Original Article

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

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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]

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Policymakers argue that developing the FPs program in cities is one of the most major challenges of Iran's health system.[4,12] 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.[13]

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.

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 FP's capitation has been designed based on pay for performance. Therefore, detachment of midwives shares from FPs capitation may lead to disobedience of midwives

Table 1: Policy options for the financing of urban family physician

Category	Policy Options
Revenue Collection	Moving from Bismarck to Beveridge by dedicated budget line for UFPP: 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 FP's 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 UFPP 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 Pooling	Creating an integrated virtual fund 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) 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
Behavior change	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 FP's correct use. Besides, it is recommended to apply some tactics such as referral limit, and franchise assigns to hinder the excessive referrals to FPs.

Table 2: The advantages vs. disadvantages of policy options

	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 poor 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 optio5, 4, 1, 2, 6, 7, and 3 are recommended, respectively.

Table 3: The requirements, solutions for recommended options

	Policy Options		Requirements	Barriers	Solutions	Evidences
Policy option 1	Target group	Parliament, Ministry of Health, Ministry of Welfare	The agreement to assign a budget line The coordination between the Health Ministry and the related organizations	The resistance of Ministries or organizations	Hold a meeting to justify and train key people	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				
	Managers and policymakers	Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations,				
	Related organizations	Strategic Deputy of President, Planning and Budget Organization				
Policy option 2	Target group	Public groups, benefactors, governors of the provinces	Getting attention and the agreement of benefactors	Disagreement of benefactors	Hold a meeting to justify and train rich benefactors	In the United States, 77 percent of spending on poor people comes from charity
	Providers	Municipality and universities				
	Managers and policymakers	University presidents, governors, mayors, city representatives				
	Related organizations	Broadcasting organization				
Policy option 3	Target group	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	Hold a meeting to justify and train public and justify policymakers	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				
	Managers and policymakers	Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations				
	Related organizations	The Medical Council and the Association of Physicians				
Policy option 4	Target group	Ministry of Health, Ministry of Welfare	Agreement on virtual fund and cross-sectional cooperation in this regard	The resistance of Ministries or organizations	Hold a meeting to justify and train key people	The not only virtual fund is used in healthcare, but virtual hospitals are also used in the United States.[17]
	Providers	Physicians and midwives				
	Managers and policymakers	Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations,				
	Related organizations	Strategic Deputy of President, Planning and Budget Organization				

Contd...

Table 3: Contd...

Policy Options			Requirements	Barriers	Solutions	Evidences
Policy option 5	Target group	Ministry of Health, Ministry of Welfare	Agreement on separating the midwives' share from GP capitation	Physicians' resistance	Hold a meeting to justify and train FPs	
	Providers	Physicians and midwives				
	Managers and policymakers	Top managers of the Ministry of Health, parliamentarians and the managers of insurance organizations				
	Related organizations	Strategic Deputy of President, Planning and Budget Organization				
Policy option 6	Target group	Physicians	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	In other countries, such as the United States, FP specialty converts GPs practitioners into FPs.[18]
	Providers	Universities of Medical Sciences				
	Managers and policymakers	Top managers of the Ministry of Health and universities				
	Related organizations	The medical council and the Association of Physicians				
Policy option 7	Target group	Patients	Build a culture, Cooperation of broadcasting organization	Public's resistance	Training seminars, TV programs, Commercial Ads, Mass media such as newspapers and billboards	Other countries, such as China, have also emphasized on the need for providing proper information to benefit people from family physician services.[19]
	Providers	Ministry of health and mass media				
	Managers and policymakers	President, Head of Broadcasting organization, Health Deputy of Universities				
	Related organizations	Ministry of Health and Medical Education, Broadcasting organization, Universities of Medical Sciences				

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).

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Conflicts of interest

There are no conflicts of interest.

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