Abstract

Introduction & Purpose: One of the basic aims of health systems is facilitating the access to services in a way that all walks of the society are able to properly benefit from them. In this regard, the rural family physician program was implemented in Iran in villages and cities with population under 20 thousand in 2005. The present study aims at identifying the status of different access dimensions of this program in Kerman.

Method: In this descriptive-analytical and cross-sectional study, the statistical population of all staff of health centers as well as the population under the coverage of rural family physician program was in Kerman. The sampling method was a multi-stage random sampling method (n = 1824) for people. The census method (n =220) was used for staff. The data collection tool was a researcher-made "Access to Health Services" questionnaire based on five Likert scale Lewecke model including five dimensions of appropriateness, acceptability, availability, financial capability and appropriateness. Using the comments of 29 experts, content validity was confirmed and then, to examine the reliability of the questionnaire, Cronbach's alpha was 0.87 for the people's questionnaire and 0.92 for the staff questionnaire. The questionnaires were collected and entered into SPSS 19. Mean and standard deviation were used to describe the accessibility status. For analytical statistics, the multilevel model with a reversal approach is used to estimate the effect of each independent variable (age, gender, income, family members, insurance status, type of insurance, degree of education, work experience) on the dimensions of access .

Findings: The highest and lowest mean of access respectively was related to the approachability dimension with mean and standard deviation of 3.79 ± 0.62 and the availability of the item with a mean of 3.40 ± 0.46. For the people, the highest and lowest mean of access, respectively, was related to the affordability dimension of 3.39 ± 0/92, and the availability of the item with a mean of 2.52 ± 0.52 , respectively. There was a significant difference between the viewpoints of people and staff about availability, acceptability, availability and appropriateness dimensions (P-value <0.001). There was no significant difference between the views of people and employees on the affordability dimension (P-value = 0.067).rience) on the

dimensions of access .From the perspective of employees with a history of less than 10 years and 20-11 years, the average access score was higher than those with a history of more than 20 years. From the perspective of graduate and postgraduate students, the average access score was lower for those with higher education and higher education. From the employees' point of view, the age range of 40-30 was higher than that of those older than 40, the average access scores were more than 0.38. From the point of view of people in the age group of 45-35 years, the average access score was higher than those over the age of 45 years. From the point of view of those with a postgraduate education, the average access score was higher for those with higher education than the bachelor's degree. From the point of view of people with income of 5 million to 10 million rials, the average access score was lower than those with a yield of 15 million rials.

Discussion & Conclusion: The accessibility status in the rural family physician program from people's point of view was better in affordability, acceptability, and approachability than it was in appropriateness and availability. However, from the point of view of the staff members, accessibility status in approachability, appropriateness, and acceptability dimensions was better than in affordability and availability dimensions. Factors such as peoples' lack of sufficient knowledge of rural family physicians' duties, difficulties in access to the services for people with chronic conditions, disabled and the elderly people, lack of surveys and opinion polls in the field of service quality improvement, physicians and their team not being local, and the lack of a proper queue management system create limitations for accessibility of the services. In order to improve the status of service accessibility, there is an exigent need for designing a program to reduce these limitations.

KEYWORDS: Access, Access dimensions, rural family physician program, Levesque Model, Kerman.

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