Healthcare Reform in Iran: A Market-Driven Path to Quality and Affordability

By Payam Alipour, PhD

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FOREWORD

By Kevin (Kaveh) Rod, M.D., F.C.F.P.

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Iran's current healthcare system encompasses a broad spectrum in the quality of care delivered, ranging from low to high. The existence of this spectrum of quality demonstrates major equality and quality assurance issues. In the aftermath of Iran's political transformation into a post-Islamic regime democracy, the healthcare system faces a historic opportunity for renewal. This paper envisions a market-oriented healthcare model inspired by global exemplars, such as Singapore and Switzerland. This model depicts a transition from government supported care into private supported care as Iran's economy strengthens and expands. The core reform pillars described in this paper are as follows:

- Medical Savings Accounts (MSAs) Funded by Payroll: In this model every worker will contribute a portion of earnings into a personal MSA, akin to Singapore's MediSave, to pay directly for routine care costs. This instills individual responsibility and pre-funds future medical needs while reducing reliance on state budgets.
- Catastrophic Insurance via Competitive Private Carriers: To protect against major illnesses or accidents, all citizens will have high-deductible insurance coverage for catastrophic expenses. Singapore's experience with MediShield Life illustrates how a basic universal insurance covering large hospital bills can be paired with MSAs. Private insurers in Iran will compete to offer such coverage, fostering efficiency and innovation.
- Hospital Privatization and Price Liberalization: As the economic strength of Iran expands, government-run hospitals will gradually become privatized, and price controls on services will be eased. Allowing prices to be set by supply and demand—within a transparent regulatory framework—is expected to improve service quality and cost efficiency, as competition and market forces drive providers to excel. This model will encourage private investment and innovation in the health sector.
- Mandatory (or Opt-Out) Private Insurance With Income-Based Subsidies: Following the Swiss model, Iran will require all residents to obtain basic health insurance from private (non-government) insurers, with regulated benefits and community-rated premiums. To maintain equity, the state will provide premium subsidies for low-income individuals so that no one is denied coverage. Like Germany's system, high-income citizens or specific groups may have the option to opt out of the basic insurance mandate under strict circumstances. This ensures near-universal coverage while preserving choice for those who opt for alternatives.
- Out-of-Pocket Cost-Sharing to Reduce Overuse: The reform introduces co-payments and deductibles for most services, designed to discourage unnecessary utilization. International evidence shows that when patients share a portion of costs, they tend to be more judicious in seeking care, with little adverse effect on health outcomes on average. Both Singapore and Switzerland employ such cost-sharing. To protect low income individuals and other vulnerable groups, preventative and essential services will remain subsidized or covered for those who cannot afford the cost-sharing.
- Five-Year Transition Plan: Implementation will be phased over roughly five years to ensure stability. During this period, public healthcare expenditures will be reallocated to support the new system—for instance, seeding MSAs (through one-time government credits), underwriting premiums for the poor, and bolstering hospital upgrades as they move to private management. A gradual transition avoids disruption, allowing time to build insurance markets, prepare regulators, and educate the public about the new financing mechanisms. Milestones will be set each year—such as the percentage of the population enrolled in private insurance or the number of hospitals privatized—to monitor progress and make course corrections if

needed.

- Long-Term Sustainability Through Targeted Subsidies and NGO Partnership: In the mature state of this reformed system, government spending will focus on smart subsidies rather than direct provision. Targeted vouchers or direct assistance will help cover premiums or out-of-pocket expenses for low-income families, the elderly, and those in remote areas. Additionally, the abundant charitable and non-governmental organization (NGO) capacity in Iran will be harnessed as a partner in service delivery. Iranian NGOs and charities can play a pivotal role in extending care to underserved communities. By leveraging NGO resources and volunteer networks, Iran can ensure that high cost-sharing and market prices do not exclude the poor or hard-to-reach populations.

Together, these pillars chart a path toward quality and affordability. Individual savings and private insurance harness market efficiency, while subsidies and social organizations secure solidarity and equity.

INDEPENDENT QUALITY ASSURANCE AND SUPPORT AUTHORITY

A cornerstone and the main differentiator of this reform is the creation of an effective Independent Quality Assurance and Inspection Authority (IQAI) to define and uphold standards of care across the health system. Separated institutionally from the Ministry of Health, the IQAI will serve as an autonomous regulator and guardian of patient safety. International best practice strongly favors such arm's-length oversight bodies—for instance, European health reforms have called for independent quality agencies to operate free of direct ministry control and to empower patients in reporting problems. Iran's IQAI will embody this principle, avoiding conflicts of interest and ensuring that quality regulation remains transparent and immune from political interference or industry influence.

The IQAI will set nationwide healthcare quality standards and clinical safety benchmarks in consultation with experts and stakeholders. It will inspect and accredit hospitals, clinics, and insurers, publishing performance reports to inform the public. Crucially, this authority's ethos will be not only to police the system but to support continuous improvement. Modern regulatory thinking emphasizes assistance and education for providers as the first step to improvement, reserving punitive actions as a last resort. Accordingly, the IQAI will establish units dedicated to provider support—offering training programs, technical guidance, and even grants or low-interest loans for facility upgrades where needed. For example, if a private hospital struggles to meet the new safety protocols, the IQAI might deploy a team of nurse trainers or hospital management experts to help implement corrections. Only if a provider persistently fails to meet minimum safety standards after receiving support and guidance will the Authority escalate to enforcement measures.

When necessary, the IQAI will have legal powers to enforce compliance. These graduated sanctions follow a "responsive regulation" model, which begin with education and persuasion, escalate to warnings and public disclosure of deficiencies, and apply penalties only if earlier efforts fail. Minor violations might prompt a corrective action plan and re-inspection. Serious or repeated safety lapses could lead to heavier penalties—for instance, fines or suspension of the facility's operating license. In extreme cases of negligence or risk to patients, the Authority can revoke licenses. Such strong actions, however, are truly last resorts—signaling a breakdown in all supportive interventions. The goal is to create a culture of quality improvement rather than a punitive atmosphere. Every enforcement step will be accompanied by a clear path to regain compliance, maintaining an environment where providers are encouraged to admit problems and seek help without fear, as long as they are willing to improve.

By being independent, the IQAI can objectively evaluate both public and private providers. It will coordinate with the Ministry of Health (which will focus on policy, planning, and public health) but operate under its own leadership and budget. This Authority will also involve patient representatives and civil society in developing its standards—reinforcing public trust that the health system's quality is being vigilantly safeguarded. The emphasis on education, training, and mentorship means that the Authority is viewed not just as an inspectorate but as a partner to healthcare facilities and professionals. For example, the IQAI might run annual workshops on infection control best practices or facilitate peer-learning networks for clinics to share improvement tips. It could also certify centers of excellence and disseminate their methods nationwide. Such proactive quality assurance will raise the baseline performance across Iran's health sector, ensuring that market competition never comes at the expense of patient safety or clinical effectiveness.

In summary, this plan outlines a bold vision for Iranian healthcare reform—one that marries market-driven efficiency with strong social protections and oversight. The paper to follow will delve into each of these reform components in detail, providing a roadmap for implementation. By learning from successful systems abroad and prioritizing both choice and quality, a democratic Iran can build a healthcare system that is financially sustainable, innovation-friendly, and above all, responsive to the needs of its people.

INTRODUCTION

Getting healthcare policy right will be one of the most important tasks for Iranian policymakers in the post-Islamic Republic period, especially in light of Iran's rapidly aging population, which can result in a heavy financial burden for the country. To achieve this, policymakers must be guided by both rigorous economic theory and the successful experiences of other countries. The current system in Iran suffers from barriers to competition in healthcare provision, distortionary price controls, limited choice in health insurance, and under-insurance for some segments of the population concurrent with over-insurance for others.

Our vision for Iran's future involves a market-oriented healthcare system with many similarities to the Singaporean model.[1] This system will feature: (1) mandatory (or auto-enroll with opt-out) contributions to individual medical savings accounts (MSAs) to pay for insurance premiums and out-of-pocket (OOP) costs, (2) mandatory (or auto-enroll with opt-out) enrollment in 'catastrophic' (high-OOP) insurance, (3) free choice between private insurance plans that meet minimum coverage requirements, (4) a largely private provider network with minimal government intervention and market-determined prices, and (5) targeted subsidies for low-income households in the form of premium support for purchasing catastrophic coverage, as well as direct deposits into everyone's MSAs. These features will ensure a high quality of care, encourage cost-conscious behavior by the households (including healthier lifestyles), limit the system's cost to the public budget, and minimize the disincentives to work that come inevitably with any public welfare program. All of these outcomes will be desirable for Iran's future prosperity. The main challenge for the government in the immediate aftermath of the Islamic Republic will be to engineer a step-by-step transition to the new model while minimizing disruptions to the provision of healthcare.

This chapter will start by discussing certain fundamental concepts in health economics and a comparison of the various healthcare systems around the world in Section 1. We will then describe the current state of healthcare in Iran in Section 2 and our ideal system in Section 3. Finally, Section 4 will detail the transition process from the present state to our ideal system.

1. BASICS OF HEALTH ECONOMICS AND HEALTHCARE SYSTEMS

Economists are used to approaching every problem by focusing on trade-offs rather than thinking in terms of ideal solutions [1]. In the same spirit, we begin by highlighting that any healthcare system has to navigate through the trade-offs summarized in what is sometimes called "the healthcare policy trilemma" [2 (Ch.15)]:

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[1] The proposed system will also have commonalities with the Swiss healthcare model. Both Singapore and Switzerland are ranked by various international organizations as having two of the best healthcare systems in the world in terms of patient satisfaction and efficiency.

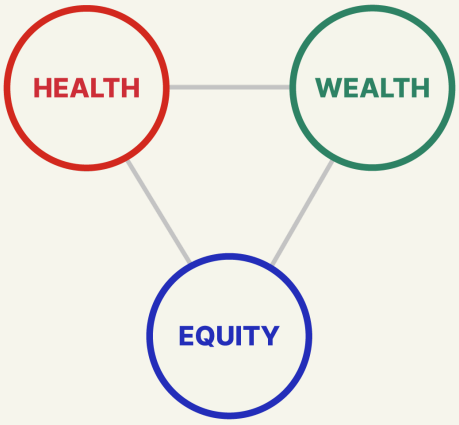

FIGURE 1: The healthcare policy trilemma, adopted from Bhattacharya, et al. (2014) [2].

A system that to aims to achieve a combination of both good health and high equity has to make healthcare effectively "free" at the point of provision [3], which, in the absence of controls, will result in overutilization and ballooning costs that often come with little or no added benefit [4, 5] (i.e., moral hazard) and require high levels of taxation that will negatively affect the economy's capacity to generate wealth. The society might respond by introducing some degree of cost sharing and OOP spending into the design, but this will inevitably reduce the degree of equity in the system. The policymakers might attempt to reduce the resulting inequity and control healthcare spending at the same time by imposing price controls on healthcare-related goods and services, but this will result in shortages and give rise to non-price rationing mechanisms such as queuing, which will jeopardize the patients' health. Policymakers may also respond to the problem of moral hazard through "gatekeeping" (i.e., the restriction of access to specialists to only those with a referral from a general practitioner) and the restriction/denial of access to certain treatments based on cost-effectiveness analysis/health-technology assessment (CEA/HTA). However, given that central planners and third parties cannot fundamentally be nor are incentivized to be as perceptive as individual patients in judging highly subjective matters such as the severity of someone's pain or the value of a certain treatment to them, such non-price measures will inevitably degrade the society's health.

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	Single-Payer	Employment-Based	Market-Oriented
Healthcare Provision	Mostly Public	Mostly Private	Mostly Private
Health Insurance	Mostly Public	Mostly (non-profit) private, but with high degrees of regulation & subsidization	Mostly private, with relatively lower degrees of regulation & subsidization
EXAMPLES	UK, Canada, New Zealand, Denmark, Sweden, Italy, Spain	Germany, France, Japan, Israel	Singapore, Switzerland, The Netherlands, United States

TABLE 1: The three main types of national healthcare systems discussed in the present chapter

Based on how they manage these trade-offs, Table 1 divides the national healthcare systems in the developed world into three main groups [2 (Ch.15), 6]: (1) single-payer or Beveridge-style[2] systems [2 (Ch.16)], such as those in the UK, several other commonwealth countries, and Nordic countries; (2) employment-based or "Bismarckian" systems [2 (Ch.17)], such as Germany, France, and Japan; and (3) market-oriented systems, such as the US, Switzerland, and Singapore. There is also a smaller group of countries, including South Korea, that combine private provision with a single-payer insurance system [7], albeit one with a high level of OOP spending (see Figure 7).

Single-payer systems prioritize equity within the healthcare policy trilemma. Everybody pays into the system through taxes, and care is provided for free or at very low cost (see Figure 8) at government-owned hospitals and clinics. Hospital resources are generally allocated as part of a global budget.

In employment-based systems, hospitals tend to be privately owned, and individuals often receive basic insurance through one of several non-profit, private sickness funds, usually depending on their occupation. Some countries allow the insured to switch between sickness funds. A robust market for private, supplementary insurance often exists as well (see Figure 8). Service prices are generally set through annual negotiations between the government and unions of doctors and nurses, and all providers must abide by these national fee schedules. Insurance premiums are often paid through payroll taxes, contributing to higher shares of government spending

[2] Named after economist William Beveridge, the architect of the UK's National Health Service (NHS).

on healthcare in those countries than in market-oriented ones (see Figure 8). The tax-funded nature of these insurance schemes means that higher-income people pay more for coverage. On the other hand, strict regulations often limit the range of products that can be offered by health insurers and the extent to which insurers can set prices based on risk indicators such as age and health status ("community rating"). Together, these two factors ensure cross-subsidization and some degree of equal access in the system. However, the presence of choice and market competition means that these systems are closer to the health pole and farther from the equity pole of the health policy trilemma compared to single-payer systems.

Finally, market-oriented systems tend to place the least emphasis on equity, at least in theory. Private provision and private, individual insurance tend to be the norm in such systems. Government spending on healthcare is generally smaller than other countries in percentage terms, and regulations on health insurance tend to be lighter. In Section 3, we will discuss the properties of these systems in more detail and also argue that systems explicitly designed around the goal of equity in theory often fail to meet this objective in practice.

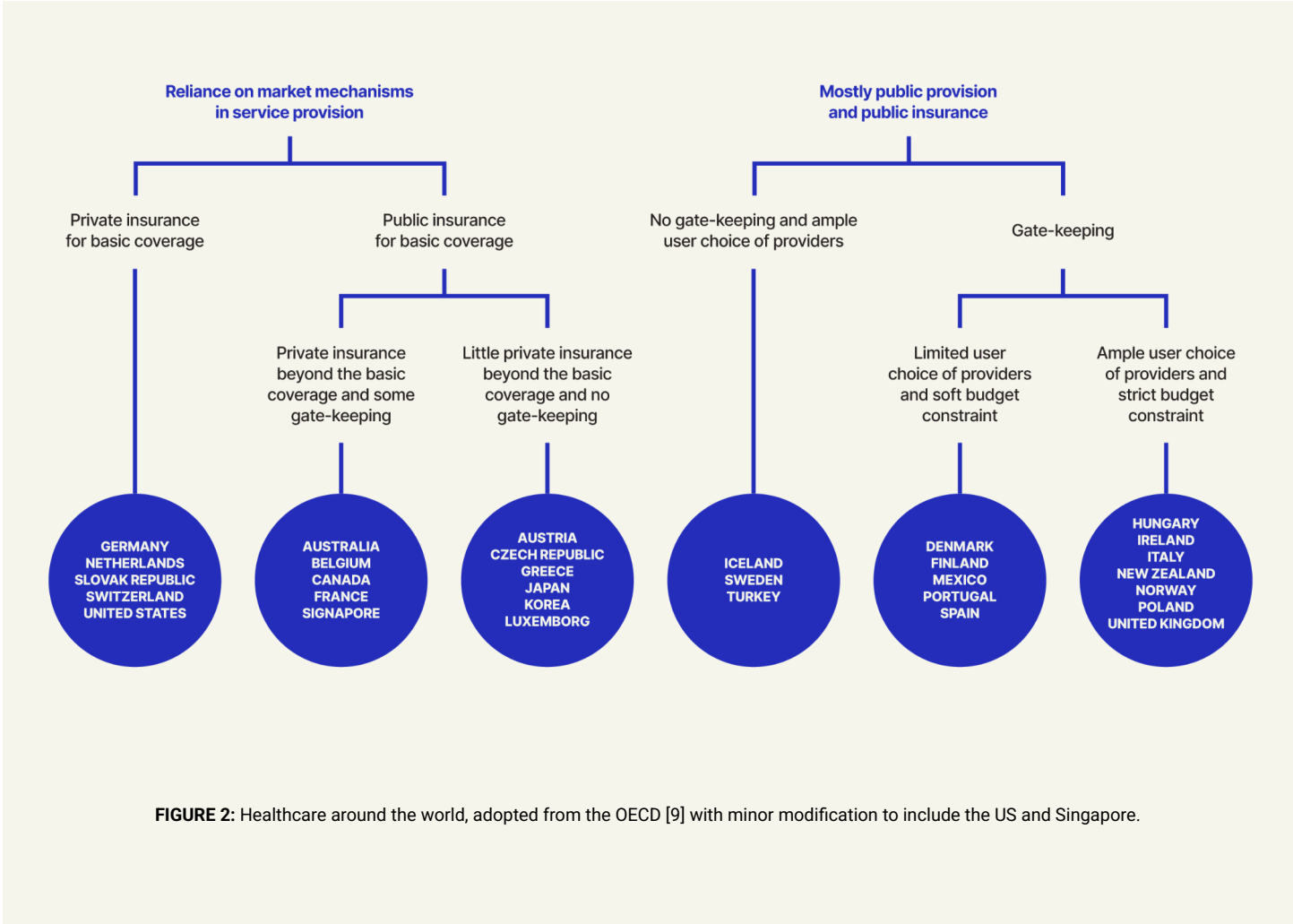

FIGURE 2: Healthcare around the world, adopted from the OECD [9] with minor modification to include the US and Singapore.

There are other ways of classifying national healthcare systems as well, such as the one shown in Figure 2. It is important to note that the distinctions between these groups are not always clear-cut. For example, while most hospitals in Canada are nominally private (as Figure 2 would suggest), their budgets are set entirely by the government, effectively making them public institutions [2 (Ch.16)]. Another example is that 55% of Americans get their health insurance through their employers [8], despite the US not being classified as an "employment-based" system. This is due to the tax exemption granted exclusively to employer-provided plans.

We conclude this section by pointing out that while market-oriented healthcare often receives criticism in the public discourse due to its perceived association with the shortcomings of US healthcare, the American system is, in reality (a) quite far from an unfettered free market, and (b) nevertheless, top-tier in terms of quality. Even before the passage of Obamacare, close to half of all healthcare spending in the US was paid by the government [6], and the market for health insurance was subject to numerous state-level regulations. Restrictions on entry into the medical profession imposed by the American Medical Association (AMA) [10] and on entry into local hospital markets through state-level certificate-of-need (CON) laws reduce supply and increase prices. Finally, the tax exemption granted exclusively to employer-provided plans creates a market distorted by third-party payments (see Figure 7) and price opacity, amplifying moral hazard and increasing administrative costs. Despite all of this, the US does quite well in terms of care quality if one focuses on metrics that are actually relevant. Critics of American healthcare often cite the low US life expectancy despite the system's high cost to argue that it is inferior (see Figure 3). However, US life expectancy at birth is lowered considerably by factors unrelated to healthcare quality, including high rates of homicide, traffic fatalities, and obesity, as well as a different official definition of infant mortality [1115]. As Figure 4(a) shows, once homicides and traffic deaths are controlled for, the US ranks highest in life expectancy among OECD countries for the period from 1980 to 1999, followed by Switzerland, another market-oriented system [11, 12]. Furthermore, as illustrated in Figure 4(b), the US, along with Switzerland, has some of the highest survival rates for medical conditions such as cancer that require advanced and expensive treatments [1116]. The key takeaway is that market-oriented systems can deliver superior quality without spending as much as the US, as evidenced by successful examples in Switzerland and Singapore.

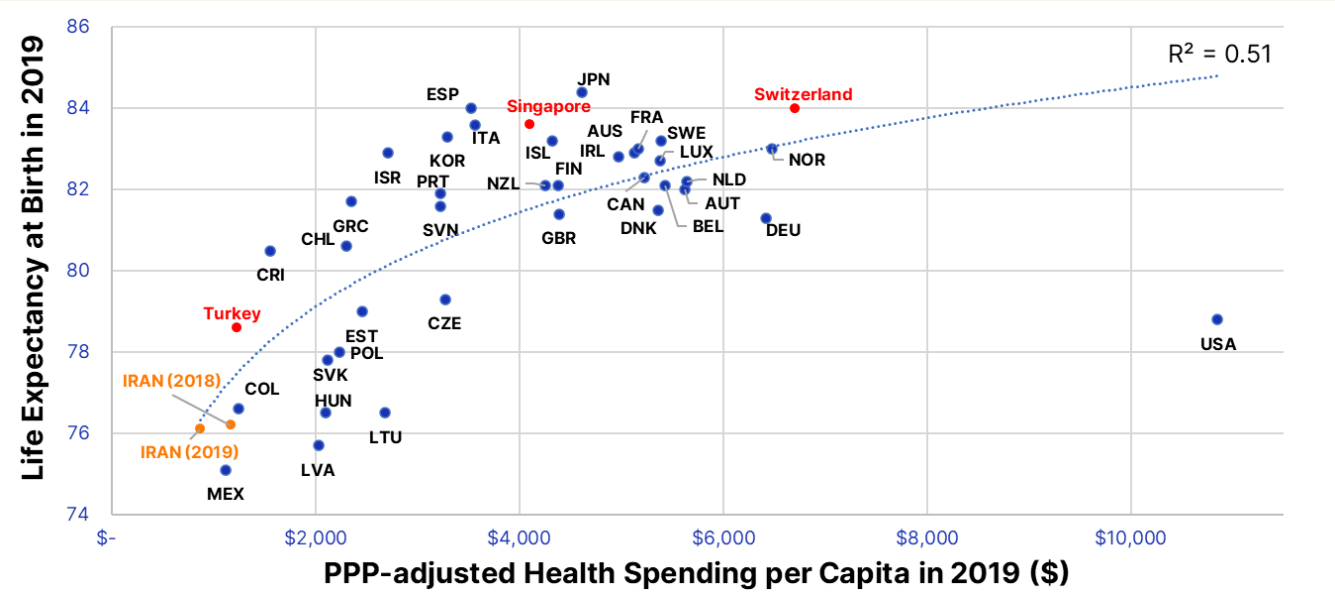

FIGURE 3: Life expectancy at birth vs. per capita health spending in the OECD plus Iran and Singapore in 2019. Countries above the trend line are sometimes considered more efficient providers of healthcare, although life-expectancy-at-birth is not necessarily an accurate measure of healthcare quality (see Figure 4). We also show the 2018 data for Iran since its 2019 health spending was somewhat of an outlier in recent years. Source: OECD & The World Bank

A National Life Expectancy 1980 to 1999

(with and without fatal injuries)

RANKING	OECD Nations	Actual Mean Life Expectancy (including Fatal Injuries)
1	Japan	78.7
2	Iceland	78.0
3	Sweden	77.7
4	Switzerland	77.6
5	Canada	77.3
6	Spain	77.3
7	Greece	77.1
8	Netherlands	77.0
9	Norway	77.0
10	Australia	76.8
11	Italy	76.6
12	France	76.6
13	Belgium	75.7
14	United Kingdom	75.6
15	Germany	75.4
16	Finland	75.4
17	New Zealand	75.4
18	Austria	75.3
19	United States	75.3
20	Denmark	75.1

RANKING	OECD Nations	Standardized Mean Life Expectancy (without fatal injuries)
1	United States	76.9
2	Switzerland	76.6
3	Norway	76.3
4	Canada	76.2
5	Iceland	76.1
6	Sweden	76.1
7	Germany	76.1
8	Denmark	76.1
9	Japan	76.0
10	Australia	76.0
11	France	76.0
12	Belgium	76.0
13	Austria	76.0
14	Netherlands	75.9
15	Italy	75.8
16	United Kingdom	75.7
17	Finland	75.7
18	New Zealand	75.4
19	Czech Republic	75.1
20	Ireland	75.0

B Deaths from Cancer

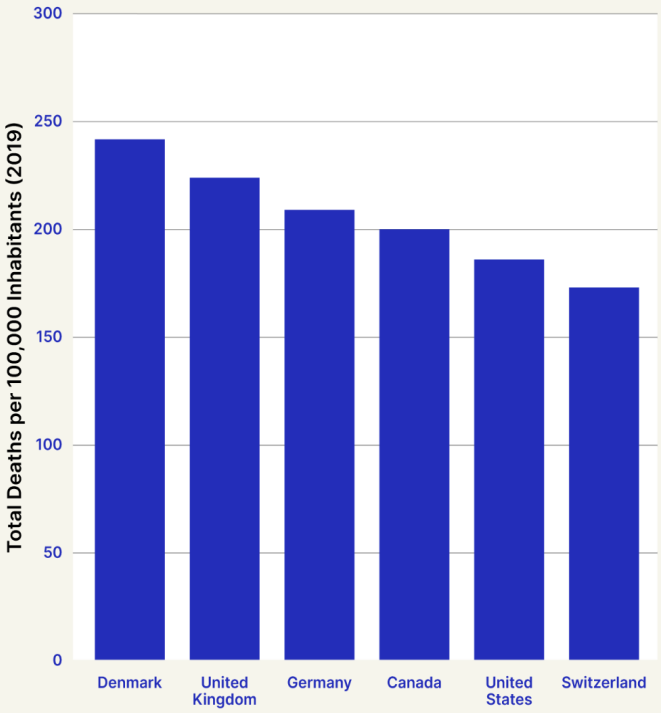

FIGURE 4: (a) Adjusted life expectancy in OECD countries, adopted from Roy (2011) [12].
(b) Cancer deaths in select OECD countries [16].

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2. THE CURRENT STATE OF HEALTHCARE IN IRAN

2.1. Healthcare Provision

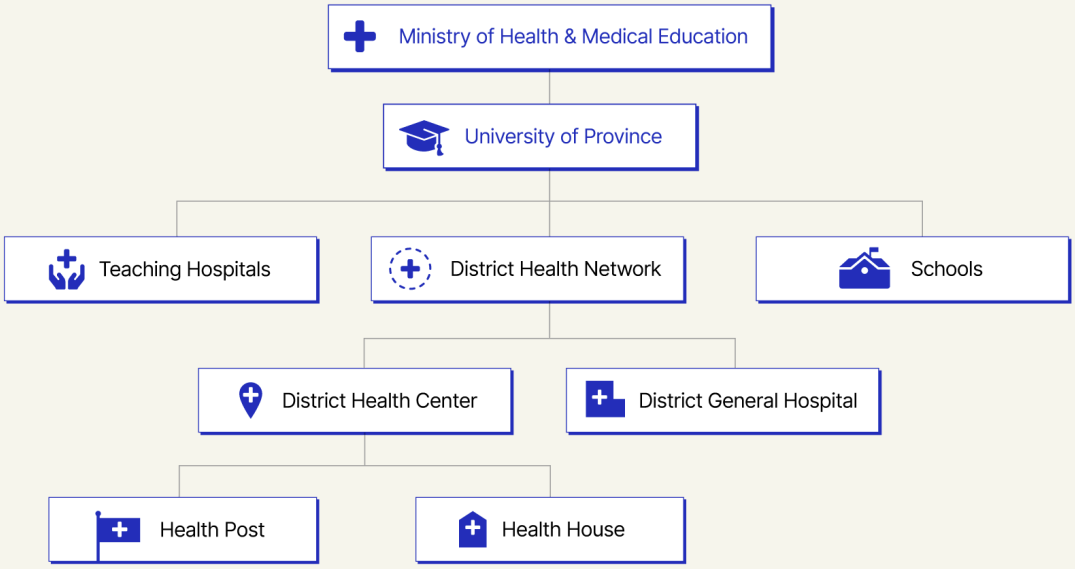

FIGURE 5: The current structure of the Iranian healthcare system, adopted from Mehrdad (2009) [17]

One of the unique features of the Iranian healthcare system is the integration of medical education and healthcare provision under the Ministry of Health and Medical Education (see Figure 5 and Figure 10 in the Appendix for a more detailed schematic), which was implemented in 1985 with the goal of adopting a more coordinated approach to healthcare provision and medical training [17]. We will discuss some of the downsides of this structure in Section 3. Each of Iran's provinces hosts at least one public medical university [17], totaling 51 public medical universities and 16 standalone public medical schools [18]. The president of the largest medical university from each province serves as the highest provincial health authority and is in charge of public health, healthcare provision in public facilities, and medical education [17]. The nationwide health network employs a referral system beginning with primary-care centers on the periphery and extending to secondary-care hospitals in district centers and tertiary-care hospitals in major cities (see Figure 5) [17, 19]. The public sector is the main provider of primary, secondary, and tertiary health services with an emphasis on primary care. Conversely, the private sector mainly delivers tertiary care in large cities [17, 19]. Notably, the referral system does not assign a gate-keeping role to general practitioners (GPs); patients can access any specialist they choose [20]. The licensing of medical professionals is the exclusive responsibility of the Iranian Medical Council (IMC), which is a trade union with more than 200 regional branches throughout Iran. Each branch's board of directors are elected by the direct vote of all the registered members of that branch [21]. The board then elects a president for the branch as well as representatives to participate in the General Assembly of the IMC [21]. A peculiar feature of the Iranian medical system is that IMC-issued licenses only allow the licensee to practice medicine in one specific city or town [22]. We will return to this topic in Section 3.1.2.

2.2. Healthcare Financing

Table 2 details the current Iranian health insurance system. Despite health insurance being made compulsory in Iran under the Sixth National Development Plan (2017–2021), effective enforcement measures are still lacking. The two largest health insurance organizations (HIOs) in Iran are currently the Social Security Insurance Organization (SSIO), which provides compulsory coverage to private-sector employees, and the Medical Services Insurance Organization (renamed the Iranians' Health Insurance Organization, or IHIO, in 2012), which covers government employees, students, rural residents, the self-employed, and other groups [17]. SSIO is nominally an NGO financed by profits from its own investments, contributions from the insured workers (7% of wages earned) and their employers (20% of wages paid), and a 3% contribution from the government [23]. About one-third of this funding (9% out of 30%) is allocated to health insurance (2% paid by the worker, 6% by the employer, and 1% by government) and the remaining two-thirds are allocated to retirement benefits [19, 23]. The organization also owns and operates many clinics and hospitals that provide free or low-cost care to its policyholders [23], making SSIO similar to a large health maintenance organization (HMO). The Social Security Insurance (SSI) program currently covers about 15 million workers, or 43 million people including their dependents.

The IHIO has several different funds, as shown in Table 2, and its minimum-benefit package (MBP) is determined by the High Council of Health Insurance (HCHI) [19]. Since the introduction of the Iranians' Health Insurance (IHI) in 1994, the share of the population with health insurance increased from 40% to around 90% in 2010, with most of the increase coming from rural areas [19, 23]. As the goal of universal coverage was still not achieved, especially among the self-employed, a new sub-fund titled the Universal Coverage Fund (UCF) was created within the IHIO in 2014 as a part of the Health Transformation Plan (HTP) to provide free coverage to the uninsured [19]. Prior to HTP, the self-employed paid half of their premiums, with the government covering the rest. After the launch of the UCF, those individuals became eligible for free coverage, increasing the overall population coverage rate to 96% [19]. This rapid expansion led to a sharp increase in health expenditures (see Figure 8), putting the system under financial pressure. Starting in November 2019, all enrollees were required to pass a means test [19]. The government now fully pays the premiums of those in the three lowest income deciles, and also 90%, 80%, 70%, 60%, 40%, and 20% of the premiums of the fourth to ninth deciles [24]. The current cost of the program is about 0.6% of the GDP [25, 26].

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Features	IHIO				SSO	Health Insurance
	Government Employees	Rural Residents	Universal Coverage	Other Sectors		
Affiliation	Governmental	Governmental	Governmental	Governmental	Public Non-Governmental	Governmental
Who is insured?	Government Employees	Residents in rural areas and cities less than 20,000 population	Self-employed	Students, disables, families with injured persons during the war, some professional associations and similar		
Membership	Obligatory	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
Population Size (2018)	5,413.088	19,969.227	14,441.544	1,438.973	43,475.548 (2019)	Not Available
Contribution Rate (2017)	7% of the wage (2%, 2%, and 3% paid by the employee, employer, and government respectively)	7% of the minimum wage (paid by the government)	Fixed premium (400,000 Rial per month, 100% paid by the government)	7% of the minimum wage (100% paid by the government)	30% of which 9% is for health benefits package (2%, 6%, and 1% paid by the worker, employer, and government respectively)	7% of the wage (2%, 2.5%, and 2.5% paid by the employee, and government respectively). An extra mandatory fixed amount is also deducted for supplementary coverage which is paid by the employees.
User Charges	10 to 30% of in patient and out-patients health services respectively in the public hospitals based on public medical tariffs. Also, the gap between private and public medical tariffs in private centres.	10 to 30%	10 to 30%	10 to 30%	10 to 30% of in patient and out-patients health services respectively based on public medical tariffs. Also, the gap between private and public tariffs in private centres. No copayment in SSO's hospitals and health centres.	

TABLE 2: Major health insurance funds in Iran as of Nov 2018, adopted with minor modification from Doshmangir, et al. (2021) [19]. UCF's current monthly premium is about 1.2 million Rials, and the government only pays the premiums of the three lowest income deciles in full [27].

Other HIOs include the Armed Forces Insurance Organization and the Imam Khomeini Relief Committee (IKRC). Additionally, there are 17 Institutional Health Insurance Funds (IHIFs) through which certain state-owned enterprises, such as the National Iranian Oil Company or the IRIB (National Broadcasting) insure their employees [19]. Those plans are often very generous, resulting in overutilization of medical services.

The HCHI has the authority to set the medical "tariffs" (fees) that HIOs and public hospitals must adhere to, while the IMC sets tariffs for the private sector [19, 28, 29]. HCHI tariffs are often set significantly below market rates, leading to several issues, including the prevalence of under-the-table fees, ineffective insurance coverage, and quality deterioration [19, 28, 29]. Another consequence is supplier-induced demand since doctors, in an attempt to compensate for below-market tariff rates, have a stronger incentive to order unnecessary medical tests with the goal of sharing the profits with laboratory owners [28]. This is yet another source of overutilization within the Iranian medical system [28, 30].

Iran spent about 6% of its GDP (or $830 per capita in PPP-adjusted terms [31]) on healthcare in 2019,[3] slightly higher than the 5% average spent by the other middle-income countries (see Figure 6). At around 40% in 2019, Iran has a significantly higher share of OOP medical spending than the world average (Figure 7), which mainly results from the prevalence of informal payments (14% out of the 53% OOP spending in 2008 [19]) and high rates of under-insurance noted above [28]. Iran's government spent around 20% of its 2019–2020 budget on healthcare [19, 32] and was responsible for about 25% [29] or 50% (see Figure 8) of all health spending, depending on the definition used.[4] Using the first definition, the direct cost to the government was about 1.6% of the GDP in 2019, down from a high of about 2% in the years 2016–2018.

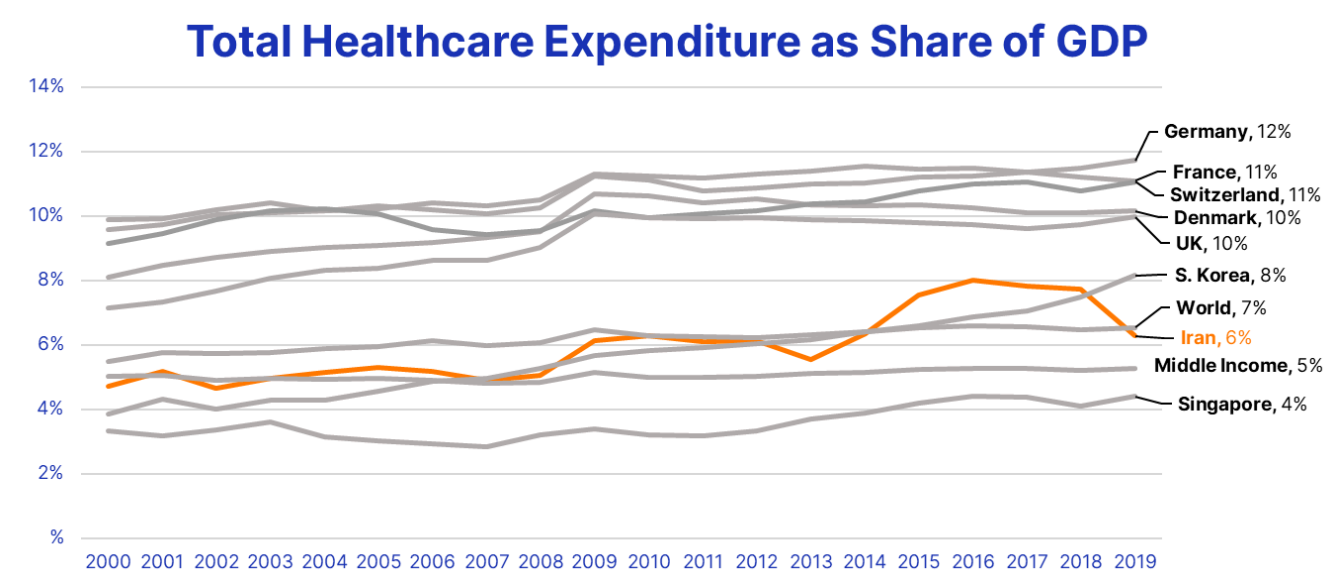

FIGURE 6: Total health spending as a share of GDP for various countries. The US (not shown) is at 17%.
Source: Our World in Data

[3] We only use pre-2020 data because the numbers since then have been distorted by the COVID-19 pandemic.
[4] In Iran and Switzerland (but not in the US or Singapore), mandatory payments by individuals toward obtaining health insurance are included in the government spending shares shown in Figure 8, even if those payments are made to private insurers. This is a convention used by the WHO and some other organizations. The 'true' share of government spending may thus be substantially lower than what is shown in Figure 8; for example, it is about half as much in both Iran and Switzerland [6, 29, 33].

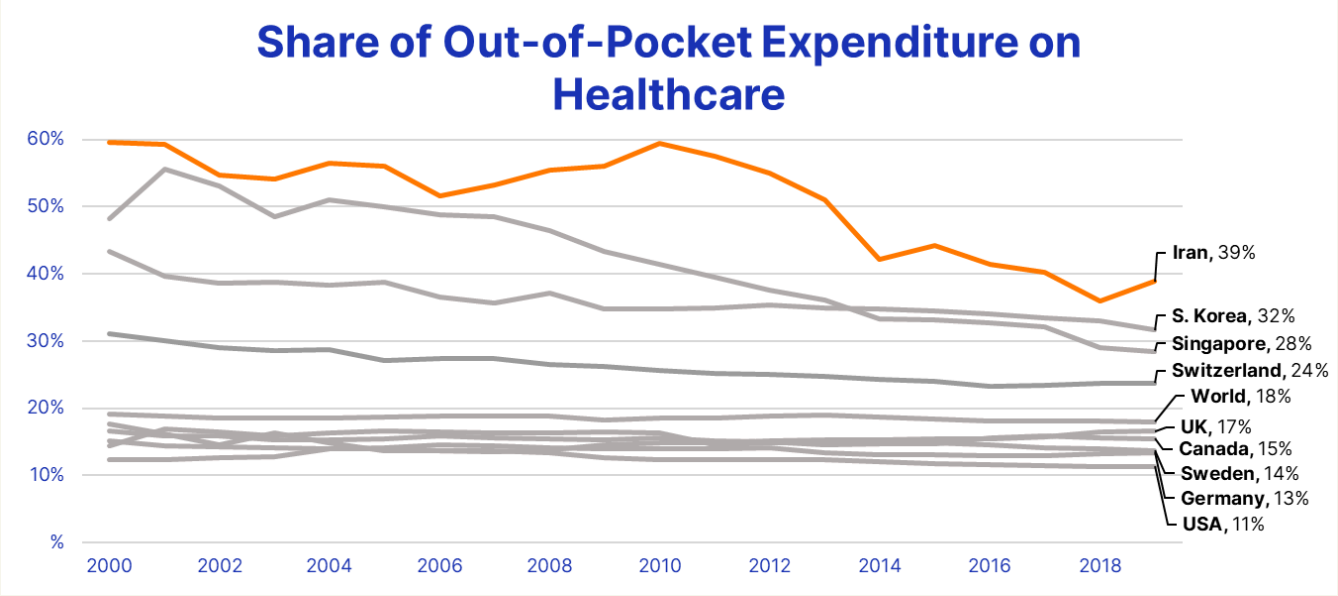

FIGURE 7: OOP spending on healthcare as a share of total healthcare expenditures by country.
Source: Our World in Data

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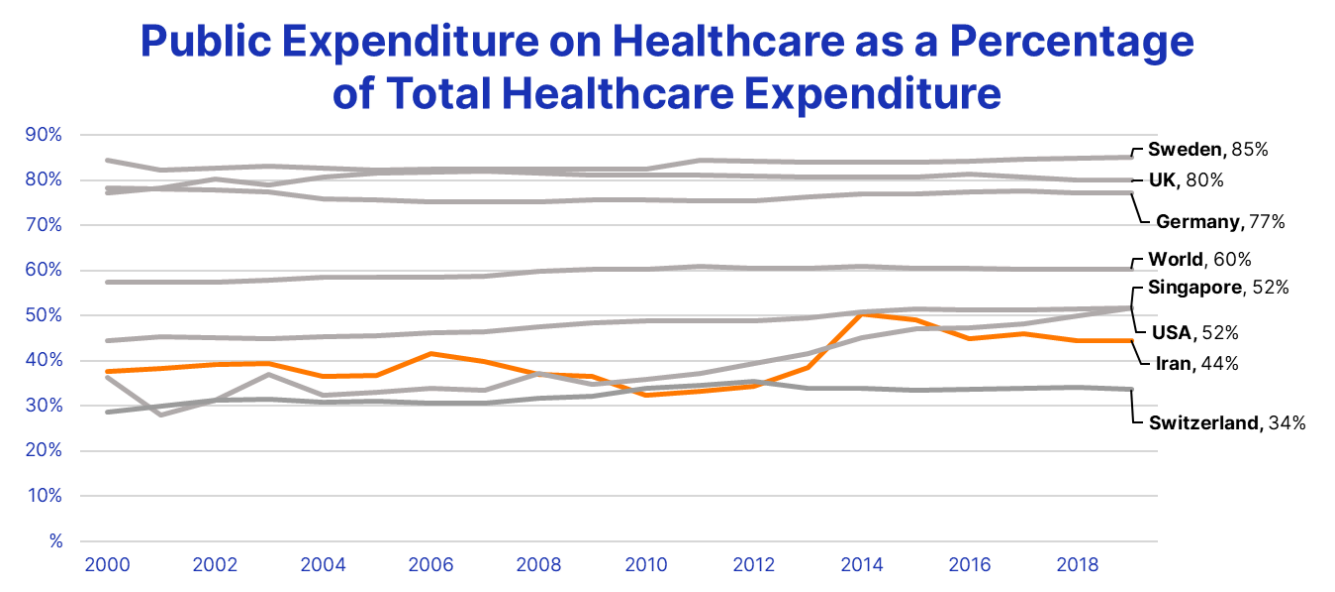

FIGURE 8: Public spending on healthcare as a share of total health spending by country. See footnote 4.
Source: Our World in Data

3. DESIGNING THE IDEAL SYSTEM FOR IRAN

3.1. Reforming the Supply Side

3.1.1. Privatization and Price Liberalization

In the long run, all hospitals, except those affiliated with public universities will be privatized, and the price controls ("tariffs") imposed by the HCHI and the IMC (see Section 2.2) will be abolished. Privatization leaves open the option of turning government hospitals into non-profits, which is the most common organizational form in both employment-based and market-oriented systems, including the US [2 (Ch.6), 7]. Both Singapore and Switzerland have a mix of private and public hospitals [7]. In Singapore, half of all hospitals are private for-profit, and the other half are public [7]. However, the "public" hospitals effectively operate as private non-profits since they have management autonomy and do not receive their budgets from the government (with the exception of subsidies directly tied to the patients) [7].

The fate of public university hospitals in Iran will depend on the fate of the universities themselves. It is important to recognize that teaching hospitals can continue to provide relatively cheap care even without receiving government subsidies due to their access to the resident workforce. This allows them to help in constructing a low-cost MBP (see Section 3.2 for more details). Hospitals currently owned by the SSIO can remain part of the SSIO in the future and help it operate as an HMO, as the SSIO is nominally not owned by the government (see Section 2.2).

3.1.2. Removal of Barriers to Entry

One of the primary sources of rent-seeking and monopolistic behavior in Iranian healthcare is the location specificity of the medical licenses issued by the IMC (see also Section 2.1) [22]. Pharmacists and dentists face similar restrictions as well. The stated rationale behind this policy is to reduce the urban-rural gap in healthcare access, as obtaining a license to practice in a major city requires a large number of "points" that can only be earned by working in underserved regions. However, it is important to consider several key points regarding the impacts of this policy (1) Most healthcare is of a non-emergency nature and addressing the non-emergency medical needs of the rural population does not require the permanent stationing of a professional workforce in those locations. Rather, those needs can be addressed by transferring the rural patients (and having insurance cover the costs of transportation) to urban centers when necessary, or during periodic visits to rural areas by city-based physicians— something they might naturally be incentivized to do by the less intense competition and lower operating costs in those areas; (2) Existing location regulations don't just prevent rural-to-urban physician movement but also urban-to-rural movement (because the ability of a physician with a city license to work in rural areas is severely restricted [22]), which exacerbates physician shortage in rural areas; (3) Location specificity also reduces physicians mobility between areas with similar levels of development, e.g., a city physician is barred from practicing in another city and a rural physician is barred from practicing in a different rural area. The result is a patchwork of local oligopolies that strive to shield their members from competition; and (4) Under the current system, healthcare professionals in underserved regions tend to have lower levels of experience, and that itself contributes to urban-rural disparity. We believe that in a system with targeted and patient-centered subsidies (to be described in detail in Section 3.2), the healthcare purchasing power of the rural poor will naturally rise to the level necessary for attracting physicians to those areas on a voluntary basis (i.e., by raising the equilibrium prices to the extent necessary). However, to prevent the urban-rural disparity from rising sharply in the short run, we will keep the point system partially intact in the immediate aftermath of a regime change (see also Section 4). Nevertheless, restrictions on movement between similarly developed areas can be immediately lifted in a post-IR Iran.

Other monopolistic practices include class-size restrictions in medical schools [10] and the prohibition on after-hours practice by newly hired faculty members. The permission for after-hours practice can only be issued by the university, which makes the decision subject to influence by the more senior faculty members who already have their own permits and are thus incentivized to suppress competition. These prohibitions can also be instantly abolished in the post-IR era. Class sizes at the specialist level are determined by the Ministry of Health and Medical Education (MoHME) after consultation with medical departments. Although the medical departments' recommendations are not legally binding, a "revolving-door" mechanism here facilitates regulatory capture, as the departments themselves are part of the MoHME. Disentangling medical education from the health ministry can alleviate this problem to some extent. In addition, the determination of class size should be decentralized and made more responsive to the level of demand by undertaking market-oriented reforms in higher education.

Finally, tariffs on imported pharmaceuticals can be immediately removed after the fall of the IR to provide price relief to the patients. These tariffs are usually around 3–4% for drugs without a domestic equivalent and 15–20% for those with a domestic equivalent, but can reach up to 100% in certain cases [34, 35].

3.1.3. Abolishing Mandatory Service for Medical Students

To receive their official diplomas, medical students in Iran are required to work for two years in underserved areas after graduation, a policy ostensibly put in place to reduce the urban-rural disparity in healthcare access. During those two years, they also earn points that can be used toward obtaining a license to practice in a large city. However, it is important to note that such a requirement discourages some potential candidates from entering the medical field altogether, reducing the total supply of practicing physicians and, more specifically, the number available in urban areas at any given time. In the best case, this policy benefits the rural and small-city residents (regardless of their financial means) at the expense of everybody else, especially the urban poor. It also results in significant levels of

corruption and bribery as people attempt to get around the requirement. We believe that this inefficient and poorly targeted method of reducing urban-rural disparity is ultimately unnecessary in a system with targeted and patient-centered subsidies (detailed in Section 3.1.2), which will raise the healthcare purchasing power of the rural poor to the level necessary for attracting physicians to those areas on a voluntary basis. Even in the short run, the urban-rural disparity can be checked by partially maintaining the point system (see Section 3.1.2 for details). Therefore, we believe that the mandatory service period can be immediately done away with in a post-IR Iran without causing significant problems. In addition, it is advisable to undertake this reform early on as its downstream impact on physician supply through encouraging more medical-school enrollment will take time to materialize. See also Section 4.

3.1.4. Reforming Quality Control

The availability and affordability of new medications and technologies can be improved by emulating the Singaporean Food and Drug Administration (FDA). In Singapore, any medication or device is automatically approved as long as it has approval from one of the major foreign drug-regulatory agencies, such as the US FDA or the European Medicines Agency [36]. In addition, unlike the US FDA, Singapore only requires proof of a drug's safety, not its efficacy [36]. The evaluation of a drug's efficacy is left to the marketplace and individuals given the potential for Type-II errors and the significant heterogeneity in individuals' responses to a drug as well as in their cost-benefit calculations. This was also the case in the US until 1962 [2 (Ch.12), 36, 37]. In addition, we propose the establishment of an independent Board of Medicine tasked with enforcing safety and quality standards in medical facilities and promoting best practices. The current medical inspections regime in Iran is handled by multiple different institutions with overlapping authority and suffers from political influence, corruption, and a diffusion of responsibility. The new Board of Medicine will be independent of the IMC and the Ministry of Health to reduce its susceptibility to industry insiders and political actors.

3.2. Reforming the Demand Side

3.2.1. Managing Moral Hazard

As Figure 6 shows, rising healthcare spending is a global challenge due to aging populations and the adoption of new, costly treatments. Iran, being the second-fastest aging country in the world by some measures [38], is no exception to this trend. We believe that the best way to control healthcare costs is through cost-sharing and limiting the use of health insurance to protection against rare and financially catastrophic events. Famous randomized controlled trials (RCTs) such as the Rand Health Insurance Experiment [4] and the Oregon Medicaid Expansion Experiment [5] have demonstrated that people randomly assigned to plans with full coverage (i.e., no OOP spending) consume substantially more healthcare than those assigned to cost-sharing plans, but do not draw any tangible health benefits from this extra consumption. Although more cost-sharing reduces the level of redistribution toward high-risk individuals, even those individuals can benefit from higher rates of cost-sharing because this can lower the premiums for everyone [39–41]. While single-payer systems with little or no cost-sharing have historically kept their health spending below many of their counterparts (see Figure 6), they have generally accomplished this through gatekeeping (see Figure 2),[5] capping physician incomes [42], and limiting investment in new technology (see [13] and Figure 11). This has resulted in long waiting times [2 (Ch.16), 6, 43–46], rationed care, and deaths from treatable conditions (see Figure 4). In contrast, countries with high rates of OOP health spending, such as Singapore, South Korea, and Switzerland (see Figure 7), have achieved some of the best health outcomes in the world (see Figure 4 and Table 3) while simultaneously limiting their expenditures (Figure 6 and Figure 8).[6]

[5] Iranians generally cherish their ability to visit a specialist of their choosing at any time and are unlikely to give up this freedom willingly under a single-payer system.
[6] As Roy [47] points out, Switzerland has had slower health spending growth than many of its counterparts despite having a higher level of such spending (which is to be expected given its income, healthcare being a normal good [13], and the high quality of the care provided).

COUNTRY/AREA	2019 (IN YEARS OF AGE)
Monaco	86.5
Hong Kong	85.3
Macao	85.0
Japan	84.4
Liechtenstein	84.3
Switzerland	83.8
Singapore	83.8
South Korea	83.7
Italy	83.6
Spain	83.5

Countries with high rates of OOP health

TABLE 3: Top 10 countries in the world by life expectancy at birth as of 2019 [48].

It is also important to recognize that while single-payer systems have been designed explicitly around the goal of equity, they often fall short of this promise in practice for various reasons. For example, life-expectancy inequality at age 40 between the richest and poorest 1% of households in Norway is comparable to its US level [49], and the correlation between income and physical health in Denmark and Sweden is among the highest in Europe and only slightly lower than the US [50].[7] Evidence shows that individuals with lower socioeconomic status (SES) in these systems face considerably longer wait times for elective surgery and specialist visits (for example, by as much as 66% in Denmark) [52, 53]. Higher-SES individuals just appear to be better at navigating systems with rationed care, and to the extent that "jumping the line" is facilitated through informal payments [54], the well-off benefit disproportionately. Finally, the rich can always rely on medical tourism as a last resort, as is the case with high-income Canadians seeking treatment in the US.

In Iran's case, there is already evidence of medical overuse (e.g., for diagnostics, antibiotic use, and C-sections [28, 30, 55, 56]) despite the relatively high share of OOP under the present system. Therefore, it is even more important to maintain a high OOP share going forward. Our preferred method of promoting cost-consciousness follows the example of the MediSave program in Singapore [57]. Singaporeans are required to deposit 8%10.5% of their monthly earnings, depending on age, into interest-bearing medical savings accounts (MSAs) that currently yield 4% and are allowed to grow year after year. The accumulated funds can be spent on both insurance premiums and OOP charges, ensuring price-consciousness both at the time of choosing insurance plans and when choosing

[7] Both of these are examples of a broader phenomenon known as the "Nordic Paradox" [51].

providers/treatments within a plan. Singapore's government requires all eligible insurance plans to have some cost-sharing. Individuals can voluntarily make additional, tax-exempt contributions to their MSAs as well, up to a limit [58]. Health savings accounts (HSAs) in the US are similar, but their funds cannot be used to pay insurance premiums.

In addition, health insurance premiums should be allowed to vary by risk in order to discourage risky and unhealthy behaviors.[8] A competitive market in health insurance will allow and incentivize insurers to develop innovative ways of promoting healthier lifestyles.

For Iran, we propose setting the default MSA contribution rate at 7% of individual income. The government will also deposit a flat subsidy equal to 1% of the national median wage into each citizen's account, initially excluding those covered by the SSI. This subsidy will put the MSA system on roughly equal footing with SSI, which we expect will continue to operate in parallel for at least some period of time in a post-IR Iran. It will also give all Iranians a sense of equal ownership in the scheme and make it more politically popular. Paying the subsidy directly to the patient rather than the providers has the added benefit of reducing "medical upcoding" [59], which is a somewhat common problem in Iran. The subsidy can be conditional on the individual's contribution to the MSA, similar to a matching contribution. This will encourage enrollment and continued compliance. The total default contribution rate of about 8% is in line with Singapore's lowest contribution limit. It is likely unnecessary to set the default rate any higher, as Singaporeans have currently accumulated about four times the country's annual healthcare expenditures in their MSA system. However, individuals can contribute more if they choose to and effectively use their MSA as a second retirement account (more on this below). The 7% individual contribution rate is also similar to the IHI and SSI contribution rates that Iranians have grown accustomed to (see Table 2), which paves the way for a smoother transition.[9]

If MSA funds cannot be used for anything except healthcare as they are in Singapore, their success in controlling overall health spending may be limited since the opportunity cost of spending those funds on healthcare is also limited. Allowing penalty-free withdrawals upon reaching retirement, similar to American HSAs, can mitigate this issue. American HSAs also permit early withdrawals subject to taxes and penalties. Both of these features can be incorporated into the Iranian system. A final step that can be taken toward enhancing the cost control feature of the MSAs is to allow unused MSA funds to be passed on to one's heirs upon death, as in Singapore [60]. This will be especially important given Iran's rapidly aging population [38] and older individuals' disproportionately high share of healthcare expenditures.

3.2.2. The Structure of Health Insurance Subsidies

Individuals will have free choice in purchasing insurance as long as it covers a minimum level of benefits to qualify for government assistance. The government must be involved in the design of the minimum-benefit package (MBP) as it will impact the level of subsidies. The MBP will be the equivalent of Medishield Life in the Singaporean system, as illustrated in Figure 9(a). Our preferred premium-support model follows Switzerland's model, which protects individuals from paying more than 8% of their income on basic insurance [61].[10] Obamacare adopts a similar approach with an income threshold of 9.5%. We believe that setting the threshold at 5% of income[11] as seen in Figure 9(b) will be more appropriate in Iran's case, although we can ultimately be flexible on the precise number depending on how generous the government can afford to be (more on this later). The MBP will cover catastrophic expenses such as hospitalization, cancer treatment, and dialysis. The list of covered services will be revised periodically using some form of cost-effectiveness analysis based on the "Value of a Statistical Life" (VSL), as is standard in many countries [2 (Ch.13–17)]. The government can leverage the existing IHIO infrastructure to provide its own version of the MBP. Private insurers will also be allowed to

[8] An interesting finding from the Rand Health Insurance Experiment was that people on full health insurance were 25% more likely to suffer from fractures/dislocations and 35% more likely to be hospitalized for substance abuse than those on cost-sharing plans! See Chapter 11 in [2] for more such findings.
[9] The contribution can be divided up between the employer and the employee (as it is in the current system) for political palatability, although the distinction is economically irrelevant.
[10] Singapore also subsidizes the purchase of basic insurance by 15% to 50% of the premium depending on the income and age of the enrollee [62]. However, we find the Swiss system preferable as it is easier to understand and has fewer moving parameters.
[11] Unemployment and retirement benefits can be included in the calculation of income.

offer MBP-equivalent and more generous plans.[12] If the cheapest available MBP in a regional market costs more than 5% of an individual's income, the government will pay the difference.[13] Individuals who qualify for the subsidy can still choose a more comprehensive plan if they wish, but they will have to pay the difference between the higher premium and the price of the cheapest MBP out of their own pockets.

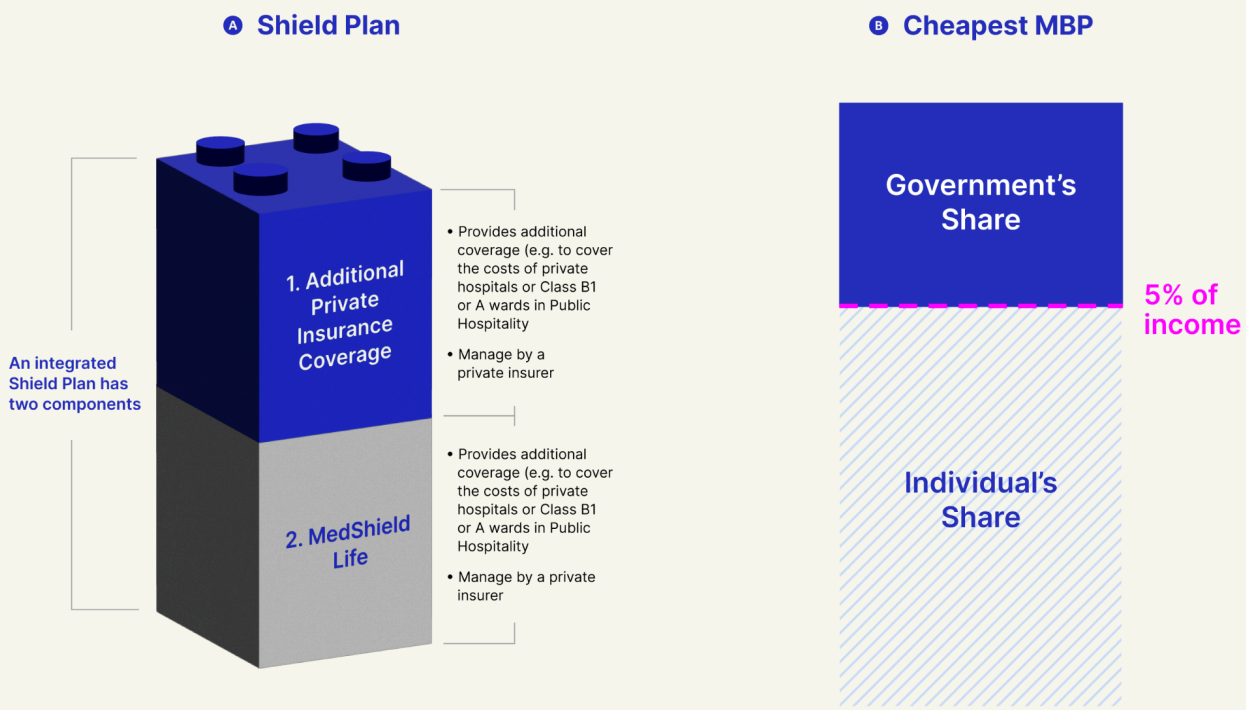

FIGURE 9: (a) Medishield Life is the compulsory minimum-benefit package administered by the government of Singapore (adopted from [64]). (b) Our proposal for premium subsidies in the future Iranian healthcare system.

The implicit marginal tax rate created at the bottom of the income distribution by our proposed subsidy scheme is equal to the income threshold, i.e., 5%. This results from the fact that the amount of the subsidy an individual receives is reduced as their income rises. In terms of disincentives to work, this design is superior to programs such as Medicaid in the US that do not have a gradual phase-out and result in a "benefit cliff" at the eligibility threshold [63].

The cost of the MBP can be reduced through gatekeeping and prioritizing the use of in-network university hospitals (see Section 3.1.1). It is also advisable to adopt a reimbursement system based on diagnosis-related groups (DRG) rather than the existing fee-for-service (FFS) system [29] to curb supplier-induced demand and limit overutilization [2 (Ch.6)]. Finally, the MPB can require a minimum level of cost-sharing (subject to an annual OOP cap), but the degree to which this tool can be used is limited because most of the covered individuals will likely be low-income and have limited means to pay OOP costs.[14] MBPs in both Switzerland and Singapore have a 10%

[12] The government can auto-enroll children and other vulnerable populations (such as those living in under-served areas) in its own MBP but allow them (or their guardians) to choose a different plan if they wish to.
[13] The fact that the cheapest MBP is identified on a regional basis will help with reducing urban-rural disparity. For example, if the cheapest MBP offered in a remote area is more expensive than the rest of the country because healthcare professionals demand higher compensation to work there, residents of that area will automatically receive more subsidies than people in the rest of the country.
[14] However, the impact can be mitigated through OOP maximums and the fact that the government is contributing to the MSAs (see the previous section).

coinsurance rate for most services, as well as a minimum deductible [7]. In Iran, existing insurance plans have coinsurance rates of 10%–30% (see Table 2).

There are several reasons we believe a 5% income threshold is more appropriate for Iran than the closer-to-10% thresholds used in Switzerland and America (for Obamacare). First, given the lower levels of income in Iran compared to those two countries, a 10% threshold may impose a significant burden on very-low-income households already struggling to pay for other necessities.[15] Second, the MBPs in Switzerland and the US have inflated costs because they include many benefits beyond catastrophic care. Finally, an implicit marginal tax rate of 10% may be too high in the context of Iran when added on top of the other taxes and benefit reductions that may exist in a future Iran. The main concern with a 5% threshold is that the subsidy-eligible population may be too large, which is why it is crucial to ensure that the MBP is a genuinely low-cost plan.

3.2.3. Managing Adverse Selection

Aside from paternalistic considerations, another reason that many countries mandate that individuals have health insurance is because of concerns about adverse selection in the insurance market arising from either private information [65] or community-rating rules that require insurance companies to ignore relevant risk information, such as age or pre-existing conditions. It is argued that, without a mandate, the young and the healthy will leave the insurance pool, and the result will be either no insurance (in the case of a "death spiral") or under-insurance for the general population.

The first mechanism described above appears to be absent in many real-world insurance markets for a number of reasons [2 (Ch.10)], including that risk-averse individuals are more likely to purchase insurance despite incurring lower costs on average. As for the second mechanism, we regard community rating as largely unnecessary. The requirement to charge the same rate to the young and the old does not make sense from a distributional perspective, as people tend to reach their peak earnings later in life. Meanwhile, low-income older individuals can be protected through the 5% rule.[16] Community rating for pre-existing conditions is also counter-productive, as it incentivizes individuals to go without insurance and not take good care of their health, and ultimately unnecessary. In Singapore, those with pre-existing conditions are also covered by Medishield Life but have to pay 30% higher premiums for their first 10 years of coverage [7]. If any additional support for this group is desired, it can be provided through subsidies attached to each eligible individual that are financed out of general tax revenues, rather than through cross-subsidization via community-rating mandates [66–68].

3.2.4 Preserving the Role of NGOs

The "Charity Foundation for Special Diseases" (CFFSD) [69] is an Iranian NGO that plays an important role in providing free care for those with "special diseases" (i.e., serious chronic conditions such as thalassemia, hemophilia, MS, cancer, dialysis, and diabetes).[17] It is also involved in compensating kidney donors. NGOs and civic institutions are integral to the functioning of a free society. Given its relatively successful record, the CFFSD can serve as a model for the creation of similar foundations in other areas. Hence, we believe that the CFFSD should be preserved as an NGO. However, the current board of the institution is mostly composed of the members of the ruling class, meaning new personnel will have to be appointed. In the future, CFFSD can cooperate with the government to focus its resources on the truly needy, such as low-income individuals who have exhausted their MSA funds and still have OOP costs to pay.

[15] Indeed, Obamacare uses a variable threshold that starts at 2% of income and gradually rises to 9.5%. However, 2% is too generous for a system that uses a fixed threshold.

[16] Singapore doesn't use community rating but provides more generous subsidies to older individuals [62]. However, there is a large difference between the premiums of the old and the young even after the subsidy. Switzerland, on the other hand, has full community rating for individuals older than 25 [7].

[17] The government also enrolls those with "special diseases" in IHI for free, but not all providers accept IHI.

4. MANAGING THE TRANSITION: THE FIVE-YEAR PLAN

4.1. The First Year

The government's top priority in the very short run will be to minimize disruptions to the existing healthcare provision and payment system, which will require it to continue its contributions to the SSI and IHI while also collecting premiums from public- and private-sector employees. Subsidies to providers currently receiving them will also continue. If the collection of premiums is disrupted, the government may have to temporarily inject additional funds into the system to cover the shortfall.

The government can undertake modest reforms on the supply side to provide some immediate relief to the population, e.g., by abolishing pharmaceutical import tariffs, lifting the after-hours practice ban on newly hired medical faculty, refusing to enforce the IMC-imposed service tariffs to allow more price competition, and allowing doctors to freely practice in all areas for which they meet the point requirements.[18] The government can also implement other reforms such as removing the mandatory service requirement for medical students and expanding the incoming class size, but these will only have an impact in the long run.

4.2. The Next Four Years

Over the next four years, the government will first liberalize the prices at the point-of-care (which includes removing both subsidies and the various existing price controls), then allow the insurance premiums to adjust to the new equilibrium, and finally move toward the new MSA-based system. During this entire period and potentially for several years afterwards, the mandate for private-sector employees to enroll in SSI will remain in effect as SSI covers about half the population and dismantling it outright will be too disruptive and harm vulnerable groups such as current pensioners. Instead, the new system will initially be open only to current IHI enrollees and the uninsured. Free movement between the two systems cannot be allowed during the initial rollout as SSI is community-rated by age, meaning that younger workers may find it advantageous to leave SSI and join the MSA system, which will result in the collapse of SSI and the loss of coverage for the elderly. We recommend that the government adhere to the following timetable:

- **YEAR 2:** The government will continue with the pre-existing system of premium collection and income-based subsidies in the IHI. However, price subsidies at the point of care will be phased out, and the released funds will instead be injected into IHIO to cover the increase in the number of patients exceeding their OOP limit. There may be some budgetary savings as a result of this process because of increased cost-consciousness on the part of the patients and reductions in medical upcoding. As prices and quantities adjust to their new levels, the government will collect the necessary information so that it can revise the insurance premiums in the following year accordingly.
- **YEAR 3:** The artificially low HCHI tariffs will be abolished, and the government will negotiate more realistic rates with the providers, which will likely necessitate the raising of IHI premiums.[19] TThis will increase the government's expenses as it will continue to pay some of those premiums. To limit the budgetary impact of this reform, IHI subsidies to some of the top income deciles can be cut. The required funds can also partly come from the budgetary savings generated in the second year. The government must communicate to the population that while IHI premiums for some of them will be going up, the net increase in their healthcare expenses will be smaller as they will no longer need to make sizable informal payments to the providers— a situation resulting from the artificially low tariffs set by the HCHI (see Section 2.2). The government will also prepare the infrastructure for launching the MSAs by leveraging the pre-existing system for paying monthly cash subsidies to the population that was implemented under the Islamic Republic.

[18] The last item will allow the system to adjust more swiftly to shifting needs while also averting an abrupt rise in the urban-rural disparity. See Section 3.1.2 for more details.
[19] IMC tariffs can be used as a (non-binding) point of reference in those negotiations. However, prices in the new equilibrium will likely be lower than those currently set by the IMC due to the supply-side reforms implemented in the first year.

- **YEAR 4:** The government will create MSAs for every citizen not enrolled in SSI and prefund them with its 1% contribution. The OOP cap for IHI plans will be raised to a level consistent with the new prices and incomes, and the resulting budgetary savings will partially fund the MSA deposits. In addition, individuals will be allowed to make voluntary and tax-free MSA contributions (up to the applicable limits).
- **YEAR 5**: The 7% minimum MSA contribution will now become mandatory for all individuals not enrolled in SSI, and the government's continued contribution will become conditional on individual compliance with the mandate. The government will continue to operate and partially subsidize the IHI plans, but for those who pay any IHI premiums, the funds will be automatically deducted from their MSAs. In parallel, the government will design a new MBP and ask private insurers to submit their bids for the next year.

4.3. Beyond the Fifth Year

At the end of the fifth year, many IHI enrollees will have built up health savings and be ready for the launch of the new insurance system. At the beginning of year six, all IHI enrollees will be required to enroll in an MBP-equivalent or higher plan. The 1% government contribution to the MSAs will also become conditional on enrollment. All subsidies currently going to IHI will be freed up and used instead to support those who would otherwise have to pay more than 5% of their incomes for the cheapest MBP (see Section 3.2.2). SSI enrollees will also be allowed to open MSAs and contribute to them voluntarily but will not receive the government contribution as they already receive a roughly equal subsidy through the SSI.

After a number of years, SSI enrollees will be allowed to make the switch to the new system.[20] Younger workers will likely find it advantageous to do so, which will destabilize the SSI fund and necessitate the injection of public funding to protect the SSI pensioners from losing their coverage. New retirees will be required to purchase a plan from the marketplace and will receive subsidies in accordance with the 5%-threshold rule based on their pension income, an approach similar to the one adopted by the Swiss [70].[21] Making retirees responsible for a bigger portion of their healthcare costs will be a fiscal inevitability given Iran's rapidly aging population [38] and ongoing increases in human lifespan.

[20] The precise timing of this transition will depend on the status of government finances and the number of SSI pensioners at the time.
[21] Singapore does not have a separate program for the elderly either, but it provides them with more generous premium subsidies (up to 50%) [62].

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Appendix

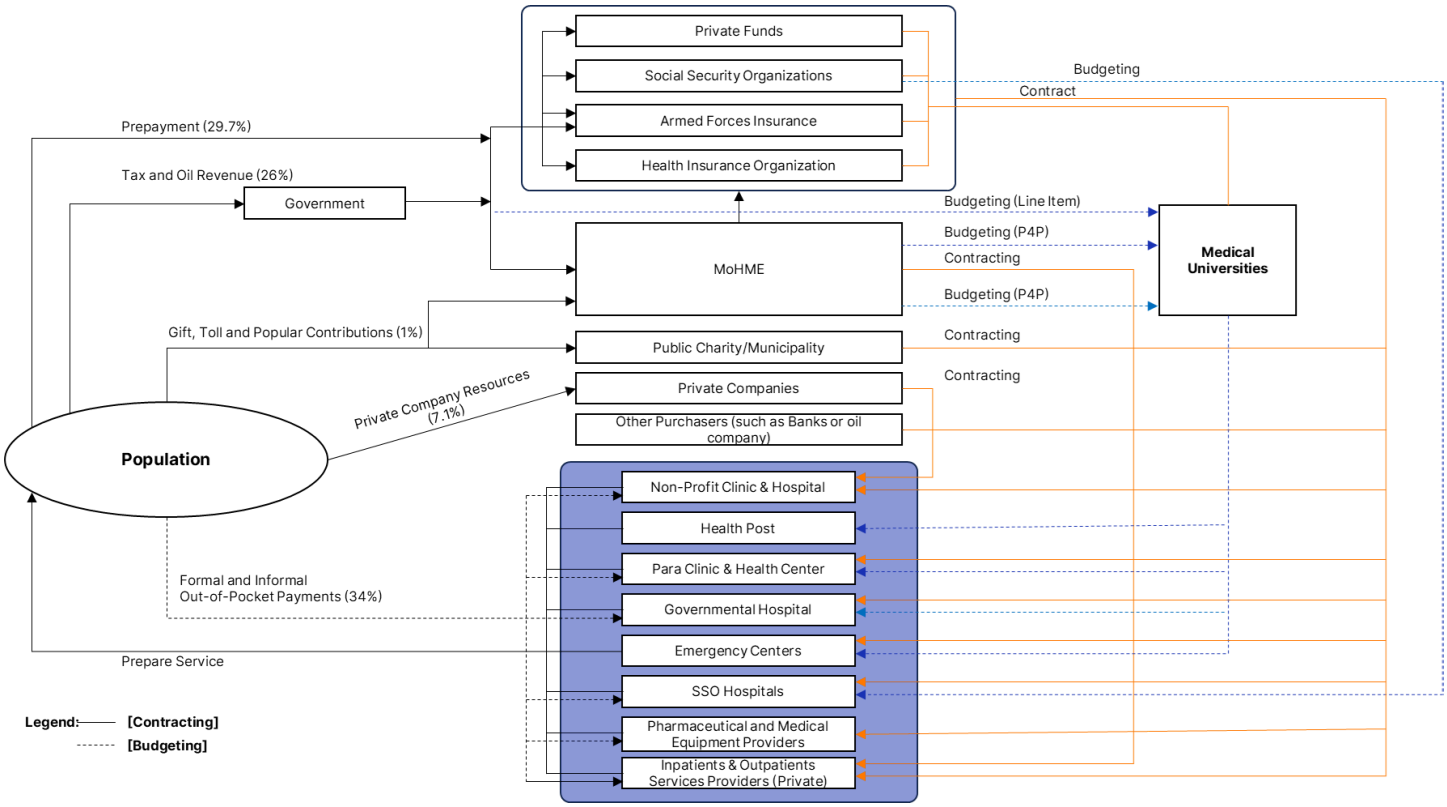

FIGURE 10: Payment flows in the Iranian healthcare system, adopted from Doshmangir, et al. (2020) [29].
Notes: SSO: Social Security Organization, MoHME: Ministry of Health and Medical Education, P4P: Pay for Performance,

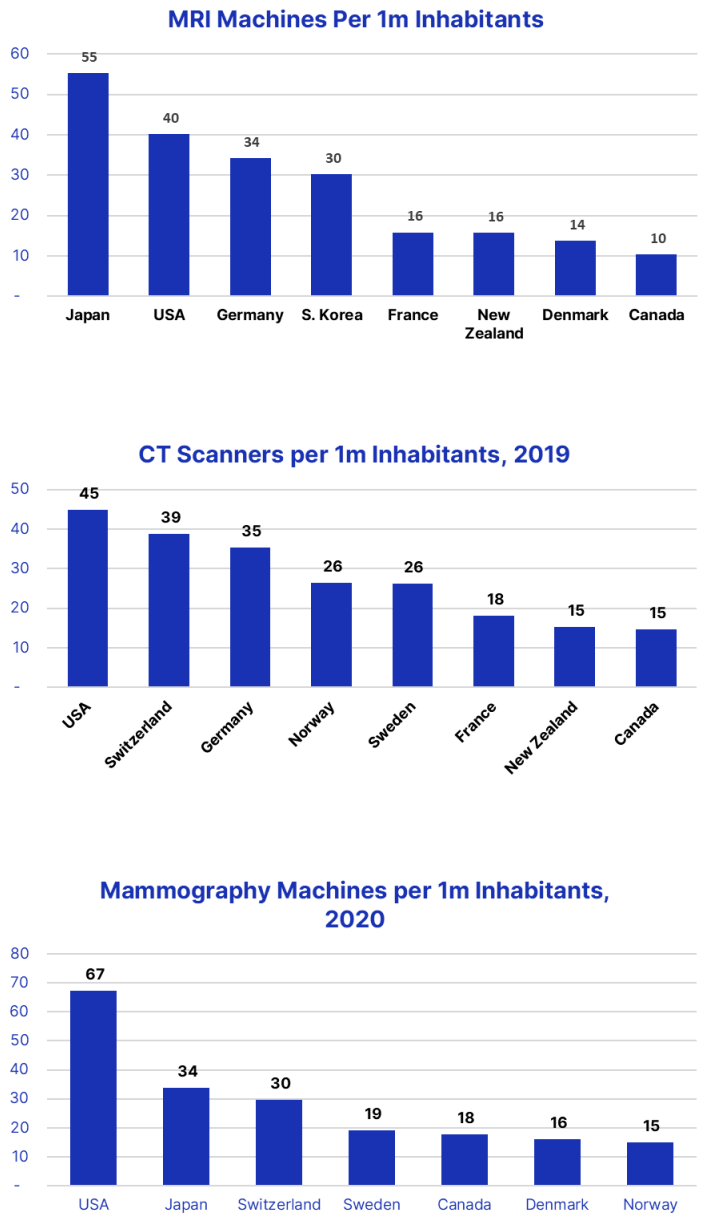

FIGURE 11: Select medical technologies per 1 million inhabitants in various OECD countries [71–73].

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