A policy brief on improving the finance of family physician program: An experience from urban areas of Iran

Mozhgan Fardid, Mehdi Jafari, Abbas Vosoogh-Moghaddam

1Center for Health Related Social and Behavioral Sciences Research, Shahroud University of Medical Sciences, Shahroud, 2Department of Health Services Management, School of Health Management and Information Sciences, Iran University of Medical Sciences, 3Health Managers Development Institute, Ministry of Health and Medical Education, 4Society and Health Policy Group, Secretariat for Supereime Council of Health and Food Security, 5Leadership and Governance Scientific Group, Health Manager's Development Institute (HMDI), Ministry of Health and Medical Education, Tehran, Iran

ABSTRACT

In the current scenario, financing suffers from problems related to lack of specific line for UFFP, lack of resource pooling, delay in payment to physicians, and conflict of interests among family physician team. As a result, this policy brief was formulated based on the role of FPs in public access to general practitioner (GP) services in the referral system on one hand, followed by the impact of it on health costs reduction on the another hand, and further considering the necessity of financing system audit to find a sustainable resources for this program to be implemented at a national level in the country of Iran.

Keywords: Family physicians, family practice, healthcare financing, health policy, Iran, primary healthcare

Introduction

Recently, the health system was rigid to face emerged needs such as life expectancy increase, immigration to cities, public expectations’ increase, and private sector extension.[1,2] In 2005, the “family physician program and referral system” was approved to be implemented in all rural regions and cities of Iran, populated less than 20000 people, by Islamic Consultative Assembly, especially the Department of Health and Cooperation Organization of Management and Planning.[3] Three years later, the urban family physician program (UFFP) has arrived at agenda-setting. Therefore, the UFFP version 01, was announced to be implemented in cities having more than 20000 population (Khuzestan, Sistan-Baluchestan, and Charmahal-o-Bakhtiyari).[4] Due to some problems like insufficient-income for family physicians (FPs), time-wasting for patient reception, and multiple insurance funds, version 02 of “UFFP and referral system” was developed.[5,6] This program, in line with the announced policies by supreme leader regarding health and according to article 32, article 35, and article 38 of the fifth development plan was implemented as pilot in Fars and Mazandaran.[7] Currently, this program is in progress as a pilot in above mentioned provinces; however, some issues hinder it from its national implementation.[8‑10] Learning from previous experiences encourages the use of evidence-based research and limits research misuse (like lobbyists). Therefore, it contributes to evidence-informed policy which assists policymakers to ask fundamental questions about available research evidence, use good information for decision making, and have fact-based outcomes in line with evidence.[11]

Address for correspondence: Dr. Abbas Vosoogh-Moghaddam, Society and Health Policy Group, Secretariat for Supereime Council of Health and Food Security, Ministry of Health and Medical Education, Simaye-Iran Street, Phase 5, Shahrak-e-Qods, Tehran, Iran. E-mail: avosoogh@behdasht.gov.ir

Received: 11-11-2019 Revised: 23-01-2020 Accepted: 07-02-2020 Published: 26-03-2020

How to cite this article: Fardid M, Jafari M, Vosoogh-Moghaddam A. A policy brief on improving the finance of family physician program: An experience from urban areas of Iran. J Family Med Prim Care 2020;9:1413-7.
Policymakers argue that developing the FPs program in cities is one of the most major challenges of Iran's health system. The establishment of family physician in cities compared with rural regions encounters some problems such as lack of required infrastructures, fragmented network of primary care, powerful private sector with high conflict interests among family physicians, public high freedom in selecting health services, tendency of urban residents to visit a specialist, treatment-centered advertisements by mass media, government enterprise, not participation of all stakeholders and the gap between theory, and practice of family physician program in urban areas of Iran.

Various individuals, groups and organizations affect family physician including: Ministry of Health, Parliament, Planning and Budgeting Organization, Health Insurance Organization, Social Security Organization, Deputy of Health in the Universities of Medical Sciences, Association of Pharmacists, Association of Physicians, Nursing and Midwifery Association, Medical Council, Representatives of Physicians and Public.

Recommendations

The recommendations for improving family physician financing are presented in Table 1.

| Category          | Policy Options                                                                 |
|-------------------|--------------------------------------------------------------------------------|
| Revenue Collection| Moving from Bismarck to Beveridge by dedicated budget line for UFFP. One of the major barriers to sustainable financing in the FP program is the payment delay to physicians which is due to Bismarck's payment to GPs, the lack of money allocation from the urban FPs dedicated budget line and money transfer due to the implementation of concurrent competitor programs. Therefore, the first policy option to improve the financing of the UFFP is moving toward the Beveridge family payment model and financing it by resource allocation from the relevant budget line in order to pay physicians from the Treasury on time and resolve dissatisfaction arisen from delayed payment to physicians. Creating a saving fund for the payment of urban family physician. Insufficient financial resources is another barrier to implement UFFP. Therefore, the resources must be increased through various ways like donates as an extra fund. This fund helps in financial crisis to reimburse FPs temporarily. When receiving the postponed revenues, that temporarily supply will be returned back to this fund for the next urgent financial need. Determining franchise and referral limit for an urban family physician. Another way of making money in the financial crisis is by assigning franchises. Zero franchise can be devoted only to lower-income percentiles while for rich regions a franchise can be assigned as mandatory. Besides, the referral limit may be considered, i.e., if individuals go to FPs more than a specific amount, they will have to pay franchise. |
| Resource          | Creating an integrated virtual fund                                               |
| Pooling           | Multiple insurance funds and lack of pooling is another barrier to finance UFFP properly. Therefore, the financial resources must be integrated virtually till the time their real polling can be reached. |
| Service Purchasing| A detachment of physician capitation from health care providers (midwives)          |
| Behavior          | A frequent problem expressed by both providers and directors of UFFP was the common share of midwives from FP's capitation. It leads to some issues including: out of pocket payment to midwives due to delay in receiving capitation and discrimination in paying to midwives due to physicians' preferences. Therefore, the fifth policy brief would be detachment of physician capitation from health care providers. Specific training of general practitioners to become family physicians. One of the expressed problems was non-readiness of physicians for caregiving as an FP and lack of experience as well as a holistic view of this program. So, training the fundamental differences between FP and GP behavior to patient as an FP, and having a holistic view of diagnostic-curative topics as specific courses for FP is another policy option. Providing the information to the public for enhancing the correct culture of FP. Another expressed issue by policymakers and providers in regard to UFFP was unfamiliarity of public with the correct use of FP services and visiting their FP only to be allowed to visit a specialist without any cost. Therefore, it is recommended to aware public indirectly by enhancing the culture of FPs' correct use. Besides, it is recommended to apply some tactics such as referral limit, and franchise assigns to hinder the excessive referrals to FPs. |

Policy Implications

Due to the importance of not-to-do as the same as the importance of policy options, it is recommended to:

- Pass laws to hinder money transfer across budget lines and health plans.
- Consider the ability to pay in assigning franchise for preventing from access reduction in poor people.
- Set a logical limit for referrals, not that bounded by which the access would be denied, not that opened by which the referrals don’t seem different from before.
- Take actions so that the share of all participants be attached to the virtual fund.
- Take actions so that the detachment of midwives from physician capitation does not lead to their disobedience from their supervisors.

The advantages, disadvantages, cost-effectiveness, and stakeholders’ comments about the recommended options using the research team are compared in Table 2.

Conclusion

Paying to midwives from FPs' capitation has been designed based on pay for performance. Therefore, detachment of midwives shares from FPs capitation may lead to disobedience of midwives.
Table 2: The advantages vs. disadvantages of policy options

| Option | Advantages | Disadvantages | Cost/Effectiveness | Stakeholders’ comments |
|--------|------------|---------------|--------------------|------------------------|
| Option 1 | Speeding up paying to physicians | high need for coordination and meetings between the Ministry of Health and insurance agencies | Low costs, high effectiveness | Agree |
| Option 2 | Speeding up paying to physicians | Need for the cooperation of donors and justifying them to devote their resources to this program | Low costs, moderate effectiveness | Agree |
| Option 3 | Reduce costs and prevent behavioral risks | The possibility of making poorer or ignoring the people in need of treatment | Very low costs, high effectiveness | Some agree some disagree |
| Option 4 | Speeding up paying to physicians | high need for coordination and meetings between the Ministry of Health and insurance agencies | Low costs, high effectiveness | Agree |
| Option 5 | More satisfaction among physicians and midwives and more fairness among midwives | Disobedience of midwives from physicians’ orders | Low costs, high effectiveness | Strongly agree (consensus) |
| Option 6 | More confidence among the public, the quality improvement of prevention and treatment, and lower referrals | Increase in physicians’ financial expectations. The training process is cost and time consuming | High costs, high effectiveness | Strongly agree (consensus) |
| Option 7 | More confidence among the public, more satisfaction, fewer costs, and lower referrals | The process of informing is costly and needs a long time to build the culture | High costs, high effectiveness | Strongly agree (consensus) |

Out of these policy options, the options 4, 1, 2, 6, 7, and 5 are recommended, respectively.

Table 3: The requirements, solutions for recommended options

| Policy Options | Requirements | Barriers | Solutions | Evidences |
|---------------|--------------|----------|-----------|-----------|
| Policy option 1 | Parliament, Ministry of Health, Ministry of Welfare | The agreement to assign a budget line | The resistance of Ministries or organizations | The United States has invested a lot of money in healthcare, like a family physician program in 2018, to ensure that all patients have access to care, regardless of geographic location. 
\[14,15\] |
| Providers | Physicians and midwives | The coordination between the Health Ministry and the related organizations | Hold a meeting to justify and train key people | In the United States, 77 percent of spending on poor people comes from charity |
| Managers and policymakers | Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations, Strategic Deputy of President, Planning and Budget Organization | | | |
| Related organizations | | | | |
| Policy option 2 | Public groups, benefactors, governors of the provinces, Municipality and universities, University presidents, governors, mayors, city representatives, Broadcasting organization | Getting attention and the agreement of benefactors | Disagreement of benefactors | Such interorganizational agreements exist in other countries as well. Even some of these agreements are cross-country, such as medical contracts and health benefits between New Zealand and the United Kingdom. 
\[16\] |
| Providers | Physicists and midwives | | Hold a meeting to justify and train rich benefactors | The not only virtual fund is used in healthcare, but virtual hospitals are also used in the United States. 
\[17\] |
| Managers and policymakers | Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations, The Medical Council and the Association of Physicians | | | |
| Related organizations | | | | |
| Policy option 3 | Parliament, Ministry of Health, Ministry of Welfare | The agreement between university, insurance organizations and the Ministry of Health | Public resistance and disagreement of policymakers/managers | Such interorganizational agreements exist in other countries as well. Even some of these agreements are cross-country, such as medical contracts and health benefits between New Zealand and the United Kingdom. 
\[16\] |
| Providers | Physicians and midwives | | Hold a meeting to justify and train public and justify policymakers | The not only virtual fund is used in healthcare, but virtual hospitals are also used in the United States. 
\[17\] |
| Managers and policymakers | Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations, The Medical Council and the Association of Physicians | | | |
| Related organizations | Strategic Deputy of President, Planning and Budget Organization | | | |
| Policy option 4 | Ministry of Health, Ministry of Welfare | Agreement on virtual fund and cross-sectional cooperation in this regard | The resistance of Ministries or organizations | The United States |
| Providers | Physicians and midwives | | Hold a meeting to justify and train key people | |
| Managers and policymakers | Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations, Strategic Deputy of President, Planning and Budget Organization | | | |
| Related organizations | | | | |

Contd...
Policy Options | Requirements | Barriers | Solutions | Evidences
--- | --- | --- | --- | ---
Policy option 5 | Ministry of Health, Ministry of Welfare Physicians and midwives | Agreement on separating the midwives’ share from GP capitation | Physicians’ resistance | Hold a meeting to justify and train FPs
Policy option 6 | Physicians Universities of Medical Sciences | Creating the FP specialty, Approval of educational curriculum, the certification of training course, the evaluation of provided training and related legal requirements | Physicians’ resistance | Hold a meeting to justify and train FPs
Policy option 7 | Patients | Build a culture, Cooperation of broadcasting organization | Public’s resistance | Training seminars, TV programs, Commercial Ads, Mass media such as newspapers and billboards

from physicians. So it is suggested that the physician signs a satisfaction certificate for the midwife under supervision prior to payment to her. It will not only make the insurance organizations’ payment to midwives uniform but also make the midwives observe job standards and respect to FPs. Besides, training the GPs increases their expectations to receive more rewards and as a result the costs will be increased. Therefore, before training GPs specifically, providing high-quality services by physicians must be assured and the relevant proper evaluation criteria should be set for service receivers. Table 3, presents the requirements, solutions for recommended options for target groups, providers, managers, policymakers, and related organizations.

**Ethical Consideration**

This study was part of a Ph.D. thesis approved by the ethics committee of Iran University of Medical Sciences and the approval from the ethics committee is obtained on 15-03-2017 (IR.IUMS.REC1395.9221557205).

**Acknowledgment**

All policy-makers, managers, FPs, and patients who agreed to participate in the current study, as well as the anonymous reviewers who helped with their suggestions, are appreciated. The authors would also like to thank the research deputy of Iran University of Medical Sciences for supporting this study (grant No: IUMS/SHMIS. REC1395.9221557205).

**Financial support and sponsorship**

This study is a part of a Ph.D. thesis approved and supported by Iran University of Medical Sciences (Grant No: IUMS/SHMIS_1395/9221557205).

**Conflicts of interest**

There are no conflicts of interest.

**References**

1. Takian A, Rashidian A, Kabir MJ. Expediency and coincidence in re-engineering a health system: An interpretive approach to formation of family medicine in Iran. Health Policy Plan 2010;26:163-73.
2. Khedmati J, Davari M, Aarabi M, Soleymani F, Kebriaeezadeh A. Evaluation of urban and rural family physician program in Iran: A systematic review. Iran J Public Health 2019;48:400-9.
3. The Executive Protocol of Family Physician Plan and Rural Insurance in 2014. Ministry of Health and Medical Education; 2014.
4. The Pathology of Implementing Family Physician Plan and Referral System in the Cities with More than 20000 Population. Ministry of Health and Medical Education; 2014.
5. Jabbari Boyrami H, Doshmangir L, Ahmadi A, Aghbari Jafarabadi M, Khedmati Morasae E, Gordeev VS. Impact of rural family physician programme on maternal and child health indicators in Iran: An interrupted time series analysis. BMJ Open 2019;9:e021761.
6. The protocol of family physician plan and referral system in the urban areas 2011.
7. Honarvar B, Lankarani KB, Rostami S, Honarvar F, Akbarzadeh A, Odoomi N, et al. Knowledge and practice of people toward their rights in urban family physician program: A population-based study in Shiraz, Southern Iran. Int J Prev Med 2015;6:46.
8. Rafiei S, Mohhebbifar R, Ranjar M, Akbarirad F. The preferences of general practitioners regarding family physician contract in the underprivileged areas of Iran in
using conjoint analysis. Evid Based Health Policy Manag Econ 2019;3:96-104.

9. Esmaeili R, Hadian M, Rashidian A, Shariati M, Ghaederi H. Family medicine in Iran: Facing the health system challenges. Global J Health Sci 2015;7:260-6.

10. Jabbari H, Azami-Aghdash S, Pirsi P, Naghavi-BeHzad M, Sullman MJ, Safiri S. Organizing palliative care in the rural areas of Iran: Are family physician-based approaches suitable? J Pain Res 2018;12:17-27.

11. Oxman AD, Lavis JN, Levin S, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking? Health Res Policy Syst 2009;7(Suppl 1):S1.

12. Kavosi Z, Keshtkaran A, Hayati R, Ravangard R, Khammarnia M. Household financial contribution to the health system in Shiraz, Iran in 2012. Int J Health Policy Manag 2014;3:243-9.

13. Khayyati F, Motlagh ME, Kabir MJ, Kazemeini H, gharibi F, Jafari N. The role of family physician in case finding, referral, and insurance coverage in the rural areas. Iran J Public Health 2011;40:136-9.

14. Ault A. Trump signs 2018 budget, with some big wins for healthcare. Medscape Logo 2018.

15. AAFP. Federal Budget Deal Brings Wins for Family Medicine. 2018. Available from: https://www.aafp.org/news/government-medicine/20180213federalbudget.html.

16. Hauora MoHM. Reciprocal health agreements. 2007. Available from: https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/reciprocal-health-agreements.

17. Durkin P. Medibank ramps up ‘virtual hospitals’, which cut costs by two-thirds. 2018. Available from: https://www.afr.com/brand/boss/home-hospitals-cutting-private-health-fund-costs-by-two-thirds-20181015-h16nzt.

18. AAFP. Family Medicine Specialty. Available from: https://www.aafp.org/about/the-aafp/family-medicine-specialty.html.

19. Liu X, Tan A, Towne Jr SD, Hou Z, Mao Z. Awareness of the role of general practitioners in primary care among outpatient populations: Evidence from a cross-sectional survey of tertiary hospitals in China. BMJ Open 2018;8:e020605.