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Establishing Medicare-Based Hospitals: A Step Towards Equitable Community Access to Comprehensive Healthcare Services in Iran

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Dear Editor,

Iran's healthcare system has achieved near-universal nominal coverage through more than 24,000 primary health centres and an extensive hospital network (1). Yet, persistent inequities in access, quality, and financial protection — especially for rural, low-income, and minority populations — prevent the country from reaching true universal health coverage (UHC). We propose the creation of Medicare-based hospitals: Publicly governed and predominantly publicly financed secondary-care facilities that provide affordable, protocol-driven inpatient and specialised outpatient services with minimal out-of-pocket (OOP) payment. For clarity and to avoid confusion, Medicare-based hospitals are not a new insurance scheme, not a substitute for primary care networks, and not intended to replace existing tertiary or university hospitals. Instead, they constitute a distinct tier of secondary hospitals with standardised financing, mandatory accreditation, digital records, and performance-based payment adapted from selected principles of the U.S. Medicare programme but universal in eligibility and Iranian in governance.

Healthcare Challenges in Iran

Iran's 89 million inhabitants (2024 estimate) are predominantly working-age, ethnically diverse, and increasingly affected by non-communicable diseases. Despite progress, infant mortality stood at 12.4 per 1,000 live births in 2020 (national estimate) (2), and approximately 7 - 15% of households face catastrophic health expenditure annually (2018 - 2022 national surveys) (3, 4). Rural areas suffer from specialist shortages and lower hospital accreditation rates (only ~30% of hospitals fully accredited in 2022) (5). Economic sanctions continue to disrupt supply chains and hospital finances (6). These systemic gaps collectively justify the need for an alternative hospital model with structural reforms in financing, governance, and quality standards.

Medicare-based hospitals would address these gaps through three interconnected domains:

- Financial protection → capped or zero OOP fees at point of service, funded by general taxation and earmarked insurance contributions
- Quality improvement → mandatory accreditation, clinical pathways, digital records, and pay-for-performance → lower preventable readmissions and complications
- Equity enhancement → deliberate geographic placement in underserved provinces and culturally adapted services → reduced rural–urban and ethnic disparities

Thus, the theory of change is: Stable public financing → predictable revenue and enforced standards → higher and more uniform quality → increased trust and utilisation by vulnerable groups → measurable reductions in financial hardship and health inequities.

Expected Benefits

- Reducing financial barriers to care: By shifting most costs to public sources, Medicare-based hospitals could eliminate the bill-related deductions that affected 20% of inpatients in a 2021 Tehran study (7).
- Enhancing and standardising quality: Rigorous accreditation and performance incentives could lower

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the current 15% 30-day cardiovascular readmission rate observed in many urban centres (8).

• Narrowing disparities: Strategic location in rural and minority-dominated provinces, combined with incentives for staff retention, would improve access for populations currently underserved.

Implementation Considerations and Challenges

- Successful rollout would require:

• Blended financing (government budget reallocation (~10% of current hospital expenditure for pilots) plus contributions from existing insurance funds;

• An independent national accreditation and performance board;

• Mandatory interoperable electronic health records;

• Expanded training programmes and rural incentive packages.

Beyond financing, critical challenges include severe shortages of cardiologists, oncologists, and nurses; limited training capacity outside major cities; technical and legal barriers to full EHR interoperability; and ongoing procurement difficulties caused by sanctions. These constraints demand phased implementation and creative domestic solutions (e.g., task-sharing, telemedicine, local manufacturing partnerships).

Potential Counterarguments and Rebuttals

Critics may worry that introducing Medicare-based hospitals risks creating a fragmented dual public system, expanding bureaucracy, or failing to maintain quality in remote areas. While these risks are real, they can be mitigated by clear legal demarcation of roles, time-bound performance contracts, and independent oversight — mechanisms successfully used in Turkey and Thailand. The far greater risk is perpetuating the status quo of inequity and financial ruin for millions.

Lessons from Comparable Middle-Income Settings

Turkey's Health Transformation Program (2003 - 2013) achieved 99% insurance coverage and sharply reduced OOP spending through unified purchasing, hospital autonomy with performance contracts, and heavy investment in rural facilities despite initial fiscal constraints (5). Thailand's Universal Coverage Scheme similarly used capitation and quality bonuses to halve catastrophic expenditure within a decade (3). For Iran, the Turkish model of performance-based hospital payment and the Thai emphasis on rural upgrading appear transferable, whereas full market-style competition or large foreign loans are not feasible under sanctions.

Novelty Relative to Existing Iranian Reforms

Iran has experimented with public–private partnerships and "self-governing" hospitals, but these initiatives retained fee-for-service incentives and voluntary accreditation (4). The proposed Medicare-based model differs by mandating population-based budgeting, compulsory accreditation, and digital integration — features absent in prior reforms.

Monitoring and Evaluation

Pilot sites should be evaluated annually using: (1) Financial-risk protection (incidence of catastrophic and impoverishing expenditure), (2) quality (risk-adjusted readmission and mortality rates), (3) equity (utilisation rates by province and ethnicity), and (4) efficiency (cost per disability-adjusted life year averted).

Ethical Considerations

Because resources are scarce, explicit and transparent priority-setting criteria will be essential. We recommend including representatives of rural and minority communities in governance bodies and using evidence-based cost-effectiveness thresholds to guide service packages.

Conclusions

Medicare-based hospitals offer a politically and technically feasible pathway to strengthen secondary care, protect households financially, and reduce geographic and social disparities. Success will, however, require sustained political commitment across the ministry of health, insurance organisations, and Parliament, as well as careful management of the workforce and procurement challenges described above. We urge the immediate launch of province-level pilots accompanied by robust independent evaluation.

Footnotes

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