Power structure among the actors of financial support to the poor to access health services: Social network analysis approach

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ABSTRACT

The extent of universal health coverage in terms of financial protection is worrisome in Iran. There are challenges in health policies to guarantee financial accessibility to health services, especially for poor people. Various institutions offer support to ensure that the poor have financial access to health services. The aim of this study is to investigate the relationship network among the institutions active in this field.

This study is a policy document analysis. It evaluates the country's legal documents in the field of financial support to the poor for healthcare after the Islamic Revolution in Iran. The researchers looked for the documents on the related websites and referred to the related organizations. The social network analysis approach was chosen for the analysis of the documents. Block-modelling and multi-dimensional scaling (MDS) was used to determine the network structures. The UCINET software was employed to analyse the data.

Most the main actors of this network are chosen from the government budget. There is no legal communication and cooperation among some of the actors because of their improper position in the network. Seven blocks have been clustered by CONCOR in terms of the actor's degree of similarity. The social distance among the actors of the seven blocks is very short. Power distribution in the field of financial support to the poor has a fragmented structure; however, it is mainly run by a dominant block consisting of The Supreme Council of Welfare and Social Security, Health Insurance Organization, and the Ministry of Health and Medical Education.

The financial support for the poor network involves multiple actors. This variety has created a series of confusions in terms of the type, level, and scope of responsibilities among the actors. The weak presence legislative and regulatory institutions and also non-governmental institutions are the main weak points of this network.

1. Introduction

'The poor' denotes the percentage of people whose income and consumption are measured to be below the international poverty line according to the standard indicators of livelihood (Bagheri and Avazalipour, 2013). In 2012, the proportion of people living below the poverty line in Iran was 5.1%. This proportion was 5.4% and 5% in the cities and rural areas, respectively. Also the poverty gap was higher in the cities than in the rural areas (Salehi-Isfahani, 2014); however, the possibility of the incidence, intensity, and depth of poverty was higher in the rural areas (Mahmoudi, 2011).

Poor people are in a worse health condition compared to the rich,

due to priorities, geography, and accessibility to health system (WHO, 2006a). They are less likely to look for the care for a disease. Even if they do so, they will choose the cheaper alternatives (Van de Walle and Nead, 1995). Here, poor people pay a higher share of their money for health services than the share paid by the rich (Rezapour et al., 2015).

In Iran, a just access to health services has been taken into consideration. Article 29 of Iran's Constitution gives every individual the right to get healthcare. But several studies indicate that there is a direct relationship between the rate of receiving health service and the income, and it is considerably less for people who cannot afford (Motlagh et al., 2015).

The World Health Organization's (WHO) 2010 report introduces

two main factors in universal health coverage (UHC). These are affordability, which means the ability to pay for the health services without facing any financial problems, and financial protection, when threatening financial risks arise from the treatment (Evans et al., 2013). While the status of the health system is far more worrying concerning the financial protection aspect than the other two aspects of UHC (NIHR, 2014), there are challenges in health policies to guarantee financial accessibility to health services, especially for poor people.

When a support programme or aid project puts the poor at the centre of attention, dealing with the issues of institutional nature finds importance. Institutional analysis is a complicated part of designing a project to support the poor (Sjöquist, 2001). Policymakers should bear in mind that proper institutions are important to alleviate poverty and make a big impact on the welfare of the poor (Azfar, 2005).

Analysis of the nature of institutions and policies leads to a deeper understanding of poverty, the pro-poor growth of support to the poor, and the creation of strategies effective strategies in reducing poverty (Deolalikar et al., 2002).

1.1. Social network analysis (SNA)

The formulation and implementation of the policies happens more like a network rather than by a sole actor. Network analysis is a method of designing the power map using the structural and communicational features of the actors. It describes the roles that influence political decisions by presenting the power and the position of lead actors (Wang, 2013).

Power is considered to be an influential factor in the development and implementation of policies at the heart of health policy processes (Erasmus and Gilson, 2008). The power of actors emanates from their position in a network. However, there are other personal factors such as property, wisdom, and commitment to the legal authority, which empowers them (Aberman et al., 2010; Easley and Kleinberg, 2010; Schiffer and Waale, 2008).

In a political society, the power distribution determines where the conflicts are and how they have to be resolved (Betts and Stouder, 2004). The unbalanced power distribution in concentrated networks means unjust distribution of the advantages from the institution's position in the network and society (Hanneman and Riddle, 2005), leading to a decrease in the decision-making authority of less powerful actors (Salonen, 2010).

The SNA approach indicates how the cooperation can be improved in a specific section of the network, and the extent to which the relationships can be improved (Kolleck, 2013). Cooperation among the organizations and their effectiveness as a whole are the two main results from the network perspective of organizations (Dávid, 2013). The analysis of coordination among the actors, done by examining their structural equivalence in a network, gives the possibility of examining their social difference (Dornisch, 2007).

In Iran, various institutions work in the area of policymaking to support the poor to financial access to health services. They are structurally separate and may not have organized relationships with each other. The aim of this research was to examine the present situation of the relationship networks among the active institutions in this area.

1.2. Iran's health system and the financial support actors

On the policy documents, some institutions are legally mandated to support financially the poor to access health services. The Ministry of Health and Medical Education (MOHME) is the main provider and policymaker of health services. The Ministry of Cooperative, Labour and Social Welfare (MCLS) is a main financier of health services and leads the insurance organizations (Takian et al., 2015). MOHME assigns the implementation of a national-wide health policy to the medical sciences universities (Mehrdad, 2009).

The four main social insurance organizations—the Iran Health Insurance Organization (IHIO), the Social Security Organization (SSO), the Armed Forces Health Insurance Organization(AFHIO), and the Imam Khomeini Relief Committee (IKRC)—work under the supervision of the Supreme Council of Health Insurance (SCHI), which is located in MCLS. Almost 90% of Iranians are under the coverage of health insurance in a Bismarkian system (Moosazadeh et al., 2016). The government pays the health costs for the poor to the IKRC, and the health costs for the people in the deprived areas to IHIO. These subsides finance the deficit of the health insurance scheme (WHO, 2006b).

IHIO covers government employees, residents of villages and towns with fewer than 20,000 inhabitants, veterans, the Welfare Organization (WO) society, students, self-employed people, and other poor and uninsured people (Bazyar et al., 2016). SSO members include employees, self-employed people, and government employees (Ansaripour et al., 2014).

The activities of IKRC charity para-governmental organization are related to health, including health insurance coverage for the poor. The financial resources of this institution come from the government budget (Bazyar et al., 2016) and charity (Esfahani and Karimi, 2016). WO, affiliated with MCLS, is a permanent and temporary shelter for homeless people, such as women, children, the elderly, the handicapped and psychological patients (Dolatabadi et al., 2016). Its services are not merely focused on the poor (Esfahani and Karimi, 2016).

The Supreme Council of Welfare and Social Security (SCWSS) is a supra-sector council that has been founded to organize, plan, and avoid interference, duplication, and waste of welfare resources (Ghaffary and Azizimehr, 2015), and its secretariat is in MCLS. The para-governmental organizations are not under government supervision and work under the supervision of Iran's Supreme Leader. These include the Islamic Revolution Mostazafan Foundation (IRMF), which helps low-income families (Enami et al., 2016), Alavi Foundation (AF), Imam Khomeini Command Execution Headquarter, Barakat Foundation (BF), which works to help the poor, and Martyrs' and Veterans' Affairs Foundation (MVAF).

At the provincial level, the social (and cultural) committee is a specialized working group of the province's Planning and Development Council. It is composed of influential institutions whose responsibilities include the support of vulnerable classes in the province (Cabinet, 2011). Also the city and village councils are among the most important centres of power in the country (Rasekhi and Mohammadi, 2016). The municipality, along with other organizations, such as the IKRC, WO, the MVAF, and SSO, has the responsibility to support and pay pensions and allowances to the needy and underprivileged people. According to the law, 3% of the Municipality's income must be spent on health costs, and 10% on social costs and poverty reduction (Damari and Riazi-Isfahani, 2016).

The office of the United Nations High Commissioner for Refugees (UNHCR) is an international institution, which has the international responsibility of providing assistance in the field of health and health insurance to refugees (UNHCR, 2012). This office works in close cooperation with the Bureau for Aliens and Foreign Affairs of the Ministry of the Interior (MOI), and MOHME (WHO, 2010).

2. Research methods

2.1. Data collection

This policy document analysis attempts to examine the legal documents of the country on financial support to the poor in access to health services. The SNA approach was selected to analyse the legal obligations. The researchers searched the healthcare system laws in Iran. These included the Islamic Parliament Research Centre database, National Database of Health Laws and Regulations, the National System of Laws and Regulations of the Islamic Republic of Iran, the country's official newspaper, Plan and Budget Organization rules, the database of the government, and also the national laws related to financial support