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ORIGINAL ARTICLE

Barriers of health equity in the Iranian health system from the medical ethics viewpoint

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ABSTRACT

In order to lessen health inequalities, the obstacles to health equity will need to be identified. This study aimed at investigating the barriers to access to health-care services from the medical ethics point of view. Data were collected through a qualitative study by performing semi-structured interviews. Purposive sampling was used to recruit participants involved in health provision and/or management. Content analysis was done using MAXQDA software. Overall, 30 interviews were conducted. The content analysis of the interviews identified two themes including "micro factors" and "macro factors", five sub-themes including "cultural, financial, geographical, social and religious

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1.
INTRODUCTION

Introduction

- Health equity as one of the ultimate goals of the care system has a significant impact on health outcomes, and therefore health managers and decision makers should carefully and persistently consider it in planning and implementations.

- It is also important to consider **equity as a extension of the four principles of medical ethics**.

Introduction

- The issue of health inequalities can be inspected from three aspects: financing contribution, health-care access and utilization and health outcomes
- To minimize health-care inequalities, the system's maximum capacity must be identified to make the necessary plans for promoting health equity in the short, medium and long term.
- The present study aimed at assessing access to health services from the medical ethics perspective and examining the barriers from geographical, financial and cultural aspects as well as providing solutions to overcome such barriers

2.
Methods

Method

- This was a **qualitative** and **descriptive-analytical** study that was conducted using semi-structured and open-ended interviews.

Context and Sampling Strategy

- The purposeful sampling method was used in this study.
- At first, 15 participants were selected, and at the end of the interview, they were asked if they could introduce other experts in the field. In this way, 15 more participant were identified and added to the study.
- Data collection continued until data saturation, which was reached at 30 interviews.

Data Collection Instrument- Data Collection Methods

- The initial interview questions were formulated.
- The interview framework was designed based on the objectives of the study.
- Then the questions were shared with the members of the research team to obtain their opinions.
- And then, the framework was reviewed and agreed upon by the team members.
- To collect data, in-depth, face-to-face and individual conversations were conducted. Each interview lasted between 25 to 80 minutes.

Table 1. Descriptive analysis of interviewees

Variables	Statistics	Value
Gender	Number of Females (%)	5 (16.6)
	Number of Males (%)	25 (83.3)
Age (years)	Mean (SD)	47.8 (7.3)
	(Min./Max.)	(32/60)
Work Experience (years)	Mean (SD)	24.4 (5.9)
	(Min./Max.)	(10/35)
Length of Interview (minutes)	Mean (SD)	45 (12)
	(Min./Max.)	(25/84)

Data Processing, Analysis, and Confirmation

- Inductive-deductive approach was used for coding.
- The primary data analysis was done simultaneously with the interviews.
- After data saturation, the researchers started the second and main stage of data analysis through content analysis.

Data Processing, Analysis, and Confirmation

- First, important sentences and concepts were identified, and to facilitate subsequent sorting, they were written on index cards or information control files to determine main concepts and topics.
- the main topics were extracted, and then the relationships among these concepts and a comprehensive description of the study subject, main themes and codes were inserted into tables.

Data Processing, Analysis, and Confirmation

- After removing duplicates, summarizing, merging and aggregating, the primary codes were formed.
- Next, the team members started the review and qualitative evaluation of the codes and classes extracted from the text.
- The results were then analyzed using qualitative study analysis methods and in the form of **MAXQDA 10.** software

Ethical Issues Pertaining to Human Subjects

- The study participants were contacted so that they could be prepared for the interview sessions and answer the questions at their preferred time and location.
- Informed consent was obtained for participation and interview recordings, and the necessary explanations were given regarding the principles of confidentiality, non-disclosure of information, and preservation of audio records.
- The study protocol was approved by the research ethics committee of the School of Medicine, (IR.TUMS.MEDICINE.REC.1401.110).

3.
Results

- In this study **the barriers** to access to health-care services in Iran were identified and categorized based on Lichter's model in **two themes** including "micro factors" and "macro factors", **five sub-themes** including cultural, financial, geographical, social and religious barriers, and 44 codes.

Sub-Themes	Codes
Cultural barriers	1. the difference between individuals' perception of the type, method and level of access 2. The effect of religious, psychological and philosophical perceptions, beliefs and backgrounds on health-care service providers 3. Patients' admission and treatment in the private sector 4. Induction of demand or false demand 5. Utilizing advertisements and commercial brands 6. Health-care recipients' religious beliefs 7. Factors affecting cultural acceptance in the context of health 8. Social stigma 9. Contradictory reactions to healthcare 10. Individuals' religious and ethnic beliefs 11. Perspectives based on lack of early benefits

Sub-Themes	Codes
Financial barriers	. Designating equitable insurance premiums 2. Receiving larger fees from individuals with higher incomes 3. Direct payments 4. Lack of adequate financial support for service recipients 5. Financial connection between physicians and patients 6. Challenges in the coverage of health-care services 7. Not allocating sufficient resources to the insurance industry 8. Segmentation of insurance systems 9. Discrimination on the grounds of income level 10. Induced demands 11. Barriers to access to outpatient services 12. Incompatibility of legal and sometimes primary and supplementary insurance obligation

Sub-Themes	Codes
Geographical barriers	1. Geographical access under four categories 2. Natural hazards, natural disasters and accidents 3. Lack of access to resources 4. The effect of managerial biases 5. Concentration of health-care services in provincial capitals 6. Considering the needs of specific geographical areas 7. Establishment of high-tech services in a geographical area 8. Availability of services as a main infrastructure 9. Lack of service leveling and referral system 10. Physical distances and geographical dispersion 11. Not differentiating among different geographical areas

Sub-Themes	Codes
Social barriers	1. A direct relationship between income level and social access 2. The effect of the type of occupation on social access 3. Literacy level and social access to health-care services 4. Tendency of low-income individuals to avoid health services 5. Social level or class as a significant barrier 6. The impact of social factors such as income and literacy levels

Sub-Themes	Codes
Religious barriers	1. Preference of certain religions 2. The religious attitude of service providers 3. Typical therapeutic interventions and modern technologies 4. Not observing some religious issues

4.
Discussion

Discussion

- Based on our findings, differences in individuals' perceptions, cultural control, religious beliefs and social stigmas create cultural barriers. Financial barriers consist of the financial connection between service recipients and service providers, insurance premiums, and inadequate coverage of health-care services.
- The most important geographical barriers identified in our study were differences in urbanization, inequality in various geographical areas, marginalization, and inequality in resource distribution. Finally, differences in the level of income, education and occupational diversity were among the social barriers.

- To the best of our knowledge, this is the first deep and extensive study of the barriers to achieving equity in access to health-care services in the Iranian health system from the medical ethics viewpoint. The findings of this study can answer some long-waiting questions of health policymakers in this regard.
- Our study had some limitations; for instance, to examine the barriers to accessing health services from an ethical standpoint, it would be better to add people's perspectives to the study, but this was not done due to time and cost constraints.
- As future work, comprehensive studies emphasizing various factors affecting healthcare from the health equity perspective should be conducted.

5.
Conclusion

- Given the wide range of barriers to access to health-care services, a comprehensive plan covering various dimensions of health equity should be implemented. To this end, innovative and progressive strategies emphasizing the principles of equity and social equality should be developed.
- Iranian policymakers and planners should keep in mind the three main stages of access to health-care services (acceptability, affordability and availability) in line with the four principles of bioethics (justice, autonomy, beneficence and non-maleficence)/

Thanks for your attention

Any questions?

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