Qualitative Research

Challenges in the rural family doctor system in Iran in 2013–14: a qualitative approach

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Abstract

Background. Family doctor is a medical specialization that provides families and people of all ages, genders and diseases with comprehensive ongoing health services.

Objective. The present study was conducted to describe challenges in the rural family physician program from the perspective of family physician program directors and family doctors in Iran using a qualitative approach.

Methods. We conducted interviews with 13 family physician program directors and 8 family doctors selected through purposive snowball sampling. The initial in-depth unstructured interviews were reviewed and transformed into semi-structured ones. The data obtained were analyzed in ATLAS.ti using the conceptual framework method.

Results. Nine main concepts (comprehensive planning, medical insurance system, compensation for services, performance evaluation, welfare facilities, recruiting and retaining a workforce, information system, culture-building and financing) and 27 subgroups emerged from the analysis of the data.

Conclusion. The main challenges in the family physician program include cultural, economic and environmental factors and work conditions. The implementation of this program can be improved through building a community culture and exercising minor and major modifications.

Key words: Challenges, content analysis, family doctor, qualitative approach.

Introduction

Health is the pillar of the social, economic, political and cultural development of all human societies with the ultimate aim of promoting people’s health to a degree that enables them to partake in social and economic activities (1). Family doctor teams are now providing health care in rural and urban areas of Iran to make health services accessible to the entire population of the country (2). Family doctor is a medical specialization that provides families and people of all ages, genders and diseases with comprehensive ongoing health services (3). Studies show that many reforms exercised in primary health care have not achieved the desired sustainable outcomes. Family doctors are involved in providing full family health services in 10 countries, relative services in 15 countries and modest services in 6 countries (4).

Studies also demonstrate patients’ dissatisfaction with family physician programs (2,4,5). The family physician program is faced with various challenges including the doctors’ general unwillingness to work in rural areas, the doctors’ inadequate training in family doctor, medical personnel shortages, time limitations, lack of resources, heavy workloads, inequity of incomes, lack of cooperation on the part of specialists, poor access to specialists, processes, laboratory tests and resources, high expectations of patients, the preservation and acquiring of skills and knowledge, and legal medical issues (6–8).
The structure of the family physician program in Iran

To reform the Iranian health sector and to maintain its effectiveness and efficiency, a new program was established in 2005 to offer health services to the country’s rural population in the form of rural health insurance. Teams of family physicians have now been assigned for providing health care in rural and urban areas of the country (7). Figure 1 demonstrates the structure of this organization. Before the execution of the program, physicians were mostly responsible for providing health care services in rural health centres; however, in the family medicine program, one of the main responsibilities of physicians is to provide primary health care services, and using the term ‘family medicine’ to connote the mere provision of health care without offering such services is unjustified (11). Family physicians have a doctor of medicine degree as a minimum requirement and are responsible for first-level medical services. In rural health centres and health houses, members of the health team managed by the family physician in charge are the first point of contact for the patients and are responsible for examining them before taking any necessary health care measures. If higher-level medical services are required, the family physician in charge fills out referral forms to higher-level medical practitioners and guides the patient in the way of receiving services from specialists, subspecialists, clinical centres and hospitals, and this referral does not relieve the family physician of his responsibilities for the patient’s health (11). In Iran, physicians’ performance is appraised once every 3 months based on two checklists: first, a checklist for monitoring the network centre, which includes technical, structural, managerial and functional questions as well as questions on satisfaction, intersectoral collaboration and guideline implementation; second, a checklist for the quarterly monitoring of different programs defined in the service package as the physician’s responsibility, carried out by various offices of the deputy of health. The results obtained from these two checklists yield the performance coefficient (11).

The studies conducted on family physician program are limited or conducted with a particular group in health care system (9,10), while the present study was conducted in a broader area and with a variety of people in health care system. The present study aims to determine the most important challenges of rural family physician program in the east of Iran.

Methods

The present qualitative study was conducted in eastern Iran in a region with an area of 118,854 km² and a population of 5,994,402. Snowball sampling was used as a purposive method of sample selection and interviews were conducted with 21 participants, including 8 family physicians and 13 executive directors of health. The study inclusion criteria consisted of consenting to participation in the study and having at least one year of work experience as a physician or manager in the rural family medicine program.

The initial two interviews were in-depth and unstructured; later interviews then tended towards semi-structured interviews. The interviews lasted 40–70 minutes and were conducted in the subjects’ work offices so that the respondents would feel more comfortable. A total of 18 interviews were conducted before reaching data saturation; however, interviews were conducted with three additional participants in order to ensure the accuracy of the data. All the interviews were conducted by the corresponding author, who began the data collection with a general question (such as ‘What are the challenges of the rural family medicine program?’), so as to include the ideas and views of all the participants. The interviewer then guided the discussion from the broad concepts towards more detailed issues.

The data obtained were analyzed in ATLAS.ti 5.0 using Grantham and Landman’s method of content analysis (2004). The interviews were transcribed verbatim and reviewed several times, so as to obtain a general feeling of their content, identify the meaning units or the initial codes, classify the codes based on similarities and differences and organize the themes as indicators of the underlying content of the text. A total of 438 initial codes and 19 subthemes were identified and classified into 6 main themes. The codes were compared by two researchers and decisions on disputes were made based on consensus.

The present study used four criteria, including acceptability, transferability, reliability and conformability, to ensure the validity and accuracy of the data. Attempts were made to ensure the accuracy of the codes and the researcher’s interpretations of them and to modify the codes that did not reflect the respondents’ views by conducting in-depth interviews, holding meetings with experts and returning a number of the interviews to five of the participants after they were encoded. The process of theme encoding, classification and extraction was reviewed by supervisors, consultants and experts so as to ensure that the classes were consistent with participants’ statements. The researcher used a clear, accurate and purposive explanation of the study process in order to increase the transferability of the findings and to assist others in tracing the researchers’ thoughts and examining the features of the study population.

Results

We conducted interviews with 8 doctors and 13 family physician program directors. As for the gender distribution, 83% of the directors, 75% of the doctors, and a total of 80% of the interviewees were male. Nine main concepts and 27 subgroups emerged from the interviews) (Table 1).

The main concepts are discussed at length in this section.

Comprehensive planning

Participants noted the failure to operate a proper pilot program prior to the actual implementation of the program. The [family physician] program was implemented rather hastily; at first, the program was to be piloted for a year, but then, after only a month in pilot mode, it was immediately implemented on the large scale and its problems began to emerge straight away” (M11). They also noted the frequent...
Table 1. The required main concept and subgroups of challenges in the rural family doctor system from clinicians and administrators point of view in Iran in 2013–14

<table>
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<tr>
<th>Main concept</th>
<th>Subgroups</th>
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<tr>
<td>Comprehensive planning</td>
<td>Failure to operate a proper pilot program prior to the actual implementation</td>
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<td></td>
<td>Lack of inter-sectoral coordination</td>
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<td></td>
<td>Focused decision-making and planning</td>
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<td></td>
<td>Long work hours</td>
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<td>Medical insurance system</td>
<td>Incomplete remuneration packages</td>
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<td>Deductions and huge payment delays</td>
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<td></td>
<td>Wrong criteria used for determining the per capita payments</td>
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<td>Compensation for services</td>
<td>Low salaries and delayed payments</td>
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<td>Performance evaluation</td>
<td>Incompatibility between the doctors’ authorized power and his responsibilities</td>
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<td></td>
<td>Incompatibility between the doctors’ level of education and the controllers’</td>
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<td></td>
<td>Invalidity and unreliability of the checklists</td>
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<td></td>
<td>Failure to monitor the other members of the family physician team</td>
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<td>Ignore the value and character of doctor</td>
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<td>Welfare facilities</td>
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<td>Doctors’ unwelcoming approach to the program inadequate number of permanent doctors</td>
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<td>Financing</td>
<td>Time-consuming nature of information registration processes</td>
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<td>People’s inadequate awareness</td>
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<td>Inadequate training provided to health service providers</td>
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<td>Lack of payments made to specialists</td>
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<td>Limited participation of the private sector</td>
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<td>Doctors’ unwelcoming approach to the program</td>
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changes in the program’s implementation rules and guidelines, ‘Many forms, rules and records changed as some of the program experts and staff directors were replaced’ (M5). Participants also discussed issues such as focused decision-making and planning, ‘It would have been better for the authorities to have talked to the medical representatives of different cities about the challenges of the program so as to ensure reform and improvement in the process of the program, but unfortunately, this consulting was never part of the proceedings’ (M9).

Participants noted the incomplete remuneration packages, ‘remuneration packages are the same across the country while they essentially have to be compatible with the socio-cultural structure of the people in each region’ (M13).

Deductions and huge payment delays were another challenge of the program, ‘Insurance covers clients on the basis of the presence of doctors, the availability of equipment and the provision of services, and since the ministry’s resources are limited and we have a shortage of doctors and equipment, insurance deductions are high’ (M1). As for delayed reimbursements made by the insurance company to the Ministry of Health, one participant said, ‘Insurance companies delay reimbursements. For example, they were supposed to reimburse us on 80% of the cost of services we had provided by the end of each month, so we could pay the staff wages and benefits, but they have made no reimbursements to us since November’ (M11).

Participants also noted the wrong criteria used for determining the per capita payments, ‘Since doctors’ income depends on the number of people they cover, and since the per capita amount for the population covered is low, doctors wish to cover a greater number of people, and they end up providing half-hearted services’ (M8).

Compensation for services
Participants considered the low salaries and delayed payments as some of the challenges of the program, ‘The financial benefits they provide to doctors are incompatible with the doctors’ level of education, work hours and job description, and this is the biggest challenge which with family doctors are faced’ (M15).

Other issues raised on this subject included the incompatibility between the doctors’ authorized power and his responsibilities, ‘The doctor has not chosen his colleagues, and maybe all five members of one family physician team are competent, while in another team, only two are; yet, the evaluation standards are the same for both’ (M6).

Performance evaluation
Participants noted issues such as being monitored by two ministries, ‘Incompatibility between the doctors’ level of education and the controllers’ and the invalidity and unreliability of the checklists used. ‘The Welfare Ministry’s checklist is different from the Health Ministry’s. The Welfare Ministry’s view is treatment-oriented while the Health Ministry’s is health-oriented’ (M4).

‘The checklist questions are limited and restrictive, and we have to award the doctors for that clause with only an affirmative or negative answer or merely by providing minutes’ (M17).

Welfare facilities
Poor residential, welfare and transportation infrastructures were considered the main challenges with respect to welfare facilities. ‘The majority of the residences in which the doctors live lack the appropriate welfare facilities. Even if the residences are fully equipped, the villages do not have good facilities for living. This is why we don’t like to remain part of the program for good’ (M20).

Recruiting and retaining a workforce
The interviewees noted issues such as having no job security, ‘We are in a state of limbo, and don’t know if we are going to be formally employed or not. We follow the rules and regulations just like other employees, yet we are not state employees’ (M21). The program is
generally not welcomed by the 82% of doctors, ‘I completed my compulsory rural service working with the family physician program but do not at all wish to renew my contract’ (M13). Participants also noted the inadequate number of permanent doctors, ‘Many centers suffer from a lack of family doctors, and nobody is willing to work in these centers. It is only the classier centers that do not suffer from a lack of doctors’ (M17).

Information system
Participants noted the time-consuming nature of information registration processes and the team’s greater tendency to forge documents showing the challenges in this area.
‘Our health system has a peculiar bureaucracy in writing records, reporting statistics and preparing audits. Family doctors have to constantly register the records, which is a time-consuming task, and some of the records end up being similar, and it is just one job done twice’ (M18).
‘There are plenty more records that have to be registered than there are services we actually provide. Everything has to be recorded in several places. So we try to prepare a series of documents just to satisfy the controllers and show them some organized documents when they come in’ (M19).

Culture-building
Participants noted challenges such as people’s inadequate awareness about the program, ‘People do not embrace the idea of having a family doctor, and only use their doctor for stamping their books and getting referrals to specialists. Some people don’t even bring the patient with them, which gives rise to arguments about referrals between the doctor and the clients’ (M3). The inadequate training (General practitioners with at least 3 years of work experience as family physician are eligible for entering the family medicine training program. This one and half year modular program is offered online using an electronic system in accordance with the curriculum offered) provided to health service providers was another challenge noted by participants, ‘Our medical universities do not train family doctors, and the medical curricula at schools are mostly focused on treatment, whereas more than 70% of the job of a family doctor concerns community health’ (M1).

Financing
Participants emphasized issues such as the lack of payments made to specialists, the limited participation of the private sector and the doctors’ unwelcoming approach to the program.
‘Specialists do not embrace this program one bit, and do not cooperate because it has no benefits for them’ (M3).
‘The patient can use only certain laboratories or radiology clinics, because the program has contracts with only a few para-clinics’ (M5).

Discussion
The present qualitative study examined the challenges in the family physician program from the perspective of family doctors and family physician program directors. The lack of planning and the failure to prepare the essentials needed for the implementation of the program created a lot of challenges and thus obliterated many of the program’s points of strength. This finding is consistent with the findings of a study conducted by Arab (11).

Given the interviewees’ notes about the doctors’ lack of cooperation in planning, developing the criteria, etc., holding collective meetings with the participation of policy-makers, senior and junior officials and family doctors appears to help improve the implementation of the family physician program, resolve the challenges in the defective remuneration packages and fix the invalidity and unreliability of the checklists, which are some of the problems noted by the majority of the participating doctors.

The family doctors considered their long work hours and heavy workloads as major challenges of the program, which is consistent with the findings of other studies conducted on the topic (11–17). Another challenge emphasized was the low wages incompatible with the huge responsibilities and long work hours, which is consistent with the findings of other studies (7,11,12,16).

A major challenge in every country’s health sector, whether the country is low or high income, is recruiting and retaining the workforce willing to work in deprived areas (18,19). Considering the shortage of family doctors and their poor retention rates in Iran (17 months on average) (20,21), a greater focus should be placed on elements that encourage family doctors to stay in deprived areas, including financial incentives, compatibility between the doctors’ capabilities and their work hours and workload, the allocation of benefits, providing job opportunities for the doctors’ spouses and providing educational and leisure facilities for the doctors’ children, as also noted in many other studies (12,20–23).

The present study and previous ones conducted on the topic suggest an insufficient culture-building around the family physician program in the general public, family doctors, specialists and subspecialists; as a matter of fact, people are mostly unfamiliar with the referral system in place and consider the family doctor’s job to revolve only around stamping their books and referring them to specialists and subspecialists. It should be noted that the referral system in place is not practical without the system having built its proper infrastructures first. Cultural efforts should be made, especially through the national media, to communicate information, spread awareness and empower the target population in relation to the benefits and goals of this program. The family physician program is faced with a variety of relatively similar challenges in developed countries too (15–26), which suggests the relative commonality of some of the challenges between different countries. In general, the results of the study showed that the family physician program is faced with various problems in the planning, implementation and evaluation stages of the program and that the general public and family doctors are not fully satisfied with the program (2,16), which necessitates greater reforms made by policy-makers.

Study limitations
The present study merely reflects the views expressed by the family physician program directors and family doctors and has overlooked the many challenges faced by community health workers, midwives and other members of health care teams in carrying out this program. Further studies are recommended to address the challenges faced by all members of the family physician team. Furthermore, this study addressed only the challenges of the family physician program and future studies are recommended to focus on the strengths of the program, as well.

Conclusion
The greatest challenges lay in cultural, economic and environmental factors and work conditions. These factors play a major role in encouraging family doctors, and the better implementation of
the program can be achieved through culture-building efforts covering the entire society and through exercising minor and major modifications. The findings of the study may be beneficial to policy-makers and national and provincial family physician program directors and might promote the quality and quantity of the services provided under this program in addition to resolving some of its defects.

**Declaration**

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Conflict of interest: none.

**References**