# Major Policies in Health Area in Islamic Republic of Iran During Past 30 Years: Results, Challenges and Strategies

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**Abstract:** To execute future policies, it is essential to analyzing health policies to recognize its success and probable failures. Various policies have been made and legislated in health area over the past years and have surely caused significant changes in health condition of the society. In this study, results, future challenges and guidelines of major policies in health area in Iran have been examined during past 30 years. This qualitative, document-exploring based study has analyzed major policies, retrospectively. We used centralized group discussions and deep half-structured interviews with provincial and state policy makers. Policymakers were selected using Snow ball method. Results were presented in terms of descriptions, results, consequences, future challenges and probable guidelines regarding major policies. Six major policies were selected, using the criteria expansion, time, focus level and subject of policy (after judgment of elites). These policies include: establishing health and treatment networks based on PHC population control; developing health education integrated with ministry of health; establishing family physician and referral system; autonomy and board of trustee in hospitals and execution of the act on public medical services insurance. Regarding special indexes, all policies had desirable results except for the autonomy and board of trustee. Findings and interviews show that in spite of some periodic shortcomings in some policies, like hospitals autonomy generally, all the six major policies have been studied and some good and suitable progresses would be achieved. In other words according to studies, approved in 4th and 5th development scheme of Iran, it is shown that policymakers and legislators have paid more attention to this issue. Thus, major policies increased the health indexes and improved the position among other countries. Thus, WHO announced that Iran has achieved the 98th rank among 182 countries.

**Key words:** Major policies, health policy making, results, challenges, guidelines, Iran

## INTRODUCTION

**Why health policy?** The nature of decision making regarding health related issues often involves matters of life and death. Health is accorded a special position in comparison to other social issues and is also affected by many decisions that have nothing to do with health care: poverty affects people's health (Sachs and McArthur, 2005; Kim *et al.*, 2000) as do pollution, contaminated water or poor sanitation.

To understand these relationships, it is necessary to better define health policy (Bambra *et al.*, 2005). Also health, like almost all other aspects of human life is political because power is exercised over it as a part of a wider economic, social and political system (Kent *et al.*, 2005). Health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interactions between institutions, interests and ideas in the policy making and processing. It is useful both retrospectively and prospectively to understand past policy failures and successes and to plan for future policy implementations (Walt *et al.*, 2008).

**Iran's profile:** Iran is located in the middle East between Turkey and Iraq on the West and Afghanistan and Pakistan on the East; its borders are the Persian Gulf and Gulf of Oman in the South and Armenia, Azerbaijan, the Caspian sea and Turkmenistan in the North.

Islamic republic of Iran is a republic with nominal separation of powers among the executive, judicial and legislative branches. The senior figure in the system is the faqih (leader), an expert in religious law, who is referred to in the constitution as the leader of the revolution. Iran is divided into 31 provinces. High representatives of the government in every province are the governors of that province and all executive authorities in addition to

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observing their related ministries, they are under supervision and cooperation of governorship.

**Iran health system:** Both governmental and non-governmental sections 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. About >50% of the financial resources for purchasing health services are paid out-of-pocket or through individual medical insurance and the rest is covered 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 (Center for Health Development, 2003).

The health system in the Islamic republic of Iran is structured into three levels. Specialty and subspecialty medical services are located and delivered at the higher levels mainly in mega cities and urban areas. The bottom two levels belong to primary health care services and they cover both the rural, remote and urban areas.

The health system is highly centralized and almost all decisions regarding general goals, policies and allocation of resources are made at the central level by the Ministry of Health and Medical Education. The ministry has the legal authority to oversee, license and regulate the activities of the private health sector.

Present structure of national policy-making in health field consists of activists of governmental section, especially Ministry of Health, Treatment and Medical Education, Ministry of Welfare and Social Security, Health and Treatment Commission and Social Commission of Islamic Consultative Assembly, various inter and intra-section councils throughout the country and its provinces (Haghighi and Mayani, 2005). Also, the most important non-governmental and private institutes like Imam committee, Well-being organization, Red Crescent organization, medical council, nursing council are active in this field (WHO, 2002). In national level, all decisions related to determining objectives, policies and allocating resources (except for insurance resources which are spent for production in social security or purchasing services in other organizations) are made centrally in The Ministry of Health, Treatment and Medical Education and according to the knowledge the of the Ministry of Welfare and Social Security and other key entrepreneurs in health system (WHO, 2002).

In provincial level, Medical Sciences Universities are in charge of presenting health services, observing activities of private sections as well as conducting trainings and researches in the field of the medical and health sciences (WHO, 2002). In other words, the main process of policy making is in national level and a small part of selected policies is related to provincial councils although in the 5th program scheme, provincial authorities have been taken into more consideration. In Iran, there are four health policy-making areas which include:

- Health inter-section councils and secretariats (like Insurance High Council which consists of representatives from Ministry of Health, Ministry of Welfare and Medical Council and its decisions are mandatory for whole country)
- Councils and secretariats inside health section (coordinator of policies within Ministry of Health)
- Provincial Councils and secretariats of health (like food health and safety workgroup by the presidency of governor and secretary of university of medical science and membership of all organizations active in provincial health area)
- Centers producing documents, statistics and information for health policies (Policy Making Council of Ministry of Health, Treatment and Medical Education, 2010a, b)

**Rules and legislation about health:** According to Iran's constitutional law, three Articles; 3, 29 and 43 have clearly emphasized on health issues. The constitution of the Islamic republic of Iran (Article 29), guarantees all citizens the right health care. The right of all citizens to benefit health care is embodied in the Constitution of the Islamic republic of Iran which recognizes the rights of all citizens to health as well as an equitable distribution of health services based on Islamic religious principles (Schieber and Klingen, 1999). Concerning special position of health in fundamental principles of constitutional law (Article 3, paragraph 12), the government is bound to besides, paying attention to housing and nutrition; remove all problems in the field of health and to generalize insurance. In Article 43, health and treatment has been introduced as a fundamental right in addition to other issues like housing, food, clothes and education. In this study, fields affecting health have been considered important and economy of the country is expected to be designed and guided based on these fundamental rights. In Articles 20, 21, 30, 31, 100 and 101, social elements of health (SDH) which directly and indirectly affect health have been taken into huge consideration. Also in 2025 outlook of Iran, we can see a specific view about factors which affect health promotion.

Concerning the necessity of analyzing health policies as one of the guidelines for evaluating the status quo and guiding future decisions in this study in addition to examining the major-policies of health area in Iran, treatment, health and education sections, results, consequences, challenges and guidelines recommended to improve policy have been examined too.

## MATERIALS AND METHODS

This qualitative, document-exploring based study has examined major policies of health retroactively. In the first part, documents, rules and documents related to the approved policies were determined using centralized group discussions and half-structured deep interviews with state and province policy makers regarding major-policies. In the second section, in addition to reviewing legal documents and witnesses resulted from executing and evaluating policy, results and challenges in the field of determined policies were explained using centralized group discussions and half-structured deep interviews with state and province policy makers. Research field consisted of national and provincial policy makers in decision making centers in Ministry of Health, Treatment and Medical Education and Ministry of Welfare and Social Security. Interviewers were selected by a combination of Targeted and Snow ball methods.

In the 1st part, rules and regulations, documents and witnesses related to health policies were studied, using retroactive approach. A series of main major and minor policies related to this area in national, regional and provincial levels were extracted which influenced health and treatment area. Major policies in this study are national and centralized policies. Thus, four criteria were determined to choose the most important major policies in the past 30 years based on reporters' ideas and half-structured interviews with policy makers in the health field. These criteria include policy expansion regarding compiling and executing scope (national, regional and provincial), time duration of compiling and executing policy (over past 30 years), level of focus on compiling and executing (centralized, half-centralized, decentralized) and policy subject (health, treatment and education).

Then based on these criteria and results of higher documents, documents and witnesses for examining higher documents and rules of six major policies were determined. In the 2nd section, after major policies were determined, mentioned policies were studied in three areas of describing and explaining policy, results and future challenges.

**Findings:** Findings have been divided into two parts of determining major policies in health area in Iran during the past 30 years with a retroactive approach and explaining and describing results and future challenges. In the 1st section, rules, regulations, documents and witnesses related to policies of health area were examined using a retroactive approach. In the 2nd part after determining major policies, the mentioned policies were studied in three areas of describing and explaining policy, results and future challenges.

**Section 1: Determining major policies of health area:** In the 1st part, six policies were determined in health, treatment and education sections based on elites' viewpoints and according to determined criteria of policy expansion regarding compiling and executing scope (national, regional and provincial), time duration of compiling and executing policy (over past 30 years), level of focus on compiling and executing (centralized, half-centralized, decentralized) and policy subject (health, treatment and education).

These six policies include: Establishing health networks based on primary health care. Population control. Developing health education and integrating it with ministry of health. Family physician program and rural insurance. Hospitals autonomous control and public treatment services insurance. Some cases of above policies were implied in the 1st-4th development acts of Islamic republic of Iran.

**Section 2: Analyzing determined policies**
**Establishing health networks based on Primary Health Care (PHC):** Like other members of WHO, Islamic republic of Iran has introduced Primary Health Care (PHC) as the main tool to achieve the mentioned objectives and has considered establishing and developing a system of health treatment networks in the national, provincial and town levels as infrastructures for supplying health care.

The Iranian Primary Health Care (PHC) system was established to improve access to health care for the underprivileged and to reduce the gap between health outcomes in urban and rural areas.

To improve access in remote areas in the face of shortages of human and capital resources, the system has relied on three main components:

- Establishing health houses in remote and sparsely populated villages
- Staffing the health houses with health workers known as behvarzan, recruited from local communities
- Developing a simple but well-integrated health information system

Rural households in Iran have traditionally been the most underprivileged segment of Iranian society, not only in terms of income and political power but also in accessing basic public services including health.

A major achievement of public policy in Iran, over the past 20 years has been the improvement of rural health and the near elimination of health disparities between higher-income urban populations and the deprived rural areas. For example, in 1974, the infant mortality rate was

120 and 62 per 1,000 live births for rural and urban areas, respectively. By 2000, however both the level and the differential of infant mortality had declined considerably to 30 for rural areas and 28 for urban ones (Asadi-Lari *et al.*, 2004). In 1979, the general health status of the country was still unacceptable. The infant mortality rate was 104 per 1,000 live births and life expectancy was 57 years and the total number of nurses was 7100 with just 2.1 nurses per 10,000 population.

Lack of an integrated structure in presenting health and treatment services, presenting health services and non-systematic prevention and low qualification criterion of health services in rural areas and suburbs and an unfair distribution of health-treatment resources in rural population, especially non-access to minimum fundamental needs are the main challenges in forming system of health and treatment network based on primary health care and its principles.

Primary health care is a useful mean to correct health section and to change the global attitude toward health issue: a shift from emphasis on treatment attitude to preventive care from hospital services to care in society from individual health to public health from urban health to rural health from public programs and especially mobile programs to integrated programs which are presented by fixed units (Tarimo, 1997). PHC seeks to link health to its determinant factors which are mainly out of health section and emphasizes on people's duty and responsibility in supplying their health. PHC clearly informs the authorities in health system that they should guide services to the way in which people work or live.

Many studies conducted during the past decades have shown that the health indicators have been improved to a large extent in Iran. For instance in 1976, the Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR) and Under 5 Mortality Rate (U5MR) were 32,93 and 135 per 1,000 live birth, respectively, 5 but they decreased to 18.3, 28.6 and 36 per 1,000 live birth, respectively in 2000 (Ministry of Health and Medical Education and UNICEF, 2000).

Findings reveal that in various studies and evaluations, starting health and treatment networks based on PHC would improve most health indexes like mortality levels of infants, toddlers, children and mothers, fertility level of mothers, immunization program, infectious diseases control and etc., in various parts of Iran and could reduce the gap between access to PHC in cities and villages.

In management of information system based on PHC in villages, 214 indexes of health consequence were used for collecting demographic and health data like mortality indexes, fertility and vital rate. Also, considering the ongoing growth of population in cities rather than villages

and ongoing health needs of this population another main important challenge is lack of demographic information cover in urban cities. This causes access of these areas to other centers of presentinbf services including private section, presenting health and treatmernt services nonactively unlike villages which have health houses and active health and treatment centers and uncertain number of people in these regions has caused some problems in calculating indexes for urban population.

**Population growth control:** Iran is one of the highly-populated countries in the world. According to UN, Iran is the eighteenth highly-populated country in the world. The family planning program was suspended after the revolution resulting in a huge rise in fertility and population growth rates, doubling the population between 1979 and 1991 (31 million births). This challenged the stagnant economy.

Undesirable conditions in family planning program, mother and children's health and high level of population growth before 1st development program maded policy makers to seriously follow family planning programs and to control ongoing population growth. Thus, one of the 1st policies which was introduced and designed for Ministry of Health, Treatment and Medical Education after Islamic revolution of Iran was to control population growth rate therefore in the 1st program for socioeconomic development of Iran, balancing population growth was taken into high consideration.

According to statistics of Ministry of Health, Treatment and Medical Education, population growth rate in Iran has < 3.9 in 50 sec to 1.2% after year 2006; this reflects a significant decrease in this index (Malekafzali, 2004).

Fortunately, family planning program has been very successful in Iran. These activities was started from the 1st development program in 1989 and continued till the 4th development program. In this case, average birth rate <6 in the beginning of the 1st program to 2nd in the end of the 4th program. This decrease has rarely been observed in family planning program in other countries. After revival of the program in 1989, fertility rates fell and by 2000, they were around replacement level.

**Developing health education and integrating it with ministry of health:** In a historical perspective, four major reasons underpinned the integration of medical education with the health-care delivery system, resulting MOHME: expansion of physical resources for medical education with the inclusion of health-care facilities in medical schools to conduct and appropriate research and education inside the health-care delivery system at all levels; increasing the presence of academic members in

society and coordination of medical education with the needs of the society by creating a harmonious management on both the supply and the demand side of human resources (Center for Health Development, 2003). The health system in Iran is a unique case of structural integration between the health care delivery system and medical education. Concerning the aim of this policy to develop ministry of health, some challenges appeared as a result of integrating medical education with ministry of education; the most important ones are: improper distribution of manpower in the field of medicine in various parts of the country, a weak system of prize and punishment, physicians' and educational personnel epically faculty members have part time jobs and also have >1 job, lack of utilizing private section for education, lack of authority of teachers, insufficient per capita for high education in medical science from national gross production, out-of-date educational syllabus in some fields are.

Mass production of all goods is very helpful for every society. However in terms of health and treatment, spending mass production regarding services and manpower presenting services can reduce social welfare due to a phenomenon called information asymmetry.

**Establishing family physician and referral system:** Now-a-days, >22 million people in Iran (rural and tribal people and those who live in areas with <20 thousand residents) have been covered by medical insurance for free and can benefit a health care providing team including midwives, family physicians-necessary clinical tests and primary radiology and 270 drugs.

Referral system is a system through which patient must first refer to the health house in order to receive health and medical services if necessary, he must refer to a family physician and then to specialists with their rural insurance book. After completing the treatments, giving necessary recommendations and filling in the patient's medical history form, the specialist guides the patient back to the 1st place to continue his treatment (Ministry of Health and Medical Education of Iran, 2008).

Ministry of Health and Ministry of Welfare, mainly cooperate in making policies, executing, evaluating, improving and developing family physician plan. Although, Ministry of Health is known as the biggest provider of the family medical services in villages (due to lack of activity of non-governmental section in disadvantaged and rural areas) and Ministry of Welfare is known as the only place for buying family medical services at the beginning of special program of insured people in villages and somewhere with <20 thousand inhabitants, ability of private section active in these regions has been used to receive primary level services.

Although, 5 years have passed from the beginning of this program, fortunately a desirable success has been achieved in establishment step and service receivers are satisfied with the plan. This satisfaction was observed in a survey carried out in 2009 by the State Agricultural Jihad Institute and by taking a sample universe from some villages of Iran (some villages in every province); it was shown that 85% of rural insured people were satisfied with the health team (medicine, midwife, laboratory, drug and radiology) (Medical Services Insurance Organization, 2010).

Generally, there are two main challenges regarding the policy of family physician and referral system. The 1st one is a weakness in comprehensive and complete educational system of family physician. According to the guidelines of the family physician program, the main duty of a physician is to observe the area regarding presenting services and PHC and treatment duty along with this main duty is proposed because health indexes must improve and further expenses of families must be reduced through a health approach not treatment approach. Second problem is that according to development program of physician family in urban areas with >20000 people, the transfer of physicians to urban areas due to access to better facilities and low manpower in villages and disadvantaged areas should be prevented by using a proper payment system.

**Board of trustee and autonomous hospitals:** As it can be predicted, public hospitals have been guided centrally as the main section of health system in the form of structured units (Bogue *et al.*, 2007). Ma (1994) and Chalkley and Malcomson (1998) have shown that an activity based payment system will imply both productive efficiency (Minimization per patient cost) and allocative efficiency (the treatment of the socially) optimal number of patients provided that the demand depends on the quality of health care services (Ma, 1994; Chalkley and Malcomson, 1998). On the other hand, issues like lack of technical and specialized efficiency, failure in covering low-income and poor groups as well as poor responsiveness to people are the main weak points of public hospitals (Preker and Harding, 2003).

According to the report of WHO in 1999, public hospitals have allocated around 80% of resources of health system to themselves while they only produce 20% of outputs of this section (WHO, 1999). It is claimed that changing governmental hospitals to autonomous units improves management and allocation of public resources and will increase their responsiveness (WHO, 1999; Castano *et al.*, 2004; Harding and Preker, 2000). This can be achieved through reducing governmental direct control and transferring daily decision making processes from

Table 1: major policies of Iran health area, legal back-up and their explanation

| Health policy title | Legal back-up | Policy description/explanation |
|---|---|---|
| Creating health and treatment networks based on PHC | Act approved on 01/10/1985 by Islamic consultative assembly, Articles 84-86 and 89 of 4th developing program act | Developing health network based on primary health Almata statement for villages and suburbs care according to WHO |
| Population control | First development program act, act approved on 16/05/1993 by Islamic consultative assembly | Decreasing the ongoing population growth rate through developing culture and family planning services |
| Developing health education and its integration with ministry of health | Act approved on 16/10/1985 by Islamic consultative assembly | Developing medical education through training manpower in various medical and paramedical levels |
| Establishing family physician and referral system | Article 90 and 91 of 4th developing program act | Fair distribution of medical manpower in villages, tribal areas and cities with <20000 people and reducing health expenses and preventing unnecessary service expenses through establishing referral system |
| | | Decreasing people's payment share (out of pocket) and increasing income resources for hospital, especially specific income through |
| Hospital autonomy and board of trustee | Guidelines announced by ministry of health in 1995 and Article 88 of 4th development plan low | increasing insurance resources according to hospitals autonomy plan, changing organizational structure of governmental hospitals from bureaucratic and centralized structure to board of trustee structure and presenting authority, responsibility and managerial independency in managing affairs of the mentioned hospitals |
| Execution of medical services public insurance plan | Act approved on 25/10/1994 by Islamic consultative assembly | To cut financial relationship between patient and health service providers and to financially support patient during disease and according to Article 29 of constitutional law to prove all people with health right, treatment services public insurance act was approved |

Table 2: Results and future challenges in major policies regarding Iran health area

| Health policy title | Policy results and consequences | Future challenges |
|---|---|---|
| Establishing health and treatment networks based on PHC | Improved people's access to PHC in villages and cities by 93 and 100% in 2001, respectively | |
| | Decreased population growth rate from 3.9 in 50 sec to 1.2% in 85 | |
| | Increased vaccination cover for preventable diseases for all vaccines to >90% | Lack of a software and hardware infrastructure to transfer data from villages to provinces and centers |
| | Reduced mortality of children <5 years from 174 in 1974 to 36 per every 1,000 live birth in 2000 | |
| | Reduced mortality of children under one month from 120 in 1974 to 28 per every 1,000 live birth in 2000 | |
| | Reduced mortality of mothers from 255 in 1974 to 25 per every 1,000 live birth in 2006 | Lack of suitable tools for covering urban demographic information concerning increased percentage of cities to villages |
| | Increased number of physicians to 1000 from 0.38 in 1981 to 0.87 in 2001 | |
| | Access to drinking water in rural areas from 67.7 in 1984 to 89% and in cities to 99% in 2000 | |
| Population control policy | Significant decrease in population growth rate from 3.9 in 50 sec to 1.2 in 80 sec | High population of young people and challenges for preparing housing, employment and juveniles |
| | High population of young people (15-39 years) in comparison with other age groups equal top 50% of country population | Increased population growth in disadvantaged areas and unsuitable living quality indexes |
| | Relative improvement in economic and welfare status of households to reduce total fertility from 4 in 1978 to 1096 in 2006 | Transformation of population age pyramid as aging will appear in future and changes in health needs pattern |
| Developing health education and its combination with ministry of health | Increased number of dentistry and medical universities from 19-105 | Inadequate role of faculty members in execution area |
| | Increased capacity of admitting medical, dentistry and pharmacology students from 1600-11500 students | Low quality of treatment services in governmental centers in comparison with private centers |
| | Increased capacity of faculty members from 2264-12500 members | Centralized supervision, education and execution |
| | Increased capacity of special medical students from 420-6616 students | Faculty members do not work full time in governmental system |
| | Starting specialty and subspecialty courses which did not exist before: emergency medicine social medicine radiography re habilitation nuclear medicine, traditional medicine, immunology, oncology, hematology, plastic surgery and etc. | Inadequate education per capita from national gross production |
| | Establishing new paramedical fields in various university levels | |
| | Starting medical permanent education center | |

Table 2: Continued

| Health policy title | Policy results and consequences | Future challenges |
|---|---|---|
| Establishing family physician and referral system | Covering >23 million people (about 30% of total population of Iran) in rural and tribal areas and <20000 people along with PHC and family physician and referral system Satisfaction of covered people with family physician (85%) Improved fair access of people to health services | Relative success in rural society Weakness in making culture Inadequate motivational system for physicians' shift to villages Threat of beginning of this plan in urban areas and possibility of immigration of physicians from villages |
| Hospital autonomy and board of trustee | Entrusting more responsibility in guideline management and human resources management to board of trustee hospitals without allocation authority with special responsibility in financial management and physical resources management Lack of supplying financial resources for service buyers proportional to tariff growth of services in hospitals Lack of changes of payment system to these hospitals from FFS to other new systems | Lack of full success based on objectives Lack of supplying budget t for creating board of trustee |
| Executing treatment services public insurance act | Increased influence index of basic medical insurance to >91% of people Improved relative status of hospitals income from medical insurance Suitable growth of treatment tariffs to cover treatment expenses by insurance organizations Reduced financial relationship between patient and providers of treatment services | Insurance interaction with various insurance organizations Low of lack of insurance cover for some drugs and especial services and expensive foreign drugs Unbalanced liabilities of different insurance organizations |

government to managers of the hospitals (Castano *et al.*, 2004; Abdullah and Shaw, 2007). At the beginning of 70 sec, autonomous program or the work reward program was executed in all public hospitals of Iran. According to this plan, budget of treatment section of Ministry of Health was given to insurance companies so that 75% of treatment expenses were paid by the instance companies and 25% was paid by the people.

According to this plan, hospitals became autonomous and out of 100% of hospitals incomes, 10% was given to hospital, 5% to university, 20% to personnel except physician and about 55-60% to physicians. But now, the results of this plan are announced to be negative. First of all, people's share of treatment expenses (or out of pocket) increased from 25-60% and 2nd is that reward of work in hospitals was distributed unequity.

Although, the issue of autonomous hospitals and decentralization are very useful, this program did not succeed due to some problems in designing and performance. In this plan, financial supply and a part of payment system was done by the hospital.

Hospitals were bound to use their incomes to run these sections. However since, financial supply was not predicted from public resources like insurance companies and treatment interferences, most people who did not use insurance cover were not able to have a suitable and fair access to services. Accordingly, autonomy was not a very successful idea regarding social satisfaction aspect.

**Executing treatment services public insurance act:** Hospitals bankruptcy, existence of financial relationship

between physicians and patients and lack of insurance cover for all people caused this act to be approved and executed (Table 1 and 2).

**RESULTS AND DISCUSSION**

In policy making area, future challenges and damage points have to be mainly recognized. Challenges will never finish but they change their ways or nature. Thus, policymakers must compile a necessary strategy to overcome them. Obviously, these strategies must be made before strategists get unable. According to the findings, major policies studied based on deep interviews with experts in the field of policy making can be classified as follows:

**Establishing health and treatment networks:** Establishing these networks improve physical, financial and cultural access which conforms to the results of similar studies.

Present main challenge in these networks is lack of a software and hardware infrastructure in cities and villages, lack of suitable tools for collecting information in urban areas to establish health information management system and inadequate capacity for presenting integrated health care. Thus, creating a telecommunication and software program in the 1st place and then correcting information system based on witnesses in the 2nd step are expected in this matter.

**Population control policy:** Concerning reduced population growth rate in Iran, compiling and executing

the mentioned policy have created some needs to change the age pyramid like health needs of middle aged and old people in near future. Although, today we have some problems like housing and unemployment for 50% of young people in the society, these challenges have not appeared due to population control but rather due to lack of a suitable policy to control population in decades prior to execution of this policy.

**Developing health education and its integration with ministry of health:** Integrating medical education with ministry of health has improved the qualitative education of medical and paramedical manpower and results in fair access of public to health and treatment services. However, the quality of medical education is expected to be taken into more consideration according to needs of Iran and other region countries to high quality services.

**Establishing family physicians and referral system:** Since, establishing family physician and referral system, >23 million people in rural and tribal areas and cities with <20,000 people have been covered by medical basic insurance without paying money. We can observe the success of this plan in these areas. Thus, physical, financial and cultural access of people to medical services has been improved.

However, cultural access ca not be considered ideal because referral system and family physician established within health and treatment networks are not completely accepted by both service receivers and service providers specially specialists.

**Hospitals autonomy and board of trustee policy:** Since, this policy was compiled to resolve bad conditions in managing governmental hospitals, especially regarding financial supply and performance independency even by changing autonomy to board of trustee only the structure was changed and it is expected that by making policy of board of trustee, financial credit will be allocated and given to organizations buying services (insurance companies) based on their tariff growth.

**Public medical services insurance:** Influence index of basic insurance which is >90% reflects the success of Iran in developing treatment services public insurance. However, executing this policy in one hand, causes insurance interaction between various insurance organizations and on the other hand, causes lack of insurance cover for some people. It is predicted that as mentioned in Article 42 of 5th program of development act of Iran, about 100% of people will be covered and a basic insurance company will remove this interaction challenge.

It is hoped that as this insurance organization changes to health insurance, instead of treatment in Ministries of Health and Welfare will be replaced by improvement and development.

## CONCLUSION

Finally, findings and interviews show that in spite of some periodic shortcomings in some policies like hospitals autonomy, generally every six major policy has been studied and some good and suitable progress will be achieved. In other words according to the articles approved in 4th and 5th development scheme of Iran, it is shown that policymakers and legislators have paid more attention to this issue. Thus, major policies increased health indexes and improved state rank among countries of the world so that WHO has announced that Iran has achieved the 98th rank among 182 countries. Further, studies in terms of analyzing policy making process in health field, separate and comprehensive study of every major policies in health area and their relationship with status of international indexes, especially millennium development indexes in Iran are recommended.

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