

Letter to the Editor

Population-Level Equity May Not Be Achievable At the First Level of the Iranian Family Physician Program (IFPP)

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Dear Editor-in-Chief

According to the current legislation and article 89 of Iran's Fourth Development Program (I4DP), the Ministry of Health and Medical Education (MOHME) is responsible for the countrywide planning of health policies.¹ Thus, MOHME with the help of all other organizations that have direct role in provision of health care (e.g. governmental health insurance companies) started to study and compile regulations of *referral system and family physician program*, introduced later as the "*Iranian National Family Physician Program*" (IFPP).² The initiative was put in practice in 2005 with the cooperation of the Ministry of Welfare and Social Support (MWSS) in rural areas as well as cities with population of less than 20,000.³ The program aimed to overcome barriers in achieving the objective set in the article 91 of I4DP. The main intent within the program is provision of facilities to expand health insurance coverage for all through reinforcing family physician and referral system as decided by the Higher Council of Program Planning (HCPP) in the MOHME.¹ Provision of health care by family physicians at the first level of the Iranian Health System (IHS) was compromised to devel-

op equity; however, certain deficiencies seem to exist in practice as follows:

Health care in the IHS was disembarked at three levels for all: at the first level, services are provided by family physician or semi-professional health workers in the rural health units, called as "*health houses*", or *rural/ urban health centers*. At the second and third levels, special or sub-special outpatient or inpatient health services are provided to those referred from the first and second levels.³ Health services in rural areas were scheduled to be provided through two methods: *active method* (physicians or health care providers go to the peoples' living place) and *passive method* (individuals approach the health care provision centers).³

In the case of passive health care provision, individuals' access to the defined health services could depend on various factors including geographic location of the health center, weather and transportation facilities etc. Such a limitation may lead to deprivation of a part of the population regarding facile access to health care. Therefore, explicit planning of family physicians distribution in rural health centers and monitoring of their work timetables have a great importance.

Short and long term employment of family physicians in the rural health centers is conspired in the IFPP and they are asked to visit patients, assess health problems in their health center's catchment area and supervise health care provision in line with health promotion activities imparted or coordinated by the members of the center's health care team. According to the article 40 and notes 1 and 2 of the instruction 15 of the IFPP, family physicians duties are defined as followings:

- Visit patients and supervise health problems within their center's catchment area three times or at least twice a week. Once a week visits are allowed only for those family physicians

that are only responsible bodies in the health centers during whole week or those who should provide services in more than three Health Houses in a week.

- **Note 1:** Family physicians are also requested to visit and assess population's health needs in their under supervision peripheral villages monthly.

- **Note 2:** Family physicians are asked to visit and assess health needs in the satellite villages once every three months if there are appropriate roads and vehicles.³

A summary of disposed family physicians duties in the IFPP is provided in Table 1.

Table 1: Family physicians' visiting schedule of rural areas for active health care delivery as instructed in the IFPP

Village type	Visit schedule	Maximum suggested times of visiting a village in a season
Main	Once or twice a week	12-24
Peripheral	Once a month	3
Satellite	Once every three months (provided that appropriate roads and vehicles exist)	0-1

As explained; family physicians in the IHS are requested to visit a main village at least 12 times a season, therefore; these villages' habitants are able to go to the Health Houses or to the rural health centers anytime they need. The number of instructed visiting times for main villages in the IFPP is about four times more than the visiting times considered for peripheral villages. Thus, for people living in the main villages there is a more possibility to use health services provided by the rural Health Houses or health centers. This is while; access of the inhabitants in the satellite villages to the health care is limited and depends on the roads and weather. These villages usually possess limited health and welfare facilities because of low population density, geographical dispersion, etc. It is not surprising so, populations in these remote villages even have higher demand for health services, which is not fully considered in the current framework of the IFPP. A number of satellite villages have even no access to the primary health care (PHC) services such as access to adequate and safe water, basic sanitations, appro-

priate treatment for prevalent illnesses and injuries and permanent access to essential medicines as they were emphasized in the Almaty (Alma-Ata) conference.⁴

Another dimension of disparity for satellite villages is deprivation of their populations from the majority of the country's macro-health programs including integration of mental health program into the PHC elements, prevention and control of hypertension and diabetes which have been defined at least on the paper for the whole population of the country (including the rural, peripheral and satellite villages' populations).

Equity in health means distribution of opportunities, services and health facilities based on population needs.^{4,5} Accordingly, all sub-groups of the country's population could be able to use definite health services proportionate to their needs. Such equity should not be achievable through the current version of the IFPP due to the inherent differences people living in the satellite villages have in access to health care services when comparing with their counterparts living in the main

villages. As a result, those people who probably require more attention in the satellite villages receive the least services in practice.

The country's top-level policy makers in the MOHME are already aware of the health problems people in the satellite villages are suffering and their difficult living conditions. Therefore, a boosted vaccination program (e.g. receiving polio drops twice a year in addition to the country's routine vaccination program) for instance was scheduled for the villages. However, with sporadic health interventions the current health gaps between satellite and main villages could not be filled. Comprehensive tailor made health interventions are required to ensure health equity for whole country's population. Our suggestion however, is to start with revision of the current IFPP to make equity a reality for people living in the satellite villages throughout the country.

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