Review Article

Reviewing the National Health Services Quality Policies and Strategies of the Iranian Health System: A Document Analysis

Abstract

Background: High-quality health care is an important component of efforts to reach Universal Health Coverage (UHC). Given this pivotal fact, poor quality of care is a significant bottleneck in the endeavors of Iran to UHC. This study was part of a broader qualitative study and aimed to provide supplementary data about the documents related to the National Quality Policies and Strategies (NQPS) health services in the health system of Iran to determine the degree of alignment with the World Health Organization (WHO) approach for NQPS, and to track change and development over time. **Methods:** This document analysis was performed following the READ approach for systematic document analysis in health policy research. Furthermore, qualitative content analysis following parallel forms of the mixed analysis in which the textual material proceeded with different inductive and deductive content-analytical procedures simultaneously, applying the WHO practical approach for NQPS, was selected. **Results:** The 15 included records that met the inclusion criteria were released in the post-Islamic Revolution period. The Ministry of Health was found as the most responsible authority for publishing the NQPS among the other authorities. Furthermore, 67% of NQPS was aligned with the goals and priorities of a broader national plan or policy. Contradictions, variations, and ambiguities were also found in the literature circumstances of the NQPS. There was no NQPS concentrated on the entire pathway of care in the Iranian health system, which developed according to the WHO approach for NQPS. **Conclusions:** Qualitative analysis of the current NQPSs based on the eight inter-dependent elements and critical supplements, the technical perspective of broad stakeholders, community engagement, and steady commitment of policymakers are our recommendations for future efforts towards having NQPS.

Keywords: *Government programs, Iran, policy, policymaking, quality improvement, quality of health care*

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Introduction

Background

Poor care not only jeopardizes the health of individuals but also erodes trust.[1] By contrast, high-quality care that improves health outcomes and provides value to people,[2] can have an effect on people's health, their confidence, and trust in health systems, and economic outcomes.[3] The World Health Organization (WHO) defines "high-quality care" as "care that is safe, effective, people-centered, timely, efficient, equitable and integrated."[4] With a glance at the recent researches, poor quality of care is a significant bottleneck in the endeavors of the Islamic Republic of Iran (IRI), as the second-largest country in the Middle East, to achieve Universal Health Coverage (UHC) as envisaged in Sustainable Development Goal (SDG) 3.8.[5-11] Nevertheless, quality is not a given,[1] and inaction is not a choice.[12] Publication of the handbook for National Quality Policy and Strategy (NQPS) as a practical approach for developing policy and strategy to improve quality of care in 2018 and its planning guide in 2020 authenticates national policy direction on quality at all levels of the health system to meet the ultimate aim of Quality Improvement (QI) efforts- delivering quality at the point of care.[4,12]

On the other hand, according to multiple studies reviewed by Braithwaite, dealing with quality of care is in times of national emergency, typically a local rather than a country-wide issue; for example, in the coronavirus disease 2019 (COVID-19) era, politicians, policymakers, and ministries have tended to focus on the

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management of the pandemic itself, rather than the quality of care.[13] Furthermore, he concluded that the manifold of the published articles focused on COVID-19 in two recent years is a testament to the priority this has been given by the research community, and in contrast, it has neglected to focus on quality.[13] So, the operational guidance for the COVID-19 context was published much of which speaks to providing quality of care *in situ* in the midst of the pandemic and encourages countries to have a quality policy.[14]

Theoretical framework

In this study, we benefited from the WHO approach to NQPS[4] as a theoretical framework for defining inclusion and exclusion criteria and developing research questions. Furthermore, we employed this initiative in the screening and selection of the evidence, as well as data extraction, synthesis, and analysis. In this regard, the overall structure of the handbook, which includes the elementary steps to develop NQPS as a foundation, was utilized. Figure 1 shows eight-core and inter-dependent elements and three critical supplements at a glance. Whereas the handbook of NQPS outlines a process of simultaneous development of policy and strategy, the country's needs may drive a focus on either National Quality Policy or Strategy.[4]

Rationale and objective

Documents can serve a variety of purposes as part of health policy and systems research via qualitative approaches.[16,17] Accordingly, document analysis (also called document review) as one of the most commonly used methods in health policy research, is useful for understanding policy content across time and geographies, documenting processes, understanding how information and ideas are presented formally, and understanding issue framing.[18] Furthermore, document analysis is a complementary data-collection procedure in support of triangulating with interviews and other sources of data, and theory building.[16,19] By the same token, this study was part of a broader qualitative study and aimed to provide supplementary data about general characteristics and timeline of the documents and events related to the NQPS, responsible authority of the NQPS, policy-map of the NQPSs by time frame, formation of the NQPS, elements and critical supplements of the NQPS, literature circumstances of the NQPS. In other words, we scrutinized the documents to determine the degree of alignment with the WHO approach for NQPS, and to track change and development over time.

Figure 1: The NQPS elements and critical supplements[15]

Methods

Design

This document analysis study was conducted from February to September 2021. Document analysis is a systematic procedure for reviewing or evaluating documents as a low-cost and non-reactive way to obtain data.[16] It is nearly impossible to conduct policy research without it.[18] In the current study, document analysis was selected following the four-step READ approach for document analysis in health policy research as a systematic method for interrogating documents and extracting study-relevant data that is flexible enough to accommodate many types of research questions.[18] The steps consist of the following: 1) Ready your materials (setting parameters, definition, and inclusion criteria, and collection, selection, and evaluation of the documents), 2) Extract data, 3) Analyze data, and 4) Distill your findings (refinement of data, illustrating them with graphics and quotes, and filling in any incomplete areas).[18] Since data collection and analysis are iterative as in all types of qualitative research, meaning that developing findings continually inform whether and how to obtain and interpret data,[18] these two steps of the present study were posited simultaneously in the method section.

Step 1: Ready the materials

Inclusion criteria and document collection

According to the READ approach,[18] firstly parameters and inclusion criteria [Table 1] to document acquisition were set. Next time, we searched related Iranian official websites along with the google search engine regardless of the time limitation to find the last version of the available documents only in Persian or English. As we thought some documents could not be retrieved electronically, one of the researchers referred to target offices. It is noteworthy that document acquisition was considerably facilitated by identifying and asking for documents during the related policymakers' and researchers' interviews despite the indicative list of the above places.

Selection and evaluation of the documents

Consistent with Figure 2, at first the identified documents were reviewed based upon the predefined inclusion and

Table 1: Parameters, Inclusion, and Exclusion Criteria

Parameters, definition, and inclusion criteria	Exclusion criteria
Types of documents	
The documents are as physical or virtual artifacts designed by creators, for users, to function within a particular setting. The types of documents to be analyzed may be a mix of formal documents (such as official policies, laws or strategies), gray literature (organizational materials and implementation documents such as reports, evaluations and white papers produced outside formal publication channels) and, whenever possible, informal or working documents.[18] The policy is based upon an agreed ambition with an explicit statement of intention and becomes the agreed course of action. The strategy provides a clear roadmap and outlines how the policy will come to fruition. Many aspects of the strategy process will take place simultaneously with policy development.[4] In the current study, the physical, virtual, official, and working documents pertaining to policies, laws, or strategies were collected. Furthermore, to track and achieve some policies, gray literature was included.	The document was an older version.
The full-text of the document was available.	The full-text of the document was not available.
Content	The document was not about NQPS at the point of the care.
The document was the most pertinent to the Health Services Quality Policy or Strategy or goals. Quality was regarded at the point of the entire pathway of care including the promotive, preventive, curative, rehabilitative, and palliative across all levels of the health care system[9]	The document was related indirectly to the HSQPoS at the point of care. Such as policies regarding Water, Sanitation, And Hygiene (WASH), information technology, medical education, .
The document mentioned the quality of health services in general, not even parts of the care pathway were discussed separately.	The document was about NQPS at the special point of the care pathway.
Context	The document was related to the regional or local level.
The document was related to the national level of Iran.	

exclusion criteria. Meanwhile, to select the documents, the presence of the terms was searched in the documents. We considered all the possible terms. For example, "national quality directions" might also be called "national quality plans" or "national quality program." The relevance of documents to the conceptual framework was verified in collaboration with the review panel, and any disagreements to verify those accepted into the review and those excluded were resolved in discussion with each other.

Steps 2 and 3: Extraction and analysis of data

Methods

Qualitative Content Analysis (QCA) following parallel forms of the mixed analysis[20] was selected as a systematic and flexible process of coding that researchers in the field of health care commonly use.[21]

Data were extracted by a researcher-made tool, whose validity was evaluated and verified by the content validity method through the research team besides six experts in health policy and health services management. Findings were synthesized in both quantitative (using frequencies) and qualitative (thematic analysis) format via Microsoft Excel 2016.

Phases

As a unique characteristic of QCA, the parallel mixed procedures proceed with different inductive and/or deductive content-analytical procedures simultaneously.[20] In the first phase, the retrieved data was structured via a seven-step-deductive procedure applying the WHO practical approach for developing NQPS.[4] In the second simultaneous phase, data were analyzed via an eight-step-deductive procedure.[20] All over these phases, a team approach was applied to minimize individual bias related to multiple analysts involved in coding and interpreting data. Hence, all authors committed to validating coding decisions and discussing emerging themes and categories.

Research questions

The typology of articulated questions [Table 2] was based upon macro-level analysis[22] that generally encompasses the architecture and oversight of systems. To answer the questions to meet the aims, everywhere one of the above terms (step 1) at least was mentioned, the document was read thoroughly from the outset to end including annexes, and the terms related to the NQPS elements and critical supplements in pursuit of the WHO approach was searched.

Step 4: Distill your findings

In this step, the analyzed data were refined, and the full picture of the analyzed data was mapped in results as some tables and figures, then the final products of the study were concluded through the discussion narratively.

Result

There were 390 identified documents. After two screenings, 15 documents [Table 3] were eligible for inclusion in this review.

Table 2. Research questions sets and sub-set

Research Questions	Remarks
1- General characteristics of the documents and timeline of events: What is the type, level, and reason for creating the document? How is the timeline of events? This question makes it possible to track change and development of the national quality efforts for policymakers and researchers over time.	The last version of the official sources before and after the Islamic revolution were considered. We defined documents based on Iran's policy-making system into three levels: upstream documents announced by the leadership. midstream documents that are restricted to the government/cabinet and parliament level, and downstream documents that include ministries. Each country addresses health service quality issues by creating NQPS based on its own reasons, logics, and entry points for action.[4]
2- The responsible authority of the NQPS: Which person or organization is responsible for the development of an NQPS? The answer to this question is determinant for the primary audiences- government and policymakers- striving to have NQPS.	The ultimate responsibility for the development of such documents is commonly held by the Ministry of Health which closely works with a range of policymakers and implementers, but this should be tailored to each country's ultimate designated governing body.[4]
3- Policy map of the NQPS by time frame: What are the time frame classifications of the documents? This question guides policy-makers in decision-making about the horizon of the document.	It was responded wherever had been exactly reported concerning the following horizon classification: short-term (one year or less), medium-term (between one and five years), and long-term (between five to ten years or more). [23,24]
4- Formation of the NQPS: How does the NQPS form? This question can be helpful to inform policymakers and researchers about national efforts.	It was noticed in terms of the integration (whether by fully integrating the development and publication processes of NQPS or simply aligning the goals, priorities, and actions and cross-referencing documents or a stand-alone NQPS document that needs to be linked closely with the wider national health policy and planning), process of policy and strategy development (simultaneous or non-simultaneous development of the policy and strategy), publication of the policy and strategy (just one integrated document or complementary and co-dependent policy and strategy documents developed as part of a systemwide effort to improve the quality of care), and type (A: a stand-alone document that needs to be linked closely with the wider national health policy and planning process, B: a part of the formal long-term health sector national policies and plans, C: a national quality statement drawing on existing relevant policies and national health documents, D: a constitution or terms of reference for the responsible ministry of the health department or national quality body outlining agreed policy direction, E: enabling legislation or regulatory statute to support the national efforts to improve quality of health care F: NQPS is part of the formal broader national policies and plans, and G: Combination of types) of the NQPS.[4] wherever had been exactly reported.
5- Elements of the approach and critical supplements: Which posited elements and critical supplements of the approach[4] were seen in the documents? This question can inform the stakeholders about the policy-making process.	
6- literature circumstances of the NQPS: Are the documents of the NQPS valid? How are documents similar or different across governance levels? This question makes it possible for policymakers and researchers to inform about the contradictions, variations and ambiguities of the documents.	

General characteristics of the documents and timeline of events

Given that no document met the inclusion criteria before the Islamic Revolution of the IRI (1979), all documents were related to the post-revolutionary period. Furthermore, more than half of the documents (53%) were related to the fourth decade after the Islamic Revolution (2012–2021). Figure 3 shows a map of the documents found (above the timeline). For further interpretation by readers, the most important national events (white cells) and international events (colored cells) related to the quality of health services after the Islamic Revolution were displayed below the timeline. As Table 3 shows, among the reviewed documents, laws and plans were the most common documents (each of them 27%), and most of the documents originated from the downstream level. The references made in the Constitution of the IRI and General Health Policies (GHP) announced by the supreme leader[25] were the most frequent creation reasons for upstream documents [Table 4].

Table 3: Overview of the ultimately included documents regarding NQPS (Sorted by policy level)

Title of the documents	Announced/approved/ presented by	Level	Time frame (year)	Formulation	Integration	Process of development	Publication	Type of the NQPS
General Health Policies (GHP) announced by the supreme leader of the IRI[25]	Supreme leader	Upstream	10	Development	Aligned1	Indeterminate	Indeterminate	B
General policies of the sixth Five-Year Plan for economic, social and cultural Development of the IRI (5YPFD) announced by the supreme leader[26].	Supreme leader	Upstream	5	Development	Independent	Indeterminate	Indeterminate	A
General policies of the resistance economy announced by the supreme leader[27]	Supreme leader	Upstream	10	Development	Independent	Indeterminate	Indeterminate	Combination of A and F
Law on the state services management[28]	Islamic parliament of Iran	Midstream		Refinement	Independent	Indeterminate	Indeterminate	Combination of A and F
Regulations of the supreme health council and the reform program in the health system[29]	Council of ministers	Midstream		Development	Aligned	Indeterminate	Indeterminate	D
Law of the second 5YPFD[30]	Islamic parliament	Midstream	5	Development	Independent	Indeterminate	Indeterminate	Combination of A and F
Law of the fourth 5YPFD[31]	Islamic parliament	Midstream	5	Development	Independent	Indeterminate	Indeterminate	Combination of A and F
Law on the structure of the comprehensive system of welfare and social security[32]	Islamic parliament	Midstream		Development	Aligned	Indeterminate	Indeterminate	D
Memorandum of understanding between the Ministry of Health and Medical Education) MOHME(and vice president for women and family affairs[33]	MOHME and vice president for women and family affairs	Downstream	4	Development	Aligned	Indeterminate	Indeterminate	E
Comprehensive scientific map of the health[34]	Supreme council of the cultural revolution	Downstream	20	Development	Aligned	Indeterminate	Indeterminate	B
Map of the health system reform based on the Islamic-Iranian model of progress (MHSR)[35]	MOHME	Downstream	13 years to horizon of 1404 Solar Hijri	Development	Aligned	Indeterminate	Indeterminate	B
Plan of Dr. Seyed Hassan Ghazizadeh Hashemi, proposed minister of health, for submission to the Islamic parliament[36]	MOHME	Downstream		Development	Aligned	Indeterminate	Indeterminate	B
Policies and plans of Dr. Saeed Namaki, proposed minister of health, for submission to the Islamic parliament[37]	MOHME	Downstream		Development	Aligned	Indeterminate	Indeterminate	B
General plan of the proposed minister of health, Dr. Bahram Ainollahi, for submission to the Islamic parliament[38]	MOHME	Downstream	4	Development	Aligned	Indeterminate	Indeterminate	B
Joint operational plan of universities and faculties of medical sciences in 2021[39]	MOHME	Downstream	1	Development	Aligned	Indeterminate	Indeterminate	B

Aligned with the broader national policy

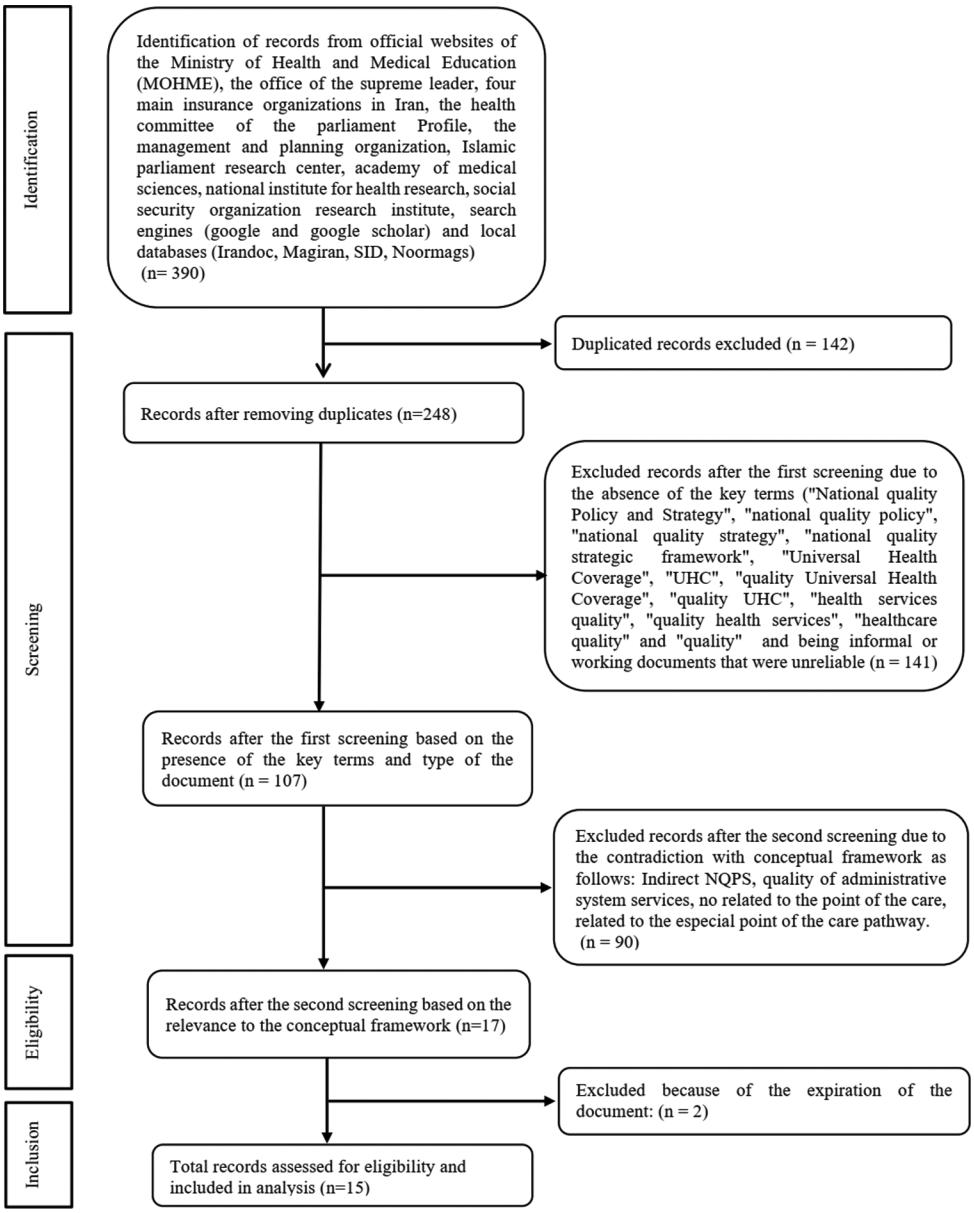

Figure 2: The flow diagram illustrating the selection process, reasons for exclusion, and final documents number

Responsible authority of the NQPS

By reviewing the documents, an organigram [Figure 4] was obtained from the responsible authorities of NQPS. As can be seen in Table 3, the Ministry of Health and Medical Education (MOHME) was responsible for creating 47% of the documents at two levels in total.

Policy map of the NQPSs by time frame

The data in Table 3 shows that 67% of the documents had a time frame, half of which had a medium-term horizon.

Formation of the NQPS

As Table 3 shows, 67% of NQPS were aligned with the goals or priorities of a broader national plan or policy, including health or non-health issues, and the process of development and publication of the NQPS was indeterminate. Furthermore, the NQPS as a national quality statement drawing on existing relevant policies and national health documents to improve the quality of health care did not exist in Iranian documents.

Elements and critical supplements of the approach

As displayed in Table 5, the improvement methods and interventions were the most frequent in the documents. Furthermore, the elements and critical supplements were most frequently found in MHSR.[35]

Literature circumstances of the NQPS

As displayed in Table 6, the highest number of codes were related to variations. If the lack of continuity of quality-centeredness over time is taken as the lack

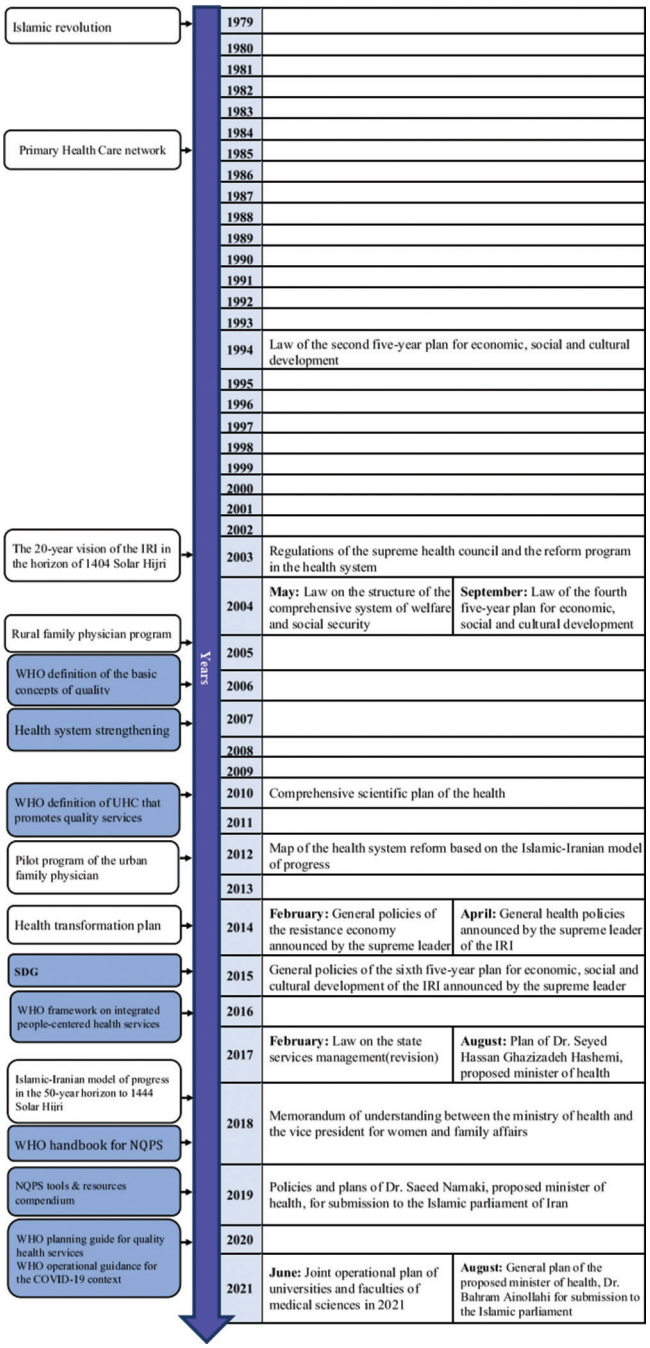

Figure 3: Timeline of events (national and international)

of continuity of horizontal quality-centeredness, the inter-contradictions between the documents and related sub-documents in this study can be taken as the lack of continuity of vertical quality-centeredness across the documents.

Discussion

General characteristics of the documents and timeline of events

In this section, four points are discussed. The first point is the non-compliance of the fundamental documents of the health system with the quality of health services at the service delivery point. It is crystal clear that documents such as the law on the organization and duties of the MOHME, statement of mission, goals, and tasks of the MOHME have not referred to the quality of health services at the delivery point. The second point is that policies and programs such as the primary health care network, national health insurance coverage program, and rural family physician program were implemented to improve health status and achieve UHC in the first three decades after the Islamic Revolution,[8,7] but did not focus on the quality of services across the entire pathway of care at all levels of the health system. The third point to note is the non-implementation of policies and programs that referred to the quality of services through the entire pathway of care at all levels of the health system. So far, three of the 36 policies announced by the supreme leader referred to the quality of all health services. Studies indicated that among these policies, GHP was based on the design of the MHSR,[40,41] that explicitly emphasized the realization of a healthy human and comprehensive health approach in all laws, executive policies, and regulations. Contrary to Sajadi and Majdzadeh who stated that the implementation of policies is highly dependent on leadership in Iran,[42] the national midstream or downstream quality policy as complementary and co-dependent documents of the GHP[25] has not been implemented in the last decade for covering the quality of all services at all levels. Accordingly, several studies have concluded that a comprehensive national action plan for the implementation of GHP is necessary.[43-45]

In line with the implementation of GHP, recent health system reforms to achieve UHC which is called Health Transformation Plan (HTP) were implemented.[46,47] Evidence showed that one of the objectives of this program was to improve quality,[48] and even proposed the plan as a goal to quality UHC in the public center.[49,50] However, the result of a study[51] showed that HTP does not meet the criteria of the NQPS for the present study. Because in the first phase, it referred merely to improving the quality of care in the hospitals affiliated with MOHME through different increasing specialists, improving the quality of outpatient services of the attached polyclinics, and improving hospital amenities and lodging services. The improvement of the outpatient services quality was also monitored by a quantitative time-based index, whereas contrary to the WHO definition of quality dimensions,[4] spending more time on a visit does not necessarily mean a higher quality visit. Mahdavi *et al*.[52] also confirmed this and referred to this instruction as a lever for health operations management and also to enhance patient health and experiences. Finally, content analysis of the HTP in two studies also showed that the main goal was "financial protection" interventions.[53,54] The other study also confirmed that the second phase of HTP was related

Table 4: The frequency of the creation reasons (Theme and category)

Title of the documents	Constitution of the IRI	Past policies	General policies of article 44 of constitution	Joint proposal of MOHME & the management and planning organization	General population policies	GHP	Charter of civil rights	Sixth 5YPFD
GHP announced by the supreme leader	*							
General policies of the sixth 5YPFD announced by the supreme leader								
General policies of the resistance economy announced by the supreme leader		*	*					
Law on the state services management								
Regulations of the supreme health council and the reform program in the health system	*			*				
Law of the second 5YPFD								
Law of the fourth 5YPFD								
Law on the structure of the comprehensive system of welfare and social security	*							
Memorandum of understanding between MOHME and the vice president for women and family affairs					*	*	*	*
Comprehensive scientific map of the health								
MHSR								
Plan of Dr. Seyed Hassan Ghazizadeh Hashemi, proposed minister of health					*	*		*
Policies and plans of Dr. Saeed Namaki, proposed minister of health						*		
General plan of the proposed minister of health, Dr. Bahram Ainollahi						*		
Joint operational plan of universities and faculties of medical sciences in 2021								
Total	3	1	1	1	2	4	1	2
Percentage	12%	4%	4%	4%	8%	16%	4%	8%

Title of the documents	Vision of the IRI on the horizon of 1404 Solar Hijri	Comprehensive scientific map of health based on Islamic-Iranian model of progress	Upstream documents	General policy of the resistance economy	General policy of the Science and technology	Comprehensive scientific map	National document approving and controlling non-communicable diseases	International health obligations and regulations
GHP announced by the supreme leader								
General policies of the sixth 5YPFD announced by the supreme leader								
General policies of the resistance economy announced by the supreme leader								
Law on the state services management								
Regulations of the supreme health council and the reform program in the health system								

Contd...

Table 4: Contd...

Title of the documents	Vision of the IRI on the horizon of 1404 Solar Hijri	Comprehensive scientific map of health based on Islamic-Iranian model of progress	Upstream documents	General policy of the resistance economy	General policy of the Science and technology	Comprehensive scientific map	National document approving and controlling non-communicable diseases	International health obligations and regulations
Law of the second 5YPFD								
Law of the fourth 5YPFD								
Law on the structure of the comprehensive system of welfare and social security								
Memorandum of understanding between MOHME and the vice president for women and family affairs								
Comprehensive scientific map of the health	*							
MHSR		*						
Plan of Dr. Seyed Hassan Ghazizadeh Hashemi, proposed minister of health				*	*	*	*	*
Policies and plans of Dr. Saeed Namaki, proposed minister of health			*					
General plan of the proposed minister of health, Dr. Bahram Ainollahi			*					
Joint operational plan of universities and faculties of medical sciences in 2021			*					
Total	1	1	3	1	1	1	1	1
Percentage	4%	4%	12%	4%	4%	4%	4%	4%

Table 5: Policy map of the documents by classification of the eight elements and critical supplements (Theme and category)

Title of the documents	National health priorities	Local definition of quality	Stakeholder mapping and engagement	Situational analysis	Governance and organizational structure	Improvement methods and interventions
GHP announced by the supreme leader	*	*	*		*	*
General policies of the sixth 5YPFD announced by the supreme leader			*			*
General policies of the resistance economy announced by the supreme leader			*			*
Law on the state services management			*		*	*
Regulations of the supreme health council and the reform program in the health system					*	*
Law of the second 5YPFD						*
Law of the fourth 5YPFD					*	
Law on the structure of the comprehensive system of welfare and social security						
Memorandum of understanding between MOHME and vice president for women and family affairs	*			*		
Comprehensive scientific map of the health	*				*	*
MHSR	*		*	*	*	*
Plan of Dr. Seyed Hassan Ghazizadeh Hashemi, proposed minister of health	*		*	*		*
Policies and plans of Dr. Saeed Namaki, proposed minister of health	*			*		*
General plan of the proposed minister of health, Dr. Bahram Ainollahi	*					*
Joint operational plan of universities and faculties of medical sciences in 2021					*	
Total	7	1	5	4	7	11
Percentage	15%	2%	10%	8%	15%	23%

Title of the documents	Health management information systems and data systems	Quality indicators and core measures	Operational planning	Integrating technical programs with NQPS	Community engagement	Total	Percentage
GHP announced by the supreme leader		*				6	55%
General policies of the sixth 5YPFD announced by the supreme leader		*				3	27%
General policies of the resistance economy announced by the supreme leader						2	18%
Law on the state services management		*				3	27%
Regulations of the supreme health council and the reform program in the health system						2	18%
Law of the second 5YPFD						1	9%
Law of the fourth 5YPFD	*	*				3	27%
Law on the structure of the comprehensive system of welfare and social security						0	0%
Memorandum of understanding between MOHME and vice president for women and family affairs	*					4	27%
Comprehensive scientific map of the health						4	36%
MHSR	*	*	*			8	36%
Plan of Dr. Seyed Hassan Ghazizadeh Hashemi, proposed minister of health		*				4	73%
Policies and plans of Dr. Saeed Namaki, proposed minister of health		*			4	36%	36%

Contd...

Table 5: Contd...

Title of the documents	Health management information systems and data systems	Quality indicators and core measures	Operational planning	Integrating technical programs with NQPS	Community engagement	Total	Percentage
General plan of the proposed minister of health, Dr. Bahram Ainollahi						2	18%
Joint operational plan of universities and faculties of medical sciences in 2021			*			2	18%
Total	3	8	2	0	0	48	100%
Percentage	6%	17%	4%	0%	0%	100%	

to a part of the entire pathway of care to provide quality integrated health services.[55] As a result, the so-called "beautifully formulated policies remain on the shelf."

Generally, it seems that MHSR[35] and HTP[46] have emerged as two documents based on upstream goals and priorities but as independent and parallel programs, and even MHSR has faded and almost disappeared after the implementation of HTP in recent years. While it may have been better to first announce GHP to align policies and programs, then the MHSR document was unveiled, and finally, the national programs of MHSR would have been implemented under the HTP as part of the Sixth Five-Year Development Plan. This was observed in Zimbabwe, which has multiple NQPS documents with common goals in the field of service quality. So that, despite having a separate quality policy and a separate quality strategy,[56,57] a national strategy for equity and quality in health was developed in the same period (2016–2020),[58] which was not explained their relationship in any of these documents.

Fourth, in addition to domestic reasons for creating documents, explicit reference was made to the international health obligations and regulations as additional reasons only in the proposed program of one minister of health,[36] while the predominant theoretical model of documents has been derived from international programs and policies. Unlike IRI, in the NQPS of some developing countries such as Afghanistan,[59] Indonesia,[60] Malawi,[61] Palestine,[62] Sudan,[63] Tanzania,[64] and Uganda,[65] adherence to global quality-related initiatives such as the SDGs and the UHC was seen.

Responsible authority of the NQPS

Given the highlighted role of the MOHME for NQPS, other studies also confirmed the stewardship of the Ministry of Health in the context of quality in national-level public organizations.[42,66,67]

Policy map of the NQPSs by time frame

Given that most documents had a time frame, as well as, the reasons for the development of more than half of the documents originated from upstream documents with a long-term horizon, adherence to a mid-term time frame is obvious. Also, the results of the other studies confirmed that the goals of the health system related to GHP should be implemented in the 5-year programs.[40,43]

Formation of the NQPS

Based on the findings, no document was formed according to the WHO approach for NQPS. Unlike IRI, in the NQPS of some developing countries such as Indonesia[60] and Sudan,[63] formulation of the NQPS followed the WHO approach. These documents have the potential to learn for IRI.

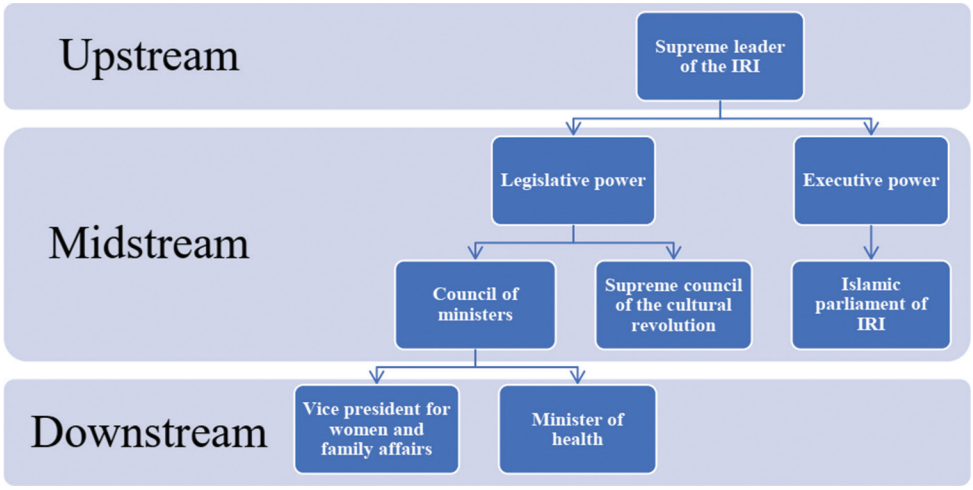

Figure 4: Organigram by levels of the national policy-making system

Elements and critical supplements of the approach

There was not an NQPS that completely contain elements and critical supplements of the approach. The identified roles of stakeholders corresponded to the results of Esmailzadeh *et al.* s' study.[68] Also, community engagement for the quality of health services is not mentioned in any document. This gap was also highlighted in a content analysis of GHP by Sajadi *et al*.[45] The Italian document analysis conducted by Luisi and HämelIn also concluded the policies show only a vague conceptualization of community participation and empowerment in primary health care; moreover, strategies to promote the participation of vulnerable groups are lacking.[69] Generally, qualitative analysis of the included documents based on the elements and critical supplements to be aware of the national efforts detail is recommended for future research.

Literature circumstances of the NQPS

Three chief drawbacks that literally require the action are as follows: First, the existence of intra-contradictions of the documents and inter-contradictions between the documents and related sub-documents, call the validity of documents into question and can be an obstacle to the implementation of the policy. GHP,[25] for example, was developed as evidence-based upstream documents derived from the MHSR[40] but over time, the exact transfer of content flaws from the source document is not negligible. It seems that creating common literature to improve the quality of discourse requires the attention of policymakers to the precedence and latency of documents and updating them using current knowledge and global experiences. Furthermore, even though the quality of health services was mentioned in GHP and general policies of the sixth 5YPFD,[26] it was not addressed in the sixth 5YPFD, meanwhile, one of the reasons for creating this plan was the realization of GHP. Accordingly, results of Sajadi,s study also confirmed some deficiencies and reported that misunderstanding GHP might be the main cause of failure in their implementation.[45] There seems to be a lack of technical perspective on the continuity of policies and their implementation, and somehow over time, the production of policy documents will assume a document-creating and legally binding aspect.

Second, the variations in the documents call into question the stability of NQPS. For example, the time of Memorandum of Understanding (MOU) between the MOHME and the vice president for women and family affairs[33] is up to the end of the presidency. It seems that especially in the context of quality if the creation of an MOU is a lever for the quality of services of priority groups in society, it should not be limited to time to prevent policy instability during different periods of government. Accordingly, Damari *et al*[70]*'s* study also indicated that in many cases of the MOHME in Iran, MOU comes to an end without the least impact on the advancement of the joint programs. Poor political support of senior managers for the implementation of the MOUs and lack of a legal guarantee for the implementation of MOUs are also mentioned as obstacles to the implementation of MOUs and offered solutions.

Around another example of sustainability barriers, even though the quality of services in the health system reform program has been referred to in regulations of the supreme health council and the reform program,[29] it was not implemented until the last amendment whereby the supreme health council was changed to supreme council for health and food security.[71] In none of its minutes, the part of the council's tasks focusing on sectoral programs related to health promotion has not been addressed, versus some issues about food quality and inter-sectional were enacted. Reviewing the enactments of minutes indicated that needs assessment in order to the development of national documents does not perform that generally needs assessment of national document development does

Table 6: Theme and categories, and subcategories of the literature circumstances of the NQPS

Theme	Categories	Subcategories	Documents
Incredibility	Intra-contradictions of the documents	Using synonyms words together	General health policies announced by the supreme leader of the IRI
		Using subset words together	Map of transformation of the health system based on the Islamic Iranian model of progress
	Inter-contradictions between the documents	Eliminate "quality of health services "between the documents and related sub-documents	Between map of transformation of the health system based on the Islamic Iranian model of progress and family physician program and referral system
			Between general policies of the sixth five-year social economic development plan announced by the supreme leader and the sixth five-year social economic development plan
Variations	Instability of the NQPS	Time-boundness caused by document-dependency on the person	Memorandum of understanding between the ministry of health and the vice president for women and family affairs
		Ignoring nature of the documents	Regulations of the supreme health council and the reform program in the health system
		Lack of continuity of quality-centeredness over the time	Five-years economic, social and cultural plans
		Inconsistency between policies and non-dissemination of policies to executive body	Plans of the governments and the ministers of health
Ambiguities	Intra documents ambiguities	Relationship ambiguity between goals and strategies	Memorandum of understanding between the ministry of health and the vice president for women and family affairs
			General plan of the proposed minister of health, Dr. Bahram Ainollahi
		Impossibility to accurately distinguish Policy from strategy	General plan of the proposed minister of health, Dr. Bahram Ainollahi
		Lack of unification in applying the goal, objective, strategy, and activity	General health policies announced by the supreme leader of the IRI
		Lack of policy and strategy definition	Joint operational plan of universities and faculties of medical sciences in 2021
			Policies and plans of Dr. Saeed Namaki
			All documents
	Inter documents ambiguities	Lack of unification in applying the goal objective, and strategy	All documents

not perform. Documents are prepared elsewhere under the urgent situation, then the developed documents are automatically approved, enacted, and communicated by the council of ministers. Damari *et al*[72]'s study also indicated that the effectiveness of the council based on the relevant spectrum was low and very low. The process of suggestions provided in the context of health is very slow. The council does not address health priorities and its weakness is in the preparation and fulfillment of documented laws in health.

The quality of the health service at the point of care in 5YPFDs also did not persist.[73-75] This issue could be a sign of political unwillingness because it occasionally addresses the quality of the health service at the point of care depending on the prevailing opinion of experts. The results of a study showed that whenever senior management within the health system of Iran changes, different strategies are then established and followed.[44] Another inconsistency was observed between the 11th and 12th government plans and proposed programs of the ministers of health[36,37] that causes inconsistency between policies and non-dissemination of policies to executive agencies. Accordingly, the results of one study also confirmed that the next health minister of IRI in the 12th government should not only be close to the plans and policies of the 11th government but also be involved in executing them.[42]

Third, the ambiguity between concepts used in the documents, as well as, no uniformity in the application of these between the documents prevent the tracking of quality programs. This problem is clearly reported in the policies of other countries. In this way, Luisi and HämelIn concluded the vague conceptualization of some Italian policies in primary health care.[69] Furthermore, Blasimme *et al*.[76] pointed to no uniformity in documents addressing a given data type that do not give similar emphases to the various themes. Given that most of the included documents in the present study are fundamental documents of the health system, the lack of literature on policy and strategy is visible. It seems that to standardize the discourse at

different levels of policy-making, institutionalizing the nature of these words is a priority and prerequisite for the development of the NQPS.

Conclusions

Although many national initiatives were developed to improve the quality of health services after the Islamic Revolution of Iran, we concluded that there was no NQPS concentrated on the entire pathway of care in the Iranian health system, which developed according to the WHO approach for NQPS. Given some problems explored in the literature circumstances of the documents, as well as more compliance of MHSR with the WHO approach, further efforts by organizations and policymakers are needed to develop the appropriate NQPS for IRI. Qualitative analysis of the current NQPSs based on the eight inter-dependent elements and critical supplements, the technical perspective of broad stakeholders, community engagement, and steady commitment of policymakers are our recommendations for future efforts towards having NQPS.

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Conflicts of interest

There are no conflicts of interest.

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