

Abstract

Introduction: Implementation of Family Physician Program (FPP) was one of the most important reforms in Iran, according to the requirements of the health system. FPP plays a central role in global efforts to improve the quality, cost-effectiveness, and equity in health systems. After the successful implementation of FPP in rural areas due to lack of proper coverage of the health system in cities, urban FPP began in the provinces of Fars and Mazandaran. The reform has been restricted to the two pilot provinces since 2012. However, its policymakers request scientific evidence of the reform in order to extend the program to other provinces. Therefore, the study aimed to the analysis of policy implementation of urban FPP in Iran.

Methods: This multilevel mixed study was conducted between September 2015 and March 2016. The three levels of the study were national, provincial and local. Data collected at the national and provincial level from 11 policy-makers and 12 managers through interviews, review of documents and reports. Data collected at the local level was of the 141 family physicians (FP) and 710 patients from the questionnaire. Qualitative data analysis using framework analysis was performed with the triangle health Policy and quantitative data analysis was performed with the statistical methods and SPSS software using a primary care evaluation framework. Finally, the integration of qualitative and quantitative data analysis was performed.

Results: The quantitative results of this study showed that in health accessibility, 81% workload of FP in a week was patient visits. The co-payment in second and third levels was a real obstacle for some patients. The majority of patients can receive their preferred healthcare facilities in up to 40 minutes. In the continuity of care, there was no software program or it had a poor capability. The length of registration time with an FP was a relatively short time. On average, patients visited their doctors 5.5 times. About 80% of patients' consultation times were up to 10 minutes. In coordination of care, regular consultation and advice relationship between FP and specialists were rarely done. Referral from the FP to the medical specialist was reported by 14%. In comprehensive of care, an average of 30 out of 45 medical equipment was available to FP. Access to the pharmacy (91%) was the best situation compared with radiology and laboratory. FP involved in maternal, childcare and reproductive health by 80%. The final results of the quantitative aspects showed that in service delivery, access to services has the highest coverage (63%) and coordination of care has the lowest coverage (37.8%). The weighted average of the service delivery in the country was 56.4%. The qualitative results showed that the contextual factors that have influenced the urban FPP were situational, structural, cultural and external factors. The content of the program was the purposes and principles which

identified with the history of regulations and instructions. Power and influence of advocate actors were more than the opponents, which make the continuation of the program. In the process, three streams put the program on the agenda setting entitled: problem stream, policy stream, and politics stream. In the implementation, the role of factors such as financial resources, structures and communications, information technology, human resources, information and culture, and facilities and equipment was important. According to participants, a variety of insurance companies at the beginning of the program and delay in payments, difficult in providing and funding the program at the following, were causing problems in the implementation. However,

the health system and the insurance company have had good interaction to solve these problems. The final results showed that in most cases, quantitative results were matched with qualitative results, and both complemented or developed each other.

Conclusion: Results indicated that urban FPP was more successful in terms of access to services and comprehensiveness of care, compared with the coordination of care and continuity of care. Implementation of the program influenced by the contextual factors, the role of actors and the program contents. So far, the program has continued its path in the two provinces. Finally, although Urban FPP in Iran was successful in some areas, but there were some challenges in implementation. Therefore, it is better to resolve the root causes of these challenges prior to extending this program to other provinces in Iran.

Keywords: urban family physician, program analysis, health care evaluation, accessibility of care, continuity of care, coordination of care, continuity of care, Iran



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