Healthcare and justice in Iran
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Justice, often conceived as fairness or equity, is an essential element of healthcare in theory and practice. The implementation of justice in terms of healthcare policy requires an understanding of health as a human right, and a just society is one in which human rights are recognised and practiced. This paper will focus on social justice which is the intersection of justice and healthcare in the context of Iran. Social justice is culturally, economically and historically nuanced, as it does not focus on what is merely just for the individual but what is just for the whole society.

Iran is a vast country encompassing a wide and diverse geographical area in southwest Asia and has a dispersed population. Great diversity in the weather, culture, environmental hazards and infrastructure has ultimately shaped the country’s health profile. The specific geographic situation of Iran and mass immigration from Afghanistan and Iraq, the eight year war with Iraq, two neighbouring wars in Iraq and Afghanistan and insecurity after these wars in the region and illegal drug trafficking from the eastern borders with Pakistan and Afghanistan all affect the health system in Iran. All this adds serious burdens to the structural inefficiencies in the Iranian healthcare system.

Iran became an Islamic republic after the 1979 Islamic Revolution. It is is the 18th largest country in the world located in the Middle East and has around 80 million population. Many different ethnic groups live together including Persian 61%, Azeri 16%, Kurid 10%, Lur 6%, Baloch 2%, Arab 2%, Turkmens and Turkic tribes 2% and others 1%. Iran has the 19th highest GDP in the world, but GDP per capita was 12,800 USD in 2013 (ranked 103rd). The inflation rate in Iran was 42.3% in 2013, the 3rd highest after Syria and Venezuela. Health expenditure is around 6% of GDP (ranked 110th). The United States spends slightly more than 17% of GDP on healthcare, whereas the average OECD (Organisation for Economic Co-operation and Development) country spends 9.5% of its GDP on healthcare.  

Health is an international human right and this right corresponds with an obligation for every state to provide adequate health for all members of the society. Healthcare should at least be adequate, affordable and accessible. From the standpoint of this paper, meaningful engagement in the various activities of life, the pursuit of prosperity and happiness and the enjoyment of human rights in their fullest expression requires health and wellbeing. Therefore, following other experts and social activists, we consider the right to health as foundational. Article 12 of the Convention on Economic, Social and Cultural Rights states:

‘The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ Iran ratified this treaty in 1966.

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Article 29 of the Islamic Republic of Iran’s constitution stipulates this concept as: ‘entitlement to health services and medical care, is everybody’s right...’. The Ministry of Health and Medical Education is mandated to fulfill this goal through designing and implementing a national level health policy.

In 1985, at national level, medical education was merged into the health system duties; therefore the ‘Ministry of Health and Medical Education’ (MOHME) was developed. At the regional level, a University of medical sciences and at the local level, health networks were formed which were responsible for health and education in the community, using a ‘health house’ structure with rural healthcare workers (called Behvarz) as the first line of healthcare provision. Health indicators in all areas during the first two decades after the reform indicate the efficiency of the Iranian health system in achieving predetermined goals.

It should be noted that, according to Iran’s Ministry of Health and Medical Educations (MOHME), the health workers (Behvarz) manage health houses, ‘the initial group was based on those rural inhabitants whom completed their elementary education. They then entered the special training program for 2 years and

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appointed as Behvarz to the health house covering up to 1,500 people: This created an environment in which the health system had the support of the community and, for instance, it took only 3 years to increase neonatal vaccine coverage from 33% to over 90% nationwide, which was an unprecedented success. The World Health Organization (WHO) report in 2008 confirmed this success: ‘The Islamic Republic of Iran’s progressive roll-out of rural coverage is an impressive example of this model.’

Health, as a fundamental human right, is considered as one of the development factors in every society. Justice in health is one of the most important components of development, measured by its quality of public health, fair distribution of health services among different social classes, as well as, the level of support of disadvantaged people against factors harmful to health. Social Determinants of Health (SDH) play a crucial role for health provision and health maintenance of individuals within society. Equity, as an overarching value, is influenced by these social determinants. Inequitable opportunities based on socioeconomic positions, race/ethnicity, gender, disabilities, geography as well as group differences manifesting as differences or variations of health indices across the country lead to disparities.

Examples of health inequities in Iran include; the mean Maternal Mortality Rate (MMR) in 2004-2006 at 24.7 per 100,000 live births, but MMR varies from 6.3 to 61.3 across the different provinces in Iran, clearly showing unfair distribution and health disparities. Also, the illiteracy rate, – an influential factor on health, is around 15% (2008 estimate), distributed unequally according to gender (19.3% in women versus 10.7% in men) and geographic location (minimum of 6.4 and maximum of 38.9). Other important health indices such as Infant Mortality Rate (IMR), Life Expectancy (LE), Quality Adjusted Life Years (QALY) and combined indices such as Human Development Index (HDI) are also unequally distributed across the country and different socio-demographic groups.

Another dramatic health-related issue is the high prevalence of drug abuse, especially opioid addiction. The head of harm reduction at the Iran Drug Control Headquarters (DCHQ) recently announced there are 3 million drug users in Iran. However, unofficial sources estimate there are up to 6 million people with substance use disorder in Iran. A member of the Health Commission of Iran’s Islamic Consultative Assembly recently announced the detriments caused by drug use are estimated at 200,000 billion IRR per year, which is equal to the annual health-care budget of Iran.

While more than 24,000 HIV-infected cases have been identified in Iran, current estimates from UNAIDS claim more than 90,000 HIV-positive people are living in the country. Although injection drug use (IDU) has

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9 Bahadorim R, Ravangard R, ‘Analysis of the Systematic Relationships among Social Determinants of Health (SDH) and Identification of Their Prioritization in Iran Using DEMA TEL Technique’ Iran J Public Health [Internet], December 2013, 42(12), http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=22516085&AN=93352389&h=xtAKYf%2BZIn8Bd36l%2FpfQg8aZtQTn%
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been primarily introduced as the main route of transmission, sexual transmission has also been speculated as the second most prevalent way of HIV acquisition. In fact, except for a prevalence rate of more than 5% among IDUs, it is estimated the prevalence rate remains at less than 1% among general public, ranking Iran among countries with a concentrated epidemic status.\textsuperscript{14}

Although the burden of disease in Iran has shifted from communicable disease to non-communicable disease (NCD) in recent years, the communicable disease outbreaks are still a chief concern in deprived areas.\textsuperscript{15} Also, disparities in nutritional status manifested as under-nutrition and over-nutrition are noticeable across the country and different socio-economic groups.\textsuperscript{16}

Insurance coverage deficits and high out of pocket expenditures are another topic of concern, especially for the poor. The Iranian Development Plan set the goal for out-of-pocket payments to be as low as 30% in 2008. Nonetheless, almost 55% of health spending is still paid out of pocket. Studies on change in household catastrophic healthcare expenditures (CHE) and inequality in facing such expenditures in low-income societies in Iran have shown no significant change in the CHE proportion despite policy interventions aimed at reducing such expenditures. Any solution to the problem of CHE should include interventions aimed at the determinants of CHE. It is essential to increase the depth of social insurance coverage by expanding the basic benefit package and reducing co-payments.\textsuperscript{17}

In addition to the above mentioned issues, other challenges at the national level, such as new changing demographic patterns, the ageing of the population, economic influences, as well as the challenges of globalisation, changing and emerging patterns of disease, immigration and the geopolitical location of Iran should be major issues of concern in any strategic planning. Also, socio-economic inequalities in major health indices such as the MMR, IMR, Burden of Disease and Injuries (QALY / DALY), Life Expectancy across the country indicate alarming justice issues. Regardless of noticeable progress in different aspects of Iran’s primary healthcare and prevention program, the authors have divided the future challenges for the Iranian healthcare system from the perspective of social justice into the following categories:

1. Healthcare financing

Worldwide, the financial resources of health systems are a real challenge. According to Iran’s health officials, the amount of public budget devoted to health is not sufficient. In recent years, Iran’s government has made the key decision to increase the share for health tax through taxation on tobacco and a share of vehicle insurance, but since the system is faced with a fundamental shortage of financial resources, these steps do not go far enough. Inefficiency and high administrative costs have also added to this problem and out-of-pocket payments are estimated to amount to over 70% of total healthcare expenditure in Iran.

2. Sustainable human resources for the health system

Although human resource development has improved in the past three decades and the number of health professionals has increased, the sustainability of a near adequate workforce is a cause for concern.

3. Noticeable health inequalities within the country

The WHO’S statistics reveal that differences in health status and the distribution of health determinants between different population groups in Iran is high. For example, the difference between life expectancy between different provinces is 24 years and health disparities are seen in women, minorities, injection drug users (IDU), sex workers and street children.

4. Epidemiologic transition

Iran is in an epidemiologic transition and faces a double burden of disease. New emerging threats such as Crimean Congo fever and Middle-Eastern Respiratory Syndrome (MERS) should be considered. These will


become bigger factors as Iran becomes more integrated into the global economy and if the current détente with the United States becomes more permanent.

As we explained earlier, the new patterns can easily be undermined given that the disease burden moving away from communicable diseases in larger population centres. This epidemiological transition will affect the pattern of morbidity and mortality of non-communicable diseases and problems related to the ageing population. According to MOHME, the ‘major burden of disease as a whole and especially in the large metropolitan (areas) is non communicable diseases (NCDs) including cardiovascular disease (CVD), cancer and injuries.’

5. Inadequate mental health services
There are challenges at both primary and secondary healthcare levels; integration in the primary healthcare system and an immature family-physician programme, funding for mental healthcare services of good quality, providing a wide range of services to meet diverse clinical needs and preventive measures, and the absence of a single authority for mental health policy making and strategic planning are the most noticeable issues.

6. E-health
Although several pilot studies have been done in Iran with the largest now covering nearly 1 million people in Golestan province, computer-based health data gathering and e-health expansion is not effective.

7. Weak surveillance systems
These include: the cancer registry programme, AIDS, drug abuse, STDs, violence against women and self-burning (self-immolation).

8. Hospitals & ambulatory services
According to the Joint Commission on the Accreditation of Healthcare Organizations; ‘The [Iranian] health system is one of the most complex systems with many variables and uncertainties. The management of this system needs trained managers.’ One of the current shortcomings in Iran is the lack of trained managers for hospitals. The managers for health centres are usually physicians who are not trained for this job.18

9. Structural political violence and the prison system
Lastly, mention must be made of the issues related to the systematic violence as seen in the aftermath of the disputed 2009 Presidential elections and the treatment of political prisoners, as well as healthcare delivery in the prison system. The international accords to which Iran is a signatory emphasise guarantees for the well-being of prisoners with standards exceeding those that are not confined.19

Conclusion
Iran is a rich country with significant human and economic resources to create a structure amenable to concerns of social justice. Iran has also proven very successful in the past at population control and in launching the Behvarz program. According to Iran’s vision for the future, ‘Iran should be the most developed healthcare system in the region in 2025.’20 However, inequalities in health are remarkable between groups of people in Iran. These unjust differences in health status have a profound impact on people’s lives, determine their risk of illness and the actions taken to prevent them becoming ill and their ability to access treatment when illness occurs. The government of Iran has demonstrated a groundswell of interest in reducing the unfair distribution of health, but no strategic direction for achieving this. There is an emergent need to pay more attention to issues of equality in the distribution of health prospects and medical care and to consider justice as an important priority for the Iranian health system. Making policy, training, research and providing tools and guidelines are essential steps to reduce regional disparities in health.

19 It is maintained that the standards should even exceed the non-incarcerated populations. For an up to date and interesting discussion see Zuniga, Jose M. et al, Advancing the Human Right to Health (Oxford University Press. 2013): 291-304.