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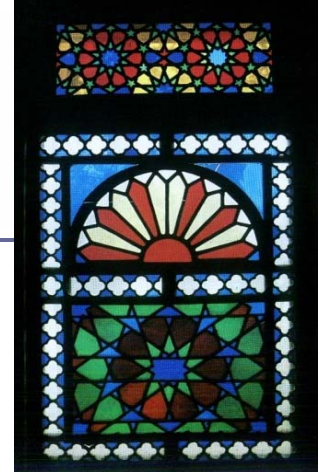


**Evaluating Impact:
Turning Promises into Evidence**

**The family physician
system reform in small
cities in I.R. Iran**

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Team members



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- ❑ Deputy Minister of Health and Medical Education for Coordination
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Islamic Republic of Iran



Area :

1'648'000 km²

Population :

Total : 70'500'000

Urban % : 65

Administration :

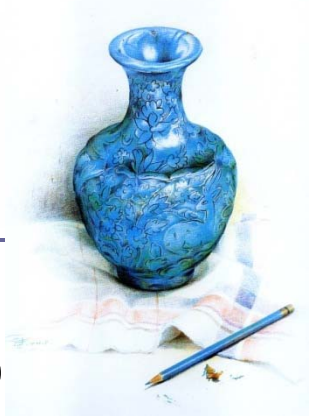
Provinces : 30

Districts : 400

Villages : >65000



1. Background



- PHC network in rural areas with 95% coverage and significant achievements (immunization rate, F.Planning, Communicable diseases, MCH, ...)
- Problems in access to secondary care for rural population
 - Hence the rural family physician and health insurance reform three years ago
 - It is currently under impact evaluation
- National budget (>300b Tomans at start, increased to >500b)

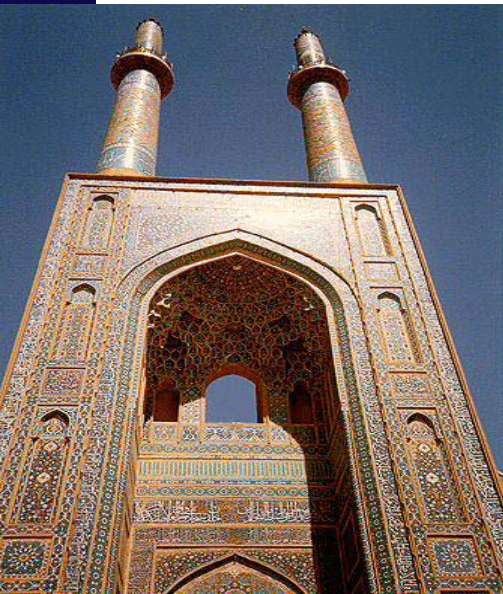
1. Background



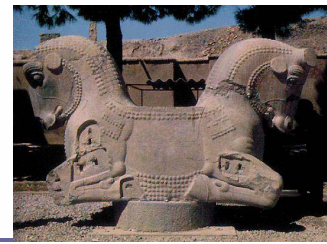
- ❑ Problem of chronic non-Communicable diseases
- ❑ Very fragmented provision of health services including different types of insurance funds and abundance of private physician offices
- ❑ Lack of a working referral system
- ❑ Concerns about quality of services and equity in financial contribution and access
- ❑ Concerns about the depths and coverage of essential health benefit packages

1. Background

- According to the 4th 5-year National Development Plan the family physician reform should be extended to the whole country
- Legal binding for improving equity of access and financing of health care

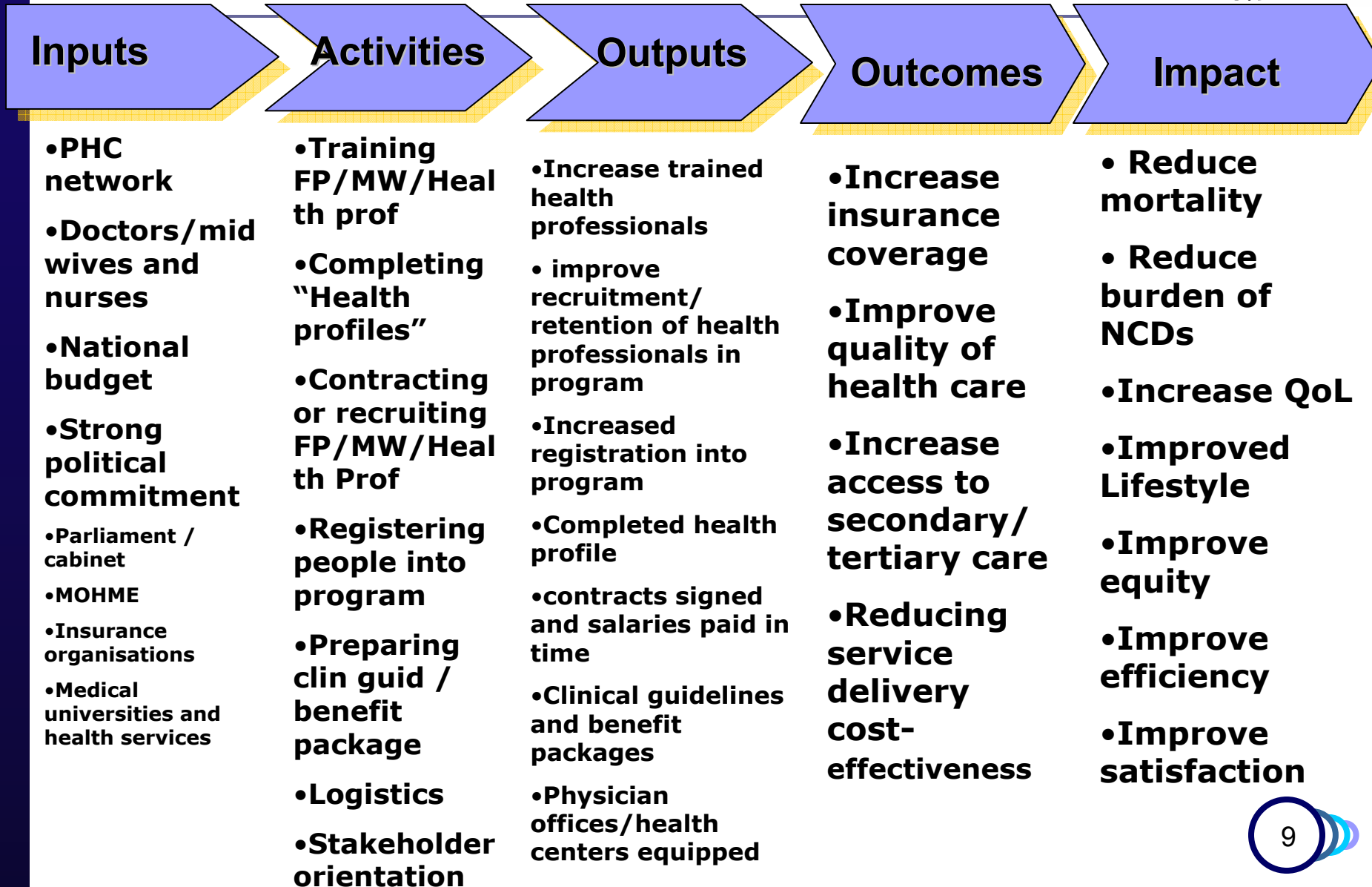


1. Background (the intervention)

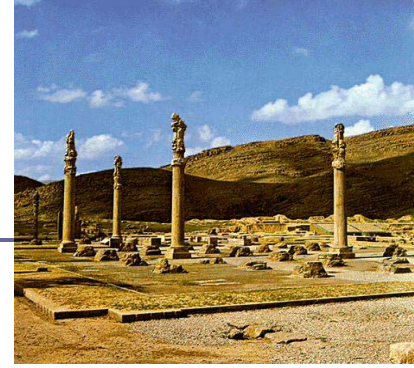


- In cities with a population of 20,000-50,000
 - Smaller cities are already covered through previous reform
- Family physicians (mainly contracted - some employed)
- Patient registration
- Gate-keeping
- Expected 1 physician plus 1 midwife or nurse for every 2000-2500 population

2. Results Chain

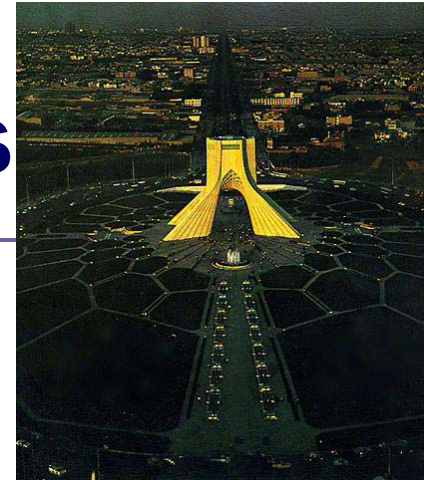


3. Primary Research Questions



- To assess the impact of the family physician reform in small cities on
 - service delivery
 - health status
 - satisfaction with services
 - equitable access and utilisation
 - equitable financial contribution
 - and efficiency outcomes

4. Outcome (output) indicators



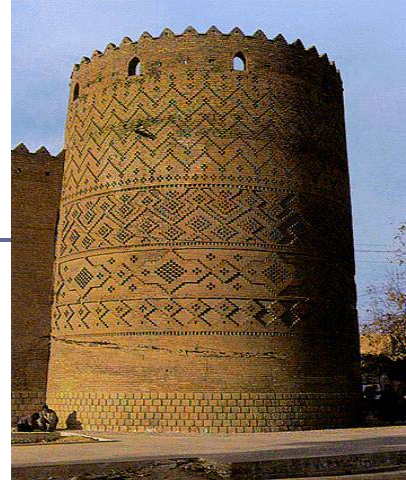
- N of health prof completing training
- N of FP/ health prof in program
- FP/elig. pop ratio
- Family physician registration/elig. pop
- Completed health profile/eligible pop
- Ratio of contracts signed and salaries paid in time
- Number of CPG??
- Physician offices/health centers equipped

4. Outcome Indicators



- Insurance coverage
- Within system referral to secondary care / total secondary care utilisation
- Proportion of insured population satisfied with the services
- Public knowledge and behaviour related to NCD prevention

4. Outcome Indicators



- Catastrophic health expenditure proportion
- Impoverishing Health Expenditure
- Proportion of Out-of-Pocket expenditure to total expenditure
- NMR, IMR, <5MR, SMRs
- Burden of disease and DALY, QALY
- Immuniozation rate*

5. Identification Strategy/Method

- Cities with population less than 50,000 will be eligible for inclusion into the programme
- A randomised controlled trial
 - A before-after RCT to take into account the baseline differences
- Cities will be the level of allocation of the “treatment”
 - Probably cluster effects (i.e. health centers or family physician offices located within cities) will also be considered

6. Sample and data



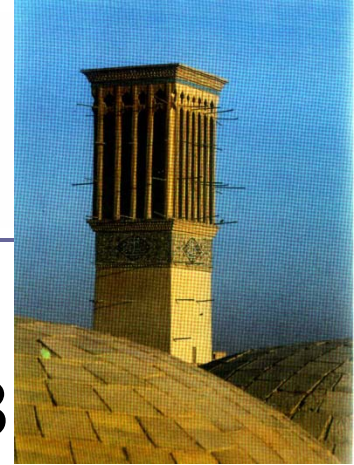
- Formal sample size calculation based on one of the key variables:
 - Within system referral to secondary care / total secondary care utilisation
 - Design effect $(1 + (m-1)\rho)$ will be considered
- From each province 1 (or 2) cities will be randomly sampled into the programme
 - There are 30 provinces, 30-60 cities as "treatment"
 - Stratification strategies may be used based on the geographical characteristics of the cities (in certain large provinces)

6. Sample and data

- Other eligible cities will act as controls
 - At least one control city for each treatment city
- Data from routine administrative, utilisation and demographic sources
 - Ministry of Health and Medical Education
 - Ministry of Welfare and Social Security
 - National Office of Statistics
- Further data from randomised surveys
 - services users
 - general (eligible) population



7. Time Frame/Work Plan



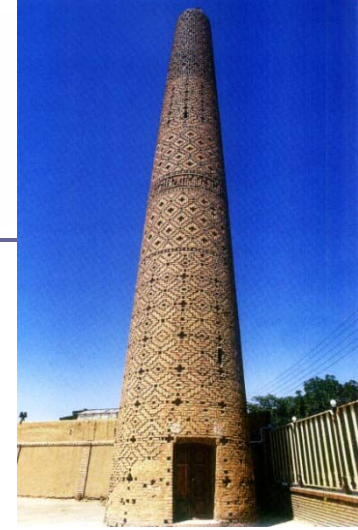
- Finalising the proposal: 15 March 08
- Getting agreement for the: 15 April 08
- Phase 0: 15 July 08
 - Preparation of the data collection tools and piloting the tools
 - Coordinations, getting agreements for access to required data, finalising the research team members
- Phase 1: 15 Nov 08
 - Randomising cities to treatment and control
 - Baseline data collection

7. Time Frame/Work Plan



- Phase 2:
 - Intervention is being implemented
 - Collecting implementation data
- Phase 3: 15 July 10
 - Final data collection
- Phase 4: 15 Dec 10
 - Data analysis
 - Preparation of the final report

8. Sources of Financing



- ❑ Ministry of Health and Medical Education
- ❑ Ministry of Welfare and Social Security
- ❑ Different estimations of cost
 - Likely budget required: \$200,000
 - With 50% error margin at this stage!



Tehran, Laleh Park, 2008 (photo by Arash Rashidian)