HEALTH CARE MANAGEMENT

Embedding political economy in Iran's health policy cycle: necessity and pathways

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Keywords

Political Economy Analysis • Health Policy • Health System Reform • Policy Cycle • Iran • Health Governance

Summary

Health policy is often presented as a technical process guided by scientific evidence and managerial expertise. However, policy decisions are equally shaped by political institutions, economic constraints, stakeholder interests, and power relations. In Iran, these political-economic dimensions remain insufficiently integrated into health policymaking despite their substantial influence on policy formulation, implementation, and sustainability. This viewpoint argues that political economy analysis (PEA) should be institutionalized throughout the health policy cycle as a core component of evidence-informed decision-making. Drawing on the characteristics of Iran's health system, the article identifies four interrelated factors that underscore this need: institutional fragmentation, fiscal instability associated with a rentier economy and economic sanctions, discontinuity arising from political transitions, and the influence of organized interest groups. These factors illustrate why technically sound reforms may fail to achieve sustainable outcomes when political and institutional realities are overlooked. Building on this analysis, the article proposes four practical pathways for institutionalizing PEA: introducing a mandatory Political Economy Annex for major policy proposals, establishing a permanent Political Economy Advisory Unit, strengthening capacity through education and professional training, and promoting long-term policy–research partnerships. Collectively, these recommendations provide an operational framework for embedding political economy considerations into routine health policymaking. Institutionalizing PEA will not eliminate political conflict from health policy; rather, it will improve policymakers' ability to anticipate competing interests, enhance the political legitimacy of reforms, manage implementation challenges, and design reforms that are both technically effective and politically sustainable.

What is health policy and why does it matter?

Health policy is commonly defined as the set of decisions, plans, and actions undertaken by governments and other institutions to achieve specific health goals within a society [1]. These goals generally include improving population health, ensuring equitable access to health services, protecting households from financial hardship, and maintaining the quality, safety, and efficiency of healthcare delivery [2]. Although this definition appropriately captures the technical dimensions of policymaking, it does not fully reflect the complex political and economic context within which health policies are formulated and implemented. Health policy is not simply a rational or evidence-informed process in which policymakers identify a problem, evaluate scientific evidence, and adopt the most effective intervention. Rather, it is a dynamic process shaped by competing priorities, institutional arrangements, resource constraints, and interactions among multiple actors with differing interests [3].

The significance of health policy extends well beyond the health sector itself. Health is widely recognized as a fundamental human right and an essential component of social and economic development [4]. Consequently, decisions regarding the allocation of health resources have profound implications for equity, economic productivity, social welfare, and public confidence in government institutions [5]. In Iran, as in many middle-income countries, health expenditure accounts for a considerable proportion of national public spending, making health policy a major determinant of fiscal sustainability as well as population wellbeing. Poorly designed policies may result in inefficient resource allocation, widening inequities, financial hardship for households, and deterioration in public trust, whereas effective policies can improve health outcomes while simultaneously strengthening social cohesion and economic resilience [6].

Despite this importance, health policy is frequently conceptualized as a predominantly technical exercise [7]. Such a perspective implicitly assumes that stronger scientific evidence, improved managerial capacity, and more sophisticated analytical tools are sufficient to produce successful reforms [8]. However, experience from numerous health systems

demonstrates that technically sound policies often fail because they encounter political resistance, institutional fragmentation, conflicting stakeholder interests, or fiscal constraints that were not adequately anticipated during policy design [9]. Consequently, policy success depends not only on the quality of technical evidence but also on the political and institutional environment in which policies are developed and implemented [10].

In practice, every major health policy decision is embedded within a network of formal institutions, informal rules, competing interests, and power relationships [11]. Decisions regarding health financing, provider payment mechanisms, pharmaceutical regulation, insurance coverage, or priority setting are rarely determined solely by scientific evidence [12]. Instead, they emerge through negotiation among governmental organizations, professional associations, private sector actors, civil society organizations, and other stakeholders whose interests may converge or conflict [13]. The eventual policy outcome therefore reflects not only the available evidence but also the relative influence, bargaining power, and institutional position, and the prevailing ideas and cultural norms of these actors [14]. Understanding health policy thus requires examining who participates in decision-making, whose interests are prioritized, and which institutional arrangements facilitate or constrain policy change [15].

This perspective provides the foundation for the central argument of this viewpoint. Many explanations for unsuccessful health reforms emphasize deficiencies in evidence translation, managerial capacity, or implementation processes. Although these factors are important, they often represent the observable manifestations of deeper political and economic dynamics. Policy failures frequently arise because insufficient attention is paid to stakeholder incentives, institutional structures, power asymmetries, fiscal realities, and broader political contexts that ultimately determine whether reforms become politically feasible and sustainable. Accordingly, political economy analysis should not be regarded as an optional complement to conventional policy analysis, but rather as an essential analytical framework for understanding, designing, implementing, and evaluating health policies, particularly in complex health systems such as that of Iran.

What is political economy analysis and how does it affect health systems?

Political economy analysis (PEA) is an analytical approach that examines how power, institutions, ideas, and economic interests interact to shape public policy and its outcomes [17]. Although the term is sometimes associated primarily with economics or electoral politics, its scope is considerably broader. Rather than focusing exclusively on economic efficiency or political competition, PEA seeks to explain why particular policies emerge, whose interests they serve, and why implementation succeeds or fails under specific institutional and political conditions [18]. Unlike conventional economic evaluation, which primarily asks whether an intervention is cost-effective, PEA asks complementary questions: Who possesses decision-making authority? Which actors are likely to support or oppose reform? What formal and informal institutions shape policy choices? And how do prevailing ideas and political narratives influence what is considered feasible or legitimate? These questions are fundamental to understanding health policy because technically sound interventions frequently encounter barriers that cannot be explained by technical evidence alone [19].

Contemporary political economy frameworks generally emphasize four interrelated dimensions [20]. The first concerns actors and interests, requiring systematic identification of relevant stakeholders, their objectives, resources, incentives, and relative influence over policymaking [21]. The second dimension focuses on institutions, encompassing not only formal organizations and legal frameworks but also informal norms, routines, unwritten rules, and decision-making practices that often govern policy processes in practice, particularly in hierarchical bureaucracies [22]. The third dimension examines ideas and narratives, including dominant beliefs, policy paradigms, and societal discourses that influence how health problems are defined and which policy solutions become politically acceptable [23]. Finally, PEA considers broader political and economic structures, such as fiscal conditions, macroeconomic arrangements, dependence on natural resources, demographic pressures, and geopolitical factors that shape the policy environment [24]. Together, these dimensions provide a comprehensive framework for understanding why similar health policies produce different outcomes across countries and institutional settings [25].

Applying PEA fundamentally changes how health system performance is interpreted. Conventional health system analyses often attribute policy shortcomings to technical limitations, including insufficient financing, weak management capacity, inadequate infrastructure, or shortages of skilled personnel [26]. Although these factors are important, they frequently represent the consequences of deeper political and institutional processes rather than their underlying causes [27]. For example, persistent underinvestment in primary healthcare may reflect political priorities that favor hospital-based services, stronger lobbying by urban medical interests, or institutional incentives that allocate resources toward curative rather than preventive care [28]. Likewise, inefficiencies in pharmaceutical procurement or health financing may arise not solely from administrative weaknesses but also from governance arrangements, accountability deficits, and incentives that permit rent-seeking behavior [29]. By shifting attention from what is happening to why it is happening, PEA enables policymakers to identify structural barriers that conventional technical analyses may overlook [30].

The value of PEA extends across every stage of the

health policy cycle. During agenda-setting, it helps explain why certain health problems receive political attention while others remain neglected, enabling advocates to frame issues in ways that resonate with influential decision-makers [31]. During policy formulation, PEA facilitates identification of potential winners and losers, allowing policymakers to anticipate resistance, negotiate compromises, and build supportive coalitions before implementation begins [32]. During implementation, it identifies institutional bottlenecks, organizational resistance, and governance challenges that may compromise policy execution [33]. Finally, during evaluation, PEA provides a deeper understanding of policy performance by distinguishing between technical shortcomings and failures arising from political, institutional, or economic constraints [34]. Experiences from countries such as Thailand, Turkey, and Rwanda illustrate that incorporating political economy considerations can contribute substantially to the successful implementation of complex health reforms, including universal health coverage, health financing reforms, and tobacco control policies [35].

Conversely, neglecting political economy considerations exposes health reforms to predictable risks. Policies that are technically robust may nevertheless prove politically infeasible if they threaten influential stakeholders or fail to account for institutional realities [36]. Even reforms that initially achieve measurable success may lose momentum because of changes in political leadership, fiscal pressures, bureaucratic resistance, or declining stakeholder support [37]. Furthermore, the absence of systematic political economy analysis limits institutional learning, as the political determinants of previous policy successes and failures remain insufficiently documented and therefore cannot inform future reforms [38]. Consequently, integrating PEA into health policymaking should be viewed not merely as an analytical enhancement but as a fundamental requirement for designing policies that are both technically effective and politically sustainable.

The necessity of using political economy analysis in Iran's health system

The need to integrate PEA into Iran's health system is rooted in the country's distinctive institutional, economic, and political context. Although many health systems face governance challenges, Iran presents a particularly compelling case because multiple structural factors simultaneously influence health policymaking and implementation [38]. These factors include institutional fragmentation, fiscal uncertainty, political discontinuity, and the influence of organized interest groups, all of which interact to shape policy outcomes beyond what technical analyses alone can adequately explain [39].

First, Iran's health governance is characterized by a highly fragmented institutional architecture [40]. Unlike health systems in which policymaking authority is concentrated within a single organization, responsibility in Iran is distributed among multiple governmental and quasi-governmental institutions [41]. The Ministry of Health and Medical Education (MOHME) shares responsibilities with organizations such as the Plan and Budget Organization (PBO), the Social Security Organization (SSO), military health services, charitable foundations, and several public insurance organizations, each possessing distinct legal mandates, financial resources, and organizational priorities [42]. Although such institutional diversity can potentially increase system capacity, it also creates substantial coordination challenges, overlapping responsibilities, and competing policy priorities [43]. Consequently, reforms frequently depend not only on technical quality but also on the ability to negotiate institutional interests and build consensus among multiple decision-makers [44]. PEA provides a structured framework for identifying these actors, understanding their incentives, and anticipating potential sources of support or resistance before reforms are implemented.

Second, the structure of Iran's economy reinforces the need for political economy analysis [45]. The country's dependence on oil revenues, combined with prolonged economic sanctions, exposes the health sector to persistent fiscal volatility and uncertainty [46]. Currency depreciation substantially increases the costs of imported medicines, medical technologies, and pharmaceutical raw materials, while periods of fiscal constraint often require governments to make difficult budgetary trade-offs among competing sectors [47]. These decisions extend beyond technical budgeting exercises because they involve political choices regarding resource allocation, distributional priorities, and protection of vulnerable populations. Consequently, policies designed under assumptions of stable financing may become difficult to sustain when economic conditions change [48]. Incorporating PEA into the policy process enables decision-makers to consider fiscal risks, identify politically acceptable financing strategies, and develop contingency plans for periods of economic instability [49].

Third, political dynamics substantially influence the continuity and sustainability of health reforms in Iran [50]. Changes in political leadership and administrative priorities may alter the direction of health policies, affecting implementation even when reforms are technically well designed. The Health Transformation Plan (HTP), introduced in 2014, illustrates this challenge [51]. The reform achieved important early improvements, including reductions in out-of-pocket expenditure and expansion of hospital services [52]. However, its longer-term implementation was increasingly constrained by fiscal pressures, institutional disagreements, and changing political priorities. Although these challenges cannot be attributed solely to the absence of political economy analysis, they illustrate how insufficient attention to stakeholder incentives, long-term financing arrangements, and institutional ownership may undermine policy sustainability [53]. A systematic PEA conducted during

policy design could have helped identify potential risks, strengthen stakeholder engagement, and support mechanisms that enhanced resilience across successive political administrations.

Finally, the influence of organized interest groups further demonstrates the importance of PEA within Iran's health system. Stakeholders including pharmaceutical manufacturers, medical equipment suppliers, private healthcare providers, and professional medical associations, and influential semi-public entities such as military-affiliated health organizations, possess varying degrees of influence over policy decisions through their technical expertise, organizational capacity, and established relationships with policymakers [54]. Their participation is an inevitable component of health governance; however, differences in bargaining power may lead to policy outcomes that do not always align with broader public health objectives [55]. Decisions concerning physician payment mechanisms, pharmaceutical pricing, insurance benefit packages, and specialist workforce planning are therefore influenced by both scientific evidence and stakeholder negotiation [56]. The presence of military-affiliated health organizations, which operate across pharmaceutical production, medical equipment supply, and service delivery, adds an additional layer of complexity to health governance in Iran. These entities often possess substantial financial resources, political connections, and operational autonomy, making their interests particularly influential in policy decisions. PEA offers a systematic approach for making these relationships more transparent, identifying potential conflicts of interest, and strengthening governance mechanisms that promote accountability and balanced decision-making.

Taken together, these institutional, economic, political, and stakeholder-related factors demonstrate that the principal challenges facing Iran's health system cannot be fully understood through technical analysis alone. Rather, they reflect interactions among governance structures, political incentives, and economic realities that shape the feasibility, implementation, and sustainability of health reforms. Recognizing these dynamics provides the rationale for moving beyond diagnosis toward practical institutional solutions, which are discussed in the following section.

Practical pathways for institutionalizing PEA in Iran

Recognizing the importance of PEA is only the first step; the greater challenge is translating this perspective into routine policymaking practice. Many discussions acknowledge the relevance of political factors in health policy but provide limited guidance on how political economy analysis can be systematically incorporated into existing governance structures. Accordingly, this viewpoint proposes four complementary pathways that are both institutionally feasible and responsive to the specific characteristics of Iran's health system. Rather than representing isolated interventions, these pathways should be viewed as mutually reinforcing mechanisms that collectively strengthen evidence-informed and politically feasible policymaking.

Introduce a mandatory political economy annex for major health policies

The first priority should be the institutionalization of political economy assessment within the policy development process itself. One practical mechanism would be the introduction of a mandatory Political Economy Annex accompanying all major health policy proposals submitted to national decision-making bodies. Similar to fiscal or regulatory impact assessments, this annex would require policymakers to evaluate the political and institutional context before implementation rather than after challenges emerge. The annex should systematically assess stakeholder interests, potential sources of political support and opposition, institutional barriers to implementation, and fiscal or governance risks that could threaten policy sustainability. Embedding these questions into routine policy preparation would encourage policymakers to anticipate implementation challenges at an early stage instead of responding to them reactively. To ensure quality and prevent tokenism, the annex should be reviewed by an independent technical committee comprising experts in political science, public administration, and health policy before the proposal is submitted for final decision. Rather than creating unnecessary administrative complexity, such an approach could improve decision quality by ensuring that technical evidence is interpreted alongside political feasibility.

Establish a permanent political economy advisory unit

Institutional capacity is essential if PEA is to become a routine component of health governance rather than an occasional analytical exercise. For this reason, establishing a permanent Political Economy Advisory Unit within the Ministry of Health or the Secretariat of the Supreme Council of Health would represent an important institutional investment. Rather than serving as another administrative department, the unit should function as a strategic advisory body responsible for producing political economy assessments, monitoring stakeholder dynamics, identifying emerging implementation risks, and preserving institutional memory across successive administrations. Maintaining such expertise within government would reduce dependence on ad hoc external consultations while improving policy continuity despite changes in political leadership. To increase the feasibility of establishment and reduce bureaucratic resistance, the unit could initially be anchored within existing structures such as the Secretariat of the Supreme Council of Health or the Deputy for Planning at the Ministry of Health, thereby leveraging existing mandates and avoiding perceptions of creating redundant bureaucracy.

Build human capacity for PEA

Institutional reforms cannot succeed without individuals who possess the knowledge and skills necessary to implement them. At present, most health managers in Iran receive extensive training in medicine, public health, or health services management but relatively limited exposure to stakeholder analysis, institutional governance, negotiation, or political strategy. Consequently, capacity building should be regarded as a central component of institutionalizing PEA rather than a supplementary activity. Training initiatives could be tailored to different professional groups. Senior policymakers would benefit from executive programs emphasizing political leadership and strategic decision-making, while policy analysts, senior advisers, and mid-level managers could receive structured training in applied political economy analysis, focusing on stakeholder mapping, conflict negotiation, and institutional diagnostics. Long-term sustainability would also require integrating PEA into graduate curricula in public health, health policy, and health management, thereby preparing future generations of policymakers to routinely incorporate political and institutional considerations into health policy analysis.

Strengthen policy–research partnerships

A persistent challenge within Iran's health system is the limited interaction between academic research and practical policymaking. Although universities generate substantial health policy research, much of this evidence remains insufficiently connected to ongoing policy processes and implementation challenges. Strengthening long-term partnerships between academic institutions and health policymakers would help bridge this gap. Collaborative research agendas, researcher secondment programs within governmental organizations, joint policy dialogues, and funding mechanisms that prioritize politically informed implementation research would enable evidence generation to become more closely aligned with real policy needs. Such partnerships would also encourage continuous learning by ensuring that political experiences from previous reforms are systematically documented and incorporated into future decision-making.

Moving from recommendations to institutional change

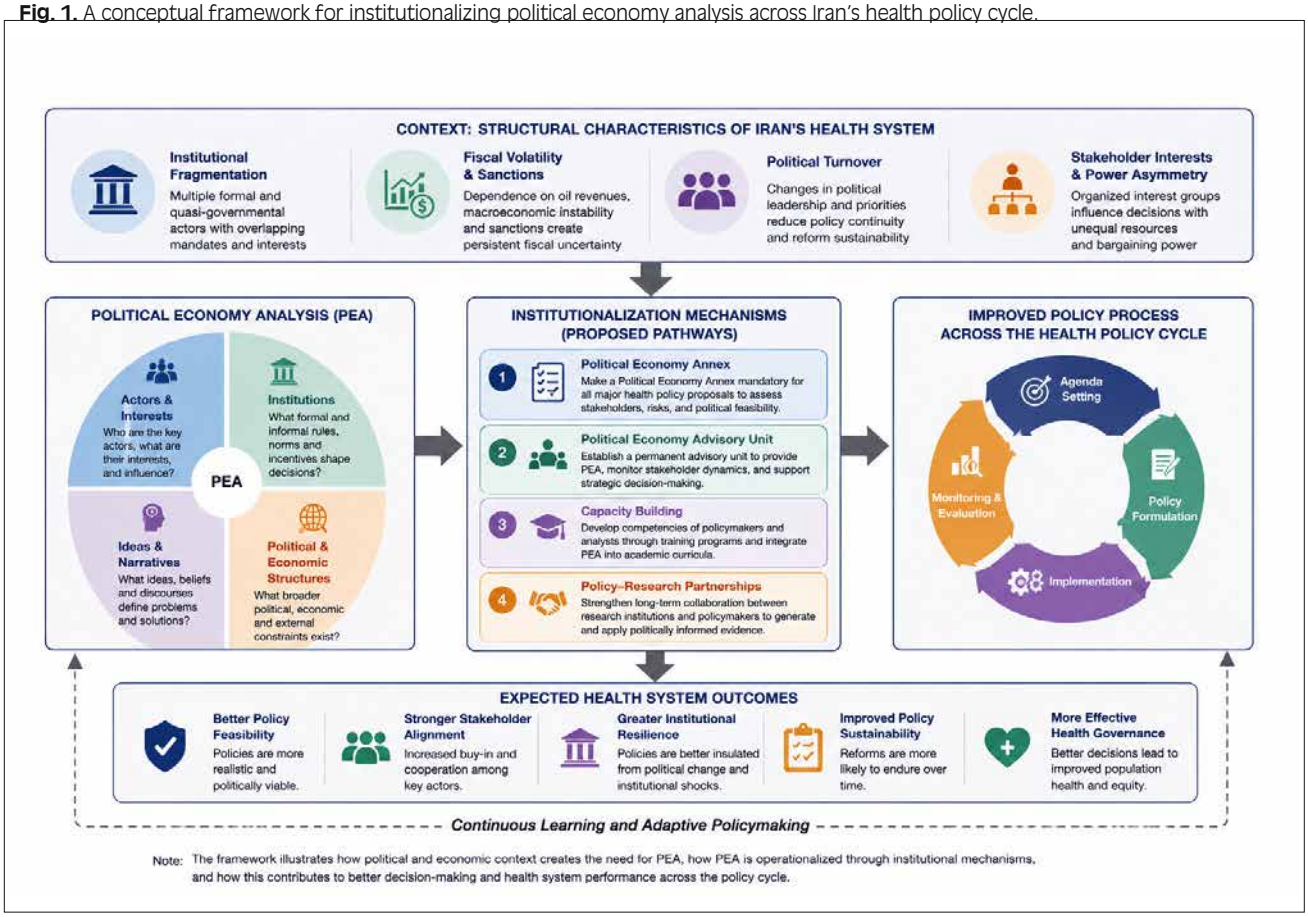
Implementing these reforms will inevitably encounter institutional resistance, competing organizational priorities, and resource limitations. However, these challenges reinforce rather than weaken the rationale for adopting political economy analysis, since they illustrate precisely the governance dynamics that PEA is designed to identify and address. Accordingly, institutionalization should be approached incrementally. Early efforts might focus on pilot implementation of the Political Economy Annex and targeted capacity-building initiatives before expanding toward permanent institutional arrangements and broader research partnerships. A phased strategy would allow policymakers to demonstrate early benefits, build stakeholder confidence, and generate the institutional support required for longer-term reform. As an initial concrete step, we recommend piloting the Political Economy Annex for one major upcoming reform, such as the revision of the national health insurance benefit package or the development of the next national health development plan, to demonstrate its value, generate actionable insights, and build momentum for broader institutional change. Ultimately, institutionalizing political economy analysis should not be understood as adding another bureaucratic requirement to health policymaking. Rather, it represents a shift toward a more comprehensive model of policy analysis in which technical evidence, institutional realities, and political feasibility are considered simultaneously. Such an approach is essential for improving the durability, legitimacy, and effectiveness of health reforms in Iran.

Figure 1 illustrates the conceptual framework proposed in this viewpoint. The framework demonstrates how the structural characteristics of Iran's health system, including institutional fragmentation, fiscal volatility, political turnover, and stakeholder power asymmetries, create the need for systematic PEA. PEA, operationalized through the assessment of actors, institutions, ideas, and political-economic structures, is translated into practice through four institutional mechanisms proposed in this article: a political economy annex for major policy proposals, a permanent political economy advisory unit, capacity-building initiatives, and policy–research partnerships. Collectively, these mechanisms strengthen decision-making throughout the health policy cycle and contribute to more feasible, resilient, and sustainable health policies.

Conclusion

This viewpoint has argued that many of the persistent challenges confronting Iran's health system cannot be adequately understood through technical analysis alone. Institutional fragmentation, fiscal uncertainty, political transitions, and stakeholder interests interact in ways that shape the feasibility, implementation, and sustainability of health reforms. PEA provides a systematic framework for understanding these interactions and complements conventional evidence-based policymaking by incorporating the political and institutional realities within which health policies are developed. Rather than viewing political economy analysis as an additional analytical exercise, it should be considered an essential component of health governance. Institutionalizing PEA through routine policy assessment, dedicated advisory structures, capacity-building initiatives, and stronger policy–research partnerships would improve the ability of policymakers to anticipate implementation challenges, manage competing interests, and enhance the long-term sustainability of health reforms. The recommendations proposed in this viewpoint are intended as practical and incremental steps rather than comprehensive institutional reforms. Their successful

Fig. 1. A conceptual framework for institutionalizing political economy analysis across Iran's health policy cycle.



implementation will inevitably depend on political commitment, organizational learning, and sustained collaboration among policymakers, researchers, and other stakeholders. Nevertheless, integrating political economy analysis into the health policy cycle represents an important opportunity to strengthen governance capacity and improve the effectiveness of future health reforms in Iran. Ultimately, strengthening health policy requires not only better and more relevant evidence but also a deeper understanding of the political and institutional contexts in which evidence is translated into action. Embedding political economy analysis within routine policymaking can help ensure that future reforms are not only technically sound but also politically feasible and institutionally sustainable. As a first step toward this vision, we recommend initiating a pilot application of the Political Economy Annex for a forthcoming major health policy decision – such as the revision of the national health insurance benefit package or the formulation of the next five-year health development plan, to generate practical experience, demonstrate value to decision-makers, and create momentum for sustainable institutional change.

Acknowledgements

The authors would like to thank colleagues and anonymous reviewers for their valuable comments on earlier drafts of this manuscript. The authors also acknowledge the contributions of the broader health policy research community whose work on political economy analysis has informed this viewpoint. No specific individuals or organizations provided funding or support that requires acknowledgement beyond this statement.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors conducted this work as part of their academic and professional responsibilities without external financial support.

Ethics approval and consent to participate

Not applicable. This manuscript is a viewpoint article that does not involve human participants, human data, or animal subjects. No original empirical research was conducted, and therefore ethical approval was not required.

Consent for publication

Not applicable. This manuscript contains no individual person's data, images, or identifiable information. No consent for publication is required.

Availability of data and materials

Not applicable. This viewpoint article presents conceptual arguments and policy analysis based on previously published literature. All sources cited in this manuscript are publicly available in the academic literature and are referenced accordingly. No new datasets were generated or analyzed during this study.

Competing interest statement

The authors declare that they have no competing interests. No financial or non-financial conflicts of interest exist that could have influenced the content, analysis, or conclusions presented in this manuscript.

Authors' contributions

MM conceptualized the theoretical framework and critically revised the manuscript. MeB and AB contributed to the contextual analysis, developed practical pathways, and drafted the initial version. SA and AB contributed to the literature review and provided critical revisions. MaB supervised the project, contributed to conceptualization and design, and finalized the manuscript. All authors read and approved the final manuscript.

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Received on June 18, 2026. Accepted on June 25, 2026.

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How to cite this article: Martini M, Behzadifar M, Azari S, Bakhtiari A, Behzadifar M. Embedding political economy in Iran's health policy cycle: necessity and pathways. J Prev Med Hyg 2026;67:E263-E271. https://doi.org/10.82082/2421-4248/jpmh2026.67.2.4009