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Analysis of Pakistan and Iran Health Care Delivery System

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Abstract:
Health plays a key role to maintain human welfare, improves economic conditions, helps in social development, and sustains life. Therefore, the WHO member countries have planned to target their health sectors financing to ensure that all people have the accessibility to free or economical health services at their region. Many countries in the world (developed, developing) are introducing health sectors reform in varying steps and system. Recently, the developing countries in Asia (Philippines, South Korea, Malaysia, and Thailand) and Africa (Nigeria, Tanzania, and Uganda) have initiated the health sectors reform. The main goal of health sector reform system is to improve the effectiveness of the health care system. Furthermore, the health care system effectiveness is possible by improving the quality of service (technical), and to generate new resources (human, financial, material) for the health care system (Islam, 2002).
The Devolution Plan (2001) guide and provides an opportunity to the health care system to justify the health requirements of the population. Pakistan is a developing country and needs reform in the health care system. For this purpose, Pakistan has shown little basic improvement in the health care system. Unfortunately, Pakistan is facing the worse economic situation which leads to poor health care reform, and is far away from the Millennium Develop Goal (MDGs) of 2015.
This report will focus on brief summary of the Pakistan and Iran health care delivery system and its organization environment (goal, expectation, resources, technology), authority, power, and status structure, decision making process, primary problems, challenges, and strategies to improve our health sector.

1. Summarization of Pakistan and Iran Health Care Delivery System

1.1. Pakistan

In Pakistan, the 18th amendment of constitutional bill was passed on April 8, 2010; massive changes have been undergone in its federal structure. Under this constitution, health is the responsibility of provincial government, except of health information, national health policy, interprovincial synchronization, global health, and health regulation. Besides these, the federal health of ministry is also accountable for the some vertical programme like malaria, AIDS, and TB (Mirza, 2013).

In Pakistan, the health care provision comprises of public and private health delivery system. The public sectors hospital encompasses of Basic Health Units (BHUs), which covers around 10,000 residents. The Rural Health Centers (RHCs) provide services to 30000-45000 residents. BHUs and RHCs are Primary Health Care (PHC) units. In addition, the tehsil headquarters hospital and districts headquarters facilitates the sub districts and district respectively. Tehsil and district headquarters are secondary health sectors, and covers 100,000 to 300,000 and 1-2 million people correspondingly. Furthermore, tertiary care hospitals are providing services in the major cities and it is controlled by the provinces (Appendix A). In Pakistan, approximately 11,000 health facilities (BHUs, RHCs, tehsil and district headquarters) are functioning, in which 22 are tertiary care facilities (mostly teaching) in major cities(WHO, 2007).

Military health care system also providing the services to the population, and consist of primary, secondary and tertiary health care. The primary health care centers comprises of medical battalion and field medical units. The secondary health care centers consist of combined military hospitals (CMHs), which are divided into category “A”, “B”, “C”, and “D”. The tertiary care centers are well equipped from modern health care facilities. These hospitals provide services to armed forces, arm forces families, retired soldier, and citizens paid from defense estimations and to the non-entitled citizens (WHO, 2007). Further these, autonomous bodies are also providing services to their employees and dependents, like Pakistan international airline, railway, water and power development authority, atomic energy commission, and telecommunication organization. In addition, Private health system is well industrialized in

Pakistan and it provides health services to the population on the bases of fee for services. These health facilities are range from low quality to high quality services and working autonomously

In Pakistan, the health care provision involves public and private delivery system. The Public sectors covers 30 % of the population and the government services for their expenditure. In the same way, the private sectors covers 70% of the population and the services are given on the basis of fee for services. In Pakistan 32.2 % of total health expenditure are funded by government, in which 69.9% are for civil part and the remaining 30.1% are disseminated through military setup. Sixty six percent of the expenditure is provided by private sectors in which 97.5% are by households. The remaining 1.9% expenditure is providing by donors/ Non-Government Organizations (NGOs) (Islam, 2002).

1.2. Iran

Major changes have been done since last forty years in the Iran health care system. A health directorate general (semi-independent organization) was introduce along with the Ministry of Health (MOH), to deal with preventive issues. Another change is the entrance of private sector's representative in the MOH, increasing and strengthening the private health sectors. Furthermore, pilot of new management order into the health system which led to the instituting of regional health organization in the provinces.

At the national level, medical education and MOH is working on policy making, planning, financing, funding, and navigating the programs. The Universities of Medical Sciences and Health Services (UMSHS) are the important institute to provide health services as well as meeting their needs in the field of individual, communal, and environmental health. The health system in Iran is structured in three levels. The first level consists of specialty curative services, which are located and delivering health services in mega cities and urban areas. These services are provided by public and private sectors and play a distinguishing role (Mehrdad, 2009). The other two level focus on primary health care services at rural, deprived, and remote areas. Primary health care is provided at district level comprises of district health center (DHC), district general hospital, and rural-urban health centers. The Primary health care facilities are delivered by the public sector and are almost free. Furthermore, the primary health care is divided into peripheral units and is called health house or health post. This network involves a referral system, which open at primary care centers in the periphery working through secondary-level hospitals in the provincial capital and tertiary hospitals in major cities. (Shadpour, 2000).

Apart from the public and private health care system, there are other health care organization which contribute in health care management of Iran in health policy making and services delivery for example, insurance companies, and the social welfare organization at district and provincial level.

2. The Organizational Environment (Goals, Expectations, Resources, Technology)

2.1. Pakistan

Pakistan health care system is of poorer quality in the required outcome. Pakistan has set the target of millennium development goals (MDGs) (2015) for health system, and it is doubtful to be achieved. These eight MDGs include: Reducing Child Mortality, Improving Maternal Health, and Combating HIV/AIDS, Malaria and Other Diseases (Akram, & Khan, 2007).

Pakistan health system consists of private and public health delivery system. In public health sector approximately 11,000 health facilities are working. These health facilities are 919 hospitals, 560 RHCs, 5334 BHUs, 4712 dispensaries, 905 MCH centers, and 288 TB centers (Shaikh, 2012). Beside this, Pakistan health system human resource are 1, 16,189 general physicians, 22,799 Specialists, 9,193 Dental Surgeons, 33,427 Nurses, 7,073 LHVs, 23,897 Midwives, 95,000 LHWs (WHO, 2007). In the private health sector limited data are available related to the human and building resources. The private health sector comprises on clinics, small hospitals, and large tertiary care hospital. The primary, secondary and tertiary care hospitals both private and public are well equipped from modern health facilities, but the influx of patient is very high in the country and they cannot manage it for the patient. The budget allocation for the health technology and resources are enough but utilization is deprived. For example, in Civil Hospital Karachi the budget was allocated for the Hospital Management Information System (HMIS) in 2011 but it is still not working due to corruption.

For the achievement of eight MDGs, it is expected from the government of Pakistan to change the policies and strategic direction. Pakistan health system has all the essential resources but proper management, monitoring, and evaluation is missing. Along with distribution of important additional resources for health, it needs to evaluate and re-prioritize the use of existing and new resources. Pakistan needs to adopt a holistic combined approach that views health, education, and other social sector development as basically interrelated.

2.2. Iran

In comparison, Iran health care system is noticeable successful, because of the strong grounded primary health care system and it is totally free. Secondary and tertiary care is based on private and public health sector, and it is well developed from modern technology and resources. Government of Iran has put emphasis on that every citizen has the right to enjoy the optimal conceivable level of health. It is expected from the Ministry of Health and Medical Education (MOHME), to plan, monitor, and supervised health related activities in public and private health sectors of Iran. Furthermore, it is also expected to establish and implement a more coordinated approach to health care delivery and modern medical education in both urban and rural areas. Government of Iran has implemented innovative approach MOHME approach in health, which is very successful (WHO, 2006).

3. Authority, Power, and Status Structure

Pakistan consists of four provinces Punjab, Sindh, Baluchistan, and Khyber Pukhtunkhwa (KPK) and two federal areas FATA and Islamabad. After 18th amendment the provincial government is responsible for their health.

3.1. Pakistan

In Pakistan, the health care system is vertical and horizontal, Vertical system is shown in a way in which separate organization are working in independently and they allocate their funds, pay, resources, and deliver the services under own policy and directions. For example, Federal Ministry of Health, Provincial health departments, NGOs, armed forces, private health care providers provides the health services in corresponding areas independently (Nishtar, 2006). Some program are controlled by the federal level and implemented across the country and it is vertical like TB, HIV, and malaria

Constitutionally**,** health is provincial matter in Pakistan. A public health sector is a horizontal at the provincial level, and they are in authority to develop policy and implement it in the province. The provincial ministries have legal responsibility for budgeting, delivery, and management of health services in the province. At the provincial level, the public health is provided at three levels which are primary, secondary, and tertiary health care system. BHUs and RHCs form the core of the primary healthcare structure. Secondary and tertiary care including first and second referral facilities Tehsil Headquarter Hospitals (THQs), and District Headquarter Hospitals (DHQs) which are supported by tertiary care from teaching hospitals. Maternal and Child Health Centers (MCHCs) is also the portion of public health system (WHO, 2007).

At the provincial level the power of health is headed by the provincial director general health services (DGHS). DGHS is responsible to ensure delivery of policies and plans related the health sector. The DGHS supervise the work of divisional director health (DDH) who works at divisional level. After that the executive district officer health (EDO-H) is in charge of the district and it is accountable for district activities of health. Managers of tehsil, RHUs, and BHUs directly report to EDOHs. In addition, medical superintendent are the chief of DHQ hospital. Both the medical superintendent and EDOHs report to the DGHS through their corresponding divisional directors.

The health status in Pakistan is very low as compare with Iran health care system. In Pakistan, 70% of the health facilities are provided by the private health sectors and a diverse group are involved in it for example, doctors, nurses, homeopaths, pharmacists, laboratory technician, shopkeepers, traditional healers, and unqualified practitioner. In Pakistan, legislation for accreditation, quality assurance, and check and balance mechanism is absent for public and private health sectors. The private health sector is working independently and the government has no control on them. Government needs to improve a dynamic relationship between private and public health sector as they complement or substitute to each other. Currently, few public-private partnerships are introduced in the health care system, which play a shared role for the achievement of health.

3.2. Iran

In comparison, the health system of Iran is highly federal. Authority and power control is at the central level by the MOHME. The MOHME is authorized for planning, monitoring, and regulation of the activities for the public and private health sector. Due to this exceptional structure it is different from the health ministries of other countries. This new approach has boosted the quality of health services in the country. WHO reports, that over the past 20 years Iran health sector has shown a remarkable improvement in the health services.

MOHME give its implementation to the medical universities through the country and every province has at least one university (Mehrdad, 2009). The president of medical university is accountable and has the authority to implement the health policies and services. Beside these, the president is also responsible for the public health, medical education, and health care delivery in public facilities. Iran has a wide health network across the country. This network consists of primary care centers in the periphery and finished in secondary and tertiary hospitals in major cities of the province. Then president forwards the feedback and evaluation of the province health system to the MOHME (Shadpour, 2000).

4. Decision Making Process

4.1. Pakistan

Before 2012, health related decision making was done at federal level which were used to be implemented at provincial and district level, however, after the 18th amendment in 2012 federal health ministry has been dissolved and all rights have been given to provinces . Federal ministry should not have abolished and efforts must have been put in order to make service delivery functional. However, this act has given autonomy to provinces and can help in retaining national targets. (Nishtar, 2013)

No national programs are present at this point in time except few programs like TB, malaria and AIDS control programs. All other vertical programs have been handed over to provincial health ministry and their funding is done at provincial level and then disseminated to district level. No existence of federal health ministry is unique in its own way and Pakistan seems to be the only country having no federal system for health but provincial system only. Each province runs the program at its own level and arranges funding for it. For a justifiable planning and implementation there must be some evidence or statistics to make the decision about a health system or develop a program to work effectively for people but unfortunately we lack evidences and statistics also, which makes it further difficult to effectively make a decision about health of people here. Hence we have weak policy making or strategic planning system which leads to poor decision making in health sector. Appendix D has a model of sources and utilization of evidence

in decision making mentioned by Nishtar, 2006. Decisions like recruitment, medical supplies, establishment of a new department, renovation which can be done at hospital management level are done by provincial health ministry. This process not only delays the decision making process but also has high probability of not dispensing the resources well. This also gives rise to questions like correct allocation and utilization of resources and corruption or politically influenced decision making.

4.2. Iran

Iran seems to have an organized and structured way of policy making and decision making at public level. Iran's health care system is centralized and ministry of health and ministry of education take decisions about goals, policies and resource allocation. It also has legal implications like licensure and regulation of activities in private health sector. (WHO, 2007)

As it is evident from the above mentioned literature that Iran has a formal policy making body. Unlike Pakistan decisions are not taken in assembly without any evidence based support. In Iran health surveys are done every 5 early and according to socio economic conditions of people and health indicators policies are reviewed or changes are proposed. Most of the Iranian heath sector is either privatized or moving towards it and its accessible and affordable but it is not so in Pakistan but private health facilities are not affordable and out of reach of common man. Hence Iran has a well-established and controlled health care sector with evidence based decision making.

5. Primary Problems and Challenges

5.1. Pakistan

The most highlighted issue in our health care system is political influence. Our health sector is badly infected with politics and thus leads to poor health system management at national and provisional level. The allocation is one of the lowest in the region with less than 1% of GDP deployed for this very important function. and evidences are available suggesting that even these resources are not properly utilized as most of it is Either not fully handed over to the designated areas or it is used in unnecessary things. Though, Health budget is increasing from the previously allocated budget but even then it is not evident in health system because of lack of monitoring and evaluation and people are not held accountable for their acts. Inflation poor law and order situation and lack of job opportunities make it further difficult to properly utilized or administer health facilities of common people. Unlike Iran Pakistan has very less public private partnership or insurance system which can make the health facilities accessible and affordable to all. At ground level it is observed that even health care professionals are not sincere to their jobs. Issues like Ghost workers, doctors forcing patients to visit their private clinics and unskilled workers are very common. Above all poor waste management or disposal of hazardous medical surgical supplies is very common and this has become a business through which infections like hepatitis and HIV is becoming common. People from rural areas travel and spend money to come to cities for their treatment but they are even deprived of health care facilities. Out of pocket expenditure is increasing and even then a satisfactory level of facilities is not achieved. Corruption and political influence makes it challenging to achieve the set targets. Additionally there is violence is common in health care professionals. Doctors and nurses are not protected and many cases of murder and rape is happening with them.

5.2. Iran

As previously mentioned that survey are done and based on that policies are reviewed but policies are centralized to whole country but statistics can be different for urban and rural population, so this should be taken care of that policies are made in such a way that rural population is not ignored. Moreover, as their ministry of health and ministry of education work in collaboration so that education and health system can be streamed line but it leads to few issues as well. Moreover, involvement of ministry of education in health sector has led to increase numbers of medical graduates which leads to unemployment because of the fact that they are unwilling to work in rural areas. Another issue is about the prioritization of resource allocation since both are ministries are working in collaboration it is anticipated that resource allocation would not be same as per need in primary care and university hospital. (WHO, 2007)

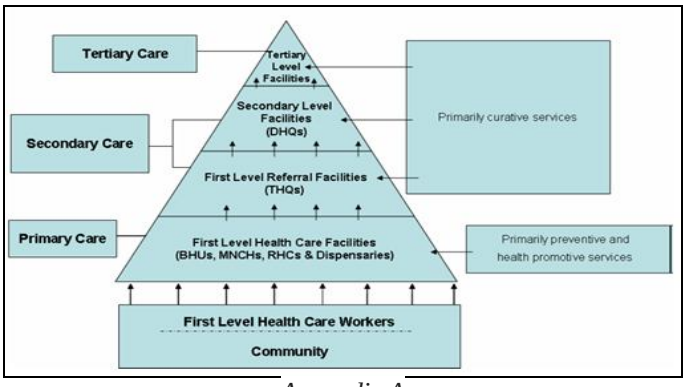
So the autonomy to each province can lead to issues in health sector which can badly affect the system and ultimately health of people.

6. Conclusion and Recommendations

- Human resource management and enough deployment of health care professionals in public sector
- Creating a motivated and safe environment for doctors and nurses
- Reinforcement of law and order to have a safe environment
- Giving autonomy to each hospital in order to take correct decisions
- Provision of enough supplies and other facilities in order to provide a complete heath care facility
- Setting priorities for allocation of funds on need basis
- Strict system of monitoring and evaluation
- Political influence can be diminished from the health care system
- Statistical data must be gathered to have evidences of prevailing heath issues
- Policy making and decision making must be evidence based
- Establishing audit system to identify any loop holes
- Publishing cell should be created so that publications can be done and international agencies can be attracted to work with our public sector in order to promote health

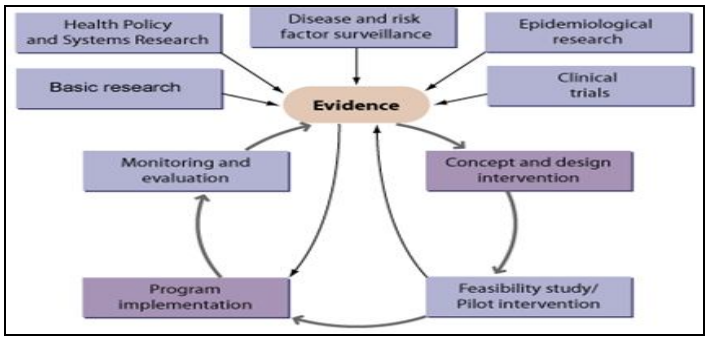
- Promoting public private partnership to make the health care facilities accessible and affordable to all
- Introduction of social insurance system to make health facilities available to common people
- Making the system transparent so that information is disseminated across the board and trust relation can be promoted

It is concluded, that health care system is a complex process in the present situation of Pakistan. Pakistan is facing many hurdles to attain the MDGs (2015). Deprived polices, strategies, and management are the main reasons of poor health care system in Pakistan. For the solution a strong encouragement is required for continue funds. The government and the health ministry need to play a pivotal role in the solution of these areas. In short, resolving of mentioned challenges and limitation can make substantial impact in Pakistan's reaching of MDGs of 2015.



Appendix A

Source: Adapted from: S Siddiqi et al. The effectiveness of patient referral in Pakistan. Health Policy and Planning; 16 (2): 193 – 198



Appendix B

Sources and utilization of evidence in decision making

7. References

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