Original Article

Urban Family Physician Program after a Decade of Implementation from the Perspective of People: A Qualitative Study from Iran

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Abstract

Background: A decade after the implementation of the Urban Family Physician Program (UFFP) in Fars province, southern Iran, we aimed to reveal people's opinions regarding the strengths and challenges of this program, which help policymakers for evidence-based improvement of this program. **Methods:** In this thematic content analysis qualitative study, which was performed in 2023, one adult individual of each family under the coverage of UFPP was selected using a purposeful sampling method. Then, an in-depth and semi-structured phone interview was conducted with each participant. Interviews were continued until the achievement of data saturation. The trustworthiness of data was checked according to Guba and Lincoln criteria. Data analysis was accomplished using MAXQDA software version 10. **Results:** A total of 25 participants with a mean age of 41 ± 12 years old were interviewed. Extracted strengths points of UFPP consisted of 390 meaning units, 41 open codes, 16 subcategories, 9 categories, and 3 themes, of which the main themes consisted of proper governance, adequate service provision, and promoting community health. In contrast, the challenges of this program comprised 127 meaning units, 54 open codes, 17 subcategories, 7 categories, and 3 themes, the main themes of which included weak governance, inefficient service provision, and limitation of resources. **Conclusions:** After a decade of implementation, people demonstrated contradictory opinions about many aspects of UFPP. Strength points should encourage policymakers to advocate more for this program and extend it to the other provinces of Iran, whereas weak points should be used for its revisions and improvement.

Keywords: *Challenges, family physician, Iran, qualitative study, strengths*

Introduction

The Family Physician Program (FPP) was established to improve both efficiency and effectiveness, establish justice, and provide universal access to healthcare services.[1,2] More than 80 countries are members of the World Organization of Family Doctors (WONCA).[3] As a result of the implementation of FPP, a comprehensive and prevention-based approach to health and improving health at the individual, family, and community levels was achieved in some pioneer countries.[1,3,4] In Iran, FPP was implemented in rural areas and small towns in 2005, and following its reported success,[5,6] the pilot phase of the urban family physician program) UFPP (was implemented in the cities of Fars and then Mazandaran provinces in 2012, which is still ongoing.[7] Evidence showed that implementing FPP in the cities can be more challenging than in rural areas due to more differences in cultures and populations.[8] Most UFPP studies in Iran focus on policymakers and staff, neglecting people's point of view who are the program's primary beneficiaries. This study was conducted to determine the current public opinion on the strengths and challenges of the UFPP in Fars province, which can help policymakers improve the program.

Materials and Methods

Study design and setting

This qualitative study was conducted in 2023 in Fars, Iran. In this study, thematic content analysis was applied to explore people's opinions about the strengths and challenges of UFPP.

Study participants and sampling

First, the cities of Fars province were divided into two groups based on their population: populous cities (over 50,000 people) and small cities

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(less than 50,000 people). Then, in addition to Shiraz City (the capital city of Fars province), eight other cities (four populous and four small cities) were randomly chosen considering their geographical directions. After negotiations with the health deputy of Shiraz University of Medical Sciences (SUMS), we received a list of names and contact information for our target population. As inclusion criteria, the target population consisted of Iranian adults over 18 years who were residents of Fars province for the past 2 years and were under the coverage of UFPP. Then, considering high variation, purposeful sampling was applied, and interviewees were selected. Each interviewee was from one family; no exclusion criteria existed except non-willingness to join this study.

Data collection tool and technique

Due to the wide geographical distribution of the target population, logistic difficulties in face-to-face interviews, and the importance of the observance of homogeneity in the data-gathering method, we performed all interviews through phone contacts. Interviews were performed by a trained interviewer who had experience in conducting qualitative studies. After introducing and explaining the aims of this study and obtaining verbal consent for participating, phone interviews were performed at participants' preferred time according to the appointments. Afterward, general questions (age, level of education, marital status, job status, being the head of family, living place in the Fars province, and years of being covered by UFPP) were asked of the participants. Then, an in-depth and semi-structured interview was conducted with each participant. In interviews, the participants were first asked about their experiences with UFPP as open encoded questions. Next, they were asked to explain their positive and negative experiences with this program. We also requested follow-up/probing questions such as "What?" "How?" "Why?" and "May you explain more?" to obtain much more information in each interview. Furthermore, notes were taken during the interviews, and two voice recorders were used to ensure that no problem could occur while recording the interviewees' voices. The interviews continued until data was saturated; no new information and codes could be extracted.

Data analysis

Data collection and analysis were performed concurrently. After each interview, the audio file was transcribed into meaning units. The transcripts and notes were reviewed multiple times to gain a general understanding of them. The Erlingsson and Brysiewicz content analysis approach[9] and MAXQDA software version 10 were utilized to analyze the data. In this way, texts were reviewed, and meaning units were extracted. Then, open codes were shaped, and we categorized them into subthemes. Afterward, the main themes were created via the interpretation of subthemes.

Trustworthiness and rigor of the study

The trustworthiness of the data was approved based on the four criteria offered by Guba and Lincoln, including transferability, credibility, confirmability, and dependability.[10] The transferability of the data was guaranteed through providing an inclusive explanation of the subject, and the characteristics of the interviewees and gathering and analyzing the data. Moreover, utilizing purposive and theoretical sampling methods heightened transferability. The credibility was considered through semi-structured interviews, field notes, and extensive involvement with the subject matter accompanied by constant peer probing as well as expert and member checking. Data confirmability was warranted by the lead researcher, who conducted several comprehensive meeting reviews to gather concepts and ideas from other research teams and kept records of the relevant study documents. Also, an audit trail was performed by several researchers familiar with the healthcare system and qualitative research. Finally, dependability was addressed through in-depth negotiations with experts and a review by the interviewees and other researchers.

Ethical considerations

The ethics committee of SUMS approved the study's proposal, which was encoded as IR.SUMS.REC.1401.347. Also, the 1964 Helsinki Declaration was considered in this study. All participants were provided with enough information about the study's aims. Furthermore, verbal informed consent was obtained from each participant before attending the interview session. In addition, all interviewees were informed about the voluntary participation and the possibility of withdrawing from the study at any stage. Moreover, interviewees were assured that the interviews would be confidential and stored anonymously, and after the article's publication, the audio would be deleted entirely.

Results

In this qualitative study, we interviewed 25 participants with a mean age of 41 ± 12 years old (min: 18, max: 67), including 16 female and nine male participants. The mean years they have lived in Fars province was 21 ± 20 years. The mean family size was four individuals, and basic insurance systems covered all, whereas 8 (32%) were under the coverage of supplementary insurance. Other characteristics of the interviewees are shown in Table 1.

Strengths of UFPP

The strengths of UFPP consisted of 390 meaning units, 41 open codes, 16 subcategories, nine categories (subthemes), and 3 themes. As Table 2 shows, the main themes consisted of proper governance, adequate service provision, and community health promotion. Categories included appropriate legislation, high financial protection,

Table 1: Participants' characteristics in this study

ID	Gender	Age (year)	Level of Education	Marital Status	Job Status	Being the head of the family	Living Place in the Fars Province	Years past from being covered by UFPP†
≠1	Female	27	Bachelor	Married	Unoccupied	No	Shiraz	9
≠2	Female	39	Diploma	Married	Unoccupied	No	Abadeh	9
≠3	Male	46	Diploma	Married	Occupied	Yes	Abadeh	9
≠4	Male	25	Master	Single	Occupied	Yes	Abadeh	5
≠5	Female	50	Diploma	Married	Unoccupied	No	Abadeh	8
≠6	Male	43	Bachelor	Married	Occupied	Yes	Lamerd	10
≠7	Female	44	Diploma	Married	Unoccupied	No	Lamerd	8
≠8	Female	37	Bachelor	Married	Occupied	No	Lamerd	6
≠9	Female	35	Diploma	Married	Unoccupied	No	Kazeroon	11
≠10	Female	32	Diploma	Married	Unoccupied	No	Kazeroon	10
≠11	Male	62	Diploma	Single	Retired	Yes	Neyriz	5
≠12	Male	63	Diploma	Married	Retired	No	Neyriz	9
≠13	Female	55	Under diploma	Married	Occupied	Yes	Neyriz	10
≠14	Female	67	Diploma	Married	Occupied	Yes	Neyriz	10
≠15	Female	18	Diploma	Single	Unoccupied	No	Rostam	10
≠16	Female	50	Diploma	Married	Unoccupied	Yes	Rostam	11
≠17	Female	38	Bachelor	Single	Unoccupied	No	Pasargad	11
≠18	Male	40	Diploma	Married	Occupied	Yes	Pasargad	11
≠19	Female	37	Diploma	Married	Unoccupied	No	Qir karzin	8
≠20	Male	30	Bachelor	Married	Occupied	Yes	Sepidan	4
≠21	Female	21	Diploma	Married	Unoccupied	Yes	Sepidan	10
≠22	Female	34	Bachelor	Married	Occupied	No	Shiraz	11
≠23	Female	53	Diploma	Married	Occupied	Yes	Shiraz	11
≠24	Male	41	Master	Married	Occupied	Yes	Shiraz	10
≠25	Male	42	Bachelor	Married	Occupied	Yes	Shiraz	10

†UFPP: URBAN Family Physician Program

high responsiveness, optimal delivery of services, comprehensive accessibility, appropriate health systems, client-based services, improving public literacy about UFPP, and appropriate preventive services.

Some examples of quotes about the strengths of UFPP

Proper governance

An example of quotes about proper governance was providing affordable services and financial protection. A 46-year-old male patient mentioned that: *"The costs of being visited by a FP are much more reasonable than an independent doctor. Well, in this bad economic situation, it is really better and affordable for us. Medical drugs are also cheaper this way."*

Adequacy of service provision

As it was revealed in Table 2, the adequacy of service provision in UFPP was also addressed by people in different aspects, such as reserving patients' dignity through the good manner of the FP team toward people. This was mentioned by multiple participants, such as: *"In terms of the behavior of the family doctor, their behavior was good, yes, it was appropriate. The behavior of the doctor and health care team where we were was good and excellent... (a 42-year-old male participant)."*

Promoting community health

People also believed that UFPP promotes community health through the implementation of appropriate preventive services such as providing necessary supplements for each age group as a participant mentioned it: *"My vitamin D was always good... maybe that's why they didn't give it to me... but my mom was older, I saw that they gave her vitamin D... (a 34-year-old female participant)."*

Challenges of UFPP

The challenges of the UFPP program comprised 127 meaning units, 54 open codes, 17 subcategories, 7 categories, and 3 themes. The main themes included weak governance, inefficient service provision, and limitation of resources. As Table 3 shows, categories (subthemes) included problems in the legislation of UFPP, poor financial protection, low transparency, low responsiveness, low accessibility, problems in the sub-structures, and shortage of medical products and equipment.

Some examples of quotes about the challenges of UFPP

Weak governance

Facing bureaucracies that result from weak governance was the cause of dissatisfaction toward UFPP in some people.

Table 2: Strengths of urban family physician program from the viewpoint of people

Theme	Category	Subcategory	Open codes
Proper Governance	Appropriate legislation	Logical referrals	• Reducing unnecessary visits by specialists
	High financial protection	Low visiting Fee	• Providing affordable services
Adequacy of Service Provision	High responsiveness	Having choice	• People have a choice in choosing their FPs[1]
		Preserving patient's dignity	• Good manners of FP
			• Good manners of the FP team members
		Respecting patient's confidentiality	• Preserving patients' privacy
		High Quality of care	• The FP's patience during the examination
			• Detailed examination of the patient by FP
			• Re-checking the medicines by the FP in each visit
			• Providing appropriate treatment for various diseases
			• Providing complete explanations and counseling about the disease
			• Providing complete explanations on how to take the prescribed drugs
			• More accurate diagnosis and clinical excellence of FPs compared with non-FPs and some specialists
		Providing necessary amenities	• Cleanliness of the FP clinic
			• Proper ventilation of the FP clinic
			• FP clinic is equipped with an elevator
		Continuous Follow-ups	• Continuous follow-ups after treatments of patients
			• The seriousness of the FP and FP team for follow-up the patients with chronic diseases
			• Continuous follow-ups in terms of the health status of non-patient people
	Optimal delivery of services	Providing virtual access	• Easy appointment-making by phone
			• Constant availability of healthcare workers through calls, SMSs[2], or available social networks
			• Phone counseling by FP in urgent situations
	Comprehensive Accessibility	Providing in-person access for all groups of the population	• Providing home visits by FP in smaller cities
			• Easy and fast referral to specialists
			• Long working hours of UFPP[3]
			• Nearness of place of residence to the FP service delivery place
		Comprehensive HIS[4] website	• Documentation of disease history for each patient
			• Documentation of medical drug history for each patient
			• Documentation of the health status of each patient
	Appropriate health systems	Appropriate electronic prescribing	• Mitigation of medical errors
			• A good alternative for FPs different handwriting
			• Less commuting between clinic and pharmacy for the FP bad handwriting
	Client-based Services	People's positive feelings about UFPP	• Having more trust in the FP compared with non-FPs
			• Being satisfied with treatment methods which are applied by FPs
Promoting community health	Improving public literacy about UFPP	Providing appropriate education	• Providing effective educational materials
			• Creating question/answer groups in social networks
			• Training the community health volunteers
	Appropriate preventive services	Preventive supplies	• Providing necessary supplements for each age group
		Preventive procedures	• Periodic check of different items of health status
			• Providing vaccinations
			• Providing screening services

[1]FP: Family Physician.,[2]SMS: Short Message Service, [3]UFPP: Urban Family Physician Program., [4]HIS=Health Information System

Table 3: Challenges of urban family physician program from the view point of people

Theme	Category	Subcategory	Open codes
Weak Governance	Problems in the legislation of UFPP[1]	Issue with health services	• Focusing on treatment rather than prevention
			• Not covering of some of the insurance systems by UFPP
			• Unreasonable cost of services
			• Too many bureaucracies
			• Obligatory joining of people to UFPP
	Poor financial protection	Poor supervisions	• Non-free patients' visiting fees
			• A periodic increase in the visiting-fees
			• Illegal Paying for injections
			• Illegal Paying for the visiting by substitute FPs[2]
			• Full payment for insurance-covered medical drugs if there is an interruption in the electronic prescription system
	Low transparency	Insufficient literacy of people about UFPP	• Inadequate information of people about the goals of UFPP
			• Inadequate information of people about the services of UFPP
			• Inadequate information of people about substitute FPs
			• Inadequate information of people about their rights and entitlement in the UFPP
			• Inadequate education of People about the place which they should refer or phone number which they should contact in case of any complaint about UFPP
			• Shortage of educational books and brochures about UFPP
			• Small number of face-to-face health-related educational classes
		Non-qualified educations	• Low quality of educational classes
			• Non-expert instructors
Inefficient Service Provision	Low Responsiveness	Lack of prompt attention	• Long waiting time for visiting by FP
		Undignified care	• Bad manners of FPs and team members
			• Being disregarded by FPs
			• Moodiness of the FPs
		Non-confidentiality	• Ignoring patients' privacy by FP due to concurrent visits of different patients
			• Ignoring patients' privacy by the FP team members due to their shared rooms
		Lack of autonomy	• Not asking patients' opinions about the treatment process
		Inadequate medical knowledge and expertise	• Inadequate knowledge of FPs and FP team
			• Lapses in the clinical skills of FPs
			• Inaccurate diagnosis by FPs
			• Quick and careless examination of patients by FPs and FP team
			• Prescribed unnecessary tests
			• Quick prescribing of drugs by FP without a complete examination
			• Prescription of inappropriate and ineffective drugs
			• Improper treatment of complicated diseases
		Inefficient service delivery	• Inadequate follow-ups
		Insufficient amenities and facilities	• Small FPs clinics' waiting room space
			• Not enough seats for the patients in the FPs clinics' waiting room
			• No water dispenser machine in the FP clinic
		Negative perception about UFPP	• Being dissatisfied with FPs and their substitutes' presented care
	Low accessibility	Limitations in virtual access to the FPs	• The impossibility of making phone appointments
			• Lack of constant communication with healthcare workers through calls, SMSs[3] or available social networks

Contd...

Table 3: Contd...

Theme	Category	Subcategory	Open codes
		Limitations of in-Person access to the FPs	• Short availability of FPs during the scheduled working hours of the UFPP
			• A limited number of patients are visited daily by FPs
			• Limited daily working hours of the FP clinic
			• Limited allocated visiting time for each patient
			• Long distance from the FP's clinic to the pharmacy
			• Limited access to the various specialists
			• Low access to a fixed FP due to the high turnover of FPs
			• Lower access of men (compared to women) to FPs
	Problems in the sub-structures	Problems in the integrated electronic health record system	• Low speed and other problems in the electronic health record system (Sib[4] website)
		Problems in the electronic prescribing system	• Software problems in the e-prescription system
			• Hardware problems in the e-prescription system
Limitation of resources	Shortage of medical products and equipment	Poor medical supplies	• Insufficient necessary equipment for service delivery such as screenings and vaccinations
			• Insufficient supplies of necessary supplements for each age group

[1]UFPP: Urban Family Physician Program, [2]FP: Family Physician, [3]SMS: Short Message Service. [4]Sib: Due to the need to provide inter-organizational non-attendance services, the Ministry of Health of Iran launched an integrated electronic health record system called Sib (a Persian backronym meaning apple)

For example, one interviewee mentioned: *"I came for a test at a laboratory, they said that it (insurance card) must be stamped by the family doctor so that we can calculate it by insurance tariff; otherwise, the cost of the test will be calculated as non-insurance (a 53-year-old female participant)."* Compulsory joining of people to UFPP was another aspect of poor legislation and weak governance in UFPP that many of the participants mentioned, as one interviewee said: *"… the family doctor will reduce only a series of costs and a series of parameters, mostly because of this reason that we joined… (a 53-year-old female participant)."*

Inefficient service provision

Inefficient service provision was one of the themes, which was extracted about the challenges of UFPP, in this study. Inappropriate patient's examination by FPs was one of the examples of this theme, as one interviewee explained: *"I think since we pay the FP a small amount of money for the visit, the doctor does not give enough time to accurately examine us and he disregards our questions. When we ask more than one or two questions, he said that we don't get paid enough to answer more to your questions (a 37-year-old female participant)."*

Limitation of resources

Resources' limitation was another extracted theme regarding problems in UFPP. Among peoples' concerns were insufficiency and inefficiency of medical services; as one person mentioned: *"… because their facilities are limited and they don't diagnose well, people are forced to go to Isfahan (another province) to visit by a specialist doctor (a 50-year-old female participant)."*

Discussion

This qualitative study aimed to investigate the strengths and challenges of UFPP after one decade of its implementation from the people's point of view in Fars Province, Iran. Twenty-five individuals were interviewed. The three extracted themes about the strengths of UFPP consisted of proper governance, adequate service provision, and promoting community health, whereas three extracted themes regarding challenges included weak governance, inefficient service provision, and limited resources. Overall, people believed more in strengths than challenges in UFPP, however discrepancy and in many aspects a contradictory opinion toward UFPP was found. Some of these conflicts may come from Fars province's varied geography and huge cultural heterogeneity. However, these conflicts may also come from a large gap in populations' literacy toward this program, the provision and sustainability of resources, the appropriateness of infrastructures, and FPs 'motivations and experiences in the different regions. Furthermore, mismanagement in different aspects of UFPP should not be overlooked. In the following, we discuss these aspects and investigate all extracted themes.

Strengths of UFPP

Proper governance

The UFPP in Iran aims to provide cost-effective primary healthcare (PHC) services to the population, reducing the need for specialist visits and improving healthcare provision. Furthermore, by providing accessible, affordable, comprehensive, and patient-centered care, the UFPP can improve the health outcomes of the Iranian population. All

these items were addressed by some of the interviewees in this study. Furthermore, by providing affordable services and financial protection, this program can reduce out-of-pocket expenses for medical services. Other studies also emphasized the role of scientific governance strategies in the efficacy of FPP.[1,11]

Adequacy of service provision

This study identified several strengths of the UFPP, including good manners of FPs and their team members and preserving patients' privacy and dignity. This is important in building trust between patients and FPs, which subsequently gives people the feeling of having access to comfortable healthcare services and also brings positive healthcare experiences for FP teams, as another study also remarked.[12] Goldman believes that protecting privacy improves the healthcare system.[13] Participants in this study reported that they have more satisfaction about and trust in the clinical judgment and skills of FPs compared to non-family physicians. They explained that their FPs conduct detailed examinations of patients and provide appropriate treatment for them. These are important in building a strong patient-physician interaction and ensuring patients that they receive appropriate and effective care. Participants also reported that FPs and their teams were serious about following up on the status of patients with chronic diseases, which ensured the patients received appropriate and timely care for their chronic conditions. Another survey insisted on the positive roles of family doctors for follow-ups of patients, family history taking, reasonable referrals to specialists, and money savings.[14] As the other strengths of UFPP in Iran, people mentioned virtual and in-person access to healthcare services, which include easy appointment-making by phone, availability of healthcare workers through calls, SMSs, and social networks, and phone counseling with FPs in urgent situations. Home visits by FPs in the smaller cities and the nearness of living places to the FPS' clinic were also among the other positive views of people toward UFPP. These findings ensure patients that can access healthcare services easily and conveniently. In a study by Jahromi *et al*.,[15] FP accessibility was studied considering patients' perspectives and they found that most patients were satisfied with the visiting hours in non-holidays and mostly had received medical care in less than an hour. Electronic documentation of medical history and patients' diseases in the UFPP led to the less medical errors. It can also result in less-needed commuting between FPs' clinics and pharmacies due to bad handwriting of prescriptions, which was problematic in the previous traditional paper-based prescription. Some studies concluded that electronic prescription of medical drugs significantly reduced the rate of prescription errors.[16,17] Cleanliness and proper ventilation of FPs clinic, which were mentioned by some of the interviewees in our study, were among other strength points of UFPP. Vosgan studied the microbiota of the FP's office and found that the treatment room has the highest germs, and concluded that proper air ventilation is crucial for the FP's office.[18]

Promoting community health

Educating patients using health-related brochures, booklets, classes, and social networks was mentioned as another of UFPP's strengths. FPs build a long-term trusting relationship with people and encourage and reinforce them to improve their health behavior.[19] For example, in fighting against COVID-19, FPs showed a determining role in providing information about this infection and guiding people in timely referring for diagnosis and treatment.[20,21] Periodic checking of different items of peoples' health status, providing necessary supplements for each age group, and providing vaccination and screening services were among the other mentioned strengths of UFPP in our study.

Challenges of UFPP

Weak governance

Some people were concerned about illegal issues, low transparency, poor official supervision, and low responsiveness in the UFPP. Frequent changing and increasing trends of service fees, which were previously free, caused the cost of provided services to become unreasonable and make them unaffordable, especially for deprived individuals and families; as some interviewees declared. Lack of coverage of UFPP by some insurance systems, and spending a lot of time and money due to multiple visits are among other UFPP challenges that a group of interviewees are concerned. In line with our study, another study revealed that lack of insurance coverage is a major barrier to healthcare for low-income families.[21] Mehrolhassani *et al*.[22] found that the diversity of insurance organizations in Iran confronted the FPP with some obstacles. Insufficient fostering of a health-based culture was another outcome of low transparency, resulting in poor governance. Low levels of public knowledge and education about UFPP after 5 years of its implementation in Iran, especially in lower-income populations, were shown in other studies.[23,24] Lack of transparency in the health system can lead to suspicion, mistrust, and even corruption. The low transparency in the UFPP is not limited to the lack of information or misinformation about this program but it also extends to some illegal expenses that people should incur.[24] Bureaucracy in the healthcare system can lead to excessive administrative burdens, which in turn is costly and time-consuming for patients and healthcare providers. To address the mentioned challenges, it is important to improve management and planning and increase access to educational resources and opportunities for patients and healthcare providers.[25,26] Some interviewees in our study also expressed that men have difficulties in access to their FPs, which may be due to far distance of FPs' clinics from their place of employment.

Inefficient service provision

According to some interviewees' statements, lapses in clinical skills, quick and careless clinical examination, inaccurate diagnosis, and inadequate follow-ups of patients by FPs are among the challenges of service provision in UFPP. These challenges can lead to prescribed unnecessary tests, improper treatment of complicated diseases, and prescription of inappropriate and ineffective drugs. Similarly, Golalizadeh and Fardid mentioned that insufficient knowledge of the FPs is the main challenge that patients face.[8,27] To address these challenges, it is important to improve the quality of care by FPs including holding feedback and ensuring patients receive appropriate and necessary care.[19,20] Some participants in this study complained about the impossibility of making phone appointments with FPs and the lack of constant communication with FPs' team through calls, SMSs, or available social networks. They also were dissatisfied about poor availability of FPs during the scheduled working hours, limited working hours of FPs, limited number of patients that are visited daily by each FP, and limited visiting time for each patient. Long distance from the FP's clinic to the pharmacy, limited access to the various specialists who are involved in the UFPP and insufficiency of their cooperation with general FPs, and low access to a fixed FP (due to high turnover of FPs) were among other negative opinions of people toward UFPP. Another study also reported a lack of cooperation of specialists with UFPP.[27] Above mentioned challenges can lead to poor communication between FPs and people, increase dissatisfaction in people, cause inefficient use of resources, result in overwork and burnout of physicians, and finally induce a high economic burden on the health system. To combat some of these challenges, it is important to improve communication between FPs and patients by considering different cultures, applying professional skills, and integrating telemedicine into the healthcare system.[1,28] Fitzsimon *et al*.[14] presented an innovative, community-based, hybrid model; the Virtual Triage and Assessment Center (VTAC) that combines virtual care with in-person care, and they found that this model was effective in improving access to healthcare and reducing waiting times. As the other challenges of service provision in UFPP, some people complained about problems in the Sib and electronic prescribing systems and lack of information technology specialists in the health centers, as other studies similarly emphasized.[8,29]

Limitation of resources

The UFPP faces challenges related to the low amount of necessary equipment for screenings and vaccinations and the low amount of necessary supplements for each age group, as some people in this study stated. These challenges can lead to inadequate patient care and treatment, which can result in negative health outcomes. The lack of necessary equipment and supplements can also lead to increased healthcare costs and decreased patient and clients' satisfaction. Another study remarked that the most common barriers in UFPP were poor organization, weak management and planning, inadequate resources, limited number of general practitioners, limited access to various specialists, and limited access to technology.[19]

Strengths, limitations, and recommendations

In this study, we explored both strengths and challenges of UFPP from the people's point of view, after the first decade of its implementation. This evidence can be the background of the next large quantitative studies toward making more representative evidence for the improvement and nationalization of this program. As a limitation, and because of logistic shortages, the wide geographical distribution of the target population, and the importance of homogeneity in data gathering, we had to perform phone interviews instead of face-to-face interviews. As a recommendation, considering the opinions of FPs and their teams, policymakers, para-clinic services staff, and insurance systems is also needed to improve and extend UFPP.

Conclusion

After a decade of implementation, UFPP is at a critical point. People demonstrated contradictory opinions about many aspects of UFPP. Strength points should encourage policymakers to advocate more for this program and extend it to the other provinces of Iran, whereas weak points should be used for its revisions and improvement.

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Conflicts of interest

There are no conflicts of interest.

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