



A Brief History of Family Medicine Development and Training in Iran (2005-2018)

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Review Article

Abstract

Background: Health care systems in the world are continually modified to increase efficiency and effectiveness. In Iran, the Family Physician Program (FPP) was started in 2005 as one of the main policies of the ministry of health and was continued in the fourth and fifth national development plans. The aim of this study was to get acquainted with the history of FPP in Iran.

Methods: This was a narrative review conducted by studying the documents and articles related to the history of family physician (FP) development and training in Iran. The documents and articles were obtained from searching in databases such as Google Scholar, PubMed, Magiran, and Scientific Information Database (SID). Finally, 26 articles related to the purpose of the study were selected. Furthermore, the related contents of the FPP were extracted from the site of the Ministry of Health and the Iran Health Insurance.

Results: The FPP was first implemented in villages and small towns (population \leq 20,000), and then, in larger cities (population = 20 to 50 thousand). The governors are currently concentrated on the borders of cities with basic health services. Launching the FPP in metropolitan areas is still a problem to be solved. In addition, physicians need to acquire the necessary skills to provide the desired service quality to the covered population.

Conclusion: A brief history of the FPP in Iran shows dramatic changes over 13 years. The subjects to be considered in this program are the implementation of FPP in megacities after providing the required infrastructures such as electronic health records, the appropriate training of skillful FPs, and private sector participation in implementing the FPP.

Keywords: Family medicine, Family physician program, Health system, Rural insurance

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Introduction

In most countries, the health system undergoes various changes in order to increase efficiency and effectiveness (Ministry of Health and Medical Education,

1999). Categorizing health care services into the first, second, and third level is one of the largest reforms that have taken place in the health system (Pileroudi, 1999). The World Health Organization (WHO) considers the implementation of the Family Physician Program (FPP) as a key to improved service quality, cost reduction, effectiveness, and equality in the health care system (Rivo, 2000). A family physician (FP) works in the first level of health care, within the framework of service to the family and through the referral system, refers the patient to the second level and follows him until a result (Amiri, Raei, Chaman, & Nasiri, 2012). According to the fourth national development plan, FPP is the most appropriate strategy for implementing the rural insurance program in the form of the referral system.

Of the FPP benefits is that the FP provides healthcare actively to the covered population. In other words, in the FPP and the referral system, the responsibility for individuals' health lies with the general practitioner (GP) and his or her team, and after the referral, it is also the responsibility of the GP to follow up and continue treatment. For this reason, it is possible to provide health services simultaneously as the most important task of the FP.

FPP in most health care systems in the world has been highly emphasized, so that many countries have already recognized the necessity of this reform in their health system. By 1997, almost 56 countries had begun an FPP (Masoudi, 2003). A comprehensive FP reform in Iran was mentioned in the third national development plan (2000-2004) and also followed in the fourth and fifth development plans. For example, Article 91 of the fourth national development plan affirmed that by the end of the plan, the Higher Council of Health Insurance should provide preparations to establish universal health coverage based on the FP and referral system (Ministry of Health and Medical Education, 2009).

More than 13 years has passed since the implementation of the FPP and Rural Insurance Program. Over time, the national program has confronted many fluctuations. This study aims to integrate the development of the FPP and training of the FP in Iran

Methods

This was a narrative review conducted by studying the documents and articles related to the history of the development and training of FP in Iran, using keywords such as "Family Physician", "Family Medicine", "Program", and "Rural Insurance". The documents and articles were obtained from searching in databases such as Google Scholar, PubMed, Magiran, and Scientific Information Database (SID). Finally, 26 articles related to the purpose of the study were selected. Furthermore, the contents related to the FPP were extracted from the site of the Ministry of Health and the Iran Health Insurance.

Results

A. Implementation process of the Family Physician Program in Iran (2004 to 2018):

The Ministry of Health and Medical Education in Iran, in order to ease access to primary health care (PHC), provides basic health care based on three domains, including prevention services, deprived areas services, and rural services. These domains were organized in 1981 in the form of health networks. The Rural Insurance Program was developed to establish a referral system in the country and prevent people from visiting various doctors (Jannati, Maleki, Gholizade, Narimani, & Vakeli, 2010).

After the seventh parliament allocated the budget required to implement the insurance plan for villagers, tribesmen, and residents in urban areas with a population of less than 20,000 in the 2005 budget law, the Health Ministry and the Ministry of Social Welfare decided to use the opportunity to jointly implement the rural insurance plan and FPP, simultaneously. Therefore, the Health Insurance Organization was developed, and

through it, a number of health services were provided by the FPs to all residents in rural areas and cities of less than 20,000 residents (Tavassoli, Reisi, Alidosti, & Motlagh, 2012).

In the next step, when the eighth government's duration of appointment had reached its end (mid-2005), the Health Insurance Organization undertook the expansion of the FPP to small towns ($\leq 20,000$ residents). By the end of 2005, the FPP covered more than 25 million citizens living in rural areas and small towns. This project continued in the ninth government and expanded to greater cities (population of 20,000 to 50,000) with the start of the tenth government.

On the next level, in 2011, the Fars and Mazandaran provinces, Iran, were selected to be the pioneers for the implementation of FPP at all service levels of the province. Surprisingly, this pilot is still running after seven years. Documents show that at least a part of this time was spent on conducting studies to answer the fundamental questions about the burden of disease and the service packages, while the other part was spent on drafting regulations. The authorities hope that by implementing the FPP at pioneering universities and by increasing GPs' skills, the transference of responsibilities to the FP team will gradually take place.

The eleventh government (2013-2017) decided to concentrate on some other issues instead of continuing the FPP. In fact, they believed that the necessary requirement for the implementation of the FP was not available, and the full implementation of the FPP would require more time and more comprehensive infrastructure (Doshmangir, Bazayr, Doshmangir, Mostafavi, & Takian, 2017). Therefore, the eleventh government began with a reform known as the Health Transformation Plan (HTP) with initiative services. In this reform, after providing financial support, especially for reducing out-of-pocket payment in university hospitals, attention was paid to non-communicable diseases, oral health, nutrition, and mental

health. For this reason, more than 2000 nutritionists and mental health workers and 1500 healthcare professionals were employed. Currently, basic healthcare services are available in both rural and urban areas. Evidently, launching the FPP in metropolitan areas is still a problem to be solved.

To know why the eleventh government has changed the scenario, it should be noted that in great cities people have access to doctors and in villages they also have a health house to provide health services to them. However, there are fewer opportunities on the border of cities, which has led to a shortage in health indicators in these areas. For this reason, the first priority of the eleventh government was deprived areas and slums of large cities. To this end, some good steps have been taken, and health complexes have been built on the border of large cities. Moreover, since the electronic health record is a crucial requirement of FPP, all medical universities have been asked to launch the Integrated Health System (SIB) since 2015. The results of a recent study recommended redesigning the structure of SIB to a structure more consistent with the needs of employees and with a user-oriented approach (Kabir, Ashrafian Amiri, Rabiee, Keshavarzi, Hosseini, & Nasrollahpour Shirvani, 2018).

B. Training process of family physicians in Iran: FPs should have some necessary skills in screening, diagnosis and treatment, communication, and the ability to analyze biological, psychological, and social aspects of their patients and their families. They are the first contact person for the enrolled population.

Over time, various training programs have been launched to train skillful FPs in Iran. Initially, GPs were serving as FPs; however, it is evident that GPs are trained based on a hospital-based traditional curriculum. Thus, in order to meet the minimum expectations of the health system as FPs, they must undergo some special training programs. For this purpose, an MPH training course for GPs was established.

After that, an idea was shaped in the Ministry of Health, according to which the FP should become a medical specialty degree. Training a GP as a specialist to provide services as an FP has many pros and cons. The first advantage is that they can have a better position and can provide many different services. Despite the benefits, this idea has many disadvantages like long-term training, increasing costs, and irrelevancy to the formal medical education. As it could be guessed, the plan did not succeed much.

After reviewing the program, policymakers concluded that they should arrange some modular training courses for GPs. The implementation of this training course is on the agenda of the twelfth government. Accordingly, GPs will be

practicing as FPs after completing several short courses and gaining basic skills. The development process and expansion of the FPP in Iran can be seen briefly in the following timeline (Figure 1).

As can be seen in the diagram, the beginning of every national development plan was almost coincident with introducing a new minister of health. Furthermore, by looking at the timelines, it can be concluded that most governments in the late stages of their appointment paid more attention to FPP.

According to statistics obtained in large cities, around 70% of hospital beds are public and less than 30% of them are private. Nevertheless, in outpatient services, the shared amount of the private sector is 70%, and the remaining 30% are public (WHO EMRO, 2006).

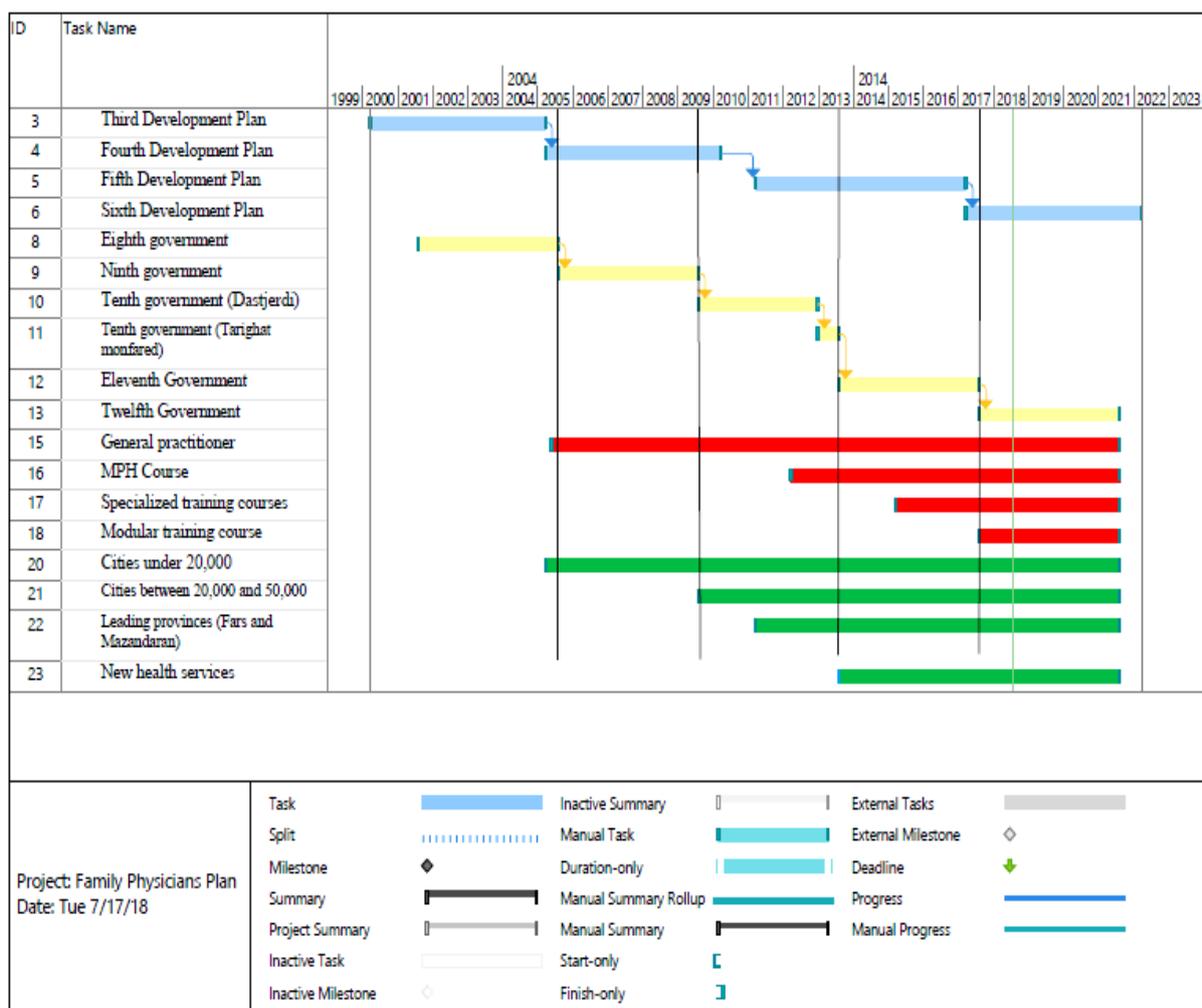


Figure 1. History of the Family Physician Program and training in the National Development Plans of the Ministry of Health and Medical Education

Discussion

This study was conducted with the aim of narrating a brief history of FPP in Iran. The story of the FPP began at the end of the appointment of the eighth government and continued until the tenth government. However, at the beginning of the eleventh government another scenario (HTP reform) came to the scene and FPP was substituted by basic healthcare services at deprived city borders. During 9 years, the FPP program, which started from rural areas, expanded to towns and cities, but the most dramatic part, i.e., establishing FPP in mega-cities, still remains to be done. This is why the Iranian people who live in large cities have not experienced the FPP yet.

Training the FPs had a dramatic story with many fluctuations. In fact, the FP training program has been modeled by distinctive styles obtained from different countries without sufficient adaptation. Considering the great share of private sectors in outpatient services, it can be concluded that, without the involvement of the private sector, the FPP would not succeed in metropolises.

In summary, FPP started from the fourth national development plan. Most of the health ministers paid attention to it at the end of their time. In each period, there have been plenty of changes both in the training plan and roles, and it seems that these changes will continue. Some experts believe that the HTP reform, especially establishing health complexes, could prepare the required infrastructures for FPP in metropolitans. Others may say that some good opportunities have been missed in the past years and that we should go back to the main scenario as soon as possible.

Conflict of Interests

Authors have no conflict of interests.

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