Mohammad Meskarpour Amiri 1,2 and Ali Mehrabi Tavana 1

1Health Management Research Center, Baqiyatallah University of Medical Sciences, Tehran, Islamic Republic of Iran. 2Faculty of Management and Economics, Tarbiat Modares University, Tehran, Islamic Republic of Iran. (Correspondence to: Ali Mehrabi Tavana: Mehrab@bmsu.ac.ir).

Abstract

Background: The Supreme Leader of the Islamic Republic of Iran approved the General Health Policies (GHPs) for the country in April 2014.

Aims: This study examined the barriers currently faced by GHPs and the mechanisms required for the successful implementation of these policies.

Methods: This qualitative study was conducted as a two-phase project based on standard CAN-IMPLEMENT© guidelines. A set of qualitative methods, including face-to-face in-depth interviews, focus groups, and in-person consensus meetings, were used to clarify mechanisms and barriers.

Results: Twenty-one mechanisms and 13 barriers were identified. The majority of mechanisms were related to the development of health infrastructures and appropriate allocation of resources. The most significant barriers to implementation of GHPs were lack of formulated strategies, poor management, lack of a comprehensive national action plan, minimal information infrastructures, and inadequate funding.

Conclusions: A thorough understanding of barriers and mechanisms for implementation of GHPs can provide the necessary background to ensure successful health promotion in the country.
Introduction

During the three last decades the health system in the Islamic Republic of Iran has experienced various reforms with many different challenges and successes. The first and foremost was the establishment of the National Health Network in 1983 (1). The National Health Network was progressive in its establishment of a primary health care network in the country, but the advantages were restricted to the level of primary health care only, and the country’s medical care still suffered from a poor referral system (2,3). Over the next two decades, the health system underwent several reforms including integration of health provision and medical education, universal medical insurance, hospital autonomy, and rural health insurance (2). In 2005, deficiencies in the National Health Network were addressed through the Family Physician Programme, which was implemented to improve the referral system through a gatekeeping mechanism, but despite the programme’s achievements it is still far from ideal (4,5).

The latest attempt to reform the health system saw the Ministry of Health and Medical Education (MoHME) apply a set of reforms in the health care system in 2014 titled ‘Health Sector Evolution Plan’. The two main objectives of these reforms were to reduce direct expenditure for inpatients and improve the quality of care in governmental hospitals (6). However, the presence of some challenges – including lack of sustainable financing, neglect of primary and preventive health care, and disregard for patients in private hospitals – had a negative effect on the reform (2). Today, the Health Sector Evolution Plan still faces criticism (7–9).

More than three decades of health reforms in the Islamic Republic of Iran has shown that there is a state of chaos at the health policymaking level, where a number of health reforms were not successful due to the country’s political upheavals (2,5). To address this situation, the Supreme Leader of the Islamic Republic of Iran approved the General Health Policies (GHPs) for the
country on 7 April, 2014 (10), which define the principles and aims of the country’s health system (11). These policies include implementation mechanisms for quantitative and qualitative development of health insurance and sustainable health financing, as well as emphasizing the comprehensiveness of health and community contributions to health promotion. The GHPs also emphasize improving the quality and safety of services, establishing infrastructures for producing medical products and equipment, organizing healthcare demand, traditional medicine, and medical education (11,12).

Despite MoHME’s responsibility for policy-making, planning, evaluating, and monitoring of GHPs, barriers faced and mechanisms required for successful implementation have not been properly specified. Therefore, there are concerns that required changes in the health system have not been addressed (11,12). Hence, this study researched such barriers and mechanisms for GHP implementation in the Islamic Republic of Iran.

**Methods**

This qualitative study was conducted in 2015. It was implemented as a two-phase project adapted from standard CAN-IMPLEMENT guidelines (13). Methods included face-to-face in-depth interviews, focus groups, and in-person consensus meetings to define mechanisms and barriers. The document under review in this study was the General Health Policies (GHPs) of the Islamic Republic of Iran, issued 7 April, 2014 (10).

Based on the CAN-IMPLEMENT guidelines (13), a series of semi-structured in-depth face-to-face interviews were conducted with health system administrators and top-level planners. These individuals were composed of presidents and deputys of medical sciences universities, health research centres, and health care centres. Each participant received a package including the GHPs document and a general format of the questions, and were asked to highlight important barriers and facilitator mechanisms for the implementation of GHPs. During the interview, snowball sampling was employed to identify additional participants until saturation. All the interviews were performed by two experienced interviewers in associated fields of study.

For data analysis, the thematic analysis was performed through the process of a coding framework as reported by Braun et al. (14) and used in previous studies (15,16). The framework included six phases: familiarizing with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report (14). Each interview was transcribed immediately after recording. After transcribing all interviews, the researchers reviewed the text several times until a general impression was received. Then a coding process was conducted for each interview manually by using constant
comparative methods (17,18). Thus, all texts were broken down into meaningful units and initial
codes were obtained. Codes with similar meanings were grouped into subcategories; similar
subcategories were grouped into main categories. The credibility of the categories was
determined by using frequency of occurrence and consistency mentioned by participants in the
interviews. The themes were discussed, defined and refined by research members repeatedly
until no new themes were detected.

For the second step of study, three 90-minute in- person focus groups were formed with the
presence of all participants. These focus groups were managed and recorded by a professor
within a relevant research field and a research assistant. In the first two focus groups, the
results of the previous interviews were revealed and the participants asked to discuss the
barriers and implementation mechanisms of GHPs (elicited from the context of the interviews).
In the third focus group, participants were asked to rate the importance of each proposed barrier
and mechanism from one to ten on a Likert scale (8). The purpose of this third focus group was
to rank the study results using RAND appropriateness (9) with regard to barriers and
mechanisms consensus.

To ensure reliability within the study, face-to-face involvement with participants extended over
long periods, with repeated sessions and feedback received from participants in order to
minimize inaccuracies and maintain the trustworthiness of the study guaranteed through
participants’ confirmation, consensus meetings and related evidence.

Results

A total of 32 health system top-level managers and plan- ners were interviewed face to face.
More than 90% of participants were male with PhD degrees, half were in the age range of 50 to
60 years old, and 37% and 50% held the position of president/deputy of medical sciences uni-
versities or heads/deputies of health research centers, respectively. The remaining participants
were chiefs or deputies of hospitals (Table 1).

During the interviews, all comments concerning mechanisms and barriers were collected and
were identified at the level of health system policy-making and management. Majority
of mechanisms were related to the development of health infrastructures (including family
practitioner, referral system, health insurance system, electronic health records, etc.) as well as
appropriate allocation of resources within the health system (including attention to the needs of
the health sector, targeted subsidies to promote health, and development financial controllers).
When discussing a successful model for the Primary Health Care (PHC) network in the Islamic
Republic of Iran, participants emphasized that establishment of health infrastructures can lead
to major improvements in public health indicators. Furthermore, many participants
acknowledged that having accurate and targeted allocation of resources within the health system is essential to fulfill national health needs and better achievement of GHPs. For example, regarding the family physician and referral system, one of the interviewees stated that:

“Proper implementation of a family physician plan facilitates access to an effective and efficient referral system and leads to the realization of many paragraphs within GHPs. For instance, in Paragraph 5 of the GHPs we can see the organization of demands, or even in Paragraphs 2–5 we can see the promotion of health indicators to the first ranking in the region. All of these require a comprehensive national plan for the development of a fundamental programme … therefore, in my opinion, the implementation of a family physician plan is the cornerstone of the GHPs.”

In terms of attention to GHPs in the formulation process of the country’s five-year economic, social and cultural plans; one interviewee noted that:

“I have noted the GHPs document as one which determines to a great extent the dominant factor of activities in the health sector. To meet these goals, we need accurate and long-term planning … we have had five-year economic, social, and cultural development plans for several decades in our country; however, we have overlooked health development and even there is no trace of health in naming development programmes. Our development plans should be one for economic, social, cultural, and health development. In my view, the GHPs do not have a suitable place in Iran’s development plans.”

Another interviewee pointed out the importance of conducting applied research to meet national needs in the health sector as follows:

“Under the current conditions where our country is facing problems in terms of imports of medications and medical equipment, conducting applied research to deal with national needs has been doubled. Our experts and scientists have made broad progress in this field, which has led to the production of medications in the treatment of a number of incurable diseases such as hepatitis, multiple sclerosis, Alzheimer’s and cancer; thus, the country does not need to import some of these medications anymore. Therefore, in my opinion, targeted allocation of resources for conducting applied research can support GHPs and a resistant economy.”
Also in terms of the significant role of electronic health records, one interviewee commented that:

“Nowadays, having access to health data can contribute to providing health services in order to meet the basic health requirements for each person … Of course, this does not end here, but electronic recording of medical histories can help not only in upgrading individual health, but also in reducing the costs of frequent diagnostic tests and medication transcriptions. Therefore, health promotion based on the professional and economic principles and consistent with GHPs depends on having electronic health records from birth to death.”

In addition, one interviewee raised the following issues in terms of changing the role of the health insurance system:

“The issue of prevention before cure is the first and foremost paragraph in the GHPs. In my opinion, insurance companies should be the catalyst for changes in attitudes. Currently, insurance agencies in our country insure the illness and treatment but not the health and prevention. Prevention services and screenings do not have any place in our insurance packages. Most of those insured are not encouraged to take prevention activities such as weight control, blood pressure and so forth. Lots of important diseases are identified and treated in the final stage, which is usually costly and ineffective … insurance companies should identify economic measures for cost-effective prevention and screening and make them mandatory for those groups at risk.”

The results of the consensus meetings to rate the implementation mechanisms, based on a Likert scale (0–10), are illustrated in Table 2.

Barriers to implementing GHPs were elicited from individual interviews and focus groups as well as the results of ranking barriers in consensus meetings (Table 3). The most important barriers to the implementation of GHPs were lack of formulated strategies, poor management, lack of a comprehensive national action plan, minimal information infrastructures, and inadequate funding. Most of the interviewees argued that no definite and fixed strategies have been determined for the realization of GHPs and whenever senior management within the health system changes, different strategies are then established and followed. In this context, one of the interviewees reiterated that:
“Unfortunately, reforms were not pieces of a puzzle to solve a problem … each government tries out their own procedures to meet the goals while the processes conducted by former governments remained unfinished. One government pays attention to the issue of family physician programmes, while the next government puts health sector evolution plans at the centre of attention.”

Moreover, some interviewees believed there are not appropriate information infrastructures and financing for realization of GHPs. Regarding information for decision-making, one interviewee stated that, “Most of our decisions are made based on speculations and guesswork, not based on reliable data and evidence … sometimes we are not even able to screen or observe the results of our enforced policy.” In addition, in terms of financing health systems, most of the interviewees pointed to issues such as instability in financing the health sector evolution plan (HSEP), changes in income and the annual government budget, as well as the health-care sector’s share of GDP.

According to findings, GHPs might not necessarily be accepted or attempted by policy-makers due to conflicts of interests among certain stakeholders. For example, one of the interviewees with medical specialism clearly expressed opposition to the promotion of traditional medicine, stating that, “Today, some claim that they can heal bedsores through traditional medicine. However, as a surgeon I reject this issue. I even had patients using traditional methods who were referred to me with severe conditions. Traditional medicine has been abused and has become an excuse for fraud.”

Discussion

This study was implemented immediately after notification of the country’s GHPs by the Supreme Leader. According to the results, organizing the referral system through the Family Physician Programme (FPP) was the first and foremost mechanism for successful implementation of GHPs in the Islamic Republic of Iran. The availability capacity of family physicians for developing the country’s referral health system has already been mentioned in previous studies (19,20). Although the FPP has been termed the second health reform revolution (3), there is still not sufficient effort made to implement it across the country. Despite the significant and positive effects of FPP on health indicators (21), the programme is still far from ideal when it comes to universal coverage. Policy-makers need to develop FPP as one of the most important mechanisms for realizing Iranian macro-health policies.

Lack of agreed health policy-making and planning has always been one of the most important challenges for the Iranian health system (22). According to our study results, attention to GHPs in formulation processes of five-year development plans is necessary for the successful
The issue of setting up an efficient electronic health record was recognized as one of the most important mechanisms for implementing GHPs. However, lack of necessary information infrastructures for evidence-based decision-making was elicited as one of the most important barriers to implementing GHPs. In this regard, Mehrdad (23) in his study stated that the lack of integrated health information systems in the Iranian health sector limits the possibility of health systems performance analysis. In addition, Larijani et al. (22) emphasized the need for more attention given to an evidence-based policy-making process in Iran health system, yet data base infrastructures are still not completely operational in the country. This was clearly seen in the transcribed interviews in the present study. However, it should be noted that in the past few years MoHME has made great progress in electronic health record creation, particularly in out-patient services (24).

Inadequate and unstable financing in the health system is another barrier to successful implementation of GHPs. These include limited and unsustainability of financial resources and an imbalance between resources and expected services (11,25). Such financial issues make it difficult to define healthcare objectives for health reforms (26) and many health reforms have begun to falter due to a lack of sustainable financing. The most recent example was the Health Sector Evolution Plan (HSEP) (27), which received extensive reaction in official and social media, but concerns raised about the economic burden of the programme on public finances meant it was viewed as unviable.

In such situations a rigorous economic analysis of the priorities and trade-offs inherent in the system would help health policy-makers to confront financial challenges and to achieve their desired objectives more effectively (26). Unfortunately the lack of prioritization for health-care reforms at the national level was identified as one of the major barriers to the implementation of the GHPs. Asadi et al. (28) mentioned in their study the achievements of the primary health care (PHC) system in the Islamic Republic of Iran and considered needs analysis and prioritization of health reforms essential for the improvement of PHC performance. Similarly, the World Bank also acknowledged the Iranian PHC system and argued that its performance should be prioritized based on new needs analyses in order to make structural reforms. This would be required for upcoming health needs and priorities in the country, including changes in the
patterns of disease and an ageing population (29). The latest HSEP has invested new financial resources in therapeutic and hospital services; however, some experts believed that any reforms should be started by PHC and the preventative medicine sector. Although many efforts have been made to develop PHC as part of HSEP, the plan has still been criticized for not considering the primacy of PHC and preventive programmes (27,30).

Finally, the issues raised by the interviewees and the empirical evidence cited suggest that GHPs might not be necessarily accepted and attempted by policy-makers due to conflict of interests among certain stakeholders, which was also emphasized by the Health Policy Council (HPC) of MoHME (11). Policy-making, pricing, provision and monitoring are done by medical doctors simultaneously in the country’s health system, which could create conflict of interests for policy-making and greatly harm the principle of impartiality. Ellen et al. (31) stated conflict of interests as a general reason for negative attitudes and resistance to change and identified it as the most important barrier to evidence-based decision-making in Canada’s health system. Likewise, findings by Wye et al. (32) indicate that many health policy-makers in the British health system are concerned about their personal interests and benefits. Therefore, attention to policy-makers’ priorities and development of mutual interests remain influential for successful implementation of health policies and plans.

Limitations

The first limitation to this study was that due to the expansion of GHPs, many of the paragraphs remained without any comment. Future studies should categorize GHPs and have a detailed paragraph by paragraph review. The second limitation was the selection of interviewees only from the Iranian health-care system of Iran, since GHPs address all organizations and systems relevant to health. Finally, we would like to re-emphasize that this study only highlights a number of the most important barriers and mechanisms necessary for successful implementation of the GHPs; further studies may identify still more barriers and mechanisms.

Conclusion

The GHPs have created a great capacity for quantitative and qualitative health promotion in the Islamic Republic of Iran. Correct implementation could lead to a revolution in health services in Iranian society, which itself can be a model for health promotion in low-income countries. A better understanding of barriers and mechanisms to the successful implementation of GHPs would provide the necessary background to support the current potential for health promotion. Finally, we suggest that the application of GHPs must be evaluated by health policy-makers every five years at least.

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