

Family Physician Implementation and Preventive Medicine; Opportunities and Challenges

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Review of Iran's experiences regarding health following Islamic Revolution suggests that two major events influenced on health system structure; establishment of Primary Health Care (PHC)^[1] and integration of medical education in former ministry of health and formation of Ministry of Health and Medical Education (MOHME).^[2] Both of these important developments began in the first decade after the revolution resulting from immediate needs of the country and spirit of social justice that dominated the country. In fact, these two major events occurred for development of health services to disadvantages parts of the country, especially rural and remote areas, as well as provision of human resources for delivering necessary health services. Outcome of development, in various social and economical aspects, and interventions in the health system had sharp improvements in important health indicators such as maternal mortality,^[3] life expectancy,^[4] control of infectious diseases^[5] and provision of manpower.^[6]

After three decades, now the country is on the verge of running family physician and referral system plan in the cities, which is the third milestone in the restructuring of health services. Of course to achieve this point, years of planning and dialogue in the country's high levels of policymaking have been done. Iran initiated implementation of this plan in rural areas,^[7] secondly, cities with less

than 50 thousand population were covered and now it has been generalized to the entire country, including major cities.

In fact, it is the most important reform plan in the health sector, which has also been done in different countries.^[8] Reforms in the health sector are important due to several reasons including advent of advanced technologies, which are mainly expensive and increase the cost of treatment and diagnosis costs.^[9] It is believed that health suffers from market failure. That, which is due to information asymmetries between service recipients and providers, justifies the need for a regulatory body for this relationship. This matter is justifiable also in terms of ethical philosophy in this way that a systematic structure should be available for fair (with appropriate quality) service delivery to all people.^[10] Manifestation of this structure in different countries has led to this fact that instead of offering simple supply and demand market, i.e. free market such as other goods, a novel structure would sought for which this change is called health sector reform.^[9]

One of the examples of this kind of health sector reform, emergence of family physician and referral system, had been occurred in UK since late 1950s. It is interesting to note that Beven, British Minister of Health following initiation of national health services, said: 'We now have the moral leadership of the world'.^[11] Subsequently this plan expanded

to other countries, e.g. North Europe and Canada, which showed improve in efficiency of health systems along side of social justice.

Principles of family physician plan

Important changes which occur following establishment of this plan can be categorized into four classes. Firstly, service delivery is for 'a defined population'. In fact, according to administrative plan of family physician, respective team (including physician, nurse, midwife, etc) should register a defined population, and population based payment should be defined by insurance organization. Payment system is based on the number, population composition and service quality. This team is responsible for population health, PHC delivery, and referral to the next level, if necessary. Secondly, is referral system in which it is predicted that one should utilize specialized services if needed, and in case he is introduced by family physician team, the insurance should pay most of his cost, but if referral system is not used, insurance financial resources cannot be enjoyed. If the service provider also provide feedback and preserves principles of this system, bonus is anticipated for them. Thirdly is change in payment system and funding, which occurs following realization of family physician plan and referral system.^[12] According to the last National Health Account study, which was done in 2007 in Iran, "Out of Pocket Payment" was almost 54 percent.^[13] According to former economic, social and cultural development plan of the country this indicator must be 30 percent in 2010, which shows that this objective was not fulfilled.^[14] Thus, elimination of service receiving costs at first level of service delivery and cost of drugs and better insurance coverage in case of referral system observance leads to reduction on direct costs of households for health and treatment and receiving fairer services. Fourthly is important element of family physician plan which is change in service delivery system from treatment oriented to health oriented view. In delivering medical services, family physician team should give priority to preventive measures.^[12]

Family physician opportunities for preventive medicine

Important changes on preventive medicine resulting from implementation of family physician

plan can be introduced in four topics. First, is sensitivity to population health. In fact, the population under coverage has centrality in family physician plan and also the basis of the payment is per-capita (in addition to service quality and so on).^[12] Therefore, it is expected that service delivery units, as well as insurances pays much attention to prevention, at least for reducing referral burden and costs. Actually, the way for financing and establishing these services is giving priority to prevention. Second, in order to control receiving unnecessary service which may occur because of cheap services, it is expected that the insurance organizations and health authorities look for more standardized services. Thus, despite of the fact that there has not been considerable attention for production^[15] and use of Clinical Practice Guidelines (CPG) in Iran,^[16] now it is expected that this issue will be more organized, at least for the peripheral level of service delivery. Considering importance of preventive medicine services (mentioned in the aforementioned item of opportunities) it seems that the next step must be adaptation and implementation of 'Public Health Guidance's (PHGs). Actually, PHGs are recommendations like CPG, which are prepared for preventive measures and public health issues.^[17] Despite of the fact that evidence based educational programs has been initiated for over one decade, there is no case of PHGs. It seems that in this step health system and insurances would also emphasize on these guidelines to reduce costs. Third, in long term, in case referral system executed appropriately and with the presence of standardized services, excessive burden due to direct admissions of specialists and subspecialists will be reduced. It means, in case referral program is executed properly in a continuous manner, it is expected that health service utilization become more logical. Then, referral burden to these service providers would be modified. It might adjust the subspecialty development and fragmentation, which is faced by the country's clinical training at present. Perhaps by development of the need to preventive medicine (first and second items aforementioned here in the opportunities), further development of preventive medicine services will be obtained and it will be viewed in a more specialized way. Currently, specialized family medicine training program has been designed^[18] with a high admission, it has been

planned to take residents at the next academic year.

Fourth, is the 44th national reform plan, in long-term health sector reform plan, which titled 'establishment of strategic health service purchase mechanism'.^[19] It has special focus on health promotion activities and enhancing preventive medicine. It is possible that preventive medicine services in this area could gain an ordered structure.

Family physician challenges

There are some challenges in implementing family physician and referral system plan. First is the gap between a plan and its implementation. In fact, implementation barriers in every major plan, especially change in management and policies may easily influence on the plan progress. Second is the deficiency on financial support for the implementation of this plan. Separate structure, insurances existing in a ministry other than MOHME, creates concern in implementation progress. When it is seen that basic insurances, should turn into 'health insurance' according the present 5-year plan of the country, are called themselves as funding organizations and are regarded more as financial institutions, there is concern on their social accountability in health. In addition to structure issue, required financial resources are also an important concern. It should be noted that currently health share from Gross Domestic Product (GDP) of the country is a little less than 6%, which is reasonable.^[20] However, as it was mentioned regarding the 'Out of Pocket Payment', the bulk of healthcare costs are paid directly by people. If, no financing funding is provided for family physician plan from the public budget, the plan will not accomplish. Fortunately, in 'item b' of '34th article, 34 of the fifth 5-year development plan' of the country, the health costs have been considered as 'targeted subsidies',^[21] however, its implementation is on doubt. It appears that the only way to overcome this challenge is considering family physician and referral system as a macro-governance project behind MOHME and that the government supports it. Third, medical education in Iran, conventionally, do not prepare trainees appropriately for their future career,^[22] while family physician plan is more than ordinary practice and has health orientation. Necessary capacity building should be done.^[20] The fact that family physician team has not gained required

training for role playing as a public health and or preventive medicine team is a great danger, and people may offer their old training in service locations. Third challenge is that health system has not acted as successfully in urban areas as rural. However, it is possible by development of family physical plan; even current structure of health service delivery such as health centers in the cities becomes fainter. This issue becomes more serious, especially if it comes with third challenge, which is treatment oriented conventional training. In addition, now in most health programs it is seen that potential experts of surveillance system prefer to work in family plan rather than in public sector due to wage difference between public sector and family physician plan. The fourth challenge is the plan's content. The question is that how much family physician plan has been designed according to preventive medicine and public standards. In World Health Organization's report in 2008, health primary care was reviewed and with slogan 'primary health care; now more than ever' emphasized on the fact that these services should be organized with a novel look. Major part of this novel look is considering people as the centrality of the service delivery. With this look, people are not considered just as service recipients, but their participation in health should be thought.^[23] If it is aimed that family medicine plan would be a health oriented one and not disease oriented, ways to empower people and attract their participation must be a key element of family medical team services and should be defined and valued. Fifth challenge is threat resulting from conflict of interests of different groups, which may be affected by implementation of family physician plan and referral system. The question is whether family physician plan is going to and can change current status of private sector in health service delivery, which in cities has three times more first-contact admissions in comparison to public sector.^[24]

Experience of health system reform in the various countries implies that main interventions for health sector reform are categorized in the following control knobs: payment mechanism, financing, roles and regulations, service provision and changing behaviors.^[9] In implementation step, the important factor of reforms, that is, 'management behavior change of people and service providers' should be seriously considered. Therefore, one

of the main levers that through which the health sector can be reformed is behavior change, and this change must occur in both service recipients and providers. When we look at components of family physician plan, from people registration in the plan to their adherence to referral system and utilization of service, all require behavior change. Now the question is that how ready people are to accept these new behaviors. Social marketing is needed so that people accept these services. To this end, mass media and opinion leaders should promote for its acceptance. Using family medicine services should be represented as a value and this change is gradually obtained in the community. Now demand for seeking specialized services has increased and by specialization of fields, people think that they must use services in sub-specialty form, while family physician plan is aimed at confronting people with first level of services. This change in though is not obtained overnight and requires trust building. Thus, family physician plan should be considered as a big change with subsequent impact on social issues beside health ones.

To sum up, the family physician and referral plan is a promising opportunity for individuals and community health through strengthening public health and preventive medicine services. However, its implementation is seriously challenged, especially in by the financial resources, separation of insurance organization from MOHME, changing utilization behavior of the community and finally service providers who should be enrolled in the plan and provide preventive services.

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