COUNTRY STUDIES ON HEALTH AND WELFARE SYSTEMS
– Experiences in Indonesia, Islamic Republic of Iran and Sri Lanka –
WORLD HEALTH ORGANIZATION
CENTRE FOR HEALTH DEVELOPMENT
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COUNTRY STUDIES ON
HEALTH AND WELFARE SYSTEMS
– Experiences in Indonesia, Islamic Republic of Iran and Sri Lanka –

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Preface

Nations are facing difficulties in setting up equitable health and welfare services for the people. Despite the various types of health sector reform attempted, large segments of the population in many countries have inadequate or no access to health and welfare services. This is a major challenge of our time and needs to be looked into and addressed in an innovative and pragmatic manner at the global level.

As a research arm of the World Health Organization, the WHO Kobe Centre (WKC) seeks to contribute to global health development through international, interdisciplinary research. Such research aims to define and support practical strategies that can respond to current and future global health and welfare issues. Health and welfare systems development in the 21st century is the unifying theme of all WKC activities and those of its global network of partners. In an increasingly globalized and complex world, it is essential to mobilize all partners and stakeholders to join forces in developing systems that are responsive to the needs of communities in all nations. Bringing together and sharing the world’s store of health-related knowledge and experience is the key to future meaningful action.

In 1999, WKC embarked on promoting the collection of information on new approaches and models of health and welfare systems in countries. The collection of sound information and its analysis and dissemination are crucial to providing evidence for sound decision-making. To enable countries and communities to learn from each other through the sharing of such information, experiences and other resources, WKC has organized annual global symposia and is now working with partners to develop a database on health and welfare systems.

In 2002, as part of the ongoing process of collecting relevant information from countries, WKC commissioned operational research activities in the area of health and welfare systems development in three countries: Indonesia, the Islamic Republic of Iran and Sri Lanka. The reports from these three countries have been compiled into the present technical report. The report summarizes the evolution of health and welfare systems in these countries, the present situation, the achievements, and the constraints and challenges they face in developing equitable health and welfare systems. There is much to learn from these experiences for everyone working towards building fair and responsive health and welfare systems.

I am therefore pleased to present this technical report for global distribution. It is particularly relevant for decision-makers and for all those working in health and welfare and related sectors, whose work could be enhanced or take on a different perspective in order to achieve the most important goal of all societies: universal attainment of a level of health permitting a good quality of life, and a socially and economically productive life, for the citizens of the world.

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Executive Summary

The Islamic Republic of Iran is the sixteenth largest country in the world, with an area of some 1,648,195 km². It is located in the Middle East region and has a population of over 65.5 million, more than 65% of whom live in urban areas. Its GDP is estimated at US$ 105 billion, and the overall literacy rate exceeds 79%. According to major development indicators, it is a typical country in the lower- to middle-income group.

The health system in Iran has a long history, with the world’s first medical school established in Jundishapur around 531 AD. From that time until the 12th century, Iranian physicians such as Mohammad Zechariah Razi, Ali ebne Abbas Majusi, Ebne Sina (Avicenna) and Ismail Jorjani considerably influenced the history of medical sciences worldwide. The first Ministry of Health in Iran was established in 1941 and the first state-owned medical school in 1934. The World Health Organization (WHO)’s pilot project for a primary health care delivery model was carried out in Iran’s West Azarbaijan Province from 1971 to 1976. Since the Revolution in 1979, Iran has seen major improvements in public health: life expectancy has increased from 57 to around 70 years, and the infant mortality rate has been almost halved.

The health system in Iran is a unique case of structural integration between the health care delivery system and medical education. Both governmental and nongovernmental bodies play a role in the stewardship of the health system. Resources are generated by the Government through its state-funded medical education and construction of major health facilities. More than 50% of the financial resources for purchasing health services are paid out-of-pocket or through individual medical insurance, and the rest by the Government. The Government, through its regional enterprises known as Universities of Medical Sciences, delivers most of the care, the rest being supplied by the Social Security Organization, the private sector and charities.

The health system in Iran faces challenges such as the low percentage of GDP dedicated to health, insufficient insurance coverage and effectiveness, efficiency problems in the delivery of care, fragmentation of care provision and an ineffective referral system, insufficient provision of primary health care for the urban population, the increasing burden of disease due to road traffic accidents, newly emerging and re-emerging diseases, problems with the emergency medical system, and temporary shortages of certain pharmaceuticals. Current strategies in the health system include efforts to increase public expenditure on health, health care rationing, and privatization of health care delivery.
Up to 80 years ago there was no state welfare system in the country, this function being carried out by charity and religious groups. The first law on social security was enacted in 1922. There were various structures for the delivery of social welfare before 1974, when the first Ministry of Social Welfare was established. This Ministry was merged with the Ministry of Health in 1976 and, after the Revolution, in spite of maintaining an apparent relationship with health, it functioned independently. Nowadays, around 29 organizations are active in the social security and welfare system, in two systems of contributory social insurance, and in the noncontributory social assistance system. The total budget for supportive and social services in 2002 was estimated at 93,530 billion rials (approximately US$ 12.15 billion) or 66% of the total government budget.

The welfare system in Iran also faces other challenges, such as social insurance coverage, structural causes of difficulties in policy-making, coordination, overlapping services, lack of financial resources and government debt to the insurance organizations, unemployment, the increase in the elderly population, an increase in the rate of social diseases, an underserved handicapped population and other vulnerable groups, and lack of an information support infrastructure for social welfare.

Current strategies in the welfare system include expansion of social insurance coverage in two dimensions: extensive basic insurance and complementary insurance; redistribution of charity contributions; improvement in competition between insurance organizations; privatization of the provision of social services, and employment loans to disadvantaged groups. Suggested priority areas or suggested changes in this system include structural reform in the social security and welfare system; establishment of an integrated social security information infrastructure; improvement of employment opportunities for vulnerable groups; prevention of further increases in government debt to the welfare system; financial policies to support insurance and pension funds; decentralization of authority or devolution; economies of scale in insurance organizations; reducing the demand for illicit drugs; and establishment of universal insurance coverage for children. These challenges and the effectiveness of current strategies in health and welfare systems are important areas for further research.

Research objectives and methodology

Project objectives

The project objectives are:

- to conduct a situation analysis on the health and welfare system at national level;
- to review historical trends in strategies culminating in the current structure of the health and welfare system;
- to identify and appropriately categorize major services and groups of clients in the health and welfare system (identifying outputs and major stakeholders in a systems analysis);
- to describe the role of nongovernmental organizations in stewardship, resource generation, financing and provision of health and welfare systems;
- to describe the financing of the health and welfare system at national level;
- to identify major issues and problems of health and welfare programmes; and
- to make suggestions for improving the health and welfare system in the country.
Methodology

The project comprises five stages.

1. A thematic framework is established, based on the research objectives (as this research is qualitative and the thematic framework is analogous to “research data variables”). A group of keywords and subjects are identified. The necessary forms are developed at this stage.

2. An archival search is made among the following databases: (a) academic dissertations indexed by the Iranian Information and Documentation Centre and relevant schools; (b) official reports on the status of the health and welfare system; and (c) relevant periodicals and the Internet. At this stage, particular attention is paid to the historical development of the health and welfare system in the country. The gathered document data are indexed according to the thematic framework.

3. Owing to the limited timeframe of the project, five key executive and academic experts are interviewed in a semi-structured manner by phone or in person. All of the interviews are tape-recorded and carefully compiled, taking into account the thematic framework.

4. The research team reviews all of the indexed material and makes the final selection under each topic of the thematic framework. Two researchers go through the final material of each topic in sessions and make concluding interpretations. They then make relevant recommendations for better health and welfare systems development.

5. The research report is then drafted, and reviewed and finalized before submission.

Thematic framework

After an initial familiarization with the retrieved documents, the thematic framework was established (Table 1). It was then utilized in the next phase of the research project, indexing. Fig. 1 shows a sample of indexed material, and Fig. 2 a sample of charted material.

Table 1. Thematic framework matrix

<table>
<thead>
<tr>
<th>Health codes</th>
<th>Welfare codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td>WH</td>
</tr>
<tr>
<td>HD</td>
<td>WD</td>
</tr>
<tr>
<td>HF</td>
<td>WF</td>
</tr>
<tr>
<td>HS</td>
<td>WS</td>
</tr>
<tr>
<td>HC</td>
<td>WC</td>
</tr>
<tr>
<td>HG</td>
<td>WG</td>
</tr>
</tbody>
</table>
Fig. 1. A sample of indexed material

Fig. 2. A sample of charted material
Introduction to health and welfare systems in Iran

According to The world health report 2000, eight topics are considered when developing a conceptual basis for health systems performance: the boundaries of the health system; the difference between intrinsic and instrumental goals; mapping between social systems and social goals; the main goals of a health system; the instrumental goals for health systems; the concept of performance and efficiency; the concept of performance in subsystems and institutions; and the key factors influencing health system performance (1).

The concept of performance is centred around three goals: improving health, responsiveness to nonmedical expectations of the population, and assuring fairness of financial contributions of individuals and households (1).

Health systems perform the following four basic functions, which are the key factors in determining performance (1):

- health system financing, covering revenue collection, fund pooling and purchasing, which includes allocations to service providers;
- provision of health services, personal and nonpersonal;
- resource generation, encompassing human resources or personnel, physical resources, and knowledge and technology; and
- stewardship, the most important of all, with six subfunctions: overall system design, performance assessment, priority setting, intersectoral advocacy, regulation and consumer protection.

A health system consists of interrelated components, one of them being a health infrastructure that delivers a variety of health programmes and provides health care to individuals, families and communities. Such health care should be provided using an integrated approach that combines promotive, preventive, curative and rehabilitative measures (1).

The following principles have been defined as applicable to almost all health systems (1):

- inclusion of the entire population on the basis of equality and responsibility;
- inclusion of components from health and other sectors whose interrelated actions contribute to health;
- delivery of primary health care at first point of contact;
- other levels of the health system support the first level;
- the intermediate level deals with more complex problems and specialized care; and
- the central level leads and coordinates all parts and all levels of the system.

Iran is the sixteenth largest country of the world, with an area of over 1,648,195 km². It is located in the Middle East region. The country has 676 cities and towns and over 66,000 villages located in 28 provinces (2). According to the latest estimations, its population is 65,540,224, nearly 65% of whom live in urban areas (3,4).

With regard to development indicators, Iran ranks relatively high among countries with a similar level of income. The same also holds true in comparing Iran with countries in the Middle East and North Africa. In the World Bank categorization, Iran is among the lower- to middle-income countries (5) with a GDP in 2000 of nearly US$ 105 billion (6). In Table 2 and Fig. 3, Iran is
compared with other lower- to middle-income countries in terms of four basic development indicators (5).

Since the Revolution in 1979, Iran has been among the few democratic countries in the region. As a result of this democratization process people’s social expectations in various areas, including health and welfare, have increased considerably (2).

Table 2. Comparison of Iran with other lower- to middle-income countries in terms of four development indicators, 2000

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Iran</th>
<th>Other lower- to middle-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNP per capita (Atlas method, US$)</td>
<td>1640</td>
<td>1140</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>71</td>
<td>69</td>
</tr>
<tr>
<td>Population with access to impr</td>
<td>95</td>
<td>80</td>
</tr>
<tr>
<td>Gross primary enrolment (percentage of school population)</td>
<td>98</td>
<td>114</td>
</tr>
</tbody>
</table>


Fig. 3. Development diamond
Health system

Historical analysis

Medicine has been taught and practised worldwide for thousands of years since the days of Hippocrates and Susruta, but health care as a system was conceived only about 100 years ago (1). National health services have existed only since 1948, when an integrated health and welfare system was created in the United Kingdom (1).

In 1978, after a 28-year study and experimentation (8), the Declaration of Alma-Ata urged governments and the world community to endeavour to develop Health for All strategies, in which the central theme was assessing the functioning of health systems with a view to their further improvement (1).

The Alma-Ata Declaration, endorsed unanimously by 134 governments and 67 United Nations and other organizations, was a landmark event that provided a platform for health management and international collaboration for the following decade (1).

The health system in Iran has a long history. It is said that the world’s first academic hospital (a university with a medical school and a hospital) was established by Khusraw Anushirwan the Wise, a Sasanid emperor, in the city of Jundishapur in south-western Iran in 531–579 AD (9). At the time of the Islamic invasion (around 640 AD), the school of Jundishapur was well established and had become renowned as a medical centre of Greek, Syriac and Indian learning. After the advent of Islamic rule, the University continued to thrive (10).

Ancient Iranian medicine has considerably influenced the history of medical sciences. In the past, Persian physicians, who also used to be prominent figures in other areas of science, were called Hakim; Avicenna (Ebne Sina, 980–1036 AD) and Averroes (Ebne Roshd) are internationally well known examples. In the late 8th century AD the first medical book, entitled Delflein, was written by Massuyeh’s son Yuhanna, followed by Ali ebne Raban Tabari (Razi’s teacher), who compiled his important book Ferdowsolhekmat in 850 AD. In the 10th and 11th centuries, medicine achieved its utmost splendour with the works of Mohammad Zechariah Razi, Ali ebne Abbas Majusi and Ebne Sina (Avicenna). Services rendered by Razi and Avicenna to medical science caused Iranian medicine to become known and to have far-reaching effects throughout the world (11) (see Fig. 4). Of great influence in western European medicine were systematic and comprehensive works such as Avicenna’s Canon of medicine, which were translated into Latin and then disseminated in manuscript and printed form throughout Europe. During the 15th and 16th centuries alone, the Canon of medicine was published more than 35 times (12,13). In 12th century, medicine continued to develop with the works of Ismail Jorjani. Jorjani served as Court Physician under the Kharazmshahi dynasty. In 1110 he compiled the Zechariah Kharazmshahi, which brought together in ten volumes, in Persian and Arabic, Razi’s Al-Havi, Avicenna’s Canon and a treasury of pharmacological knowledge. This soon became one of the most read medical books.

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1 A dynasty that ruled over Iran from 212 to 632 AD.
2 Remnants of this city are now located in south-western Iran near Ahwaz.
3 In Farsi, a Hakim is a very wise person proficient in many branches of science, including medicine and philosophy.
4 One of the dynasties that ruled over Iran from 1097 to 1229 AD.
Iran has enjoyed a public structure for medical education for more than 150 years. The first modern centre for medical training was founded in 1851 as part of the Institute for Higher Education (Dar-ol-Fonoon) by Amir Kabir, one of the Qajar dynasty’s senior officials. By 1931, however, sending medical students to European universities was the most important mechanism for medical education. At this time, Professor Oberlin from the University of Paris was requested to reorganize the structure of medical education in Iran. He selected the most outstanding among the Iranian medical students studying in Paris, and these people became the most famous medical professors in the modern medical history of Iran. The School of Medicine was established as a part of the University of Tehran in 1934. Training of medical specialists started in 1943 through the sending of a group of Iranian physicians to foreign countries.

It is said that, up to the 1920s, health status in Iran was relatively poor and mean life expectancy was low, increasing only gradually from 25 to 40 years. The first health services legislation was enacted in 1911, entitled the Law of Medical Practice. In 1914, a group of Iranian and European physicians formed the Health Maintenance Council or Majlis-e-hefz-e-sehe (16). In 1915 the first Iranian high school of nursing was established by an American religious group in Urumia. The Central Bureau of Sehieh – de facto the first Ministry of Health – was established in 1926. In 1921, the fight against disease began by focusing on malaria in northern areas of the country. These activities led to the establishment in 1956 of the Malaria Eradication Organization, with the support of WHO. A few years after the Second World War, other ambulatory care groups were formed to eradicate communicable diseases such as tuberculosis, leprosy and smallpox. Group members had received 6–12 years of formal education and also participated in vaccination and case-finding programmes.

In 1941 there were only four hospitals in the country and 0.3 physicians for every 10,000 population. The Central Bureau of Sehieh changed its name to the Ministry of Health in 1941.
and was responsible for supervising all health care organizations in the country. In 1958, for the first time, some of the duties of the Ministry of Health were devolved to local authorities (18).

In order to generate the required human resource needs for rural areas, a Health Worker (Behdar) Training Programme began in 1940 in Mashad. These training programmes lasted four years and consisted of theoretical, practical and internship courses. The programme discontinued in the early 1960s; thereafter almost all of its graduates gradually entered medical schools and were awarded an M.D. degree after three years of training (16). Similarly, from 1964 the Health Brigade Act (Sepah-e-Behdasht) was enacted by Parliament to deliver health care services to the rural population. Under this Act, all medical school graduates, graduates of related disciplines and high school graduate recruits carried out their civil service in rural areas under the supervision of the Ministry of Health. Although this strategy had remarkably positive outcomes, problems arose owing to cultural mismatches between the health care personnel and the population and problems with the numbers and reliability of assigned personnel (16).

Before 1940 there were no food control regulations, although municipalities were responsible for supervising the price and safety of food. In 1940, the Epidemic Diseases Act was passed and food control began. This duty was also carried out by municipalities until 1955, when it was transferred to the Ministry of Health (16).

The first law on pharmaceuticals, food and medical equipment was passed in 1955, together with a mandatory review of the credentials of health care professionals. In 1966 this task was transferred to the Ministry of Health (16).

Expansion of the resources of the health system started in the early 1960s, when both the Government and the private sector constructed many hospitals (17). Further decentralization of health care provision was carried out in 1965. Some health care organizations were transferred to public bodies and nongovernmental organizations to improve health care delivery to rural areas (18). In addition to medical treatment, they taught villagers how to prevent disease and improve health conditions. They supervised water supplies, recommended sewerage schemes, gave vaccinations, trained midwives and advised on birth control.

The establishment of the Dr Abidi Laboratory in 1946 is considered to be the beginning of the modern era of pharmaceutical industry in Iran. Later, multinational companies such as Baxter, Merck and Pfizer entered the pharmaceutical market. Before 1979, most of the market share belonged to these companies and the share of domestic production was at most 25%. In 1974, pharmaceutical affairs were delegated to a newly formed Deputy of Drugs and Food in the Ministry of Health. Up to 1979, the functions of this deputy were: licensing pharmacies; certification of pharmaceutical companies; licensing pharmaceutical manufacturers; issuing drug import certificates; pricing pharmaceuticals; and controlling the pharmaceuticals manufacturing industry (16). After the Revolution in 1979 two major changes were introduced: nationalization of pharmaceutical industries and implementation of the Generic Drugs List Programme (16). Later, the Iranian Pharmaceutical Company and Daroo-Pakhsh were permitted to import drugs with generic names under the direct supervision of the Bureau of Drug Control of the Ministry of Health. Thereafter, following the Iran–Iraq War, the Red Crescent Society was also permitted to import drugs. In 1996, the Red Crescent Society with 304 drug items and US$ 47 million, the Iranian Pharmaceutical Company with 181 items and US$ 50 million and Daroo-Pakhsh with 76 drug items and US$ 15 million comprised the US$ 112 million market of imported drugs. Giant distribution companies were formed after the Revolution under the common investment of domestic manufacturing companies (16).

In 1976 the Ministry of Health was apparently restructured and, through a horizontal integration strategy, social security and welfare were added to its purview and the Ministry of Health and Welfare

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8 The capital of Khorasan Province in north-eastern Iran.
was created. A few months later, a totally public national health system was created under the supervision of the newly formed Ministry of Health and Welfare, with the advent of Regional Organizations for Hygiene and Treatment (18). Public health services such as vaccination and environmental sanitation were free, pharmaceutical prices and medical care charges were strictly controlled, and a proportion of the population enjoyed the benefits of health insurance. Children up to two years of age were given free school meals. The Fifth National Five-Year Development Plan increased the number of hospital beds from 13.6 to 17.2 per 10,000 population. Between 1962 and 1973 the number of physicians and dentists rose from 5264 to 11,774, nurses from 114 to 5428 and pharmacists from 1511 to 3954 (17).

On the question of primary health care (PHC), it should be emphasized that a large preparatory phase for the implementation of a PHC plan was carried out between 1971 and 1977 (8). It was called the West Azarbaijan project, and was carried out as a pilot project with the collaboration and support of WHO (Fig. 5) (19). This led to a decree that the pattern of primary care developed by the West Azerbaijan Project should become national policy, and it was planned that it would cover the whole country during the forthcoming Sixth National Five-Year Development Plan. A time frame for those events is presented in Table 3 (8). Nevertheless, it is believed that the new Iranian health system was actually formulated after 1979, with easy access to services (particularly in rural areas) at its heart (2). The basic policies that underlay the new system (19) were:

- priority to preventive health services as a long-term asset;
- priority to rural and underprivileged areas, with special attention to high-risk groups;
- priority to general practice over specialized medical care;
- priority to outpatient over inpatient care;
- maximum feasible integration of preventive and curative services; and
- decentralization of authority.

Community Health Workers (Behvarz) were considered the pivotal strategy in PHC. They were selected from the same district that they were to serve, and received formal training for four years. As mentioned above, before 1979 there was a proposed academic curriculum for them to continue their education even to a doctorate level (20).

Fig. 5. Dr F. Amini, Director of West Azarbaijan project (last person in the left row) along with Dr Jakšic (seated closest to the window) and Dr Newell of WHO (to the right)

Source: Health by the people (21).
Table 3. Time frame of events pertaining to the history of PHC network development before the Revolution in 1979

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>The Chinese Barefoot Doctor Scheme begins.</td>
</tr>
<tr>
<td>1959</td>
<td>Dr Carrol Berhorst starts his community health worker (CHW) scheme in Guatemala.</td>
</tr>
<tr>
<td>1965</td>
<td>The Third Iranian National Five-Year Development Plan defines health activities in a comprehensive sense for the first time. The Ministry of Health assumes responsibility for preventive activities as well as for the overall supervision of health services.</td>
</tr>
<tr>
<td>1968</td>
<td>The Fourth Iranian National Five-Year Development Plan provides for a national network of health centres, and pursues the policy of transferring medical care to the private sector. Loans are made to private institutions, insurance programmes are extended, and local Community Health Councils are strengthened.</td>
</tr>
<tr>
<td>1969</td>
<td>Dr Ch. Moffidi and Dr Newell of WHO meet and discuss the possibility of a joint project.</td>
</tr>
<tr>
<td>1971</td>
<td>After further discussions, a formal agreement is signed between the Ministry of Health, the University of Tehran and WHO. The criteria for the field site of the project are chosen. The design of the project is carried out in one year.</td>
</tr>
<tr>
<td>1972</td>
<td>A long-term WHO consultant (Dr Jaksic) joins the project. Between West Azarbaijan and Kermanshah, study areas of Azarbaijan are accepted. Preparatory work and the first field tests end. A team comprising participating agencies, field workers and expert staff from the Ministry of Health, School of Public Health and WHO conduct and process the situational analysis. The first training programme for CHWs by the University of Shiraz begins, with a grant from the Canadian International Research Center.</td>
</tr>
<tr>
<td>1973</td>
<td>Specific targets for medical care, preventive services and nutrition are set in the Fifth Iranian National Five-Year Development Plan. One of these was to provide &quot;a minimum level of medical treatment services to the general public&quot;. The term &quot;primary health care&quot; is used for the first time in the project. The decision to implement the project is taken. Training starts in Chonqralu.</td>
</tr>
<tr>
<td>1974</td>
<td>The Ministry of Health agrees to extend the project field in Azarbaijan.</td>
</tr>
<tr>
<td>1975</td>
<td>The project extends in West Azarbaijan.</td>
</tr>
<tr>
<td>1976</td>
<td>A WHO mission evaluates the project. The Ministry of Health accepts the pattern of health care developed by the project as the standard for nationwide implementation.</td>
</tr>
<tr>
<td>1977</td>
<td>Extensive training begins for CHW instructors from all over Iran. A decree is issued that the pattern of primary care developed by the West Azarbaijan project will become the national pattern, and will cover the whole country during the forthcoming Sixth National Five-Year Development Plan. It was planned that every Iranian citizen would be provided with primary health care until April 1983.</td>
</tr>
<tr>
<td>1978</td>
<td>The development of primary health care in Iran is announced at the annual meeting of the Iranian Public Health Association. The WHO/UNICEF Conference on Primary Health Care is held in Alma-Ata, USSR.</td>
</tr>
</tbody>
</table>

Source: King (8).

In 1979, the general health status of the country was still unacceptable. The infant mortality rate was 104 per 1000 live births and life expectancy was 57 years (16). The total number of nurses was 7100 with just 2.1 nurses per 10 000 population (16). Several thousand foreign physicians were present in different regions of the country, at an annual cost of nearly US$ 100 million (16).

After the Revolution, three major changes were introduced in the national health system. First, an extensive public PHC network was developed; second, medical education was incorporated into the public health care delivery system; and third, there was an intensive expansion of the human and physical resources of the health system.

PHC was the leading strategy for achieving WHO’s vision of Health For All by the year 2000. The ideology behind PHC closely matched the Iranian people’s unfulfilled expectations in 1979 about social justice, equity, human rights and universal access to services, and was thus easily adopted (2).
In 1980 the Council for Evaluation of Programmes and Structure was formed in the Ministry of
Health and, with the aid of specialized subcommittees, drafted a provisional report on national health
policies and priorities for the coming years. In spite of the Iran–Iraq War, directions for the
implementation of national PHC networks were developed by 1984; these directions were published
in a book entitled *An approach to health and medical education*. With the tremendous efforts of two
experts from the Ministry of Health and health care professionals in various provinces, detailed PHC
network plans were designed for each individual town in the country. In February 1985, Parliament
approved a budget of approximately US$ 35 million for the setting up of health networks in one town
in each province of the country (16).

After the setting up of PHC networks, the most important intervention in the creation of a
nationwide health system was the formation of the Ministry of Health and Medical Education
(MOHME) and the integration of medical facilities. MOHME was established in 1986 as a result of
the Ministry of Health taking over responsibility for medical schools (16). However, owing to the
lack of a holistic design for the health system and ignorance of a logical rationing policy, unfair and
inappropriate allocation of resources occurred as a major unwanted consequence. Direct influence by
some politically powerful figures and selection of various policies without proper policy analysis
resulted in uncontrolled growth of health facilities and hospitals and further fragmentation within the
health system. Thus, this system has always suffered from a lack of a functioning referral system (16).

The ultimate outcome of these structural changes was the creation of giant regional health­
related enterprises (Universities of Medical Sciences). These organizations now had multiple lines of
business, from medical education and research to provision of health care (both primary and
secondary), plus control and regulation. As a result, they were highly inefficient.

In a historical perspective, four major reasons underpinned the integration of medical education
with the health care delivery system, and the resulting MOHME (16):

- expansion of physical resources for medical education, with the inclusion of health care
  facilities in medical schools;
- conduct of appropriate research and education inside the health care delivery system at all
  levels of care;
- increasing the presence of academic members in society; and
- coordination of medical education with the needs of society by creating a harmonious
  management on both the supply and the demand side of human resources.

Now it is believed that, in spite of remedying the previous shortage of human resources, this
strategy has led to a remarkable decline in the quality of medical education. On the other hand, the
national PHC network policy and the subsequent integration strategy of medical education in the
health care delivery system undermined the issue of social welfare in the Ministry of Health. In other
words, although in 1976 social welfare became the responsibility of the Ministry of Health, because of
structural problems two important subdivisions of the Ministry of Health – the Welfare Organization
and the Social Security Organization – functioned independently after 1979. Although these two
organizations were theoretically accountable to the Minister of Health, they lacked a systematic
interaction with the rest of the health system. Expansion and development of these two organizations
also took place in an independent fashion.
Health and Welfare Systems in the Islamic Republic of Iran

Current status of the health system

Major health indicators

The post-Revolution period has witnessed impressive gains in various national indices of public health. The widespread immunization of children in both urban and rural areas against various diseases, along with the active promotion and encouragement of breastfeeding, seem to have played a major role in the fall in infant and child mortality rates. As a result of this, the crude death rate among the population as a whole has also dropped significantly, while average life expectancy at birth has risen considerably. Since the end of the Iran–Iraq War, there have been noticeable improvements in indicators of access to health services, such as the various doctor:patient ratios and numbers of hospital beds per unit of population. It is evident that these improvements in the health status of the nation are mostly due to increased government spending on health, medical care and general community development projects and the fact that, according to the annual household budget surveys conducted by the Statistical Centre of Iran (SCI), household expenditure on medical care and social security as a percentage of annual non-food expenditure has not changed noticeably since 1973. These rates have vacillated between 6% and 8% in urban areas and between 8% and 9% in rural areas for most of the period since the Revolution (22).

WHO ranks Iran 96th in the world regarding its level of health in terms of Disability Adjusted Life Expectancy (DALE) (23). According to the latest official health data, mean life expectancy in Iran is 70.7 and 73.4 years for men and women, respectively (24). According to WHO, Iran ranks 114th among 198 countries of the world in terms of overall attainment of health system goals (23). This reduction in rank is due to not only the level of health indicators but their dispersion in the population that reflects a lack of fairness among different groups. The trend in major health indicators is demonstrated in Table 4.

Table 4. The trend in major health indicators in Iran, 1984–2000

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1984</th>
<th>1997</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate per 1000 live births</td>
<td>51</td>
<td>28</td>
<td>28.6*</td>
</tr>
<tr>
<td>Under-5 mortality rate per 1000 live births</td>
<td>60</td>
<td>35</td>
<td>36*</td>
</tr>
<tr>
<td>Life expectancy, males (years)</td>
<td>67.7</td>
<td>70.7</td>
<td>—</td>
</tr>
<tr>
<td>Life expectancy, females (years)</td>
<td>71</td>
<td>73.4</td>
<td>—</td>
</tr>
<tr>
<td>Population with access to PHC in rural areas (%)</td>
<td>20</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Annual population growth rate (%)</td>
<td>3.2</td>
<td>1.4</td>
<td>1.34</td>
</tr>
<tr>
<td>Hospital beds per 1000 population</td>
<td>1.50</td>
<td>1.58</td>
<td>1.64</td>
</tr>
<tr>
<td>Overall bed occupancy rate in public hospitals (%)</td>
<td>48</td>
<td>51</td>
<td>58</td>
</tr>
<tr>
<td>Mean length of stay in public hospitals (days)</td>
<td>—</td>
<td>3.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Population : physician ratio</td>
<td>2915</td>
<td>1078</td>
<td>955</td>
</tr>
<tr>
<td>Access to improved water resources (%)</td>
<td>71*</td>
<td>83*</td>
<td>95</td>
</tr>
<tr>
<td>Maternal mortality rate per 100 000 live births</td>
<td>140</td>
<td>37.4</td>
<td>—2</td>
</tr>
</tbody>
</table>

* Official data for rural areas for 2000 = 32.3 (25).
* World Bank (2).
* Statistical Centre of Iran (3).
* Official data for rural areas for 2000 = 35 (25).

Source (unless otherwise given): ESCAP Group (22).

9 WHO considers three general goals for health systems: level of health (measured in DALE), responsiveness to people's non-health expectations, and fairness in financial contributions.
It has been shown that the performance of health system of Iran is very different from that of some countries with comparable incomes. In Table 5, the performance of the health system in Iran according to *The world health report 2000* is compared with that of the health systems of five other countries with nearly equal per capita income (26).

**Table 5. Comparison of health systems performance and some national health accounts in countries with nearly equal per capita income**

<table>
<thead>
<tr>
<th>Country</th>
<th>International ranking of health system performance</th>
<th>GNP per capita (US$)</th>
<th>International ranking of GNP per capita</th>
<th>Health expenditure per capita (US$)</th>
<th>Public expenditure on health as a percentage of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thailand</td>
<td>47</td>
<td>1960</td>
<td>102</td>
<td>71</td>
<td>1.7</td>
</tr>
<tr>
<td>Dominica</td>
<td>51</td>
<td>1910</td>
<td>103</td>
<td>212</td>
<td>1.5</td>
</tr>
<tr>
<td>El Salvador</td>
<td>115</td>
<td>1900</td>
<td>104</td>
<td>164</td>
<td>2.6</td>
</tr>
<tr>
<td>Namibia</td>
<td>168</td>
<td>1890</td>
<td>105</td>
<td>145</td>
<td>3.8</td>
</tr>
<tr>
<td>Iran</td>
<td>93</td>
<td>1760</td>
<td>107</td>
<td>155</td>
<td>1.7</td>
</tr>
<tr>
<td>Guatemala</td>
<td>78</td>
<td>1660</td>
<td>110</td>
<td>78</td>
<td>1.5</td>
</tr>
</tbody>
</table>

*a The world health report 2000 (23).  

*Sources (unless otherwise given): Ameli (26); WHO (27); International Monetary Fund (28).*

**Structure of the health system**

A health system has recently been defined as “all organizations, institutions and resources that are devoted to producing health actions”. Health actions are “any efforts, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health” (23). All of the functions of a health system can be placed under four headings: (a) stewardship or oversight of the health system; (b) creation of resources (investment and human resource training); (c) financing (collecting, pooling and purchasing); and (d) delivering services (provision of care) (23) (Fig. 6 and Table 6). This classification is taken into account in describing the structure of the health system in Iran.

**Fig. 6. Relations between the functions and goals of a health system**

Health and Welfare Systems in the Islamic Republic of Iran

Stewardship

In Iran, health services fees are strictly regulated by the Government. Each year the Supreme Insurance Council, consisting of delegates of MOHME, insurance corporations and economic governmental bodies, develops suggestions for medical fees for Cabinet approval. All health care professionals comply with these decisions. Most of the other supervisory and regulatory functions are carried out by MOHME itself or by the Universities of Medical Sciences on its behalf.

The Universities of Medical Sciences have a functional authority for supervising health care organizations and care standards, and they are ultimately responsible for the protection of patients and other citizens as consumers of health services and health-related products such as food and drugs. All health care organizations, from hospitals to physicians’ offices, governmental or nongovernmental, must be licensed by MOHME or the Universities of Medical Sciences (17). According to the first clause of the Organization and Functions of the Ministry of Health Act of 1988, the Ministry is also responsible for regulating and standardizing pharmaceuticals and medical equipment (16) and is required to strictly regulate drug prices (16). MOHME has also joint and sometimes overlapping supervisory and regulatory functions in such areas as occupational health (with the Ministry of Labour), water sanitation (with the Ministry of Energy), food safety (with the Ministry of Agriculture), environmental health (with the municipalities and the State Environmental Protection Organization) and school health (with the Ministry of Education).
Table 6. Types of organization performing or greatly influencing different health system functions in Iran

<table>
<thead>
<tr>
<th>Function</th>
<th>Governmental</th>
<th>Nongovernmental public or not-for-profit</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewardship</td>
<td>• MOHME&lt;br&gt;• Supreme Insurance Council&lt;br&gt;• Health Commission of Parliament and State Management and Planning Organization&lt;br&gt;• XUMS&lt;sup&gt;a&lt;/sup&gt;</td>
<td>• Medical Council of the Islamic Republic of Iran</td>
<td></td>
</tr>
<tr>
<td>Creating resources</td>
<td><strong>Human resources:</strong>&lt;br&gt;• XUMS&lt;br&gt;• Military and other government medical schools</td>
<td><strong>Investment in equipment:</strong>&lt;br&gt;• Government&lt;br&gt;• Military, other ministries, banks and some government corporations (to a minimal extent)</td>
<td>• Private physician corporations</td>
</tr>
<tr>
<td>Finance</td>
<td>• Government (less than 50% of total expenditure)&lt;br&gt;• Insurance Organization for Civil Servants&lt;br&gt;• Insurance Organization for the Army</td>
<td>• Social Security Organization (SSO)</td>
<td>• Out-of-pocket payments&lt;br&gt;• Health insurance through for-profit governmental insurance corporations (Bimeh Iran, Bimeh Asia, Bimeh Dana)</td>
</tr>
<tr>
<td>Provision of care (medical)</td>
<td>• XUMS through (a) PHC network, (b) teaching hospitals, (c) non-teaching hospitals&lt;br&gt;• Other public hospitals (military, other ministries, banks and some government corporations)&lt;br&gt;• Central health programmes (MOHME)&lt;br&gt;• Red Crescent Society and emergency centres</td>
<td>• SSO clinics and hospitals&lt;br&gt;• Charity institutions</td>
<td>• Private physicians&lt;br&gt;• Private physician corporations</td>
</tr>
<tr>
<td>Provision of care (pharmaceuticals and medical goods)</td>
<td>• MOHME&lt;br&gt;• Pharmaceutical Company of Iran</td>
<td>• Red Crescent Society&lt;br&gt;• Revolutionary foundations&lt;br&gt;• SSO</td>
<td>• Smugglers&lt;br&gt;• Private corporations</td>
</tr>
</tbody>
</table>

<sup>a</sup> X University of Medical Sciences (X is any province).

The Islamic Republic of Iran Medical Council (IRIMC) is a nongovernmental organization that also regulates the relationship of most health care professionals with the Government. It is involved in the licensing of medical professionals and acts as a union for the medical community. The structure of the stewardship of the health system in Iran is shown in Fig. 7.

Fortunately, there is considerable political will for the improvement of health system performance in Iran. Overall, the 1979 Revolution could be considered a social revolution, so social demands have been on the political agenda for most of the time.
Fig. 7. The current structure of the stewardship of the health system in Iran

![Diagram of the current structure of the stewardship of the health system in Iran](image)

**Resource generation**

Since 1985, medical schools have acquired regional public health care facilities. These hybrid governmental enterprises, the Universities of Medical Sciences (referred to as XUMS, X being a province), train most health care professionals and all specialist physicians (see Table 7 for statistical data on medical education). Every year over 3000 general practitioners and over 1000 specialists graduate from the XUMS. If we consider hospital beds as an index of investment in health care equipment, the number has doubled since 1979, the government, SSO and private sector shares being 85%, 10% and 5%, respectively.

**Table 7. Structural indicators (reflecting existing resources) for medical education and health-related physical resources in Iran (2000/2001)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of medical universities and educational or research institutions</td>
<td>52</td>
</tr>
<tr>
<td>Total number of students in health-related studies (1997)</td>
<td>42,000</td>
</tr>
<tr>
<td>Medicine, pharmacy, dentistry</td>
<td>19,633</td>
</tr>
<tr>
<td>Health-related M.Sc. studies</td>
<td>737</td>
</tr>
<tr>
<td>Health-related Ph.D. studies</td>
<td>5,300</td>
</tr>
<tr>
<td>Medical specialties and subspecialties</td>
<td>7,456</td>
</tr>
</tbody>
</table>

| Number of academic members                                               | 10,883          |
| Number of non-academic members                                           | 16,915          |
| Number of hospital beds                                                  |                 |
| XUMS                                                                      | 75,549          |
| Private                                                                   | 11,338          |
| Charity                                                                   | 2,700           |
| SSO                                                                       | 10,169          |
| Other governmental organizations                                          | 5,960           |
| Total                                                                     | 105,716         |

| Number of health houses in the PHC network                                | 16,281          |
| XUMS                                                                      | 5,626           |
| Private                                                                   | 401             |
| Charity                                                                   | 246             |
| SSO                                                                       | 293             |
| Other                                                                      | 414             |
| Total                                                                     | 6,980           |

| Number of emergency centres                                              | 377             |
| Number of active ambulances                                              | 913             |

*Sources: Marandi (16); MOHME (29–36, 38); Parliament Research Center (37).*
Finance: national health accounts

Although WHO estimated a per capita health care expenditure of US$ 155 for the year 1998 (27), it is estimated to be as low as US$ 70 for 2000. The calculations are presented in Table 8. This contradiction may be due to the adoption of different exchange rates by the two sources, e.g. 1750 instead of 4800 rials to the dollar.

Based on financial figures, the health system in Iran cannot be considered public any more. As from 1998, the non-public share in financing exceeds 50% (27). Annual public expenditure on health for 2001 was nearly US$ 1.27 billion\textsuperscript{10} or 6118.2 thousand billion rials (39,40). According to WHO, the public contribution to health care expenditure is nearly 42.8% of the total per capita health care expenditure, of which 7.3% goes on social security; we estimate, however, that the public share is not more than 34.5% (Table 8).

**Table 8. Annual per capita health care expenditure calculations for 2000**

<table>
<thead>
<tr>
<th></th>
<th>Out-of-pocket medical charges</th>
<th>Health insurance charges\textsuperscript{a}</th>
<th>Public expenditure on health</th>
<th>Other public subsidies, pharmaceuticals, etc.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rials</td>
<td>272,314</td>
<td>62,810</td>
<td>30,000–35,000</td>
<td>83,329\textsuperscript{d}</td>
<td>11,485</td>
</tr>
<tr>
<td>US$ equivalent</td>
<td>34.0</td>
<td>7.9</td>
<td>3.75–4.43</td>
<td>17.4\textsuperscript{d}</td>
<td>6.6</td>
</tr>
<tr>
<td>Percentage of GDP</td>
<td>2.1</td>
<td>0.49</td>
<td>0.23</td>
<td>1.07\textsuperscript{d}</td>
<td>0.41</td>
</tr>
<tr>
<td>Percentage of total</td>
<td>48.8</td>
<td>11.3</td>
<td>5.4</td>
<td>25.0</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.3 (WHO estimate 4.4)</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Insurance companies health expenditure is estimated to be 74,123 rials (US$ 9.26) per capita.

\textsuperscript{b} Only the subsidies that are paid to the Social Security Organization of Iran.

\textsuperscript{c} According to World Bank estimates for 2000 this figure is 1.5% of GDP, i.e. US$ 25.5.

\textsuperscript{d} From Ref. 39 minus subsidies for pharmaceuticals, medical equipment, etc. equalling approximately 11,485 rials per person. The exchange rate for this subsidy was constant at 1750 rials to the US dollar from 1994 to 2002. This figure also excludes "specific incomes" of XUMS, which are the direct incomes of public facilities that result from the selling of their services.

Source: Iran Statistical Yearbook (41).

A typical household in Iran has relatively low financial protection against health problems. The ratio of prepaid health costs to out-of-pocket payments is relatively low, nearly 70% of private health expenditure being disbursed out-of-pocket (Fig. 8). Some of the figures in Fig. 8 may be misleading, however. For example, the Thai Government covers 61.4% of total expenditure (27), so the real financial protection for people may be much more than it appears. The same holds true for Turkey and the United Arab Emirates, where the government finances nearly 72% and 80% of total health expenditure, respectively.

\textsuperscript{10} In that year the exchange rate for public budgeting varied from 1750 to 7900 rials to the US dollar. A rate of 4800 rials to the dollar is usually used in exchange rate calculations.
The Social Security Organization of Iran (SSO) is affiliated to MOHME. Its social security programmes cover nearly 26 million people, serving 40% of the overall population and 66% of the urban population. Its health care costs exceeded 4280 billion rials (nearly US$ 537.5 million or about US$ 21 per capita) in 1999 (42). Other insurance companies paid nearly 483 billion rials (over US$ 60 million) on health care in 2000 (43). Every urban household spent some 1318 000 rials (nearly US$ 165) (out-of-pocket) health care costs and about 304 000 rials (nearly US$ 38) for health insurance in 2000 (44).

From 1994, governmental hospitals under MOHME have a system of dual finance (45). These beds comprise nearly 75% of the total number of hospital beds in the country (17,29). The programme allows hospitals to receive fees for services provided and therefore to draw up their annual budget based on their income. Nevertheless, part of their expenditure on human resource and educational costs are provided by central government.

Provision of health care

The health care delivery system is a composite of three organizational forms: hierarchal bureaucracies, long-term contractual arrangements, and short-term market-based interactions between patients and providers (Fig. 9). The structure of the public health care delivery system and SSO medical facilities is an example of the first structural form. Nearly 200 000 people work in public hospitals. There are still no private providers with this kind of structure in Iran, but some physician cooperative corporations are beginning to appear. Long-term contractual arrangements under some degree of non-market control are also present in the national health system. The purchaser–provider interaction between insurance companies (including SSO) and the public and not-for-profit and private hospitals, physicians, paramedical facilities and pharmacies are of this second type. Owing to artificially low medical fees and poor reimbursement mechanisms of insurance companies, this organizational form is to some extent fraudulent and dysfunctional. The coverage is unpredictable.

The number of households in Iran in 2000 was estimated at 13 332 264.
Health and Welfare Systems Development

and corruption (under-the-table payments) is frequent. Short-term interactions between individuals and private medical bodies are highly prevalent, with medical fees as high as 12 times the formal fees received by private medical bodies.

The national Generic Drug List now includes more than 1300 drug items. Some 650 items, comprising more than 95% of total domestic demand, are manufactured by 56 Iranian companies; the remainder are imported. Six large companies now carry out over 90% of drug distribution (17).

The public health care delivery system has a regional structure. Universities of Medical Sciences are responsible for delivering health care to the population of their catchment areas. In addition to their academic units, these organizations have two infrastructures for service delivery,12 namely PHC networks and public hospitals. The PHC network is responsible for delivering PHC to all the people in the catchment area, both rural and urban. As mentioned above, PHC with its community health worker (CHW) strategy benefits from an internal referral system: from health houses (with resident CHWs) to health centres. From this point, selected patients are referred to county hospitals then to regional and national hospitals (Fig. 9) (46). The former part of this referral process has never actually been enforced (O. Ameli, unpublished data, 2002).

Fig. 9. Structure of health care delivery system in Iran

There is sometimes a lack of harmony between the PHC system and the acute care system (hospitals) in the Universities of Medical Sciences. Hospital administrators are appointed by the

12 A third infrastructure was previously described in the text as a part of the "stewardship" of the health system. These organizations take care of patients' rights by supervising and accrediting institutions involved in people's health.
University President and enjoy a considerable amount of authority, particularly in financial areas. They therefore do not necessarily follow network administrators’ policies (O. Ameli, unpublished data, 2002). Another reason for this problem is that most of the PHC programmes are centrally defined and governed by the Department of Health in the Ministry, which means that PHC networks usually have direct dealings with MOHME itself.

SSO owns 60 hospitals and 260 clinics and some 34 000 medical treatment centres (public, not-for-profit and private) have contracts with it. It has thus become the principal supplier of medical treatment in the country (42).

Role of the public, private non-profit and for-profit sectors

All the insurance companies are governmental corporations, and 65% of hospital beds belong to the government. Nevertheless, the private sector is very active in health care provision in Iran.

Major challenges for the health system

There are a few general issues confronting the health system in Iran. First, it is said that the unrealistic social expectations of the Iranian people explains to some extent the current negative judgement about the performance of the national health system (O. Ameli, unpublished data, 2002). Second, the health system has some structural discrepancies. There are many organizations that can directly influence health system policies and MOHME, although the most influential, is just one of them. The separation of medical education from the national higher education system has raised major concerns over the quality of training delivered by MOHME (O. Ameli, unpublished data, 2002). The third general conclusion is that the current system may not ensure the necessary continuous development of human resources (O. Ameli, unpublished data, 2002).

Low percentage of GDP dedicated to health and medical fees

Based on the most optimistic figures, expenditure on health does not exceed 5% in Iran, whereas the average for the Middle East and North Africa is 6.3% (47). A symptom of this phenomenon is the very low medical fees in the country. For instance, the charge for a basic medical examination is US$ 2, compared to nearly US$ 100 in the United Kingdom. The formal fee for a minor surgical operation is less than US$ 25 and the informal price never exceeds US$ 250, whereas in the United Arab Emirates it is at least US$ 550 (more than 20 times the formal fee) (48). The cheapest drug prescription in the United Arab Emirates is US$ 5.4, while it is less than US$ 0.5 in Iran. Every year a considerable number of citizens from neighbouring countries come to Iran to receive less expensive health care. MOHME is now conducting a multidimensional project to increase this figure. In addition, there is a large difference in household expenditure on health among the different regions of the country. This means that there is an unfair and non-homogeneous distribution of financial resources between the more developed and the less developed provinces of the country. In 1994, for example, on average every household in Tehran spent nearly 6.5% of its income on health, whereas in Kermanshah the figure was half of that at 3.3% (16). The proportion of household expenditure spent on health care services has steadily declined since 1991, despite the ageing of the population. Health care services are increasingly considered to be luxuries.

Insurance coverage and effectiveness

Despite the country’s impressive achievements in the area of public health, the past five years have seen a steep rise in the cost of medical services. This is due partly to the high rate of inflation that has affected various sectors of Iran’s economy, and partly to government efforts to reduce across-the-board public subsidies to various consumer commodities and services established during the war period. Because of the intrinsic importance of health services and the commitment of the Constitution to the provision of free public health services, the increasing cost and allegedly falling quality of
health services have created a great deal of public concern and discussion. The political groups opposed to the Government's economic readjustment policy have taken advantage of these concerns and turned the rising cost of public health and education, and government plans to encourage more active private sector investment in these areas, into a highly sensitive political issue. Partly in response to these concerns and political pressures, a Universal Health Insurance Scheme was ratified by Parliament in October 1994 and was expected to cover the entire population of Iran by the end of the second development plan in 1998/1999. According to official estimates, about 26 million of the 65 million population of Iran are presently covered by the SSO health insurance services. Another 3 million are covered by the Armed Forces Health Services System. The remaining 40 million are expected to be covered by the newly created Universal Health Insurance Organization (UHIO) within the next three years. Those falling below certain income levels (estimated to be around 4 million) will be insured free of charge and their premiums paid by the Government through the Imam Khomeini Social Assistance Committee. The urban self-employed have to pay their membership fees annually, whereas those employed by various organizations will have to pay only 20% of their premiums, the remaining 80% being paid by their employers (to be refunded by the Government as a subsidy to the employer). Villagers who are members of rural cooperatives are also allowed to pay their annua; dues by installments. The insured are expected to pay 25% of the cost of ambulatory services and 10% of inpatient hospital care expenses, the rest being covered by UHIO. The budget allocated to UHIO in the 1996/1997 fiscal year was estimated to exceed 600 billion rials (nearly US$ 100 million) (22). However, other studies show that at least 25% of the Iranian population currently have no insurance coverage (49). On the other hand, owing to the very low medical fees, collaboration between insurance companies and health care providers is ineffective. This is because the major insurance companies are mandated by law to base their contracts with health care providers on the medical fees approved by the government, although most private health care providers in large cities claim that these fees do not even cover their basic fixed costs. Therefore, a large proportion of physicians and private hospitals have practically discontinued their contracts with insurance companies. Those who are insured are in fact underinsured, owing to the ineffective relationship between health care providers and insurance companies.

**Inefficiency**

There is too much waste in the health sector. In some areas of the country, bed occupancy rates in hospitals never exceed 30% (39). It is generally believed that the private sector could run most of the health care services more efficiently. The State Management and Planning Organization estimates that 30% of the public budget dedicated to hospitals is wasted (50). One important source of waste in the public sector is the uncompleted construction of hospitals in various parts of the country (49, 51).

**PHC for the urban population**

PHC for the urban population is poor (O. Ameli, unpublished data, 2002). While the rural branch of the PHC network currently covers a sizeable portion of the population, the urban PHC project is in its early stages of implementation. For instance, in 1990 complete immunization in the first year of life was 44.1% in rural areas with the PHC services, whereas for urban areas other than Tehran it was 28.1% (in 1991) (51). There is also doubt as to whether the current PHC strategy is effective for urban areas.

**Road traffic accidents**

Road traffic accidents are increasing rapidly in poor countries and are projected to move from ninth to third place in the worldwide ranking of burden of ill-health by the year 2020 (23). In Iran, nearly 19,000 deaths and 91,000 casualties due to road traffic accidents are recorded every year. The mean age of those killed is 25 (50), which translates to at least 675,000 life-years lost.
Newly emerging and re-emerging diseases

Although AIDS and other sexually transmitted diseases are not newly emerging diseases, there is a growing awareness of their serious impact on public health. Research on 8,900,000 blood samples shows that the prevalence of HIV infection is 41 per 100,000 population. This means that there are approximately 27,000 HIV-positive people in Iran (52). The number of cases has increased more than 600 times in 15 years. In 1988, only 40 patients were diagnosed in Iran (52), and most of these people contracted the disease through infected syringes and intravenous drug abuse (52). In 2000 alone, there were nearly 30,000 new cases of syphilis and 22,000 gonorrhoeal infections in Iran. These figures have caused concern among the health officials because the former assumptions were contradictory. Tuberculosis, and malaria are other re-emerging diseases that have recently caused major concern.

Emergency medical system and rescue services

The international standard for the appearance of the rescue services at the scene of an accident is 8 minutes. In the best circumstances it is more than 15 minutes in Iran (53). In the large cities such as Tehran, freeways are one of the most accident-prone places. Health officials believe that one of the most significant weaknesses of the emergency centres is their poor capacity owing to a lack of sufficient human and physical resources. It must be emphasized that the rescue process is not the only problem with the system; the suboptimal performance of emergency medical departments in public hospitals plays a major role (53). The Emergency Organization of Tehran was formed in 1975 after the incident at Mehrabad Airport in which the ceiling fell and a number of people were killed or injured. There is now an emergency centre in each town of the country. Except in Tehran, these centres come under the Universities of Medical Sciences. As of 1996, there is a central staff organization in MOHME for the supervision and coordination of operational units all around the country (16).

Temporary shortages of pharmaceuticals

One of the most serious problems for the health system is the temporary shortage of certain pharmaceuticals (16). The importing of drugs and raw materials is complex and intersectoral, because various ministries are involved in the process. This usually slows the responsiveness of the market to alterations in demand. Another related shortcoming in the field of pharmaceuticals is the problem of inappropriate distribution, which leads to artificial shortages in some places and unnecessary surpluses in others (16).

Lifestyle modification and control of noncommunicable diseases (hypertension, ischaemic heart disease, diabetes)

It is estimated that over 30% of the adult population are obese and 60% of them undertake insufficient physical activity.

Occupational safety

The coverage of occupational safety programmes is far from acceptable. For instance, in 1996 fewer than 2 million workers or less than 20% of the eligible population were covered by the occupational safety measures of MOHME (16). In addition to MOHME, the Ministry of Labour and Social Affairs as well as the Social Security Organization are involved in the area of occupational safety and health (16), and this is a likely cause of inefficiency and poor coordination.

Other important issues that require urgent attention in Iran’s health system include nutrition and food safety, mental health, the ageing population, control of drug abuse, social and domestic violence, environmental health and intersectoral coordination.
Current strategies

The following are the most important national strategies implemented by MOHME.

Increasing public expenditure on health

The basis for this strategy is discussed in more detail above. MOHME is working hard to increase public awareness of the importance of the health system in the process of sustainable development, so that people consider expenditure on health as an investment. Health policy-makers are working with the press and other media to do this. Nongovernmental organizations such as the Islamic Republic of Iran Medical Council are also active in this regard. At the same time, there are efforts to increase the share of prepaid expenditure on health, through the promotion of health insurance plans. There also exists an active lobby involving MOHME, the State Management and Planning Organization, the Government and Parliament to increase public expenditure on health through the process of annual government budget approvals.

Health care rationing

One of the most popular strategies for improving resource allocation in the health sector at macro level is health care rationing. As it can be seen from Fig. 10, there is a particular kind of relationship between need and demand in the health system. It is the unique role of health care providers, such as physician, to translate needs into demand. Generally, this means that most of the demand in the health system is directly or indirectly determined by the providers themselves. This will generally lead to an ever-increasing demand for health care, precipitated by the advent of new health care technologies. Two kind of regulatory mechanism have been developed to combat this trend: (a) the regulatory role of purchasers (e.g. supervision by insurance companies of the validity of need to translate need into demand); and (b) the regulatory role of government through various forms of health care rationing (46). The latter strategy is based on the concept of “new universalism” concerning equity in access to health care (23). In this new concept, the minimum package of health care services is developed after cost-effectiveness studies of different health interventions (ranging from simple vaccination to magnetic resonance angiography). The most cost-effective health interventions are selected and their delivery to the whole population is guaranteed by certain strategies (46). This strategy is closely coordinated with the means of establishing a more effective referral system in the country. To achieve health care rationing goals in 2002, feasibility studies of 25 hospitals with capacities from 25 to 200 beds will be performed in underserved areas of the country.

Fig. 10. The relationship between health needs and demand and the key players
Privatization of health care delivery

As stated earlier, the health care delivery system has major efficiency problems, which means that a lot more could be accomplished with the current resources. Privatization of health care delivery is a strategy that the Government is deploying to improve the efficiency of the system. This strategy allows for the implementation of free market relationships within the health system.

Developing the management skills of health care managers

MOHME is investing heavily in training courses for health care managers. This type of human resource development is expected to influence the quality of care and institutional efficiency (54).

Postgraduate continuing education for health care professionals

One of the duties of MOHME is to continuously monitor the technical competence of health care professionals in the country. To this end, in 1996 Parliament enacted a law on continuing education obliging all physicians, dentists, pharmacists and nurses to renew their working licences every five years. A licence will not be renewed unless the person has undertaken sufficient continuing education in the previous period. The needed organizational structure for implementing this law was created in the following years. Nowadays, professional scientific associations and Universities of Medical Sciences jointly implement the continuing education programmes. In fact, associations implement the programmes and the Universities oversee the validity of the curriculum and sometimes provide lecturers (16).

Suggested priority areas or changes

In summary, the following priority areas are identified:

- improving the accuracy and scope of the present health information infrastructure;
- evaluating effectiveness in the integration of health education and health care provision;
- improving PHC coverage in urban areas; and
- establishing a universal and widespread referral system in the country.
Welfare system

Theoretical overview

Social protection and welfare programmes are a collection of measures designed to improve or protect human capital, ranging from labour market interventions, through publicly mandated unemployment or old-age insurance, to targeted income support for underprivileged groups of the population (55).

Social protection interventions assist individuals, households and communities to better manage the risks that leave people vulnerable (55). Social protection seeks to: (a) reduce the vulnerability of low-income households with regard to basic consumption and services; (b) allow households to shift income efficiently over the life cycle, thus financing consumption when needed; and (c) enhance equity, particularly with regard to exposure to and the effects of adverse events (55).

Social protection contributes to solidarity, social cohesion and social stability (55) and thus promotes the social development of a country. In fact, existence of a powerful and extensive social security and welfare system is a prerequisite of every development plan (56). Well designed and implemented, these interventions support substantial economic development in a participatory manner (55). The existence of social protection reduces disease rates and improves mental well-being. It has long-term effects and reduces overall costs (57). There is a relationship between social security and economic development (58).

On the other side of the coin, however, the exact same processes that increase opportunities to improve welfare increase the vulnerability of a society, particularly for specific groups within it (55).

According to Clause 29 of the Constitution, and in order to expand social justice, the benefits of a social security system are considered the right of every Iranian citizen. This system is intended to protect various groups of society against economic, social and natural risks and their consequences, such as unemployment, retirement, ageing, physical, mental or psychological disability, accidents and the need for health care. This is carried out through insurance and non-insurance (support and rescue) mechanisms, and the Government is obliged to provide such protections for every citizen based on the relevant legislation and to provide for the costs of this from its general revenues and the revenues collected from people’s cooperation (59,60). In addition to Clause 29, the second paragraph of Clause 3 and the first paragraph of Clause 23 of the Constitution emphasize care for the retired and aged and the provision of justice to eradicate poverty and to create welfare and health (56).

Interestingly, the design of the welfare and social security system is now a top priority in the political agenda in Iran. One of the goals of the 1979 Revolution was to support the poor and underprivileged groups in society. As in many other countries, there have been various points of view and debates among policy-makers, the media and the population around this topic in the past 40 years, and it has still to be settled. It is believed that many social disturbances have resulted from deficiencies in this system (61,62).

It must be emphasized that social welfare and social security are intersectoral issues, and no single organization is able to cover all of their aspects (63).

Four major areas should be covered by a comprehensive social security system (1):

- health insurance;
- social insurance (including issues such as retirement, work-related disability and pensions);
Health and Welfare Systems in the Islamic Republic of Iran

- support services for those who lack the ability to satisfy their basic needs, including: (a) the physically or mentally disabled; and (b) the poor and those without any guardianship or economic support; and
- rescue and assistance in the case of natural or man-made disasters, aimed at educating people and increasing their preparedness in order to prevent or reduce injury as a result of disasters.

Targeted subsidies are one of the important elements of the comprehensive social security system. The design of such subsidies is not possible until the design of the total system is clear (64).

Health and welfare are closely linked and mutually support development. Activities aimed at reaching social goals can contribute to achieving health goals as well. On account of this close interaction, there can also be cross-system goals (1). It is therefore imperative that health system development and welfare system development are conceived together and implemented simultaneously (1).

Historical analysis

For centuries, health has been deemed an intrinsic part of welfare and, at the end of the 19th century, the interest of philanthropists in the welfare of humankind promoted action to improve people’s health. Like the Poor Law Commission in the United Kingdom in 1842 that led to the Chadwick report, Lemuel Shattuck’s report on a sanitary survey of Massachusetts in 1849 brought forth far-reaching health reforms in the United States. Bismarck’s introduction of social insurance in Germany in 1883 also influenced the concept and application of welfare systems elsewhere, with Belgium, Japan and Norway adopting national insurance systems. In the United Kingdom, the 1942 Beveridge report on social insurance and allied services provided the basis for the post-war welfare state, which finally led to the British National Health Service Act of 1948. One of the major technical inputs of the United Nations in the 1950s was the establishment of community welfare work as a basis of welfare systems in the newly independent developing countries, covering health, education, agriculture and social welfare (1).

The era before 1979

Social security in Iran has an 80-year history. Before that, serving the disabled and social protection mechanisms existed only in the form of charity and religious activities. Insurance services were first provided for in the Civil Employment Act in 1922 (16). Social security in Iran began in 1930 with a decree insuring road construction workers against work accidents resulting in disability or death (16,65). Before 1935 there were only foreign insurance companies in Iran, but in that year the Insurance Company of Iran started formal activities (16). The Law of Obligatory Insurance against Work-related Injuries and the Labour Law were enacted in 1943 and 1946, respectively (16). In 1953 the Civil Workers Insurance Law was enacted, providing for Medicare-like coverage, sickness and disablement benefits, marriage and maternity grants, pensions and family allowances (16,65). In 1969, the Law of Insurance for the Rural Population was enacted, but did not become fully effective (16).

Apart from insurance activities, the creation of other public institutions for the provision of welfare services began under the Fourth National Five-Year Development Plan, which had a social welfare chapter for the first time. The comprehensive social welfare chapter of the Fifth National Five-Year Development Plan was a result of experience with the implementation of this plan (1).

Iran’s Fifth Development Plan has been described as a “welfare plan”, because social affairs accounted for a large proportion (21%) of government spending (65). The Fifth Development Plan’s target was to increase coverage to 14 million persons, including dependants, and to raise the total coverage to the entire active population by the end of the Sixth Development Plan (1983) (65).
The organizations providing social services for the disabled at that time, covering physical disabilities, mental disabilities and social disabilities, included (16):

- the Rehabilitation Society, founded in 1957 by law and delivering educational services and psychological support to the physically disabled;
- the Society for the Protection of the Iranian Handicapped, founded in 1956 and conducting research activities in addition to service provision;
- the National Organization for the Welfare of the Blind, founded in 1960 and providing educational and employment services for the blind;
- the National Organization for the Welfare of the Deaf, founded in 1961 and providing educational, employment and other welfare services for the deaf; and
- the Society for Protection of the Mentally Retarded.

Two comprehensive seminars on social welfare were held in 1974 and 1976, and proved to be landmark events in the national history of social welfare. The first seminar was composed of ten committees covering the following topics: welfare of children, welfare of youth, welfare of the aged, welfare of women, welfare of workers, welfare of the rural population, welfare of the handicapped, welfare and social security, leisure time, and coordination of welfare institutions (16). In fact, the establishment of the Ministry of Social Welfare in 1974 emerged from this seminar. Its purpose was to create a comprehensive social security system with the aim of expanding and integrating the welfare services, coordinating among the institutions involved, and facilitating the implementation of welfare, social security, health and rehabilitative programmes (16). Two important insurance organizations, the Social Security Organization and the Civil Servants Insurance Organization, were placed under the Ministry of Social Welfare (16, 62), whereas social welfare had hitherto been the responsibility of the Ministry of Labour. However, from the beginning of its work, two facts were evident: (a) health and welfare services were highly interdependent and their independent provision was not cost-effective; and (b) the resulting centralization and bureaucracy acted as an impediment to the rapidly expanding welfare and social security activities (16). Thus in 1976 the Ministry of Health and the Ministry of Social Welfare were integrated and social welfare became the responsibility of the amalgamated Ministry of Health and Welfare (16, 65). Thus, before the Revolution, the Ministry of Health and Welfare took care of the disabled through various institutions and its Deputy of Welfare performed staff activities (16).

In 1974 the Social Insurance Organization was replaced by the Social Security Organization (SSO), with increased responsibilities (65). In 1975 the Social Security Law came into force (65), providing more substantial benefits financed from a contribution equal to 30% of the insured person's earnings, 7% paid by the insured, 20% by the employer and 3% by the Government (65). By the end of 1975, over 1.5 million individuals were covered by social security legislation, or over 6 million if their dependents were included (65). It is said that in the 1970s, the intention was to start social security coverage in urban areas and then expand to the rest of the population. So that an extensive social security system could be realized, therefore, the rural population had also been included in the Social Security Law (62).

Social security and welfare programmes absorbed over US$ 800 million in the 1976/1977 financial year alone (65). This occurred while top priority continued to be given to public health, improved medical services (through a low-cost nationwide insurance network) and an overall expansion of social services (65).

**Post-Revolution era**

Despite evidence of widespread deprivation and poverty, insufficient attention had been given to poverty alleviation in the development plans of the country during the pre-Revolution period (22). The prevailing development model pursued by Iran and many other developing countries in the 1960s...
and 1970s also tended to regard some increase in relative poverty and income disparity as an inevitable by-product of economic growth, which would gradually balance out through a rise in overall economic productivity and growth – the so-called “trickle down effect” (22).

The social initiative toward welfare goals, as reflected in the welfare-type Constitution of the Islamic Republic of Iran, resulted in the formation of several nongovernmental organizations under the supervision of the Leader of the Revolution. These functioned along with, and sometimes in parallel with, governmental institutions involved in social welfare (66). The vast amount of property and assets left behind from wealthy groups associated with the pre-Revolutionary regime was turned over to a public nongovernmental foundation called “Bonyad-e Mustaz’ a fin” (Foundation for the Impoverished). A similarly constituted, nongovernmental Islamic Housing Foundation was created to provide the homeless with land, building materials and interest-free loans. Simultaneously, a volunteer social assistance organization developed by the traditional business classes (Bazaar) during the Revolution, known as the Imam Khomeini Social Assistance Committee, was provided with new resources and the official mandate to continue its poverty relief activities throughout the country (22).

The welfare division of the Ministry of Health and Welfare underwent a substantial structural change in 1979 (16). Charitable health and social protection organizations that had developed during the last years of the old regime were grouped together under the general umbrella of a new government agency affiliated with the Ministry of Health and known as the Behzisti (Welfare) Organization (22,67). These organizations included the National Organization for Family Welfare of Iran, the Welfare and Education Organization of Children and Youth, the National Organization for the Welfare of the Blind, the National Organization for the Welfare of the Deaf, the Women’s Organization and four other organizations and two hospitals. Dr Faizabakhsh was the founder of the Behzisti Organization in its current form, which, despite its affiliation with the Ministry of Health, functioned independently.

In 1979 the Revolutionary Council integrated the Provision of Treatment Organization, comprising the SSO and the Civil Servants Insurance Organization, into the Ministry of Health. In 1989, however, the SSO was separated from the Civil Servants Insurance Organization (16). In 1995 the Extensive Insurance Law was enacted and the Treatment Services Insurance Organization (Civil Servants Insurance Organization) was obliged to insure the poor, rural populations, war veterans, students, families of martyrs and the self-employed (16). Health insurance coverage in 1997 is presented in Table 9.

Table 9. National statistics of health insurance coverage in 1997

<table>
<thead>
<tr>
<th>Insurance organization</th>
<th>Covered population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Services Insurance Organization</td>
<td>Civil servants and their families</td>
</tr>
<tr>
<td></td>
<td>Rural population</td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
</tr>
<tr>
<td></td>
<td>Other groups</td>
</tr>
<tr>
<td>Imam Khomeini Social Assistance Committee</td>
<td>The poor</td>
</tr>
<tr>
<td>Social Security Organization</td>
<td>Labour force</td>
</tr>
<tr>
<td>Treatment Services Insurance Organization of Armed Forces</td>
<td>Armed forces and their families</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

Source: Marandi (16).

To deal with poverty and other problems of traditionally neglected rural areas, a volunteer organization called Jihad Sazandagi (Crusade for Reconstruction) was first developed to help villagers
carry out normal agricultural production activities, as well as general development projects such as environmental sanitation, electrification and the provision of piped water. A government-funded, noncontributory retirement scheme was also developed to help the disabled, which in fact represented the first effort by the national government to establish a social assistance programme targeting the rural poor in Iran (22). In 1986 a law obliged the Government to dedicate 3% of its job positions to the disabled (68). A universal subsidy system aimed at maintaining the purchasing power of households with fixed incomes was also developed (22). Thus, despite the debilitating pressure of the eight-year Iran–Iraq War, the Government was able to create a modest system of social protection for the most needy segments of the population (22).

The First National Five-Year Development Plan aimed at further consolidating gains made by Iran in the area of social development by revitalizing the national economy through encouraging private initiatives and giving market forces a better chance to operate. Any rise in unemployment and poverty caused by this policy was expected to be tackled through improvements in economic growth, productivity and increased employment opportunities. The special needs of the most vulnerable segments of the population were to be addressed through a more streamlined social assistance system requiring a better coordinated approach by the existing governmental (Behzisti Organization) and nongovernmental organizations (Imam Khomeini Social Assistance Committee). Universal rationing and across-the-board subsidies were to be replaced by a more targeted programme. A safety net system was to be set up to meet the temporary needs of the working population who might lose their jobs due to the proposed economic restructuring programme. At the same time, the existing contributory social insurance and pension systems were to be strengthened, and retirement and other benefits extended to the whole labour force (22).

The failure of economic adjustment measures to revive the economy, along with rising inflation, an unexpectedly marked growth in foreign debt, and signs of deteriorating living conditions of some segments of the population towards the end of the First Development Plan, rekindled public and media interest in social justice and poverty alleviation. In response to rising signs of public dissatisfaction and political pressure, the Government had to drop some of the major goals and strategies for economic adjustment and take fiscal measures aimed at lowering inflation and controlling the cost of living. The new orientation to economic development, aimed at achieving economic efficiency with minimal disturbance of social equity, is clearly reflected in the Second National Five-Year Development Plan, whereby poverty alleviation was presented as one of the explicit goals of the Government (see Table 10). In line with this new economic policy, a National Poverty Alleviation Conference was held in Tehran in May 1996. During this conference, the Poverty Alleviation Bill prepared for ratification by the Islamic Consultative Assembly (Parliament) was also put to public debate (22).

It can thus be argued that almost all of the recommendations of the Regional Social Development Agenda have been taken into consideration in the preparation of the Second Five-Year Plan, which was formally launched in 1994 and expected to conclude in 1999. The commitment of the country to the guiding principles of social development was clearly reflected in the letter sent by the Spiritual Leader (Head of State) to the President of the Republic concerning the Second Five-Year Plan upon of the final ratification of the Plan by the Islamic Consultative Assembly. The Leader listed the following principles of social justice to be adhered to (22):

- optimal distribution of public resources;
- collection of taxes according to level of income;
- legal protection of the impoverished segments of society in areas of government and judicial services;
- priority attention and assistance to deprived regions and rural areas, particularly with respect to employment generation, health and expansion of educational facilities and opportunities;
• prevention of accumulation of wealth through illegitimate means;
• creation/expansion of employment opportunities according to relative capabilities and regional priorities; and
• expansion and improvement of the social security system.


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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidies for pharmaceuticals, milk powder, medical equipment, etc.</td>
<td>3.531</td>
<td>3.253</td>
<td>3.014</td>
<td>2.814</td>
<td>2.586</td>
<td>2.323</td>
<td>2.760</td>
</tr>
<tr>
<td>Other social and public affairs</td>
<td>28.924</td>
<td>27.918</td>
<td>28.795</td>
<td>29.612</td>
<td>31.522</td>
<td>32.378</td>
<td>30.248</td>
</tr>
<tr>
<td>Total share of social and public affairs</td>
<td>51.23</td>
<td>50.73</td>
<td>51.88</td>
<td>52.56</td>
<td>55.32</td>
<td>55.75</td>
<td>53.48</td>
</tr>
</tbody>
</table>

Source: ESCAP Group (22).

The social development ideology of the Second Five-Year Plan received renewed attention and emphasis under the administration of President M. Khatami. Economic and political orientation included a deeper commitment to social justice and equity as compared to market-oriented efficiency.

The mass participation of women and young people in the presidential election was probably the first clear manifestation of the political gains from Iran’s massive investment in public education since the Revolution.

Partly owing to the crisis that has ravaged many South-East Asian economies, and the continuing dependence of the economy of Iran on oil revenues, a sharp decline in government revenues since 1997 threatens to constrain the Government’s ability to maintain the previous level of investment in social services and human development. The emergency “economic reorganization plan” unveiled by the President in 1998, however, reiterated the Government’s commitment to sustain investment in social development, particularly public health and education, and to maintain the purchasing power and living standards of the more vulnerable segments of the population through continued government subsidies.

The commitment of the Government to social development is clearly reflected in the share of the social services sector in total government expenditure (annual budget) as indicated in Table 11. The share of the social sector in the annual government budget was just over 30% in 1981. It rose to over 40% by 1986, and has remained above that point ever since. Among the five main components of social development, education and social security consistently tended to consume more than 30% each of all government spending on social services, with health expenditure taking third place. As a result of this high level of investment in social services, the Government has succeeded in raising most of the social development indicators of the nation far above their pre-Revolutionary levels. The achievements of the Government in this area are most noticeable owing to the fact that, during the first part of this period (1976–1986), the population increased at a staggering rate of 3.9% per annum, and a significant amount of the country’s resources were forced into defence (22).
Table 11. Percentage share of various social development sectors of the annual budget allocated to “social affairs”, 1981–1994

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Public education</td>
<td>46.68</td>
<td>35.28</td>
<td>33.09</td>
<td>34.96</td>
<td>35.44</td>
<td>32.56</td>
</tr>
<tr>
<td>Culture and arts</td>
<td>0.73</td>
<td>0.82</td>
<td>1.06</td>
<td>1.12</td>
<td>2.07</td>
<td>2.22</td>
</tr>
<tr>
<td>Health and nutrition</td>
<td>16.07</td>
<td>13.71</td>
<td>17.39</td>
<td>17.07</td>
<td>17.41</td>
<td>19.74</td>
</tr>
<tr>
<td>Social security and welfare</td>
<td>26.57</td>
<td>37.21</td>
<td>30.45</td>
<td>28.30</td>
<td>25.89</td>
<td>25.37</td>
</tr>
<tr>
<td>Physical education and youth</td>
<td>1.03</td>
<td>0.61</td>
<td>1.09</td>
<td>0.96</td>
<td>1.09</td>
<td>1.21</td>
</tr>
<tr>
<td>Urban development</td>
<td>2.33</td>
<td>0.86</td>
<td>1.66</td>
<td>2.21</td>
<td>3.05</td>
<td>2.87</td>
</tr>
<tr>
<td>Rural development</td>
<td>0.58</td>
<td>0.48</td>
<td>1.08</td>
<td>1.28</td>
<td>1.24</td>
<td>0.96</td>
</tr>
<tr>
<td>Housing</td>
<td>5.64</td>
<td>1.41</td>
<td>2.02</td>
<td>1.48</td>
<td>1.61</td>
<td>2.85</td>
</tr>
<tr>
<td>Environment</td>
<td>0.21</td>
<td>0.22</td>
<td>0.20</td>
<td>0.22</td>
<td>0.25</td>
<td>0.28</td>
</tr>
<tr>
<td>Multisectoral projects and regional development</td>
<td>0.16</td>
<td>0.28</td>
<td>0.44</td>
<td>0.48</td>
<td>1.51</td>
<td>1.01</td>
</tr>
<tr>
<td>Technical/vocational education</td>
<td>0.00 a</td>
<td>3.96</td>
<td>4.15</td>
<td>4.12</td>
<td>2.47</td>
<td>0.02 a</td>
</tr>
<tr>
<td>Higher education and research</td>
<td>0.00 a</td>
<td>5.16</td>
<td>7.39</td>
<td>7.79</td>
<td>7.99</td>
<td>10.91</td>
</tr>
</tbody>
</table>

a Accuracy in doubt.

Source: ESCAP Group (22).

In 1996 the Insurance Organization for Health Care Services was established and insurance coverage was extended to other groups such as the rural population (62).

The Third National Five-Year Development Plan mandated the Government to develop the needed legislation for establishing the Extensive Social Security and Welfare System (69). It was approved in 2000. Such a system has always been an important vision of the Islamic Revolution (66). Owing to the existence of multiple stakeholder organizations, various plans were prepared by at least ten of these organizations, including the SSO, the State Management and Planning Organization, the Welfare Organization and the Imam Khomeini Social Assistance Committee (69,70). This issue was complicated by political campaigns. In June 2001, one of the members of the Health Committee of Parliament presented a modified form of the SSG plan (69). Four months later this plan started its legislative process in Parliament. In April 2002 Parliament postponed its final ratification for three months (45,60).

Current status of the welfare system

Organizational set-up for social development and poverty alleviation

The various activities undertaken as part of the social development programme require interventions by a large number of national ministries, each with its own national and provincial executing agencies. These include MOHME, the Ministry of Education, the Ministry of Labour and Social Affairs, the Ministry of Housing and Urban Development, the Ministry of Jihad and Agriculture, the Ministry of Power (Water and Electricity), and the Ministry of Roads and Transportation. Other specialized government departments, such as the Central Bank of Iran, the Ministry of Culture and Higher Education, the Ministry of Culture and Islamic Guidance, the Ministry of Economy and Financial Affairs, the Ministry of Trade, the Ministry of Industry, the Ministry of Cooperatives, the Ministry of National Defence and the Ministry of Mining, play relatively important roles in social development and poverty alleviation through their contribution to economic productivity and growth, human resource development and employment generation.
The State Management and Planning Organization (MPORG) is the national planning agency. Headed by a Deputy President of the Republic, MPORG is responsible for assessing the general economic situation, allocating national resources, preparing the annual budget, formulating the National Five-Year Development Plans, and the monitoring and evaluating development activities undertaken by different government departments and organizations. The annual budget of all government departments and activities is prepared by MPORG in close consultation with various executive departments and agencies, as well as the relevant parliamentary committees. The budget is formulated as a parliamentary bill for further discussion and final ratification by the Islamic Consultative Assembly. Once ratified, the budget bill becomes law and the Government is legally obliged to implement, monitor and evaluate it. A similar process is followed in the case of the five-year development plans, which are partially designed to direct the day-to-day activities and investment of the Government towards the attainment of certain longer-term strategic goals. The government budget consists of two major components: the current budget and the development budget. While both of these components have specific implications for social development, the long-term objectives of poverty alleviation are mainly addressed through development activities and the resources earmarked for them.

MPORG may thus be regarded as the main focal point for overall social development and poverty alleviation in Iran. Within MPORG, responsibility for poverty alleviation rests with the Social Affairs Division, which is headed by a Deputy Director for Social Affairs. Monitoring and evaluation of progress made in the attainment of the social development and poverty alleviation goals of Iran also rests with the Social Affairs Division. In practice, however, responsibility for the actual implementation of the social development programmes lies with individual government departments and several semi-governmental organizations created since the Revolution with the objective of meeting the needs of specific vulnerable groups. The most important among the latter are the Imam Khomeini Social Assistance Committee, the Islamic Housing Foundation, the Foundation for (the protection of) Wounded Veterans of the Revolution and the Imposed War, and the Martyrs Foundation. These autonomous organizations are affiliated with the office of the Leader and are expected to be funded through their own endowments. In practice, however, all of them have become increasingly dependent on government funding and thus subject to degrees of supervision, monitoring and evaluation by MPORG.

Among the government departments, MOHME bears the main responsibility for poverty alleviation. This is due to the fact that the two main government agencies for contributory social insurance (SSO) and non-contributory social assistance (the Behzisti Organization) are administratively part of this ministry. In addition to its direct role in poverty alleviation, MOHME is also exclusively responsible for providing basic health and medical services throughout the country, particularly in traditionally neglected rural areas and to more deprived segments of the urban population.

With regard to housing and shelter, the Ministry of Housing and Urban Development is the official government agency for ensuring access to decent and affordable housing by all citizens. Meanwhile, the Islamic Housing Foundation is expected to look after the housing needs of the most vulnerable segments of the population in both urban and rural areas, while the Jihad division of the Ministry of Jihad and Agriculture is responsible for such fundamental rural development projects as the extension of piped water and environmental hygiene. The Ministry of Education is also indirectly involved in poverty alleviation, both through its normal efforts to raise the level of literacy and human capital of the population, and through the provision of residential facilities for the education of children and young people from poor or deprived family backgrounds.

All these agencies are required by law to collect periodic data on their activities and attainments, and to make them available to MPORG for evaluation. These agencies are also practically motivated to do so because continuation of their funding may depend on satisfactory assessment by MPORG experts (45).
The existing social insurance, welfare and poverty alleviation systems

More than 29 different organizations and insurance funds are directly involved in social security and welfare in Iran (69). Social security experts place these institutions in two broad categories: (a) the contributory social insurance system that delivers health and social insurance to the employed population and their families; and (b) noncontributory social assistance organizations that deliver social supportive and emergency and rescue services (69). The first group covers those individuals who are employed and productive, and aims to reduce the risks of retirement and disability (69). The latter are those who are not productive owing to disability and other vulnerable groups like the poor; also included in this group are those who are victims of disasters. These organizations are funded through government revenues (69).

The total budget for supportive and social services in the country in 2002 is estimated to be 93,530 billion rials (approximately US$12.15 billion) or 66% of the total government budget (69). Some 22.5% of the total government budget in this year is devoted to social security and welfare (72). The proposed budget for social security and welfare in 2002/2003 is 22,776.2 billion rials (from general government revenues) or approximately US$2.96 billion (73). To this figure should be added institution-specific revenues such as SSO revenues from insurance premiums and returns on investment.

An overview of the services, covered population and approximate resources of the institutions involved in social insurance and welfare is presented in Table 12. A schematic presentation of the structure of the social security and welfare system is shown in Fig. 11.
### Table 12. An overview of the existing organizations involved in social security and welfare in Iran, 2001

<table>
<thead>
<tr>
<th>Organization</th>
<th>Groups covered</th>
<th>Services</th>
<th>Covered population (thousands)</th>
<th>Budget in billions of rials (US$ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Organization</td>
<td>Labour force</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>26 000</td>
<td>18 233 (2368)</td>
</tr>
<tr>
<td>Civil Servants' Pension Fund</td>
<td>Civil servants</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>6300</td>
<td>39 82 (517)</td>
</tr>
<tr>
<td>Treatment Services Insurance Organization</td>
<td>Civil servants, rural population, self-employed, Behzisti referrals</td>
<td>Treatment</td>
<td>23 100</td>
<td>30 85 (401)</td>
</tr>
<tr>
<td>Armed Forces Pension Fund</td>
<td>Armed forces</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>1246</td>
<td>19 75 (256)</td>
</tr>
<tr>
<td>Revolutionary Guards' Pension Fund</td>
<td>Armed forces</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>690</td>
<td>48 0 (62)</td>
</tr>
<tr>
<td>Law Enforcement Forces Pension Fund</td>
<td>Armed forces</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>739</td>
<td>86 0 (112)</td>
</tr>
<tr>
<td>Treatment Services Insurance Organization for the Armed Forces</td>
<td>Armed forces</td>
<td>Treatment of working and retired workers</td>
<td>2 900</td>
<td>47 6 (62)</td>
</tr>
<tr>
<td>Other Ministries' Pension Funds</td>
<td>Civil servants</td>
<td>Retirement, death and disability pensions, treatment</td>
<td>1800</td>
<td>18 00 (234)</td>
</tr>
<tr>
<td>Imam Khomeini Assistance Committee</td>
<td>The needy</td>
<td>Insurance, pensions, treatment, loans</td>
<td>4 865</td>
<td>38 61 (501)</td>
</tr>
<tr>
<td>Behzisti Organization</td>
<td>Handicapped, the needy, children and women without guardians, socially disadvantaged groups, etc.</td>
<td>Prevention, rehabilitation</td>
<td>550</td>
<td>14 33 (186)</td>
</tr>
<tr>
<td>Bonyad-e Mustaz' a fin</td>
<td>The war-related disabled</td>
<td>Support, treatment</td>
<td>340</td>
<td>1 264 (164)</td>
</tr>
<tr>
<td>Red Crescent Society</td>
<td>Rescue, support, assistance</td>
<td>Entire population</td>
<td>480</td>
<td>48 0 (62)</td>
</tr>
<tr>
<td>Martyrs Foundation</td>
<td>Families of Martyrs</td>
<td>Support, employment, cultural, legal</td>
<td>500</td>
<td>2 262 (293)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>40 191</strong></td>
<td><strong>40 191 (5219)</strong></td>
</tr>
</tbody>
</table>

*Sources: Statistical Centre of Iran (4,75); SSO (74); Hamshahri newspaper (76).*

**The contributory social insurance system**

The contributory social insurance section of the welfare system has hardly changed since 1979 in terms of basic components, objectives and administration. At present it comprises 20 insurance funds, not all of which are governmental (22,69).

In its health and social insurance services, SSO covers nearly 66% of the urban population and 42% of the total population. It delivers 12 different types of insurance and supportive services to 26
million people (6 million employees and 20 million members of their families), including those covered by the labour law, drivers, artists, the self-employed, and the retired and other pensioners (77–79). In fact, this organization is not governmental and is funded through insurance premiums paid partly by employees and partly by employers (both private and government employers) (77). Interestingly, this organization is the second major provider of health services in the country, with 50 hospitals and 260 health centres (78). It has nearly 10 000 hospital beds in various regions of the country (78) and has contracts with more than 40 000 health care providers (80). Those with certain diseases, such as thalassaemia, haemophilia and renal failure, are reimbursed 100% of their treatment costs (80). SSO possesses more than 70 industrial and manufacturing companies and is one of the major financial trusts in Iran (78).

According to figures from 2000, 24.4% of the SSO’s resources are used to provide health care and health insurance, 50.9% for retirement and other pensions, 9.3% for administrative costs and expansion of facilities, and 19.8% for investment (78). Between 1999 and 2001, 12 budget lines in SSO increased by more than the general rate of inflation (81). SSO’s financial resources in 2002 were approximately 26 000 billion rials (US$ 3.38 billion). Since SSO is financed through insurance premiums paid by employees and employers, it is highly accountable to them. The political pressure on the organization is thus quite substantial (69).

Other insurance funds include:

- the Civil Servants’ Pension Fund (Sandooghe Bazneshastagi Keshvari);
- the Armed Forces Pension Fund (Sandooghe Bazneshastagi Niroohaye Musallah);
- the Law Enforcement Forces Pension Fund (Sandooghe Bazneshastagi Niroohaye Entezami);
- the Revolutionary Guards’ Pension Fund (Sandooghe Bazneshastagi Sepahe Pasdarane Enghelabe Islami);
- the Treatment Services Insurance Organization (Sazmane Bimeh Khadamate Darmani);
- the Treatment Services Insurance Organization of the Armed Forces (Sazmane Bimeh Khadamate Darmanie Niroohaye Mosalah); and
- almost a dozen other pension funds covering special groups of government agencies and organizations such as banks, the National Oil Company, the National Broadcasting Organization, Iran Air, salaried staff of nationalized industries, the National Steel Company, etc.

The main reason that these funds resist all government efforts to integrate them into the SSO or the Civil Servants’ Pension Fund is their ability to extract somewhat better terms from their employers, and their realistic fear that if made part of the government controlled social security system they would lose their independence to maximize the use of their resources. They are also concerned about politically inspired pressure to change regulations concerning the minimum age of retirement, and that they may eventually suffer from the collapse of the state-controlled social insurance system owing to the additional burdens it has incurred since the Revolution.

Noncontributory social assistance organizations

This sector of the welfare system consists of eight major organizations. All but two of these (the Red Crescent Society of Iran and the Organization for the Protection of Prisoners) were created after the Revolution. Four of them may be considered as part of grassroots organizations created in response to the specific needs and circumstances brought about by the Revolution and the Iran-Iraq War (45).
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Among the half dozen welfare organizations created after the Revolution, by far the largest and most active is the Imam Khomeini Social Assistance Committee (IKSAC), which is responsible for looking after the needs of the poor in the population at large (45). It covers over 6 million people (82), 4 million of whom receive continual assistance (83). In addition to its own financial resources (mostly expropriated property, farms, factories and firms of people associated with the old regime and/or condemned by Revolutionary Courts), IKSAC has developed an extensive network of “collection boxes” and regular subscribers to its various charitable activities. It also uses special occasions such as religious feasts, periods of mourning and the approach of national festivals for launching nationwide charity campaigns. In addition to these private sources, its extended network of religiously motivated and dependable local volunteers receives the majority of the Government’s cash transfer distributions.

It is estimated that 92% of the overall support services in the country are delivered by IKSAC and the remaining 8% by the remainder of the institutions involved. IKSAC receives an important proportion of its resources through charitable contributions and religiously donated money known as Vaghf and Hebeh (82,84). Its services cover a variety of phases of life, such as pregnancy, breastfeeding, childhood, adolescence, education, marriage, employment, shelter and health (82). IKSAC has nearly 16,000 employees and over 62,000 volunteer workers (82).

In addition, there are two other major social assistance organizations that emerged after the Revolution and are directly responsible for addressing specific problems of families and individuals who have lost a member, or suffered permanent loss of normal physical or psychological functions during the Revolution or the Iran–Iraq War. These are the Martyrs’ Foundation (Bonyad Shahid) and the Injured Veterans Foundation (Bonyade-Mostazafin-va-Janbazan), respectively. In theory, both are supposed to be self-sufficient and not accountable to the Government because of the considerable assets (including property, industrial and commercial firms) belonging to the deposed royal family that they inherited under expropriation laws. In practice, many of the martyrs covered by these two foundations were officially employed members of the armed forces, and entitled to survivor and work injury/retirement benefits. Both foundations are believed to have received considerable contributions from the public social security system as compensation for serving such groups. The variety of services and benefits offered by these foundations to the families and individuals covered by them go far beyond the realm of responsibility of any contributory social assistance system. Despite its enormous resources and expansion of its economic activities, some leaders of the Injured Veterans Foundation have occasionally warned that with the rising cost of its services, the Foundation may have to ask for government assistance in the near future.

Two other social assistance organizations deserve to be mentioned. They are the Fifteenth Khordad Foundation, run by a group of leading clergy through income derived from some of the expropriated factories and commercial firms turned over to them, and the Society for the Protection of the Families of Prisoners, run by the Prisons Bureau of the Ministry of Justice and private donations from charitable individuals and organizations.

Immediately after the Revolution, the Government felt obliged to dismantle all charitable and health organizations associated with the deposed royal family and regroup them under a new organizational structure. This resulted in the creation of the Behzisti Organization (BO, which literally means “Well-being organization”), to look after such groups as orphans, disabled people, and residents of chronic mental hospitals and centres for the care of abandoned physically disabled people (45,70). BO delivers three types of rehabilitative services to the handicapped: medical, social and occupational rehabilitation. All of these are delivered in a community-based approach, with services tailored to the specific needs of local communities.

As the eradication of traditional social problems such as drug addiction, street children, runaway girls and prostitution occupied important positions in the priority list of the Revolutionary regime, the rehabilitation of these groups also became a responsibility of BO. In 1980, the Government introduced a bill to extend certain publicly funded retirement benefits to destitute older
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men and women from rural areas. Later renamed the “Shahid Rajai Scheme”, this was the first effort by the Iranian Government to assume responsibility for the welfare of older people from rural areas, who had previously been more-or-less completely excluded from the coverage of the social security system. The implementation of this important task was also delegated to BO, which by now had become an official government agency within MOHME with a large number of professionally trained doctors, social workers, psychologists and paramedical personnel.

With the expansion of IKSAC’s welfare activities in rural areas in later years, BO has reluctantly handed over most of its direct transfer functions to the former. It has concentrated its resources on problems and groups that require relatively longer-term intervention and care by its professionally trained staff. When the problem of drug addiction was redefined as a criminal act rather than a health problem, this issue was no longer handled by BO but placed under the aegis of the Drug Control Headquarters under the Office of the President. With the renewed interest in the treatment of drug users and promotion of demand control strategies over the past five years, BO has once again become active in the area of substance abuse prevention and treatment. In addition, the law concerning the care and protection of households and women without a male guardian, passed by Parliament in 1993, designated BO as the responsible agency for this group.

In 2001, 1350 24-hour rehabilitative centres served nearly 500 000 handicapped people around the country. Some 700 of these centres are nongovernmental and take care of 35 000 disabled and elderly people. In 2001, these centres received US$ 15 million in subsidies from BO (67,85,86). One hundred governmental or nongovernmental day-care centres deliver services to 8000 elderly individuals (67). Nearly 6000 people with chronic mental disorders have been rehabilitated in 50 mental health centres. BO also covers 1.5 million pensioners in the country (63), monthly pensions on average amounting to 375 000 rials (US$ 47) (63). Each year nearly 50 000 drug addicts give up their addiction with the aid of BO centres (67). Some 2400 BO centres take care of orphaned and street children, socially disadvantaged women, runaway girls, chronically ill mental patients and addicts (67). There are now safe houses for runaway girls in 18 of the 28 provinces. In the Deputy of Preventive Affairs of BO, which is considered a research and development department, several programmes are designed to reduce the rate of social problems such as drug abuse, divorce, delinquency and disability.

About 7–8% of the annual budget of BO is from charity contributions (67). This figure is expected to reach 25% in 2005 (67).

In addition to BO, several nongovernmental organizations are active in providing services for the handicapped. The National Society for the Handicapped, with more than 300 branches around the country, is the largest of such institutions (68).

It must be emphasized that the ultimate goal of rehabilitative services for the handicapped is to restore a normal life for them. This is an intersectoral goal in which other Ministries such as the Ministries of Housing, Interior Affairs, Labour, Education, Economics, Higher Education, Cooperative, Culture and Islamic Guidance and MPORG are also closely involved.

The Red Crescent Society and emergency centres in the provinces provide rescue services. Other than in Tehran, in which there is an independent emergency centre, the provincial emergency centres are part of the Universities of Medical Sciences (53).

Other poverty alleviation policies

In addition to the increasingly large share of annual government spending devoted to social affairs in general, to maintaining and strengthening the contributory social insurance organizations described above, and to creating a multi-agency social assistance/welfare system, the Government has tried to deal with problems of poverty and inequity in several other ways. These include:
• expropriating property illegally accumulated by landlords and capitalists associated with the previous regime and the deposed royal family;
• further expanding the land distribution programme initiated by the previous regime;
• expanding social services, particularly education and health, to the more deprived sectors of the population, especially in long-neglected rural areas;
• adopting an affirmative action policy in the distribution of publicly created or government-funded opportunities for human resource development, particularly at the tertiary level; and
• maintaining the purchasing power of the population by providing extensive subsidies for both production (particularly in the area of agriculture and food production) and distribution of basic necessities.

Major challenges for the welfare system

Unemployment

In spite of the lack of direct unemployment data for developing countries, proxy indicators suggest widespread problems of underemployment, marginal occupations and unstable employment in the unprotected informal sector in many low-income countries (55). In Iran, nearly 3 million able-bodied people are unemployed (78).

Social insurance coverage

It is estimated that 34 million people all over the country are covered by the various insurance funds described above (62). Thus, of a population of nearly 65 million, only 52% have social insurance coverage in its exact meaning (62) and some 8 million people lack any form of insurance coverage (72). In a recent study, at least 42% of patients who visited public hospitals had no health insurance (72). There are also similar discrepancies in other forms of social insurance. For instance, to be eligible for unemployment benefit one must have at least a 6-month record of payment of insurance premiums; thus those who have never been employed or insured will have no financial protection.

Structural causes of difficulties in policy-making, coordination and control of services

The overall structure of the welfare system (Fig. 11) lacks a systematic relationship between its elements, proper division of responsibilities and specialization of services, integrated information systems and unified policies (56,62,69,87,88). This has placed insurance, supportive and rescue organizations in a persistent state of financial crisis and they gradually lose their investments (56). It has also led to a state of extensive public dissatisfaction with the welfare services (62). There are structural causes for coordination problems and overlapping activities among various organizations involved in the social welfare system (70). Owing to the social nature of the Revolution, a number of nongovernmental revolutionary organizations were formed immediately after 1979 to improve the poverty eradication activities of government structures. With the passage of time, some of these organizations have been involved in activities beyond their original mission (70). The country is now in a phase of consolidation and the various lines of accountability and authority in these institutions have resulted in serious inefficiencies and duplication of work. For example, the types of activity carried out by the Martyrs Foundation are the same as those carried out by BO, IKSAC, RCS and SSO (66). Important overlaps in activities are shown in Table 13. Thus although nearly 66% of the government budget is expended in this highly fragmented sector and other social affairs, there is little government control over most of this figure (71).
Table 13. Duplication of activities among institutions involved in social security and welfare services

- Behzisti Organization (BO) and Imam Khomeini Social Assistance Committee (IKSAC) – pension services to the poor and socially disadvantaged.
- IKSAC and the Red Crescent Society (RCS) – social support services to the poor and those affected by disasters.
- IKSAC and the Treatment Services Insurance Organization (TSIO) – insurance for the poor.
- BO and RCS – rehabilitative services, medical equipment and social and supportive services.
- BO and Bonyad-e-Mostazafin – the handicapped and in the area of medical equipment.
- Bonyad-e-Mostazafin, the Martyrs Foundation and Armed Forces Pension Funds – pension services for families of war-related handicapped and martyrs.

Lack of financial resources and government debt to insurance organizations

According to Clause 29 of the Constitution, the Government is ultimately responsible for establishing the national social welfare system. It is estimated that resolving the basic need of over 6 million people living under the poverty line would require a fund of 70,000 billion rials (approximately US$ 9.1 billion), of which the Government can afford only 10% (89). Unfortunately, not only has the Government been unable to establish an effective welfare system, but it also has failed to pay part of its liabilities to the insurance organizations (56). The volume of government debt to the SSO and the Civil Servants’ Pension Fund now exceeds 9000 billion rials (approximately US$ 1.17 billion).

Increasingly aged population

It is estimated that by 2030, the number of people over 60 in the world will have tripled to over 1.5 billion (55). In 1956 in Iran, the elderly made up only 3.3% of the population, whereas by 1996 it had risen to 6.6% (56). It has been estimated that some 45.3% of those over 70 years have financial problems (56). In Iran, 68.1% of the aged live with their spouse and children, 22.9% with their children and 7.4% alone (56). Resolving the financial problems, shelter and transportation, leisure facilities and provision of health services for the aged are among the most pressing challenges of the national welfare system (56).

Increase in the rate of social disturbance

The most important social pathologies in Iran are drug abuse, suicide, street children, runaway girls, prostitution, violence, financial crime, begging and burglary, the most prevalent of which is drug abuse (52,89–91). It is estimated that 1.15 million Iranians are addicts, 880,000 use drugs for pleasure and 500,000 are semi-addicts (91,92). Every addict places an annual financial burden on society of US$ 1250, or collectively US$ 3–7 billion a year (93,94). Every year 528 tons of pure opium and 29.6 tons of heroin are consumed in the country (92). The actual price of drugs has decreased, and it is thus expected that the prevalence of consumption will increase (92). The spread of poverty and unemployment have also contributed to this problem (92). Unfortunately the average age of addiction has also decreased (92). Owing to the lower cost of heroin, addiction to this drug is spreading more quickly (92).

Child labour and street children comprise another prominent social pathology. It is estimated that the number of street children has increased from 20,000 in 1996 to over 1 million in 2001 (95). These children are often denied the chance to get out of poverty by improving their human capital, and can be exposed to physical and mental dangers that perpetuate the cycle of poverty (55). There are also over 3000 prostitutes in the country (86).
Underserved handicapped population

The proportion of the population of the country with some sort of disability is estimated to be between 3% and 11% (94). Of these, approximately 2.5 million have moderate to severe handicap. It is also estimated that annually 30 000–40 000 individuals are added to this population (97). There are 12 mentally handicapped, 11 blind and 7 deaf people per 1000 population. Improvement in the quality of health services, and even general social and economic development, increase life expectancy and result in an increase in the absolute numbers of the handicapped. Only 500 000 (25%) of the handicapped are served by BO. In addition to the volume of services, their quality also needs to improve (96). The problem of unemployment is more serious for the handicapped; their health care costs are much higher and their respective poverty line is therefore set much higher (98). All employers (whether governmental or nongovernmental) are obliged by law to dedicate 3% of their employment opportunities to the handicapped, but this law is widely disobeyed (87). Despite these facts, there is little general awareness of the issue of disability.

Other underserved vulnerable groups

One of the noticeable vulnerable social groups comprises prisoners. In 2000, 600 000 people were sent to prison, 96% of whom were males. They are usually between 19 and 40 years of age with low levels of literacy. During their imprisonment, their families require social support services (94).

Information support infrastructure

Insurance and welfare organizations suffer from major problems in the area of information technology. For instance, in the 50-year history of the SSO, the huge volume of records has created serious problems.

Current strategies

Particular emphasis has been laid in the Third National Five-Year Development Plan on social security and welfare affairs, which comprise Chapter 5 of the Plan.

To expand social insurance coverage, insurance services are supposed to expand in two dimensions: extensive and basic insurance and complementary insurance (39,99). The extensive and basic insurance services are funded by contributions from the insured, the employer and the government and cover health, retirement, disability, unemployment and abandonment. The level of these services is proportional to the insurance premiums received, the financial power of the insuring organization and government contributions. The Cabinet has the authority to determine this level (59). The complementary insurance includes more modern, sophisticated and expensive services. These services are provided according to an agreement between the insured person and insurance company, and involve extra charges (59). In 2000–2002, approximately US$ 18.2 million has been devoted to a complementary insurance scheme for the retired population covered by SSO and the Civil Servants’ Pension Fund (81).

Between 1999 and 2002 the Government paid back nearly US$ 1 billion of its debt to the insurance organizations in the form of shares in state-owned companies (56,87).

Redirection of charity contributions is a measure that has been adopted in order to strengthen the financial power of the social security and welfare system. The share of this financial resource is expected to increase to 25% of the budget by 2005 (86). In 1999, charities contributed more than US$ 15.75 million to IKSAC. Growth in this kind of contribution from 1995 to 1999 exceeded 39% (83).
According to the Third Plan, the insured can change their insurance organization at any time (59). This is intended to improve competition between insurance organizations in order to achieve better levels of quality and efficiency.

According to the Third Plan, provision of social services should be gradually outsourced to nongovernmental institutions. The Government is obliged to pay subsidies to these institutions to provide certain levels of services. Up to 2005, 52% of BO welfare centres should be outsourced (61).

The Government is liable for covering 100% of the costs of basic and complementary insurance for those with war-related handicap (59).

In 2002, nearly US$ 173 million was paid out in employment loans to create employment opportunities for the handicapped, almost triple the sum paid out in the previous year (100).

One of the important groups from a social perspective comprises unemployed and guardianless women (100). In 2002, the Government dedicated US$ 260 000 to assist such women (76). Up to now, more than 50 000 such women have been covered by charity institutions (89). In the next 10 years, 13 million housewives in the country will receive insurance coverage (67). To achieve higher levels of decentralization in the support programmes for guardianless women and children, more than 97% of financial resources in IKSAC and the Injured Veterans Foundation are expended through provincial allocations.

**Suggested priority areas or changes**

There is a universal agreement on the need to restructure the social security and welfare system (69,88,101). The primary intent is to improve the current status of social welfare through coverage of the whole population, creation of a centralized policy-making body, prevention of duplication of work and the elimination of indirect governmental subsidies (1,45,56,58–60,88,102). Based on a focus on structural integration in policy-making, management, resource allocation, and control, the following structural alternatives have been proposed by various actor groups (57,58,66,70,102–105). The final structural form should make clear the boundaries between staff and operational activities and also the functional boundaries between the existing institutions (106). Conflicting points of view among the various institutions involved have delayed the final formulation of the structure of the system (37,106).

- **Ministry of Social Security and Welfare.** This structural form will include all the existing social security and welfare organizations that are state funded (57). Three technical divisions of insurance, social assistance (support) and emergency and rescue services will be formed as deputies of the newly formed Ministry (58,62). The Ministry will be accountable to the President and the Parliament (66). It will also lead to a centralized policy-making (66,70,102) and budgetary control over resources (71) and will facilitate the creation of a comprehensive information system on social welfare (1). It will also decrease the administrative and logistical costs of multiple organizations (59). Some believe this Ministry should only encompass the staff functions of the existing institutions and should avoid operational activities (106). The critics believe that this structural design will create a highly bureaucratic and huge enterprise with multiple separate buildings and non-homogeneous administrations probably devoid of the formerly established revolutionary spirit. In contrast to the downsizing strategies of the Third Plan, this Ministry will probably increase the size of the Government (57,59,103,106) and will require extensive financial resources (104). There are also serious concerns over the integration of the various insurance and pension funds (59,107).

- **State Social Security and Welfare Organization.** The head of this organization will be a deputy of the President (70).
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- **Supreme Council of Social Security and Welfare.** This council will be headed by the President (108); its duties include policy-making, intersectoral coordination and control. The Supreme Council of the Disabled will be a subdivision of it. BO is strongly supporting this alternative (58,89).

- **Deputy of Welfare and Social Security in MOHME.** This organization will be accountable to the Minister of Health and Medical Education, and will have staff and functional authorities in the area of social security and welfare.

An integrated and comprehensive social security information infrastructure will be developed as a structural element of the Ministry of Social Security and Welfare. It will facilitate the identification and categorization of socially disadvantaged citizens and the targeting of subsidies (88). As in many other countries, personal social identity codes will be used for other purposes such as taxation and social surveys (88).

The existing legislation reserving 3% of positions in governmental organizations for the disabled should be reinforced by the State Management and Planning Organization (68). Other measures, such as subsidies to employers for insuring employed handicapped workers, employment loans, and supporting the disabled associations and foundations, are additional action plans (109). Development of specific environmental and working standards for the disabled, expansion of occupational rehabilitation and specific vocational education can also improve employment opportunities for the disabled and socially disadvantaged (29,63,96). Special attention should also be paid to the issue of encouraging the employment of prisoners (105).

Charity contributions to social security and welfare institutions should be redirected through media interventions and expansion of nongovernmental organizations (83). Government sources will not be sufficient to meet the financial requirements of the disabled population and redirection of charity resources will become essential (61,85). Such contributions should make up 25% of the overall budget of organizations like BO (86).

Further increases in government debt to insurance and pension funds and increasing government contributions to the welfare system should be discontinued. The Third Plan obliges the Government to pay back at least 50% of its debt to various pension funds and SSO (59). One of the important contributions of the Government is to pay health insurance capitations for all citizens to the insurance organizations (59).

Financial policies should support insurance and pension funds. In developed countries the economic activities of social insurance organizations and pension funds benefit from financial opportunities such as tax exemptions (52,56).

According to Clause 43 of the Third Plan, a considerable proportion of the budget of social support institutions is devolved to the provincial level. Further involvement of nongovernmental organizations in the provision of educational services for the handicapped, and discontinuing government intervention in the provision of such services, is another policy for privatization in the provision of social support services (61,96). Three forms of privatization are explicitly permitted in the Plan: (a) outsourcing services to the nongovernmental sector; (b) partnerships and joint investment with the nongovernmental sector; and (c) purchasing management services from the nongovernmental sector. The participating party will benefit from low interest or long-term loans, mortgage agreements and facilitation of administrative processes for formal registration, accreditation, etc. Up to 2005, 1250 rural centres, 800 urban centres and 1200 governmental nurseries belonging to BO will be transferred to charities. This programme will also include centres for the disabled, the aged and guardianless children (110). Some believe that organizations such as BO should be totally nongovernmental (86). Those charity institutions that take part in the provision of social services to disadvantaged groups will receive 20% of allocated pensions from public sources (110). Government
involvement in the provision of social services will be confined to those areas where the private sector has no initiatives (86).

Some of the insurance organizations and pension funds have gradually transformed themselves into huge economic trusts. Through investment in the stock market, they have been increasingly involved in the ownership and management of a variety of industries, including pharmaceuticals, electronics and chemicals. In addition, the Government has paid back most of its debt to insurance organizations in the form of shares in nationalized companies, and this has worsened the situation. As a result, they face serious problems of economy of scale. For instance, SSO is now involved in the ownership and management of over 3000 different service and industrial companies, ranging from pharmaceutical manufacturing to production of cement (111).

The creation of employment opportunities in the eastern provinces of the country, media interventions and improving anti-drug activities are effective measures in reducing the demand for illicit drugs (94).

Other priority areas include:

- universal insurance coverage for children;
- development of the required legislation for the prevention of child abuse and child labour (95);
- improving disaster preparedness through coordinating and expanding the capacity of emergency and rescue organizations (54);
- media interventions and appropriate education to improve public opinion and attitudes towards disability (112); and
- preventive measures to reduce the prevalence of other social disturbances (59).
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The authors greatly appreciate the contribution and advice of Dr Bagher Larijani, Dr Bahman Nikpoor and a group of health care administrators from regional health centres including Dr S. Torkmannezhad, Dr Mohammadi, Dr Mehr, Dr Sanjari, Dr Sohrabi and Dr F. Ajamian.

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Assessment and mapping of integrated health and welfare development in Indonesia

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Executive summary

After the various crises faced by the Republic of Indonesia in 1997, and with changes in the political situation, government policies and leadership and other destabilizing factors, the existence of integrated community health and welfare activities has been placed in doubt. Assessment and mapping of these activities in Indonesia are crucial in developing the reform policies of an integrated health and welfare system. The objective of this assessment is to obtain a general picture and to develop recommendations for health and welfare systems development in Indonesia.

Secondary data collection, interviews and group discussions were carried out in the western part of Indonesia (4 provinces, 11 districts, 22 villages and 22 community groups) and the eastern part (2 provinces, 5 districts, 11 villages and 11 community groups). In general, it was found that the economic, sociocultural, infrastructural and geographical conditions of provinces and districts in western part (Sumatra, Java and Bali) were better than those in the east (Kalimantan, Sulawesi, Papua, etc.). Profiles, management and mechanisms of integrated community-based health and welfare activities indicated some differences before and after the crises in both regions. The profile findings concentrated on activities resulting from government- or community-driven programmes. The findings also addressed specific management and mechanism components of the community-based integrated health and welfare activities, such as manpower, budget, approaches, target and implementation activities.

Some performance indicators, which emerged from community group discussions, revealed some decrease in the number of integrated health and welfare activities in the villages, but these were more varied in nature. This variety of integrated health and welfare activities resulted from efforts to meet local needs and solve local problems, particularly poverty. Although there have been several health and welfare policy changes in Indonesia, most of the community-based health and welfare activities, whether government- or community-driven, tend to be integrated at village or sub-village levels. The strengths and weaknesses of integrated community health and welfare in both regions before and after the crises are discussed. Some recommendations are also discussed, although this study needs further in-depth analysis.

Research background, objectives and methodology

Background

The First Global Symposium on Health and Welfare Systems Development in the 21st Century was conducted by WHO Kobe Centre (WKC) in Kobe, Japan on 1–3 November 2000. The preamble to the recommendations of the Symposium states that the goal of health and welfare systems development should be physical, social, mental and spiritual well-being for all. The term "welfare" suggests that access to quality health care should be available to all, particularly the poor, women and
vulnerable groups. Among the recommendations of the Global Symposium were that the integration of health and welfare systems should be improved, that each country should work out a strategic vision for health and welfare development, and that the activities of the two sectors should be coordinated in order to increase efficiency and equitable access to services in order to best meet the needs of the people. Several other recommendations addressed capacity development, training, community participation, gender dimensions, partnerships, the private sector, financial schemes, technologies, traditional/alternative practices, collaboration and the coordination of health and welfare. The Second Global Symposium, held in October 2001, also emphasized that integration of health and welfare systems meant not only structural, functional and physical integration but also integration of activities and programmes. It also stressed the importance of the access to and quality of social welfare and health care for the various disadvantaged groups.

In May 1998, Indonesia entered an era of reformation and democratization. Beginning in September 2000, under the leadership of the newly appointed President Abdulrahman Wahid, the Ministries of Social Welfare and of Community Problems and Crisis were integrated into the Ministry of Health, which thereafter became the Ministry of Health and Social Welfare. While the structure, programme, budget and concept were still under discussion, the political situation in Indonesia kept changing. The new policy of the Government, to decentralize almost every development programme to the provincial and district authorities after January 2001, made the integration of health and social welfare more complicated. Only 10 months later, in August 2001, the new Government headed by President Megawati Sukarnoputri divided the Ministry of Health and Social Welfare again to form two separate ministries, the Ministry of Health and the Ministry of Social Welfare.

Before 1997 there were many integrated health and social welfare activities in Indonesia, based on community participation. These activities were carried out in the villages, mainly to improve the health status of the under-fives and to empower the families through income-generating programmes. However, after the various crises faced by Indonesia in 1997, and with changes in the political situation, government policies and leadership and other destabilizing factors, the existence of integrated community health and welfare activities has been placed in doubt. Some programme officers say that the integrated health and welfare activities have still been running well, while others insist that they have been abandoned or changed by confusion among local providers and new policies of local administrators.

At the Consultative Meeting following the Second Global Symposium in March 2002, the participants agreed that the assessment and mapping of integrated health and welfare activities were crucial to developing policies for the integration of health and welfare systems in countries or at subnational level. The outcomes of the assessment and mapping of integrated health and social welfare activities were also seen as important in supporting the development of indicators of integrated health and welfare systems, reforming national health systems and empowering parliamentarians, decision-makers and so forth. Some of the follow-up actions proposed by the Indonesian representative during the Consultative Meeting were: (a) assessment and mapping of all health and programme activities (public, private and nongovernmental), weaknesses and strengths and other inputs in all provinces and districts; (b) reform of national health systems according to the evidence provided by the assessments; (c) empowering members of parliament, decision-makers, the private sector, nongovernmental organizations, party leaders, etc. in the concept of health and welfare systems; (d) focusing the decentralization of health and welfare systems at the district level to make them more sensitive to vulnerable groups (the poor, the elderly, women, children and other disadvantaged groups); and (e) developing information systems and tools to measure the impact on health and welfare systems.

After developing a proposal for the first follow-up action, WKC agreed to support the assessment and mapping of integrated health and welfare activities in Indonesia. The preliminary findings of this study were presented and discussed at the Third Global Symposium on Health and Welfare Systems Development in the 21st Century, held in Kobe on 6–8 November 2002.
Objectives

The general objective was to obtain a general picture of the situation and to develop recommendations on health and welfare systems development in Indonesia.

The specific objectives were:

- to obtain a profile of community-based and integrated health and welfare activities in Indonesia before and after the crises of 1997;
- to ascertain the mechanism of community-based and integrated health and welfare activities before and after the crises;
- to analyse the strengths and weaknesses of community-based and integrated health and welfare activities before and after the crises;
- to analyse the possibility of performance indicators for community-based and integrated health and welfare activities before and after the crises; and
- to develop alternative recommendations and advocacy materials for further policy development regarding the health and welfare systems in Indonesia.

Methodology

Assessment and mapping of some community-based health and welfare systems have been carried out in the eastern and western regions of the country. Between two and four provinces were taken to represent each region. East Java, DKI Jakarta, Banten and West Sumatra represented the western region, while the eastern region was represented by West Kalimantan and East Nusatenggara. The sampling frame was as follows.

<table>
<thead>
<tr>
<th>Level of administration</th>
<th>Western region</th>
<th>Eastern region</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of provinces</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>No. of districts</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>No. of villages</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>No. of community groups</td>
<td>22</td>
<td>10</td>
</tr>
</tbody>
</table>

Secondary data collection on integrated health and welfare activities was made at province, district and village levels. The data collected comprised month and year when activities started, components, organization and mechanism of integration, indicators for monitoring and evaluating integration, strengths, weaknesses, problems, etc.

Group discussions and in-depth interviews were carried out at each level and in each group in order to gain more in-depth information on the variable collected through secondary data collection. These techniques were used particularly to find out the perceptions, suggestions and concerns of local health care providers concerning integrated health and welfare activities. The study started in the first week of August 2002 and ended in the fourth week of December 2002.
Obstacles and limitations

1. Strong bureaucracy in most provincial and district authorities inhibits the collection of primary and secondary data. Researchers are sometimes obstructed in finding the information they seek.

2. There are transportation problems in some areas owing to such factors as geographical inaccessibility and inadequate infrastructure.

3. Some of the primary and secondary data are of low quality.

General findings

The general findings are based on an analysis of various studies and secondary data sources at national level. The remaining findings are based on the primary and secondary data collection at the following levels.

- **Provincial level:** studies, secondary data and interview in 6 provinces: DKI Jakarta, Banten, East Java and West Sumatra in the western part of Indonesia, and West Kalimantan and East Nusatenggara in the eastern part.

- **District level:** studies, secondary data and interviews in 16 districts: Serang, Pandeglang and Tangerang (Banten Province); Padang, Pariaman and Limapuluh Kota (West Sumatra Province); Central Jakarta and South Jakarta (DKI Jakarta Province); Sidoarjo, Magetan and Bangkalan (East Java Province); Pontianak City, Pontianak and Sanggau (West Kalimantan Province); and Timor Tengah Utara and Timor Tengah Selatan (East Nusatenggara).

- **Village level:** collection of secondary data in 32 villages.

- **Community level:** secondary data and group discussions in 32 groups of communities (village leaders, key persons, religious leaders, lay persons, women and social organization leaders).

In general, it was found that most of the population in the western part of the country (Sumatra, Java and Bali) were economically, physically and geographically better off than those in the eastern part (Kalimantan, Sulawesi, Papua, etc.).

**Percentages of poor villages and poor families**

The Podes (Village Potential) Survey 2000 (/) showed that, compared to Indonesia as a whole and particularly Java and Bali, the eastern part of Indonesia has more poor villages, especially East Nusatenggara, West Nusatenggara, Maluku and Papua Provinces (Table 1). This survey also indicated that many more poor villages are in rural areas. Fig. 1 shows the distribution of poor families by area, based on the same survey. More poor families are also found in the eastern part of Indonesia.
Table 1. Percentages of poor villages by area, 2000

<table>
<thead>
<tr>
<th>Area</th>
<th>Urban</th>
<th>Rural</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Indonesia</td>
<td>11.1</td>
<td>49.1</td>
<td>46.9</td>
</tr>
<tr>
<td>Borneo</td>
<td>4.9</td>
<td>39.4</td>
<td>37.9</td>
</tr>
<tr>
<td>Celebes</td>
<td>10.5</td>
<td>39.3</td>
<td>37.1</td>
</tr>
<tr>
<td>Other islands</td>
<td>17.6</td>
<td>66.3</td>
<td>64.2</td>
</tr>
<tr>
<td>Sumatra</td>
<td>10.4</td>
<td>48.3</td>
<td>45.2</td>
</tr>
<tr>
<td>Java &amp; Bali</td>
<td>4.1</td>
<td>19.8</td>
<td>17.1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6.8</td>
<td>38.8</td>
<td>35.3</td>
</tr>
</tbody>
</table>

Source: National Health Survey 2001 (2), based on Podes Survey 2000 (1).

Fig. 1. Percentages of poor families by area, 2001

Source: National Health Survey 2001 (2).

Educational level of population over 10 years of age

Fig. 2 shows the educational level of the population over 10 years of age. The education level in this segment of the population is higher in the western part of Indonesia as compared to both the eastern part and the country as a whole. More people graduated from universities, academies and senior high schools in the west than in the east of Indonesia.
Fig. 2. Percentage educational levels of people over 10 years of age, by area

Source: National Socioeconomic Survey 2001 (3).

Occupations among people over 10 years of age indicated some differences between the western and eastern parts of Indonesia as shown in Fig. 3. Industry, trade and service occupations are higher in the west, while agriculture and mining predominate in the eastern part of Indonesia.

Fig. 3. Percentage occupations of people over 10 years of age, by area

Source: National Socioeconomic Survey 2001 (3).

Incidence of health problems

The incidence of health problems is based on data from the National Health Survey 2001 (2) coordinated by the National Institute of Health Research and Development. This survey also used the sampling frame of the National Socioeconomic Survey (3). Table 2 shows health problems or symptoms of illness reported by a community within one month. In the eastern part of Indonesia fever, breathlessness and repeated headache occur more often than in Sumatra, Java and Bali, whereas cough is more common in Sumatra and runny nose more common in Sumatra, Java and Bali.
compared to the eastern part of the country. Fever, cough, runny nose and breathlessness are mostly reported by parents with children under 5 years. These are proxy and subjective measurements indicating some febrile diseases such as malaria and influenza. Combined symptoms of fever, cough and breathlessness can predict moderate and severe pneumonia. Repeated headache is mostly reported by adults.

Table 2. Percentages of health problems by area, 2001

<table>
<thead>
<tr>
<th>Area</th>
<th>Fever</th>
<th>Cough</th>
<th>Runny nose</th>
<th>Breathlessness</th>
<th>Repeated headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Indonesia</td>
<td>40.9</td>
<td>41.0</td>
<td>37.6</td>
<td>4.1</td>
<td>16.2</td>
</tr>
<tr>
<td>Borneo</td>
<td>29.9</td>
<td>38.2</td>
<td>38.8</td>
<td>3.6</td>
<td>15.7</td>
</tr>
<tr>
<td>Celebes</td>
<td>42.9</td>
<td>37.4</td>
<td>29.0</td>
<td>3.6</td>
<td>16.4</td>
</tr>
<tr>
<td>Other Islands</td>
<td>48.7</td>
<td>47.5</td>
<td>46.3</td>
<td>6.1</td>
<td>16.3</td>
</tr>
<tr>
<td>Sumatra</td>
<td>34.2</td>
<td>42.3</td>
<td>41.8</td>
<td>3.6</td>
<td>12.7</td>
</tr>
<tr>
<td>Java &amp; Bali</td>
<td>30.5</td>
<td>39.0</td>
<td>40.1</td>
<td>3.4</td>
<td>13.8</td>
</tr>
<tr>
<td>Indonesia</td>
<td>33.0</td>
<td>39.9</td>
<td>39.9</td>
<td>3.6</td>
<td>14.0</td>
</tr>
</tbody>
</table>

Source: National Health Survey 2001 (2).

Allocation of health budget

Although the budget allocated to health is much higher in the eastern than in the western part of Indonesia, this budget allocation is not sufficient owing to geographical, transportation and climatic difficulties in the east of the country (Table 3).

Table 3. Per capita health budget allocation in rupiah, a 1998

<table>
<thead>
<tr>
<th>Region</th>
<th>Lowest</th>
<th>Highest</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>5474</td>
<td>30 607</td>
<td>10 540</td>
</tr>
<tr>
<td>Eastern</td>
<td>14 628</td>
<td>50 427</td>
<td>24 015</td>
</tr>
<tr>
<td>National</td>
<td>13 056</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Rp. 10 000 is roughly equivalent to US$ 1 (1998).

Access to health services

Table 4 shows that 50% or more villages in the eastern part of Indonesia have difficulties with access to hospitals, maternity hospitals, clinics, private doctors and pharmacists, whereas in the western part the figure is less than 20%. Nevertheless, only a small percentage of villages have difficulties in accessing the posyandu, an integrated health services post run and organized by the communities themselves.
### Table 4. Percentages of villages with difficulties accessing health service facilities, 2002

<table>
<thead>
<tr>
<th>Health facility</th>
<th>East Indonesia</th>
<th>Sumatra</th>
<th>Java &amp; Bali</th>
<th>Indonesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>62</td>
<td>49</td>
<td>16</td>
<td>41</td>
</tr>
<tr>
<td>Maternity hospital</td>
<td>72</td>
<td>55</td>
<td>20</td>
<td>47</td>
</tr>
<tr>
<td>Clinic</td>
<td>64</td>
<td>46</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Health centre</td>
<td>35</td>
<td>23</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Sub-health centre</td>
<td>21</td>
<td>15</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Posyandu</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Maternity clinic</td>
<td>30</td>
<td>13</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Private doctor</td>
<td>50</td>
<td>29</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>Private midwife</td>
<td>49</td>
<td>22</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>62</td>
<td>44</td>
<td>13</td>
<td>38</td>
</tr>
</tbody>
</table>

*Source: National Health Survey 2001 (2).*

## Profile of community-based and integrated health and welfare activities in sample areas before and after the crisis

Based on secondary data, interviews and group discussions at the province, district, village and community levels, the profile and mapping of the community-based and integrated health and welfare activities are discussed in several ways. First, community-based and integrated health and welfare activities in the sample areas are defined. Second are the main activities of the community-based and integrated health based on the definition. Third is the availability of these activities before and after the crisis.

Definitions of community-based and integrated health and welfare activities vary among community groups. Nevertheless, community-based and integrated health and welfare activities can be defined as follows:

- activities take place at the level of hamlet, sub-village, village, sub-district or district;
- activities are managed and funded by the community themselves with some assistance from the government, local government or nongovernmental, professional, religious or private organizations, and are based on community needs; and
- health should not be the only entry point or main activity; it can be welfare activities with health as the supporting component.

Using these criteria, several community-based and integrated health and welfare activities have been identified. Their main activities are basically similar between the western and eastern parts of Indonesia, although activities in the western part are more advanced, frequent and accessible, and the quality of community resources is much better compared to those in the eastern part of the country.

### West Sumatra Province

In West Sumatra there are two principles of local community culture that can be used as a conceptual foundation of community-based and integrated health and welfare. The first is the concept of nagari, which is the smallest autonomous local community structure based on the traditional way of life of West Sumatran communities. It is consisted of 500–1000 households or about 2500–5000 people. It is headed by a local leader directly selected by the local communities. The leader is assisted by one secretary and several heads of division. This structure acts as the executive...
component of the nagari and carries out daily activities or programmes. The programmes are decided by the community through discussion, in order to reach a consensus and a commitment in deciding the programme priorities.

There is also a judicial component of nagari called Lembaga Adat Nagari, whose function is to judge cases reported by the local communities. Another is the legislative component called Badan Perwakilan Anak Nagari, whose function is to develop regulations and monitor the application of programmes carried out by the executive component.

Before the crisis of 1997, the nagari mechanism was not functioning well. It was dominated by modern village governance and was a very bureaucratic, top-down structure. Although at that time there were similar community-based and integrated health and welfare activities, they were very much influenced by the national programmes, with only a small concern for local community needs. After the crisis, and the effort to go back to nagari, it has been recognized by local communities that democratization has been promoted. This is an effort to obtain community-based activities with a real concern for the local community needs.

The second fundamental concept is tungku tigo sajarangan or TTS. TTS is an integrated concept of unity of three important elements in the community – the local nagari providers or umarak, the religious leaders or alim ulama and traditional leaders or ninik mamak. In West Sumatra, ninik mamak are particularly represented by women leaders or bundo kanduang. These three elements of community are very important for the sustainability of community-based programmes or activities. When these three discuss and agree certain community-based activities, all of the community will then follow and carry out their decisions and commitments immediately.

One example of a community-based and integrated health and welfare activity is the Family Welfare Movement or PKK. This is a movement in which women play a central role in terms of food, housing, clothes, health, economy, environment, gardening, animal husbandry, religion, education, etc. Basic components of welfare activities are education and training, advocacy, financing, sound planning, monitoring and essential application of welfare programmes. All of these integrated activities are run by PKK’s voluntary workers or kader, who are mostly women. Before the crisis, voluntary workers in West Sumatra Province were given an incentive of Rp. 10 000 (approximately US$ 4 with the rate of early January 1997) per person per activity from the district, province or national levels. After the crisis, owing to the decentralization policy, most of the incentives are taken over by the nagari. The incentives are not the same in every nagari, as they depend on the commitment of the TTS and the availability of resources owned by the nagari. For example, some nagari give a transportation fee for each kader of only Rp. 5000 (about US$ 0.6) per activity.

The integrated health services post or posyandu is another example of community-based and integrated health and welfare activities in West Sumatra Province. Before crisis, it was served by 4–5 cadres per posyandu. The cadres were appointed and assigned by the village head man or village administration staff. However, after crisis, there are only 1 or 2 cadres per posyandu. The total number of posts is also decreasing as some of the posts have been merged with others.

Another example is the General Fund Collection for Perished Household Members (Kongsi Kematian). This is a real community-driven activity to assist families when a member of the household dies. This facility has increased significantly since the crisis and is now available in almost every nagari. In most of the nagari, this activity has been integrated with other health and welfare programmes. Some of the nagari are able to buy an ambulance or a hearse and other burial ceremony equipment.

**Banten Province**

Banten is a new province, formerly a part of West Java Province. Some of the interviews and group discussions conclude that the PKK in Banten is now more intensive than before crisis when it
was still the part of West Java. This is because the implementation of PKK activities is based on local community needs and uses the cultural approaches of the local community.

Another community-based and integrated health and welfare activity is *posyandu*, which used to be a government effort to achieve equity in the maternal health services. Since the crisis, most of these posts are supported by private companies in Banten Province, such as the Krakatau Steel Factory, the Chandra Asri Pulp Company and others. The number of *posyandu* have increased from approximately 5000 to 8000 posts, with active voluntary workers exceeding 17,000 cadres spread out over 4 districts and 2 municipalities.

The Majlis Taklim religious group can be found in most of the villages in Banten Province. Its main activity is religious gathering and education, but most of the group also carry out welfare and health activities in such areas as health education, family planning, nutrition, animal husbandry, home industry, agriculture and drug addiction.

There are hundreds of nongovernmental organizations in the province with integrated humanitarian, health and welfare activities. Not all of them have seriously assisted the communities to solve their health and welfare problems. Some of them do not have conceptual programmes to meet the community needs and demands, and some are developing proposals to obtain financial support from the local government. Nevertheless, some of them have helped the community to develop activities, such as Yayasan Ujung Wahaten, which actively assists the community in education, welfare, cultural and economic programme development.

**East Java Province**

Community participation in long-term care for cancer patients is demonstrated by the PKK in Sidoarjo District, East Java. The PKK *kader* are trained by local health centres, district hospitals, provincial hospitals, private foundations and research institutions as caregivers for this population. They learn how to provide care, palliative treatment, health education, morale boosting and spiritual care, as well as how to create a favourable environment and avoid secondary infections and other dangerous complications. Traditional herbs, acupressure and other traditional techniques are also used by the PKK for palliative treatments. PKK members encourage families of cancer patients to provide care for them at home. The PKK also manages the village health insurance with the local hospital, and provides escorts (by the *kader*) for routine medical examinations and laboratory tests.

Before the crisis all PKK chairpersons in East Java had to be wives of local government administrators. Since the crisis the situation has become more democratic, in that chairpersons are freely elected. The PKK programmes are also more varied and are based on local community needs. For example, some villages have programmes for teenagers and students that concentrate on drug abuse and HIV/AIDS, while others may have reproductive health education, sex education and so forth.

Income-generating activities, through the production of traditional medicine by families or credit union groups, are one of the predominant activities in improving family welfare. In the village of Banjar Rejo in Magetan District, most of the families have a traditional medicine business. A local credit union group managed by the village organizes this business.

The *posyandu* activities in East Java still exist, although they are on the decline. The coverage of under-five children and pregnant women who attend the *posyandu* is decreasing significantly owing to the limited numbers of clients. The total number of these posts is also decreasing drastically because of a dearth of *posyandu* volunteer workers.
East Nusatenggara Province

The majority of the population of East Nusatenggara are either Catholic or Protestant, while the populations of the other sample provinces are predominantly Moslem. However, the everyday life of this community is influenced very much by local ancient beliefs, which have very strong articulation with most of the values and principles in the application of community-based and integrated health and welfare activities.

The annual rainfall in East Nusatenggara is very limited. Therefore, the priorities of community-based and integrated health and welfare activities concentrate on increasing the availability of clean water and on diseases associated with a lack of clean water, such as diarrhoea, malaria and tuberculosis. Promotion of traditional medicine is also one of the community-wide activities.

Before the crisis, most of the activities were organized directly by the national government through provincial and district administrations. There were also some activities supported by church or missionary organizations, but they were not as widespread as the government activities such as PKK and posyandu. After the crisis, some of the top-down national government activities were decentralized to the local government, nongovernmental and religious organizations and others. The intensity of posyandu and PKK activities has decreased since the crisis and with government policy reform, and financial support from the national level has been reduced significantly. This budget reduction has slowed down some of the other activities, such as clean water projects and traditional medicine activities.

However, there has been a significant increase in new nongovernmental organizations, such as Yayasan Tanpa Batas, which focuses on promoting health and welfare programmes among sex workers, sailors, harbour workers, military personnel and truck and bus drivers. Yayasan Haumeni Sani also concentrates on reproductive health, including HIV/AIDS programmes. This foundation has also tried to prevent the continuation of the traditional practice of sifon, in which boys must have sexual intercourse with a woman soon after being circumcised. Yayasan Sanggar Suara Perempuan has some programmes related to improving the welfare of women, including health, education, financial and occupational programmes. This foundation campaigns strongly for gender equity in health and welfare. Another foundation is Yayasan Wahana Visi Indonesia, which promotes curative and preventive activities in tuberculosis and assists the availability of public latrines and clean water for the local communities.

West Kalimantan Province

This province has been suffered from tribal conflicts since the crisis. These occur between the local Dayak tribe and the Madura people, who migrated to the area from Madura Island in East Java. Conflict has been significantly reduced by agreement between the tribal leaders and the local authorities, but still occurs sporadically. The conflicts have had a serious impact on the development of community-based and integrated health and welfare activities.

The most popular activities in West Kalimantan are posyandu, polindes or maternity clinics, village drug posts, family gardens for the production of traditional herbal medicines, local health insurance, health posts for traditional Moslem schools and occupational health posts. PKK and posyandu activities have decreased since the crisis, and particularly after the tribal conflicts. However, some other integrated health and welfare activities organized by nongovernmental and local community organizations have increased significantly.

Jakarta Municipality Province

This province is a typical urban province, community-based and integrated health and welfare activities being concentrated mainly in the slum areas of Jakarta City. Most of the activities are
similar to those in other provinces, but the target groups are different. In this province the target groups are street children, sex workers, the unemployed, women and so forth.

Table 5 summarizes the community-based and integrated health and welfare activities taking place in the six provinces before and after the crisis

<table>
<thead>
<tr>
<th>Activities</th>
<th>Before crisis</th>
<th>After crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government-driven</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated health post (<em>posyandu</em>)</td>
<td>a. Very active, could be found in every village/hamlet</td>
<td>a. Reduction in activities; some merged with other <em>posyandu</em>, some non-active</td>
</tr>
<tr>
<td></td>
<td>b. Some financial assistance from government, especially for food supplements, family planning</td>
<td>b. Decreasing and some no longer available, for example community funds has to buy contraceptives</td>
</tr>
<tr>
<td></td>
<td>and incentives for local cadres</td>
<td></td>
</tr>
<tr>
<td>Family welfare movement (<em>PKK</em>)</td>
<td>a. Very active with 10 basic social welfare programmes</td>
<td>a. Not very active, depending on the chairperson, but still concentrating on 10 basic social welfare</td>
</tr>
<tr>
<td></td>
<td>b. Chaired by the wives of national and local authorities; members of the organizing committee were</td>
<td>programmes</td>
</tr>
<tr>
<td></td>
<td>mostly civil servant’s wives</td>
<td>b. Mostly chaired by elected persons</td>
</tr>
<tr>
<td></td>
<td>c. Top-down and very well organized</td>
<td>c. More concern for local community needs and demands</td>
</tr>
<tr>
<td></td>
<td>d. Budget: national and presidential decisions</td>
<td>d. Budget: small amount from national, province and district governments</td>
</tr>
<tr>
<td></td>
<td>e. Leader of community activities</td>
<td>e. Partner in community activities</td>
</tr>
<tr>
<td>Foster home</td>
<td>Available</td>
<td>No longer available in some areas</td>
</tr>
<tr>
<td>Home care for elderly</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Clean and healthy behaviour movement</td>
<td>Very active in every district and city</td>
<td>Roughly only half of sample districts still have this movement</td>
</tr>
<tr>
<td><strong>Community-driven</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Village Health Fund</td>
<td>Available in certain villages</td>
<td>Available, and significantly more villages have this activity</td>
</tr>
<tr>
<td>Friday Welfare Fund</td>
<td>Available in some community groups</td>
<td>Increasing and available in almost all community groups</td>
</tr>
<tr>
<td>General Fund Collection for Perished Household Members</td>
<td>Available in some community groups</td>
<td>Increasing and available in almost all community groups</td>
</tr>
<tr>
<td>General Fund Collection for Family Welfare</td>
<td>Available in conjunction with other <em>PKK</em> activities</td>
<td>Increasing and available in almost all community groups</td>
</tr>
<tr>
<td>Various local integrated health and welfare</td>
<td>Not very active and not available</td>
<td>Very active and available depending on local community needs</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mechanisms of community-based and integrated health and welfare activities before and after the crisis

Important components of the mechanism of community-based and integrated health and welfare systems are manpower, budgeting, approaches, target groups and the activities themselves. There are some differences and some similarities among these components before and after the crisis in Indonesia. However, it seems that the differences between the eastern and western parts of the
country are only qualitative in nature. In the western part, the quality of manpower is better, the budget is larger and local cultural-based approaches are more comparable as compared to those in the east.

Differences in some crucial components of the mechanism before and after the crisis are shown in Table 6.

Table 6. Components of community-based and integrated health and welfare activities in the six provinces, before and after the crisis.

<table>
<thead>
<tr>
<th>Component</th>
<th>Before crisis</th>
<th>After crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manpower</td>
<td>• Local health and welfare volunteer providers appointed by village leaders and key persons&lt;br&gt;• Most members of the committee organizing integrated activities were selected based on the decision of village and sub-village leaders&lt;br&gt;• Professional health and welfare providers were contracted by the national departments</td>
<td>• Mostly elected by local community according to criteria provided by national, provincial or district authorities. Village and sub-village leaders give only formal recognition&lt;br&gt;• Most organizing committee members are elected and represent various major parties&lt;br&gt;• Professional health and welfare providers are paid by the district administrators except for the poor areas</td>
</tr>
<tr>
<td>Budget</td>
<td>• Cadres received transportation fee from the national government&lt;br&gt;• Fund for supplementary feeding provided by the national government&lt;br&gt;• Most of the budget for integrated health and welfare provided by the national government</td>
<td>• Depending on the local authorities&lt;br&gt;• Funds for supplementary feeding provided by community or local donors&lt;br&gt;• National budget support has decreased and mostly taken from the allocated general budget</td>
</tr>
<tr>
<td>Approaches</td>
<td>• Top-down&lt;br&gt;• Very structured&lt;br&gt;• Only some pilot projects or small scale initiatives used bottom-up approaches&lt;br&gt;• General programmes&lt;br&gt;• Mostly derived by civil servants</td>
<td>• Bottom-up&lt;br&gt;• Less bureaucratic&lt;br&gt;• Depend on the needs of the local communities&lt;br&gt;• Only poor people and some emergency national priority programmes are financed by the national government&lt;br&gt;• Involvement of professional, private, community and nongovernmental organizations encouraged</td>
</tr>
<tr>
<td>Target group</td>
<td>• Massive coverage with aim of achieving equity&lt;br&gt;• Targeted at infant, under-fives, eligible couples and pregnant women</td>
<td>• Massive coverage for poverty alleviation&lt;br&gt;• Targets vary based on local community needs</td>
</tr>
<tr>
<td>Integrated activities</td>
<td>• Entry point mostly from the health sector programme</td>
<td>• Vary depending on the needs of the local community</td>
</tr>
</tbody>
</table>
Strengths and weaknesses of community-based and integrated health and welfare activities before and after the crisis

The principal strengths and weaknesses of community-based and integrated health and welfare activities are shown in Table 7.

Table 7. Strengths and weaknesses of community-based and integrated health and welfare activities in the six provinces, before and after the crisis

<table>
<thead>
<tr>
<th></th>
<th>Before crisis</th>
<th>After crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
<td>• Budget provided by national government</td>
<td>• Budget provided by local government and community based on needs</td>
</tr>
<tr>
<td></td>
<td>• Salaries of health and welfare manpower provided by national government</td>
<td>• Salary of health and welfare manpower provided by local government and other sectors, including private</td>
</tr>
<tr>
<td></td>
<td>• Efforts to improve community-based programmes</td>
<td>• Efforts to improve community participation and partnerships</td>
</tr>
<tr>
<td></td>
<td>• Stability of government: economic and political</td>
<td>• The priority of integrated health and welfare programmes can be decided by local government and the community</td>
</tr>
<tr>
<td></td>
<td>• High national security: ethnic, religion, crime</td>
<td>• Empowerment of nongovernmental organizations, private sector and religious groups in community development activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Innovation and creativity of community is to be more developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low level of paternalism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Very strong monitoring from legislative sector and nongovernmental and community organizations</td>
</tr>
<tr>
<td><strong>Weaknesses</strong></td>
<td>• Budget decided at central level</td>
<td>• Budget insufficiency at district level and inadequate budget support from the national level</td>
</tr>
<tr>
<td></td>
<td>• Development planning not based on evidence and community needs</td>
<td>• Egoism in each programme sector</td>
</tr>
<tr>
<td></td>
<td>• Top-down development programmes</td>
<td>• Low priority of health and welfare programmes</td>
</tr>
<tr>
<td></td>
<td>• Roles of legislative, judiciary, nongovernmental, private and professional sectors not well developed</td>
<td>• Enhanced transparency tends to become euphoria of democratization and decentralization</td>
</tr>
<tr>
<td></td>
<td>• Very strong paternalistic leadership</td>
<td>• Economic and political instability</td>
</tr>
<tr>
<td></td>
<td>• Low innovation and creativity by the community</td>
<td>• Low national and local security: ethnic, community groups and religious group conflicts, crime, etc.</td>
</tr>
<tr>
<td></td>
<td>• High collusion and corruption and low transparency</td>
<td>• Decentralization policy still new and not very clear</td>
</tr>
<tr>
<td></td>
<td>• Weak monitoring and supervision</td>
<td>• High levels of collusion and corruption</td>
</tr>
</tbody>
</table>
Performance indicators of community-based and integrated health and welfare activities before and after the crisis

Performance indicators in this study are concentrated on what are perceived of integrated health and welfare community-based activities by the local providers and communities. Some examples of indicators used by the local providers and communities found in this study are shown in Table 8.

Table 8. Community-based and integrated health and welfare indicators in the six provinces, before and after the crisis

<table>
<thead>
<tr>
<th>Activities and Indicators</th>
<th>Before crisis</th>
<th>After crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village integrated health post (posyandu)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Number of posyandu</td>
<td>In every hamlet (4–6 posts in each village)</td>
<td>Merged posts in every 1 or 2 villages</td>
</tr>
<tr>
<td>b. Coverage of weighing children</td>
<td>Very high</td>
<td>Decrease</td>
</tr>
<tr>
<td>c. Coverage of antenatal care for pregnant women</td>
<td>High</td>
<td>Lower</td>
</tr>
<tr>
<td>d. Coverage of family planning for eligible couples</td>
<td>High</td>
<td>Lower</td>
</tr>
<tr>
<td>e. Coverage of elderly services</td>
<td>Low</td>
<td>Increase</td>
</tr>
<tr>
<td>f. Number of welfare activities to support posyandu</td>
<td>Few and decided mostly by village officers</td>
<td>Mostly supported by social economic activities and decided by community needs</td>
</tr>
</tbody>
</table>

| Family Welfare Movement (PKK) | | |
| a. Coverage of 10 basic programmes | Information should be available, therefore it was easily tabulated and measured (high coverage) | Only programmes related to local needs; information varied and not easily tabulated and measured |
| b. Community roles | As participants of the movement | As subject of the movement |
| c. Activities | Carried out based on national guidelines | National guidelines still used |
| d. Providers and organizers | Predominantly village officers and formal leaders; mostly organized by local formal institutions | Nongovernmental and professional organizations, political and formal leaders; can be organized by nongovernmental organizations and others |

| Village health fund | | |
| a. Coverage | Only small community groups (30–500 households) | Higher coverage |
| b. Support activities | Mostly supported by local health post and uniform model of activities | Supported by various health and socioeconomic activities |
Some of secondary performance indicator data based on the national and international agencies analysis have also been collected in this study, i.e.:

**Infant and child mortality rates**

The infant and child mortality rates are two of the most important indicators in the health sector and are also recognized as prominent welfare indicators. Fig. 4 shows that these indicators are higher in eastern Indonesia than in Sumatra, Java and Bali (western Indonesia). These indicators tend to be persistent, especially in eastern Indonesia, and indicate serious health and welfare problems. Fast, specific and serious efforts need to be made to deal with the situation.

**Fig. 4. Infant and child mortality rates, 1995–2001**

*Source: National Socioeconomic Survey 2001 (3).*
Human development index

The Human Development Index (HDI) is a composite measure that reflects not just income but also life expectancy and educational attainment. Fig. 5 shows a longer time series (blue line) based on data from UNDP’s *Indonesia human development report* (4). The blue line shows an uninterrupted rise in HDI from 1975 to 1999, while the black line indicates the HDI calculated by the Indonesian Central Bureau of Statistics from different and more recent data, and shows the sharp decrease of HDI since 1997.

Fig. 5. Human Development Index, Indonesia, 1975–1999

![Graph showing Human Development Index from 1975 to 1999](image)

*Note: The HDI is presented in a scale of 0–1.*

*Source: UNDP Human Development Report (various year).*

Poor population

Table 9 shows the trend in the poor population of Indonesia from 1990 to 2001. This particularly reveals the substantial growth in poor population following the crisis of 1997. Fortunately, the table also shows the decrease in the numbers and proportions of poor people beginning in 2000.

Table 9. Numbers and proportions of poor people in Indonesia, 1990–2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Number (million)</th>
<th>Proportion of the total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>27.20</td>
<td>15.08</td>
</tr>
<tr>
<td>1993</td>
<td>26.90</td>
<td>13.67</td>
</tr>
<tr>
<td>1996</td>
<td>22.50</td>
<td>11.34</td>
</tr>
<tr>
<td>1998</td>
<td>49.50</td>
<td>24.20</td>
</tr>
<tr>
<td>1999</td>
<td>79.40</td>
<td>39.10</td>
</tr>
<tr>
<td>2000</td>
<td>37.30</td>
<td>18.90</td>
</tr>
<tr>
<td>2001</td>
<td>37.10</td>
<td>18.10</td>
</tr>
</tbody>
</table>

*Source: Welfare indicators 2001 (5).*
Health and Welfare Systems Development

Indicators from The world health report 2000

Table 10 shows health system performance in several countries according to The world health report 2000 (6). Of the leading countries in the South East Asia Region of WHO, Indonesia is ranked only third in terms of overall attainment and fourth in terms of overall performance. Although the figures are debatable, a general picture of the situation can be gained from the table.

Table 10. Ranking of the health systems of WHO-SEARO countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall attainment (rank among SEARO countries)</th>
<th>Overall performance (rank among SEARO countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>131 (6)</td>
<td>88 (3)</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144 (7)</td>
<td>124 (6)</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>149 (8)</td>
<td>167 (9)</td>
</tr>
<tr>
<td>India</td>
<td>121 (4)</td>
<td>112 (5)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>106 (3)</td>
<td>92 (4)</td>
</tr>
<tr>
<td>Maldives</td>
<td>128 (5)</td>
<td>147 (7)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>175 (10)</td>
<td>190 (10)</td>
</tr>
<tr>
<td>Nepal</td>
<td>160 (9)</td>
<td>150 (8)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>80 (2)</td>
<td>76 (2)</td>
</tr>
<tr>
<td>Thailand</td>
<td>57 (1)</td>
<td>47 (1)</td>
</tr>
</tbody>
</table>


Compared to the other ASEAN countries, the ranking of Indonesia’s health system performance is even worse (Table 11), with Indonesia ranked 6th out of 10 countries.

Table 11. Ranking of the health systems of ASEAN countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall attainment (rank among ASEAN countries)</th>
<th>Overall performance (rank among ASEAN countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td>37 (2)</td>
<td>40 (2)</td>
</tr>
<tr>
<td>Cambodia</td>
<td>166 (9)</td>
<td>179 (9)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>106 (6)</td>
<td>92 (6)</td>
</tr>
<tr>
<td>Laos</td>
<td>154 (8)</td>
<td>165 (8)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>55 (4)</td>
<td>49 (4)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>175 (10)</td>
<td>190 (10)</td>
</tr>
<tr>
<td>Philippines</td>
<td>54 (3)</td>
<td>60 (5)</td>
</tr>
<tr>
<td>Thailand</td>
<td>57 (5)</td>
<td>47 (3)</td>
</tr>
<tr>
<td>Singapore</td>
<td>27 (1)</td>
<td>6 (1)</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>140 (7)</td>
<td>160 (7)</td>
</tr>
</tbody>
</table>


GINI coefficient

Another proxy indicator for health and welfare, as well as income distribution, is the GINI coefficient, which ranges from 0 (extremely even distribution of income) to 1 (extremely uneven distribution of income). The GINI coefficient for Indonesia has slightly increased, from 0.294 in 2000 to 0.299 in 2001 (Table 12).
Table 12. Percentage share of expenditure of several population segments and GINI coefficient, 2000 and 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>20% lowest</th>
<th>40% middle</th>
<th>20% highest</th>
<th>GINI coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>24.1</td>
<td>39.1</td>
<td>36.9</td>
<td>0.294</td>
</tr>
<tr>
<td>2001</td>
<td>23.2</td>
<td>38.1</td>
<td>38.7</td>
<td>0.299</td>
</tr>
</tbody>
</table>

Source: National Socioeconomic Survey 2000 (7) and 2001 (3).

**Household consumption pattern**

Household expenditure is one of several indicators that are able to give a picture of health and welfare in a country. As the level of income increases, the proportion of expenditure will shift from food expenditure to non-food expenditure. The economic crisis since 1997 has greatly influenced the household consumption pattern, particularly for those on a low income. Changes in consumption patterns have been caused by the dramatic decline in living standards due to the increase in the market price of food. This forces people to give priority to foodstuffs rather than to non-food items.

Table 13 shows changes in consumption patterns between 1996 and 2001. The share of food expenditure to total expenditure was approximately 55.3% in 1996 and increased to 64.1% in 2001. Meanwhile, the share of non-food expenditure to total expenditure decreased from 44.7% in 1996 to 35.9% in 2001.

Table 13. Pattern of consumption expenditure per capita per month, 1996 and 2001

<table>
<thead>
<tr>
<th>Item</th>
<th>Consumption expenditure per capita per month</th>
<th>Nominal (Rp)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>38 725</td>
<td>93 310</td>
</tr>
<tr>
<td></td>
<td></td>
<td>55.3</td>
<td>64.1</td>
</tr>
<tr>
<td><strong>Non-food</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Housing</td>
<td></td>
<td>31 337</td>
<td>52 193</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 574</td>
<td>23 257</td>
</tr>
<tr>
<td></td>
<td></td>
<td>44.7</td>
<td>35.9</td>
</tr>
<tr>
<td>2. Education</td>
<td></td>
<td>—</td>
<td>43 155</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—</td>
<td>19.4</td>
</tr>
<tr>
<td>3. Health</td>
<td></td>
<td>—</td>
<td>37 85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—</td>
<td>5.3</td>
</tr>
<tr>
<td>4. Clothing</td>
<td></td>
<td>37 13</td>
<td>66 13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—</td>
<td>3.0</td>
</tr>
<tr>
<td>5. Others Non Foods</td>
<td></td>
<td>14 050</td>
<td>14 223</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20.0</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>70 062</td>
<td>145 503</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: National Socioeconomic Survey 1996 (8) and 2001 (3).

**Recommendations and advocacy for the further policy development of the health and welfare system in Indonesia**

1. The central government of Indonesia should develop a clearer decentralization policy and detailed guidelines as to how to decentralize integrated health and welfare activities at the lower levels. The central government should promote its decentralization policy and guidelines more intensively to local health and welfare providers.
2. Central government should encourage local government, the private sector and nongovernmental, professional and community organizations in developing community-based and integrated health and welfare activities based on local community needs. The entry point to these activities can be through either the health or the welfare sector, as long as they are needed and welcomed by the local community.

3. The components of community-based and integrated health and welfare activities, such as budgeting, mechanisms and management, should be promoted through the intensive training of community leaders by health and welfare providers.

4. Communication forums at district, sub-district, village, hamlet and community levels need to be properly established so as to improve the quality and ensure the sustainability of health and welfare activities.

5. Proper policy and stewardship of community-based and integrated health and welfare systems should be developed by the national government. Local or other providers can modify this policy and stewardship as long as the focus is community needs and community commitment to the activities.

6. By playing appropriate roles, women can make a significant contribution to community-based and integrated health and welfare activities. Women should be empowered by being given more opportunities to improve their technical and managerial abilities.

7. More studies need to be carried out on the cost-effectiveness of community and integrated health and welfare activities.

Conclusions

Owing to the economic crisis, natural disasters and the political changes taking place, Indonesia is in the midst of a transition. As part of the measures to mitigate the impact of the crisis on the health and social welfare sector, several initiatives are being taken in both the public and the private health and social welfare sectors. New integrated health and social welfare priority targets, areas and strategies are needed in order to provide health and social welfare care in the most equitable, effective and efficient way. This begs the following questions.

- What is the profile of some community-based and integrated health and welfare activities in Indonesia before and after the crisis?
- What is the mechanism of some community-based and integrated health and welfare activities in Indonesia before and after the crisis?
- What are the strengths and weaknesses of some community-based and integrated health and welfare activities in Indonesia before and after the crisis?
- What are the possible performance indicators for some community-based and integrated health and welfare activities in Indonesia before and after the crisis?
- What are alternative recommendations and advocacy materials for further policy development regarding health and welfare system in Indonesia?

This study was conducted to answer these questions. Secondary data collection, interviews and group discussions were carried out in western Indonesia (4 provinces, 11 districts, 22 villages and 22 community groups) and eastern Indonesia (2 provinces, 5 districts, 11 villages and 11 community groups). In general it was found that the economic, sociocultural, infrastructural and geographical conditions of provinces and districts in the western part (Sumatra, Java and Bali) were better than those in the eastern part (Kalimantan, Sulawesi, Papua and elsewhere). Some differences were
revealed in the profiles, management and mechanisms of integrated community-based health and welfare activities before and after the crisis in both regions. The profile findings were mainly concerned with the move from government-driven to community-driven activities. The findings also discuss specific management and mechanism components such as manpower, budgeting, approaches, targets and implementation of programme activities. Some performance indicators, which emerged from community group discussions, revealed some decrease in the number of integrated health and welfare activities in the villages, but these were more varied in nature. This variety of integrated health and welfare activities resulted from efforts to meet local needs and solve local problems, particularly poverty. Although there have been several health and welfare policy changes in Indonesia, most of the community-based health and welfare activities, either government- or community-driven, tend to be integrated at village or sub-village levels. The strengths and weaknesses of integrated community health and welfare activities before and after the crisis in both regions are also discussed. Some policy recommendations are also discussed, although the study needs further in-depth analysis.
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Health and social welfare in Sri Lanka: Its evolution and future research priorities

Dr Palitha Abeykoon, Member, National Health Advisory Council, Sri Lanka

Executive Summary

The first part of the paper provides insights into the evolution of health and welfare policies and programmes in Sri Lanka, draws lessons from these experiences and records the emerging health and welfare issues in the country. Next, it identifies issues in this area that need further study and analysis in order to support the policy formulation process and programme implementation.

While the concept of health has been clearly defined, welfare has generated a diversity of interpretations and their dividing lines have been vague. The meaning that has been assumed here is that welfare is an institutional mutual support mechanism that delivers services and activities required by persons or groups who are not self-reliant in the short or long term. In this definition, the provision of health and education in the public sector is not a direct welfare measure but a response to basic human rights and needs. However, making health care of appropriate quality accessible to the poor, the underprivileged and the disabled would constitute an important welfare function.

Since the turn of the 20th century, and particularly after independence in 1948, successive Sri Lankan governments have given high priority to the universal provision of basic health care and to ensuring minimum consumption levels for the population. In the 1970s, with the introduction of market reforms, this was extended to include specific safety nets, and these policies have helped Sri Lanka to achieve levels of human development unknown in similar low-income countries.

However, there is increasing evidence that the costs of these anti-poverty programmes are becoming difficult to sustain. It is clear that pockets of poverty persist, with many population groups having no access to sanitation and safe water, being subject to malnutrition and stunting, and having a high prevalence of domestic violence and substance abuse. Also, the existing welfare programmes are slow to develop small entrepreneurs, as envisaged and planned for. All of this calls for a review of the welfare programmes in the country, and specifically in relation to the health of the people.

There are a few major challenges that are currently emerging in the health care system in Sri Lanka. These derive from the demographic changes that will produce a rapidly ageing population, the double burden of disease that will require long-term care, the expansion of the private sector, and issues related to equity and health care financing. All of them demand better targeting of social sector programmes and the promotion of high economic growth, with built-in measures to ensure equity in the health programmes.

The paper closes with an identification of the major research areas and issues that would help the development of a viable health and welfare system in Sri Lanka. These include conceptual and hypothesis-building studies, studies related to health care organization, health economics and behavioural studies. Finally, a reality check is made regarding the current situation and the prospects for enhancing research in these crucially important areas.
Research objectives and methodology

Objectives

The objectives of this paper are to provide insights for the development of relevant health and welfare policies by:

- learning from the evolution of welfare in Sri Lanka and what already exists; and
- identifying the basis for further development, and the research priorities that are emerging in this regard.

Methodology

The review of the health-related welfare policies in Sri Lanka was undertaken on the basis of available secondary data – both published literature and “fugitive” or grey literature as yet unpublished. Information on the current health status of the population and the emerging health needs and priorities was also obtained from issues of the National health bulletin over the past two decades and a few relevant papers that have been published in national journals. In addition, a few key informants currently engaged in activities related to the provision of health-related welfare services were interviewed to obtain the priority needs as experienced and envisaged by them. Responsibility for the opinions expressed in the paper is predominantly with the author.

Introduction

First of all, we need to take note of the meaning of some concepts inherent in the title of this paper, in order to attempt to place the subject in the proper perspective. WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. While this definition is in some measure aspirational and open-ended, and expresses the goal of all health development activities, it does not lend itself to direct objective measurement. There have therefore been other definitions of health such as, “health is the reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health” (1). Following the Fourth International Conference on Health Promotion (2), the definition given for health was, “health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personnel resources as well as physical capabilities”. Thus it is seen that there are some features of health that are universally accepted and have remained inviolate for a long time.

Social welfare, on the other hand, has been more elusive to define. The terms social welfare, social services and social work have been used at various times with overlapping meanings. For the purposes of this paper, “social welfare” is the term that will be used to reflect its relationships with health and health care.

The concept of social welfare has also undergone a paradigm shift over the years. All human societies organize life into enduring patterns that carry on essential social functions. These include human activities such as child rearing, production, consumption and distribution, socialization, social control, social integration and mutual support. These are addressed by “institutions”, which are networks of relationships that are generally accepted as the ways to carry out these essential social functions. The institution of social welfare is more functionally diffuse than the others and its primary
function is mutual support, a function that comes into play when some of the human needs are not being met by the other institutions. This way social welfare appears not as a primary function but what may be termed a *residual function*, and this was the concept of social welfare for a considerable period of time (3,4).

According to many social theorists this view is no longer valid. All societies have recognized the need for mutual support to all or many of their members as an essential, and not merely a residual, responsibility.

Therefore, competing with the earlier concept is the “institutional” view of social welfare as a distinct pattern of activities, serving not as a safety net after all else has failed but as a normal, first-line function of modern society. Seen in this way, social welfare does not carry the stigma of charity. Rather it is seen as a normal and accepted means by which individuals and communities fulfil their social needs and attain healthful living.

For the purposes of this paper, and thus for practical reasons, we propose to take the position that the provision of health care and education through the public sector are not direct welfare measures but are responses to basic human rights and needs. However, making health care of appropriate quality accessible to the poor, the underprivileged and the disabled would constitute an important welfare function. The case of health insurance being provided to the government employees of Sri Lanka is a special instance of health being addressed as a welfare measure.

In this paper, social welfare is thus seen as an essential component of the array of social instruments that have been adopted for mutual support.

**Origins and evolution of health and social welfare policies in Sri Lanka**

In the pre-independence period before 1948, social welfare policy in Sri Lanka started as a number of schemes that were designed for special occupational groups (5). During the past five decades it has evolved towards a basic system covering the whole population of the country. Legislation specifying health and educational standards and providing social security was introduced for the benefit of the Indian immigrant labour that was brought into the plantations. These were then incorporated into the local labour legislation at the turn of the 20th century, triggered by the improvements that were simultaneously being introduced in India. Unemployment, poverty and destitution were first recognized as serious problems in the Depression of 1930–1933. This was aggravated by the malaria epidemic of 1934–1935, and brought to the forefront the necessity for government intervention.

Alailima (5) points out that, as early as the 1930s, the medical services were the most highly developed of the social services, but were concentrated in the estates and urban areas. Medical treatment was provided free in all hospitals, clinics and dispensaries, and preventive care services were institutionalized with the establishment of the Health Unit system. Declines in crude death rates and infant mortality accelerated in the late 1930s and the 1940s. The declining crude death rates and infant mortality rates showed dramatic decreases between 1946 and 1947, owing primarily to the use of DDT in the anti-malaria campaign and the availability of the new antibiotics in the health system (Table1).
Table 1. Vital statistics over the period 1920–1990

<table>
<thead>
<tr>
<th>Year</th>
<th>Crude birth rate per 1000 population</th>
<th>Crude death rate per 1000 population</th>
<th>Infant mortality rate per 1000 live births</th>
<th>Maternal mortality rate per 1000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>36.5</td>
<td>29.6</td>
<td>182</td>
<td>17.7</td>
</tr>
<tr>
<td>1930</td>
<td>39.0</td>
<td>25.3</td>
<td>175</td>
<td>21.4</td>
</tr>
<tr>
<td>1940</td>
<td>35.7</td>
<td>20.6</td>
<td>149</td>
<td>6.5</td>
</tr>
<tr>
<td>1950</td>
<td>40.2</td>
<td>12.6</td>
<td>82</td>
<td>16.1</td>
</tr>
<tr>
<td>1960</td>
<td>36.6</td>
<td>8.6</td>
<td>57</td>
<td>6.5</td>
</tr>
<tr>
<td>1965</td>
<td>33.1</td>
<td>8.2</td>
<td>53</td>
<td>2.4</td>
</tr>
<tr>
<td>1970</td>
<td>29.4</td>
<td>7.5</td>
<td>48</td>
<td>1.5</td>
</tr>
<tr>
<td>1975</td>
<td>27.8</td>
<td>8.5</td>
<td>45</td>
<td>1.0</td>
</tr>
<tr>
<td>1980</td>
<td>27.6</td>
<td>6.1</td>
<td>38</td>
<td>0.8</td>
</tr>
<tr>
<td>1985</td>
<td>24.6</td>
<td>6.2</td>
<td>24</td>
<td>0.5</td>
</tr>
<tr>
<td>1989</td>
<td>21.3</td>
<td>6.2</td>
<td>17</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Source: Central Bank of Ceylon (6).

In the early post-independence period (1948–1970), the Finance Minister pointed out that about 40% of the government budget was being devoted to health, education, labour and social services, and concluded that, “free independent Ceylon may very justly and proudly call itself a Social Service State” (7). The increase in the numbers of health personnel during this period was far in excess of the natural population increase. By 1960 the crude death rate had fallen to 8.6 per 1000 population, the infant mortality rate to 57 per 1000 live births, and the maternal mortality rate to 3.0 per 1000 live births.

The middle post-independence period (1970–1990) was characterized by a number of socioeconomic changes. It was also significant for the fact that the two regimes in power during that time adopted two widely different sets of policies in order to radically transform the socioeconomic landscape of the country. The structure of the social services did not change during the 1970s, although funding for health was subject to severe constraints in the context of the deteriorating economic situation.

There was an overall decline in expenditure on the social sectors in the early 1980s, owing mainly to a reduction in the food subsidy and stagnant expenditure on education, health and the social sector (Table 2). The social sector allocation decreased from 17.1% of the government budget in 1980 to 14.8% in 1984. This affected the quality of services, owing to poor maintenance and repair of infrastructures and the inadequate provision of essential services such as water and sanitation.

Table 2. Government expenditure as a percentage of GDP

<table>
<thead>
<tr>
<th>Year</th>
<th>Welfare expenditure</th>
<th>Food subsidy</th>
<th>Janasaviya programme</th>
<th>Transfers (households)</th>
<th>Health</th>
<th>Education</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>9.3</td>
<td>0.5</td>
<td>—</td>
<td>3.6</td>
<td>1.2</td>
<td>2.8</td>
<td>0.3</td>
</tr>
<tr>
<td>1981</td>
<td>7.3</td>
<td>0.4</td>
<td>—</td>
<td>3.0</td>
<td>1.2</td>
<td>2.4</td>
<td>0.4</td>
</tr>
<tr>
<td>1982</td>
<td>6.9</td>
<td>0.1</td>
<td>—</td>
<td>2.7</td>
<td>1.7</td>
<td>2.5</td>
<td>0.3</td>
</tr>
<tr>
<td>1983</td>
<td>6.5</td>
<td>0.1</td>
<td>—</td>
<td>2.1</td>
<td>1.1</td>
<td>2.3</td>
<td>0.3</td>
</tr>
<tr>
<td>1984</td>
<td>5.5</td>
<td>0.1</td>
<td>—</td>
<td>2.0</td>
<td>1.3</td>
<td>2.0</td>
<td>0.3</td>
</tr>
<tr>
<td>1985</td>
<td>6.3</td>
<td>0.1</td>
<td>—</td>
<td>2.1</td>
<td>1.6</td>
<td>2.5</td>
<td>0.5</td>
</tr>
<tr>
<td>1990</td>
<td>9.2</td>
<td>0.8</td>
<td>1.5</td>
<td>1.7</td>
<td>3.1</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: Central Bank of Ceylon (6).
During this period, general government policy was to encourage private sector participation, and private organizations in the health and education sectors received direct support for their activities.

The main welfare programmes in the late 1980s and the 1990s were the Janasaviya and Samurdhi programmes. Janasaviya (JSP) was introduced in 1989 and was the primary poverty reduction programme of the then government. The original purpose of this programme was to provide income transfers to about half the population for two years, but because of the high cost it was trimmed and phased over fewer geographical areas.

The Janasaviya programme was discontinued in 1995 and replaced by the Samurdhi programme, which then became the government’s main vehicle for poverty reduction. It combined the functions of the Janasaviya and the Trust Fund, which were disbanded in 1998. The Samurdhi programme covered 50% of the population, or 1.8 million families, and had two components: the first provided direct income support in the form of food coupons, and the second aimed at promoting self-reliance and rural entrepreneurship through savings and credit.

There were other programmes, such as the emergency relief and public assistance programme and special protection programmes for the disabled and the physically and mentally challenged, which also brought nongovernmental organizations into the mainstream of welfare service provision.

Issues and challenges for the health care system

Sri Lanka was and remains a high performer in health status terms, with better indicators than other low- and middle-income countries. Mortality is low and continues to decline, fertility is already below replacement level and by current trends is expected to reach 1.4–1.6 by 2015 (8). Life expectancy is high and is projected to reach current United States levels by 2015–2020, and the country faces a rapidly ageing process with concomitant increases in chronic diseases. The epidemiological transition is well under way. All of these have serious implications for health and social welfare, and would call for a close scrutiny of the current policies and priorities in the health and health-related sectors.

We have also seen that, despite low levels of expenditure on the health sector, health care in Sri Lanka has been technically of acceptable quality, has been relatively inexpensive and has maintained reasonable equity under the circumstances. The coverage by the health services that has been achieved, the good level of education (particularly of mothers) and the social sector policies that have been adopted for over five decades have all contributed to the impressive health outcomes that are seen in the country (9). Further, there is a reasonable complementarity between the public and private sectors in health care, although undoubtedly much more needs to be done in this area. The private sector has been able to cater to a section of the population that values consumer quality and responsiveness, and has thereby relieved somewhat the pressure on the public sector services.

The poor, even those living in rural and remote areas, have access to public sector care under the prevailing system. There are studies that show that the poorest quintiles receive a greater share of the benefits of the tax-based health services than do the richest quintiles. The poor have full access to the public sector, where the technical quality is reasonable and sufficiently effective in improving health status. The public health system may rank lower in terms of consumer-perceived aspects, such as overcrowding, proximity, waiting lists, waiting times and overall responsiveness, but according to a study carried out in 1998 (10) the majority of the population was satisfied with the public health services. However, it was also seen that a significant number of the rich were dissatisfied with the services they received.
There is recent growing evidence that, in spite of all of these positive features, the public health sector in Sri Lanka is overburdened. This has led to many calls for reform. The key issues in the public health sector include emerging demographic patterns (Table 3), epidemiology, and the financial sustainability of the present system. Also important are changes in the roles and responsibilities of the central and provincial health services, the public–private mix of services, and emerging human resources development issues.

Sri Lanka already has the highest percentage of people over 65 years of age in South Asia, and this will increase still further. Therefore, the first major issue facing the country is the need to secure sustainable financing and to ensure that patients are able to avail themselves of costly secondary and tertiary health care. Sri Lanka, therefore, faces a major epidemiological transition. The percentage of the population over 60 years will increase from 8% at present to 13% by 2010, making Sri Lanka the country with the third oldest population after Japan and Singapore (Table 3).

### Table 3. Demographic projections, 1991–2031

<table>
<thead>
<tr>
<th>Year</th>
<th>1991</th>
<th>2001</th>
<th>2011</th>
<th>2021</th>
<th>2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (millions)</td>
<td>17.0</td>
<td>19.2</td>
<td>21.1</td>
<td>22.4</td>
<td>22.8</td>
</tr>
<tr>
<td>Median age (years)</td>
<td>25.0</td>
<td>28.5</td>
<td>32.6</td>
<td>37.0</td>
<td>41.1</td>
</tr>
<tr>
<td>Age group (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 15 years</td>
<td>31</td>
<td>25</td>
<td>22</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>15–59 years</td>
<td>60</td>
<td>65</td>
<td>65</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>≥ 60 years</td>
<td>8</td>
<td>10</td>
<td>13</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>2.2</td>
<td>1.9</td>
<td>1.7</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>69.3</td>
<td>72.1</td>
<td>73.6</td>
<td>75.2</td>
<td>76.4</td>
</tr>
<tr>
<td>Females</td>
<td>74.0</td>
<td>77.0</td>
<td>78.8</td>
<td>80.3</td>
<td>81.6</td>
</tr>
</tbody>
</table>


Over the years, the government has been unable to increase its funding sufficiently to keep pace with the changing epidemiology, population increases and medical progress (Table 4). This is shown by the shortage of specialist services, the overcrowding of hospitals, the long waiting lists, consultations that are all too short, and occupation rates in tertiary hospitals that exceed 100%. Insufficient funding has also kept doctors' salaries low compared to those of other professionals in the private sector. This has led the government to permit private sector work for all government health staff, particularly doctors, and this situation will have to remain since significant salary increases are not possible. The implication for welfare is that the under-funding of health services leaves the poor exposed either to higher out-of-pocket expenses (which they can ill afford) or to a lower quality of care.
Table 4. Health expenditure in Sri Lanka compared with selected other countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>GDP per capita (US$)</th>
<th>Health expenditure per capita</th>
<th>Health expenditure per capita US$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>1997</td>
<td>1090</td>
<td>43</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>1995</td>
<td>3050</td>
<td>59</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>1997</td>
<td>3670</td>
<td>131</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>1996</td>
<td>6650</td>
<td>247</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>1997</td>
<td>19,510</td>
<td>1619</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1997</td>
<td>20,430</td>
<td>1389</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>1997</td>
<td>24,400</td>
<td>1830</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>1997</td>
<td>29,401</td>
<td>4087</td>
<td>13.9</td>
<td></td>
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<td>Sri Lanka</td>
<td>1997</td>
<td>2460</td>
<td>79</td>
<td>3.2</td>
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</tbody>
</table>

Source: Shião (10).

Implications for the future

Sri Lanka seems to be faced with is a long-term fixation on absolute poverty and disparities in the distribution of income, which calls for a poverty alleviation strategy that concurrently provides for:

- a better targeting of social protection programmes, particularly to the vulnerable poor; and
- the promotion of high economic growth with measures to ensure better equity in the distribution of the benefits of that growth, particularly health and education.

The government has now opted for a development strategy that reflects an advance over the former balancing strategy (11). A liberal economy, fiscal and monetary discipline and productive investment with good governance as cornerstones of the new development strategy are expected to place the economy of the country on a high growth path. Such actions are also expected to facilitate economic growth, and consequently lead to a qualitative improvement in health and education services, provision of refined and targeted social protection and poverty alleviation programmes. The private sector, nongovernmental organizations and civil society are expected to be integral partners in this strategy to provide the required dynamism to the economy and social welfare programmes. In the midst of these developments, it may be prudent, may essential, to rethink the most appropriate and viable health and welfare paradigm for the country. The challenges that confront the health sector are new and the older, time-tested strategies alone – even if they are relevant – may not be sufficient.

The ageing population, with an increase in dependants (and a fast-changing dependency ratio owing to the reduced numbers entering the productive age group) and the consequent increases in the costs of care will place great burdens on the current “free to the consumer” health services. The disease patterns will change, leading to the classically described “triple burden”, with degenerative diseases and mental illness also coming to the fore as conditions demanding extensive and long-term care. All of this will be compounded by the rapid developments in health technology and the access to this information that the vast majority of the population will have, thus creating rising demands for these services.

The emerging problems of providing health care and social welfare to the population, particularly to internally displaced people in the conflict-ravaged north and east, are also immense and will demand a very well coordinated effort by the public and private sectors and nongovernmental
organizations. The health services and the other welfare measures will need to be undertaken jointly by these sectors if these problems are to be mitigated in the short term, and waste and inefficiency are to be avoided. In the medium and longer term, more durable planning processes and adequate resource mobilization will be required to build on these short-term measures.

It is also important to stress that over the years there have been serious inefficiencies inherent in the allocation and use of resources within the social welfare and agriculture systems, and that if these deficiencies had been attended to proactively they could have yielded more benefits. These lessons should enable Sri Lanka to put together managerial systems to make the best of the inputs that will be made in the health and welfare sector in the future. Ultimately, however, it needs to be stressed that, in the present situation, all of these measures are still likely to leave a substantial resource gap that will have to be met from external sources.

The need to rethink

The above-mentioned challenges will demand a rethinking of the way that health services and welfare services are financed. We have seen the current pattern of health care financing in Sri Lanka, with the main contributions being from tax-based revenues and direct out-of-pocket payments. The government employees' health insurance system and private health insurance together cover less than 15% of the population. The private health insurance sector is unlikely to undergo a rapid increase in the near future, primarily because the vast majority of the country's population is in the unorganized sector and a large proportion lives below the poverty line. Newer modalities of health care financing as well as more innovative ways of delivering health care, particularly long-term care, have to be explored. The place of social health insurance, managed care and capitation fees, in different combinations, will need to be considered as complementary modalities.

The place of research in future policy formulation with regard to health and welfare will become paramount, and development policies should be determined on the basis of the best available evidence and research into the possible options. Research is needed for two specific purposes – to determine the appropriate policy mix, and to support the efficient implementation of such policies. Specifically, there will be a need for: disaggregated data on the health status and progress of vulnerable groups, so that health and welfare services can be better targeted; the adoption of benchmarks of equity; improvements in the synergy between the public and private sectors; and the strengthening of intersectoral action for health. Increasingly, Sri Lanka will need to pay greater attention to ensuring evidence-based policy formulation.

Conceptual and normative issues

To devise appropriate research priorities and formulate research questions, it is necessary to clarify a number of conceptual and normative issues.

- **The concept of welfare in relation to health.** As there are various levels of understanding, it is necessary from a research perspective to seek a common understanding of this concept.

- **Linkages between health and welfare.** Much of the literature on health and welfare identifies the linkages between the ranges of social sector welfare programmes, including poverty alleviation programmes implemented in different countries. While these are relevant to these studies, we need to tease out more specifically the directly health-related welfare programmes.

- **Successful models of health and welfare.** This is an area where immediate action can be implemented, and the WHO Kobe Centre (WKC) could provide a valuable service in this regard by functioning as a clearinghouse for successful (and unsuccessful) experiences.
• **Hypotheses and indicators to measure relationships between health and welfare.** These could result from some of the earlier mentioned studies.

**Priority research areas**

In the context of Sri Lanka, in addition to the clarification of these conceptual issues there emerge three specific areas of research that are of immediate importance with regard to health and welfare. These relate to overall concerns in public health, health economics and welfare, and behavioural studies in relation to health and welfare.

**Public health research**

The public health issues include:

• burden of disease studies in relation to the poor, and the determinants;
• measures of child welfare – nutrition status of preschool children (as a marker);
• drug policies and the availability of drugs to the poor (including implications of TRIPS¹);
• disaggregated data to measure equity in different groups;
• policies that support the aged and infirm, now and in the future;
• analysis of the effectiveness, costs and benefits of ongoing interventions, in order to decide where to invest for the best gain; and
• studies on risks to health for the poor.

**Health economics research**

In the area of health economics, the following are some of the immediate priorities for Sri Lanka:

• the links between poverty, macroeconomic variables and health in the Sri Lankan context;
• analysis of different health financing models;
• the impact of various tax reforms on poverty and health;
• decentralization and its effects on equitable resource sharing; and
• health impact evaluation of welfare programmes such as Samurdhi.

**Behavioural health research**

Behavioural studies are a very important area for identifying clients’ perceptions and their needs for welfare services related to health. The more obvious areas for such research include the following:

• studies on patient/client satisfaction;
• the health-seeking behaviour of the poor in rural and urban slum populations; and
• utilization patterns of different systems of health care.

¹ TRIPS: Trade-related aspects of intellectual property rights of the World Trade Organization.
While the above are the priority research areas in relation to health and welfare in Sri Lanka, we may pose questions in order to provide proper orientation to the research work that will be undertaken. These questions relate to issues of advocacy, relevance, resources, the methods to be used, and the client orientation of the work. For example, the following five questions are of immediate significance.

- How can we get health research accepted as an economic investment? (advocacy)
- How can we get health research to focus on diseases that mainly affect the poor? (relevance)
- How can we close the 10/90 gap\(^2\) in research funding between developing and developed countries? (resources)
- How can we promote multidisciplinary research teams and projects? (methods)
- How can we involve the community in identifying research priorities? (client orientation)

Research in health and welfare is needed in Sri Lanka to develop a new paradigm for the coming years to meet the emerging health needs and the socioeconomic imperatives. The government and the people of Sri Lanka will have to urgently determine the most appropriate mix of health and welfare policies and health financing mechanisms, for both the public and private sectors, without compromising the traditions and the principles of fairness and equity in which the country’s health services have justifiably taken great pride over the past decades.

\(^2\) The 10/90 gap: the fact that only 10% of global expenditure on health research is on health conditions that represent 90% of the global burden of ill-health.
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