

Original Article

A governmental model for special patients

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ABSTRACT

Background & Aim: Over the past decades, due to the high acceptance of patients in hospitals, the consequent relapse of the disease, the high cost of treatment and medication, the lack of coordination between the provision of hospital services and the needs of the community, the necessity of paying attention to the status of special patients and conducting a study for designing a suitable model in the country has been increased.

Methods & Materials: This research is descriptive-correlation-exploratory and the data were collected through qualitative and quantitative methods. The research sample involves 392 persons in the quantitative section and 20 in the qualitative section. The research instrument was an open-ended questionnaire and a test; the data were collected using cluster sampling.

Results: A total of 7 factors were identified as the final model of health management services for special patients, including: policymaking and load factor planning (0.72), organizational structure (0.63), government intervention methods in financing (0.81), control mechanism (0.88), government intervention in the affairs of special patients (0.79), pharmaceutical and therapeutic support services and medical aids (0.69), and educational support and prevention services (0.68). Also, the fitting of the designed model is 0.027, indicating appropriate fit for the model.

Conclusion: Providing health services to patients by government has a significant role in the patient health services management, and prevention-based education, identification of primary risk factors, and preventing the epidemics and applying the pattern of health services management to special patients with all dimensions and emphasizing the effective role of government control over the provision of services can lead to presenting executive strategies over time.

Introduction

Over the past few decades, particular attention has been given to the caring for special patients in the healthcare systems. The high acceptability of these patients in hospitals, sequential recurrence of illness, high cost of treatment and medicine, lack of coordination between hospital services and community needs, severe pressure of special patients on the family

and the patient family's dissatisfaction with the quality of available services, introduced the need to pay attention to the status of chronic psychiatric patients (1). To overcome or minimize these problems, Tenhoor and Turner (1998) introduced the social protection program (community). The program stipulates that special patients need more services than health care services, and they can live well in the community if they have comprehensive services (2). The purpose of social support is the capability and quality of communication with others that provide resources in the right circumstances. Two social support models have been investigated in an attempt to understand the role of social support and its impact on health

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and well-being (3). Social support is effective through two major processes in controlling diabetes: the direct impact of social support through two major processes is effective in controlling diabetes. The direct effect of social support through health-related behaviors, such as encouraging healthy behaviors and the shield-like effect, such as social support, helps to alleviate the effects of acute and chronic stress on health and also increases the adaptation to the nervous stress of diabetes (4). Morse, Bottorff, Neander & Solberg (2011), in the study of nursing texts, found that the two concepts of care and support are similar in some respects and different in some cases (5). Experts say that the meaning, scope and method of applying patient support have not yet been explained to patients and nurses. Gardner and Wheeler (1981), reviewing clinical research on support, say that support is a more detailed concept of care. Their findings showed that the meaning of support and its process should be further investigated. Thus, the studies show contradictory results in comparison of these two concepts; and further studies in this regard are recommended in order to achieve a clearer understanding of the concept of support. There are also many deficiencies in this area, in spite of some support provided by some popular organizations as well as government assistance. The health minister emphasizes that 7% of people every year go below the poverty line because of the high cost of treatment, but it can be easily predicted that the proportion of special patients in these 7% is high, because the cost of treating a certain disease is very high and incomparable with other diseases, and it continues until the end of life, and the total amount of governmental and nongovernmental support, though, is not such that it cannot make the special patient financially unconcerned (6). These patients are often concerned about the unpredictable future and the imbalance in their lives due to their type of illness. They often have financial problems, various costs of treatment and travel to health centers, drug provision and etc. are considered as the main effects of the disease on them. Occupational issues are other problems that these patients face; as a result of illness, these patients are confronted with loss of employment or reduced occupational, educational, family activities, and loss of economic security and social status, which, due to the increasing costs

of life, has adverse consequences for the patients and their families (7). Studies in this field show different methods of governmental and non-governmental support for special patients. Barry & et al. (2006) in a study dealt with "presenting a policymaking model for assigning subsidies to certain medications using the dynamic systems approach." In that research, first, the key variables that express the structure of the system to a large extent are identified, and their relationships are formulated in the form of causal and impulsive circles. These variables are divided into endogenous and exogenous types. Then, the dynamic structure of the system is simulated with designing the main model in the form of the accumulation-flow chart in the software. By implementing the model and analyzing the sensitivity and developing the necessary policies, it will be clarified that with what combinations and what changes in the extent and the requirements of the system variables, the best possible conditions can be achieved which would include patient satisfaction and economically reduce the governmental expenses (8). 1- Examining the impact of social support on the ability to cope with cancer, Lorenzo & et al. (2010) found a direct and significant relationship between social support and the ability to cope with breast cancer. Also, each of the independent variables studied - namely, tangible, emotional, affective, informational, and emotional support along with positive social interactions, as well as the support of formal and informal sources and family support has separately a direct and meaningful relationship with the patients' ability in dealing with the illness (9). 2- Studying the need for supportive care and its relationship with perceived social support for cancer survivors, Faghani Aboukhalili et al. (2014) found that cancer survivors perceive high social support, and receive the highest levels of support first and foremost from the family, and then from certain individuals. As social support increases, the need to supportive care in all aspects will decrease (10). 3- Ali Pourbaghi (2012) in studying the role of social support in improving the quality of life in hemodialysis patients found that patients enjoy more emotional support than other types of support. Respondents also emphasized the priority of family as a source of social support. This research confirms and reinforces the theories in previous studies on the role of social

support in improving the quality of life in hemodialysis patients (11). Therefore, given the harmful effects of special diseases on the patients and the affected families, and given that special diseases have a wide impact on the individual's physical and psychosocial ability in coping with the disease in this research, it will be tried to identify the deficiencies and strengths and weaknesses of the supportive models for the special patients in Iran, while taking into account the patterns of other countries in this field and adapting the supportive patterns of the advanced European and American countries. Therefore, according to this approach, the most important questions of the research are:

- What are the governmental support areas for special patients in the health system of Iran, and which countries are studied?
- What are the variables associated with policymaking and planning of government support for special patients in the country?
- What are the variables associated with the organizational structure of government support for special patients in the country?
- What are the variables associated with financial governmental support for special patients in the country?
- What are the variables associated with the control mechanism of the governmental support for special patients in the country?
- What is the proper pattern of governmental support for special patients in Iran?

Methods

The main objective of this research is to design a model for governmental support programs for special patients in Iran. Therefore, this research is a descriptive-correlation, exploratory type and the

method used is survey. After studying the theoretical foundations, the research was designed based on similar studies and research models. The statistical population of the study includes all professors (faculty members), managers, and health care management experts of the country and the organization for the protection of special diseases. Given the fact that the number of statistical population is unclear, and with an approach to the sample size chart for Krejcie and Morgan, which sets the standard sample size for uncertain statistical societies to the infinite number as many as 384 (12), a sample of 384 people was estimated. The research instrument was a researcher-made questionnaire consisting of 77 test items with Likert scale. In order to investigate the validity of the research, the researcher, referring to the viewpoint of experts and professors, ensured the validity of his instrument for measuring the variables of the research (formal validity method) and in order to measure the reliability, a pre-test was performed with 20 samples. The obtained data were analyzed using Cronbach's alpha method, the method of retest analysis and reliability of the appropriate research instrument were evaluated as proper. Finally, after ensuring the validity and reliability of the research instrument, the questionnaires were distributed among samples. To collect data, cluster sampling method was used due to the wide range of research areas and time and cost constraints. After collecting data from samples, using SPSS and Amos software, the data were analyzed and the research results were presented in two descriptive and inferential levels.

Results

Findings related to the scope of government-

Table 1. Comparison of areas of support for special patients in the studied countries

Areas	Countries	The U.S	Italy	Sweden	England	Iran
Financing types	Payment mechanism to providers	General (global) budget	General budget	General budget	General (global) budget	General budget
	Supervisory style of budget expenditures	By the federal health ministry	Government	By the local government	Regional health departments	Government
	Financing coverage Methods of providing the required funds	45 percent Through indirect taxes and popular contributions	100 percent Health services, Sunny Tortoise system	100 percent Tax revenues, centralized remittances and patient premiums	100 percent Through taxes and popular contributions	Providing 85% Through the tax, the annual government budget
	Distribution methods of service financing	Decentralized	National, state-centered	Centralized regionalization	Centralized	Through the provinces and in a decentralized way

Table 1. Cntd

	Macro structure of custodians of the special patients health	Public sector, Medicare and Medicaid	Public sector health and treatment services	Non-governmental organizations-districts-local communities	By NGOs and NHSs	Ministry of Health, NGO, committee on the control and prevention of special diseases
Organizational and managerial structure	How other organizations contribute to support special diseases	Public and nongovernmental assistance	National health fund - regional health services agencies	Public and nongovernmental assistance	Governmental, private, charity	Public and governmental assistance
	How to use government assistance to get support for special patients	Governmental	Private governmental	Central government	Trust and NGO	Special diseases control and prevention center
	Organizational structure of special patient protection organizations	Governmental and private	Governmental and private	Governmental and private	Government and charity	Governmental and private
	How to provide health care services to special patients	Decentralized	Decentralized	Decentralized	Decentralized	Mixed
	Level of implementation of special patients support programs	State under the auspices of the ministry	National - state decentralized	National - local decentralized	National decentralized	National - provincial
Steps to control and monitor the implementation of programs	Organizing method of government grants	Medicaid control center	Ministry of health	Ministry of health	By NHS trusts	The center for special disease control and prevention
	The level of control over the implementation of services	Medicare and Medicaid programs	Control at all levels	Control at the primary and secondary and third levels	Control at all levels	Secondary levels
	Service monitoring method	Decentralized	Centralized monitoring	Semi-centralized monitoring	Centralized monitoring	Decentralized monitoring

sponsored programs of special patients in the health system of the countries under study: In order to compare the policymaking of health services for special patients in Sweden, the United Kingdom, the United States, and Italy with Iran and to achieve a suitable model for managing special patients in the country, health systems of selected countries were studied in terms of organizational structure, planning and policymaking, financing and control mechanism, and the results are presented in Table 1.

Kaiser- Meyer- Olkin sampling adequacy index

This test, identified by the KMO abbreviation, specifies whether the variance of the research variables is influenced by the variance of some of the underlying factors. The value of the test statistic varies between (0) and (1). Based on the results of the KMO test, which is equal to 0.636 and greater than 0.6, the results of the Bartlett test (3850/895), which is at a significant error level of less than 0.5, factor analysis is permitted.

Table 2. KMO Sampling Adequacy Test

KMO		0.636
Bartlett test	Kai Scherver	3850.895
	Standard Deviation	2016
	Significance level	0.000

Exploratory Factor Analysis

To categorize the items among the factors, based on their factor load, the Rotated Component Matrix results should be used. This

Table 3. Rotational correlation matrix among items

	Factor load						Factor load				
	1factor	2factor	3factor	4factor	5factor		1factor	2factor	3factor	4factor	5factor
Q1	0.759		0.297		0.234	Q33		0.188	-0.137	0.180	
Q2	0.795	-0.150	0.104	-0.138	0.205	Q34		0.225		0.116	
Q3	0.583	-0.178	0.130		0.201	Q35	-0.306	0.228	-0.136	-0.153	
Q4	0.747		-0.112			Q36		0.458	-0.120	0.266	
Q5	0.504		-0.194			Q37	-0.216	0.470	-0.146	0.306	0.149
Q6	0.787					Q38	-0.300	0.421	-0.213	0.298	0.162
Q7	0.520		0.243	0.346	0.212	Q39			0.148	0.533	0.205
Q8	0.709		0.402	0.238		Q40	-0.110	0.291	-0.306	0.106	
Q9	0.615	0.216	0.156	0.362		Q41	-0.181	0.318		0.557	
Q10	0.680		0.453			Q42		0.213		0.339	-0.124
Q11	0.690				-0.211	Q43			-0.129	0.279	0.281
Q12	0.500	-0.102	-0.145	-0.108	-0.109	Q44	0.283				
Q13	0.186	-0.196	0.148		0.134	Q45	0.169			0.121	-0.150
Q14	0.221	-0.178		0.167	0.175	Q46		0.123	0.455		
Q15		0.150	-0.145	0.217		Q47		0.343			0.392
Q16		0.248	0.114		-0.215	Q48		0.225	0.318		
Q17		0.235	-0.192	0.102	0.218	Q49	0.138		0.246		-0.131
Q18	-0.208	0.292	-0.121	0.239		Q50			0.267	-0.173	
Q19					0.877	Q51			0.702	-0.285	
Q20			0.149		0.793	Q52	0.132		0.718	-0.470	
Q21	0.108	0.293	-0.102		0.468	Q53	0.306		0.815	-0.172	-0.114
Q22	0.213		-0.111			Q54	0.136		0.859		0.146
Q23	-0.346	0.265	-0.387	0.356	0.181	Q55			0.754	0.176	0.30
Q24				0.251	0.106	Q56	0.104	0.330	0.282		0.226
Q25		0.229		0.166	0.356	Q57	0.300	0.242	0.231		
Q26			0.220			Q58		0.799	-0.118	0.258	
Q27	0.215			0.483	-0.190	Q59		0.813			
Q28		0.182		0.760	-0.202	Q60		0.687	-0.260	0.229	
Q29				0.788		Q61		0.782		0.199	
Q30	-0.213	0.296	-0.249	0.715		Q62	0.103	0.437	-0.129	0.152	0.170
Q31		0.243	-0.251	0.170	-0.169	Q63		0.613		-0.157	-0.221
Q32	0.227			0.629	0.372	Q64			0.106		0.120

table shows the correlation matrix between items and factors after rotation, in which the correlation value varies between -1 and +1. Based on this table, the researcher, based on the largest factor load of each item, classifies them according to the degree of correlation with each other. Classification of variables (items) in factors is usually based on the first variable of the factors and its implicit meaning. According to the results of this test, all of the indicators of support programs to special patients in the questionnaire consist of a total of 5 main factors, and these factors explain and cover a total of 82.674% of the total variance of factors. Finally, 27 items and 5 factors were extracted.

Variable Factor Analysis of the type of Supportive Services for Special Patients

According to the results of the table, all the indicators of the type of supportive services for special patients in the questionnaire consist of two main factors and these factors account for a total of 73.528% of the total variance of factors

and cover it. Finally, 9 items and 2 factors were extracted.

As it can be seen in the table, the items and final factors of the research are categorized into 7 factors and 35 items.

The Structural Model of the Research

After confirmation of the measurement model and calculating the validity of the structure and diagnostic processes at this stage, one can test the relationship between the research structures. For this purpose, the model was implemented in AMOS software and, using the structural equation modeling method in Amos22 software, the relationship between variables was tested.

Considering that the root mean of estimating the variance of the RMSEA approximation error for the structural model of the research was reported (0.027) and it was less than 0.08, therefore, in order to use this structure in designing the structural model of the research and testing the hypotheses, there is no need for corrections and the model enjoys a good fit.

Table 4. Rotational correlation matrix among items

	Factor load			
	1 factor	2 factor	1 factor	2 factor
Q65	0.124		Q72	0.451
Q66	0.176	0.642	Q73	0.711
Q67	0.110	0.402	Q74	0.889
Q68	0.267	0.569	Q75	0.813
Q69	0.332	0.641	Q76	0.872
Q70	0.247	0.428	Q77	0.674
Q71	0.335	0.503		0.385

Table 5. Items and factors derived from exploratory factor analysis

Factor	Item No	Items
Policymaking and planning	1	Healthcare services policies for special patients at the national level
	2	Health service policies for special patients at the regional level
	3	Implementation of health care programs for special patients in a centralized manner
	4	Implementation of health care programs for special patients as semi-centralized
	5	Policies for health services to special patients in the health department of the Ministry of Health and Medical Education
	6	Policies for health services to special patients are combined, including: the Foundation for Special Diseases, the Health Department of the Ministry
	7	Planning of special patient services at the national level
Government intervention in the affairs of special patients	8	Planning of health services for special patients at the regional level
	9	Government
	10	Government and charity
	11	Ministry of Health and Treatment
	12	Ministry of Welfare and Social Security
	13	Welfare Organization of the country
	14	Special Diseases Foundation
	15	Health Insurance Organization
	16	Non-governmental organizations and associations
Financing practices	17	Taking financial and pharmaceutical assistance from foreign international organizations
	18	Assigning a percentage of doctors' income to support special patients
	19	Assigning a percentage of the revenues of pharmaceutical companies and medical equipment to support special patients
	20	Assigning a percentage of the social security organization's income to support special patients
	21	Assigning a percentage of the income of the NHS to support special patients
Control mechanism	22	Assigning a percentage of income to support special patients
	23	Welfare Organization of the country
	24	Medical Organization of the country
	25	A combination of service providers to special patients
	26	Ministry of Welfare and Social Security
	27	Representatives of the Judiciary
Types of support service	28	Providing auxiliary equipment for special patients
	29	Home care treatment
	30	Laboratory services
	31	Sanatorium services to special patients without a supervisor
	32	Pharmaceutical services
	33	Informing (publishing booklets, leaflets and health journals, making films and educational animations, etc.)
	34	Healthy lifestyle education and special patient care
	35	Health counseling

Statistically, the model can be perfectly reliable, and therefore, the hypothesis testing can be applied. Also, the relative chi-square ratio or the ratio of chi-square to the degree of freedom (CMIN / DF= 2.73), adaptive fit indices (0.95), and target indicators greater than 0.80 and RMSEA index (0.027) indicate usability of the model.

Discussion

Comparative studies on the comparison of government-sponsored programs for special patients in the health system of Iran and the countries involving Iran, the United States, Sweden, the United Kingdom, and Italy showed that policymaking at large-scale levels for all the affairs of special patients in the countries studied

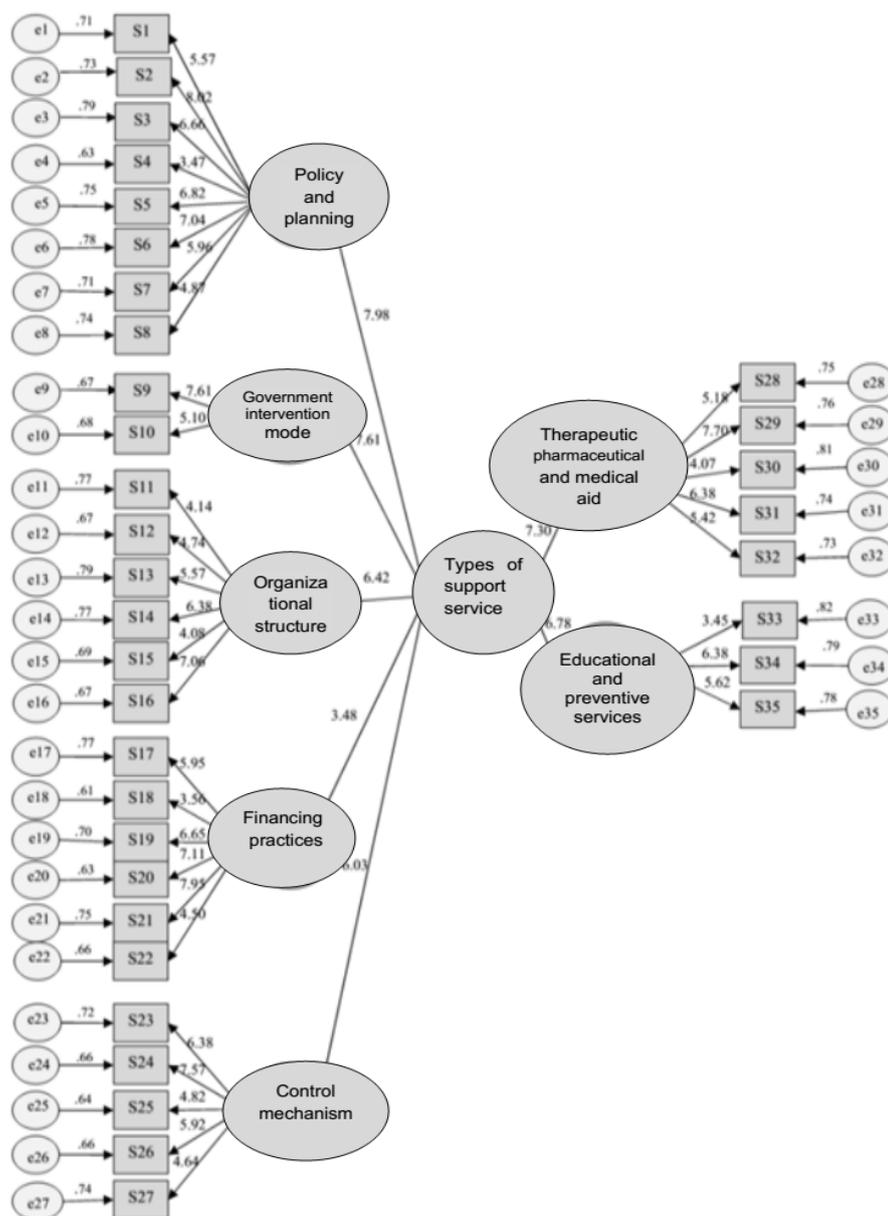


Figure 1. The final pattern confirmed by meaningful coefficients

is carried out by the Ministry of Health and Welfare or the highest health councils that are composed of representatives of ministries. In Iran, the Center for Transplantation Management and Special Diseases in the Ministry of Health, Treatment and Medical Education, which is not organizationally approved, is subject to carry out this responsibility with very high constraints. The responsibility of legislating and defining policies for the management of chronic diseases in the UK is entrusted to the Parliament and the Ministry of Health. Under the Social Care and Health Care Act 2012, the responsibility for

implementing all policies of the Ministry of Health was delegated to the National Public Service Agency. The National Health Service (NHS), which is responsible for determining the budget of the National Health Service, provides health care services through its subsidiaries and through its regional and local executive bodies to the individuals under its coverage. In the United States, private health insurance is often sold to workers through the work places to prevent reverse selection. The findings of the research regarding the policy making, planning and structure of the appropriate governmental

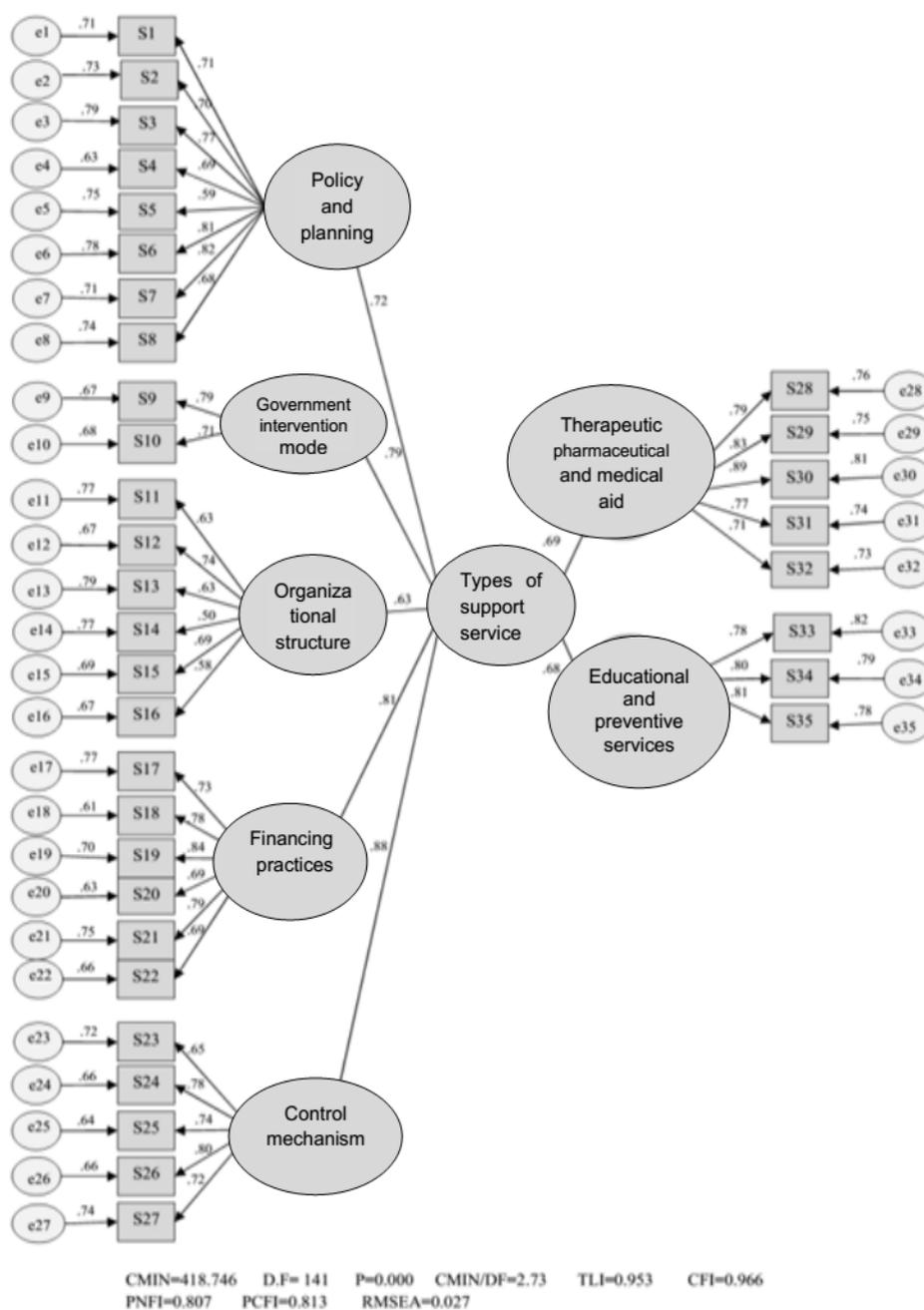


Figure 2. The final approved pattern based on standardized coefficients

support for special patients in the country show that the official position of special diseases at the level of the Ministry of Health, medical treatment and education, is at the Department of Health and at the Centre for Neuropathic Disease Management. In 2015 the National Committee for the Prevention and Control of Non-Infectious Diseases was established. The task of this center is prioritizing, policymaking and planning at large-scale levels of the country for non-

transmissible diseases. The committee began to act as a government agency and is interacting with the private sector and charity associations in the field of chronic diseases. The Ministry of Health and Medical Education is responsible for policymaking in the health sector nationwide, and then it is sent to the medical universities. The provincial planning committees, according to the plans of the subsidiary counties, set up the provincial plan and submit it to the planning

committee (health care department). Section committees regulate the overall program, but detailed and executive planning is carried out in the regions and provinces. The findings of this study showed that, from the point of view of the elites and the sample individuals, considering the state of the health system in Iran, the policies for healthcare services to special patients at the national level is more appropriate. It is also advisable to decentralize health care programs for special patients. In the results of the Bighole's study (2011), the necessity of designing a pattern conforming to the conditions of the country is mentioned. However, many studies have confirmed that many of the special diseases are not detected, and even after the diagnosis, they are not treated sufficiently. In the present study, the necessity of designing a model for the management of special patient services has been mentioned and in this regard, a functional model was designed considering the regional conditions of Iran. It is also necessary to educate and inform a healthy lifestyle and awareness of the risk factors of certain diseases and contagion in the community. On the one hand, according to Danz (2001), the problem of certain non-transmissible diseases in Southeast Asia has become an epidemic, which is due to an increase in tobacco use, unhealthy diet, and inadequate physical activity. The cost of treatment for these diseases is often high and deprived families suffer most from financial losses and sometimes death; and despite efforts to control and prevent diseases and focus more on primary health interventions, redesigning health service management to special patients seems essential in the healthcare systems and the need for government intervention and the importance of lifestyle and primary health care and an effective referral system and national policymaking have been considered in this research. Research findings also show that planning, policymaking and taking measures for special diseases require interparty participation, appropriate legislation, healthcare reform and cooperation with nongovernmental organizations, industries and private sector. The need for active involvement of Health-related organizations has been mentioned in the proposed model. Also, the results of the study are consistent with the results of Meter (2008) research on the importance of planning and policy making and assessment for preventive

measures; this is evident in all of the World Health Organization's codified strategies as well as national policies and programs which illustrate the existence of a comprehensive guide at the national levels. The findings of the study indicate the importance of providing services in a decentralized form and in line with regional needs, under the auspices of the major policies of the Ministry of Health; from this dimension, it showed alignment with Aloti (2011) and from the viewpoint of the importance of focusing on the prevention of special diseases, it was in line with the results of Wagley (2007) and Lee (2007). In this regard, in a study conducted in South Asia by Mawosi (2009), the need for policy-making at the macro level aimed at integrating preventive plans and management of the risk factors for non-transmissible diseases and AIDS has been highlighted and the establishment of a national health system in this way has been emphasized. In the present study the above factors are also mentioned.

About the financing methods of special patients in the country, it should be mentioned that the government usually carries it out by collecting the government and private subsidies and allocating it to the Ministry of Health as a general budget through the Parliament. Therefore, the financing of the Committee for the Prevention and Treatment of Special Patients is carried out by the government. Considering the findings of the research and the necessity of providing health services to special patients and the high volume of patients and the increasing number of these patients, it is important to provide these resources from the state taxes and receiving no franchise from special patients, and it continuously requires the government interference and presence in this regard which is in line with the research results of Paul (2016). In his study in the United States, he considers the achievement of three goals of health care, health and cost reduction as necessary for promotion of the health care system.

In the present study, the importance of discussing the control mechanism of government support for special patients and the necessity of participation of all the involved organs were mentioned. From the elite's point of view, the best way to control supportive services for special patients is to use a combination of representatives from the Ministry of Health, the Welfare Organization and the Special Patient

Affairs Foundation. In this regard, in a study by Zarshenas (2007) aimed at developing nursing standards, the necessity of planning for control at the level of the ministry and the participation of all members involved in nursing including nursing management and data collection manager in hospitals were mentioned. In the present study, the active participation of organizations of the Ministry of Health and Medical Education, the Health Committee of Non-transmittable diseases, the medical system and a combination of organizations providing health services to special patients have been mentioned; since the hospitals are the most important centers for providing services to special patients and require a single protocol for monitoring and controlling, and all of them have also been referred to in our study, they are aligned. Finally, according to the research findings, the following practical suggestions are presented:

– It is suggested that the health policy of special patients be conducted at the national level and in a centralized manner, but the provision of special patients care services should be decentralized.

– It is suggested that the composition of the members of the health committee for special patients include representatives of the following organizations and institutions:

– Special Patients Affairs Foundation, Ministry of Health and Medical Education, Ministry of Welfare and Social Security, National Welfare Organization, Health Insurance Organization, and NGOs.

– It is suggested that the health policymaking for the special patients be carried out in the presence of the representatives of the Ministry of the Interior, the Foundation of Special Diseases and the Ministry of Health.

– It is suggested that services provided to special patients involve services for all three levels of prevention, including: vaccination, healthy lifestyle education and caring at the disease period, distribution of health books, health counseling, health check-up services for the early diagnosis and treatment of certain diseases, provision of auxiliary equipment for special patients, laboratory services, home care and treatment, pharmacy and sanatorium services.

– Financial resources for healthcare services to special patients are proposed to be provided

by tax, premium, state subsidy, charitable contributions, NGOs, and sources of investment and technical and financial assistance from international organizations.

– It is suggested that health care services be provided free of charge to vulnerable special patients at all three levels of prevention.

– It is advisable not to receive medical care franchise from special patients whose illnesses are improved and their treatment costs are high.

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Conflicts of interests

The authors declare that there is no conflict of interest regarding the publication of this article.

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