Factors Affecting Health Policies for Older People in Iran

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Abstract

Introduction: Globally, the number and proportion of people aged 60 years and older is growing fast. As people age, health needs become more complex, and the health system responsiveness to older people's needs requires evidence-informed policies. This study explored the factors affecting the process of health policies development for older people in Iran.

Methods: We reviewed and analysed policy documents related to health policies development for older people in Iran. We also conducted 32 interviewers with people aged 60 years and older and 21 interviews with key informants involved in policy-making related to older people. Qualitative data were analysed using thematic analysis.

Findings: Actors and stakeholders, policy structure and selected health policy processes, the system of health care service delivery, government financial support, community and culture building are prominent factors that influence health policy-making for older people.

Conclusion: To identify and implement effective policy options for older people, the Iranian health system needs to change its health policy-making approach for this target group. It requires a revision of existing structures and processes, timely planning and provision of a comprehensive range of quality services tailored to specific needs of older people, strengthening intersectoral cooperation and coordination to enable evidence-informed policies, facilitation and maintenance of health system responsiveness.

Introduction

At the beginning of the third millennium, ageing is an emerging global phenomenon. It is a natural irreversible process; however, its detrimental effects on health can be controlled when necessary policies are set in place. The suggested term for people aged 60 years and older is ‘older people’ [1]. Changing the epidemiological pattern of diseases in older age and the tendency towards chronic diseases on the one hand and facing healthy older people in need of health care on the other hand highlights the need for appropriate preventive and therapeutic interventions for older people. Public health and medical care services are interrelated, and a combination of their advances with other factor led to increased life expectancy worldwide [2].

Today, the number and proportion of people aged 60 years and older is growing fast. Estimates suggest that in 2018, globally, persons aged 65 or above outnumbered children under five years of age. By 2050, one in six people in the world will be over age 65 (16%), an increase from one in 11 in 2019 (9%) [3]. The number of persons aged 80 years or over is projected to triple to 426 million by 2050. Such a considerable increase in the older population's share influences social and economic systems in different societies [4]. Health policy discussions and policy-making frequently consider the data on population and vital statistics, based on births, death and migration [5]. With ageing, health needs become more complex, and given current demographic trends with increasing longevity, the health system responsiveness to older people's needs requires the development of tailored evidence-informed health policies [6].

Overall, ageing is a global phenomenon that is now occurring fastest in low and middle-income countries (LMICs), a home to over 83% of the world's population. The need to finding solutions to keep and ensure the health and well-being of their current and future older people becomes pressing [7]. Moreover, since many of the fastest-growing populations are in the poorest countries, there is even less time for necessary making policy and planning to deal with an ageing population's additional challenges and ensuring that no one is left behind [7, 8]. According to the World Health Organization(WHO), Iran is one of the three countries with the most dramatic demographic changes, and soon, together with Chile and Chine, it will have a greater proportion of older people than the USA [9]. Following the latest general population and housing census in Iran (2001), 8.2% of Iran's population were older people. However, older people's share is expected to rise to 25% by 2051, making it the fastest-growing population demographic group [10]. Considering this possible shift in the demographic composition, Iran needs to adopt new policies to tackle possible challenges, create opportunities for the growing older population, and ensure adequate geriatric and gerontological capacity among the health and social care workforce[11]. Therefore, this issue should be given special attention in policy-making. Considering the demographic challenges that Iran faces, this study explores the factors affecting health-related policy-making related to older people in Iran. This study's results can play a significant role in moving towards better health and social care service coverage of older people.

Method

This study was conducted through a qualitative research approach, using document review and semi-structured interviews. We reviewed and analysed national policy documents related to health policy development for older people in Iran. The list of the key documents and policies was identified using internet search and consulting key informants and specialists working in the field. Whenever electronic versions of the documents were not available, we requested hard copies and reviewed them.

Following document review, we conducted 32 face-to-face semi-structured interviewers with people aged 60 years and older (respondents' characteristics in Table 1) and 21 interviews with key informants involved in policy-making related to older people (respondents' characteristics in Table 2). Purposive sampling was used to select participants representing different groups, including health planners, health policy-makers, and older people. Four experts in the field of older people health and policy-making reviewed and assessed the validity of the preliminary interview guide. The interview guide was revised following the results of the pilot interviews with two experts and three older people (Appendix 1). The final focus group discussion guide consisted of seven main questions (Appendix 2). All interviews lasted between 50 to 80 minutes. Before starting the interview, the purpose of the study, how to cooperate, methods of data collection and recording, the researcher and participants' role in the research, and the confidentiality of information were explained to the participants, and informed consent was obtained. During the interview, with the interviewee's consent, the conversation was digitally recorded, then transcribed verbatim, coded and categorised.

Table 1
Characteristics of expert' interviewees

Participants	esponsibility	Level of Education	Work Experience	Gender	
				Male	Female
1	Senior managers of Iran Welfare Organization	Doctor of Medicine	20 year	*	
2	University professor	Specialised doctor	18 year	*	
3	General Manager of Health	Doctor of Medicine	16 year	*	
4	Professor and Director General in Iran Welfare Organization	Specialised doctor	14 year	*	
5	University professor and subspecialty physician	Specialised doctor	26 year	*	
6	Deputy Minister of health and Medical Education	Specialised doctor	28 year	*	
7	Head of department and subspecialty physician	Specialised doctor	14 year		*
8	Medical university Professor	Specialised doctor	18 year		*
9	Member of Parliament and former Head of the Iran Welfare Organization and Member of the city council	Doctor of Medicine	24 year	*	
10	Responsible for the WHO Aging program in Iran	Doctor of Medicine	14 year		*
11	Former Minister of Health and Member of Parliament	sSpecialised doctor	26 year	*	
12	Deputy of Health Insurance Organization	sSpecialised doctor	24 year	*	
13	Vice-Chancellor for Health, University of Medical Sciences	sSpecialised doctor	22 year	*	
14	Director-General of the Imam Khomeini Relief Committee	Master of Science	19 year	*	
15	Dean of Faculty and Older People Health Policy Advisor	Specialised doctor	18 year	*	

Note: :World Health Organization, MoHME: Ministry of Health and Medical Education, MPH:Master of Public Health, MD: Medical Doctor, PHC:Primary Health Care

Participants	esponsibility	Level of Education	Work Experience	Gender	
				Male	Female
16	Head of Non-Governmental Organization in older people health	Master of Science	34 year		*
17	Adviser and former Deputy Minister in the MoHME	Specialised doctor	26 year	*	
18	Former Head of Health Insurance and senior Expert in the field of health and Technical deputy of the deputy of treatment of Ministry of Health	Doctor of Medicine	14 year	*	
19	Vice-Chancellor for Health of university and member of the Health Policy Council	Specialised doctor	12year	*	
20	Advisor of the Minister and former head of the Health Network and Technical Deputy of the Vice-Chancellor of the university for Health	Doctor of Medicine & MPH	24 year	*	
21	Senior Officer of MoHME	MD&PHC	11 year		*

Note: :World Health Organization, MoHME: Ministry of Health and Medical Education, MPH:Master of Public Health, MD: Medical Doctor, PHC:Primary Health Care

Table 2
Characteristics of interviewed older people

Participants	Employed or retired/Current Job	Level of Education	Age	Gender	
				Male	Female
1	Employed/Faculty Professor	Professor	62	*	
2	Employed/tax office employee	Master	62	*	
3	Retired/writer	Post-Doc	71		*
4	Retired/Gardener	Diploma	70	*	
5	Emplyed/university employee	Associate	65	*	
6	Emplyed/Athletic Coach	Master	63	*	
7	Employed/Physician	PhD	64		*
8	Retired/ Farmer	Diploma	78		*
9	Retired/taxi driver	Diploma	65	*	
10	Retired/ Bookkeeper	Master	68		*
11	Retired/No job	not known	79	*	
12	Retired/ truck driver	not known	66	*	
13	Emplyed/Faculty member	Ph.D	61	*	
14	Retired/Janitor	Diploma	73	*	
15	Retired/housekeeper	Diploma	67		*
16	Employed/Translator	Master	86		*
17	Employed/hospital employee	Associate	66	*	
18	Retired/ No Job	Master	84		*
19	Retired/medical clinic emloyee	Master	63	*	
20	Retired/Gardener	not known	74	*	
21	Retired/ accountant	Bachelor	68		*

Data were reduced and structured using the framework analysis through five main steps [12, 13]. Framework analysis is a qualitative methodology that is aptly suited for applied policy research [14]. The flexibility of this methodology allowed us to do data analysis during the collection process. In the first

stage of analysis, the researchers (LD&AA) became immersed in the data by listening to audiotapes, reading the transcripts and reviewing field notes. Throughout this process, the researchers became aware of key ideas and recurrent themes and noted them. In the second stage, through the notes taken during the sfamiliarisation stage and the a priori issues, the thematic framework was identified. The developed framework was used to filter and classify the data. In the third stage, portions or sections of the qualitative data that correspond to the particular theme were identified. MAXQDA 12, as a qualitative data analysis tool, was used for the indexing references and annotated in the margin beside the text. In the fourth stage, the specific pieces of data indexed in the previous stage were arranged in charts of the themes. In the final stage, the key characteristics, as laid out in the charts, were analysed and guided the researchers in the mapping and interpreting the data.

Results

Based on the results of document review and semi-structured interviews, five main themes were identified (i.e., actors and stakeholders, policy structure and process, financial support, services delivery structure, and community and culture building). We used these themes to report our results.

Actors and stakeholders

Respondents believed that the Iranian Ministry of Health and Medical Education (MoHME) is the main custodian of community health in policy-making, particularly concerning older people's health. The most important stakeholders in this field are organisations and groups such as State Welfare Organisation (SWO) and Ministry of Cooperatives Labour and Social Welfare(MCLS), non-governmental organisations, charities, health service providers, international organisations, and medical professionals. Most of the interviewees believed that stakeholders' role and power and their support in implementing older people health policies would help achieve the goals of the designed policies. However, MoHME could not manage this issue alone. MoHME does not have the needed facilities to provide necessary support and rehabilitation services to older people, and the welfare organisations were deemed most suited for their provision. Others, based on legal documents, consider the National Council of the Older People to have a more colourful role in this regard and consider this organisation as the main policy-maker in the affairs of older people.

"*In the Fifth Plan and the new policies of the integrated health system, the Ministry of Health is in charge of health. However, the important thing is that health is a social issue, and many of its dimensions, such as the environment, social welfare and livelihood and retirement, are not subdivided by the Ministry of Health, and these challenges unfortunately exist*." (Senior MoHME policy maker)

Interviewees also noted conflicting roles and existing overlaps between the MoHME and the MCLS and SWO, which are the subset of MoHME. Following the existing legislature, the responsibility of the disabled persons is with the SWO, and the responsibility of public health is with the MoHME, which causes conflicts.

"*The main responsibility has not been determined - the legislator has given the responsibility of disabled people to the State Welfare Organization and the responsibility for people's health to the Ministry of Health and Medical Education. Therefore, when we say that the health policies of the older people are partly related to the Ministry of Health and Medical Education and partly related to the state Welfare Organization, which is itself a problem*." (SWO policy maker)

Respondents believed that older people have no representation or power to influence decision-making and policy development, and people from other age groups prepared policies concerning older people. There is also no specific forum or channel for older people to participate in policy-making. Ageing health policies are mostly made by political and technical elites, politicians, specialists and physicians.

"Older people are a group that, for various reasons, do not have a tribune and cannot defend their rights." (older people). "But really, one of the problems for the older people in many countries is that they do not have a voice, which causes their social isolation, and it is almost the same in the world, and it causes the rights of the older people to be violated." (older people)

According to the interviewees, only a small number of charities are active in older people's health, and they have a very limited role in the development of policies related to older people. However, they have the potential to play a mediating role between the policy-makers and older people. For example, one of the oldest charitable associations is the Kahrizak Older People Complex, which provides services to the poor older people for a very long time. Another example is the non-governmental organisation, the Dementia and Alzheimer's Association of Iran, that also works in older people's health. The private sector's role is mainly summarised in the establishment and management of nursing homes and residential complexes for older people, and they do not play role or influence policy-making. Overall, non-governmental organisations' capacity to intervene in health policy-making is insufficient, and even the existing capacity is underutilised, and these organisations must be trained to work better.

According to the interviewees, the media in Iran can play an important role in health policy-making and bringing issues to the policy agenda. However, this capacity has not been used, and even the media itself is not aware of the importance of older people's issues.

"*The media is more focused on specific issues and issues where the money is involved, and the voices of older people are not being heard*." (MoHME officer)

Policy structure and process

Despite some specific policies in some areas of health of older people, the Iranian MoHME does not have a specific action plan for this large group of population and have neglected related policies. Particularly, the policies related to the prevention and treatment of chronic diseases are missing, and older people are usually provided care by relatives at home, and there is no dedicated (health) insurance that would cover associated risks and costs. The current insurance coverage does not include social health services and home health services, so it is quite difficult to appoint a home nurse and pay for it. According to the

interviewees, the MoHME has not paid enough attention to ageing and does not have a long-term strategy or vision. Inadequate coherence between upstream and downstream policies and a lack of communication between existing policies have also resulted in a lack of specific interventions or specific service packages for older people. Existing policies and programs are often passive, short-term and cross-cutting, and lack a holistic and macro perspective.

"*The policy of forming the National Council of the Older People, which was formulated and approved in 2004, had an appropriate and coherent content and for this reason was accepted by the parliament in its time. However, this policy, for some reasons, was not implemented properly*." (Senior policy maker)

Interviewees stated that to maintain the health of older people and achieve healthy ageing, policies that address youth and working-age people's health are needed. Another problem that was mentioned is the lack of intersectoral policies.

"We have not done anything about the mental health problems and depression of the older people. Families of older people should be educated about the specific characteristics of older people and their needs." (SWO officer)

Interviewees noted that indicators and tools for evaluating these policies and existing programs are not found in the existing policies' content.

"So far, not only we have not evaluated the policy; we do not even have a way to measure the scale of a problem in this field." (Senior MoHME officer)

However, participants also noted some positive aspects in the field of health of older people. Such aspects include the sensitisation between the state officials and academic institutions on the ageing population, training of medical students in various fields of ageing, the establishment of a geriatric office in the MoHME, and the existence of clinical expertise to cover services for older people. At the same time, interviewees scored the health status of the older people in the structure of the MoHME as weak. Extensive structural changes, separation of the SWO from the MoHME and the health policy-making process related to older people have had a significant impact on past policies in this regard and how they were implemented. The SWO and the MoHME often confront each other in matters related to the health of older people.

"Unfortunately, with the very heterogeneous integration that has taken place in previous governments and the merging of three heterogeneous areas such as cooperation, labour and social welfare, and the formation of a ministry, the current situation of the welfare organisation and social activities has worsened." (Faculty member)

Respondents believed that the social security system does not provide adequate protection for older people and that the views are usually unidimensional, and there is no adequate insurance for older people.

“The older people are retiring, but their pensions are not enough. It is very important to link older people health policies to welfare policies. Do our policies respond to access to affordable food and fruit?The cost of fruit and preparing proper food are high. When we plan, we usually look and move one dimension forward. Only one dimension usually dominates our minds” (Health insurance officer)

Most interviewees stated that the existing insurance programs do not have a specific plan for older people, geriatric services and common diseases of older age. The insurance mainly covers older people the same as other age groups in society. Supplementary insurance for older people is available only in a very limited number of business structures.

“...Insurance companies remove deceased people from the list and invalidate their insurance books so that no one can deceive them. The older people must go to the insurance office and prove that they are still alive. What does it mean for older people if they are disabled?” (older person)

Experts say that most of older people health issues are outside the scope of the MoHME and there is a need for strong inter-sectoral leadership and intra-sectoral governance, while there are very few capable people in the MoHME and there is serious concern about governance and leadership. Also, the implementation of policies in the country follows the top-down approach, and policy-makers formulate and announce policies that must be implemented in any way possible, and this top-down attitude prevents the formation of social participation.

“We usually formulate and approve a policy and then force it to be implemented.” (Health policy maker)

Other inhibiting factors considered by the participants in the study included intra-sectoral and inter-sectoral inconsistencies, the inability of the MoHME to externally influence other sectors involved in the health of older people, lack of consideration to the issues of ageing and insufficient attention of policy-makers and politicians to the ageing society, lack of the multiplicity programs in the health sector, the inability and inefficiency of the structure of the health network and family physician to implement the announced policies and programs.

“The most important difficulty in the health of older people is that the Ministry of Health and the health system has the least role in the health of older people.Everything we want to do about the health of older people is faced with the external sector, and we do not have the tools to manage and examine the external health sector, which is our biggest problem.” (MoHME officer)

Financial support

Interviewees believe that the high cost of health care for older people has attracted politicians and policy-makers' attention, and they have developed and implemented programs and policies in this area. Other interviewees cited the economic hardships of older people as a source of influence on older people's policies and health. Inadequate pensions and the majority of older people's poor economic situation were among the issues raised by the vast majority of interviewees, who acknowledged that more than one-third

of the country's older people were covered by aid from support organisations such as the Imam Khomeini Relief Committee and the SWO.

"8% of the population are older peopleand 27% of health care costs are being spent on them." (MoHME, Health policy document). "One-third of older peoplepopulation will have difficulty surviving if no one pays them. Economic problems contribute to many of the problems of older people ." (SWO, *Health policy document*)

According to the interviewees, chronic diseases and associated high costs of treatment are also among factors that strongly affect older people's economic situation and the insurance organisations. Moreover, Iran's current economic situation, international sanctions, and high inflation also have adverse effects on policies.

"Out of every four older people, three have chronic diseases, which are very costly and economic factors can have a huge impact on policies." (Family physician)

Interviewees consider the annual budget, expenditure of the health sector and financing to be potentially effective in the formulation and implementation of programs and policies for older people's health. They believe that the budgets allocated to these issues are insufficient, and the lack of financial resources does not usually allow for any long-term policy-making. The MoHME spends all its efforts on solving urgent problems and matters.

"Budgets allocated to the health of older people are very limited and are distributed among different organisations."Unfortunately, the allocation of budgets, neither at the national level nor especially within the Ministry of Health, does not correspond to the older people needs at all." (NGO for the Welfare of Older People)

The independence of the SWO causes the country's budgets related to the health of older people to be divided. A large amount of the budget is given to the SWO, while the MoHME has no role in policy-making.

" *The budget of the State Welfare Organization and its independence in practice on the one hand, and the very small share of the Ministry of Health in the budget for the older people on the other hand, actually reduces the leadership role of the Ministry of Health in policy-making, management, implementation, monitoring and evaluation of older people*." (SWO officer)

In the past and now, priority is still given to other age groups. Resources and budgets are mostly devoted to children and youth health programs.

"In terms of resources and budget in society, more attention is paid to young people and children. There is no more positive view of older people and older age in society. Moreover, some say that they have lived their lives, and it is not rational for them to spend resources on them(Older person)

Community and culture building

Several interviewees believed that due to Iran's religious context, religious and cultural factors play an important role in policy-making for older people by emphasising respect for them. However, they acknowledged that attention to these factors was more rhetorical, and one of the main problems in the issue of older people is the cultural problem in society.

"*In our culture, there is more emphasis on respect for older people, which is done in words, but in practice, it seems there is no practical action*." (older person) "*We have to use religious factors. Clergy and mosques are places that I think are influential in social and behavioural leadership*." (older person)

Interviewees believe that social factors have been less influential in older people health policy-making in the past, but today more attention has been paid to this issue. It has also been stated that in Iranian society, there is ageism, and this is an influential social factor. However, some of the interviewees mentioned that the adoption of a legal article in the law of the Third Development Plan and awareness of the issue of ageing in the country and public opinion had been an appropriate way in attention to older people by policy-makers and government officials.

Service delivery system

Experts said no comprehensive system for providing proactive health services for older people, especially in the cities. This issue has been abandoned, and all services are inactive. Our primary health care system is incomplete in this area, and the prevention, treatment and rehabilitation services for older people are not included. In the current framework, it is not possible to provide appropriate services to older people. There is a need to create new templates and capacities for such services. Experts participating in the study expressed different views on the problems of providing health services to older people. Some emphasised the different abilities of the SWO and the MoHME in providing services to older people and believed that the SWO is active and capable in providing support and rehabilitation services but cannot provide acute medical services. The MoHME is active in acute treatment of patients, but a follow-up treatment of older people has been practically abandoned.

"*The State welfare organisation does not have the capacity and facilities to cover all aspects. The work was suspended and was not completed. However, in my opinion, the Ministry of Health, which has a very good capacity but does not have a sanatorium, is also weak in the field of rehabilitation, and these areas have not been developed in the Ministry of Health. The Ministry of Health pays full attention to acute care and does not pay attention to the individual after treatment and discharge from the hospital. After-hospital care is very important for* older people." (Health researcher)

The interviewees acknowledged that the country's health care networks had not received the necessary training in the field of prevention and provision of primary health services to older people, especially related to chronic diseases and mental illnesses. Most importantly, there are no facilities to provide the desired service to older people in the country's health network. Because the country's health care network has been designed and implemented to maintain and promote the health of mother and child, therefore, introducing the provision of older people services to health centres is associated with resistance and,

together with the lack of necessary facilities and workforce, has caused the inefficiency of these services in the network.

"The system and structure we have to provide services is a very old system and is designed to provide limited services to mother and child, and if we want to put the heavy task of providing basic health services to older people in this system, this structure will not be able to do it, and we need to change the structure of health centres." (related document)

The nature of the problems of older people is different from other age groups. It was stated that a package of treatment and prevention services provided by the MoHME should take into account other sectors.

"The nature of ageing problems is different from other age groups. With increasing age, physical strength decreases. We try to maintain other dimensions of health in older people, which is possible." (National Doc for older people)

The lack of special structures to provide services to older people in the country, such as specialised hospitals or medical wards or clinics, was one of the interviewees' points of interest, which greatly affects the implementation of the older people health policies.

"Why shouldn't ageing people, which make up a large part of the countries population, do not have its special hospital? Unfortunately, we do not have a geriatric hospital in our health system." (health care provider)

Another important problem in the structure of providing health services to MoHME is their access to services. Many older people are unable to leave their homes and are denied access to health care.

"*.... Some older people have no job and do not have the physical ability to leave home. Now, what are our plans for these people who cannot leave home, so if we want to talk about health needs and medical needs? We think there are many problems with physical access*". (public health officer)

Discussion

We identified five groups of factors that can influence policy-making related to older people's health and social care. These factors include actors and stakeholders, health policy structure and policy process, healthcare service delivery system, government financial support, community and culture building.

Community and cultural awareness

As a very strong background factor, cultural and religious factors play a major role in the country's decisions and policies [15]. In older people's health, these factors have also been influential elements, but it seems that attention to these factors is more of a slogan and in practice, proportionate attention has not been paid to the older people's health [16]. Our study shows that in policy-making for older people,

religious components, especially the clergy, are not used properly, and this underlying factor plays a major role in implementing policies and achieving health goals in our country. Studies in several developing countries also show the significant role of religious clerics and tribal leaders in the policy-making process and the success or failure of policies [17-19].

Actors and stakeholders

According to the study's findings, the conflict of interests of individuals and different specialised departments seriously affects policy. At the same time, the short period of responsibility of managers and the instability of management also causes haste in decision-making and policy-making and weakens the policy-making system. In analysing the role of policy actors, it should be noted that stakeholders' role and power and their support for the implementation of health policies for older people will lead to the achievement of the objectives of the designed policies [20]. The results of our study show that in the health policies of older people, the strongest beneficiary and the main trustee is the MoHME, but alone cannot cope with this because the MoHME does not have the necessary facilities for older peoplein support services and rehabilitation. Instead, the SWO is more capable in this field. Social Security Organization, Iranian Health Insurance, National Pension Organization and Imam Khomeini Relief Committee are among the role models whose behaviours and policies directly affect the health of older peopleand related policies and the health behaviour of older people. These institutions and organisations have less power than they do, but they are the main role models in shaping the health behaviours of older people.

Some studies have reported no integrated governance in the policy-making for older people [21, 22]. The contradictions between the MoHME and the SWO of Iran [23], absence of a specific structure for the older people health [22], inactivity of the national council for the older people [24], and the existence of parallel and non-professional sorganisations [25] were among the issues mentioned in various studies. Other studies had stressed poor inter-sectoral cooperation between key stakeholders [22-25]. Some other studies had argued for poor policies due to the absence of general health-based policies, exisiting priority of treatment over prevention [25], and the lack of strategic orientation in ageing health programs [26].

Service delivery system

Services provided to the older people in Iran are poorly organised, facing challenges such as the lack of sspecialised older people clinics and hospitals, accumulation of facilities in metropolises, absence of older people friendly centres, lack of a dedicated queue and priority for older people treatment in hospitals, lack of links between different levels of prevention to rehabilitation, absence of palliative and end-of-life care, lack of attention to annual check-ups and overall poor quality of care in home-care and daycare centres [21, 23, 25, 27].

The current structure of health care centres in the first level of services and prevention is a structure established in the past to provide outpatient and prevention services and maternal and child health and now needs to be updated in terms of structure, human resources and facilities [19]. The results of this

study show that according to the existing conditions in the country, in order to provide appropriate health services to older people, appropriate structures are need and universities of medical sciences at the provincial and regional levels should examine health care delivery systems as an important part of service delivery to older people. Research in other countries also emphasises that the first step in policy-making for the health of older peopleis to evaluate and review the provision of existing services and the current functioning of health systems at the national, provincial and regional levels, in order to evaluate how to provide health services for older peoplein the current structures [28].

The population of older people as the target community has no power in decision-making and policy-making, and policy-makers do not hear their voices, and usually, other age groups make policies for them. The World Health Organization (WHO) states that in its efforts to promote health services for older people, health policy-makers and planners often neglect to ask older people about their problems in health care and community-based care centres and call for ideas for change. Both users of the services and its providers, such as physicians, nurses, and other health care workers, are not asked about changes needed for improvement [9].

Financial support

The system and economic factors, budgets, and financing health services have not had much effect on the health policies of older people, in the sense that when formulating policies, little attention has been paid to the available budgets and resources. Considering the very limited budget in older people's health and considering the formulation of idealistic policies and setting ambitious goals in most of the existing policies, it is clear that these factors have not been taken into account in formulating policies. Research shows that the effect of population ageing on health care costs is much greater than previously thought [29, 30]. Therefore, financing of health services for older people should be seriously considered in new policies.

A review of the policies and programs of developed countries shows that in most European countries, retirees, who are naturally older people, are fully covered by social protection and full health insurance. In some of these countries, in addition to older people, all residents and citizens of those countries are eligible for full social and welfare support. Studies show that in all European Union countries, older people are fully supported by society and have a full health services coverage. Most studies had reported that increasing poverty and economic dependency in older people reduced their economic access to health care and increased their exposure to devastating health costs [23, 24, 26]. Other studies reported that older people's health insurance was inappropriate, due to inadequate coverage of services, such as rehabilitation services, and the inability of insurance policies to prevent the likelihood of households enduring frustrating out-of-pocket costs [21, 22, 25, 26].

Policy structure and process

Overall, our results suggest that currently, there is a lack of specialised programs and policies by the MoHME that would address older people's health needs. Therefore, even in the inter-sectoral

communication between the health sector, which operates as two deputies, logical coherence and strategic orientation are not observed. Our study shows that in the past, at different times, units have been established to coordinate policies that have changed over time and there is practically no coordination between the majority of existing programs and policy packages, which shows the weak policy-making capacity in the MoHME. Results of our study reiterated the necessity to account for international experience, successfulinternational policies and paradigms, and international community's recommendations when formulating national and local policies.

Numerous changes in the policy-making structure and organisations in charge of older people caused the policy-making process regarding the health and welfare of older people to undergo fundamental changes. Formation of a new Ministry of Welfare, and the merger of the Ministry of Welfare with the Ministry of Labor and Social Security, followed by the heterogeneous merger of the Ministry of Welfare and Social Security with the Ministry of Cooperatives, and subsequent formation of the Ministry of Cooperatives, Labor and Social Welfare – - all affected policy-making in social affairs, especially in the field of health and welfare of older people. Moreover, serious damage has been done to the policy-making structure in the health and well-being of older people. The frequent change of rule-makers in policy-making and structural change and the separation of the Welfare Organization from the MoHME and its continuation of activities under the Ministry of Welfare caused matters related to the health of older people to be left out of the view of senior policy-makers.

According to the WHO, one of policy-making problems in developing countries is the lack of attention to all components and stakeholders in policy-making [31]. Studies show that in developed countries, stakeholders' role in well-organised structures is more prominent in the policy-making process. Also, in these countries, policy-making processes have formal and specific procedures and steps and are institutionalised in democratic systems. While in developing countries, the policy-making process is different; in many cases, the implementation of policies based on the specific relationship and interaction between policy-makers and executives may have different policy outcomes [18].

According to the country's upstream laws, the MoHME is responsible for identifying problems and preparing agendas and approving health policies. Of course, the Islamic Consultative Assembly also has full authority in policy-making and the adoption of laws for all sectors in the country. Usually, experts and employees of different ministry departments, with the knowledge of health problems and issues in the community, prepare and formulate solutions and present them to the ministry's senior officials. At the national level, policy decisions on health policies have been made centrally in the MoHME. Some policies have been submitted to the Islamic Consultative Assembly, the government or the High Council for Health and Food Safety for legalisation. Our research shows that in policy-making for the health of older people, their problems and the specific characteristics have not been properly and carefully considered. Our findings show that this issue has not been properly studied in the past, because if it had been properly examined, it would have led to the adoption of a policy and the formation of the National Council of the Older People, which should have continued.

Hhealth systems are complex interactive systems [32], planning and policy-making in this system and all organisations require system thinking and a comprehensive view. This approach requires an in-depth understanding of the connections, interactions, and behaviours among the system's components that make up the entire system. In the health system, system thinking focuses on the relationships between the system's components, the synergy created between the components as a result of these relationships and the events that occur in the system [33]. According to the theory of systems thinking, everything is related to something else. Implementing a reform or changing a policy is very complex, so it is very difficult to predict health care system outcome with certainty[19].

Conclusion

Success in effective policy-making for older peopleand its proper implementation require a change in approaches in stakeholders' participation, policy structure, implementation processes, service delivery capacities and attention to the strong areas of Iranian society. Creating integrated cohesion and strengthening cross-sectoral capacities will enable the move towards evidence-based policy-making and system thinking, and increase the power of analytical skills and long-term and strategic vision in a higher level of policy-making. Enhancing the ability to translate international evidence and local realities into effective policies and then creating an integrated policy process for their adoption and implementation will be possible by modifying existing decision-making and enforcement structures. By increasing its monitoring capacity and improving its intra-sectorial and inter-sectorial communications, the Iranian health system can move towards achieving an integrated and effective policy for the health of older people.

Abbreviations

LMICs
low and middle-income countries, WHO:World Health Organization, SWO:State Welfare Organisation, MoHME:Ministry of Health and Medical Education, MCLS:Ministry of Cooperatives Labour and Social Welfare,

Declarations

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Authors' contributions

L.D. designed the study. L.D. and A.AT. contributed in conducting interviews, the analysis and the interpretation of the findings. P.D. and R.KhZ. drafted and wrote the manuscript. V.SG. contributed in

making critical revisions to different versions of the manuscript. All authors have read and approved the final version of this manuscript.

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Availability of data and materials

Data and material can be obtained by contacting the corresponding author

Ethics approval and consent to participate

This study was approved by regional research ethics committee of Tabriz University of Medical Sciences; Approval ID: IR.TBZMED.REC.1399.899. Before starting the interview, the purpose of the study, how to cooperate, methods of data collection and recording, the researcher and participants' role in the research, and the confidentiality of information were explained to the participants, and informed consent was obtained, which was approved by the ethics committee. All research methods were carried out in accordance with relevant ethical guidelines and regulations.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no conflict of interest regarding this study.

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