Comparison of Health Status Indicators in Iran with the Eastern Mediterranean Countries using Multiple Attribute Decision-Making Methods

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Abstract

Background: Improving public health is the main goal of healthcare systems across the world. Healthcare policymakers often use comparisons between different healthcare systems to better position their country and use the outcome to develop novel strategies to improve their own public health. The present study aimed to compare the health status indicators in Iran with those of the Eastern Mediterranean (EM) countries using the multiple attribute decision-making (MADM) methods.

Methods: A descriptive-analytical study was conducted in 2021 at Shiraz University of Medical Sciences, Shiraz, Iran. Data on the ranking of health status indicators in EM countries were obtained from the annual publications of the World Health Organization, World Health Statistics (2016-2020). As part of the MADM mathematical models, the “criteria importance through intercriteria correlation” (CRITIC) model was used to assign weights to health status indicators. In addition, the “multi-criteria optimization and compromise solution” (VIKOR) model was used to rank the EM countries.

Results: The results showed that Bahrain and Somalia ranked first and last on health status indicators, respectively. Iran ranked fifth with only 415 USD health expenditure per capita. While Iran has a better status on all indicators than the mean value of all EM countries, there is a significant gap between the health status in Iran than the top-ranked countries.

Conclusion: Health care strategies adopted by top-ranked countries, such as Bahrain and Qatar, can be used by Iran and other EM countries as a model to improve their healthcare system.

Keywords: ● Health status ● Developing countries ● Developed countries ● Health services ● Decision making

Introduction

Public health is central to any society and is associated with the level of productivity, development, and revenue of a country.1 Due to the importance of this subject, different healthcare systems have been thoroughly studied and compared in the past several decades.2 According to the World Health Organization (WHO), the main objectives of healthcare systems are to improve the health status, respond to the health care needs of the public, and establish an equitable health financing system. The performance
of the healthcare system of a country is measured by the level at which these objectives are met. Of these objectives, improving health status is most prominent, as it drives the other two. Indicators used to measure health status are life expectancy, maternal mortality, neonatal mortality, mortality associated with chronic diseases, and parameters representing the level of public health.

The success rate of a country in achieving the above-mentioned objectives can be determined by comparing the performance of its healthcare system with that of other countries. Such comparisons allow policymakers to position the health status of their respective countries and propose specific action plans for improvement. The ranking method is commonly used for this purpose, whereby a set of relevant indicators is determined and weighted (based on statistical methods, surveys, or expert consensus), based on which the performance of different health systems is mapped.

In the present study, we specifically focused on the performance of health systems in the Eastern Mediterranean (EM) countries, which is one of the six regions defined by the WHO. EM comprises 22 countries with a combined population of nearly 583 million people, namely Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates (UAE), and Yemen. These countries vary in terms of gross domestic product (GDP), demographic characteristics, health status indicators, and the coverage and capability of their healthcare systems.

Several studies have compared the healthcare systems of different countries in terms of health status indicators. For example, Cinaroglu determined the efficiency of healthcare systems in Organization for Economic Co-operation and Development (OECD) countries using health status indicators. Boz and colleagues determined Turkey’s position among the OECD countries in terms of health status indicators, both before and after its health transition program. In another study, Mberu and colleagues compared urban and rural regions of Bangladesh, Kenya, Egypt, and India based on health status indicators.

Multiple attribute decision-making (MADM) methods refer to mathematical models used to decide on issues, where available alternatives are evaluated with different and at times contradictory indicators. In this method, the main objective is to choose the best alternative for different indicators. Initially, indicators are assigned certain weights using methods such as the linear programming techniques for multidimensional analysis of preference (LINMAP), least squares method (LSM), Shannon entropy, or criteria importance through intercriteria correlation (CRITIC). Then, the alternatives are ranked using methods such as the technique for order preference by similarity to ideal solution (TOPSIS), elimination and choice translating reality (ELECTRE), or vIekriterijumsko kompromisno rangiranje (VIKOR) which is a Serbian term for multi-criteria optimization and compromise solution. Considering the above, for the first time, we compared the health status indicators in Iran with those of the EM countries using MAD methods.

### Materials and Methods

A descriptive-analytical study was conducted in 2021 at Shiraz University of Medical Sciences, Shiraz, Iran. The study was approved by the Ethics Committee of the University (code: IR.SUMS.REC.1398.1234).

The performance of the EM countries healthcare system was assessed according to the framework proposed by Kruk and Freedman. Based on the availability of data for EM countries, seven health status indicators were used, namely “Life expectancy at birth”, “Healthy life expectancy (HALE) at birth”, “Maternal mortality ratio (MMR)”, “Neonatal mortality rate (NMR)”; “Under-five mortality rate (U5MR)”, “Probability of dying from any of the cardiovascular diseases (CVDs), cancer, diabetes, or chronic respiratory disease (CRD)”; and “Mortality rate attributed to exposure to unsafe water, sanitation, and hygiene (WASH)”. The required data as well as some other indicators (table 1) were obtained from the WHO’s annual World Health Statistics report (2016-2020). The report additionally includes the trend in life expectancy, causes of death, progress on the millennium development goals, and other health-related goals. Given the exclusion of Palestine by the WHO, the remaining 21 EM countries were ranked according to the above-mentioned indicators. Mathematical modeling was performed using MAD methods (CRITIC to assign weights to the indicators and VIKOR to rank the countries). Data were analyzed using Microsoft Excel 2019 (Microsoft Corporation, USA).
Assigning Weights to Indicators Using the CRITIC Method

The process of assigning weights to indicators requires knowledge, experience, and understanding of the problem. As the number of indicators increases, the likelihood of human error and thus doubts about the reliability of the assigned weight increases. To overcome these, objective weighting methods confirmed with real data are used. One such method is CRITIC, as proposed by Diakoulaki and colleagues, which solves the interdependence between criteria based on the correlation between variables. Unlike the Shannon entropy method, it does not solely rely on data distribution but allows proper determination of the role of each factor in the final result. Moreover, in this method, the inverse or direct relationship of indicators with healthiness (known as a negative or positive indicator) does not affect the results.

Among the seven indicators considered in our study, two indicators were positive (life expectancy at birth and HALE at birth) and the remaining five indicators were negative (MMR, NMR, U5MR, probability of dying from diseases, and mortality rate attributed to exposure to unsafe WASH). A description of the main steps in the CRITIC method is presented below.

Step 1: Building a decision matrix composed of health status indicators (seven columns) and EM countries (21 rows).

\[ r_{ij} = \frac{x_{ij} - x_{ij}^{\text{min}}}{x_{ij}^{\text{max}} - x_{ij}^{\text{min}}} \]

Step 2: Normalization of the decision matrix. where \( r_{ij}, x_{ij}, x_{ij}^{\text{max}}, \) and \( x_{ij}^{\text{min}} \) denote normalized values, elements of the decision matrix, maximum element in criteria \( j \), and minimum element in criteria \( j \), respectively.

Step 3: Calculation of the initial weight of the criteria.

\[ C_j = \sigma_j \sum_{i=1}^{m} (1 - r_{ij}) \]

where \( \sigma_j \) is the standard deviation of the \( j^{th} \) criterion and \( r_{ij} \) is the correlation between \( j^{th} \) and \( i^{th} \) criterion. Criteria with higher \( C_j \) will be assigned more weight (i.e., a higher value of \( C_j \) provides more information about the given criterion).

Step 4: Calculation of the final weight of the criteria.

\[ W_j = \frac{C_j}{\sum_{j=1}^{m} C_j} \]

where \( W_j \) is the weight of the \( j^{th} \) criterion, and \( C_j \) is the amount of information of the sum of the \( j^{th} \) criterion (\( j=1, 2, \ldots, m \)).
Ranking of Countries using the VIKOR Method

The VIKOR method is used to rank alternatives with criteria and units that are different and at times conflicting. The main feature of this method is the prioritization of alternatives, as an optimal checklist, based on a compromise solution in the presence of conflicting indicators such that only a unique ranking or optimal alternative is not provided. A description of the main steps in the VIKOR method is presented below.

Step 1: Determination of the best \( f_j^* \) and worst \( f_j^- \) value for all criteria functions (i=1, 2, ..., n)

\[
f_j^* = \max f_{ij} \text{ and } f_j^- = \min f_{ij}
\]

Step 2: Calculation of \( S_j \) and \( R_j \) values for j=1, 2, ..., J.

\[
S_j = \sum_{i=1}^{n} w_i \frac{f_j^* - f_{ij}}{f_j^* - f_j^-} \\
R_j = \max \left[ w_i \left( \frac{f_j^* - f_{ij}}{f_j^* - f_j^-} \right) \right]
\]

where minimum S value indicates maximum group utility, minimum R value shows the minimum individual regret, and \( w_i \) indicates the relative weight of each criterion and its relative importance.

Step 3: Calculation of the \( Q_j \) value for j=1, 2, ..., J.

\[
Q_j = \nu \left( \frac{S_j - S^*}{S^* - S} \right) + (1 - \nu) \left( \frac{R_j - R^*}{R^* - R} \right)
\]

where

\[
S^* = \min S, \ S^- = \max S, \ R^* = \min R, \ R^- = \max R
\]

Q is a synergistic value created by combining R and S, \( \nu \), which is introduced as the weight of the strategy of “the majority of criteria”. (here \( \nu = 0.5 \) indicating the priority based on consensus).

Step 4: Ranking of alternatives sorted by the values of S, R, and Q in descending order. Thus, the results are three ranked lists.

Step 5: Proposed a compromise solution for an alternative \((\alpha')\) ranked by minimum Q, if the two following conditions are satisfied.

- Condition 1: Acceptable advantage, \( Q(\alpha') - Q(\alpha) \geq DQ \), where \((\alpha')\) is an alternative, which has the second rank in the Q classified list,

\[
DQ = \frac{1}{J-1}
\]

, and J is the number of alternatives.

- Condition 2: Acceptable stability in decision-making. The alternative \((\alpha')\) should also be the best ranked by S or/and R. This compromise solution is stable within a decision-making process, which could be the strategy of “the majority of criteria”.

If one of the conditions is not satisfied, a set of compromise solutions is suggested, which include:

- Alternatives \((\alpha')\) and \((\alpha'')\) if only the second condition is not satisfied.
- Alternatives \((\alpha'), (\alpha''), ..., (\alpha''')\), if the first condition is not satisfied and \((\alpha''')\), is determined by \( Q(\alpha'') - Q(\alpha) \leq DQ \). For each “M", alternative one to M will be the optimal solution. The best alternative, ranked by the Q, is a value with the minimum value of Q.

Results

Five of the several indicators in the EM countries are presented in table 1. Among the countries, Pakistan and Djibouti have the highest and lowest populations, respectively. In terms of the service coverage index, Bahrain and Somalia have the highest and lowest index values, respectively. Kuwait has the highest density of medical doctors (26.5) and nursing and midwifery personnel (74.1) per 10,000 population. Whereas, Somalia has the lowest number of medical doctors (0.2) and nursing and midwifery personnel (1.1). Pakistan ranks the lowest in terms of current health expenditure (CHE) per capita (40 USD) and 2.8% GDP. Whereas, Qatar ranks the highest with a CHE of 1,827 USD and 3.1% GDP.

Based on the data from the WHO’s annual World Health Statistics report (2016-2020), the results of the CRITIC weighting method showed that U5MR (in 2016 and 2017) and NMR (in 2018, 2019, and 2020) were assigned the maximum weights compared to other indicators. Whereas, HALE at birth (in 2016 and 2017) and life expectancy at birth (in 2018, 2019, and 2020) were assigned the minimum weights (table 2).

Based on the same annual reports, the mean health status values of the seven indicators in our study were determined for all EM countries, except for Palestine (table 3). As mentioned earlier, indicators one and two were positive, whereas indicators three, four, five, six, and seven were negative. This means that the higher the positive/negative indicator value, the better/worse the health status of the population is. The results showed that Iran has a better status on all indicators than the mean value of all 21 EM countries. Bahrain obtained the best status for life expectancy at birth (78.22), NMR (2.26), U5MR (6.8), and probability of dying from CVDs, cancer, diabetes, or CRD (12.54); and mortality rate attributed to exposure to unsafe WASH (0.09). Kuwait, Qatar, and UAE also obtained the best status for mortality rates attributed to
exposure to unsafe WASH. The health status values for Iran were 75.62 for life expectancy at birth, 9.32 for NMR, 15.02 for USMR, and 15.3 for the probability of dying from any of CVDs, cancer, diabetes, or CRD between age 30 and exact age 70 (%). The mortality rate attributed to exposure to unsafe WASH (water, sanitation, and hygiene services) per 100,000 population was 0.96.

The ranking of EM countries in terms of health status indicators was also determined based on the Q values of the VIKOR method. In 2016, the Q values for Bahrain, Kuwait, Qatar, and Lebanon were low (because the first VIKOR condition was not met) and thus ranked high. This was also the case for Qatar and Bahrain, in 2017, sharing the top rank. However, only Bahrain achieved the top rank from 2018 to 2020.

### Table 2: The weights assigned to indicators using the CRITIC method

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years)</td>
<td>0.0773</td>
<td>0.0750</td>
<td>0.0760</td>
<td>0.0756</td>
<td>0.0750</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (years)</td>
<td>0.0748</td>
<td>0.0727</td>
<td>0.0924</td>
<td>0.0918</td>
<td>0.0911</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>0.1827</td>
<td>0.1775</td>
<td>0.1759</td>
<td>0.1749</td>
<td>0.1807</td>
</tr>
<tr>
<td>Neonatal mortality rate (per 1,000 live births)</td>
<td>0.1769</td>
<td>0.1718</td>
<td>0.1853</td>
<td>0.1893</td>
<td>0.1900</td>
</tr>
<tr>
<td>Under-5 mortality rate (per 1,000 live births)</td>
<td>0.1836</td>
<td>0.1783</td>
<td>0.1746</td>
<td>0.1743</td>
<td>0.1715</td>
</tr>
<tr>
<td>Probability of dying between age 30 and exact age 70 from diseases* (%)</td>
<td>0.1261</td>
<td>0.1513</td>
<td>0.1270</td>
<td>0.1263</td>
<td>0.1253</td>
</tr>
<tr>
<td>Mortality rate attributed to exposure to unsafe WASH (per 100,000 population)</td>
<td>0.1783</td>
<td>0.1732</td>
<td>0.1684</td>
<td>0.1675</td>
<td>0.1661</td>
</tr>
</tbody>
</table>


### Table 3: Mean health status values for the seven indicators in each Eastern Mediterranean country

<table>
<thead>
<tr>
<th>Country</th>
<th>I1 Rank</th>
<th>I2 Rank</th>
<th>I3 Rank</th>
<th>I4 Rank</th>
<th>I5 Rank</th>
<th>I6 Rank</th>
<th>I7 Rank</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>61.78</td>
<td>20</td>
<td>52.68</td>
<td>20</td>
<td>444.4</td>
<td>20</td>
<td>37.40</td>
<td>19</td>
</tr>
<tr>
<td>Bahrain</td>
<td>78.22</td>
<td>1</td>
<td>67.66</td>
<td>2</td>
<td>14.80</td>
<td>5</td>
<td>2.26</td>
<td>1</td>
</tr>
<tr>
<td>Djibouti</td>
<td>63.68</td>
<td>19</td>
<td>56.28</td>
<td>16</td>
<td>232.80</td>
<td>17</td>
<td>32.72</td>
<td>18</td>
</tr>
<tr>
<td>Egypt</td>
<td>70.66</td>
<td>13</td>
<td>61.54</td>
<td>13</td>
<td>33.80</td>
<td>10</td>
<td>12.28</td>
<td>13</td>
</tr>
<tr>
<td>Iran</td>
<td>75.62</td>
<td>7</td>
<td>65.88</td>
<td>8</td>
<td>23.20</td>
<td>9</td>
<td>9.32</td>
<td>11</td>
</tr>
<tr>
<td>Iraq</td>
<td>69.48</td>
<td>14</td>
<td>59.40</td>
<td>14</td>
<td>55.80</td>
<td>12</td>
<td>17.40</td>
<td>15</td>
</tr>
<tr>
<td>Jordan</td>
<td>74.22</td>
<td>11</td>
<td>65.84</td>
<td>9</td>
<td>55.60</td>
<td>11</td>
<td>10.16</td>
<td>12</td>
</tr>
<tr>
<td>Kuwait</td>
<td>74.76</td>
<td>9</td>
<td>66.10</td>
<td>5</td>
<td>5.60</td>
<td>2</td>
<td>3.76</td>
<td>2</td>
</tr>
<tr>
<td>Lebanon</td>
<td>75.74</td>
<td>5</td>
<td>65.94</td>
<td>7</td>
<td>17.80</td>
<td>7</td>
<td>4.66</td>
<td>5</td>
</tr>
<tr>
<td>Libyan</td>
<td>72.22</td>
<td>12</td>
<td>62.90</td>
<td>12</td>
<td>21.60</td>
<td>8</td>
<td>6.90</td>
<td>8</td>
</tr>
<tr>
<td>Morocco</td>
<td>75.32</td>
<td>8</td>
<td>65.14</td>
<td>11</td>
<td>110.80</td>
<td>15</td>
<td>16.20</td>
<td>14</td>
</tr>
<tr>
<td>Oman</td>
<td>76.84</td>
<td>4</td>
<td>66.04</td>
<td>6</td>
<td>17.40</td>
<td>6</td>
<td>5.12</td>
<td>6</td>
</tr>
<tr>
<td>Pakistan</td>
<td>66.46</td>
<td>15</td>
<td>57.74</td>
<td>15</td>
<td>170.40</td>
<td>16</td>
<td>44.52</td>
<td>21</td>
</tr>
<tr>
<td>Qatar</td>
<td>78.14</td>
<td>2</td>
<td>68.24</td>
<td>1</td>
<td>12.2</td>
<td>3</td>
<td>3.94</td>
<td>3</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>74.68</td>
<td>10</td>
<td>65.22</td>
<td>10</td>
<td>13</td>
<td>4</td>
<td>6.14</td>
<td>7</td>
</tr>
<tr>
<td>Somalia</td>
<td>55.24</td>
<td>21</td>
<td>49.12</td>
<td>21</td>
<td>751.4</td>
<td>21</td>
<td>39.04</td>
<td>20</td>
</tr>
<tr>
<td>Sudan</td>
<td>64.7</td>
<td>17</td>
<td>55.78</td>
<td>19</td>
<td>307.8</td>
<td>18</td>
<td>29.6</td>
<td>17</td>
</tr>
<tr>
<td>Syrian</td>
<td>64.08</td>
<td>18</td>
<td>55.92</td>
<td>18</td>
<td>60.6</td>
<td>14</td>
<td>8.18</td>
<td>9</td>
</tr>
<tr>
<td>Tunisia</td>
<td>75.72</td>
<td>6</td>
<td>66.46</td>
<td>4</td>
<td>58.2</td>
<td>13</td>
<td>8.7</td>
<td>10</td>
</tr>
<tr>
<td>UAE</td>
<td>77.16</td>
<td>3</td>
<td>67.18</td>
<td>3</td>
<td>5.4</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Yemen</td>
<td>65.46</td>
<td>16</td>
<td>56.14</td>
<td>17</td>
<td>340.8</td>
<td>19</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Mean</td>
<td>70.96</td>
<td>61.77</td>
<td>131.11</td>
<td>15.58</td>
<td>32.26</td>
<td>19.81</td>
<td>10.18</td>
<td></td>
</tr>
</tbody>
</table>

Source: WHO's annual World Health Statistics report 2016-2020; Indicator I1: Life expectancy at birth (years), I2: Healthy life expectancy (HALE) at birth (years), I3: Maternal mortality ratio (MMR) (per 100,000 live births), I4: Neonatal mortality rate (NMR) (per 1,000 live births), I5: Under-5 mortality rate (USMR) (per 1,000 live births), I6: Probability of dying from any of CVDs, cancer, diabetes, CRD between age 30 and exact age 70 (%), I7: Mortality rate attributed to exposure to unsafe WASH (water, sanitation, and hygiene services) (per 100,000 population).
### Table 4: Ranking of the Eastern Mediterranean countries based on the Q values of the VIKOR method

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahrain</td>
<td>0.000</td>
<td>1</td>
<td>Qatar</td>
<td>0.000</td>
<td>1</td>
<td>Bahrain</td>
<td>0.000</td>
<td>1</td>
<td>Bahrain</td>
<td>0.000</td>
<td>1</td>
<td>Bahrain</td>
<td>0.000</td>
<td>1</td>
</tr>
<tr>
<td>Kuwait</td>
<td>0.016</td>
<td>2</td>
<td>Bahrain</td>
<td>0.007</td>
<td>2</td>
<td>Qatar</td>
<td>0.082</td>
<td>2</td>
<td>Qatar</td>
<td>0.080</td>
<td>2</td>
<td>Qatar</td>
<td>0.079</td>
<td>2</td>
</tr>
<tr>
<td>Qatar</td>
<td>0.024</td>
<td>3</td>
<td>UAE</td>
<td>0.070</td>
<td>3</td>
<td>Iran</td>
<td>0.119</td>
<td>3</td>
<td>Iran</td>
<td>0.116</td>
<td>3</td>
<td>Saud Arabia</td>
<td>0.116</td>
<td>3</td>
</tr>
<tr>
<td>Lebanon</td>
<td>0.026</td>
<td>4</td>
<td>Saud Arabia</td>
<td>0.066</td>
<td>4</td>
<td>Iran</td>
<td>0.120</td>
<td>4</td>
<td>Saud Arabia</td>
<td>0.122</td>
<td>4</td>
<td>UAE</td>
<td>0.117</td>
<td>4</td>
</tr>
<tr>
<td>Saud Arabia</td>
<td>0.110</td>
<td>5</td>
<td>Tunisia</td>
<td>0.094</td>
<td>5</td>
<td>Saud Arabia</td>
<td>0.130</td>
<td>5</td>
<td>UAE</td>
<td>0.121</td>
<td>5</td>
<td>Iran</td>
<td>0.119</td>
<td>5</td>
</tr>
<tr>
<td>Oman</td>
<td>0.120</td>
<td>6</td>
<td>Oman</td>
<td>0.096</td>
<td>6</td>
<td>Tunisia</td>
<td>0.131</td>
<td>6</td>
<td>Tunisia</td>
<td>0.129</td>
<td>6</td>
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Source: WHO’s annual World Health Statistics report 2016-2020
table 4 to determine the overall ranking of the EM countries (table 5). In this method, the arithmetic mean of the ranks in 2016-2020 was determined for each country (alternative), based on which the alternatives were prioritized. Alternatives with a lower mean rank will have higher priorities. The results showed that Bahrain and Somalia ranked first and last on health status indicators, respectively. Iran was ranked fifth among the EM countries.

As mentioned in step three of the VIKOR method, the value of \( v \) was set to 0.5. To analyze the sensitivity of the country ranking results, the effect of \( v \) on \( Q \) was examined by changing its value from 0.1 to 0.9 (figure 1). The results showed that changing the \( v \) value did not affect the \( Q \) value and the overall position of Bahrain did not alter. Besides, regardless of the \( v \) value, the trend of the country ranks remained stable, and no sensitivity to \( v \) values was observed.

### Discussion

In the present study, 21 EM countries were ranked in terms of seven health status indicators, namely life expectancy at birth, HALE at birth,
Health status indicators in Iran and Eastern Mediterranean countries

MMR, NMR, U5MR, probability of dying from CVDs, cancer, diabetes, and CRD; and mortality rate attributed to exposure to unsafe WASH. Among all indicators used by the WHO, the selected indicators will give an overall indication of the health status in the EM countries.

The results showed a significant variation among the EM countries in terms of population, health service coverage, health human resources, health expenditures, and health status. For example, Pakistan has the lowest CHE per capita, which is 45 times lower than that of Qatar. In Somalia, the density of medical doctors and nursing and midwifery personnel (per 10,000 population) is 0.2 and 1.1, respectively. Whereas, in Kuwait, they were 26.5 and 74.1, respectively. Moreover, life expectancy at birth (an important indicator of health status in a country) in Somalia is 23 years lower than Bahrain. In this regard, Iran scored 75.62 years and ranked 7th in the region (after Bahrain, Qatar, the United Arab Emirates, Oman, Lebanon, and Tunisia). Iran scores better on all health indicators than the mean value of the EM countries and therefore has a reasonably good health status. However, there is a significant gap between Iran and the mean values of the top-ranked countries. Previous studies have also reported similar differences in health resources and outcomes among the EM countries.

Based on the final ranking of the 21 EM countries, using the weighted average method, the health status in Iran ranked 5th after Bahrain, Qatar, Saudi Arabia, and the UAE. However, another study that used the infant mortality rate (IMR) indicator assigned first place to Qatar. Interestingly, Qatar, UAE, and Saudi Arabia had higher CHE per capita than Bahrain (>1,000 USD), but they were ranked lower in terms of health status. Similarly, Iran ranked 5th with only 415 USD expenditure per capita. This means that a country can spend less, but be more efficient and achieve a better health status. On the other hand, Somalia, Pakistan, and Afghanistan with a minimum CHE per capita had the lowest health status among the EM countries. In a previous study, Pourmohammadi and colleagues used the total health expenditure as an indicator and ranked Iran 10th out of the 19 assessed EM countries. In their study, Qatar and Pakistan had the highest and lowest total health expenditure, respectively. It is clear that CHE per capita is a better indicator for assessing health systems than CHE as a percentage of GDP, because it takes population size into account. The results of other studies also showed a significant relationship between CHE per capita and health status, such that countries that allocated more money per capita to their healthcare systems had significantly lower IMR and U5MR.

Another important indicator for assessing healthcare systems is human resources. According to the WHO report 2000, a sufficient number of medical doctors and nursing and midwifery personnel is important to deliver adequate health services. Typically, countries that were ranked higher in health status than Iran had much more nursing and midwifery personnel than medical doctors (per 10,000 population). In contrast, the number of medical doctors in Iran is much higher than nursing and midwifery personnel. It seems justified to argue that increasing the number of nursing and midwifery staff is a logical step for the Iranian healthcare system towards a better health status. Overall, while CHE per capita is extremely important, a range of other factors also contributes to the health status of a country. This is in line with the findings of other studies stating that quality management and leadership in the healthcare system, sufficiency of skilled personnel, and an effective referral system greatly contribute to the health status of a country.

The results of the present study showed that Bahrain has achieved a high-ranking position among the EM countries during 2016-2020. This is primarily attributed to its adaptation of the Alma-Ata Declaration, which emphasizes a well-organized primary health care (PHC) system as the cornerstone of healthcare services. Bahrain offers a free-of-charge comprehensive package of preventive, promotive, therapeutic, and rehabilitative care services to its nationals, and at heavily subsidized rates to non-citizens. The public sector accounts for approximately 90% of health services in Bahrain. Their PHC team consists of family physicians, nurses (including community nurses, specialist nurses such as diabetes nurses), healthcare staff, medical social workers, and health educators. Accessing secondary health care is possible only through referral and PHC systems, but direct access is foreseen for trauma and emergency patients. The referral process is well-organized, however, the feedback mechanism from secondary to primary care needs improvement. Overall, in several consecutive years, Bahrain has achieved the highest human development index and health indicators in the Arab world, and their healthcare system is comparable to developed countries.

In 2005, Iran initiated the family physician program in small cities (population density <20,000) and rural areas. In 2013, a pilot program was implemented in two Iranian provinces (Fars and Mazandaran) to improve
the referral system and provide equitable and efficient health care. However, there were contradictory reports on its outcomes. Some studies reported a reduction in IMR, NMR, and MMR, whereas others claimed no significant difference between pre- and post-implementation of the program. Another study reported that the family physician program was successful in screening diabetes and hypertension. However, Fallah and Rostamzadeh reported that the family physician program was not successful in preventing and reducing the short- and long-term complications in diabetic patients. Nonetheless, Iranian healthcare policymakers remain optimistic that the family physician program will make the healthcare system more efficient and considerably improves Iran's health status indicators.

The main limitation of the study was the review of only some and not all output indicators. Further studies are recommended using a simultaneous review of output and input indicators.

Conclusion

Based on the WHO’s annual World Health Statistics report 2016-2020, in terms of the health status in the EMR countries, Bahrain and Iran achieved the first and fifth health status ranking positions among the EM countries, respectively. However, while Iran has a better status on all indicators than the mean value of all EM countries, there is a significant gap between the health status in Iran compared to the top-ranked countries. Health care strategies used by countries such as Bahrain and Qatar can be used as a model by Iran and other EM countries to improve their healthcare system.

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Conflict of Interest: None declared.

Authors’ Contribution

R.R: contribution to conception and design, analysis and interpretation of data, drafted the article, contribution to the article revision; Z.K: contribution to conception and design analysis and interpretation of data, contribution to the article revision; P.B: contribution to conception, design and article revision; H.J: contribution to conception, design and article revision; N.B: contributed to acquisition, analysis and interpretation data, drafted the article, contribution to the article revision; P.S: contribution to conception and design, analysis and interpretation of data and article revision; All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

References

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20 Baschieri A [Internet]. Health inequities in the eastern mediterranean region selected country case studies. c2014. Available from: https://researchonline.lshtm.ac.uk/id/eprint/2550783


29 Raeissi P, Azar FEF, Roudbari M, Kia H. The impact of family physician program on mother and child health indices in rural population auspices of Mashhad University of
Medical Sciences and Health Care Services, Iran; 2009. Journal of Health Administration (JHA). 2011;14.


