Effective Factors on the Unwillingness of Physicians to Participation in the Family Physician Program: Tehran Province Health Care System

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Abstract

Introduction: The present study is an attempt to survey the reasons for the physicians’ reluctance to take part in the family physical program in the Tehran province health care system.

Methods: Considering this purpose, the study is an applied work carried out through a correlative method in Tehran’s Province Health System in 2012. The study population was comprised of all the physicians in the Tehran Province health system. The participants were selected through census sampling procedure. A questionnaire was used for data gathering and the data were analyzed using SPSS16.

Results: The mean point of economic stage, work conditions, health, welfare, structural-organizational, and social-cultural problems in the health centers under study were less than midpoint. Additionally, a statistically significant relationship was found between these problems and the tendency of physicians to take part in the family physician program (P<0.05).

Conclusion: The results indicated a significant relationship between the problems of physicians and their tendency to take part in the family physician program in Tehran. Given the necessity of creating motivation among physicians to take part in the program effectively and willfully, solving the physicians’ problems appears to be effective in motivating the physicians in this regard.

Keywords: Family Physician, Referral System, Problems of Family Physicians, Health Centers

Introduction

Health is one of the principal rights and a valuable capital at every social level [1]. Along the main objective of the national health system, which is to improve public health where the healthy citizens have capability to take part in economic and social activities [2], there are other tasks to be fulfilled by the health system. These tasks include raising hope for a healthy life, responding to reasonable expectations of the public, reducing social gaps (social justice) and providing financial coverage for medical services [1]. It is essential, therefore, to design and adopt a proper model for health services to realize health objectives, maintain/improve health, and improve equal access to health services.

In this regard, many have supported the idea of a health system in which all citizens regardless of their living condition and place (even those living in remote areas) have access to adequate specialized health services. Such services are provided by the facilities where experts are trained based on the available resources in the shortest feasible time and for reasonable costs as required by cultural and time constrains [3].

In fact, family physician programs and referral systems are in line with the realization of a primary care health system that actualizes considerable potential resources towards the improvement of the health conditions of the society [4].

The family physician program is a comprehensive health system and among the main achievements of this program are helping people to refer to the right specialist and an increase in the public satisfaction of health services [2]. Additionally, the American Physician Academy believes that the family physician system is the best and most effective way to provide health services for patients [3].

In spite of this, the government of the Islamic Republic of Iran, in cooperation with the Ministry of Welfare and Social Security, Ministry of Health, Treatment, Medical Education, and Health Service Insurance Org. triggered a rural health insurance programs through a referral system based on a family physician program in 2005. This program, considered as one of the main elements of health system development, was aimed to expand the health insurance coverage and to promote equal access to health diagnostic services [5].

In addition to supplying health services required by the public, the family physician program prevents negligence of patients’ right or any abuse of people’s need to health services [1].

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Given that the family physician program is a nationwide program and all insurance organizations participate in this program, it is essential to survey the performance of the program regarding implementation, quality, and quantity of the services provided to insured patients. By this survey, the weaknesses and advantages of the program can be highlighted. Consequently, the family physician program may lead to immense changes in treatment behavior models as well as changes in consumption patterns in this field [6].

Santos and Amado believe that the knowledge of a family physician to provide primary care services leads to a long-term relation between the family and the physician; which is an advantage of the family physician program [7].

In addition, ranking the health services by the referral system gives the people in need access to more specialized services based on their true needs [8].

At first, the referral visits the family physician and, if needed, the physician recommends them to a special practitioner. The special practitioner, then, checks the patients, carries out the required measures, records the measures in the patients’ file, and returns the patients to the family physician [9].

Although, the family physician program is initially aimed to improve public access to health care systems and cuts the unnecessary medical costs, there are evidences that the program is not free of weaknesses [10].

In his study titled “challenges of family physicians in the world of the 1980s” Donald Rice (1980), studied the status of family physicians and challenges ahead of them in different countries and highlighted some main challenges including financial support for the graduates, salary of the physicians and the staff from community sources, and so on.

After the implementation of health networks, family physicians are the next biggest reform in health systems, which promises to solve many of the problems of the health system. It is reasonable to expect a variety of economic, social, and cultural problems ahead of the program and failures to overcome. These problems threaten first level of services and the poor’s health. Above all, solving a problem needs developing an accurate insight to the problem. Analyzing the causes and the factors effective on high turnovers of family physicians is the first step to reach a right policy to improve health services nationwide.

**Methods**

The study is a descriptive analytical work carried out on the Tehran Province health system in 2012. Given incongruity of the districts under study and sensitivity of the issue, a census was taken in the system and all 100 physicians in the system agreed to participate. No sampling was done in this study and all the study population took part in the survey.

Questionnaires were used for gathering the data. These questionnaires were divided into two sections. The first section included the demographic information of those who had took part in the survey. The second section included the questions which showed the unwillingness of the physicians towards the family physician program. The results of these questionnaires were classified into five main axes: 1- economic variables (questions 1-6); 2- work conditions, health, welfare, and educational variables (questions 7-12); 3- systematic-organizational variables (questions 13-18); 4- organizational-administrative variables (questions 19-24); and 5- social and cultural variables (questions 25-30). The questionnaire was designed based on Likert’s five-point scale.

The validity of the questionnaires was approved by ten experts. Also, the stability was gained by the Cronbach’s alpha coefficient test. The gleaned data were analyzed using descriptive and inferential statistics in SPSS. Among descriptive statistics frequency, frequency rate, mean, and standard deviation were used. Also in order to survey the independence/dependence of the variables, Chi Square was used as inferential statistics.

**Results**

Female and male participants constituted 65% and 35% of the sample group respectively. In addition, 24% of the participants were unmarried and 76% were married. Regarding employment status, 68% had lifetime employment and 32% were employed in the program for a specific time.

The average age of the participants was 34 and the youngest and oldest participants were 25 and 54 years old respectively. Moreover, 23% of the participants were at the age range of 25-35, 58% were at the age range of 35-45; and 19% were at the age range of 45-55. Work records also showed that the lowest work experience was 1 year and the highest work experience was 29 years. On average, the participants had 10 years of work experience; 30% less than 19 years, 50% between 10 to 20 years, and 20% between 20 to 30 years.

<table>
<thead>
<tr>
<th>Response</th>
<th>Very Low F</th>
<th>Low F</th>
<th>Very Low F</th>
<th>Low F</th>
<th>Moderate F</th>
<th>Very Low F</th>
<th>Low F</th>
<th>Moderate F</th>
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<th>Low F</th>
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<tbody>
<tr>
<td>Economic Problems</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>29</td>
<td>71</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Work Condition Problems</td>
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<td>0</td>
<td>25</td>
<td>25</td>
<td>65</td>
<td>65</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Problems</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>36</td>
<td>36</td>
<td>22</td>
<td>23</td>
<td>33</td>
<td>33</td>
<td></td>
</tr>
<tr>
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<td>0</td>
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<td>15</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>66</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Structural-Organizational Problems</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>44</td>
<td>44</td>
<td>28</td>
<td>28</td>
<td>18</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Social- Cultural Problems</td>
<td>8</td>
<td>8</td>
<td>19</td>
<td>19</td>
<td>31</td>
<td>31</td>
<td>21</td>
<td>21</td>
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</tbody>
</table>

**Table 1. Distribution and frequency rate of the response**
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Discussion

The family physician program has aimed to completely implement a referral system in the health and treatment sector. Among the main advantages of the program are preventing physicians ‘confusion and, more importantly, to improve public satisfaction from health services. This research also minimizes the waste of resources and leads to great economic savings. The early years of implementing the program have been featured with an increase of availability index in different aspects of the family physician program (human resources and preclinical services). Still, the ahead challenges are not deniable. The findings showed that there was a significant relationship between economic, work conditions, health, welfare, structural-organizational, and social-cultural problems on one hand and the physicians’ willingness to participate in the family physician program on the other. This is consistent with Hosseing Fahreji’s study [11] on the family physician program in the Imam Khomeini Charity Committee. A study by Masoodi Asl [12] on the assessment of the satisfaction of the service takers under the Imam Khomeini Charity Committee program showed that 31.25% were satisfied with the program, 51.5% were relatively satisfied, and 10% were relatively dissatisfied; which is inconsistent with the present study.

Motlagh (2009) in a study titled “physician’s satisfaction” on the factors effective on creating dynamism in the family physician program and rural medical insurance indicates that minimum satisfaction level in the medical education universities is with financial problems [13].

Taking into account the findings of the study and significant effect of welfare and financial problems on the physician’s tendency to take part in the program, one may conclude that poor welfare facilities and accommodations for the physicians in the health and treatment network leads to high turnover rates among the physicians. The majority of the physicians only take part in the program for short and temporary terms and to only spend their obligatory service terms. Dieleman et al. also mentioned low salaries and hard work conditions as the reasons for lack of motivation in the health and treatment system [14].

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Economic Problem</td>
<td>1.96</td>
<td>0.28</td>
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<tr>
<td>Work Condition Problems</td>
<td>1.97</td>
<td>0.14</td>
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<tr>
<td>Health Problems</td>
<td>2.2</td>
<td>0.45</td>
</tr>
<tr>
<td>Welfare Problems</td>
<td>1.99</td>
<td>0.18</td>
</tr>
<tr>
<td>Structural-Organizational Problems</td>
<td>1.7</td>
<td>0.41</td>
</tr>
<tr>
<td>Social- Cultural Problems</td>
<td>1.98</td>
<td>0.36</td>
</tr>
</tbody>
</table>

Table 2. Family physician problem

Given that a successful implementation of the family physician program needs public participation and cooperation for different sections, cultural works on all the effective actors is essential. Failure to successfully implement referral to a specialist practitioner plan, poor follow up by the family physicians, and poor public support for the program are the signs of low public participation rates in the program. The reasons of poor cooperation are lack of cultural and public informing measures regarding family physician programs and negative attitudes and distrust in family physicians. Nasrollahpour et al. highlighted resistance among family physicians and specialist practitioners against the family physician program [15]. Professional satisfaction of the family physicians is a key factor in the health system. In addition, professional satisfaction might be related to the quality and effectiveness of the health services provided [16]. On the other hand, probability of attracting new work forces decreases with an increase of professional dissatisfaction among family physicians and replacement applications by the physicians. Payment terms and work conditions are key factors in attracting and keeping skillful physicians [17]. In regards to the causes of dissatisfaction among the family physicians are high workloads, being busy doing supportive works in health centers, lack of welfare, negligence of specific needs of different regions, and lack of proper cultural preparation (the public and specialist physicians are not properly trained).

Ebadifardazar et al. [18] found that issues like low salaries, delay in payments, remote work place, long working hours, and no promising future for this national program are the causes of dissatisfaction of family physicians that increases turnover rates. Understaffed work force and high rates of turnover or replacement during the first 5 years of family physician program indicate problems of attracting and keeping general practitioners in the program. Also decreasing the number of service takers assigned to each practitioner, proving decent work conditions, providing welfare facilities to attract physicians and keeping the balance between demand and supply, clarifying health service packs, and providing required equipment and support are the effective factors in attracting and keeping the physicians [19].

Table 3. Correlation among problems of family physicians to take part in the program

<table>
<thead>
<tr>
<th>Variables</th>
<th>Correlation Coefficient</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Problem</td>
<td>-0.51</td>
<td>0.033</td>
</tr>
<tr>
<td>Work Condition Problems</td>
<td>0.09</td>
<td>0.400</td>
</tr>
<tr>
<td>Health Problems</td>
<td>0.12</td>
<td>0.002</td>
</tr>
<tr>
<td>Welfare Problems</td>
<td>-0.11</td>
<td>0.048</td>
</tr>
<tr>
<td>Structural-Organizational Problems</td>
<td>0.18</td>
<td>0.045</td>
</tr>
<tr>
<td>Social- Cultural Problems</td>
<td>-0.20</td>
<td>0.010</td>
</tr>
</tbody>
</table>
Conclusion

In conclusion, the results showed that there was a significant relationship between the problems experienced by physicians and their willingness to participate in the family physician program in the health centers located in Tehran. In spite of the fact that satisfactory implementation of the program is the intention of the policy makers, solving the problems participating physicians face and increasing their willingness to participate appears to be an effective approach to improve the outcomes of the program.

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