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Health Priority Setting in Iran: *Evaluating Against the Social Values Framework*

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Abstract

Background: Health systems, as part of the social system, consider public values. This study was conducted to examine the role of social values in the health priority setting in the Iranian health system.

Methods: In this qualitative case study, three main data sources were used: literature, national documents, and key informants who were purposefully selected from health care organizations and other related institutions. Data was analyzed and interpreted using the Clark-Weale Framework.

Results: According to our results, the public indirectly participates in decision-making. The public representatives participate in the meetings of the health priority setting as parliament members, representatives of some unions, members of the city council, and donors. The transparency of the decisions and the accountability of the decision makers are low. Decision makers only respond to complaints of the Audit Court and the Inspection Organization. Individual choice, although respected in hospitals and clinics, is limited in health care networks because of the referral system. Clinical effectiveness is considered in insurance companies and some hospitals. There are no technical abilities to determine the cost-effectiveness of health technologies; however, some international experiences are employed. Equity and solidarity are considered in different levels of the health system.

Conclusion: Social values are considered in the health priority decisions in limited ways. It seems that the lack of an appropriate value-based framework for priority setting and also the lack of public participation are the major defects of the health system. It is recommended that health policymakers invite different groups of people and stakeholders for active involvement in health priority decisions.

Keywords: health, Iran, priority setting, resource allocation, social values

1. Introduction

Priority setting is one of the most important issues in health policies because none of the health systems can meet all the health needs of the population (Kapiriri & Norheim, 2004; Lim, Bae, Choi, Lee, & Lee, 2012). Moreover, there is no agreement on the methods of priority setting in health systems in the world. Some believe that a wide range of criteria and variables are used in the practice and some of them are more prevalent such as "specifications of the decision outcome, the indications considered for appraisal, identification of incremental cost-effectiveness ratios, appropriateness of evaluation methods, type of economic or clinical evidence used for assessment, and the decision date" (Fischer, 2012). In many countries, the economic approach is used (Mitton & Donaldson, 2004; Mitton, Smith, Peacock, Evoy, & Abelson, 2009) but because of the importance of priority setting, health policymakers not only must consider a range of technical and financial criteria, but also should act according to ethical and subjective values of the public (Mitton, Patten, Waldner, & Donaldson, 2003). In other

words, priority setting is a value-based and subjective process that requires the participation of stakeholders more than the involvement of experts (Vuorenkoski, Toiviainen, & Hemminki, 2008). It should be noted that having clear values increases the acceptability of the decisions (Stafinski, Menon, Marshall, & Caulfield, 2011). The way of involving the public in prioritizing the health care is a major challenge for health policymakers in regional, district, and national levels (Kapiriri, Norheim, & Martin, 2007). Citizens always demand transparent and accountable decisions about the health system and, on the other hand, health policymakers seek methods for increasing the public participation, as well (Abelson, Eyles, McLeod, Collins, McMullan, & Forest, 2003; Teng, Mitton, & Mackenzie, 2007). Various studies show that the public preferences in the world are different; however, some suggest that the young are preferred over the old, the more severely ill are favored over the less severely ill, and people with self-induced diseases or a high socioeconomic status have a tendency to receive a lower priority (Gu, Lancsar, Ghijben, Butler, & Donaldson, 2015).

Some countries have made efforts to clarify the decision making and priority setting processes and contents; for example, the UK has established the National Institute for Clinical Excellence (NICE) that supervises the individual choice, equity, and responsibility in decisions (Mirelman et al., 2012; Rawlins, Dillon, & Leng, 2013). There are some frameworks that present societal judgments as important criteria in decision making. The "Accountability for Reasonableness" framework proposed by Daniels and Sabin, as an example of these frameworks, includes four criteria: relevance, publicity, appeals/revision, and enforcement (Daniels, 2000). The first three criteria indicate the importance of the public participation in health priority setting decisions. Furthermore, Clark and Weale presented a framework that consisted of process and content values (Clark & Weale, 2012). The framework (Table 1) has been applied in some studies in the UK (Littlejohns, Sharma, & Jeong, 2012), Korea (Ahn, Kim, Suh, & Lee, 2012), Germany (Kieslich, 2012), Thailand (Tantivess et al., 2012), China (Docherty, Cao, & Wang, 2012), and Australia (Whitty & Littlejohns, 2014) for examining social values in the health system.

Health priority-setting studies in developing countries have increased recently (Youngkong, Kapiriri, & Baltussen, 2009). Nonetheless, our investigation showed that there was no specific study on the social values in health priority setting in Iran. As a result, this study aimed to examine social values in health priority setting in Iran.

Table 1. Social values in the clark-weale framework (2012)

Content Values	Process values
Participation: using the views of the public in decision-making	**Cost-effectiveness:** Achieving expected outcomes via appropriate health technology application
Transparency: Explaining institutions involved and the laws considered in decision-making	**Clinical effectiveness:** Achieving the expected treatment outcomes
	Individual choice: having the right to choose among different treatment options and health care providers
Accountability: Explaining the reasons for decisions	**Solidarity:** people support against the financial risks associated with health costs
	Equity: having equal access and availability of health services for all people

1.1 Context

Delivering health care services is the main responsibility of the Ministry of Health and Medical Education (MOHME) which was established in 1985 through the assignment of the medical education function to the former Health Ministry (Azizi, 1997). This merger holds medical-educational organizations accountable for providing comprehensive health care services (Lebaron & Schultz, 2005). These services are provided in three levels and via private and public sectors (Takian, Doshmangir, & Rashidian, 2011). A simple view of the structure and organization of the Iranian health system has been shown in Figure 1. The public sector provides preventive, medical, and rehabilitative services while the private sector often delivers the last two services (Jahanmehr et al., 2015). Primary health networks are the main centers for delivering some essential health services. These networks are founded by the public budget and focus on the societal participation. The wide distribution of the network has resulted in major achievements such as a significant reduction in infant, mother, and newborn mortality rates in the country (Esmaeili, Hadian, Rashidian, Shariati, & Ghaderi, 2015). During the

past two decades, the Iranian public health policy has led to greater reductions in health disparities between the urban higher-income and the rural low-income populations. For example, in 1974, the infant mortality rate was 120 per 1000 live births in rural and 62 per 1000 live births in urban areas (Lebaron & Schultz, 2005) while these indicators have been improved by now.

The majority of the people are under health insurance coverage but some groups of the population such as unemployed individuals have no insurance coverage yet (Nosratnejad, Rashidian, Mehrara, Akbari, Mahdavi, & Moeini, 2014). Recently, the government has developed a sort of national health insurance to cover the unemployed. Moreover, In April 2014, the first stage of a new national health plan (Tarh-e tahavoll-e Salaamat) was announced covering up to 90 percent of costs for inpatient medical bills at public hospitals.

All major decisions of the health system are made by the MOHME. Each province has at least one university that acts as the representative of the MOHME (Mehrdad, 2009). Decisions about resource allocation are made in three levels: micro (hospitals and health care networks), meso (medical universities), and macro (MOHME; Health Commission of the Parliament; Planning and Management Organization; Ministry of Labor, Welfare, and Social Security; Supreme Counsel of Insurance). The expenses of last year activities are the basis of funding for each university and a new budget is allocated considering a little increase in last year costs. The resources are allocated based on the appeals of the hospitals and health care networks within universities. In this level, the budget is distributed to expand the environment, maintenance, equipment, and improvement of standards and development of human resources.

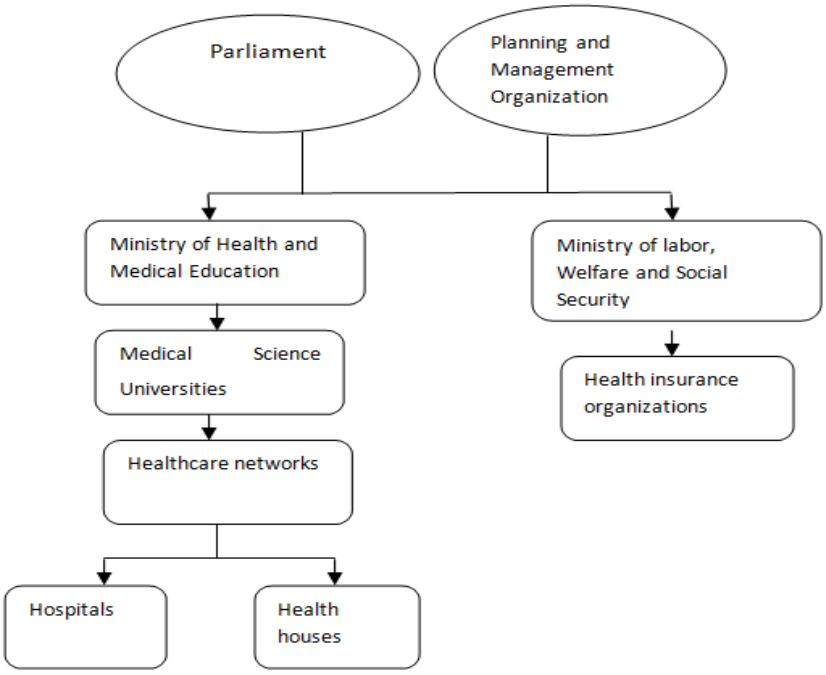

Figure 1. Simple view of the structure and organization of the Iranian health system

2. Method

2.1 Data Collection

This qualitative research was a case study examining the social values of the Iranian health system based on the Clark-Weale Framework. Literature, national health related documents, and key informants in the health organizations and some other organizations in macro, meso, and micro levels were three main resources of data.

2.2 Sampling

National documents were selected based on a review of the literature and consulting senior policymakers. The selected documents included all eminent legislations from 1979 (the establishment of the Islamic Republic of Iran) to 2014 and available to public. We also reviewed the titles of all health care related legislations in Iran

from 1979 to 2014 in order to ensure major legislations were included. The study team included both health policy and public policy researchers with the experience of involvement in national decision-making. As we included legislative documents in our policy analysis, we used the Clark-Weale Framework to ensure that we extracted authentic (true presentation of the policy), accurate (providing enough details) and representative concepts that captured a full range of the relevant meanings in the documents. The research team reviewed the documents several times. We also looked for all other words that were synonymous in meaning with social values (the words in Persian are available upon request). After extracting all statements within the documents that contained any of the social values, a qualitative content analysis was done to analyze the data and provide an understanding of the role and meaning of the social values in each of the policy documents. Eleven main policy documents were reviewed and analyzed: the Constitution of Iran, five Consecutive 5-year Development Plan Legislations, the Universal Health Insurance Act, the Family Medicine Plan, the Health Road Map, the Act of Health and Medical Education Ministry's Structure and Duties, and the Act of Formation of "Ministry of Health and Medical Education". Given the time span of the study, the included documents that represented the viewpoints of the consecutive governments and legislators in Iran since the Islamic Revolution in 1979.

Key informants including the managers that had direct participation in the health system priority setting were selected purposefully from the micro (hospitals and health care networks), meso, (city council and medical universities) and macro (MOHME; Ministry of Labor, Welfare, and Social Security; Health Commission of the Parliament, Supreme Council of Insurance, Planning and Management Organization) levels (Table 2). All interviews took place in the interviewees' offices. The interviews were carried out through a semi-structured guide and by one member of the study team (HM). In addition, the literature review was used for developing the topic guide. All interviews were recorded and transcribed. The average time of the interviews was about 60 minutes. The interviews were stopped after data saturation.

Validity was ensured in three ways. First, different data sources were used including the documents, literature, and interviews, which allowed for triangulation (Denzin & Yvonna, 2005). Second, respondents from different levels were interviewed. Third, codes and themes were developed and reviewed by all members of the research team to check for probable biases (Rosenberg, Zahava, Thorsteinsdóttir, Daar, & Martin, 2012).

2.3 Data Analysis

Interviews and documents were analyzed through thematic framework analysis that had six distinct and in-row steps including familiarization, identifying a thematic framework, indexing, charting, mapping, and interpretation (Rashidian, Eccles, & Russell, 2008). Finally, the data was interpreted and analyzed based on the Clark-Weale Framework.

Table 2. Level, organization and number of interviewees

Level	Organization	Number of Participants
Macro	Ministry of Health and Medical Education	4
	Ministry of labor, Welfare and Social Security health Commission of parliament	2
	High Counsel of Insurance	2
	social security Organization	2
	Planning and Management Organization	2
Meso	Medical Science Universities	3
	City consuls	3
Micro	hospitals and health care networks	10
Total	---	30

2.4 Ethical Considerations

The study was approved by the Ethics Committee of Tehran University of Medical Sciences. Information about the study was verbally presented to interviewees and the interviews were conducted after obtaining their consent.

3. Results

3.1 Social Values in National Documents

The Constitution of the Islamic Republic of Iran is the most prestigious national document that forms the basis of all legislations. It was developed in the first year after the Islamic Revolution (revised in 1989) and was put to a national vote. Most Articles of the Constitution have emphasized issues such as ethnic equality and human rights in the community ("Constitution"). Values such as equity, public participation, transparency, freedom, solidarity, and accountability have been emphasized several times. Five-Year Development Plans were more tuned to economic prosperity and development, and formed the basis for the formulation of medium-term and short-term programs at national, regional, and local levels (Five year Development plans). They had different statements of social values. An interesting finding was that all plans commonly emphasized equity. The Universal Health Insurance Act refers to the values of equity and social solidarity; however, the transparency of decisions, the use of the public opinion, accountability, and other social values have been neglected ("Health Insurance Act,"). The Formation Act has only maneuvered on the value of equity (Formation Act of the Ministry of Health and Medical Education), and the Act of Structure of MOHME and the Family Medicine Plan (Family Medicine) have mentioned only two social values of equity and participation. The Health Road Map ("Health Road Map") is the only document that has explicitly stated a relatively wide range of social values related to health and health care. Given the fact that it is the most recent document studied, it shows the increasing importance of attention to social values in the health care system in Iran. Values such as equity, participation, solidarity, accountability, transparency, and cost-effectiveness have been considered in this document.

Our investigation revealed that “equity” and other concepts with the same meaning were repeated more than other values. It can be claimed that “equity” has been mentioned at least once in each document, indicating the particular significance of the equity in the Iranian health system. Expressions such as fairness, equitable benefit, justice, equality, distributive justice, equitable access, equal rights, “everyone”, equitable, universal, or public accessibility have been used in the documents. Participation has been stated with words and expressions such as effective public participation, public cooperation, public involvement, and individuals’ and families’ structured participation. Transparency indicates the responsibility of the policymakers to communicate with the public. Based on the 5th Development Plan, the MOHME must present annual reports, which shows the importance of transparency in national documents. Analysis of the documents indicated that there were different approaches toward social values in national documents. Some of them included only one of the values mentioned in the Clark-Weale Framework while some covered more values; however, none of them mentioned all social values of the framework. Furthermore, different documents had different values; it is assumed that time requirements had a significant role in developing the documents.

The results of the study showed that according to the Clark-Weale Framework, process values were described less than content values in the documents. The importance of social values has been recently increased in the new national documents, but to what extent these values are considered in practice remains uncertain. Some examples of social values in the documents have been presented in Tables 3, 4, 5.

Table 3. Some examples of social values in national health related documents

Document	Article	content
Iranian Constitution (1979, revised in 1989)	19	people from every race and ethnicity have joint rights
	6	In the Islamic Republic of Iran, affairs should be run by reliance on public opinion
	69	The negotiations of parliament should be open and its complete reports have to release via media and official newspapers to the public
	84	Each representative member of parliament is accountable to all people and is entitled to comment about all internal and external issues of country
The Formation Act of MOHME (1985)	3	Providing social and political freedoms
	4	This Ministry must develop the draft to expand the universal health insurance within one year
The Act of MOHME Structure and Duties (1988)	7	Providing all necessary facilities for all people for using the health care services
	8	Financing through public funds, premiums, revenue allocation and public participation

	--	Attempt to provide the social justice
First Development Plan (1990)	--	to strengthen the foundations of theoretical and scientific equity of public in front of the law, and the implementation of equity and protecting the legitimate rights and freedom of the individual and society
	--	Reinforce the Spirit of responsibility and participation of families in political and social affairs

Table 4. Some examples of social values in national health related documents (continued)

Document	Article	content
Second Development Plan (1995)	1th Goal	Efforts to achieve social justice
	8th goal	Strengthening public participation and adopting the necessary arrangements for appropriate and continuous supervision of the program implementation
The Universal Health Insurance Act (1995)	4	Government shall provide all necessary conditions for all groups and individuals seeking health insurance
	7	All government agencies and government-related agencies and Imam Khomeini Relief Committee and all individual and organizations can select the insurance companies for health care contracts based on this act
	9	Insurance premium for groups covered by health care insurance and the copayment based on the economic and social situation of country will be determined by the MOHME and the Planning and Budget Organization.
Third Development Plan (2000)	2	The government shall perform necessary structural reform plans to strengthen the government supervision, to pave the way for people to have more effective contribution
Fourth Development Plan (2005)	9	In order to achieve distributive justice and equitable access to health services and to reduce the proportion of low-income and vulnerable households, some appropriate actions will be performed.
Family Physician Plan (2006)	--	Establishing social equity, intersectional collaboration; community participation and using appropriate technology are the most important principles in all stages of the implementation of family physician plan
Fifth Development Plan (2010)	38	managing the resources, improving the tariffs, using internal sources of funds and the state supports to develop the quality and quantity of health insurance, universal coverage and equitable access to health services and to reduce people's share of health expenditures to thirty percent
	16	Ministry of Science, Research and Technology and MOHME are obliged to monitor and report annually to the Assembly Education Committee With cooperation of other relevant agencies

Table 5. Some examples of social values in national health related documents (continued)

Document	Article	content
Health Road Map (2012)	4th policy	To increase the awareness, accountability, empowerment and structured and active participation of individual, family and society for preserving and improving the health
	6th policy-section first	Comprehensive and integrated health care with a focus on equity, accountability, transparent communication, effectiveness, efficiency and productivity criteria in the health care networks
	6th policy-section 41	Increasing the cost-effectiveness of health care via science and new technologies
	15th macro goal	To achieve the public and all beneficiary organizations support for health services

3.2 Participants' Perspective about Social Values

Health policymakers and stakeholders accept the importance of values, but they do not have any consensus on the concept of values (Giacomini, Hurley, Gold, Smith, &Abelson, 2004). An interesting finding of the study was defining the social values in different words by participants. Most of them stated that they had never precisely thought about social values in the health sector. Some believed that social values not only were different in various countries, but also had different interpretations within a country and among provinces. Social values are based on the people's epistemology and affect their expectations and beliefs. According to some participants, equity is a common value in most communities. Some participants believed that social values included cultural, humanity, and religious values. Based on the interviews, in Iran with a majority of the Muslim population, Islamic values should be considered in the decisions because most values such as equity, freedom, and public right are universal. Table 6 presents some definitions about social values.

Table 6. Participants' perspective about social values

Participant	Definition
Participant 1	In my opinion, social values are different in various communities and even among different cities of a country.
Participant 15	Social values are all the values that have been transferred from one generation to the next.
Participant 7	I think anything that is important to the society is a social value.
Participant 28	Social values come from public vision and approaches, and priority setting should be done based on these values.
Participant 11	The definition of social values depends on people's viewpoints and we must consider them.
Participant 22	I believe social values have no certain definition because they are not the same in various groups of people.

3.3 Social Values in Health Priority Setting

3.3.1 Participation

According to the Clark-Weale Framework, participation means the involvement of patients, health professionals, insured citizens, and taxpayers in health system decisions. The participation of different groups in decision making improves the quality of the decisions, makes the decisions legitimate, and also eliminates objections (Clark & Weale, 2012). Interviews indicated that people participate in decision making through different ways and in three levels of the health system. In the macro level, the Members of the Parliament are involved in the Combination Commission of Budget as representatives of the public. According to one of the interviewees, in the early years after the establishment of the MOHME, two main actions were performed to involve the public and trade unions in health sector decisions. First, the Supreme Council of Health emerged in the capital and other provinces. The Council was chaired by the President, and the Minister of Health was the secretary. Second, the law of Hospital Board of Trustees was adopted in the 5th Development Plan for involving the people in health decisions, but only 54 hospitals (among 746 hospitals) executed the law.

"The crucial reason for not performing the law was the frequent changes of health managers and also unawareness of health policymakers about the importance of the Board of Trustees in the hospitals," said one of the macro level managers.

In meso and micro levels, people participate in different ways in the health care system. The forms of participation in hospitals include providing suggestion boxes, involving the representatives of the City Council in resource allocation decisions, and establishing the Board of Trustees in some hospitals. In health care networks, health volunteers are the representatives of the public and represent the health needs of the rural areas. A meso level manager said, *"The SDH program was suggested by the city council and then was considered in the Ministry of Health and Medical Education; therefore, people can indirectly participate in decisions"*

In contrast, according to some interviewees, public participation in resource allocation decisions is not real, meaning that the MOHME and the Ministry of Labor, Welfare, and Social Security claim that they are representatives of the public, but they make efforts based on the physicians' interests and their organization's goals. Although people and organizations have been participating in the decisions of the health system, the

partnership is not strong and effective. Some interviewees believed that low awareness of the public about major issues of the health system and priority setting, inadequate authority to express opinions, and the unwillingness of some qualified individuals to participate in the decisions were the main reasons of low involvement of the public in decision-making processes.

"Sometimes we decide to make major changes in some health programs while people may think that they are not necessary," said a macro level manager.

3.3.2 Transparency

According to the Clark-Weale Framework, transparency introduces the decisions, explains the decision-making process, and clarifies the reasons for making a decision. More than half of the respondents reported the main reasons of decisions were presented to the public. However, they believed that if a provider wished to attract more customers, it would provide some general information about the resource allocation and new health services to the public. For instance, insurance companies that claim protecting the public health rights present most news about health decisions.

"When a new drug or service is added to the list of insured options, it is revealed via the media," said a macro level manager.

Some interviewees specified that hospitals, health care networks, and health centers did not explain the health priority setting process but if a project was implemented at the national level, they transparently revealed the decisions because of the high level of resources that should be allocated. In contrast, some interviewees believed that there was no necessity to clarify the decisions because people did not have enough knowledge about health priorities; therefore, providing extra information about health priorities would make them confused.

3.3.3 Accountability

According to the Clark-Weale Framework, accountability has two aspects: first, people to whom decision makers should be accountable; second, decisions for which decision makers should be accountable. The health system is accountable to patients, insurers, taxpayers, health professionals, courts, etc. According to managers, there is no protocol or guideline for responding to the public. As a result, the MOHME cannot justify decisions and public groups or other organizations protest them.

"I think if there were instructions about accountability, managers would feel more responsible," said a micro level manager.

According to the participants, objection to decisions generally has two main causes: first, authorities do not have enough information about the main reasons of the decisions and second, there is a conflict of interests among various decision makers. While the public does not have enough understanding and sufficient power for objection to health care organizations, any supervising institution such as the Supreme Audit Court and the Inspection Organization wants health care providers and medical universities to provide logical explanations about their decisions in the priority setting. Furthermore, sometimes unclear law articles result in the objection of other organizations.

3.3.4 Clinical Effectiveness

According to the Clark-Weale Framework, clinical effectiveness means ensuring that the desired results are achieved after using the drugs or other health technologies. Randomized clinical trials, controlled observational studies, and experts' opinions are often used to determine the clinical effectiveness of health technologies. According to interviewees, while the clinical effectiveness is the major concern of the physicians in hospitals and medical centers, some hospital managers worry about costs. In other words, there is a disagreement between physicians and managers.

"A doctor advises a drug because of clinical effectiveness but the manager does not provide it because of its high price," said a micro level manager.

Differently, some of the interviewees believed that some physicians in private hospitals prescribed expensive drugs and devices in spite of their low clinical effectiveness, which imposed high costs on the patients and the health system. One of the main ways of increasing the clinical effectiveness of the interventions is by using the guidelines, but the Iranian health system does not have a suitable system for providing guidelines. However, some managers stated that the experiences and guidelines of other countries were used apparently.

"Now we study and use American and European medical guidelines, but they are not exactly what we need; I think they should be customized based on our requirements," said a meso level manager.

3.3.5 Cost-effectiveness

The concept of cost-effectiveness in the Clark-Weale Framework is similar to what is accepted in economic sciences. It means achieving expected outcomes via appropriate health technology application. Interestingly, the interviewees' perception about cost-effectiveness differed from its original concept. According to the interviewees, the cost-effectiveness of the technologies is not calculated and only their price and costs are considered. The lists of new health technologies that are tailored to the needs of hospitals are provided; then, the device or drug with minimum costs and maximum efficiency is purchased. Interviewees believed that insufficiency of HTA activities in the Iranian health system resulted in inadequate attention to the importance of cost-effectiveness in health priorities.

"We do not have technical abilities to determine the cost-effectiveness of health technologies. Moreover, we are not sure about the efficacy of other countries' experience for our health system," said a meso level manager.

3.3.6 Equity

Equity in the health sector means that people with the same health need receive the same services. Prioritization of the people based on the severity of illness is another form of equity (Braveman, 2014a; Braveman, 2014b). According to the interviewees, important factors for resource allocation in the macro level are population, disease burden, and distance to the capital. Health care networks have been established in rural and urban areas to ensure equity in access to the primary health care. Equity is also considered in hospitals and medical centers as micro level entities; for example, patients are admitted and provided with the services based on their admission time and severity of the illness. Providing health insurance coverage for poor people via Imam Khomeini Relief Committee as well as approving the Universal Health Insurance Act in 1998 represent the consideration of equity in the country's strategic plans.

"We try to provide basic health coverage for all people regardless of their economic or social status," said a macro level manager.

According to the respondents, approval and implementation of the Family Medicine Act in villages and cities have been major steps in providing equity and justice in access to the primary health care. Equipping the health teams with physicians in undeveloped villages and constructing the health centers and clinics have been other attempts to achieve equity. Despite the items mentioned, distributive equity for specialty and subspecialty health services is not acceptable. While there are various specialty and subspecialty health services in most of the developed provinces, other provinces do not have any necessary services.

"Some managers think that their efforts in rural areas are efficient but in my opinion, we have a huge gap for achieving even relative equity. Some cities have no hospitals and their population has problems in access to basic health care services," said a macro level manager.

More importantly, according to the respondents, there is inequity in access to health care services among different areas of big cities; for instance, there are many equipped hospitals in the west and north of Tehran (Capital of Iran) while other areas of the city do not have enough hospitals and clinics.

3.3.7 Solidarity

Clark and Weale defined solidarity as cost sharing or co-payment. Also, they used this concept as giving the priority to people with a bad health status. The concept of solidarity has an overlap with equity (Whitty & Littlejohns, 2014). In fact, it means that everyone should support other people via participation in health services financing.

Collaboration in the financing of social services has an old history in Iran and comes from humanitarian beliefs of Iranians. Various types of health insurance for different groups of the population indicate the importance of solidarity and equity. However, the proportion of the premium is not the same for all. Some insurance plans are progressive and some others are regressive. Recently, the Iranian Health Insurance Organization has been established to cover the whole population, but a small percentage is uninsured yet and has to pay for health services at the delivery point. Similarly, in Australia, although there is a universal health care system, some services like pharmaceuticals and other health technologies require the direct payment of the people (Yusuf & Leeder, 2013).

Furthermore, diverse charities and NGOs participate in financing public health providers. Some managers believed that a great part of the financial supports of the charities was invested in building hospitals and that the government had to devise plans for proper utilization of the funds.

A micro level manager said, "Sometimes charities like to participate in building a hospital in a city that has

other health centers, so I think they need to be led in a correct way to spend the money in right places".

3.3.8 Freedom of Choice

The last value in the Clark-Weale Framework is related to the individual choice. It means that people have a right to select the desired health services or health care providers and they are independent to spend their money on health. Preventive and therapeutic services are delivered through two independent deputies in the Iranian health system: the Deputy for Health and the Deputy for Treatment. Preventive and hygiene services are often provided by health care networks and clinics affiliated with the Deputy of Health. People have a limited right to select the health care networks and health services. The main reason of limitation is the nature of services in the health care networks. Services delivered in health care networks include maternal and child health services, primary health education, and screening for communicable diseases. They are substantive steps for achieving basic health in the population.

A micro level manager said, "We do not like people with a communicable disease to be free in the community and behave as they want because their disease threatens others."

According to the respondents, useful information about the consequences of non-healthy behaviors is given to patients to inform them of the importance of basic principles of primary health care. On the other hand, treatment and rehabilitation services are provided in hospitals and day clinics affiliated with the Deputy for Treatment. People can choose their desirable physicians in the hospitals and day clinics. Some respondents opposed freedom or individual choice of the patients because first, they thought it was inconsistent with the principles of justice and resulted in making rich people take pleasure in more and better services while poor people could not have access to some necessary services and second, they believed people did not have enough knowledge about health needs and might demand services not appropriate for their needs. Controversially, some interviewees stated that physicians misled unaware patients and recommended some unnecessary treatments and diagnostic tests. An interesting point was that some managers believed that people did not have real freedom in the health sector because of the asymmetry between them and health care providers; they could choose the hospital and even the physician, but they often had no chance to select the preferred treatment.

A meso level manager said, "In my opinion, people think they have more freedom of choice but in fact they act based on their physician's advice."

Another aspect of the individual choice is related to the selection of health insurance companies. According to the respondents, people can choose the insurance company without any obligation from the government. However, there is an exception for military forces as they have a special coverage of health insurance and cannot choose other health insurance companies.

4. Discussion

The study provided a snapshot of the social values in the Iranian health system. As a process value, participation is considered in decision-making but the public has no direct participation in macro, meso, or micro levels. In other words, parliament members, representatives of some unions like the Worker's House, City Council members, and charities participate as public representatives in the health priority setting. In fact, the public involvement in decisions is low and decisions are made based on the policymakers' judgments (Tourani, Maleki, Hadian, & Amiresmaili, 2011). Differently, in the UK, local authorities, government agencies, the private sector, and the representatives of the patients are involved in decisions via the NICE (Biron, Rumbold, & Faden, 2012). Also, the views of the pharmaceutical industry as well as people are used in decisions in Germany (Kieslich, 2012). However, public participation in health system decisions is limited in Tanzania (Maluka et al., 2010) China (Docherty et al., 2012), Korea (Ahn, Kim, Suh, & Lee, 2012), and to some extent in Australia (Street, Duszynski, Krawczyk, & Braunack-Mayer, 2014). Findings indicated that the meaning of accountability and transparency in the views of decision-makers was similar and largely overlapped with together. According to the interviews, transparency and accountability in decisions are low. Managers respond only to complaints that are made by the Supreme Audit Court and the Inspection Organization. In many cases, decision makers only represent the basic act or law and do not explain decisions to the public because they believe their decisions are aimed at improving the public health and welfare. Another reason is that some macro issues are very sensitive and cannot be publicly presented. Similarly, in some other countries, health policymakers remove such health decisions from public priority setting sessions (Kirigia, Zere, & Akazili, 2012). In Tanzania, the government has tried to improve the transparency and public participation by decentralization but the results of examining the plan have been far from reality (Maluka, 2011). While the approval panel in the UK (Littlejohns et al., 2012) and Germany (Kieslich, 2012) are responsible for decisions, there is no specific accountable body in Korea (Ahn, Kim, Suh, & Lee, 2012), China (Docherty, Cao, & Wang, 2012) and Germany (Kieslich, 2012).

Since the Iranian health system has no sufficient technical capabilities to determine the clinical effectiveness of health technologies, the experience of other countries are used as a criterion for decision-making. However, in some cases, the lack of information on the clinical effectiveness of drugs and instruments results in wrong and unfair decisions. This means that doctors and managers decide to allocate resources based on their personal interests, without considering the patients' needs. In contrast, a structured set of criteria is applied for determining clinical effectiveness in the UK (Littlejohns et al., 2012). Germany (Kieslich, 2012) and Australia (Whitty & Littlejohns, 2014) also have appropriate processes, but china (Docherty, Cao, & Wang, 2012) and Korea (Ahn, Kim, Suh, & Lee, 2012) do not have enough evidence and data for determining clinical effectiveness like Iran.

An interesting finding about cost-effectiveness was that most of the respondents did not have a clear understanding about the concept of cost-effectiveness and thought it meant efficiency. Based on this interpretation, they often consider the price of drugs, devices, or services as a key criterion for decision making and there is almost no list of cost-effectiveness for health technologies. In Ghana (Jehu-Appiah et al., 2008), Uganda (Kapiriri, Arnesen, & Norheim, 2004), and Norway (Defechereux et al., 2012) cost-effectiveness is one of the most important criteria in the health priority setting. In Australia (Whitty & Littlejohns, 2014), a list of cost-effectiveness for health technologies has been developed but neither of the Medical Services Advisory Committee (MSAC) and Pharmaceutical Benefits Advisory Committee (PBAC) has an explicit threshold for cost-effectiveness. For instance, using Quality Adjusted Life Years (QALY) as an indicator to assess the final outcome of health technologies is recommended but is not compulsory (Whitty & Littlejohns, 2014).

Although there are major efforts in expanding equity in the health system, the Iranian health system is far from an ideal situation. Establishing the health care networks and referral system in the villages and cities has improved the access (Takian et al., 2013) and our findings confirmed it. Furthermore, increasing the health insurance coverage for the poor and vulnerable people and establishment of the Iranian Health Insurance Organization are two instances of the enhancing efforts for improving the equity in the society. On the contrary, there are some features of inequity; for example, access to specialty and subspecialty services is difficult in some regions, indicating the need for stronger attempts. Furthermore, resource allocation for building specialized hospitals in big cities and also purchasing unnecessary health technologies reveal inequity. Some believe that commitment to increasing the equity has a significant effect on resource allocation decisions and causes the equity of allocations (Asante & Zwi, 2009) but in the real world, policymakers often make trade-offs between efficiency and equity (Mirelman et al., 2012).

Social solidarity represents the spirit of empathy and collaboration in the community. Moreover, each policy to change the proportion of the coverage in the health system is a type of the solidarity tools (Saltman, 2015). However, these policies sometimes cause managers and policymakers to rely on the public financial share; as a result, a significant portion of the health costs is imposed on people. Hence, it is necessary to integrate various financing sources such as private payments, tax incomes, and other available revenues (Titelman, Cetrangolo, & Acosta, 2015). The results of some studies show that some medical principles are accepted for prioritizing health priorities whereas socio-economic criteria are neglected (Diederich, Swait, & Wirsik, 2012). It should be considered that creating appropriate mechanisms for public participation in the health system financing is imperative.

There are two different approaches to independence or freedom of choice in the health system of Iran. In other words, people have limited autonomy to choose the preventive services or health care networks and should take action according to the referral system; instead, they can choose the hospital and the doctor independently and without any limitations. Similarly, a review of the literature suggests that freedom as a value has a great importance in Korea historically because of the strong presence of the private sector in the health system (Ahn et al., 2012). In contrast to our findings, some scholars have stated that all citizens can select both private and public health services if they have the financial ability and appropriate health information (Khayatzadeh, Fotaki, & Harvey, 2013). Moreover, freedom of choice is a core value for evaluating health technologies in some contexts (Bombard, Abelson, Simeonov, & Gauvin, 2011).

Our study had a number of limitations. First, some managers were not familiar with some social values and interpreted them wrongly, which undoubtedly affected our interpretation of their words. Second, we interviewed Parliament Members as public representatives because they claim that their views are similar to the public. Third, the number of health related documents was limited and we only found 11 documents. Finally, our perception about some social values in the national texts may be different from the main meaning of the values in the Clark-Weale Framework.

5. Conclusion

Social values are considered in health priority decisions in a limited way. It seems that the lack of an appropriate value-based framework for priority setting and low public participation are the major defects of the health system. Moreover, providing a national league of cost-effectiveness and clinical effectiveness of the health technologies is most necessary for making appropriate decisions. Undoubtedly, a national support and collaboration of various groups of people and health professionals will be useful. It is recommended that health policymakers invite different groups of people and stakeholders for active involvement in health priority decisions.

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Conflict of Interest

The authors declare that there is no conflict of interests regarding the publication of this paper.

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