

Opinion

Family Physician Program in Iran: Considerations for Adapting the Policy in Urban Settings

Akram Khayat-zadeh-Mahani PhD¹, Amirhossein Takian MD PhD^{2,3,4}

Abstract

Nationwide implementation of Family Physician (FP) program started in 2005 and targeted almost 25,000,000 citizens residing in rural areas and cities with less than 20,000 populations in Iran. Despite its blatant initiation that resulted in some modest achievements,^{1,2} the future of FP looks unclear in Iran. Thus far, no longitudinal evaluation of the implementation and impact of FP program has been conducted. However, meager evidence highlights the facilitating role of an existing and strong Primary Health Care (PHC) network in the implementation of FP in rural areas in Iran.² A longstanding challenge, however, as emphasized by most stakeholders, remains to be the expansion of FP program into urban settings,³ where the PHC is undeveloped and fragile as well as the powerful private sector is resistant. Using an adapted conceptual framework of institutions, ideas, and interests,⁴ this policy perspective aims to shed light on main difficulties of FP implementation in urban areas of Iran. We analyze FP policy in the context of ongoing interactions and conflicts among institutions (the structures and rules that shape policies), interests (the groups and individuals influencing policy), and ideas (discourses around policies).⁵ Our argument will, we envisage, help plan for more appropriate implementation of FP in cities in Iran, and hopefully beyond.

Keywords: Family physician program, ideas, institutions, interests, Iranian health system, primary health care (PHC)

Cite this article as: Khayat-zadeh-Mahani A, Takian A. Family physician program in Iran: Considerations for adapting the policy in urban settings. *Arch Iran Med.* 2014; **17(11)**: 776 – 778.

Institutions involved in FP program

The organization of health system depends on the institutional context, which influences the policy environment and its outcomes. The institutional context of rural areas in Iran is different from that of urban areas. This necessitates contextualization of FP policy, when planning its expansion into urban settings.⁶ A core institutional context, namely an active PHC network facilitated the implementation of FP program in rural settings. Meanwhile, the PHC, alongside other institutional factors may hinder the implementation of FP in urban settings.

Before the Islamic revolution in 1979, the rural parts of Iran, accommodating 65% of the population (about 35,000,000 in 1979), were generally underdeveloped and had poor public health indices. The declaration of Alma Ata (1978), issued by the World Health Organization (WHO), highlighted the fundamental role of PHC in strengthening health systems. Values and goals of PHC strongly matched with the underlying ideology of the Islamic revolution, i.e. social justice, equity, human rights, universal access to health services, prioritization of the most vulnerable, and community involvement.⁷ The Parliament (Majlis) and the government endorsed the Alma Ata declaration in 1984,⁸ as a result of

which, the Ministry of Health (MoH) at the time (now the Ministry of Health and Medical Education: MoHME) adopted the PHC approach as the core to redesign the delivery of health services in Iran. National, comprehensive and inexpensive implementation of community-based PHC network began in the early 1980s in Iran. Widely expanded during the 1990s, the PHC aimed to deliver basic health services (i.e. child immunization, oral rehydration, family planning, prenatal care, respiratory infection management and environmental health⁹) through indigenous community health care providers, called Behvarzes. The PHC remained comprehensive in rural areas, where Behvarzes provided proactive health services and played gate-keeping role. While it was fragile in urban setting, the PHC was a key to major improvements in several health indices in Iran (Table 1).¹⁰

Notwithstanding exemplary achievements, the PHC network became gradually weak to respond to the emerging needs of population (e.g. high burden of non-communicable diseases, increasing public expectation to access qualified physicians, as well as fast growing and expensive medical technologies). Hence, reforming the Iranian health system through two parallel policies: FP (to re-engineering service delivery) and universal health insurance (to enhance affordability) started.¹ FP endorsed the principles of an effective PHC; i.e. accessibility; continuity; team-based and community-oriented; coordination; preventive focus; and evidence-based care.¹¹ Given these considerations, the pre-existing, trustworthy, and reputable PHC network was a core institutional facilitator of the implementation of FP program in rural settings in Iran.

Contrary to rural areas, the institutional characteristics of urban settings in Iran may hinder the implementation of FP policy. These include: the passive and fragile PHC network, strong private sector with massive conflict of interest with FP, public's high

Authors' affiliations: ¹Research Centre for Health Services Management, Institute for Futures Studies in Health, Kerman University of Medical Sciences, Iran, ²Department of Global Health & Public Policy, School of Public Health, Tehran University of Medical Sciences, Iran, ³National Academy of Medical Sciences, Tehran- Iran, ⁴Department of Clinical Sciences, College of Health & Life Sciences, Brunel University London, Uxbridge, UK.

•**Corresponding author and reprints:** Amirhossein Takian MD PhD, Department of Global Health & Public Policy, School of Public Health, Tehran University of Medical Sciences, Iran. Address: Poursina Ave, Keshavarz Blvd, Tehran-Iran, Tel: +98(21) 42933225 E-mail: takian@tums.ac.ir, takiana@gmail.com. Accepted for publication: 20 August 2014

Table 1. Comparison of selected health indicators in Iran in 1981, 2000, and 2011²

Health Index	1981	2000	2011
General life expectancy (years)	46.7	69	73
Infant mortality rate (IMR), death/1000 live births	94	28.6	22
Population growth rate (%)	3.9	1.24	1.3
Overall vaccination coverage (%)	40	> 90	> 90

freedom of choice to use health services, and multi-dimensional and more diverse cultural norms than rural areas, among others.

The role of ideas

Ideas and the way that they were shaped, influenced the implementation of FP policy significantly.⁵ Lack of a macro philosophy for the entire Iranian health system led to contradictory interpretations of FP goals and hampered its implementation in almost all cities.⁹ There exists, also, a gap between the rural PHC equity-focused system and the urban curative model, where the evidence suggests the dominance of the latter.¹² In line with principles of the Islamic revolution, while equity and outreaching the poor (i.e. the egalitarian philosophy) facilitated the approval of FP program and its bumpy implementation in rural Iran;¹ the libertarian philosophy (i.e. the pro-market ideology) and strong unregulated private sector in urban areas hindered the expansion of FP program into cities. Prior to health transformation plan currently being implemented in Iran, pro-market perspectives, driven by individual choice and influenced by powerful medical professional lobbies, with a strong bias towards curative medicine and expensive diagnostics,¹³ have been dominant face of health system in Iran.¹² This contradicts, very clearly, the egalitarian intentions proclaimed in the Iranian constitution and many national laws (e.g. Iranian Constitution, the 5-Year Development Plans, mega policies for health recently announced by supreme leader, and National Health Insurance Act).

An interesting point to consider is the advocacy and support for FP policy by politicians, policy makers and other stakeholders from across political views (i.e. reformists versus conservatives).¹ However, despite these congruent ideas, the national implementation of FP and its expansion into urban areas has remained rhetoric. This could be partly due to the strong tendency among Iranian urban residents towards specialized and curative care, which is mostly provided by specialist doctors. There is also an overwhelming emphasis, by the media and policy makers, on the curative versus preventive care and health promotion, which may be perceived as less necessary due to their little direct and immediate impact on health problems. In addition, the entire health system has been chronically suffering from the lack of integration in healthcare provision and a holistic view towards health.¹⁴ Whereas, strong focus on specialized and niche care, mostly provided by the private sector, has been dominant in Iran. This has faded the role of general practitioners, whom have been employed as family physicians in FP, particularly in the cities.⁹

The importance of interests

Stakeholders' underlying interests, their political incentives, and actions to galvanize their interests, may play a fundamental role in policy implementation.⁵ Medical doctors possess three sources

of power: resources, technical skills, and knowledge.^{15,16} As the most powerful players in the Iranian health system, many specialist doctors, the majority of them work in the private sector and are responsible for above 80% of outpatient care provision in cities, do not support preventive services provided through FP in Iran. This phenomenon can be explained by the rent-seeking model: a process by which the medical professionals compete to obtain the surpluses created by imperfectly competitive markets.¹⁷ The model illustrates stronger influence of medical doctors, particularly specialists, compared to non-physicians and general physicians in the Iranian health system. This is partly due to unequal distribution of political influence among healthcare providers in favor of physicians, mainly specialists in the private sector, who may possess the biggest proportion of various investments in healthcare system.¹⁸ Let alone the possibility of making public policies by some stakeholders with meaningful interests in the private sector.

Moreover, the nature of services, provided through FP gives the fore for rent-seeking in that resources meant for FP services are much easier to transfer compared to curative and diagnostic services, which require high medical technologies.¹⁹

We used the conceptual framework of institutions, ideas, and interests as well as the complex interaction among them, to portrait the challenges of expanding the implementation of FP policy into urban areas in Iran. Specialist doctors in the private sector are the most powerful stakeholders in healthcare provision in cities in Iran. Unless a winner-winner situation for the private sector is created to exploit their capacities, FP program will achieve no or little success in the cities. Smooth and meaningful implementation of FP in Iran can be achieved through fundamental changes in the governance and organization of health system towards greater decentralization; robust transparency, balanced distribution of power among various healthcare providers, adjusted tariff system for medical services, and most importantly educating people to seek their care through referral system.

References

1. Takian A, Rashidian A, Kabir MJ. Expediency and coincidence in re-engineering a health system: an interpretive approach to formation of family medicine in Iran. *Health Policy and Planning*. 2011; **26(2)**: 163 – 173.
2. Takian A, Doshmangir L, Rashidian A. Implementing family physician programme in rural Iran: exploring the role of an existing primary health care network. *Fam Pract*. 2013; **30(5)**: 551 – 559. DOI: 10.1093/fampra/cmt025. (Epub 2013 Jun 20).
3. Majdzadeh R. Family physician implementation and preventive medicine; opportunities and challenges. *International Journal of Preventive Medicine*. 2012; **3(10)**: 665.
4. John P. Analysing public policy. *Continuum International Publishing Group*. 1998.
5. Buse K. Addressing the theoretical, practical and ethical challenges inherent in prospective health policy analysis. *Health policy and Planning*. 2008; **23(5)**: 351 – 360.
6. Dickinson C, Buse K. Understanding the politics of national HIV policies: the roles of institutions, interests and ideas. *HLSP Institute*. 2008.
7. Shadpour K. Primary health care networks in the Islamic Republic

- of Iran. *Eastern Mediterranean Health Journal*. 2000; **6**: 822 – 825.
8. Asadi-Lari M, Sayyari AA, Akbari ME, Gray D. Public health improvement in Iran—lessons from the last 20 years. *Public Health*. 2004; **118(6)**: 395 – 402.
 9. Takian A. Implementing Family Medicine in Iran: Identification of Facilitators and Obstacles. PhD thesis submitted to the University of London, UK. 2009. Available from: URL: <http://researchonline.lshtm.ac.uk/878723/1/536859.pdf>
 10. Aghajanian A, Mehryar AH, Ahmadnia S, Kazemipour S. Impact of rural health development programme in the Islamic Republic of Iran on rural-urban disparities in health indicators. *Eastern Mediterranean Health Journal*. 2006; **13(6)**: 1466 – 1475.
 11. Sloane PD. Essentials of family medicine. *Wolters Kluwer Health*. 2008.
 12. Khayat-zadeh-Mahani A, Fotaki M, Harvey G. Ethical Theories and Values in Priority Setting: A Case Study of the Iranian Health System. *Public Health Ethics*. 2013; **6(1)**: 60 – 72.
 13. Paresh M, Tishelman C, Fredrikson S, Jamshidi H, Tomson G, Emami A. We noticed that suddenly the country has become full of MRI; Policy makers' views on diffusion and use of health technologies in Iran. *Health Research Policy and Systems*. 2010; **8(9)**: 1 – 10.
 14. Khayat-zadeh-Mahani A, Fotaki M, Harvey G. Priority setting and implementation in a centralized health system: a case study of Kerman province in Iran. *Health Policy and Planning*. 2013; **28(5)**: 480 – 494. DOI: 10.1093/heapol/czs082. (Epub 2012 Sep 22).
 15. Mintzberg H. Power in and around organizations. *Englewood Cliffs, NJ: Prentice-Hall*. 1983.
 16. Llewellyn S. Two-way windows': clinicians as medical managers. *Organization Studies*. **22(4)**: 593 – 623.
 17. Krueger AO. The political economy of the rent-seeking society. *The American Economic Review*. 1974; **64(3)**: 291 – 303.
 18. Khayat-zadeh-Mahani A. Health care priority setting and implementation in a centralized health system: a case study of Iran. *PhD Thesis. UK: The University of Manchester*. 2010.
 19. Goddard M, Hauck K, Smith PC. Priority setting in health—a political economy perspective. *Health Economics, Policy and Law*. 2006; **1(1)**: 79 – 90.