Iran's National Health Accounts: Years 1971-2001, Analytical Framework and Methodological Issues.

*Mahmood Kazemian * and Syed Aljunid***

**Assistant Professor of Health Economics, Health Economics Department, Shahed University, Tehran, Iran*
*** Professor of Health Economics Department of Community Health Faculty of Medicine*
Universiti Kebangsaan Malaysia

Abstract

Iran's National Health Accounts, NHA, provides useful information on health financing and sources and uses of health expenditure, and on sources of health policies and programs for a long period of 31 years. This information is useful for health reforms and financial restructuring programs, representing experiences from changes in financial and regulation arrangements and in the social health insurance system in the past. Today, after more than two decades of international efforts to standardize definitions and expenditure classifications, the NHA structure of Iran takes into account these features to enable international comparisons. The methods and applications for structuring Iran's health expenditure accounts conform to the regular specifications for analyzing the results, concerning economic and social aspects of health systems and the conditions for time-series and cross-section studies.

Introduction

National Accounts, (NA), expressed in terms of expenditure, provides information about total sources and uses of financial resources and total value of national output in market prices, in a one-year basis. National Health Accounts, (NHA), as a part of the NA, gives information on the total value of health outputs or services, financial consequences of health system performances, and shares of the public and private sectors and sub-sectors in total expenditure. When the information is applied to a period of more than one or two decades and on a time-series basis, it becomes feasible to follow changes in financing policies and operations in a health system, regarding the impacts of economic and health policies and economic fluctuations on the health sector. In this study, it was essential to provide a framework for the NHA to illustrate health service consequences in terms of financial trends, and on the basis of classifications for the public and private sectors in the SNA.

The National Health Accounts in Iran for a period of 31 years presents feature and categories of health expenditures, using data collection from financial records in all groups of financing and health providing institutions. For a number of health providers in the private non-profit group and for a small part of other payers, in some years the relevant information has come from some estimation. The estimates, however, as will be shown later, have been sources of a very small part of data used in this study.

The study employed the same definitions and classifications as introduced in the SNA and for country and sectors' national accounts. It was also required that changes in financial arrangements during a long period of three decades be correctly considered, satisfying the comparative features of NHA results for subsequent years. This gave rise to the need for introducing standards for the NHA data

and tables that made them suitable for time-series studies. This, in turn, required that the results comply with the conditions given by the random nature of statistics.
This paper presents Iran's national health accounts by distinction between sources and uses of expenditure and between the public and private sectors. The next section introduces the expenditure classifications for financial and institutional arrangements in Iran. Section three provides solution for the changes in the regulations and financial arrangements in Iran's health sector during the period 1971-2001, to make the trends appropriate for policy and situation analyses on the basis of historical data. Section four presents the international comparative characteristics of this study and the methods and applications for the NHA. Section five presents conclusions and the main characteristics of the framework of Iran's NHA for empirical studies.

Classifications for Sources and Uses of Health Expenditure in Iran's Health Sector.

This section explains sources and uses classifications and the requirements for consistency in the arrangements of facts and statistics for whole of the period, and in definitions and trends. Four basic classifications for NHA expenditure have been considered: a) classification of sources of expenditure, b) classification of uses of expenditure in health institutions (representing their financial and performance capacities), c) classification of final consumption in the public and private sectors, d) exchange of financial resources within source-use tables. At the first step, data collection, derived from financial records of the public and non-public health institutions' accounts, are arranged and fixed on a source and use basis, then, the framework for each classification was individually developed, and at the end, all the tables and different classifications came into the same rationale to conform to each other and to Iran's National Accounts.

Classification of Sources of Health Expenditures

Following Iran's NA classifications, sources of health expenditure break down into the public and private sectors, and then, disaggregated in sub-sectors, as the following: 1) General government, for allocating the public sector budget; 2) Social Security Organization, (SSO), and from the year 1995, National Health Insurance Organization, (NHIO), for making use of premiums received from the public for social health insurance; 3) Tehran municipality, as a local government body; 4) State-owned firms; 5) The Public sector charity foundations, for applying donations of the public to non-profit health care benefits. The NHIO has founded for universal health insurance coverage of the public, who already were excluded from the SSO coverage, and government employees. The latter were insured 25 years earlier and managed by an insurance division of the Ministry of Health. The NHIO has obtained two different sources for health insurance, the public budget for social health insurance programs, and the insured payments of premium. Also, from the year 1995, the public budget for the health services in Armed Forces and for the assistance programs in the public sector charity foundations were changed into the social health insurance programs. Tehran Municipality has contributed in health financing, since 1992, as a third party payer exclusively for its own employees.

Since the year 1995, part of the public budget, which previously was directly allocated to the public health service system for diagnostic health care and hospital services, was changed into indirect payment allocation via the NHIO. This change in the year 1995, and then, in NHA sources is viewed as payments from the public budget to the public health service system, which holds the

comparative nature of the trend for whole of the period. In 1979, there was a big change in Iran's health system, regarding the pluralistic nature of the public health service system along with the accountability of the Ministry of Health for all facilities and services in the public sector. As will be shown later, this situation has changed gradually since the late1980's, arising from changes in regulations and expectations that were inclined to raising roles of other public and non-public institutions in Iran's health system. In this study, the financial arrangements of the health system have been presented by the current state of arrangements in the health sector.

In the public sector, the public budget and its financial sources, consisting of taxes, public revenues from oil exports and other general revenues are regarded as the main source of funds for the public health service system and social health insurance programs. In the public system, there are also service revenues from supplying services to the public, which mostly are financed by households' co-payments. There are a few sources in the public budget, which are regarded as not-directly-allocated health budget, and are included in tables as "other health sources". There are additional sources for health financing in the public sector that come from some state-owned firms. For such sources, these firms are excluded from the SSO health coverage.

In the private sector, the classification for sources of expenditure takes into account four main groups. The first group is households in both urban and rural areas. In sources classification, health services expenses of this group, as parts of households' budget, are shown as payments contribution of the public. The contributions are annually presented in details in the reports of household budget surveys by Iran's Statistics Center. Since a part of these payments are paid to the public health service system, we excluded this part from the service revenues of the public system, to avoid double counting. The second group is the commercial insurance companies that provide private health insurance services. These companies provide complementary health insurance services since 1992.

The third group in the private sector is the private and non-governmental medical schools, which spend a part of their budget for medical training in their hospitals and clinics on health services. In the private medical schools, households, by paying tuitions, have already financed the schools contributions in total health payments. The other part of contributions comes from the transfer of similar financing supports from "the non-governmental medical training system" to the health sector. The fourth group is private non-profit institutions, providing financial supports for non-profit health services to households. The two latter groups are viewed as the main financiers of their own heath service systems. The health institutions in these two groups are also allowed to obtain additional sources for financing, e.g. from social health insurance programs and the public's co-payments. The data for the private non-profit health institutions were obtained by estimations, using statistics of their share in the health sector and their sources in the NA. The estimates totally account for up to .64 percent of the health expenditure in 2001.

Table 1 shows the classification and data for sources of health expenditures in the public and private sectors. In this table a distinction has been introduced for consumption expenditure and investments or fixed capital formation expenditure. Such a distinction is considered important in all presentations of the NA. In this study the relevant sources of health investments are from the government and SSO annual budgets and the NA data. In general, in this presentation of sources of health expenditures, the main effort was to provide a complete data collection, regarding a universal approach to health-

related expenditures for whole of the period. When it was necessary, in a few cases, the required data were estimated on the basis of other relevant statistics, e.g. the capacity of services in health institutions, number of people that received health services, and average per-bed or per-patient costs. It was important that the estimations satisfy the criterion for random observations in the statistics. The average annual share of estimations in total expenditure, however, in the years 1971-1979, 1980-1990 and 1991-2001 were respectively 5.6, 2.3 and 1.1 percent, and for the year 2001 it was less than .7 percent. It is worth noting that, households' budget and other NA-related data are considered given and with no need for further estimations.

In this study, it was important to provide expenditure information in terms of both, the current and constant prices. Price deflators for the public and private sectors services were considered different, and at the rates of service provision for final consumptions. Since the services in the public and private sectors are not homogenous, the trends of deflators for the two sectors were treated as separate, both equal to 1.00 in the base year 1990. In general all prices were viewed as market prices, and for the public sector and the private non-profit institutions the service profit was taken equal to zero. There is also a distinction between individual consumption and collective consumption in the health sector. The latter includes the former along with health researches and logistic services in accounting total expenditure. In the accounts, government subsidies have been excluded from total expenditure since the main purpose of health subsidies in Iran has been reducing the prices of health services.

Classification of Uses of Expenditures in the Public and Private Health Institutions

In this classification, service revenues from total health payments represent the operational capacities of health institutions. As shown in **Table 2**, there are three groups with different institutional settings for the public sector health services. Two of them are the health institutions in the public health service and SSO systems, and are financed by the public budget and the SSO budget, respectively. There are also additional sources of revenue in these institutions. In the former institutions, the additional revenue comes from consumers' co-payments and social health insurance programs, and for the latter from providing health services to the public not insured by the SSO. The third group in the public sector is the health institutions that belong to state-owned firms. This group provides health services exclusively to their firms' employees.

In the private sector, there are also three groups: a) private and non-governmental medical schools' health institutions, b) private non-profit health institutions, and c) private for-profit health institutions. The first two institutions obtain financial resources not only from their own financiers but also from social health insurance programs and consumers' co-payments. The third group is financed by households, health insurance organizations and by any other payers within the health sector.

Classification for Final Consumptions

In this classification, there are two main groups for final consumption of health services, namely as the public and private sectors. As shown in **Table 3,** in the public sector, government and the SSO, with sources from the public budget and social health insurance premiums, are viewed as final consumers of their health services. In the private sector, households and private non-profit institutions are considered final consumers. For households, sources of health expenditure are from households' budget, and the transfers to the

households' budget. The transfers are specified by all the health payments except those made by the public budget and the SSO for their own services, with additional exceptions for payments made by the households and non-profit institutions. These institutions are viewed as financiers, and then, final consumers of their own health services, produced by the private non-profit health institutions. This classification is the most similar to the consumption categories in NA accounting of national expenditure. This means that the final consumption classification is the most suitable one for comparing the financial data of the health sector with the other sectors and with national expenditure, regarding the NA system.

Financial Exchanges between Sources and Uses of Expenditure

The distribution of total health expenditures between payment sources and payment receivers, and the financial exchanges between these two groups, completed the information for all the above classifications. In **Table 4,** the first three rows represent sources of expenditures, and the first column shows uses in health institutions, regarding the specifications in the first and second classifications, respectively. The data within the table shows financial exchanges between different sources and users of payments. In the table, final consumptions for the main groups, specified in the third classification, are shown by partitioning the table into three areas. The final consumption of the public sector is shown at the north-west of the table; and the final consumption of households and private non-profit institutions are shown at the middle and east areas, respectively.
The table, therefore, represents the unified nature of the analytical framework Iran's National Health Expenditure, (NHE), in the three basic classifications, given that the classifications have common basis for definitions and in data collection. Each of the classifications was specified and developed, at the first step, independently, and then, was followed by the path that there should be no conflicts among definitions and conclusions in different classifications. In general, the process introducing Iran's NHE is considered a sub-system of Gross National Expenditure, (GNE), and consistent with the features introduced by the SNA and international NA comparisons.

Arrangements for Expenditure Classifications and Changes in Financial Management for the Period 1971-2001

In structuring Iran's NHA for a long period of 31 years, it seems important to take into account many historical changes in the administrative and financial arrangements of the health system. In Iran, prior to the year 1979, the Ministry of Health, (MOH), had manage directly up to 8,400 hospital beds, which were less than one forth in the 1980's, and had no interest in administrative controls on the other publicly financed hospitals and clinics. From 1979, and for a long while, the MOH followed pluralistic controls on financial and administrative issues in these hospitals and clinics, and also in those were financed by the SSO. The controls, from the year 1985, extended to the public medical schools, and hence, to the training hospitals and clinics. In these years up to now, a small group of the health institutions, which are financed and managed by the state-owned firms and not funded through public budget, remained out of reach of that pluralistic framework. The Act of SSO accountability on health services for the SSO beneficiaries, in 1990, returned the management controls of the SSO health institutions to the SSO. In coming years the pluralistic controls has almost stopped growing; and the regulations allowed rising non-publicly financed health care services. This gave rise to the opportunities for growing and

improving health care services in the private and other non-publicly financed health institutions.

In whole of the period, there were considerable fluctuations in the number of the private non-profit health institutions, especially in 1980's and the first half of the 1990's. This was because the government was viewed as responsible for financing them when they faced financial crisis. There were also important changes in the public health expenditure from the year 1982, arising from the new plan for development of public health services especially in rural areas. There were also two other important changes in Iran's health system. The first one was the rapid increase in the number of public medical schools, from 8 in the 1986 to 28 within 10 years. The second change was the integration of public health services and service programs of medical schools in the 1994. From 1988, the private medical school was allowed to develop its owned hospitals and clinics in a number of cities; and the number of third party payers increased remarkably from this year and in 1990's

To introduce Iran's NHA with historical changes in health system, all the changes in administrative and financial arrangements were reviewed carefully, and then, the statistics were specified by correct definitions. It was also important that the NHA allow for the statistics concerning issues such as evolution of Iran's health care system and financing policies, and health market development. Given that the current setting of Iran's health system is important in situation analyses, the NHA was required to present historical data in the classifications on the basis of the current health system framework. The NHA was also required to be consistent with the evolution processes in Iran's health system, which was followed by situation differences in NHA trends.

International Comparative Health Expenditure Accounts, Methods and Applications

It is important that standardized definitions and accounting methods, used by international researchers, to be applied to in studying the national patterns of health care financing. As the government and many payers seek to control rising health care expenditures, other countries experiences can be used to support health financing policies. The approach in this study is a pluralistic health care system where multiple sources of finance and uses of payments, classified in the public and private sectors, present the dominant nature of Iran's national pattern of health expenditure. In this pattern, different categories for uses of payments could be specified for creating balance in expenditure accounts. Berman (1997) proposed five main classifications for uses of financial resources.

a) Providers and institutions
b) Functions or types of health care services
c) Line item or economic expenditure categories
d) Regions or geographic/administration categories
e) Socio-economic categories

Iran's NHA balancing process takes into account expenditure uses for the first classification. Berman pointed out that there is still lack of uniformity, especially when the "uses" categories are defined across countries and there are different disaggregating basis, for example for payments for different types of service providers or health care services. There are also differences in presenting the above distinct types of classifications for national health expenditure. In the OECD system of NHA (2000), provider, function and line item categories are mixed in a single category. The NHA system in OECD countries expands a method, introducing

highly disaggregated sources and uses matrix and a tri-axial system for the recording of health expenditure, defining health care by functions, service providers and sources of funding. This method also provides links with employment and other resource statistics. In this approach expenditure categories focus on expenditure uses that could be different in countries accounts; and sources break down into the public and private expenditures and by social health insurance or tax-financed expenditure within the public sector. Today, there are considerable efforts to develop NHA frameworks in developing countries. World Bank and some UN agencies and international organizations, through financial supports and technical assistance, have played important role in developing NHA classifications and uses accounts.

Rannan-Eliya (1997) introduced the NHA framework of Egypt by specific features of the country health system, which are highlighted in different categories of uses of financial resources. The usefulness of NHA for socio-economic studies in Doherty et. al. (2002) and Cornell (2001) was met with significant consequences for South Africa, since in this country they faced highly unequal income distribution, an extensive role of private health sector and a big share of tax-financed expenditure in the public health service system. In Magnoli (2001) the importance of NHA programs in Latin America are discussed in details for the features attributing to NHA clearing aspects for the financial structure of health systems, and to opportunities for creating national programs in the health sector.

In this study, there is an opportunity to introduce more than 100 ratios that are key issues to recognize the financial characteristics of Iran's health system, and help evaluating expenditure policies and processes. There are still many features of Iran's health system, concerning issues such as socio-economic structure, provider's interests and opportunities, and health care functions, which remain for further explorations.

It is worth noting that there are some issues that may cause the results from the NHA be considered with cautious. The financial results from the NHA are not easily practical for describing changes in the quality of services. This is because a higher or lower quality of services cannot be attributed easily to raises in per-capita or per-patient average costs at constant prices. The use of advanced technologies, much laboratory tests and expensive drugs, for developing primary or preventive health care at the first level, may restrict increases in the average costs at national level in following years. When such advances and expenses are directed to reduce uncertainty in diagnostic processes, they increase the average costs in oncoming years. In general, the NHA results for the trends of costs at constant prices for representing changes in terms of the quantity of services need to be regarded with special conditions for health services characteristics, in the years in which a number of factors may change. The special conditions allow for unchanged state of: quality of health services, diagnostic technologies, drugs qualifications and costs, service ratios for different levels of preventive health care, rate of per-capita health referrals, ratios for different payers and for the average costs of different health service packages, purchasing power of the public, and other qualitative issues affecting per-capita average costs. Such unchanged conditions may only exist in short periods of 3 to 5 years. In longer periods, however, the trends obtained from the NHA tables, with less regards to health services characteristics, could be applied to trend studies for different expenditure categories.

Conclusion.

The framework introduced for national health accounts in this study is on the basis

of the health financing records in Iran for accounting sources and uses of expenditure. In this context, the NHA process could be applied reliably to health systems that make use of pluralistic frameworks of accounting records, especially for sources of funds and money exchange within the systems. The growing interests in such studies arise from the fact that financial resources have become increasingly the main limiting factor for raising health productions or services in almost all countries. This study showed that the financial structure in Iran, with a long period of regulated accounting systems, could provide successfully the data for expenditure movements in the long term trends. In this study health expenditure pattern conforms to the NHA standard definitions and categories, and analytical frameworks.

While the sources of expenditure could break down appropriately, the information for uses of expenditure has limited disaggregating to the levels that represent health care functions and providers' interests. There is, however, complete information for the exchange of health funding between different health financiers and payers and health institutions. The latter are represented by the uses category and a framework that health institutions may receive service compensations. The table for exchange of health spending introduces payment mechanisms in Iran's health sector which is the main policy interests in funding reforms. The methods and applications in this study take into account other countries expectations from the NHA results, concerning the economic and social aspects of the financial characteristics of health systems, and the random nature of statistics for empirical studies.

In general, Iran's NHA shares the SNA and standard definitions and classifications of NHA's for comprehensive, internally consistent and internationally comparable accounts which is also compatible with aggregate economic and social statistics. The accounts, disaggregating at the level required by the precision and timeliness criteria, present no conflict with judgments for international reporting and for expenditure projections. Iran's NHA also takes account of policy sensitivity for frequent changes of public policies and regulations in the past. The standard tables in this study are flexible to developments to the extent of provider industry and health care functions.

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Table 1. Sources of Expenditure in the Health Sector

(Current Prices)

	Million Rials,	1971	1980	1990	1995	1998	2000	2001
	National Health Expenditure, NHE	34,138	358,834	1,480,941	7,817,920	15,727,288	27,602,497	35,046,987
1	Health Recurrent expenditure in the Public Budget	8,422	156,003	425,241	2,222,603	4,368,200	6,626,622	8,652,003
	PHC Programs	2,424	40,499	125,428	698,300	1,293,021	1,899,039	2,459,502
	Diagnostic and inpatient Services	3,353	75,345	202,826	747,424	1,195,861	1,829,921	2,416,078
	Rehabilitation Services	39	2,850	15,498	117,915	270,410	449,866	589,253
	Health Research	106	632	3,774	29,745	59,380	110,961	156,601
	Logestic Services	589	7,901	24,348	159,703	236,844	367,979	444,953
	Social Health Insurance Programs	1,911	28,294	51,005	468,500	1,296,712	1,940,427	2,553,386
	Other Health Expenditure	-	482	2,362	1,017	16,172	28,429	32,231
2	Health Expenditure on Fixed Capital Formation in the Public Budget	3,626	25,069	111,660	451,016	521,250	631,370	537,302
3	Health Consumption Expenditure in the Other Public Institutions	4,053	40,971	150,339	923,129	2,596,887	3,947,880	5,386,762
	Tehran Municipality, Expen. Financed by Employees Compensation	-	-	-	4,240	12,682	30,279	45,573
	NHIO, Expen. Financed by Health Premium	-	-	-	82,750	312,713	430,325	575,726
	SSO, Expen. Financed by Health Premium	3,040	34,170	111,720	705,607	2,019,944	3,014,415	4,090,995
	State-owned Firms, Expen. Financed by Employees Compensation	1,013	6,676	27,588	106,722	247,557	429,344	556,962
	Public Sector Charity Foundations	-	125	11,031	23,810	3,991	43,517	117,506
4	Health Expenditure on Fixed Capital Formation In SSO and other Public Institutions	84	364	4,603	80,702	328,552	385,400	558,848
5	Total Health Consumption Expenditure in the Public Sector	12,474	196,974	575,580	3,145,732	6,965,087	10,574,502	14,038,767
6	Total Health Expenditure On Fixed Capital Formation in the Public Sector	3,711	25,433	116,263	531,718	849,802	1,016,770	1,096,150
7	Total Health Expenditure in the Public Sector	16,185	222,407	691,843	3,677,449	7,814,889	11,591,271	15,134,917
8	Households Health Consumption expenditure	17,770	134,900	779,110	3,991,520	7,698,015	15,466,485	19,080,185
9	Commercial Insurance Co., Health Consumption Expenditure	-	-	-	70,312	112,793	402,642	637,174
10	Private and Non-governmental Universities, Health Consumption Expenditure	-	-	1,353	18,473	42,955	80,966	82,968
11	Private Non-profit Institutions, Health Consumption Expenditure	63	1,070	2,691	9,034	6,755	8,483	11,734
12	Total Health Consumption Expenditure in the Private Sector	17,833	135,970	783,154	4,089,339	7,860,517	15,958,575	19,812,060
13	Total Health Expenditure On Fixed Capital Formation in the Private Sector	121	457	5,944	51,131	51,882	52,650	100,010
14	Total Health Expenditure in the Private Sector	17,954	136,427	789,098	4,140,470	7,912,399	16,011,225	19,912,070

** Expenditures on "Health Research" and "Logestic Services" are excluded from Consumption Expenditure in tables 2, 3, 4.

Table 1-1. Sources of Expenditure in the Health Sector

(Constant Prices 1990)

	Million Rials,	1971	1980	1990	1995	1998	2000	2001
	National Health Expenditure, NHE	336,759	1,366,952	1,480,941	1,478,206	1,545,687	1,699,618	1,916,582
1	Health Recurrent expenditure in the Public Budget	109,510	670,916	425,241	395,004	492,273	480,991	584,366
	PHC Programs	31,695	174,105	125,428	124,732	148,893	141,637	170,310
	Diagnostic and inpatient Services	43,842	323,908	202,826	133,507	137,682	136,482	167,303
	Rehabilitation Services	510	12,252	15,498	21,062	31,138	33,553	40,803
	Health Research	1,365	2,720	3,774	5,245	6,667	7,704	10,354
	Logestic Services	7,458	34,089	24,348	27,960	25,680	25,441	28,715
	Social Health Insurance Programs	24,640	121,916	51,005	82,251	140,835	134,690	165,496
	Other Health Expenditure	-	1,927	2,362	246	1,378	1,484	1,385
2	Health Expenditure on Fixed Capital Formation in the Public Budget	55,898	108,403	111,660	97,060	65,289	57,748	45,485
3	Health Consumption Expenditure in the Other Public Institutions	51,551	176,627	150,339	162,529	284,955	277,947	353,134
	Tehran Municipality, Expen. Financed by Employees Compensation	-	-	-	825	1,024	1,537	1,945
	NHIO, Expen. Financed by Health Premium	-	-	-	14,490	33,911	29,753	37,151
	SSO, Expen. Financed by Health Premium	38,726	147,291	111,720	124,358	222,742	213,963	270,514
	State-owned Firms, Expen. Financed by Employees Compensation	12,825	28,797	27,588	18,687	26,845	29,685	35,941
	Public Sector Charity Foundations	-	539	11,031	4,169	433	3,009	7,583
4	Health Expenditure on Fixed Capital Formation In SSO and other Public Institutions	2,135	2,240	4,603	18,520	40,666	32,025	42,746
5	Total Health Consumption Expenditure in the Public Sector	161,061	847,543	575,580	557,533	777,228	758,937	937,499
6	Total Health Expenditure On Fixed Capital Formation in the Public Sector	58,034	110,643	116,263	115,580	105,955	89,774	88,232
7	Total Health Expenditure in the Public Sector	219,095	958,186	691,843	673,113	883,183	848,711	1,025,731
8	Households Health Consumption expenditure	113,820	401,340	779,110	774,867	641,582	819,913	849,895
9	Commercial Insurance Co., Health Consumption Expenditure	-	-	-	13,675	9,109	20,435	27,195
10	Private and Non-governmental Universities, Health Consumption Expenditure	-	-	1,353	3,235	4,658	5,598	5,354
11	Private Non-profit Institutions, Health Consumption Expenditure	798	4,615	2,691	1,582	732	586	757
12	Total Health Consumption Expenditure in the Private Sector	114,618	405,956	783,154	793,359	846,532	846,533	883,201
13	Total Health Expenditure On Fixed Capital Formation in the Private Sector	3,047	2,810	5,944	11,734	4,375	4,375	7,650
14	Total Health Expenditure in the Private Sector	117,664	408,766	789,098	805,093	850,908	850,908	890,851

** Expenditures on "Health Research" and "Logestic Services" are excluded from Consumption Expenditure in tables 2-1, 3-1, 4-1.

Table 2. Uses of consumption Expenditure in the Health Sector

(Current Prices)

Million Rials	1971	1980	1990	1995	1998	2000	2001
National Health Consumption Expenditure in Health Institutions	29,613	324,411	1,230,611	7,045,624	14,529,380	26,054,137	33,249,273
1 Total Receipts of the Public Sector Health Institutions	11,241	155,056	487,956	2,445,430	5,491,727	9,403,793	11,410,034
2 Total Receipts of Public Health Service System	9,888	142,445	430,781	2,114,768	4,663,157	7,917,913	9,403,374
Receipts from the Public Budget	6,888	128,314	359,237	1,755,151	3,602,404	5,485,179	7,278,136
Receipts from Households and other Third Party Payers	3,000	14,131	71,544	359,617	1,060,752	2,432,734	2,125,238
3 Total Receipts of SSO Health Institutions	570	7,195	33,206	240,587	622,765	1,140,822	1,564,158
Receipts from the SSO Budget	570	7,195	29,849	228,441	550,815	1,018,832	1,383,261
Receipts from Households and other Third Party Payers	-	-	3,358	12,146	71,950	121,990	180,897
4 Total Receipts of State-owned Firms' Health Institutions	783	5,416	23,969	90,075	205,805	345,058	442,502
5 Total Receipts of the Private Sector Health Institutions	18,372	169,355	842,655	4,600,194	9,037,653	16,650,344	21,839,239
6 Private and Non-governmental Universities' Health Institutions	-	-	3,016	28,490	63,365	118,427	142,770
7 Private Non-profit Health Institutions	347	5,971	16,809	69,709	80,751	140,002	223,130
8 Private For-profit Health Institutions	18,025	163,384	822,829	4,501,994	8,893,537	16,391,916	21,473,340

Table 2-1. Uses of consumption Expenditure in the Health Sector

(Constant Prices 1990)

Million Rials	1971	1980	1990	1995	1998	2000	2001
National Health Consumption Expenditure in Health Institutions	266,856	1,216,690	1,330,611	1,317,686	1,400,963	1,572,325	1,781,632
1 Total Receipts of the Public Sector Health Institutions	145,414	666,869	487,956	434,714	618,594	679,544	769,944
2 Total Receipts of Public Health Service System	128,055	612,578	430,781	376,010	525,047	571,264	633,932
Receipts from the Public Budget	90,071	551,622	359,237	313,040	410,017	403,065	496,791
Receipts from Households and other Third Party Payers	97,984	60,956	71,544	62,970	115,030	168,199	137,140
3 Total Receipts of SSO Health Institutions	7,450	30,930	33,206	42,932	71,229	84,423	107,458
Receipts from the SSO Budget	7,450	30,930	29,849	40,805	63,427	75,988	95,785
Receipts from Households and other Third Party Payers	-	-	3,358	2,127	7,802	8,434	11,673
4 Total Receipts of State-owned Firms' Health Institutions	9,909	23,361	23,969	15,772	22,318	23,857	28,554
5 Total Receipts of the Private Sector Health Institutions	121,442	549,822	842,655	882,972	782,369	892,780	1,011,688
7 Private and Non-governmental Universities' Health Institutions	-	-	3,016	4,989	6,871	8,188	9,213
6 Private Non-profit Health Institutions	4,396	25,756	16,809	12,206	8,757	9,680	14,398
8 Private For-profit Health Institutions	117,046	524,066	822,829	865,777	766,741	874,913	988,076

Table 3. Final Consumption in the Health Sector

(Current Prices)

Million Rials	1971	1980	1990	1995	1998	2000	2001
Total Final Consumption in the Health Sector	29,613	324,411	1,330,611	7,045,624	14,529,390	26,054,137	33,249,273
1 **Total Final Consumption in the Public Health Sector**	8,808	145,359	424,496	2,323,592	4,604,283	7,205,612	9,406,362
Public Health Service System, Financed by the Public Budget & Revenues from SSO	8,238	138,164	394,647	2,095,151	4,053,488	6,186,780	8,023,101
SSO Health Service System, Financed by the SSO Budget	570	7,195	29,849	228,441	550,815	1,018,823	1,383,261
2 **Total Final Consumption in the Private Health Sector**	20,805	179,052	906,115	4,722,032	9,925,097	18,848,525	23,842,911
Households, Financed by Households' Budget and the Transfers	20,742	177,982	903,424	4,712,998	9,918,342	18,840,042	23,831,177
Private Non-profit Health Institutions	63	1,070	2,691	9,034	6,755	8,483	11,734

Table 3-1. Final Consumption in the Health Sector

(Constant Prices 1990)

Million Rials	1971	1980	1990	1995	1998	2000	2001
Total Final Consumption in the Health Sector	266,856	1,216,690	1,330,611	1,317,686	1,400,963	1,572,325	1,781,632
1 **Total Final Consumption in the Public Health Sector**	114,613	625,041	424,496	413,379	522,358	527,562	640,649
Public Health Service System, Financed by the Public Budget & Revenues from SSO	107,163	59,411	394,647	372,575	458,931	451,574	544,863
SSO Health Service System, Financed by the SSO Budget	7,450	30,930	29,849	40,805	63,427	75,988	95,785
2 **Total Final Consumption in the Private Health Sector**	152,242	591,649	906,115	904,307	878,605	1,044,763	1,140,983
Households, Financed by Households' Budget and the Transfers	151,445	587,034	903,424	902,725	877,872	1,044,176	1,140,226
Private Non-profit Health Institutions	798	4,615	2,691	1,582	732	586	757

Table 4. Sources and Uses of Health Consumption Expenditure in the Health Sector- Year 2001

(Current Prices)

Million Rials

Sources / Uses in Health Institutions	Public Sector							Private Sector				Sum of Uses
	Public Budget		Social Health Insurance Premiums		Tehran Municipality	State-owned Firms	Public Sector Charity Foundations	Households	Commercial Insurance Co.	Non-Governmental Universities	Private Non-Profit Institutions	
	Health Service System & Payments	Social Health Insurance	SSO Health Service System & Payments	Social Health Insurance								
Public Sector												11,410,034
Public Health Service System's Institutions	5,753,767	1,524,369	744,966	-	-	-	-	1,380,273	-	-	-	9,403,374
SSO Health Institutions	-	-	1,383,261	-	-	-	-	180,897	-	-	-	1,564,158
State-owned Firms' Health Institutions	-	-	-	-	-	442,502	-	-	-	-	-	442,502
Private Sector												21,839,239
Private and Non-govern. Unis' Health Institutions	-	25,611	9,129	3,092	-	-	6,533	15,436	-	82,968	-	142,770
Private Non-profit Health Institutions	-	94,217	32,502	11,013	-	-	24,088	49,576	-	-	11,734	223,130
Private For-profit Health Institutions	60,896	591,590	1,921,137	561,621	45,573	114,462	86,885	17,454,003	637,174	-	-	21,473,340
Sum of Sources	5,814,663	2,235,786	4,090,995	575,726	45,573	556,964	117,506	19,080,185	637,174	82,968	11,734	33,249,273