inequality in the amount of health care services provided by different insurance organizations is a cause of friction among different government employees.

V. Result and policy implication

Health systems reforms have important budgetary implications, health system impacts, and affect every member of a society. Thus, as governments undertake such reforms, not only must the reforms be based on sound socio-economic and health policy bases, but appropriate information must be developed to inform decision-makers and the public.

Analyst and policy makers need a picture of current health system; tehrefore they need data on health spending, accurate insurance coverage and availability of services. Consequently, the reform in system is needed for effectiveness.

It is necessary to get legislation, establishing new structure and developing new strategy, providing training where needed, and putting in place the new systems (provider, insurance, etc). These are implementation issues that are neglected in health system in Iran.

Normal competitive market supply-demand interactions do not work well in the health sector because of information asymmetries and the interdependence of supply and demand. Incentive-based provider payment systems and global cost controls are needed to assure that purchasers of health services pay ‘efficient’ prices.

Conclusion

In Iran, almost all insurance programs have deficits, and therefore they should be supported by the governemt. This stems from the lack of transparency in revenue sources, such that equity is not clear in this system.

With 10 percent of the population lacking formal insurance coverage, with significant near-term cost pressures from the health transition and advances in medical technology, with ever growing consumer expectations, with serious problems of efficiency, quality, and access for certain groups, and with the lack of transparency, solvency and sustainability of current health financing arrangements, a comprehensive reform is essential. Iran has left impressive records in primary care however, in Iran enough attention has not been paid to such concepts as health insurance, provide payment, information, hospitals and quality of life. Thus they demand accurate evaluation.

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