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Challenges of Implementing the Family Physician Program: A Qualitative Study in an Iranian Urban Community

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ABSTRACT

Background: The family physician program plays a crucial role in promoting the quality of community-based primary healthcare. This study aimed to explore the challenges and obstacles of implementing the family physician program in an Iranian urban community context.

Methods: A qualitative study design employing a conventional content analysis approach was conducted. The participants were nineteen healthcare recipients and healthcare providers from urban health centers in Bonab, Iran. Data were collected through semi-structured individual interviews until data saturation, and simultaneous data analysis was conducted. MAXQDA 10 software was used to manage the data. The study was conducted between February and July 2019 at the urban health centers in Bonab, Iran.

Results: The analysis of the collected data yielded three main categories, namely, 'socio-cultural and economic challenges', 'interpersonal communication difficulties', and 'inefficient management'. These categories emerged as the challenges faced in implementing the urban family physician program in the community.

Conclusion: The implementation of the family physician program is a long process that is influenced by various factors and the elimination of barriers requires developing infrastructures and culture growth and improving the professional settings and interpersonal relationships.

1. Introduction

The family physician program (FPP) has emerged as a highly influential strategy aimed at improving the overall health system and promoting population health [1]. Moreover, it plays a crucial role in promoting community-based primary healthcare quality [2], effectively bridging the gap between communities and the health system to ensure efficient and equitable care. FPP, as a comprehensive health plan, delivers health services to individuals across all age groups, genders, and socioeconomic statuses [3]. This inclusive approach has resulted in improvements in health outcomes across diverse countries, healthcare, and conditions [4]. FPP was first developed in the United Kingdom in the 1950s and then was expanded to other countries [5]. In Iran, it was introduced in 2005 in rural areas [6] through providing insurance coverage for all people living in villages and towns with less than 20,000 populations [7]. Due to the good achievements in rural areas, the program was then expanded to all Iranian urban communities in 2011 [6]. However, despite notable achievements of FPP, its expansion within communities continues to face a wide range of challenges and obstacles such as limited capacity, incomplete understanding of roles, variability of standards and recognition [8], and also lack of resources and capabilities [9]. The implementation of the FPP in Iran also faces several challenges as highlighted in various

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studies. These challenges encompass aspects such as financing, human resources, healthcare insurance system [10], referral system, performance evaluation, problems with health policy, health information system, and culture-building for proper policy [11]. It is important to note that the barriers to healthcare programs differ between rural and urban areas [12]. Therefore gaining an understanding of these challenges from the viewpoints of both care recipients and care providers in a specific context can provide deeper insight into the phenomenon under investigation. It can also help policymakers in designing effective reorientation programs. Also, considering the significance of providing solutions to the social and cultural context and the local conditions of each region, particularly in the case of health-related programs, it becomes imperative to conduct qualitative studies to explore the challenges and obstacles of implementing the FPP in Iranian cultural context.

2. Materials and Methods

2.1 Study design

A qualitative study with a conventional content analysis approach was conducted to elicit and explore the challenges of implementing the FPP in health centers of Bonab, Iran. The study was conducted between February and July 2019.

2.2 Sampling

The participants in the study were selected using a purposeful sampling method with maximum variation in terms of age, gender, work experience, and level of education. The participants were selected from the care recipients and the stakeholders of the program, including health practitioners and healthcare providers. After collaborating with the head of the center, the researcher selected the eligible participants from the five health centers in Bonab City. Familiarity with the implementation of the urban FPP, using healthcare services, and willingness to participate in the study were considered as the inclusion criteria. Accordingly, a total of nineteen individuals participated in the study, and their demographic information is presented in Table 2.

2.3 Data collection

Data were collected through semi-structured individual interviews using an interview guide with open-ended questions (Table 1). The interviews usually began with general questions which were then followed by follow-up probing questions, such as "Would you please detail your explanation?" and "Would you explain more, please?", according to the responses of the participants. The time and location of the interview sessions were mutually agreed by the interviewees and the interviewer, with interviews conducted either at the health center or the interviewer's workplace. Each participant was interviewed once lasting approximately 30-60 min. All interviews were audio-recorded using a voice recorder. The interviews continued until data saturation was reached, a point at which the researcher began to encounter repetitive comments and no new themes or ideas emerged [13].

2.4 Analysis

The transcriptions of the interviews were performed verbatim and subsequently reviewed several times to achieve a comprehensive understanding of the data. Then, the data were broken down into meaningful units, which were extracted from the participants' statements and labeled with conceptual names (codes). After this open coding, the codes were compared based on similarities and differences and then grouped into categories. Similar-meaning subcategories were grouped to form categories, and these categories were further grouped to create main categories [14]. MAXQDA-10 software was used to manage the textual data during the coding process.

2.5 Trustworthiness

To ensure the trustworthiness of the study, the criteria suggested by Guba and Lincoln were employed to evaluate the credibility of the data [15]. Prolonged engagement with the participants during the interview period helped to establish trust and a better understanding. Peer debriefing sessions were conducted to indicate researchers' positions toward data and analysis. The research team checked the interview data and findings at each step of the study. Moreover, analytic categories, interpretations, and conclusions were tested using member checks. All steps followed in the research process were documented by the researchers to provide auditability and dependability of the data. The guideline of consolidated criteria for reporting qualitative research (COREQ) was used while providing the manuscript [16]. We used this guideline to ensure that our paper comprehensively addressed the transparent reporting of our research.

2.6 Ethics

The aim and the process of the study were clearly explained to the participants, and their written informed consent was obtained. To ensure confidentiality, the interviews were recorded anonymously using code numbers.

Table 1. Semi-structured interview guide

	Interview questions
1	How would you describe the urban family physician program?'
2	How would you explain the health services in this new plan?
3	What changes have you made to your lifestyle since using the FPP services?
4	Has this plan made you pay more attention to your health?
5	What are the problems you feel this plan is facing?
6	What factors may facilitate and/or inhibit the implementation of family physician program?

Table 2. Demographic profile of the participants (n = 19)

Participants code	Age (years)	Gender	Education	Job	Work experience (years)
1	37	Female	Elementary	Housewife	-
2	39	Female	Masters	Employee	-
3	52	Female	Masters	Healthcare provider (General Physician)	25
4	34	Female	Bachelor	Healthcare provider (midwife)	11
5	35	Female	Bachelor	Healthcare provider (midwife)	5
6	30	Female	Bachelor	Housewife	-
7	29	Female	High school	Housewife	-
8	34	Female	Masters	Healthcare provider (maternal care expert)	9
9	42	Female	Bachelor	Healthcare provider (mental health expert)	19
10	42	Female	Masters	Healthcare provider (population and family health expert)	19
11	33	Female	Bachelor	Healthcare provider (midwife)	3
12	43	Female	Bachelor	Employee	-
13	40	Female	Bachelor	Housewife	-
14	50	Female	Diploma	Housewife	-
15	36	Female	Diploma	Housewife	-
16	34	Female	Diploma	Employee	-
17	41	Male	Masters	Employee	-
18	61	Male	High school	Retired	-
19	22	Male	Bachelor	college Student	-

3. Results and Discussion

In this study, we explored the challenges and obstacles of implementing the FPP in an Iranian urban community. Three main categories emerged as the main challenges including 'socio-cultural and economic challenges', 'interpersonal communication difficulties', and 'inefficient management' (Table 3). Each of These categories is extensively discussed as follows.

3.1 Socio-cultural and economic challenges

This category explained how cultural context and poor economy may affect health-related behaviors, and consequently achieving the goals of the urban FPP. This concept had two subcategories as follows:

3.1.1 Adherence to the indigenous norms

Participants believed that some common regional beliefs have caused people to resist training about health behaviors and lifestyle-related modifications. They reported that the indigenous norms and lifestyle originated from the common and prevailing traditions that prevent adopting healthy behaviors. In this regard, one of the healthcare providers stated:

"...Because of people's indigenous lifestyle, such as solid oil consumption, despite their much training, personal behaviors have not changed since they strongly believe that solid oil is beneficial" (P4, healthcare provider).

Moreover, despite providing male health screening in the FPP, the participation rate of men in the health programs is still low. Based on the reports of participants, men refuse to refer to the health centers because they believe that the health services are just for women and children. This can be understood from the expression of some of the participants who states:

"... Despite we call and invite men to receive the health services, they refuse even for screening programs" (P11, healthcare provider).

"...Every time I ask my husband to go to the health centers, he refuses to go; men do not care about themselves" (P15, healthcare recipient).

3.1.2 Financial difficulties

Financial difficulties and rising living costs have made it hard to change some lifestyle-related behaviors that followed in urban FPP, such as healthy eating behaviors. Some participants believed that despite the development of training provided in the program, and the rise in the level of awareness of service recipients, most of them cannot practice healthy nutrition recommendations, due to a lack of sufficient income. In explaining this, one of the healthcare providers said:

"...Financial and economic problems play an important role in adopting health-related behaviors. When we advise people to increase their protein intake, they say it's not affordable for me. If people are well-off and have enough income, they can gain better health and nutrition" (P4, healthcare provider).

3.2 Interpersonal communication difficulties

This concept refers to the communication problems in interpersonal relationships that can then affect the quality of

the FPP services. This category is extracted from two subcategories as below:

3.2.1 Disrespectful Behaviors

Disrespectful behaviors of the healthcare providers are a communication problem in interpersonal relationships that can then affect the quality of the FPP services. As participants noted, lack of face-to-face communication and disrespectful behavior of the healthcare providers have made the clients still and silent while receiving care, without asking any possible questions and not to be eager to refer to health centers for receiving the FPP services. Moreover, clients' confidence has also been undermined by such disrespectful behaviors. One of the experts said:

"...There is no connection at all between healthcare providers and the patients. The healthcare providers are careless, impatient, confused, busy, and cannot communicate so positively with the patients" (P3, health care provider).

Furthermore, inappropriate behaviors of the healthcare providers have made the clients unwilling to refer for receiving family physician services and come just to do the necessary work:

"...Because of their disrespectful behaviors, I did not want to go there at all. I went reluctantly just to do the essentials like vaccination" (P16, healthcare recipient).

3.2.2 Lack of trust in healthcare providers' competencies

According to the participants, the healthcare providers were not experts and competent enough to perform their tasks. They had previous unpleasant experiences of receiving physician care services, with the least positive results from the treatments. In explaining this, one participant said:

"...I do not want to see a doctor here at all because I do not have a good experience of receiving care services. I do not trust them at all. " (P12, healthcare recipient).

Such distrust seems to originate, to some extent, from discrepancies among the healthcare providers in delivering care with the same procedures and/or prescriptions and recommendations for the same health issues. Such perceptions of the clients on inconsistencies among the providers have led to a decrease in their willingness to refer for receiving family physician care services:

"...One of the problems with this program is that the coordination between the different departments is too weak. What a healthcare provider say may be at odds with what a nutritionist or psychiatrist or midwifery unit suggests. Sometimes some trainings are repeated a lot, and sometimes there is a conflict between the statements" (P 4, healthcare provider).

3.3 Inefficient management

Another challenge confronting the FPP was inefficient management, which was explained in the following categories: "temporary hiring and inefficient workforce", "lack of resources", "poor announcement and notification of the program", and "quantity-orientation and reducing the quality of service delivery" during the implementation of the program:

3.3.1 Temporary hiring and inefficient workforce

According to the participants, applying an inefficient workforce during the implementation of the program has led to low-quality service provision. Some of the participants highlighted the lack of an efficient workforce including physicians, healthcare providers, and other experts, such as nutritionists and midwives:

"...Most of the physicians who introduce to the health centers are those who could not provide satisfying services. They are inefficient and patients are not satisfied with them" (P12, healthcare recipient).

Using a temporary workforce who is constantly changing, was another problem mentioned by some of the participants:

"...Work forces who come here have neither been sustainable nor particularly efficient, so they do not commit to what they start to do" (P9, healthcare provider).

3.3.2 Lack of resources

As participants reported, the disproportionate number of staff in the covered population and lack of financial resources were other problems that led to a decrease in quality-of-service delivery and dissatisfaction in FPPs. In support of this idea, some of the participants said:

"...This program (FPP) is a copy of the British and/or Canadian system. In those countries there is one general physician for every 1,000 people, but in Iran we allocate 10-12 thousand people to a physician. So, this disproportion and lack of manpower could affect the quality-of-service delivery" (P3, healthcare provider).

"...Since the number of mental health experts is limited, i.e., one expert is set for every 30,000 people, how many training sessions can a mental health expert have, and how much effective could be?" (P9, healthcare provider).

Moreover, salaries for employees, especially healthcare providers, are low. It is not paid regularly and is usually faced with delays of several months, which reduces the motivation of employees and overshadows the quality of service:

"... The salary they pay is neither sufficient nor on time, so

they are working with a reduced level of motivation to work better than before " (P9, healthcare provider).

3.3.3 Poor announcement and notification

According to the participants, poor announcements and lack of public awareness of family physician care services was another problem related to the inefficient planning and management of the program. Some participants believed that achieving the goals of the FPP depends on the provision of a suitable platform for informing the community:

"...People do not know enough about family physician program services. If people were taught in the media that the health services are reoriented would be better. People's awareness of this is somewhat low" (P4, healthcare provider).

3.3.4 Quantity-orientation and poor quality of service delivery

High pressure from the management system to raise the number of daycare services has led to a focus on increasing the quantity and reducing the quality of healthcare delivery. Also, since the number of services provided for each client based on the different age groups is high, increasing the quantity hits the desired and quality service delivery.

"...Before the program, we did not have the stress of monitoring the number of health services. The number of our services was small and the quality of our services was much better than now. After implementing family physician program, the number of clients and the care process raised so healthcare providers couldn't provide the necessary services such as face-to-face health education and I think the quality is sacrificed for quantity " (P4, healthcare provider).

Moreover, due to the mandatory registration of the number of daycare services with the maximum of details in an electronic system, health caregivers are forced to focus on registering the number of services and ignore their main task, which is to educate the clients on health issues. In explaining this idea one of the healthcare providers said:

"...Sometimes the healthcare providers become so preoccupied with registering the number of health services in electronic system that they forget to teach the important subjects, such as teaching mothers how to make baby food, while one of our main tasks is health education" (P3, healthcare provider).

This study explored the challenges of implementing the FPP in an urban community. An important challenge of the FPP was the indigenous norms of the society. Participants believed that adherence to indigenous norms impedes the recipients of the FPP to uptake lifestyle modifications. Due to the culture of the region, they adopted health risk behaviors such as unhealthy eating habits like consumption of solid oil, reluctance to fish consumption, and sedentary life. Moreover, the participation of men in the program due to the cultural norm that health services are prepared for women and children, was low. In a similar qualitative study that described cultural barriers to men's participation in perinatal care in Iran, a large part of the resistance to men's participation in perinatal care was due to the undesirable dominant socio-cultural climate of the society and the traditional patriarchal culture which is dominant in the Iranian families [17, 18]. Also, another study that was conducted on the factors that preclude men from accessing healthcare has found that cultural factors, time, convenience, resources, embarrassment, and lack of awareness of healthcare options play a significant role in men's access to healthcare [19]. Financial problems of the care receivers were another big challenge of the FPP. Various studies on patients with diabetes and cardiovascular diseases have indicated financial problems as one of the main reasons for having difficulty in self-managing the disease [20, 21] Similarly, our study showed that financial challenges such as low income, unemployment, and recent inflation may lead to poor lifestyle management and lack of preventive medication use like screening for women's cancers and dental care, which may consequently result in adverse outcomes among the individuals. As participants reported, poor interpersonal relationship was another barrier to successful implementation of the FPP. For instance, the distrust of the healthcare providers' competencies made the healthcare recipients unwilling to participate in the FPP. In agreement with this finding, Hamidzadeh *et al.* reported the lack of trust in health educators' competencies as one of the barriers revealed for implementing health education programs in rural settings [22]. Lack of proper communication between healthcare providers and clients was another difficulty that may hinder their participation in the FFP. Various studies have indicated effective communication skills as a facilitator for the efficient implementation of healthcare services [12, 22, 23]. In this respect, Mannava *et al.* in a study on the behaviors and attitudes of healthcare providers, revealed that the negative interpersonal interactions between care providers and clients might affect clients' well-being, recovery, and follow-up care. They finally showed that the communication and counseling skills of healthcare providers are crucial in changing the health workers' attitudes and behaviors regarding maternal healthcare provision [24]. Another challenge reported by the participants was the use of an inefficient and temporary workforce in implementing the FPP, which leads to incomplete and inappropriate delivery of the program's healthcare to the clients and thus reduces the effectiveness of the program. Insufficient capacity of specialists to provide clients with quality care and support is among the barriers and challenges reported from low-and middle-income countries [25, 26]. As participants believed, the inability of the government to hire permanent staff has led to a lack of motivation due to job insecurity among temporary employees, and consequently lack of commitment to delivering high-quality healthcare. Poor announcement and notification were another managerial problem reported by the participants.

Table 3. Summarizing the main results of challenges and obstacles of FP

The main categories	Subcategories	A selection of codes	Units of meaning
Socio-cultural and economic challenges	Adherence to the indigenous norms	The difficulty of changing people's eating habits due to the indigenous culture of the region	Because of people's indigenous lifestyle, such as solid oil consumption, despite their training, lifestyle has not changed people since they strongly believe that solid oil is beneficial
	Financial difficulties	The role of financial problems in changing people's lifestyle	Financial and economic problems play an important role in adopting health-related behaviors. If people are well-off and have enough income, they can gain better health and nutrition. When we advise people to increase their protein intake, they say it's not affordable for me
Interpersonal communication difficulties	Disrespectful Behaviors	Lack of proper communication between the healthcare provider and the patient	There is no connection at all between healthcare providers and patients. The healthcare providers are careless, impatient, confused, busy, and cannot communicate positively with the patients.
	Lack of trust in healthcare providers' competencies	Distrusts of service recipients due to the experience of receiving inappropriate services	I do not want to see a doctor here at all because I did not receive good services. I do not trust it at all
Inefficient management	Temporary hiring and an inefficient workforce	Using inefficient workforce	Most of the physicians who are introduced to the health centers are those who cannot provide satisfying services. They are inefficient and patients are not satisfied with them.
	Lack of resources	Disproportionate number of staff for the covered population Challenges of the payment system	This program (FPP) is a copy of the British or Canadian system. In those countries, there is one general physician for every 1,000 people, but in Iran, we allocate 10-12 thousand people to a physician. So, this disproportion and lack of manpower could affect the quality-of-service delivery Salaries and benefits are not at all as good as what we offer
	Poor announcement and notification	Weakness in Information system	People do not know enough about the FPP services. If people were taught in the media that health services had changed would be better. People's awareness of this is somewhat low.
	Quantity orientation and poor quality of service delivery	Decreased quality due to high pressure from the management system to raise daycare an	"...Before the program, we did not have the stress of monitoring the number of health services, the number of our services was small and the quality of our services was much better than now. After implementing the FPP, the number of clients and the care process increased so Healthcare providers couldn't provide the necessary services such as face-to-face health education and I think the quality is sacrificed for quantity.

Based on the findings, the people are not sufficiently aware of the FFP and its services, which has resulted in low levels of service use as mentioned in many other studies [27, 28]. In this respect, Kaniz *et al*. investigated that, exposure to mass media is positively associated with comprehensive maternal healthcare services in South Asia [29]. Therefore, FFP services should be presented to the public in a planned manner through mass media campaigns and cyberspace to publicize FFP's health messages motivate people to receive healthcare services, and increase public trust and public use of the services. In the FPP, the payment system plays a key role in both the quantity and quality of health services [30]. Nevertheless, the results of the present study explained that there were problems in the payment of salaries of health workers in the FFP, and payments were too low and paid with delay. Similarly, the weakness of payment mechanisms in the health sector and its lack of clarity and notable income gap among the members of a health team are mentioned as the main challenges of such programs in previous studies [28, 30]. Hence, any countries that implemented FFP, to avoid unnecessary visits and improve the quality of care and diagnosis have used different payment methods, including salaries, per capita, bonuses and service fees [31] considering regular payment systems and fair approach to all healthcare providers in the team is essential for the success of the FPP. According to the findings of our study, high pressure from the management system to raise the indicators and set a ceiling for daycare are among the reasons for caregivers focus overwhelmingly on increasing the quantity of care provided. Such a situation brings about a huge decline in the quality of health services. In a similar study in Turkey on the challenges of implementing primary healthcare reforms, performance-based indicators were only related to the quantity of care provided, and the quality was not measured. Thus, uncertainty about the quality-of-service provision was reported as a big challenge for the investigators [31]. Further,

Jan C-F *et al.* (2018) examined a ten-year healthcare reform program in Taiwan, they examined the quality indicators of care, namely the structure, process, and outcome, and concluded that after receiving the program, members made better use of preventive health services more than others [32]. It can be assumed that to improve the quality of care and the number of registrations in the system quantity should not be considered as the basis for evaluating and judging employees so that healthcare workers don't worry about increasing the provision of poor-quality care. The strength of the current study is that the challenges of the FPP are explained in depth from the perspective of the health service recipients. One of the limitations of the present study was that most of the participants were female because according to the nature of services provided in the FPP, women are more reeve to the FPP services than men. Hence most healthcare providers and healthcare recipients were women. Considering that the findings of this study are based on the time context, it is suggested to repeat this research in the future.

4. Conclusion

The participation of individuals in the FPP is hindered by a range of socio-cultural and economic challenges, interpersonal communication difficulties, as well as inefficient management. Consequently, the implementation of FPP is a long process that is influenced by various factors, and the elimination of these barriers requires the development of infrastructures and the cultivation of a supportive cultural environment. Additionally, improving the professional settings and interpersonal relationships is crucial in fostering the effectiveness of the program.

Authors' Contributions

Parisa Hajibadali: study design; data collection and analysis. Haidar Nadrian: manuscript revision. Mina Hashemiparast: study design; writing manuscript.

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Conflicts of Interest

All authors declare that they have no conflicts of interests.

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Ethical considerations

The ethics committee of Tabriz University of Medical Sciences (TBZMED) approved the study protocol (Approval ID: IR.TBZMED.REC.1398.417).

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