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Scaling up family practice: progressing towards universal health coverage

Executive summary

1. Provision of integrated health services is an integral dimension of universal health coverage. The 60th session of the Regional Committee in 2013 in resolution EM/RC60/R.2 on universal health coverage urged Member States and WHO to expand the provision of integrated health services based on primary health care. Access to quality essential health care is part of the Sustainable Development Goal (SDG) target 3.8 to achieve universal health coverage to ensure healthy lives and promote well-being for all at all ages. Experience shows that integrated primary health care services can be best provided through the family practice approach.

2. This technical discussion paper presents the situation of family practice in the Eastern Mediterranean Region. Based upon an analysis of the situation, it describes the need for family practice and ways to scale it up. The paper proposes a framework for action for advancing family practice towards universal health coverage in the Region that outlines actions for Member States to consider and describes how WHO can support this.

3. Family practice can be defined as the health care services provided by a family physician and his/her multidisciplinary team that are characterized by comprehensive, continuous, coordinated, collaborative, personal, family and community-oriented services. In this approach, services respond to community needs and support people to make decisions and participate in their own care. People receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, throughout the life course. Regionally, there are 13 recognized core elements of family practice[1] that can be summarized into the following components.

- A defined catchment population for primary health care facilities.
- Comprehensive, affordable and quality essential health services ensuring continuity of care with a functional referral system.
- Availability of sufficient trained health workforce at primary health care facilities as a multidisciplinary team.

4. An assessment of family practice was conducted by WHO in 22 countries of the Region in 2014 and the results have been recently updated. Data was collected on the 13 core elements of family practice, covering primary health care/family practice infrastructure, challenges and opportunities for scaling up.

5. The assessment revealed that family practice is part of health policies in 16 countries in the Region, with 13 countries having plans to scale it up. As expected, huge variations exist between and within three identified distinct groups of countries in terms of the proportion of primary health care facilities implementing family practice programmes and the number of family physicians. Only one country from group 1 has 100% of primary health care facilities delivering health services through the family practice approach, while family practice is almost non-existent in most countries in group 3. Based on the available information, the total number of certified family physicians in the 22 countries is 3225. Calculating against an international standard requirement of at least three family physicians per 10 000

[1]Conceptual and strategic approach to family practice: Towards universal health coverage through family practice in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2014 (http://applications.emro.who.int/dsaf/EMROPUB_2014_EN_1783.pdf, accessed 22 August 2016).

population, the regional figure is very low. Countries of the Region are in need of 185 497 family physicians to cover 100% of population – a huge gap to overcome.

6. Analysis of the information gathered highlights a number of reasons for the situation in the Region including, but not limited to, the following: low priority given to family practice in many Member States, weak primary health care and health systems, an acute shortage of qualified and licensed family physicians, the limited number and capacity of family medicine training programmes, a maldistribution of the health workforce between rural and urban areas, lack of private sector engagement in service delivery through the family practice approach, and weak monitoring and supervision.

7. Working towards the SDG target 3.8 for achievement of universal health coverage by 2030 and focusing on the acute shortage of qualified family physicians in the Region, two scenarios have been devised for the purposes of this paper. In the first scenario, in which the existing rate of production of family physicians continues, only Bahrain will reach (maintain) the ratio of 3 family physicians/10 000 population by 2030. In the second scenario, the rate of increase in production of family physicians required to achieve 100% coverage with three family physicians/10 000 population by 2030 is calculated. The recommended annual increases required range from 2.77% for Sudan to 3.56% for Saudi Arabia. Translating the second scenario into reality would require a major policy shift to reform primary health care and increase investment to establish and strengthen the discipline of family medicine in the Region so that the required number of family physicians can be produced.

8. However, a complementary strategy, a bridging programme, is envisaged that can be defined as a transitional period in which the general practitioner will be introduced to family medicine with improved knowledge and skills in service delivery. Successful bridging programmes, such as the general practitioner transitional period, have been developed in several countries globally.[2]

9. WHO, in collaboration with American University of Beirut, has developed a six-month online course to orient and train general practitioners to become family physicians. This course is not a replacement for full training of family physicians, but can serve as an interim arrangement. While the existing generation of general practitioners is transformed into family physicians through a bridging programme, all new medical graduates will have to undertake full training to become qualified family physicians. Different models of bridging programmes with varying lengths are available to be emulated. Several similar initiatives of varying length and mechanisms have been initiated by a few countries in the Region, including Egypt, Islamic Republic of Iran, Morocco, Saudi Arabia and Sudan.

10. A comprehensive and sustainable national policy and programme is required to establish and strengthen family practice. A framework for action for Member States and WHO for advancing family practice towards universal health coverage in the Region is proposed. The actions can be grouped into the following six major areas.

- Governance. Health systems need to be reoriented and capacity needs to be built for service delivery through the family practice approach. Governments should be assisted to incorporate a family practice programme as an overarching strategy for service provision within the framework of universal health coverage and national health policies and plans. Governments need to ensure political commitment at all levels, endorse appropriate polices and regulations, and establish a sustained prepayment scheme for provision of an essential health services package through the family practice approach.

[2] The contribution of family medicine to improving health systems: A guidebook from the World Organization of Family Doctors (second edition). Bangkok: World Organization of Family Doctors; 2013.

- Scaling up of family medicine training programmes. To increase the number of licensed family physicians, the discipline of family medicine training should be established and strengthened. As a transitional arrangement, suitable bridging programmes are needed to upgrade general practitioners as family physicians. In addition, financial and professional incentives for physicians to be enrolled in postgraduate family medicine programmes should be introduced.
- Financing. There is a need to invest in establishing family medicine education and training. Countries should pilot provider payment modalities, engage in strategic purchasing and link the family practice approach to health insurance schemes as part of the move towards universal health coverage.
- Integration and quality assurance of services. A range of well-selected, quality assured health services should be provided in an integrated manner through family practice, backed up by a robust referral system. Health facilities should be accredited. Countries should be supported to follow WHO guidance on the operation of family practice, including the quality and safety of care at the primary health care level.
- Community empowerment. Community leaders and health volunteers can bridge households with health care facilities. Active community engagement in scaling up the family practice approach needs to be strengthened through local capacity-building interventions. Countries should also introduce home health care and self-care as an integral part of service provision through the family practice approach.

11. In conclusion, the family practice approach is considered to be the best way to provide integrated health services at the primary health care level. Apart from a few exceptions, the countries of the Region are generally at a low level of family practice development. While there are multiple major challenges, a framework for action to advance family practice towards universal health coverage in the Region can help to improve the situation by employing transitional and long-term strategies to overcome the acute shortage of family physicians and strengthen health systems to support family practice. WHO will support Member States in their efforts to establish robust family practice in the Region.

Introduction

12. Despite significant advances in people's health and life expectancy, relative improvements have been deeply unequal both between countries and within them. Significantly, the nature of health problems is increasingly shaped by ageing populations, urbanization and the globalization of unhealthy lifestyles. Increasing numbers of people living with noncommunicable diseases, mental health problems, and long-term and multiple comorbidities means that care has become more complex and more costly. The fragmented nature of today's health systems, however, is increasingly unable to respond to these demands. The continued and disproportionate focus on specialized and disease-based curative care models undermines the propensity of health systems to provide universal, equitable, high-quality and economically sustainable care.

13. The 59th session of the Regional Committee for the Eastern Mediterranean held in October 2012 endorsed resolution EM/RC59/R.3 on health systems strengthening in countries of the Eastern Mediterranean Region that urged Member States to strengthen and integrate the network of primary health care facilities, considering family practice as an effective approach to service provision. The 60th session of the Regional Committee held in October 2013 in resolution EM/RC60/R.2 on universal health coverage urged WHO to provide technical support for the development of a country-specific vision, strategy and roadmap to move towards universal health coverage, including a service delivery dimension.

14. This technical discussion paper is based on target 3.8 of the Sustainable Development Goals (SDGs)[3] to achieve universal health coverage by 2030. The paper is timely, as in May 2016, at the Sixty-ninth World Health Assembly, Member States adopted, with overwhelming support, resolution WHA69.24 on Strengthening integrated people-centered health services.[4]

15. The paper seeks to secure the commitment of Member States to scaling up family practice as a main strategy for service delivery towards universal health coverage. It includes a situation analysis, suggests responses to overcome challenges and proposes a framework for action on advancing the implementation of family practice and the production of family physicians in the WHO Eastern Mediterranean Region.

What is the family practice approach?

16. Family practice can be defined[5] as the health care services provided by a family physician and his/her team, characterized by comprehensive, community-oriented, continuous, coordinated, collaborative, personal and family services according to their needs throughout the life course. The family physician, as the first point of contact with the health service, is key to delivering effective health services and improving health through holistic approaches that ensure continuity of care. Family physicians can deal with the health and health care needs of families and their communities.

17. The terms family practice and family medicine are often used interchangeably in the literature. The latter is defined as the specialty of medicine concerned with providing comprehensive care to individuals

[3] Target 3.8 of SDG 3: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

[4] Resolution WHA69.24 on "Strengthening integrated people-centered health services" (http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/, accessed 22 August 2016).

[5] Boelen C, World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians, World Health Organization. Improving health systems: the contribution of family medicine: a guidebook. Singapore: World Organization of Family Doctors; 2002.

and families, and integrating biomedical, behavioural and social sciences. As an academic medical discipline, it includes comprehensive health care services, education and research.[6]

18. The scope of services delivered by family practice requires a multidisciplinary team and the spirit of family practice emphasizes a team approach to service delivery. The composition of the team may vary among countries depending on the service package, structures, resources and availability of human resources (but should include at least a family physician and a nurse).

19. The evidence supports the contribution of a well-trained family practice team to improving access to quality care. The family physician and nurse are the backbone of family practice. However, there is a worldwide shortage of family physicians, with an acute situation in the Eastern Mediterranean Region.

20. As well as improving training capacities, labour market dynamics should be taken into account in attracting and retaining health workers to work in family practice settings. Most countries of the Region face challenges in primary care settings, especially in rural and remote areas. Thus, adequate incentives should be introduced to attract physicians to specialization in family medicine as well as for the other professionals that are included in the team. These incentives, which may be both financial and non-financial, as well as professional and personal support, need to be designed considering the preferences of health professionals.

21. Almost half the countries in the Region have already adopted family practice and are at different stages of implementation. Several countries have yet to evolve workable family practice models due to such challenges as the lack of family physicians, lack of integration of prevention and care of noncommunicable diseases and mental health, and weak information and surveillance systems.

Assessment of family practice in the Region

22. A survey of family practice in the Eastern Mediterranean Region was conducted by WHO in 2014 and the results updated in 2015–2016. The assessment covered 13 core elements of family practice in all 22 countries of the Region, covering the status of the service delivery infrastructure, challenges, opportunities and key action-oriented interventions needed to improve service delivery through the family practice approach. The information was verified by the family practice focal points at Ministries of Health. The assessment covered: registration of catchment population and development of a family/individual folder; development of a family physician roster; community engagement; essential health services package; essential medicines list; staff pattern based on family practice, with updated job descriptions; a standard set of medical equipment and furniture; training programmes based on the new job descriptions; on-the-job training for general practitioners and other support staff; availability of updated treatment protocols; referral system; health care information system; and quality and accreditation programmes. The results of the assessment are summarized below into two major areas, service delivery and production of family physicians.

Service delivery

23. The assessment found that 16 countries (72%) have included family practice in their national health policy and plans and have established a unit or appointed a focal point responsible for the programme, and 13 countries have expansion plans for a family practice programme. The proportion of primary health care facilities fully implementing a family practice programme and the number of family

[6]Boelen C, World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians, World Health Organization. Improving health systems: the contribution of family medicine: a guidebook. Singapore: World Organization of Family Doctors; 2002.

physicians varies tremendously between the three identified groups of countries and even between countries within each group.[7]

24. In group 1 countries,[8] service delivery based on the family practice approach[9] ranges from 14% to 100% of primary health care facilities, with a range of 0–63% in group 2 countries and 0–14% in group 3 countries. The density of family physicians varies from zero to 1.84 per 10 000 population. Despite reasonably good political support for family practice programmes in group 1 countries, the density of family physicians was less than 0.31 per 10 000 population in 2015.

25. Population registration of over 80% of the catchment population exists in six out of the 22 countries, while in Bahrain, Kuwait and United Arab Emirates, physicians are assigned for a specific number of families. In the other countries, families may see a different physician or different facilities on each visit, except in Islamic Republic of Iran, Jordan and Pakistan (but only in primary health care facilities where the programme is being implemented).

26. All countries in the Region have developed an essential health services package, although full implementation exists in only 14 countries; in the other eight countries implementation is partial or non-existent. In addition, all have developed an essential medicines list. Although 17 countries reported the availability of medicines in primary health care facilities, the extent of full availability at all times in all primary health care facilities needs to be further assessed.

27. Referral guidelines are available in 15 countries, but are functioning only in five countries. Non-emergency patients are allowed to approach hospitals directly in 14 countries. The assessment found that 17 countries do not have a functioning referral system despite the availability of guidelines.

28. Family or individual health folders/records are available in 14 countries, but huge variations between and within countries exist. Primary health care facilities in 18 countries have information on morbidity and mortality, which is used for planning in 14 countries. Feedback to the primary care level from a higher level occurs in 12 countries. An electronic information system in primary health care facilities is fully implemented in three countries, and partially in eight. Disaggregated data at the primary health care level is available in 13 countries.

Production of family physicians

29. Although there is a worldwide shortage of family physicians, the situation in the Region is acute and requires urgent action. To assess the situation, WHO, in collaboration with Agha Khan University and World Organization of Family Doctors (WONCA), conducted a literature review and key informant survey in 2014 on family medicine education and training programmes in the Region.

[7] For the purpose of analysis of challenges, identification of priorities and for delineating options and strategies, the countries of the Region have been categorized in three broad groups based on population health outcomes, health system performance and level of health expenditure: 1) countries in which socioeconomic development has progressed considerably over the last four decades, supported by high income; 2) countries, largely middle-income, which have developed an extensive public health service delivery infrastructure but that face resource constraints; 3) Countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability, conflicts and other complex development challenges.

[8] Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates; group 2: Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic and Tunisia; group 3: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

[9] Availability of the 13 elements of family practice at primary care facilities.

30. There are at least eight countries including Afghanistan, Egypt, Iraq, Lebanon, Morocco, Pakistan, Saudi Arabia and Sudan that provide a diploma in family medicine. The length of the course varies between six months, as in Sudan, to three years, as in Afghanistan.

31. Egypt runs a two-year diploma in family medicine with 180 annual inputs (students), and recently introduced both the Egyptian and the Arab board training programmes, while Jordan has a four-year residency programme with 35 annual inputs.

32. The Islamic Republic of Iran has recognized the need for cost-effective and preventive health care and has embarked on implementing the family medicine model. A two-year Masters of Public Health (MPH) programme in family medicine through distant training was started in the Islamic Republic of Iran in 2015; the duration of the course was recently reduced to one year for general practitioners with work experience at the primary health care level with 500 annual inputs. Currently, eight universities have admitted 60 postgraduate students who have already received a family medicine MPH or diploma degrees. The board duration for diploma holders will be two years and three years for MPH holders.

33. Recently, Morocco developed a bridging programme where general practitioners with four years' work experience can participate in a two-year training course managed by the Public Health Institute in Rabat (a diploma in family health). The two-year training course is divided into different theory and practical phases, with the practical sessions held inside the participants' own health care facilities. So far 25 physicians with four years' work experience at the primary health care level have enrolled in the programme. A similar course is planned in eight other universities. Graduates who are government employees will receive a monthly financial incentive.

34. Saudi Arabia started a 14-month diploma in family medicine in 2008; currently, it lasts 24 months with 70–75 annual inputs. A diploma in family medicine exists in Sudan lasting six months and offering career opportunities in Saudi Arabia after completion. This is in addition to a two-year master's programme that allows physicians to get training on-the-job and a certification in family medicine.

Challenges in scaling up family practice in the Region

35. Analysis of the information gathered highlighted a number of reasons for the situation in the Region. These challenges are outlined below, grouped into the four categories of governance, service delivery, production of family physicians and partnership with private providers.

Governance

36. Family practice has strong political support in group 1 countries, limited support in group 2 countries and support that is limited or absent in group 3 countries.

37. The health system infrastructure in several group 2 and group 3 countries is not consistent with family practice requirements. Family practice is still a new concept to the health ministries in the Region and there is insufficient political support to strengthen the necessary interventions.

38. There is a lack of technical skills for family practice implementation among Ministry of Health professional staff and managers. In addition, almost half of group 2 countries have experienced political changes in recent years, including Egypt, Iraq, Libya, Syrian Arab Republic and Tunisia. As a result, family practice has not been recognized as a long-term priority in several countries.

39. The absence of a well-functioning district health system, inadequate capacity among district health authorities, lack of planning, monitoring and supervision capacities, and limited involvement of communities has all led to very limited success in decentralization efforts.

40. Although some countries of the Region are implementing family practice, there is a need for a regional roadmap/strategy in line with the requirements of each group of countries. This would assist Member States in developing their own national workplan to support primary health care through the family practice approach.

Service delivery

41. All group 1 countries and a few group 2 countries have a policy of adopting the family practice approach. While some progress has been made, implementation has been fragmented and patchy. For instance, while all countries provide an essential health services package, quality of care remains a major challenge in most primary health care facilities.

42. As a result of the limited quality of services at public primary health care facilities, there has been a proliferation of the unregulated private health sector in all countries of the Region. For example, 62% of so-called primary health care services/ambulatory care in Egypt and 83% in Pakistan are provided by the private health sector, which is associated with high out-of-pocket spending in most countries.

43. Patient safety, quality and accreditation of health services are serious challenges in all countries. Regional studies in Egypt, Iran (Islamic Republic of), Iraq, Jordan, Morocco and Sudan have found a prevalence of adverse events among in-patients of 18%. Many countries have developed national accreditation programmes, while others rely on external accreditation programmes.

44. Weak referral systems are leading to high utilization of hospitals, accounting for 60–80% of Ministry of Health budgets, while budget allocation to primary health care services in most countries of the Region remains very limited.

45. Integration of care for noncommunicable diseases and mental health in the essential health services package continues to be a challenge. A WHO assessment in 2014 found that only 50% of primary health care services in five countries conducted screening for diabetes and hypertension.

46. Because of the demographic transition and population aging, group 1 countries have moved towards home health care for the elderly and the disabled on a limited scale. Countries in all three groups are in need of initiatives to provide home health care.

47. Although community-based initiatives have been piloted in the Region for over two decades, through community health worker programmes in Afghanistan, Egypt, Islamic Republic of Iran, Pakistan, Somalia and Sudan, community engagement needs to be scaled up in countries as an integral part of primary health care and family practice services.

Production of family physicians

48. Lack of central workforce planning is a key challenge in many countries, along with a lack of coordination between Ministries of Health, Ministries of Higher Education and academic institutions.

49. The shortage of family physicians is a major challenge caused by a number of factors, including the absence of a vision for family practice, limited community awareness (reflected in the absence of

community demand for family physicians) and undefined professional career paths for family physicians in both the public and private sectors.

Partnership with private providers

50. Ministry of Health efforts have been mainly directed towards implementing family practice in the public sector, which in many countries provides less than 30% of outpatient services; private clinics being the major providers in these countries.[10] International experience shows that the private sector can play an important role in delivering family practice services.

51. Weak regulation mechanisms for public–private partnerships, lack of a clear mechanism for contracting the private sector for the provision of primary health care services, and lack of performance criteria are all major challenges in the implementation of family practice.

Production of family physicians and recommended actions

52. Given the huge gaps that exist in the production of family physicians in the Region, this paper examines the current availability of family physicians and provides options for overcoming the shortage.

53. The annual output of trained family physicians in 2015 was around 2020 for the 22 countries in the Region, representing 0.08 family physicians/10 000 population. Taking the current annual production of family physicians and population projections to 2030 into account, the expected ratio (without considering waste and retirement) will increase to 0.42 family physicians/10 000 population if countries follow with the same trend of inputs for family medicine postgraduate training (including all post-medical school family medicine certified degrees).

54. To reach the optimal number of three family physicians/10 000 population[11] by 2030, countries need to increase their annual production of family physicians by different rates varying from 0% to 36% in group 1 countries, 10% to 39% in group 2 countries and 10% to 82% in group 3 countries. Delivering family practice services cannot be done through public sector providers alone and the implementation of family practice has to extend to private sector health care providers.

55. Working towards the SDG target for achievement of universal health coverage by 2030 and focusing on the acute shortage of qualified family physicians in the Region, two scenarios have been devised. In the first scenario, if the existing rate of production of family physicians continues, then only Bahrain will reach (maintain) the ratio of three family physicians/10 000 population by 2030. In the second scenario, the required rate of increase in the production of family physicians needed to achieve 100% coverage with three family physicians/10 000 population by 2030 is calculated. The recommended annual increase in this scenario ranges from 3.56% for Saudi Arabia to 2.77% for Sudan.

56. A complimentary strategy is to implement a national bridging programme to upgrade general practitioners as family physicians. A six-month online course has been developed by WHO and American University of Beirut to orient and train general practitioners to become family physicians. This course can be part of a national bridging programme and is not a replacement for the full training of family physicians, but serves only as an interim arrangement for existing general practitioners. Once the existing generation of general practitioners is transformed into family physicians, all new medical

[10] Role and contribution of the private sector in moving towards universal health coverage. Cairo: WHO Regional Office for the Eastern Mediterranean; 2016 (http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_18890.pdf?ua=1, accessed 22 August 2016).

[11] World Organization of Family Doctors (WONCA) recommends three to six family physicians per 10 000 population as there are in most European countries.

graduates will have to undertake full training to become qualified family physicians. Different models of bridging programmes of varying lengths are available.

57. Assessment of primary health care in the 22 countries of the Region has found that 90% to 97% of primary health care facilities are managed by physicians called general practitioners[12], who work without further specialized training after graduating from medical schools. The number of general practitioners working at public primary health care facilities varies, including 15 000 in Egypt, 9000 in the Islamic Republic of Iran, 168 803 in Pakistan and 6000 in Saudi Arabia.

58. A WHO assessment of the status of family medicine education and training in 2014 found that almost 80% of medical schools in the countries of the Region did not have family medicine departments and the situation was worse among the newly emerging private medical schools. Family medicine, as a specialty, is less attractive to medical graduates compared with other specialties; the specialty is not well recognized by the public and other health professionals, and offers lesser pay and incentives in some countries, especially in group 2 and 3 countries.

59. In addition, the lack of role models for medical students, the nature of undergraduate medical education, which is mainly hospital-based, and lack of exposure to family medicine at undergraduate level does not augur well for the scaling up of family medicine departments. Challenges include medical school curricula that are vertical, non-integrated and hospital-orientated (mainly university hospital) and health systems that are mainly curative with a lack of the continuity of care needed given the increasing burden of noncommunicable and other chronic health problems.

60. Successful transitional retraining programmes for general practitioners have been developed in other regions in countries as diverse as Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lithuania, Poland, Portugal, Republic of Korea, Romania, Russian Federation, Sri Lanka, Turkey and Viet Nam. Some countries also retrain specialists, such as those specializing in paediatrics and internal medicine, to become family doctors.[13]

61. A national bridging programme for general practitioners on family medicine is proposed. This will have the following outlines.

- The objective will be to improve the technical skills of general practitioners and to overcome the shortage of family physicians.
- The training will be compulsory and covers all general practitioners working in public facilities with more than five years work experience and no post-medical school specialty.
- To bridge the gap, it is recommended that there is a maximum 12 months of training for general practitioners. The first six months will be through the WHO online course on building capacities of general practitioners in family medicine; WHO is providing training of trainers for all countries of the Region on the online course. Each country will decide on the duration of the practical training element and the degree acquired.
- To cover 100% of general practitioners with the training, each country will require a certain rate to go through training annually.

[12] In this paper a general practitioner refers to a physician who has completed a basic undergraduate medical degree but has not received specialized training focused on the core principles of primary care or another specialty.

[13] Kidd M (ed). The contribution of family medicine to improving health systems: a guidebook from the World Organization of Family Doctors (second edition). London: Radcliffe Health; 2013.

Projection of family physician production to 2030 in countries by group according to the different scenarios

Group 1 countries

62. In group 1 countries, annual production of family physicians has been increased over the last few years reaching 239 in 2015, with a ratio of 0.31 family physicians per 10 000 population (see Table1).

63. Taking into consideration the current production of family physicians and population projections, the ratio will be tripled by 2030 to reach 0.79 family physicians per 10 000 population.

64. To reach the optimal ratio of one family physician per 3300 population, taking into consideration population projections by 2030, each country needs to increase its annual production of family physicians. The increases required vary from 10% for Kuwait to 36% for United Arab Emirates. Bahrain will reach the optimal number of family physicians by 2030 given the current annual production of 22 family physicians per year.

65. Country training capacity varies from 30 family medicine departments in Saudi Arabia to one department in most of the other five countries.

66. Meanwhile, in order to improve the quality of service provision at the primary health care level, it is recommended to enrol general practitioners in a compulsory transitional period training programme that should cover 100% of the current general practitioners (a total of 10 969).

Group 2 countries

67. In group 2 countries, annual production of family physicians has increased over the last few years reaching 1336 in 2015, with a ratio of 0.11 family physicians per 10 000 population (see Table 2).

68. Taking into consideration the current production of family physicians and population projections, the ratio will be 3.5 times more by 2030, reaching 0.62 family physicians per 10 000 population. The expected ratio varies among countries from 0.12 in Palestine to 1.33 in Islamic Republic of Iran (which has initiated major family medicine programmes in several universities).

Table 1. Projection of family physician production to 2030 in group 1 countries

Country	Annual family physician output (2015)	Family physician working at Ministry of Health primary health care facilities (2015)	Family physician /10 000 (2015)	Cumulative trained family physicians with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10 000	Recommended increase/ year to reach 3 family physicians/10 000 (%)	Cumulative trained family physicians with recommended increase (%)	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10 000
				With current annual increase by 2030			With recommended annual increase by 2030			
Bahrain	22	228	1.84	330	558	3.40	0	330	558	3.40
Kuwait	35	194	0.64	525	719	1.49	10	1223	1417	2.93
Oman	20	143	0.4	300	443	0.90	17	1313	1456	2.96
Qatar	12	139	0.64	180	319	1.16	15	657	796	2.88
Saudi Arabia	140	600	0.25	2100	2700	0.76	20	12 102	12 702	3.56
United Arab Emirates	10	36	0.05	150	186	0.15	36	3767	3803	3.08
Subtotal	239	1340	0.31	3585	4925	0.79	19	19 392	20 732	3.34

Table 2. Projection of family physician production tol 2030 in group 2 countries

Country	Annual family physician output (2015)	Family physicians working at Ministry of Health primary health care facilities (2015)	Family physicians/ 10 000 (2015)	Cumulative family physicians trained with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10 000	Recommended increase/year to reach 3 family physicians /10 000 (%)	Cumulative family physicians trained with recommended increase (%)	Family physicians working at Ministry of Health primary health care facilities	Family physicians /10 000
				With current annual increase by 2030			With recommended annual increase by 2030			
Egypt	180	256	0.05	2700	2956	0.29	29	35 701	35 957	3.51
Iran (Islamic Republic of)	810	0	0.10	12 150	12 150	1.33	10	28 309	28 309	3.10
Iraq	120	833	0.27	1800	2633	0.52	25	16 453	17 286	3.39
Jordan	35	221	0.33	525	746	0.80	19	2760	2981	3.19
Lebanon	27	19	0.09	405	424	0.82	16	1618	1637	3.17
Libya	10	100	0.17	150	250	0.34	30	2175	2275	3.05
Morocco	50	0	0.01	750	750	0.19	31	11 921	11 921	3.04
Palestine	4	18	0.05	60	78	0.12	39	1977	1995	3.11
Syrian Arab Republic	20	201	0.10	300	501	0.17	38	9033	9234	3.08
Tunisia	80	150	0.20	1200	1350	1.07	13	3654	3804	3.03
Subtotal	1336	1798	0.11	20 040	21 838	0.62	30	113 601	115 399	3.25

Table 3. Projection of family physician production to 2030 in group 3 countries

Country	Annual family physician output (2015)	Family physician working at Ministry of Health primary health care facilities (2015)	Family physicians/ 10 000 (2015)	Cumulative family physicians trained with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians /10 000	Recommended increase/ year to reach 3 family physicians/10 000 (%)	Cumulative family physicians trained with recommended increase (%)	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10 000
				With current annual increase by 2030			With recommended annual increase by 2030			
Afghanistan	6	20	0.01	90	110	0.03	55	12 092	12 112	2.78
Djibouti	0	0	0.00	0	0	0.00	0	0	0	0.00
Pakistan	4	18	0.00	60	78	0.00	82	70 686	70 704	3.05
Somalia	0	0	0.00	0	0	0.00	0	0	0	0.00
Sudan	435	46	0.13	6525	6571	1.19	10	15 203	15 249	2.77
Yemen	0	3	0.00	0	3	0.00	0	0	3	0.00
Subtotal	445	87	0.02	6675	6762	0.18	50	97 981	98 068	2.57

69. To reach the optimal ratio of one family physician/3300 population, taking into consideration population projections by 2030, each country needs to increase its annual production of family physicians. The increases required vary from 10% for Islamic Republic of Iran to 39% for Palestine.

70. Similar to group 1 countries, it is recommended that group 2 countries enrol general practitioners in a compulsory transitional training programme on family medicine, preferably of less than 12 months duration. The training should cover 100% of current general practitioners (a total of 45 988).

Group 3 countries

71. Group 3 countries mostly have a very limited annual production of family physicians. Sudan is the only country with a reasonable annual production (of 435 family physicians). It is recommended that Sudan should increase its annual ratio by 10% to reach three family physicians per 10 000 population by 2030 (see Table 3).

72. Countries in group 3 need to enrol general practitioners in a transitional compulsory training programme on family medicine, preferable to be of less than 12 months duration. The training should cover 100% of current general practitioners (total of 178 551). Based on the total number of general practitioners per country, there is a need to enrol a certain percentage of general practitioners every year until 2030, taking into consideration that the actual number of trained general practitioners every year will be less than the year before.

Framework for action on advancing family practice towards universal health coverage in the Region

73. This paper proposes a framework for action on advancing family practice towards universal health coverage that consists of the following five major areas with actions outlined for countries and WHO (see Annex 1).

- Governance. Health systems need to be reoriented and their capacity needs to be built for family practice. Governments need to ensure political commitment and develop appropriate polices, regulations and prepayment schemes for the provision of an essential health services package through the family practice approach.
- Scaling up of family medicine training programmes. To increase the number of licensed family physicians, the discipline of family medicine needs to be established and strengthened. As a transitional arrangement, suitable bridging programmes are needed to upgrade general practitioners to family physicians.
- Financing. Countries need to enhance financing, undertake costing of essential health services packages and practice strategic purchasing.
- Integration and quality assurance of services. A range of well-selected, quality assured health services should be provided in an integrated manner through family practice backed up by a robust referral system. Health facilities must be accredited.
- Community empowerment. Community leaders and volunteers can bridge households to health care facilities. Community participation in health care needs to be strengthened by building on local systems of engagement and by respecting local cultures and belief systems.

Conclusion

74. The family practice approach is considered to be the best way to provide integrated health services at the primary health care level. With few exceptions, the countries of the Region are at a low level of family practice development. Strong political commitment is needed to improve access, coverage, acceptability and quality of health services, and to ensure continuity of care, through the family practice approach.

75. Taking into consideration the difference between the three groups of countries in the Region in terms of annual production of family physicians, current number of general practitioners and family medicine training capacity, there is no one solution to suit all. Countries need to be committed to increase the production of family physicians by 2030 to have one family physician per 3300 population. Meanwhile, countries need to implement a national training programme for general practitioners on family medicine.

76. Despite the daunting multiple challenges, a framework for action to advance family practice towards universal health coverage in the Region can help improve the situation by employing transitional and long-term strategies to overcome the acute shortage of family physicians and strengthen health systems to support family practice. WHO can assist country efforts in establishing robust family practice in the Region. Countries are urged to endorse family practice programmes as a national health goal and to incorporate them in national health policies and plans.

Annex 1. Framework for action on advancing family practice towards universal health coverage in the Eastern Mediterranean Region

Major areas	Actions for countries Short-term (24 months)	WHO support
Governance and regulation	Incorporate family practice programme as an overarching strategy for service provision within framework of universal health coverage and national health policies and plans. Assign and provide resources to the primary health care unit in the ministry of health to coordinate family practice activities. Update regulations for supporting implementation and expansion of family practice programme. Establish national training programme for general practitioners on family medicine. Develop a health information and reporting system to monitor primary health care performance. Introduce professional/financial incentives for physicians to enroll in postgraduate family medicine programmes. Strengthen public–private partnerships in service delivery through the family practice approach.	Assist Member States to publish and disseminate good practices and short policy briefs on the family practice programme. Assist in making rational projections for production of family physicians and family practice team members. Develop and present evidence case, essential standards for family practice elements and operational guide for adaptation by countries.
Scaling up of family medicine training programme	Advocate with deans of faculties of medicine to establish, strengthen and expand family medicine departments. Follow WHO recommended annual increase of family physicians up to 2030. Implement WHO online short training programme of general practitioners in family medicine. Develop continuous professional development programmes for recertification in family medicine. Harmonize curriculum, evaluation and standards of family medicine board certified programmes. Integrate a modified family medicine teaching programme in medical schools.	Prepare policy briefs and present to deans and chancellors of medical institutions on the need to strengthen family medicine departments. Scale up online six-month training courses for orientation of general practitioners on family medicine. Establish a group of regional experts to review and harmonize family medicine training programmes across the Region.
Financing	Introduce family practice financing as an integral part of the national health financing strategy, ensuring availability of sustainable funding for implementing/expanding family practice. Engage in strategic purchasing for family practice from public and private providers. Design and cost essential health services packages to be implemented through family practice and identify target population to be covered. Agree on implementation modalities of essential health services packages delivered by public/nongovernmental/private health sector providers. Build capacity to undertake contracting for family practice including outsourcing of services provision. Decide on and pilot “provider payment modalities”, for example, capitation, case payment and necessary performance-based payment or their combinations.	Update tools and guidelines for design and costing of essential health services packages and provide training in their use and implementation. Synthesize and disseminate country experiences in financing family practice under different health financing systems and provide related technical support to Member States. Disseminate WHO guidelines and provide technical support to Member States on strategic purchasing and provider (public/private) payment methods.
Integration and quality assurance of services	Use 13 core family practice elements as a guide to improve quality of primary care services. Assess service delivery to review integration of priority programmes in primary health care services. Introduce functional integration of health services through multi-tasking and staff training. Implement integration in all programmes in specific areas: training, supervision, health promotion, health information system, drug supply and laboratory services. Develop training and continuous professional development programmes for primary health care workers on improving quality of service delivery. Strengthen supervision and monitoring functions addressing quality of care. Introduce/institutionalize accreditation programmes to support primary health care performance. Enforce accreditation of primary health care facilities.	Continue to share best practices and exchange experiences. Develop an integrated district health system based on the family practice approach assessment tool. Expand the regional framework on quality indicators at primary care level.
Community empowerment	Launch community-wide campaign to encourage population to register with reformed health facilities in the catchment population (including civil registration and vital statistics). Strengthen, initiate and support training of community health workers/outreach teams and scaling up of home health care as an integral part of the family practice approach. Encourage the health volunteers approach to bridge households with health care facilities and train volunteers in the use of WHO manuals. Organize orientation training for staff of health facilities on communication skills. Develop multimedia educational campaigns.	Update tools and guides for community engagement in family practice. Provide technical support in developing a communication strategy for family practice programmes. Exchange successful experiences of community volunteer programmes in support of family practice. Provide technical support to increase access to primary health care services through community health workers, outreach teams and home health care strategies.