EXAMINING THE CURRENT STATUS OF HEALTH INSURANCES AND THEIR ROLE IN PROMOTING HEALTH (CASE STUDY: ESFAHAN PROVINCE MEDICAL SCIENCES HOSPITALS)

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ABSTRACT
One of ideal goals of each health system is providing appropriate setups of financial security for supporting families at the time of requesting for health services. Access to health services is among main rights of people in societies. Public coverage of health insurance with reduction of financial obstacles is one of the most important strategies for access to health services. The main aim of performing this study is to examine the current status of health insurances and their role for promoting health. The research method is applied- descriptive that analysis was conducted by distributing scholar-made questionnaire in the statistical population of the present study including all personnel and experts of health insurance and the sample volume corresponding to the statistical population is 350. A glance at previous research shows that the performed studies in this section have generally been case studies and their used tool for assessing health or illness has noticed a limited dimension of health and a special type of illness. Findings of these studies have often obtained based on personal information of the inquired person that performing objectivist studies is necessary due to lack of reasonable and assessable recorded information. In explaining the results obtained from this study, we can say that the more the emphasis on mandatory insurance coverage of population, that is a condition is created where all people of society are forced to be covered by insurance for using treatment services of various treatment centers and hospitals, the more will be the rate of using people from treatment health services and as a result, this will cause promoting health of the society.

KEYWORDS: insurance, health promotion, health system, illness.

INTRODUCTION

Today, many social services and institutes are provided based on private plans and employment- oriented insurance plans. In insurance affairs, complementary treatment insurance is a typical sample of such cases. Since domain and level of base (public) insurance is reducing and needs are increasing, studying complementary treatment insurance has a great significance.

One of optimal goals of each health system is to provide appropriate setups of financial security for supporting families at the time of requesting health services. High cost of health services is as costs spent for health services which go beyond a determined level of family income (often 40% of income) (Akman, 2007). This volume of family income for receiving health services could threat life standard level in short term and lone term, so that in short term family should ignore current uses of other stuff and services and in long term some consequences like sale and auction of properties, spending saving and or accumulating debts are expected for the families (Vagstaf & Vadorsel, 2003). During two past decades, all countries have experienced some considerable challenges in the domain of insurance systems. Survey in experience of other countries indicate that weakness, inconstancy, variation and crisis in the era of insurance system, besides creating many negative political, social and cultural consequences, has also caused posing very heavy financial load on the mentioned countries economy. Deliberation in these experiences has highlighted the significant role and position of health and insurance system stability and its undeniable impact on macro economy stability and also effective implementation of economic development plans (Renbao, 2004).

New venturesome factors emerge which makes very difficult access to health that according to Nezami, is the very comfort continent and in today interpretation, is the very complete physical, mental, social and spiritual welfare. Since new changes have created new needs. For this purpose, in this paper the author aims that besides defining health insurance from different views, examines existing weaknesses, strengths and challenges and also has briefly pointed to Iran position in the fourth and fifth development plans. It should be mentioned that this article is a descriptive study which addresses health insurance status in Iran and Iran access to the position which has been defined in the fifth development plan (outlook document of Islamic Republic of Iran in 20 years future horizon). For maintaining and promoting peoples health, we require some strategies for assessing health status and its record. Today, health is introduced by governments as a natural issue in social, strategic and economic aspects. The aim of generalizing health and treatment to public should be determined based on obviating discrimination between various groups of the society (Raja pour, 1998). And here the range of providing treatment services more than being considered a commercial means, is enumerated a main right so the society is obliged to provide its minimum.

For assessing peoples health paying attention to criteria introduced by world health organization is necessary. Information should be reasonable, recorded and pursuable. Using this information, the number of patients and as a result the studied society rate of request for treatment and health r restoration is revealed , various treatment shortages and health threating factors in that special society are identified and the possibility of providing required approaches for opposing with this issue in each respective organization is provided. Enjoying social security in respect of retirement, unemployment, senescence, being disabled, being derelict, staying in the way, accidents and adventures and requirement of health and treatment services and medical cares as insurance and so on is a public right. The government is bound to supply the above supports and services for all individuals according to rules from public incomes and revenues obtained from people participation (principle 29 of Iran constitution).

The present study has merely noticed the universal subject of health insurance and avoids entering other aspects of supply and social welfare and aims to examine suitable criteria for implementing health basis for reaching public coverage of insurance universal plan and assess them based on priority. According to the previously mentioned cases, it is expected that by performing this study, a complete version is provided to the extent of researcher potency for better establishment of health basic insurance and its role in promoting health in the country.

Main variable of the present study has been considered as current status of health insurances and dependent variable is health promotion. Main aim of performing this study is to examine current status of health insurances and their role in promoting health.

Theoretical fundamentals
Insurance is a contract during which an impendent risk which may occur for properties - an activity or a person's life is transferred to the insurance company by means of which financial loss due to that risk is compensated. In this process, the person who transfers the risk is called insured and the acceptor of risk is called insurer. The insured pays money to the insurer which is called premium and the subject for which the insurance contract is concluded is called subject or case of insurance.

The insurance is divided to various types based on our view on legal basis – objectives and regulations. In a division, the insurance is divided to two general types: a) social insurances, b) commercial insurances.

Health insurance: treatment insurance or health and treatment insurance is a type of insurance which accepts paying or imposing various costs of health and medical services including health promotion, prevention , treatment and rehabilitation of insured people. In other words, the arrangements whereby the insurer based on clauses of the insurance pays given amounts of money for compensating hospital and surgery costs due to illness and accidents to insured is called health insurance or treatment insurance (Zareh, 2003).

In Iran, health insurance is wrongly called treatment insurance, the reason of which is incorrect translation of the word health which is here translated as treatment and this is an event which has occurred in translation of many terms such as ministry of health and treatment and world health organization and so on. The countries health system has 4 determined tasks: 1) trusteeship of applying the government governance, 2) producing resources (physical and human), 3) supplying financial resources, 4) preparing health services (Zareh, 2003).

* The process of enabling people to increase control on determinants of health and as a result health improvement.
* The occupation of health promotion has been created in line with and in response to international movement of health promotion and wider new movement of general health (Vafaei Najjar, 2004).

Health and treatment Insurance system of Iran like many developing countries is of public insurance type. Various evolutions are among features of Iran which has led to non-formation and inconsistency in health and treatment system. In other words, countries still haven't been able to identify and find their suitable structure and organization. On the other hand, span and diversity of population in the country has always created the problem of access to and establishment of justice in using resources for different people especially in villages.

Stability of developing health and treatment networks in various regions of the country, despite growth of population, has created problems of physical, geographical and financial access whether in health or treatment sector in Iran society and caused spending many costs from people pocket (Khaleghnejad, Tabari et.al, 2000, 27-39).

In Iran, private and governmental sectors undertake providing various health and treatment services beside each other, but mainly the governmental sector and especially ministry of health, treatment and medical education has more contribution in this field. More than 70.9% of the state treatment institutes are dependent to universities of medical sciences which are operating under supervision of ministry of health and treatment and 18.8% of total treatment institutes are held by private sector. Extension of social and medical services insurances has been under consideration since at least 3 last decades in Iran and has enumerated among duties of insurer organizations. This matter has also been specified in constitution of Islamic Republic of Iran (clause 6 and 10) and also in laws like third development plan law, its full implementation has been empathized (Vafanajar, 2011).

High diagnostic and treatment costs and generally increasing growth of these costs in one hand and high existing difference between tariffs of medical services in two governmental and non-governmental sectors, on the other hand, have created a condition which decreases the economic motivation in the field of activity in treatment insurances section, since if people don't have any tendency to use complementary treatment insurances, it is due to expectation of receiving services with higher quality and along with other lateral services and non-requirement of staying in turn and such conditions that such services more exist in non-governmental sector that the services tariff in this sector is very higher than governmental sector. So, in case of existence of tendency to privatization of treatment insurances, its prerequisite will be firstly, existence of an active private sector in providing treatment services with high quality and secondly, making a logical balance between per capita rate of treatment premium with real medical tariffs (Hajinabi, 2012, 207-213).

The main philosophy in determining complementary treatment insurance is to create the possibility of insured use of private sector treatment facilities and mainly non-governmental hospitals so that in propylaeum of each section of persons insurance treatment recompenses in these insurance companies, the name of hospitals parties of their contract is seen which are mainly private and sometimes sub-specialized hospitals. In these insurances, firstly only hospitalization services are covered and also for costly diagnostic services specified and defined criteria have been provided that for coverage higher than this payment extent, either premium should be more than

this extent or this cost should be supplied by the person himself.

GDP rate specified to health sector in Iran is 5.5% and GDP per capita is 1525 $ and the government share in paying costs of health sector is 46.3% and the private cost is 53.7% that form this rate 50.9% is paid from pocket. The government pays 119$ FROM 258 $ costs for each person. Ministry of health, treatment and medical education undertakes the responsibility of the state health. Besides providing health services, this ministry undertakes the responsibility of training medical specialized forces, too. Ministry of health, treatment and medical education performs its activities through Universities of Medical Sciences throughout the country. Supervision on services quality on behalf of ministry of health and treatment exists especially about hospitals and in case of existing some points; it is performed in other activities.

High council of treatment services public insurance performs important activities about insurance activities in the country in treatment activities through insurance organizations. The list of drugs and covered services is performed yearly by ministry of health, treatment and medical education. The tariff of treatment services is determined with common cooperation of management and planning organization and ministry of health, treatment and medical education and is approved in council of ministers and the organization of treatment services insurance and social security organization and treatment services insurance organization of armed forces do insurance activities in the country. Imam Khomeini relief committee, welfare organization and several institutes in the country perform supportive activities. Moreover, commercial insurance companies, banks, Oil Company and Tehran municipality provide insurance activities for their personnel. Since August 2002, following approval of private insurance companies law, several companies have started their activities in the country. Insurance companies of Alborz, Dana, Iran, and Asia mostly operate in the format of complementary treatment insurances. As it was mentioned, among examined countries, Islamic Republic of Iran has designated the leas share of GDP to itself. This is while this status is not so appropriate. If we consider the index of the government share in paying costs of health sector, Iran has the least participation among the mentioned countries, in other words, in Iran less than 47% of costs are paid by the government and more than 51% of costs are paid by users. The above cases clearly indicate necessity of increasing GDP assigned to health sector in the country. If we look at this issue in the aspect of basic treatment insurance, low credits of the government, the rate of preferences committed by the government and consequently the state treatment insurances which have a governmental nature have reduced and besides increasing payment from the patients' pocket, this issue creates serious problems in needy groups. Generally, the insurance principle is based on participation process. In

participation viewpoint, everybody should take steps for advancing predesigned objectives in their potency extent. In the industry of health and health services insurances, the objective is providing the conditions for living with higher quality. This fact that in view of world health organization, criteria of qualitative life on literacy level, infants' mortality and life expectancy is an integration of the society culture participation for achieving a long life. It is obvious that in this regard, everyone regarding his responsibility, in his turn takes step in this direction. If the insurance industry and especially treatment insurance is treated in line with this health industry and as one of its complementary parts, we will believe in necessity of division and in other words, leveling of services means separation of service levels in respect of requirement not in respect of service providers. Generally, the existing service gap in basic insurances and in fact gaps which exist in access of insured to services, create this need that the insured supplies some services from other sectors and complementary treatment insurance has covered this service gap as a bridge and this principle is the root of shaping complementary insurance systems in the countries.

According to studies which have been performed in the country and abroad, like Kabir et.al (2015) by examining health file and recording services provided in centers executing family physician plan and rural insurance in Iran North villages, researchers believe that one of main duties of family physician plan is forming health record and registering all provided services. According to Karimi et.al (2015) supportive treatment health insurances is one of the most important methods for providing health services for people. Regarding the experiences of various countries in this field, the aim of performing this study is comparative survey of supportive treatment health insurances in selected countries. Sedighi et.al (2013) performed a study with the aim of examining effective factors in establishing health basic insurance in Iran. Raghfar et.al (2013), in a study under the title of the impact of treatment insurance system inefficiency on the state families poverty which has been published in Hakim Journal, have examined the impact of health costs on families poverty using micro data of cost- family income. Raeisi et.al (2013), the insurance organizations are among the most effective organizations in health system which may lead to promotion of effectiveness, efficiency and patients' satisfaction through disconnecting financial relation between the provider and receiver of service. Regarding that the current organizations of health insurance in the country are far from definitions and high objectives of health insurance in the world, this study has been conducted with the aim of providing some approaches for qualitative and quantitative promotion of Iran health insurances. Moshiri et.al (2012), 2008 report of world health organization, by analyzing present evidences during several decades, suggested extension of primary health cares for advancing citizens health, more justice and less costs. Ghiasvand (2011) believes that one of

favorable goals of each health system is to provide appropriate setups of financial supply for supporting families at the time of request for health services. By examining the law of electronic transfer and response of health insurance and polling the possibility of implementing it in Iran, Asadi et.al (2011) believe that healthcare is noticed in human societies as one of main human needs and treatment insurance is the most suitable option for enjoying people from healthcare. But today, various treatment insurances encounter some problems.

400 questionnaires were distributed among the considered sample by cooperating some of questioners and using SPSS software, the collected data were analyzed. Based on the software findings, besides that there is a considerable correlation between all research variables, the results obtained from regression showed that the first effective factor (the greatest factor) belongs to age factor that old people satisfaction was more than youth (age variable, 0.51). Married people satisfaction was higher than single ones (married variable, 0.26); the way of contacting with the insured (0.21), awareness variable was about 0.14. Type of insurance was effective 0.08, so that users of optional insurances have more satisfaction comparing compulsory insurance. Also, the results showed that ease of access to services is effective about 0.05. Totally, the rate of satisfaction of people covered by treatment and insurance services was observed medium to low. Nakheie, A ghmioni and Kamoie (2010), in a study examined and estimated private treatment insurance request function in Iran urban regions and Tobit analysis was confirmed. The aim of this paper is to estimate the function of private treatment insurance request in Iran urban regions. Regarding the existence of censored data, estimates are done in the format of Tobit model. For evaluating the intensity of dissimilarity variance, the demand model was estimated based on quintile regression (Powel estimator) and the differences between factors acquired for various quintiles and simple model factors are used. Also, comparing confidence distances obtained in Boot-Strap method with confidence distances in Tobit estimate shows venial impact of dissimilarity variance. Income attraction for private treatment insurances is positive. Users consider treatment- social insurances as a replacement of private-treatment insurances. Family request for private treatment insurances is a function of family warden age and supposing stability of conditions maximizes in the level of 55 years old. A similar status exists about the relation of family warden education level with request and master's degree leads to maximizing private insurance request. Wealth has a positive impact on the request for private treatment insurances. The results of estimates show that the request rate for private treatment insurance is shaped based on families prediction of treatment costs. Among other results is more request in families with retired warden despite their having public treatment insurances that could be a sign of superior quality of private treatment services comparing their public counterparts. Safdari et.al (2010) in a study

examined comparative study of payment mechanism of treatment insurances in America, Australia and Iran. Payment mechanism of treatment insurances is among challenges of policy makers in the matter of health. Access to health, definite treatment, demand of technologies and complex treatments and heavy costs have designated a considerable part of health resources to it. Therefore, modernization and organization of payment mechanism of treatment insurances is very significant in dimensions of organizational structure, method of supplying financial resources, extension of population coverage and improvement of method of providing services and determining payment methods and providers of treatment services and determining the role of standard classifying systems in payment mechanism of treatment insurances. Chima et.al (2016) in a study examined the growth of health organizations in the role of world efforts in promotion of health insurances coverage in Nigeria. There is a growing interest in growth and development of private health insurance (PHI) and capability of private organizations for helping Universal Health Coverage (UHC).

MATERIALS AND METHODS
The method of study is applied-descriptive. The statistical population of the present study includes personnel and experts of health insurance whose number is 3575 persons that the sample volume corresponding to the statistical population is 350. Regarding that no study has been conducted with this title and variables present in the respective organization till now, based on the background of research, the following scholar- made conceptual model has been designed and adjusted. In this model, the components of establishment of universal health insurance plan have been considered as independent variable and health promotion as dependent variable.

Universal health plan health promotion
Coverage being mandatory
Creating universal database
Financial supply forerunning
Complete implementation of family physician plan
Figure1- research conceptual model.

List of tables

4-2 Descriptive findings of the research
Table 4-1 Table of frequency distribution in the sample based on respondents' gender.

qualitative variable	level	frequency	frequency percent
gender	male	202	57.7
	female	148	42.3
total		350	100.0
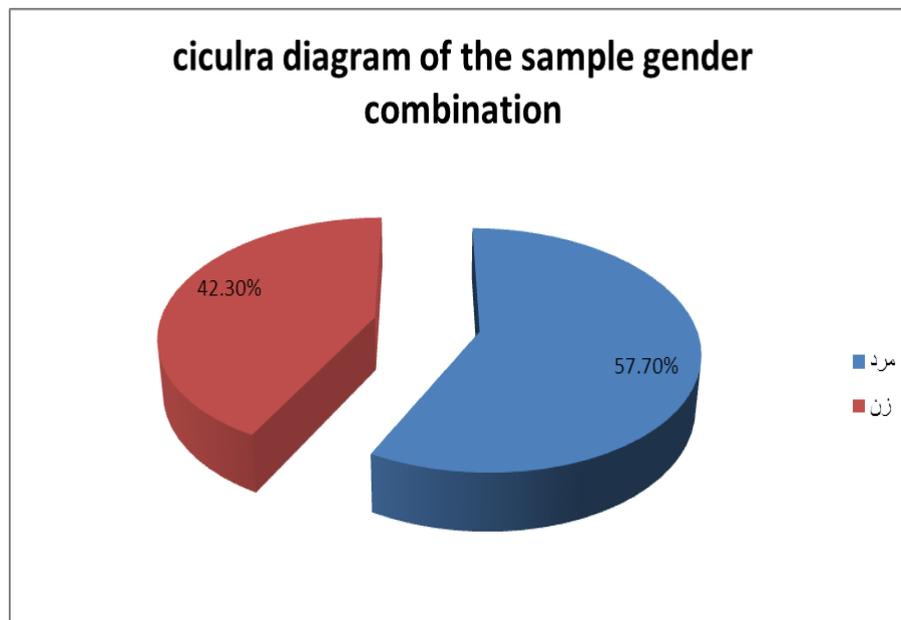
Diagram 4-1: Circular diagram of qualitative variable frequency distribution based on gender

Table 4-2: Table of frequency distribution in the sample based on mixture of marital status.

qualitative variable	level	frequency	frequency percent
marital status	single	54	15.4
	married	296	84.6
total		350	100.0
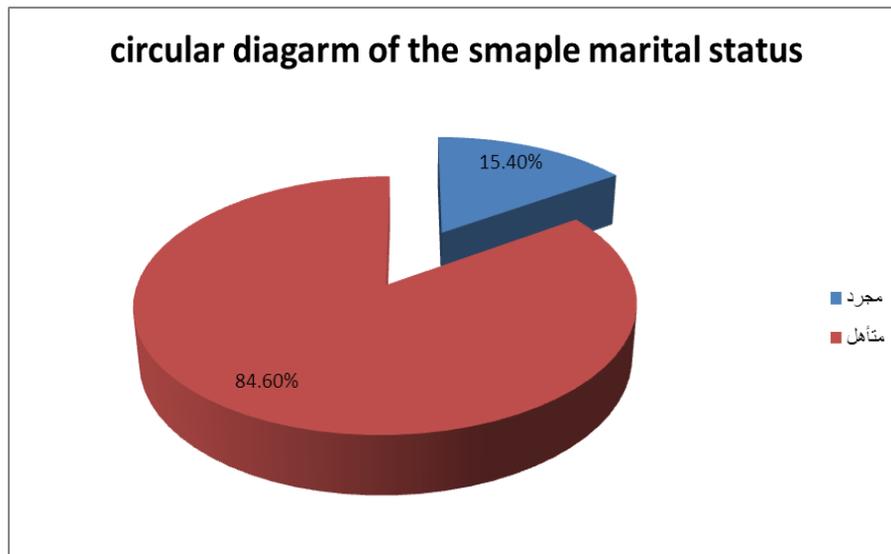
Diagram 4-2: Circular diagram of qualitative variable frequency distribution based on marital status.

Table 4-4: Table of frequency distribution in the sample based on age.

qualitative variable	level	frequency	frequency percent
age status	below 20 years old between 21 to 40 between 41 to 60 above 60	0 131 128 91	0 37.4 36.6 26
total		350	100.0
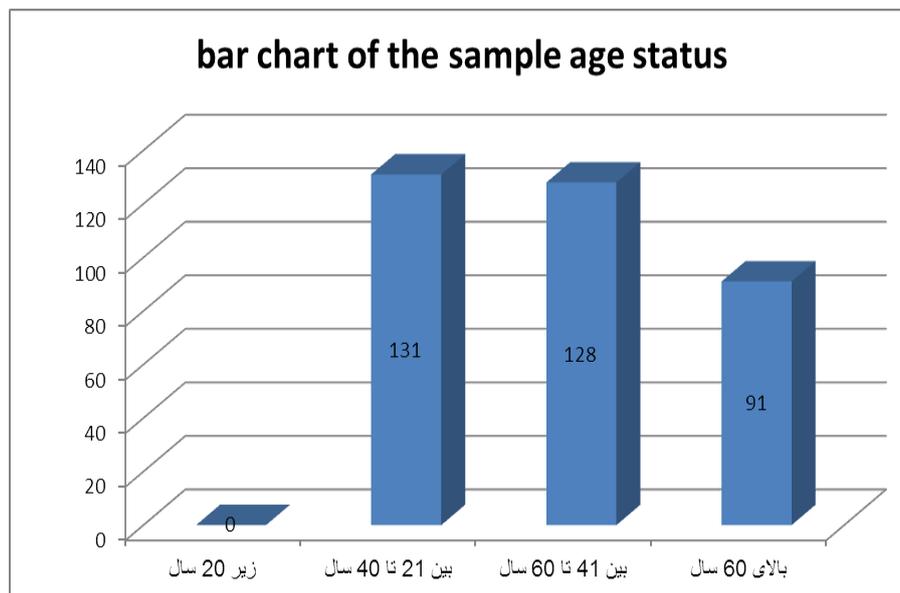
Diagram 4-3: Bar chart of frequency distribution based on age mixture.

Table 4-4: Table of frequency distribution in the sample based on education level.

qualitative variable	level	frequency	frequency percent
education level	below diploma diploma associate diploma bachelor master doctoral	24 105 46 105 57 13	7 30 13 30 16.4 36
total		350	100.0
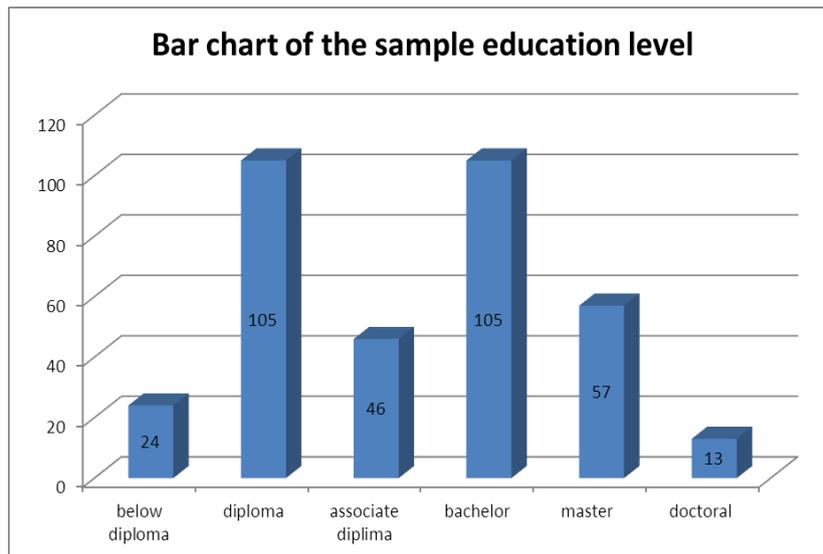
Diagram 4-4: Bar chart of frequency distribution based on education level.

Table 4-5: Table of frequency distribution in the sample based on insurance background.

qualitative variable	level	frequency	frequency percent
insurance background	below 10 years	47	13.5
	between 11 to 20	104	29.7
	between 21 to 30	151	43
	above 30 years	48	13.7
total		350	100.0
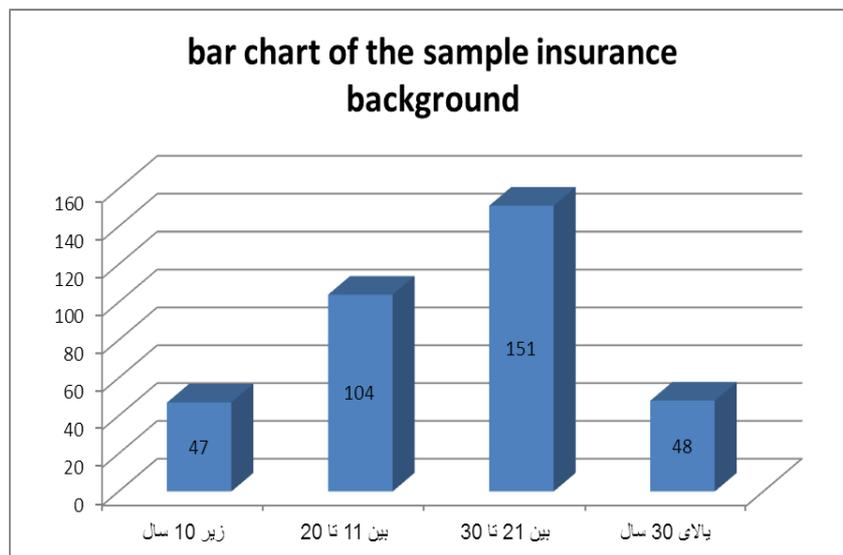
Diagram 4-5- Bar chart of frequency distribution based on insurance background.

3-4- Inferential findings

Table 4-6: The results of Kolmogorov- Smirnov test for the research variables.

factors	mean	standard deviation	t-test statistics of Kolmogorov-Smirnov	significance level	result
mandatory insurance coverage	14.9	2.399	0.102	0.112	normal
creating universal database of the insured	14.2	2.833	0.118	0.086	normal
financial supply forerunning	14.365	2.2	0.119	0.066	normal
complete implementation of family physician plan	15.25	2.208	0.156	0.073	normal
exact definition of services package and supervision on quality of provided services	15.562	2.319	0.180	0.092	normal
health promotion	35.76	4.219	0.80	0.069	normal

Table 4-7: Pierson correlation coefficient between two variables of health insurance current status and also health promotion.

variables	correlation coefficient	number	fallibility level
current status of health insurances and health promotion	0.371	350	0.0001

Table 4-8: Table of regression explanation factor for explaining the impact of health insurance current status on health promotion.

variables	explanation factor	modified explanation factor	standard error
current status of health insurances and health promotion	0.137	0.135	3.92483

Table 4-9: Table of regression variance analysis relating to the impact of health insurances current status on health promotion

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	853.136	1	853.136		
remainder	5360.704	349	15.404		
total	6213.840	350		55.383	0.0001

Table 4-10: Table of t-test statistics relating to regression factor.

regression factors	t-test statistics	fallibility level
fixed rate	6.456	0.0001
coefficient	7.422	0.0001

3-3-4 Testing the first secondary hypothesis
There is a relation between mandatory insurance coverage and people health promotion.

Table 4-11: Pierson correlation coefficient between two variables of mandatory insurance coverage and people health promotion.

variables	correlation coefficient	number	fallibility level
mandatory insurance coverage and people health promotion	0.11	350	0.0001

Table 4-12: Table of regression explanation factor for explaining the impact of mandatory insurance coverage on people health promotion.

variables	explanation factor	modified explanation factor	standard error
mandatory insurance coverage and people health promotion	0.116	0.104	4.22535

Table 4-13: Table of regression variance analysis relating to mandatory health insurance on people health promotion.

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	0.780	1	0.780		
remainder	6213.060	349	17.845		
total	6213.840	350		1.044	$P<0.01$

Table 4-14: Table of t-test statistics relating to regression coefficient.

regression coefficient	t-test statistics	fallibility level
fixed rate	24.933	$P<0.01$
coefficient	1.209	$P<0.01$

4-3-4 Testing the second secondary hypothesis
There is a relation between creating a universal database of the insured and people health promotion.

Table 4-15: Pierson correlation coefficient between two variables of creating universal database of the insured and people health promotion.

variables	correlation coefficient	number	fallibility level
creating universal database of the insured and people health promotion	0.147	350	0.0001

Table 4-16: Table of regression explanation for explaining the impact of creating universal database of the insured on people health promotion.

variables	explanation factor	modified explanation coefficient	standard error
creating universal database of the insured and people health promotion	0.522	0.122	4.221

Table 4-17: Table of regression variance analysis relating to the impact of universal database of the insured on people health promotion.

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	13.599	1	17.817		
remainder	6200.241	348			
total	6213.840	350		10.763	P<0.01

Table 4-18- Table of t-test statistics relating to regression factor

regression factors	t-test statistics	fallibility level
fixed rate	31.829	P<0.01
coefficient	10.874	P<0.01

5-3-4 Testing the third secondary hypothesis.
There is a relation between financial supply forerunning and people health promotion

Table 4-19: Pierson correlation coefficient between two variables of financial supply forerunning and people health promotion.

variables	correlation coefficient	number	fallibility level
financial supply forerunning and health promotion	0.063	350	0.0001

Table 4-20: Table of regression explanation for explaining the impact of financial supply forerunning on people health promotion.

variables	explanation factor	modified explanation factor	standard error
financial supply forerunning and people health promotion	0.086	0.063	4.217

Table 4-21: Table of regression variance analysis relating to the impact of financial supply forerunning on people health promotion.

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	24.947	1	24.947		
remainder	6188.893	348	17.784		
total	6213.840	350		1.403	P<0.01

Table 4-24- Table of regression explanation for explaining the impact of complete implementation of family physician plan on people health promotion.

regression factors	t-test statistics	fallibility level
fixed rate	25.152	P<0.01
coefficient	1.148	P<0.01

4-3-6 Testing the fourth secondary hypothesis:
There is a relation between complete implementation of family physician plan and people health promotion.

Table 4-23- Pierson correlation coefficient between two variables of complete implementation of family physician plan and people health promotion.

variables	correlation coefficient	number	fallibility level
complete implementation of family physician plan and people health promotion	0.466	350	0.0001

Table 4-24: Table of regression explanation for explaining the impact of complete implementation of family physician plan on people health promotion.

variables	explanation factor	modified explanation factor	standard error
and health promotion complete implementation of family physician plan	0.217	0.215	3.739

Table 4-25: Table of regression variance analysis relating to the impact of complete implementation of family physician plan on people health promotion.

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	1348.222	1	1348.222		
remainder	4865.618	348	13.982	96.428	P<0.01
total	6213.840	350			

Table 4-26: Table of t-test statists relating to regression factor

regression factors	t-test statistics	fallibility level
fixed rate	16.270	P<0.01
coefficient	9.820	P<0.01

7-3-4 Testing the fifth secondary hypothesis
There is a relation between exact definition of services and supervision on quality of provided services and people health promotion.

Table 4-27: Pierson correlation coefficient between two variables of exact definition of services package and supervision on quality of provided services and people health promotion.

variables	correlation coefficient	number	fallibility level
exact definition of services and supervision on quality of provided services and people health promotion	0.629	350	0.0001

Table 4-28: Table of regression explanation factor for explaining the impact of exact definition of services package and supervision on quality of provided services on people health promotion.

variables	explanation factor	modified explanation factor	standard error
exact definition of services package and supervision on quality of provided services on people health promotion	0.396	0.394	3.284

Table 4-29: Table of regression variance analysis relating to exact definition of services package and supervision on quality of provided services on people health promotion.

source of changes	total squares	freedom degree	mean squares	Fisher test statistics	fallibility level
regression	2461.883	1	2461.883		
remainder	3751.957	348	10.781		
total	6213.840	350		28.344	P<0.01

Table 4-30: Table of t-test statistics relating to regression factor.

regression factors	t-test statistics	fallibility level
fixed rate	15.050	P<0.01
coefficient	15.111	P<0.01

CONCLUSION

After performing each research activity, the scholar should provide the results regarding testing hypotheses and acceptance or rejection of them. Regarding that the results obtained from hypotheses are basis of shaping suggestions for performing studies; we can say that one of important parts of research which could, in fact, be a way for turning theories to practice for achieving success in future is providing correct conclusions and appropriate suggestions. The results obtained based on accurate and correct analyses could obviate obstacles and problems existing before the organization for actualizing the research. The main aim of each study is achieving some findings which could be utilized for providing practical and applied strategies and using them. Also, utilizing such findings could be guideline of other researchers for performing similar studies. The present study has examined the current status of health insurances and their role in health promotion (case study: Esfahan province medical sciences hospitals). For this purpose, at the beginning of study, a main hypothesis and five secondary hypotheses were posed for achieving the considered goal that the results analysis for achieving the considered goal was provided in the form of tables and descriptive statistical diagrams and also by performing inferential statistics tests. Regarding the results of previous chapters, general conclusions relating to study were overviewed and it is tried that regarding the obtained results, appropriate suggestions to be provided. The main aim of study is to examine the relation between current status of health insurances and health promotion of people. Also, our another goal, besides determining the relation between variables, is to provide some suggestions for improving the status and performance of health insurances for promoting health.

For examining the above secondary hypothesis, Kolmogorov- Smirnov test has been used for examining normality of data distribution of variables of mandatory insurance coverage of the population and health promotion of people in the society. Studying the first secondary hypothesis, i.e. "there is a relation between mandatory insurance coverage and people's health promotion", shows that the presumption of distribution normality of data relating to two variables of mandatory insurance coverage and people health promotion has been confirmed. So for testing the relation between two above variables, Pierson correlation has been used. Pierson correlation coefficient for two variables of mandatory insurance coverage and people health promotion is equal to 0.11 with fallibility level 0.0001 which confirms the relation between two variables. Regarding the regression variance analysis table, Fisher test statistics is equal to 1.044 that regarding fallibility level smaller than 0.01, we can say that regression model goodness of fit relating to the impact of the variable of mandatory insurance coverage on people health promotion has been confirmed.

In explaining the results obtained from research findings for the first hypothesis, we can say that the more the emphasis on mandatory insurance coverage, that is a condition is created so that all people of the society are obliged to be covered by insurance for using treatment services of various treatment centers and hospitals, the rate of using people from treatment health services is increased and as a result, this causes health promotion of the society. Findings obtained from testing the first secondary hypothesis are consistent and supported with the results of scholars like Sedighi et.al (2013), Hesam et.al (2012), Asadi et.al (2011), Masoudi et.al (2010).

Examining the second hypothesis showed that statistics of Kolmogorov- Simonov test are related to variables of creating universal database of the insured and people health promotion which are relatively equal to 0.086 and 0.069 with fallibility level 0.001. Therefore, the assumption of data distribution normality of variables creating universal insured database and people health promotion is not rejected. The rate of Pierson correlation coefficient for two above variables is equal to 0.147 with fallibility level 0.0001; as a result the relation between two variables is confirmed.

Form study finding relating to the second hypothesis, we can conclude that one of important factors which causes the society health promotion is creating the insured universal database through which uninsured population could be identified and measurements are accomplished for covering them. so that the whole population enjoys insurance treatment services , then the society health is increased. The results obtained from examining the second hypothesis is consistent and supported with the results of scholars like Ganjali (2011).

Regarding the statists of Kolmogorov- Smirnov test relating to variables of financial supply forerunning and people health promotion is equal to 0.66 and 0.6972 and fallibility level of both is more than 0.05, therefore, the assumption of data distribution normality for two variables of financial supply forerunning and people health promotion is not rejected. Pierson correlation coefficient for two above variables is equal to 0.063 with fallibility level 0.0001, as a result the relation between two above variables has been confirmed. In the table of regression variance analysis, the statistics of Fisher test is equal to 1.403 that regarding fallibility level less than 0.01, we can say that regression model goodness of fit relating to the impact on variable of financial supply forerunning on people health promotion has been confirmed.

From research findings relating to the third secondary hypothesis, we can conclude that the more the financial supply of insurance services is more forerunning, that is treatment costs are less for weak people of the society and the insurance undertakes more share from their treatment costs, low-income people of the society who are subjected to damage of various diseases, more welcome health insurance services and are covered by them and this issue over time causes reduction of diseases damages and as a result the society health promotion. The results obtained from third hypothesis findings are consistent and supported by the results of scholars like Raghfar et.al (2013), Reisi et.al (2013), Hajinabi et.al (2012), Ghiasvand (2011), Safdar et.al (2010), Tavakoli et.al (2006), Jariani et.al (2003) and Ayatollahi (2002).

There is a relation between complete implementation of family physician plan and people health promotion. For responding the above question, it is required that , at first the statistics of Kolmogorov- Smirnov test relating to variables of complete implementation of family physician plan and people health promotion are calculated which is equal to 0.073 and 0.069 and fallibility level of both is more than 0.05. Therefore, the assumption of normality of two variables data is not rejected. Pierson correlation coefficient for two variables of complete implementation of family physician plan and people health promotion is equal to 0.466 with fallibility level 0.0001 and as a result, the relation between two variables has been confirmed. In the table of regression variance analysis, Fisher test statistics is equal to 96.428 that regarding fallibility level smaller than 0.01, we can say that regression model goodness of fit relating to the impact of complete implementation of family physician plan variable on people health promotion has been confirmed. From testing the fourth secondary hypothesis, we can conclude that the more complete and better the family physician is implemented in the society and covers more part of the society population ,due to availability and low cost of its treatment services, various people enjoy necessary treatment services, therefore is causes health promotion of various people in long-term.

The result obtained from fourth secondary hypothesis is consistent and supported with results of scholars like Kabir et.al (2015).

For responding the fifth hypothesis, it is required that firstly, Kolmogorov-Smirnov test statistics relating to variables of exact definition of services package and supervision on the quality of provided services and people health promotion are calculated which are equal to 0.069 and 0.092 and the fallibility level of both is more than 0.05. Therefore, the assumption of normality of two variables data distribution is not rejected. Pierson correlation coefficient for two variables of exact definition of services package and supervision on the quality of provided services is equal to 0.629 with fallibility level 0.0001 that as a result, the relation between the two above variables has been confirmed. In the table of regression variance analysis, Fisher test statistics is equal to 28.344 that regarding the fallibility level smaller than 0.01, we can say that regression model goodness of fit relating to the impact of exact definition of services package and supervision on the quality of provided services on people health promotion has been confirmed. By testing the fifth secondary hypothesis, we can conclude that if an exact definition is provided about health insurance services packages and size and method of providing treatment services is specified, shortages of these services is identified , strengths and weaknesses are determined and for measurements are performed for making them more complete and also an exact supervision should be made on implementation of health insurance services so that these services are provided for people completely and cause the society health promotion. The result obtained from testing the fourth secondary hypothesis is consistent and supported by results of scholars like Karimi et.al (2015), Moshiri et.al (2012), Saei Aras et.al (2010), Abbasi et.al (2011), Nakheie Aghmioni & Kamoie (2010).

Regarding the provided topics, as the suggestion derived from the study results, we can say that it is proposed to senior managers and personnel and experts of health insurance that for insurance coverage of all people, they should measure for creating various centers of health insurance in the most remote regions and villages to big cities and identifying uninsured people of those regions. Then, by informing and various callings, it is tried that uninsured people to be invited to these centers for attending in justifying and training classes of these centers and through these courses, benefits of using health insurance to be explained for families and in each of agencies of cities throughout the country a universal database of insured and uninsured people of that city is created through which people who are covered by other treatment insurances are separated from people who are not covered by any insurance and by identifying without insurance individuals, measurements are made for covering them. one of motivational factors for people general welcome of health insurance is its financial

dimension and since most people who are not covered by any insurance are from low-income class of society, then managers and experts of health insurance are suggested to try to identify poor and low-income classes of society and consider lower treatment costs or more insurance share payment tariffs for such people so that create motivation in people for registering in health insurance and in this way help the society health promotion.

Exact and systematic supervision on high-quality implementation of family physician plan and providing services for people begins from the smallest centers in villages to big cities and big centers of provinces and by identifying weaknesses and low-quality services and facilities of various centers, measurements are taken for replacing them and providing new plans according to needs of each region based on climate and life style and hygiene culture of that region people.

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