LANDINFO

Country of Origin Information Centre

Report

Iran

The Iranian Welfare System

12 August 2020

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Summary

This report presents an overview of the welfare system in the Islamic Republic of Iran, including health and social security services. Labour laws and pension rights, which were introduced gradually during the past century, under the Iranian monarchy, were further developed following the Islamic Revolution of 1979.

Health services are provided by public health institutions, as well as private actors and non-profit charities. A recent health reform has widened the public health insurance schemes to secure almost universal coverage for Iranian citizens. Social insurance schemes, provided mainly through employment in the public and private sector, include pension rights, right to sick leave, maternity benefits, family allowances, unemployment benefits, and allocations for disabled persons. A State Welfare Organization and several charity organizations provide assistance to vulnerable groups who lack coverage through other social security schemes.

Sammendrag

Rapporten presenterer en oversikt over velferdsordninger i Den islamske republikken Iran, inkludert helse- og sosialtjenester. Arbeidslover og pensjonsrettigheter, som gradvis ble innført i løpet av det forrige århundre, under det iranske monarkiet, ble videreutviklet etter den islamske revolusjonen i 1979.

Helsetjenester leveres av offentlige helseinstitusjoner, så vel som private aktører og ideelle organisasjoner. En nylig helsereform har utvidet de offentlige helseforsikringsordningene til å gjelde alle iranske borgere. Sosialforsikring er i hovedsak knyttet til arbeidsforhold i offentlig og privat sektor, og inkluderer pensjonsrettigheter, rett til sykefravær, fødselspenger, familiegodtgjørelser, dagpenger og støtte til funksjonshemmede. En statlig velferdsorganisasjon og flere veldedige organisasjoner gir bistand til sårbare grupper som mangler dekning av andre trygdeordninger.

Contents

1 Introduction

This report presents an overview of the welfare system in the Islamic Republic of Iran. The country has an encompassing system of welfare services which includes subsidized public health services, health insurance schemes, pensions and other social security benefits.

The report is largely based on information collected during a fact-finding mission by Landinfo and the Swiss State Secretariat of Migration (SEM) to Iran in April-May 2018. Additional information is added from open written sources including news articles, academic and COI literature and reports from international organizations, UN institutions as well as Iranian governmental sources. During the mission, the delegation held meetings with various health and welfare institutions in Teheran and in the North-Western city of Tabriz, including representatives of the Ministry of Health and Medical Education (MoHME), the Ministry of Cooperatives, Labour and Welfare (MoCLW), various related health and social institutions and NGOs working in the field. Some information received under a previous mission by Landinfo to Iran in 2015 is also included. Landinfo and SEM highly appreciate the kind facilitation of these visits by the Iranian authorities, including officials in the health and social fields.

It should be noted that Iran is a country that imposes restrictions for international observers when it comes to accessing local and independent sources. State officials accompanied the delegation during the field visits to various institutions. These limitations might have influenced the quality and independence of the information gathered from these sources. The information presented should be viewed in light of these limitations.

In some cases, there may be inconsistencies between different sources who were interviewed during the fact-finding mission – concerning numbers, figures, or other information presented. As the authors could not always verify the information from other sources, these pieces of information are presented as the view of cited sources and is not necessarily the view of Landinfo or SEM.

The report is an outcome of close cooperation between Landinfo and SEM – prior, during and after the fact-finding mission – and SEM has contributed actively to the writing of the report. Early drafts of the report have, furthermore, been through an external review process.

2 Historical background

Article 29 of the Iranian Constitution establishes that "To benefit from social security with respect to retirement, unemployment, old age, disability, absence of a guardian, and benefits relating to being stranded, accidents, health services, and

medical care and treatment, provided through insurance or other means, is accepted as a universal right." The article goes on to state that "The government must provide the foregoing services and financial support every individual citizen (…) (Constitution of Iran 1979).

The welfare system in Iran has its roots in the reign of the Pahlavi shahs, before the Islamic revolution of 1979. Already in the 1920s, the National Assembly passed a series of labour laws that established pay scales, a retirement age, and a pension fund for state employees. During the following decades of state-building efforts, corporative welfare institutions were set up, yet serving only a narrow segment of the population (Harris 2017a, p. 53-54).

In the 1950s and 1960s, the government provided generous social insurance provisions for employees in the civil service, the industrial sectors and the oil industry. Although the Pahlavi monarchy embarked on a developmental program that attempted to expand welfare and access to education to new segments of the population, the implementation of this program was limited. Vast sectors of the population, especially the rural population, remained non-insured or under-insured (Harris 2017a, p. 15).

Social security in Iran is still regulated by the Social Security Law, approved by Parliament in 1952 and amended in 1975 and 1986 (Hsu et al. 2020, p. 39; Social Security Law 1975). The law, which covers all employed and self-employed persons, states that social security shall cover accident and sickness, maternity and confinement, sickness benefits, disability, retirement, and death (Social Security Law 1975, Article 3). The insurance is funded by a combination of contributions from the insured person, the employer, and the government, with shares that may vary according to the level of coverage (Social Security Law 1975, Chapter 3).

In the aftermath of the 1979 revolution and the subsequent war with Iraq, welfare policies were highly politicized. Struggles between contenders for state power, as well as social mobilization from below, contributed to the establishment of a parallel set of organizations that overlapped with existing state welfare services. New revolutionary organizations, like in particular the Imam Khomeini Relief Foundation (IKRF), targeted the poor strata of the population that had been excluded under the Pahlavi monarchy. This led to the construction of what sociologist Kevan Harris has labelled a dual-welfare regime with various institutions with sometimes overlapping responsibilities (Harris 2017a, p. 15).

During the 1980s and 1990s, the Islamic Republic implemented a vast program of health care expansion and established an extensive primary health care (PHC) network including in rural areas. After the Iran-Iraq war, family planning was promoted through PHC clinics across the country, resulting in reportedly the most rapid decline in birth rates recorded in world history (Harris 2017a, p. 18-19). Even during the liberal political and economic reforms in the early 1990s, social

welfare expansion continued further as the old corporatist organizations of pensions and social insurance expanded. The education sector, both at the primary and secondary level, also expanded considerably during the same period (Harris 2017a, p. 19).

In 1994, the Parliament mandated the High Council for Health Insurance (HCHI) as a decision-making body to ensure universal access to health insurance (Hsu et al. 2020, p. 43). The High Council for Health Insurance is presided by the Health Minister and, besides the Ministry of Health, includes the MoCLW, the Finance Ministry, the head of the Planning and Budget Organization, the country's four main health insurance companies and the I.R.I. Medical Council (*nezam-e pezeshki*) (MoHME, meeting in Tehran, May 2018). As HCHI was established, over 60% of the population still had no health insurance (Doshmangir 2019a, p. 599). By 2010, the rate of people without health insurance dropped to only 10% of the population (Davari 2012, p. 3).

The latest stage of the expansion of the welfare system came with the 2014 Health Transformation Plan (HTP), which has been a prestigious project for President Hassan Rouhani. The plan is a comprehensive policy program in health promotion, aiming at covering the uninsured, improving health service quality and enhancing financial coverage (Doshmangir 2019a, p. 600).

As a result, in principle, all Iranian citizens are now entitled to free or subsidized health services. However, the reform has been costlier than calculated, as more than 10 million previously uninsured signed up for the scheme, causing severe problems of funding the costs and thus for its implementation (Doshmangir 2019a, p. 600).

2.1 Socio-demographic context

Iran is classified as an upper-middle-income country, with a population of 83 million (WFP 2020). Living standards have generally improved since the 1990s. According to UNDP's Human Development Index (HDI), which is based on health, education and economic indicators, Iran increased its score from 0.577 in 1990 to 0.797 in 2018, which is a significant increase of 38%. During this period, life expectancy increased from 63.8 to 76.5 years, mean years of schooling went up from 4.2 to 10, while General National Income per capita increased from 11,391 to 18,166 USD (2011 value) (UNDP 2019b, p. 3). Compared to other countries, Iran ranges as number 65 of the 189 countries listed on the HDI in 2019 (UNDP 2019a, p. 301).

However, poverty in Iran, measured at a level below 5.5 USD per day, according to the World Bank increased slightly from 8% in 2013, probably more noticeably since the fuel protests of 2019/20. The economy has suffered from a lapse in oil prices since 2014 and subsequently also from a contraction following USA's

decision to re-impose economic sanctions against Iran in 2018. After a 4.7% contraction of GDP in 2018/19, GDP declined even further by 7.6% in the first nine months of 2019/20 (World Bank 2020).

The official unemployment rate remains high and has increased from 12% in 2018 to above 16% by the beginning of 2020 (IMF 2020). Some observers have challenged the government figures on poverty and unemployment, claiming the real numbers are much higher (Khoshnood 2019). A report by the Iranian Parliament Research Center concluded that in 2016, 13.3 million Iranians – close to 17% of the population – lived below the poverty line (Ranjipour 2020). Following the Covid-19 crisis, which hit Iran especially hard in early 2020, an Iranian expert claimed that the poverty level had passed 40% (Goodman 2020). The Iranian Parliament's Research Center (IPRC) published a report in late April 2020 estimating that due to sanctions and Covid-19, Iran's GDP would fall between 7.5-11%, resulting in up to 6.4 million lost jobs (Tavakol 2020).

Labour force participation rate is at 44%, with a significant discrepancy between males and females: 71% of males versus 17% of females (above 15 years) (UNDP 2019a).

For decades, the Iranian government alleviated poverty with generous subsidies of energy and food items. However, as part of economic reforms in 2010, a part of the subsidies was replaced with universal cash transfers – *yaraneh naqdi*. Initially destined for the needy, eventually, all citizens benefitted from this aid. The cash handouts, which were set at 455,000 Iranian rials (about 40 USD) per person per month, had a positive effect in reducing poverty initially. However, high inflation and a lack of adjusting the amount eroded the value, thus minimizing the poverty-reducing effect significantly within five years (Enami and Lustig 2018; Deputy for Work Relations in MoCLW, meeting in Tehran, April 2018).

Social discontent has been the backdrop of popular unrest several times in recent years. New plans for further cuts in fuel subsidies resulted in violent riots across the country in November 2019, which resulted in hundreds of deaths (Fassihi and Gladstone 2019).

Poverty is unevenly distributed geographically, from nearly zero in the northern province of Mazandaran and 33% in Kerman to as much as 53% in Sistan and Baluchestan in the south-east (at the 5.5 USD 2011 purchasing power parity daily poverty line) (World Bank 2018, p. 39).

Attendance to schooling is generally high in Iran, with enrolment at 99.7% for primary school and 86% for secondary school in 2017 (World Bank n.d.). Still, there are regional variations. Poverty and disability, immigration, distance from school and certain cultural barriers were among the major factors contributing to out-of-school children being concentrated in certain provinces. The most

disadvantaged areas are Sistan and Baluchistan, Kerman, and Hormozgan, which have the highest percentage of out-of-school children in the country (UNICEF 2018).

The Iranian state is relatively advanced in terms of administration, population registration and documentation. Internet penetration rate is high (70% are internet users according to UNDP's HDI), and various public services can be accessed via the internet.

3 Health services system

Three categories of providers offer health services in Iran: public, private, and non-profit NGOs/charities. Public hospitals are either run by the MoHME or by state institutions, such as the Social Security Organization (SSO). According to an official in the MoHME, there are a total of 1100 hospitals (MoHME, meeting May 2018). The majority – 749 – of the hospitals are affiliated to the MoHME, while 166 are private. The SSO runs 73 of the hospitals, the military 32, and charity organizations manage 37 hospitals. Further state institutions such as the Iranian National Oil Corporation, the Judiciary, and the Islamic Revolutionary Guards Corps run their own hospitals (Doshmangir 2019a, p. 596).

The Ministry of Health and Medical Education (MoHME) is responsible for health policy formulation, resource mobilization, monitoring and evaluation, and regulating health service delivery throughout the health structure (Doshmangir 2019b). The ministry's health system is organized at three levels of governance. At the central level, the ministry operates in close coordination with two multisectoral bodies: one is the Supreme Council for Health and Food Products Security (SCHFP) and the other is the Supreme Council for Health Insurance (SCHI). Iran is among some few countries that have integrated medical education with medical services, and the MoHME reaches out to the 31 provinces through 67 medical universities (Doshmangir 2019a, p. 593).

The second level of health governance lies with the Board of Trustees at the medical universities, which have semi-autonomous control within their areas. The university hospitals are localized in the major cities and provide specialized medical services. General public hospitals, on the other hand, are under the supervision of the district health network (Doshmangir 2019a, p. 593).

The third level is the network of health centres and health houses, providing primary health care services across the country.

In addition to the services of the MoHME, the SSO offers services through their separate network of hospitals, health centres and clinics. While there are over 18,000 health houses run by the MoHME, providing primary health care, the SSO

runs some 320 health centres and clinics (Doshmangir 2019a, p. 594; SSO, meeting in Tehran, April 2018).

3.1 Distribution of health services

The Iranian health system faces a range of challenges, including demographic transitions, continuing migration from rural villages to cities, occupational changes, people's health literacy, lifestyle modifications which have all led to a huge burden of non-communicable diseases and changing patterns of morbidity and population dynamics (Doshmangir 2019a). One effect of the massive rural-urban migration during the past decades is that the health infrastructure in many rural areas are oversized, as the local population has diminished, while on the other hand, the primary health system in cities has come under more pressure (MoHME, meeting November 2015).

The HTP, on the other hand, seems to be reacting on this situation by focussing more on providing support in marginalized urban areas. Following the implementation of the HTP in 2014, 2000 new health posts were created until 2018 (international organization B, meeting in Tehran, May 2020.

The medical workforce in Iran includes in total more than 51,000 general physicians, 32,000 specialists, 115,000 nurses, 33,000 midwives and 35,000 local health workers (*behvarz*) (Doshmangir 2019a, p. 596).

Officials in the Ministry of Health and Medical Education explained that the primary health care system in Iran consists of a vast network of local clinics which are called health houses (*khane-ye behdasht*) in rural villages and health posts in cities. Each health house, which covers up to 2000 inhabitants in the rural area, is staffed with community health workers, called *behvarz*, who have received two years of health education in addition to 12 years in school. The *behvarz* provide not only medical treatment but also annual censuses, health education, family planning, maternal and child health care, elderly care, oral health and occupational health (WHO 2018; MoHME, meeting May 2018)

The health houses are connected to rural health centres (*markaz-e behdasht*), which cover between 5,000 and 10,000 people in a district. In a rural health centre, there are at least two, maybe three, general physicians, one staff nurse, and one technician. These health centres should also offer more specialized treatment, including dental services, although dentistry is not covered by health insurance (MoHME, meeting in Tehran, May 2018; meeting in Tehran, November 2015).

Furthermore, in each district, there is one comprehensive district health centre (*markaz-e khass*) that functions as a headquarters for the district with the responsibility to oversee and support the rural health centres and health houses

with logistics and resources (MoHME, meeting in Tehran, November 2015; Doshmangir 2019a).

The SSO for its part runs a different system consisting of some 300 clinics and 80 hospitals. The hospitals offer more specialized treatment than the clinics; patients in need of specialized treatment are consequently referred to these hospitals by the doctors of the clinics. However, there is no official and obligatory referral system in place and the patients can directly visit the hospitals (Ali Nasab Hospital, meeting May 2018).

The community-oriented and need-based healthcare provision of the Iranian model has been widely endorsed internationally for having contributed to a fairer distribution of healthcare resources in the country (Doshmangir 2019a, p. 600).

Since 2015, there has been a plan to introduce a referral system of family physicians that would be the first point of consultation for all, before the patient is referred to specialists, if necessary. However, so far this referral system has not been implemented, except for some pilot projects in the provinces Fars, Mazandaran and East Azerbaijan. Consequently, there is no functioning obligatory referral system in place (MoHME, meeting in Tehran, May 2018; international organization B, meeting in Tehran, May 2018).

All hospitals across the country go through a statutory licensing process to be qualified to provide secondary and tertiary healthcare services (Mosadeghrad 2018, p. 286).

3.2 Health expenditures

Total health expenditure in Iran amounted to 36 billion USD in 2016. The financial sources were split between public budget (23.5%), social health insurance (30.5%), and out-of-pocket payment (35.5%) (Doshmangir 2019a, p. 597).

It is noteworthy that the share of out-of-pocket payment (OOP) has decreased considerably during the past years. Before the health transformation plan (HTP) in 2014, OOP was the primary source of financing as it was usually above 50% of the costs, peaking at 58% in 2010, while it decreased to 35.5% by 2016 (Doshmangir 2019a, p. 597). However, this is still far from the stated goal of reducing OOP to under 30%. This means that the payment system is still largely based on service fees, both in public and in private healthcare sectors (Doshmangir 2019a, p. 597).

The Health Transformation Plan expanded free basic health insurance to an additional ten million people. While the reform caused the OOP to decrease, GDP

per capita for health increased from 6.1% to 8.13% between 2013 and 2016 (Doshmangir 2019a, p. 598).

Iran uses internal reference pricing of medicines, which means that medicines are reimbursed at the price of the reference medicine, and patients have the option of purchasing drugs that are more expensive and pay for the extra costs. The reimbursement price is set by the government, while manufacturers, distributors, or retailers are free to set their own drug prices (Yousefi 2019).

Iran has adopted a full generic-based national drug policy, with local production of essential drugs and vaccines. There are about 186 local pharmaceutical manufacturers. Although domestic manufacturers produce 96% of drugs, many drugs for complicated diseases are imported. Reportedly, the economic sanctions against Iran have at times hindered access to imported drugs. This has contributed to a black market for medicines, especially high-quality imported drugs. Here, patients can purchase medicines without quality approval, often at high prices (Doshmangir 2019, p. 596; Ilia Corporation 2016, p. 7).

4 Health insurance system

Through the reforms introduced in 2014 by the Health Transformation Plan (HTP), Iran has extended health insurance coverage to an almost universal level. Different sources have deviating estimates of actual health insurance coverage, ranging from 92 to 98% of the population (Doshmangir 2019a, p. 600; WHO 2018 p. 38; international organization B, meeting in Tehran, May 2018).

4.1 Health insurance schemes

Public health insurance is provided by four main public funds that cover different categories of people, mainly according to professional and employment status. The basis of enrolment to these health insurance schemes is either mandatory, automatic, or voluntary. The details of the contribution mechanism vary for each scheme, but for employed persons, the key principle is that the contribution to the premium is shared between the member, employer and government (Hsu et al. 2020: p. 45-47).

The most encompassing health insurance scheme in Iran is provided by the Social Security Organization (SSO) and is called Social Security Medical Insurance (*bimeh-ye darmani-ye ta'min-e ejtema'i*). It covers mainly employees and self-employed workers in the private sector, as well as employees on short-term contracts in the public sector (SSO, meeting in Tehran, April 2020).

Then there is the Iran Health Insurance Organization (IHIO) that provides health insurance for government employees, students, and rural dwellers. This insurance is simply called "health insurance" (*bimeh-ye salamat*), while the new insurance in the framework of the HTP is called "insurance for Iranians" (*bimeh-ye iraniyan*).

Military personnel are covered by a separate fund, the Armed Forces Medical Services Insurance Organization (AFMSIO).

The poorest segment of the population, which has traditionally lacked health insurance, has to some extent been supported by the Imam Khomeini Relief Foundation (IKRF). Although the IKRF is often referred to as an insurance provider, it is organized differently as it provides support on a need-based assessment and is funded not by premium but rather by private donations in addition to public funds (IKRF, meeting in Tehran, April 2018). It is thus rather a charity organization that covers health costs and other social services for the vulnerable.

In addition to these large, public funds, there are around 17 smaller, semi-public health insurance schemes run by different state-owned enterprises. There also exist some private insurance funds that offer complimentary insurance packages (Hsu et al. 2020, p. 38).

4.2 Health insurance provisions

With the exception of the IKRF, the policies for cost-sharing and benefits are quite similar in all public health insurance funds. With the pre-paid premium, mostly based on deductions from the member's monthly salary and state subsidies, members of any of the public funds will have access to a common health insurance benefit package that covers emergency and curative care, including most outpatient and inpatient services and all generic medicines. Furthermore, when a member receives medical treatment, the costs are shared between the member, the insurance fund and the government (SSO, meeting in Tehran, April 2018).

In most of the schemes, there is a patient co-payment rate of 10% of the cost of the treatment – based on established tariffs – for inpatient services, and 30% for outpatient services. There are some deviations from this model, as, for instance, the rural dwellers insured by the IHIO benefit from a considerably lower co-payment rate of 3% for inpatient treatment. Furthermore, SSO members receive services for free in the health institutions run by SSO (Hsu et al. 2020, p. 48; SSO, meeting in Tehran, April 2018).

Social insurance in Iran covers dependants in addition to the insured member. Dependants are defined by the law as follows (Social Security Law 1975, Article 58):

- wife
- husband (if he is supported by her, with some additional conditions)
- children under 18 years
- unmarried daughters under 20 years or until marriage if studying
- adult children if full-time students (no age-limit mentioned)
- persons unable to work due to illness or disability
- parents if elderly or disabled

Daughters who are divorced or have become unemployed after a period of employment may be covered again by the father' insurance (SSO, meeting in Tehran, April 2018). A representative of the Social Welfare Department of the MoCLSW stated that sons will be covered by parents' insurance until the age of 20 years, or up to 28 if studying. Adult daughters are supposed to be covered until marriage or employment (MoCLSW, meeting in Tehran, April 2018).

4.3 Health and medical records

Members of health insurance schemes will have a so-called "health service note-book" (*daftarche-ye khadamat-e darmani*), with the medical record of the owner. Both SSO, IHIO and AFMSIO have their separate *daftarche*, which is to be presented and updated when receiving health services or treatment.

Furthermore, there is a plan to also insert medical data into the new national identity smart card, *kart-e hooshmand-e melli*, that all Iranian citizens above 15 years are supposed to possess. This new identity card has a data chip with personal information stored in it and can include health records (Deputy for Work Relations in MoCLSW, meeting in Tehran, April 2018).

The key health institutions keep medical records in electronic data systems. For instance, when a patient visits an SSO health institution, the medical record will be registered in a nation-wide electronic system for patient information for SSO. The hospitals of the MoHME use a separate electronic system for their patients (Ali Nasab Hospital, meeting in Tabriz, May 2018).

4.4 Challenges of the insurance system

The efficiency of the Iranian health system, which consists of many health insurance providers with limited coordination between them, has been questioned by observers (international organization B, meeting Tehran, May 2018. According

to Bazyar et al. (2016), the Iranian health insurance system suffers from structural fragmentation. Each of the insurance funds provides coverage to specific, sometimes overlapping, population groups, and there is no adequate provision for transfer of cross-subsidy among the various funds. The presence of multiple providers, including public and private insurance schemes, have contributed to a notable rate of insurance coverage duplication, lack of transparency as well as underfunding of public funds (Bazyar et al. 2016).

The absence of a single fund that pools the health costs means that there are some people with two or even three insurance schemes, which causes waste of resources (Harris 2017b, p. 27). Representatives of the Social Welfare Department of the MoCLSW authorities (meeting in Tehran, April 2020) said that they acknowledge the challenge of the numerous insurance and pension schemes and explained that there is an ongoing process to coordinate and make the schemes more equal.

A key challenge to the HTP reform has been unsustainability in the provision of funds, which has led to the inability of the health insurance organizations to reimburse costs of the health service and delivering units, including hospitals, pharmacies and companies providing medical equipment (Sajadi et al. 2019; MoHME, meeting May 2018).

The semi-official news agency Fars News reported in 2017 that Rouhanicare was "on the brink of collapse" because of weak planning and lack of funding. Initial estimates expected five million Iranians to apply for the Rouhanicare (HTP) scheme, while more than the double – 11 million – had registered (Dehghan 2017).

Despite the economic difficulties, the HTP has achieved remarkable improvements in two fields, according to observers. A representative of an international organization in Tehran stated that the reform had indeed led to a substantially increased coverage of health insurance in the Iranian population. Around ten million people who were previously uninsured because they could not afford the premium, have been included in the HTP scheme (international organization A, meeting in Tehran, May 2018).

Another important outcome of the HTP reform has been a substantial reduction of out-of-pocket payments for treatment and medicines (international organizations A and B, meetings in Tehran, May 2018).

There are still people not registered with any health insurance. MoHME estimated that some 6-7% of the population was still not covered by any of public insurances in 2018. There may be different reasons why some people are still not registered with public health insurance. Some people in remote rural areas may not be informed about the availability of services and consequently have not

signed up for the Rouhanicare scheme. Furthermore, some well-off people may depend on private insurance only and chose not to register in any of the public schemes. Ministry officials emphasized that when poor people without insurance approach a hospital for treatment, they can sign up for the Rouhanicare scheme on the spot and will receive treatment even if they are not registered before (MoHME, meeting in Tehran, May 2018).

Also, Iranian citizens who have lived abroad for several years will have the right to sign up for Rouhanicare upon return in case they do not take up employment that will provide other insurance (Deputy for Work Relations in MoCLSW, meeting in Tehran, April 2018).

5 The main health and social insurance providers

The two largest health insurance providers are the Social Security Organization (SSO) and Iran Health Insurance Organization (IHIO). Officials of the MoHME estimated that 39 million Iranians are covered by the SSO, while another 34 million are covered by the IHIO (meeting in Tehran, May 2018). These figures include 23 million persons in the countryside and six million covered through government employment.

Both SSO and IHIO depend on three sources for their revenues: contributions from employees, employers, and the Government (Hsu et al. 2020, p.42). The smaller funds – the AFMSIO for the soldiers and the IKRF for the poor people – covered 6% and 2% of the country's population respectively in 2017 (Hsu et al. 2020, p. 42). According to the Social Security Law, "[…] insured persons and members of their families may enjoy the benefit of medical services in case of injury due to accident or illness […]. The said medical services should include all outpatient medical treatment and inpatient treatment, the supply of required medicines, and diagnostic testing" (Social Security Law 1975, Article 54).

The level of social insurance coverage of the workforce and the general population has developed gradually over the decades. The Iranian Social Security Law from 1952, amended by Parliament in 1975, made it compulsory for workers in the formal private sector to obtain insurance coverage from the Social Security Organization (SSO), which was a reconstruction of the previous Social Insurance Organization. Military personnel had their own health insurance scheme set up with the establishment, also in 1975, of the Armed Forces Medical Services Insurance Organization (AFMSIO). As already mentioned, following the revolution of 1979, a charity organization called Imdad Relief Committee Health Insurance – later renamed Imam Khomeini Relief Foundation (IKRF) – was established to secure basic social and health services for the most impoverished Iranians who had not been covered by insurance before.

Representatives of the Deputy for Work Relations at the Ministry of Cooperatives, Labour and Social Services explained that employers are obliged to provide health insurance for their workers – regardless of which type of contract they are engaged on. There are basically three types of work contracts in use both for public and private enterprises: one is the permanent contract, with a start date but without an end date; another is the temporary contract, with both start date and end date defined; and, finally, a third type is the project-based contract, which has a start date but no end date defined as the contract ceases with the end of the project. In all these types of contracts, health insurance for the workers is required, and employers who fail to adhere to these requirements may be fined (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018; Social Security Law 1975, Articles 97 and 108).

According to the SSO, companies with less than five employees are exempted from paying the full contribution for the health insurance, as the government will subsidize their share of the premium (SSO, meeting in Tehran, April 2018). Scholar Mohammad Rahimi, author of a book on social security in Iran, similarly conveys that companies with less than five employees are exempted from the payment of the employer's share of the social contributions (Rahimi 2014, p. 327).

5.1 Social Security Organization

The Social Security Organization (SSO), which is administered under the Ministry of Cooperatives, Labour and Social Welfare, has provided social insurance for formal employees in large firms in the public and private sector since before the 1979 revolution (Harris 2017b, p. 26). Since the 1990s, employees in small firms and informal self-employed have also been encouraged to enrol. SSO also covers temporary civil servants in the public sector, i.e. employees on contracts of less than four years (Hsu et al. 2020, p. 46).

SSO has 14 million registered members. Ten million of them are employees, whose membership is compulsory, while four million are self-employed with voluntary membership. Dependants of members come in addition to these figures (SSO, meeting in Tehran, April 2018). Including the dependants of the insured members, the SSO covers reportedly some 41 million people – approximately half of the Iranian population (Deputy for Social Welfare in MoCLSW, meeting in Tehran, April 2018).

The SSO insurance includes a range of services, such as old-age pension and disability benefits, in addition to health services (SSO, meeting in Tehran, April 2018).

The contribution to the SSO is divided into three parts: one part is paid by the employer, one by the employee, and one by the state. Based on the insured

person's monthly salary, the employee pays 7%, the employer pays 20%, and the state pays 3%, making the total contribution equivalent to 30% of the insured person's monthly salary (SSO, meeting in Tehran, April 2018). This deduction covers the whole package of social security, of which health services are just one component. The member's contribution rate for health insurance alone is 2% of monthly salary (Hsu et al. 2020, p. 47).

Self-employed people have individual contracts with the SSO, and their premium is calculated as the total of the employer's and the employee's share, which adds up to 27% of their wages. Membership in SSO is compulsory for employees but voluntary for self-employed (SSO, meeting in Tehran, April 2018).

Representatives of the SSO explained that the SSO runs its own health institutions providing services for its members. The services are of two types: either direct or indirect services. Direct services are offered in SSO's own institutions, which include 80 hospitals and 320 health centres and clinics across all of Iran's provinces. SSO members receive medical treatment free of charge in all SSO facilities (SSO, meeting in Tehran, April 2018).

For treatment that is not available at the SSO institutions, the SSO is bound by the law to buy them from other health service providers, including medical science universities, charities, and private institutions according to the medical needs of the policyholder (SSO, meeting in Tehran, April 2018). In the case of outpatient treatment in private or non-SSO clinics, the SSO member will be charged a 30% out-of-pocket fee (Social Welfare Department in the MoCLSW, meeting in Tehran, April 2018). For instance, the SSO-run Milad Hospital in Tehran offers cancer treatment by surgery only, but for chemo- or radiotherapy the patients need to go to other institutions (doctor at Milad Hospital, meeting in Tehran, April 2018).

When SSO insured patients are treated in MoHME hospitals, they are charged 6-10% of tariffs for inpatient, according to a doctor in an SSO-run hospital (Ali Nasab Hospital, meeting in Tabriz, May 2018).

The SSO health institutions also provide services to people with different insurances (e.g. IHIO), albeit not for free (MoHME, meeting in Tehran, May 2018).

When it comes to mental illnesses, the SSO covers severe and acute cases only, while chronic mental illness should be handled by the State Welfare Organization (SWO). The SSO, however, also runs a hospital – the Lavasan Hospital – with a psychiatric ward that covers treatment for members. (SSO, meeting in Tehran, April 2018).

5.1.1 Visits to SSO clinics and hospitals

The Landinfo/SEM delegation visited an SSO-run hospital, Ali Nasab Hospital, in Tabriz in 2018. This is a tertiary hospital with 300 beds offering treatment within a broad range of fields, including brain surgery, cardiology and plastic surgery, according to the head of department at the hospital. Patients may be referred to the hospital from SSO clinics, or other institutions or private doctors, but may also approach the hospital directly. Special, high-cost treatments are usually performed by hospitals run by the Ministry of Health and Medical Education rather than SSO hospitals (Ali Nasab Hospital, meeting in Tabriz, May 2018).

Members of the SSO health insurance scheme receive treatment free of charge at Ali Nasab Hospital. Other patients, without SSO insurance, are also treated at the hospital, but they have to pay according to the following tariffs (rates from 2018): 100,000 rials for a general visit and 150,000-190,000 rials for a specialist consultation. If the patient has another health insurance than the SSO scheme, the patient will pay 6-10% of the tariff for inpatient treatment, and 30% for outpatient treatment (Ali Nasab Hospital, meeting in Tabriz, May 2018).

A doctor in another SSO-institution in Tabriz, the Martyr Mokhtari Clinic, explained that SSO members who receive treatment in any other institution than SSO – including governmental hospitals – will have to pay 10% of the tariffs for inpatient treatment and 30% for outpatient treatment (Martyr Mokhtari Clinic, meeting in Tabriz, May 2018).

The same source in the SSO clinic stated that most medicines in SSO health institutions are delivered for free, although some medicines are not covered if they are categorized as special or supplementary medicines. In that case, the patient will pay 30% out-of-pocket. The doctor explained that in some cases, charities might cover the payment for needy people. Also, if there is a difference in price between Iranian-manufactured and imported medicines, the SSO will offer the Iranian medicines for free, while if the patient prefers the imported brand, he/she will have to pay the exceeding amount out-of-pocket (Martyr Mokhtari Clinic, meeting in Tabriz, May 2018).

Prostheses are usually not covered by the SSO, except for some poor patients (Martyr Mokhtari Clinic, meeting in Tabriz, May 2018). A doctor at another SSO hospital, Milad Hospital in Tehran, confirmed that patients would have to pay for prostheses (Milad Hospital, meeting in Tehran, April 2018).

The purchase of services from external institutions represents a heavy toll on the budget of the SSO, according to SSO officials. An estimated 75% of the inpatient services are provided by state institutions, while 70% of outpatient services are delivered in private institutions (SSO, meeting in Tehran, April 2018). SSO officials stated that only a third of the SSO budget, which was estimated to four billion USD for 2017/18, was spent on SSO's own institutions, while

approximately two-thirds were used to cover the treatment of SSO members in external, private institutions. This has created a huge deficit crisis which rendered the government unable to pay its share of the insurance premium (SSO, meeting in Tehran, April 2018).

5.2 Iran Health Insurance Organization (IHIO)

The Iran Health Insurance Organization (IHIO) provides health insurance to the following categories (Hsu et al. 2020, p. 44):

1. Civil servants, through mandatory enrolment in a contribution-based fund.
2. Rural residents, through automatic enrolment in a fully subsidized fund.
3. Socially vulnerable people, through automatic enrolment in a subsidized fund.
4. Self-employed and all other populations, through voluntary enrolment in a fully subsidized fund.

The ambition of universal coverage of health insurance was formalized by the parliament passing the Universal Health Insurance Act in 1994 and the establishment of the Medical Service Insurance Organization (MSIO), which was transformed into IHIO in 2012. Over the years, MSIO gradually included several additional categories such as villagers, tribes, self-employed, martyrs' families, the injured of war, the clergy, and university students (Rahimi 2014, p. 330; MoCLSW, n.d.). In 2005, the MSIO was expanded further to cover the remaining rural population, with premiums subsidized by the Government (Hsu et al. 2020, p. 42).

An overall strategic political five-year plan from 2010 mandated to merge all existing health insurance funds into the MSIO – in order to increase efficiency. But that goal was not implemented.

The latest reform program, launched in 2014, was the Health Transformation Plan or, more popularly called Rouhanicare, with the aim to cover the remaining uninsured population. It was the IHIO that was entrusted the mandate to incorporate all remaining uninsured individuals into its schemes (Hsu et al. 2020, p. 62).

The IHIO was moved from the MoCLSW to the MoHME in 2017 (Doshmangir 2019a, p. 600). People insured by IHIO will receive treatment in the governmental facilities of the MoHME. Patients pay out-of-pocket payments according to tariffs set by the government. For outpatient services, the patient pays 30% of the tariff, while the insurance covers 70%. For inpatient treatment, the insurance covers 90%, and the patient pays the remaining 10% (MoHME, meeting in Tehran, May 2018).

Patients insured by IHIO may also go to SSO-run institutions and will have to pay 20-30% of the tariffs.

5.3 Civil Servants Pension Fund

The Civil Servants Pension Fund (CSPF) is the second biggest and the oldest of 18 pension funds in Iran (CSPF, meeting in Tehran, May 2018). CSPF covers approximately 1.25 million active state employees, including employees from large state-owned companies such as the Jam Petrochemical Company. At the same time, it pays pensions to even more retired ex-employees: 1,4 million retired men and women receive their monthly pension from the fund. 59% of all people covered by CSPF insurances work or used to work in the field of education (CSPF, meeting in Tehran, May 2018).

Representatives of CSPF (meeting in Tehran, May 2018) explained that in addition to fulfilling its primary task of paying pension to the beneficiaries, the CSPF offers additional insurance (*bimeh-ye takmili*) packages to around 1.2 to 2 million people, that include accident insurance and life insurance, which it often acquires from third party insurers. It also organizes a range of leisure activities and other services for its members. In all provinces, CSPF is present with centres, so-called "hope houses" (*khaneh-ye omid*) where retired people can gather and participate in various cultural or educational activities and debating clubs. CSPF even has its own Tourism Department that organizes tours and pilgrim travels, and it runs 70 hotels and 30 guesthouses. Accommodation in these facilities is not free but is offered at discount prices for CSPF members (CSPF, meeting in Tehran, May 2018).

5.4 Imam Khomeini Relief Foundation (IKRF)

The right to health care and social insurance for all Iranian citizens was emphasized in the new Constitution of the Islamic Republic that was adapted in 1979 (Article 29). In order to secure basic social and health services for the poorest people of the country, the Emdad Relief Committee Health Insurance was established. It was later reconstituted as the Imam Khomeini Relief Foundation (IKRF). Officials of the IKRF explained that the approach of the foundation is different from the other institutions that are based on contribution-based insurance schemes, as the IKRF provides aid to the poorest, in particular the rural population, based on a needs assessment and registration. The needs assessment is done based on application forms, which are fed into a common database of the IKRF, the MoLSW and the SWO. All sick people that are admitted for treatment by IKRF will be registered in the database (IKRF, meeting in Tehran, April 2018).

The IKRF does not run its own medical facilities but has a system of referring needy patients to treatment at some 10,000 local health centres across the country, 1300 family physicians, 2000 specialists, 700 public and private hospitals, and

300 dentists. It is the only health provider to have established a form of referral system based on family doctors in order to control the increasing health costs. As an incentive for IKRF clients to approach a family physician first, they pay only 1/7 of the usual rate of out-of-pocket payments (IKRF, meeting in Tehran, April 2018).

The reforms of the Health Transformation Plan (HTP) in 2014 has had a fundamental impact on the IKRF, as many of those who previously were supported by IKRF because they lacked health insurance, have now been admitted to the new schemes of the HTP. IKRF officials suggest that about 2 million people who previously received care from IKRF have now been transferred to the new HTP scheme. Between 1-1.5 million still receive their basic healthcare from IKRF, and another 3 million people receive selective support from IKRF for additional services such as housing loans, dowries, and basic furniture (IKRF, meeting in Tehran, April 2018).

Some mental health services are covered by the IKRF, including different types of counselling therapy sessions. Families may, in addition, receive cash support for taking care of sick people at home. However, more severe psychiatric cases must be referred to the State Welfare Organization (IKRF, meeting in Tehran, April 2018).

The IKRF does not provide aid to Afghan refugees or other foreign citizens in Iran. However, there are branches of IKRF in some foreign countries, including Afghanistan, Iraq and Syria, from where funds are collected and sent to aid the poor people among their exiled nationals via IKRF (IKRF, meeting in Tehran, April 2018).

The IKRF has a special support program for female breadwinners, based on needs assessment in each case. Assistance may also be provided when there is a problem with the husband or when the husband is in prison. In cases of neglect of care, the IKRF can offer advice and support education. There is a sponsor program for supporting education for needy children (IKRF, meeting in Tehran, April 2018).

5.5 Supplemental and private health insurance

There are private and semi-public insurance companies that mainly offer supplementary insurance for costly inpatient services. Premium insurances offer additional coverage to the basic coverage. There were ten private insurance companies offering such services in 2016 (Griffon Capital 2016, p. 10).

Private insurance companies purchase services from a growing sector of private health providers. For instance, SOS Iran Assistance will cover co-payments and provide services from private establishments in various fields, including dentistry, which is not covered by public insurance (SOS Assistance n.d.).

There are several reasons why people would prefer to be treated in private rather than in public institutions. One is that in some fields, the private institutions have a reputation of a higher quality of services, without waiting lists and less crowded as may be the situation in public hospitals. A representative of an international organization (A) in Tehran (meeting, May 2018) said that while public hospitals may be crowded, and the personnel may not have enough time for each patient, private institutions appear as more pleasant and with personnel that treat you with respect.

Furthermore, there might be a structural linkage between public and private treatment. According to a doctor at the SSO-run Milad Hospital, most of the doctors working there also run their own private clinic. Patients who see a doctor in the hospital may end up continuing treatment at the private clinic of the same doctor (doctor at Milad Hospital, meeting in Tehran, April 2018).

Some people have private health insurance schemes in order to have access to treatment in private institutions. However, private institutions are not exclusively for patients with private insurance. Members of public health insurance schemes may choose to be treated in private institutions and will have part of the treatment covered by public insurance. They will then receive a refund of the same amount as the tariff of a given treatment at a public hospital and pay the exceeding amount if the tariff is higher in the private institution. The exceeding payment to the private institution could be covered by private insurance or paid by the patient (Social Welfare Deputy Department of the MoCLSW, meeting in Tehran, April 2018).

A Western embassy in Tehran stated that some private companies offer additional private health insurance for their employees. For instance, an employee in a private company or at an embassy who is insured with the public SSO, may also have supplementary insurance with the private company SOS Iran Assistance (Western embassy, meeting in Tehran, May 2018).

Additionally, there are many NGOs and charities throughout the country running health institutions with access based on a needs assessment without any reference to prior insurance coverage. Mahak Society to Support Children Suffering from Cancer, for instance, is a well-known charitable paediatric cancer research, hospital and rehabilitation centre. Patients are referred to Mahak by doctors across the country. According to a representative of Mahak, any child who is diagnosed with cancer will receive treatment, either at the Mahak hospital or in other hospitals. Mahak also covers treatment for patients in other hospitals in Iran. The treatment is free of charge, and the patients are not required to be insured to receive treatment. Even relatives can get funding for accommodation when accompanying their sick children. Mahak receives child cancer patients from several neighbouring countries (Mahak, meeting in Tehran, May 2018).

6 Social security benefits

Below the main benefits provided by social security funds are presented.

6.1 Occupational diseases and work injury

A study led by the Institute for Health Metrics and Evaluation at the University of Washington in 2010 reported that occupational diseases in Iran were among the top ten leading risk factors causing disability or early death (Rafiei et al. 2015, p. 565). A survey conducted in Iran found that in 2008 the occupational accidents rate was 253 per 100,000 workers. Men constituted 98.2% of the injured workers, and the highest percentage belonged to the 25-34 years age group (Rafiei et al. 2015, p. 565).

Occupational health is a main public health concern in Iran, according to researcher Masoud Rafiei (2015) and is integrated into the public health system at all levels, including in primary health care. There is established a network of workers' health houses which are called *behdashtyar* for workplaces in the range of 50-500 workers and *behgar* for workplaces with 20-50 workers. Enterprises with more than 500 workers should have a labour health centre (Rafiei et al. 2015, p. 564).

Work injury, either permanent or temporary, is covered by a disability pension for employed persons. For self-employed persons, the coverage is voluntary. The pension is defined by the degree of disability as well as the previous salary and length of service.

- For a disability of 66% or more, the permanent disability pension is calculated at 3.33% of the insured person's average monthly covered earnings in the last 720 days before being disabled multiplied by the number of years of contributions.
- There is a minimum monthly permanent disability pension, which is either 50% of the insured person's monthly earnings in the last 720 days or 100% of the legal monthly minimum wage of an unskilled worker.
- There is a maximum limitation, as the monthly permanent disability pension cannot exceed 100% of the insured person's average monthly covered earnings in the last 720 days (SSA 2018).

According to representatives of the SSO, in case of work-related disability or death, the pension is more than the retirement pension, and the length of work experience does not matter. For instance, if the insured person dies on the first day at a new job, his dependants will be entitled to the pension as equal beneficiaries (SSO, meeting in Tehran, April 2018).

A reduced pension may be granted for partial disability, depending on the degree of disability. For disability assessed at between 33% and 66%, the pension is calculated as a percentage of the full permanent disability pension according to the assessed degree of disability (SSA 2018).

Finally, for a disability as a result of losing a limb or an assessed degree of disability of between 10% and 33%, a lump sum is paid, calculated at 36 times the full disability pension multiplied by the degree of disability (SSA 2018).

If a work injury causes temporary disability, the benefits are calculated at 66% of the insured's average daily covered earnings during the 90 days before the injury for a worker without dependants and 75% for a worker with dependants. The benefit is reduced to 50% of daily covered earnings for an unmarried worker being hospitalized, while there is no reduction if the worker has dependants (SSA 2018).

6.2 Sick leave

Officials in the Civil Servants Pension Fund (CSPF, meeting in Tehran, May 2018) stated that for sickness of duration of up to one full year, civil servants would have their salary – including benefits – paid from their ministry of employment. Salary is paid from the first day of sick leave. After one year, a sick person must apply to CSPF, which may take over responsibility and pay a fixed amount. However, those with sick leave surpassing a year, and people with hard-to-cure diseases will typically not return to work and will instead apply for disability pension.

Officials in the SSO similarly claimed that insured members will get paid from the first day of sick leave (SSO, meeting in Tehran, April 2018). However, the American Social Security Administration (SSA) states that the benefits are paid after a three-day waiting period (unless hospitalized) until recovery (SSA 2018).

6.3 Maternity benefits

Maternity benefits amount to 66% of the average daily covered earnings in the last three months before birth and are paid for up to six months. For multiple births, the maternity benefits are paid for one year (SSA 2018).

Representatives of the SSO explained that maternity leave lasts for six months if the mother breastfeeds the child. Breastfeeding is furthermore encouraged by the state by facilitating one free hour off every day for a time period of up to two years (CSPF, meeting in Tehran, May 2018). Depending on medical conditions, the woman may take up to 84 days of leave during pregnancy. The woman must have been employed for at least 60 days before delivery in order to be entitled the maternity benefits (SSO, meeting in Tehran, April 2018). If preferable, women

can take nine months of maternity leave with two-thirds of the entitlement per month rather than six months with full entitlement (Deputy for Social Welfare Department in MoCLSW, meeting in Tehran, April 2020).

6.4 Family allowance and benefits

Family allowance is granted as part of social insurance schemes for parents who have worked and paid contribution for at least 720 days. The family allowance is paid until the child is 18 years old, or if studying, until studies are finished (SSA 2018).

The family allowance is paid monthly and calculated as three times the legal daily minimum wage of an unskilled worker for each child. Benefits are adjusted annually (SSA 2018)

6.5 Old-age pensions

The funds for old-age pension are covered by shared contributions by the insured person, the employer and the government. The pension may be full or partial, according to the number of years of contribution (CSPF, meeting in Tehran, May 2018; SSA 2018). Old-age pension is provided through the Civil Servants Pension Fund (CSPF), the Social Security Organization (SSO) as well as 16 other pension funds in Iran.

According to the Deputy for Social Welfare in MoCLSW (meeting in Tehran, April 2018), approximately 75% of employed people have pension insurance out of which 55% are covered by the SSO. However, an estimated 25% of the workers, mainly in the informal sector and among seasonal labourers, do not have any pension coverage.

The CSPF is the main provider of pension for state employees. CSPF covers approximately 1.4 million retired people, and 1.25 million workers are under its coverage. 70% of the retired beneficiaries of CSPF are men, and 30% are women (CSPF, meeting in Tehran, May 2018). The CSPF offers old pension insurance also for rural people and nomads against a minimum contribution (Deputy of Work relations in MoCLSW, meeting in Tehran, April 2018).

Self-employed persons may have an old-age pension based on a payment of 12% of monthly earnings (SSA 2018). By increasing the payment to 14% of the monthly earnings, the pension will also cover survivors, and by paying 18%, the pension will cover disability and survivors in addition to old age (SSA 2018).

Persons who have worked simultaneously at two places may receive benefits from both, and thus receive a higher pension. However, there is a fixed maximum ceiling for old age pension which cannot be exceeded – even if the sum of the two

pensions amounts to a higher amount (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018). Persons who change employment, e.g. from a governmental institution to a private company, can transfer their pension funds from one insurer to another (CSPF, meeting in Tehran, May 2018).

The age limit of the old-age pension depends on the number of years of contribution. Full pension is paid at age 60 for men and 55 for women with at least 20 years of contribution, or age 50 for men and 45 for women with at least 30 years of covered work. Employees in an unhealthy or physically demanding working environment will receive a full pension after 20 consecutive years or 25 non-consecutive years of employment. Partial pension is granted for insured persons with less than 20 years of contribution (SSA 2018; Social Security Law 1975, Article 76). For CSPF members, men receive full old-age pension after 30 years of service, and women after 25 years (CSPF, meeting in Tehran, May 2018).

Coupled with an increasing life expectancy, this young retirement age starts to become an increasing financial problem for the pension funds (CSFP, meeting in Tehran, May 2018).

The amount of the old-age pension is calculated as the insured's average monthly covered earnings during the last two years of work divided by 30 and multiplied by the number of years of contributions, up to 35 years. However, for insured workers in unhealthy, hazardous or physically demanding environments, each year of paid contributions counts as 1.5 years (SSA 2018).

There is a minimum monthly old-age pension which equals the legal monthly minimum wage of an unskilled worker, which is adjusted annually based on changes in the cost of living. If the calculated pension is less than the minimum wage, the SSO will cover the remaining amount. There is also an upper ceiling of the pension, which is seven times the minimum wage (SSO, meeting in Tehran, April 2018; SSA 2018).

6.6 Allocations for disabled persons

In case of permanent disability, an insured person will have receive pension which equals the insured person's average monthly covered earnings in the last 720 days before being disabled divided by 30 and multiplied by the number of years of contribution. The permanent disability pension is at least 100% of the legal monthly minimum wage of an unskilled worker or 50% of the insured person's average earnings. The pension cannot exceed the average monthly covered earning during the last 720 days before the disability began (SSA 2018). According to CSFP, disability pension of at least the minimum wage is granted from the first month of work (CSFP, meeting in Tehran, May 2018).

A representative of the Deputy of Work Relations within the Ministry of Cooperatives, Labour and Social Welfare confirmed that disabled persons who have been working are entitled to unemployment benefits. The support will depend on the type of disability and on whether the person is responsible for family members or not. However, a disabled person who has not entered the labour market will have to seek assistance from the State Welfare Organization (SWO). The support from the SWO is limited and less than the legal minimum wage (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

6.7 Unemployment benefits

In Iran, based on the labour law, only employees of private companies are insured against unemployment. Self-employed and civil servants are generally not covered by the labour law and are consequently not insured against unemployment – on the assumption that their working contracts cannot be terminated. Private companies, by contrast, are obliged to insure their employees against unemployment, even smaller ones (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018). Civil servants who quit state employment, can, however, continue to contribute payments – including the employer's share – to the CSFP, in order to be able to get the full retirement pension later (CSFP, meeting in Tehran, May 2018).

Based on the 1975 Social Security Law, the employer must pay 3% of the employees' payroll for insurance covering unemployment. However, this premium is not paid by self-employed (SSO, meeting in Tehran, April 2018; SSA 2018, p. 117). The 3% paid by the employer come in addition to the employer's share of 20% of the wage for social security and health insurance (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

The right to unemployment benefits is only granted after six months of employment (SSO, meeting in Tehran, April 2018). The duration and amount of payment depend on several factors, including wage, length of service, marital status and number of dependants. The basic payment for a single person is 55% of the previous salary. According to an SSO representative, an insured person who is single can receive up to six months of unemployment benefits, while a married person who worked for more than 20 years would be entitled to maximum 50 months, which is four years and two months, of payment (SSO, meeting in Tehran, April 2018; Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

Furthermore, an insured man who is older than 55 years will have unemployment benefits until he reaches retirement age. If the insured person is economically responsible for siblings, 10% extra unemployment benefit is granted for each brother or sister, although siblings are normally not calculated as dependants when it comes to other benefit rights (SSO, meeting in Tehran, April 2018). A

representative of the Deputy of Work Relations in the Ministry of Cooperatives, Labour and Social Welfare stated that the maximum unemployment benefits, including for dependants, are 80% of the previous monthly salary (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

Newly graduated students are not entitled to unemployment benefits before they have started working (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

Unemployed persons will have to register their name with companies where their skills are being registered, and they may be approached by companies offering them employment. During the period of unemployment, the unemployed may be obliged to participate in courses aiming at increasing his/her competence. If an unemployed person is offered a job, (s)he is obliged to accept it, otherwise the unemployment benefits will be halted. Unemployed persons receive health care free of charge. The period of unemployment will be counted as working years in the individual's pension plan (Deputy of Work Relations in MoCLSW, meeting in Tehran, April 2018).

6.8 Allocations for survivors

Survivor pension is paid to dependants of a deceased person who has been insured. Dependants include widow/widower, children (that is sons until the age of 20 and daughters until they get married) (at least for CSFP) and parents. The spouse's pension is 50% of the old-age or disability pension of the insured person, while for orphans it is 25% and 20% for parents. The combined survivor pension cannot be below the legal minimum wage or above the pension of the deceased person (CSFP, meeting in Tehran, May 2018; SSA 2018).

6.9 Minimum wage

There is a legal monthly minimum wage for unskilled workers in Iran, which is annually recalculated, taking into account inflation. In April 2020, the minimum wage was increased from 15.17 million rials (94 USD) to 18.34 million rials (113 USD – at free-market exchange rate) (Financial Times 2020). This represents a 21% increase, which, however, is only half of the country's 41% inflation rate (Radio Farda 2020).

In addition to this, the state pays (practically) each family housing and foodstuff allowances, in the form of monthly cash transfers (*yaraneh-ye naqdi*), making the total amount paid to a non-married worker 25 million rials (155 USD) and 30 million rials (186 USD) to a married worker per month (Radio Farda 2020).

7 State Welfare Organization

The State Welfare Organization (SWO) was created in 1979 as a merger of different organizations offering social welfare that had existed before the revolution. The Foundation Act of 1980 tasked the SWO with the coordination and implementation of all public welfare programs for deprived people as outlined in articles 21 and 29 of the new constitution. Originally, the Imam Khomeini Relief Foundation (IKRF) and the Foundation of Martyrs and Veterans Affair were also integrated into the SWO; yet, later, they became independent again (Rahimi 2014, p. 505).

Today, the State Welfare Organization is part of the Ministry of Cooperatives, Labour and Social Welfare. The SWO runs its own training facilities, including the University of Social Welfare and Rehabilitation Science (Rahimi 2014, p. 505; Harris 2017, p. 109; SWO, meeting in Tehran, May 2018).

The programs run by the SWO are particularly directed at following groups: people with disabilities, old people in need of care, and women and children lacking support or otherwise being vulnerable (Rahimi 2014, p. 505f.; SWO, meeting in Tehran, May 2018).

The SWO is organized into different departments, corresponding to different fields of activities. Next to the central logistics department, which is tasked with providing the other departments with services, these departments are the department of rehabilitation, the department of social affairs, the department of prevention, and the department of cooperation with civil society organizations. The latter department aims at closer cooperation between public and civil society organizations. The department of social affairs and the department of prevention largely focus on the same target groups but divide their efforts into the provision of services and prevention, albeit with sometimes unclear divisions of responsibilities (Rahimi 2014, p. 506ff.).

- Department of rehabilitation (affairs): This department is tasked with taking care of physically or mentally disabled people in Iran as well as of old people in need of support. In recent years, the SWO has shifted its efforts from providing services in nursing homes to providing services in private homes (Rahimi 2014, p. 507f.)
- Department of social affairs: This department is tasked with supporting people who are not otherwise covered by social insurance schemes or supported by private bodies. In particular, the focus are on families without income, and in need of support, especially female breadwinners, children (orphans and street children), and "socially harmed" people such as women (and children) living in the streets (including sex workers) and drug users. In recent years, the SWO has increasingly shifted its efforts from the support of needy families to the support of people suffering social

harms. At least until the implementation of the HTP, the SWO also seems to have covered health insurance for needy people (Rahimi 2014, p. 506f.)

- Department of prevention: This department is tasked with developing and offering prevention programs for different profiles, including:
  - disabilities (counselling of young couples, genetic tests for babies, training for people living in areas with war mines)
  - social harms (education & counselling & training in order to prevent suicides, divorce, domestic violence, and drug addiction) (Rahimi 2014, p. 509)

The SWO runs various programs to prevent social harms and promote social participation through some 150 different activities. Also, SWO supports local NGOs working with social relief work. A female social worker with long experience in the SWO, described some key focus groups of the work of the organization, which include vulnerable women, children with lack of care, and disabled people (SWO, meeting in Tehran, May 2018).

7.1 Vulnerable women

The SWO runs self-help groups for families in difficult situations, organized at family centres. Some get assistance to obtain employment. A project with a micro-finance approach includes 50,000 people – not only women but also rural people and others. The aim is to reduce poverty.

A special focus is on female breadwinners. There are, according to a SWO social worker, three million female-headed families. 180,000 of them are under the care of SWO. The budget is limited and not all in need will receive help. The benefits do not necessarily go to the women but could for instance cover education for children. SWO reportedly pays the tuition fees for about 75,000 school students and 500,000 university students (SWO, meeting in Tehran, May 2018).

Asked about protection against domestic violence, the social worker explained that there is a harm reduction office of SWO working on the issue of domestic violence (SWO, meeting in Tehran, May 2018).

Since 1999/2000, the SWO started to build a system offering support to people exposed to social harms, in particular women and girls as victims of domestic violence. This includes the social emergency institution (*urzhans-e ejtema'i*), an institution running two hotlines, ambulant teams, and its own centres in all larger cities in the country. The social emergency institution serves as a point of initial contact for a wide range of people in need, including old people, people with disabilities, victims of domestic violence and children (SEM 2019, p. 34f.)

People can get in touch with the social emergency institution either by calling the hotlines or by visiting one of their centres. There are two hotlines: the hotline 123,

which serves as a general hotline for the SWO, particularly also for victims of domestic violence, and the hotline 1480, a specific hotline for children. These hotlines can also refer people with specific needs to the social emergency centres, which exist in 232 Iranian cities and offer counselling by a team commonly consisting of a social worker, a psychologist, a psychiatrist, a physician, a nurse, and a legal advisor. The social emergency centres basically offer outpatient services, but some also offer inpatient services for a duration of up to 20 days. They also refer people with more specific needs to other centres offering longer treatment. (SEM 2019, 35-37).

The SWO runs additional centres for female victims of domestic violence. The family intervention centres, which often seem to overlap with the social emergency centres, basically offer counselling to couples with the aim of preventing divorce, but also to women as victims of domestic violence (SEM 2019, p. 37).

SWO's health houses and safe houses are more particularly focussed on victims of domestic violence. The first health houses for women were developed from 1999, while the first safe houses were established in 2013. The difference between the two institutions is not always clear. Both are supposed to exist in all provincial capitals: up to 2019 there were 31 health houses and 26 safe houses. Despite contradictions in the literature, in theory, the health houses seem to be reserved for women "in danger of social harms", that is younger or unmarried women, while the safe houses seem to be reserved for women affected by "social harms", that is older or married women (SEM 2019, p. 38-42).

In some provincial capitals, however, only one such centre seems to exist, offering support to both groups of women. While "social harms" concerning women often imply drug addiction or sex work in Iran, the term can also refer to domestic violence. Particularly for sex workers, the SWO runs the women & girls protection and rehabilitation centres, where women usually are being sent by the courts or the police; thus, these rather seem to resemble detention centres (SEM 2019, p. 38-42).

7.2 Vulnerable children

Abuse or lack of care of children is an important issue for SWO. Child victims of violence or abuse may also call the 123 or more specifically the 1480 hotline to receive help. According to the SWO social worker, it is in such cases a legal challenge that the guardianship of the child goes to the father. The SWO is active in promoting a change in the law in this regard (SWO, meeting in Tehran. May 2018).

In some cases, children are separated from the parents and placed under the care of SWO. SWO reported in 2016 that it had 590 facilities across the country where

basic services are provided for some 9,800 children under the age of 18. Half of these children are girls, according to media reports (Financial Tribune 2016). Orphanages, by contrast, today seem to have almost been dissolved. The SWO instead prefer to place children in care of foster families (Rahimi 2014, p. 507).

7.3 Disabled people

The division for rehabilitation of the SWO is the main state institution tasked with providing support and assistance to disabled people in Iran. The services offered include rehabilitation services and equipment, vocational education, inpatient treatment and stay at residential institutions, specific financial allowances and disability pensions.

The scholar Rahimi provides an overview of some of the services offered to disabled people by the SWO, including speech therapy, literacy programs for blind and deaf, different therapies or auxiliary devices. The number of disabled people registered with the SWO is around 1,3 million people, including approximately 100,000 persons with chronic mental diseases. The SWO has shifted its focus in recent years from providing their services in residential institutions to nursing services at home. The responsibility for people disabled as a result of the Iran-Iraq war or in the service of the armed forces, in contrast, lies with the Foundation of Martyrs and Veterans Affairs, which serves approximately half a million disable persons. A further 7,500 people with disabilities are being covered by the IKRF (HRW 2018, p. 5, 15, 18, 38; Rahimi 2014, p. 507f.).

According to an international organization (B) in Tehran, the SWO has comprehensive services also for physically and mentally disabled children (meeting in Tehran, May 2018). Meanwhile, Human Right Watch has criticized the authorities for excluding too many mentally disabled children from public education and providing insufficient assistance. In a report from 2019, HRW wrote that during the 2018-2019 school year, only 150,000 out of an estimated 1.5 million children with disabilities were enrolled in school. Among those who went to school, 43% attended general public schools, while the majority attended special schools (HRW 2019).

Iran's Special Education Organization under the Ministry of Education is responsible for those children who are considered fit for attending school, while SWO is responsible for those who are considered "ineducable". Children with intellectual disabilities or autism with an IQ below 50 may access rehabilitation, education, speech therapy, and occupational therapy in SWO's day centres and receive preparation to join the special education system (HRW 2019).

The SWO supports numerous training programs and workshops that are run by private institutions or non-governmental organization. The Landinfo/SEM

delegation visited three such institutions in the city of Tabriz, in the East Azerbaijan province.

7.3.1 Arman Skill Education Centre

Arman Skill Education Centre offers vocational training and paid workshop work for mentally disabled people. The centre, which is private but supported by the SWO, is a small factory producing electric LED-lamps and car perfume. The delegation was told that there were 114 clients on training or work. After eight months of vocational training, the clients work for payment as interns for 16 months.

The clients were men and boys above the age of 14. A teacher at the institution explained that the activities had two main aims: psychological engagement and socialization. Among the staff at the centre were a psychologist and an occupational therapist available for the clients. The salary of the clients was partly covered by the sale of the manufactured products, and partly by support from the SWO (teacher at Arman Skill Education Centre, meeting in Tabriz, May 2018).

7.3.2 Azerbaijan General Center of Treatment and Rehabilitation

The delegation also visited the Azerbaijan General Center of Treatment and Rehabilitation. The clients were engaged in artistic activities, like painting, drawing and carpet weaving. In addition to the artistic work, there was a studio for physical training.

During the guided tour in the premises, the delegation attended a session of group therapy. It was said that this was a self-help group focusing on anger management. There were five people in the group, and they explained that they met twice a week. Among the staff were physicians, nurses and social workers. The centre helps the clients to sell their artistic works, according to a representative of the centre. The centre is private but receives funding from the SWO, which is the case for many similar organizations in Iran, according to representatives of the centre (Azerbaijan General Center of Treatment and Rehabilitation for Chronic Psychiatric Patients, meeting in Azerbaijan, May 2018).

7.3.3 Fatemeh al-Zahra Supporting Production Workshop

Fatemeh al-Zahra Supporting Production Workshop is a factory producing air filters for cars. The General Director of the institution explained that the clients were given tasks according to their abilities after being evaluated in a psychological unit of the institution. The workshop respected the legal standards of labour in Iran, and the salary, which was based on state regulations, was about 200 USD per month, according to the representative. The workshop traded their

products in the commercial market and was able to cover 70 of the budgets from the profit, while 30% was covered by SWO funds (Fatemeh al-Zahra Supporting Production Workshop, meeting in Tabriz, May 2018).

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