The challenges of rural family physician program in Iran: a discourse analysis of the introduction to criticizing power imbalance between rural health and mainstream urban health

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Abstract

Compared with many metropolitan residents, Iranians living in rural areas have a poorer health status partly due to the inequitable access to healthcare services. However, despite policy efforts to ameliorate the disparities, the gap in healthcare between rural and urban residents is growing wider according to several published studies. Among the fundamental causes of these disparities, dominant discourses play a critical role. This paper seeks to unpack the relations of power operated by socio-politically constructed discourses around rural health-promoting interventions, including rural Family Physician Program (FPP). We adopted a Foucauldian Discourse Analysis (FDA) to examine how well-intentioned efforts to advance equity policy may unintentionally maintain discourse and practices that reinforce inequity. We followed the analytic steps, outlined by Carabine, for distinguishing discourses in order to select and analyze 25 documents, 31 interviews, and 21 observations. The analysis revealed three interconnected discourses with supporting roles constructed in opposition to the putative role of the designed program: the rural FPP to achieve the government's ideological purposes about justice and equality (the discourse of deficits), the rural FPP to align with the urban-oriented medical curriculum (the discourse of career disadvantages) and the rural FPP to represent discipline perceptions about rural communities (the discourse of rural inferiority). These oppositional role constructions can hinder the proper functioning of this policy, usually in favor of urban claims on rural space.

Keywords Rural FPP · Power relations · Dominant discourses · Rural/urban disparities

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Introduction

Over the last four decades, the Iranian government has made efforts to implement various programs to solve rural health problems- the difficulties associated with providing accessible health services, recruiting staff, and providing quality healthcare. The rural Primary Health Care (PHC) networks were one of the most comprehensive and robust national programs across the rural areas (Fig. 1). Following the declaration of Alma-Ata and with the emphasis on the key roles of PHC in achieving health for all and reduction of health discrimination, Iranian government took measures to expand PHC networks in rural areas that actually provides services through health-care centers with various defined referral levels (Sohrabi et al. 2007). The structure of a PHC system relies on three main components: (1) establishing *health houses*¹ in remote and sparsely populated villages; (2) staffing the health houses with health workers, known as *Behvarz*² (multi-purpose health care worker), recruited from local communities; and (3) developing a simple but well-integrated health information system (Malekafzali 2009). According to the statistics reported by the World Health Organization (WHO), 95% of the rural population of Iran had access to local

Fig. 1 Organizational structure of the health system in Iran

¹ In the healthcare system of Iran, a health house (HH) is the most comprehensive health unit. At this point, there are 16,000 HHs all over the country, and their major responsibility is to provide primary health care for clients. The effects of these HHs on protecting population's health against contagious diseases, maternal and neonatal mortality, life expectancy, and vaccination have been reported.

² This word is a combination of two Persian words of "Beh" (well-being) and "Varz" (skill). Behvarzes are local staffs who are familiar with rural health needs.

health services delivered in health houses and rural health centers in 2018 (WHO 2019).

If we judge the effectiveness of resources invested in the rural PHC networks by reference to the improvements in the health status of the rural population, despite the good expansion of PHC networks, the results may partly be explained by the good performance with respect to decreasing mothers' mortality, infant and child mortality and control of infectious diseases (Majdzadeh 2012). Notwithstanding the exemplary achievements, many disparities remain in areas such as equity in health care access, universal service package, fairness in financial burden, and trained health workforce. Since then, the PHC networks became gradually weak to respond to the emerging needs of population (such as high burden of non-communicable diseases, increase in public expectation to access qualified physicians, and fast growing and expensive medical technologies) (Naeli and Mogimi 2007). According to the World Health Organization (WHO), as of 2000, Iran ranked 58 in healthcare and 93 in health system performance (WHO 2000). In 2016, Bloomberg News ranked Iran the 30th most efficient healthcare system ahead of United States and Brazil (Du 2016).

Recent interventions include the establishment of the rural Family Physician Program (FPP) and the pilot implementation of the rural insurance in 2005.³ This was a compromise between the Ministry of Health and Medical Education (MOHME), sought to implement FPP in rural areas, and the Medical Services Insurance Organization (MSIO) that was funded by the parliament, to provide universal health insurance across villages in Iran (Takian et al. 2010). The main purpose of this effective health sector program was to maintain and promote the PHC program achievements (Naderimagham et al. 2017). Currently, the total populations of villages and cities with populations less than 20000 have equal conditions and convenient access to health services based on this project (Doshmangir et al. 2017). By the end of 2005, the rural FPP covered more than 25 million citizens living in rural areas and small towns (Khayatizadeh-Mahani and Takian 2014). The rural FPP was responsible for health services within a defined package (service pack⁴), without discrimination of age, gender, social, and economic characteristics and risks of the individual patients, family, community and society under coverage.

A rural FPP, if necessary, should refer the patients to higher levels of service so as to maintain and improve their health; however, they will remain responsible for

³ There are three main insurance schemes in Iran, namely social security, health services insurance, and armed forces. The social security insurance scheme covers a number of civil servants, institutions, and manufactories to name few. The health services insurance includes two funds for civil servants and rural residents. Since March 2005, the government has provided in-patient and outpatient services to rural, tribes, and urban citizens of cities with a population of less than 20,000 through the execution of "Promotion of Rural and Tribal Medical Insurance Plan" and replacement of insurance cards by insurance books; all the premium of these people is paid by the government. This was taken through referral systems, family physicians, and following the elimination of the medical insurance overlaps; the rural insurance fund was established with about 23 million insured.

⁴ Health services package: education, prevention and health promotion, primary care, patient health record, referral, and case follow-ups.

following up the health practices.⁵ The family physician (FP) is responsible for managing the healthcare team⁶ (Sarani et al. 2016). Gradually, this program also failed to promote public health, develop social equity, and establish a universal health care system. Policymakers skillfully coupled the two policies (rural health insurance plan and the rural FPP) and defined rural FPP as the only solution to fulfill public health coverage; nonetheless, the manner in which the policy was formed was the main obstacle to the desired rural FPP implementation (Takian et al. 2011).

Considering the evidence from the two remarkable health reforms in the past four decades and their results, calls for more services, more staff, and more funding along with a growing body of research listing the intractable problems in rural health (Bourke et al. 2010, 2013). Political attention has enabled the state and national government to develop specific policies and the repeated calls for more services have identified the ways in which rural health consumers are disadvantaged in comparison to their urban counterparts (Bourke et al. 2013; Malatzky and Bourke 2016); on the other hand, many residents of Iran's rural and remote communities unfortunately have a lower life expectancy and poorer health status compared with the residents of urban Iran. We argue that these inequalities are relevant to a power imbalance between rural health and mainstream urban health or the dominance of the urban concepts in the health system (Malatzky and Bourke 2016). Here, the marginalization of rural health status in the medical hierarchy and the normalizing judgments was criticized. A growing body of literature provides details on the power relations and the dominant discourses of the rural health in comparison to its urban counterpart over the recent years (Bourke et al. 2010, 2012, 2013; Malatzky and Bourke 2016; Nimegeer and Farmer 2016); however, there is very little empirical evidence to support this perspective in rural communities (notable exceptions include Bourke et al. 2013; Nimegeer and Farmer 2016).

While much of the rural FPP research is characterized by its pursuit of adopting and implementing better health policies in Iran's rural areas, only a part of it is concerned with policy, meaning how policies emerge and are formed and implemented (rural FPP analysis). The policy component of health systems research draws attention not only to the formal content and instruments of health policy (the outputs of decision-making), but also to the forces influencing the decision-making: actors, power and politics, institutions, interests, and ideas (Ghaffar et al. 2016). The way we structure rural health policies today is very much restricted by the power relations working through discourses. Discourses may function as barriers to improving health outcomes and the implementation of equity principles in health policy (Garneau et al. 2019). We attempted to fill this research hiatus using a longitudinal study to uncover and reveal certain

⁵ Stratification of health services: first level of services (the family physician health team/rural health house- rural health center/early detection of diseases, outpatient services and referral of the patient to higher levels of service); second level of services (specialized services/district health center-district hospital/diagnosis and hospitalization); third level of services (more specialized services/district health network/diagnosis and hospitalization).

⁶ Health team: rural FPP staff members in Iran include family physicians working with physician assistants, midwives, nurses, pharmacists, social workers (Behvarzes).

power relations behind the prevalent problems in rural health. Foucault's notions of power/knowledge and discourse provide useful tools for analyzing the mechanisms that re-create and sustain health problems (Alexias 2008; Farrell and Lillis 2013).

Power in rural health

Surprisingly, power a concept at the heart of the health policy process (Raphael and Bryant 2015), is barely explicitly explored in the health policy literature. This illuminates how various rural health actors, including policymakers, academics, and practitioners are disciplined to perceive and act in response to the construction of rural health (Malatzky and Bourke 2016). Power can be defined in many ways, but we draw on the work of Michel Foucault who describes power as a productive force. Rather than being 'possessed' by certain people, power moves through all people's actions and attitudes in everyday life (Foucault quoted in Malatzky and Bourke 2018). Based on knowledge, power makes use of knowledge; on the other hand, power reproduces knowledge by shaping it in accordance with its anonymous intentions (Foucault 1972).

Power relations operate through discourse to guide and normalize particular perceptions and actions (Malatzky and Bourke 2016). Discourses are beliefs, practices, and knowledge that constructs realities and provide shared ways of understanding the world (Lupton 1992). A discourse provides a set of possible statements regarding a given area (such as non-metropolitan areas) and organizes and gives structure to the manner in which a particular topic (such as rural health) is discussed. Some discourses are awarded higher authority by certain cultural groups and are perceived as having greater legitimacy (Jørgensen and Phillips 2002). These dominant discourses are more often than not normalized as common sense (such as normative urban healthcare models), whereas other discourses are marginalized or disdained (such as alternative knowledges) (Fleming et al. 2018). In the rural health sector, the relations of power, through normative urban healthcare, construct dominant discourses that align with deficits, disadvantages, and inferior discourses, all of which can normalize certain actions and health practices as acceptable, guiding people to act accordingly (Malatzky and Bourke 2016, 2018).

In the present article, we examined the current notion of rural Family Physician (FP) reform that is constructed and promoted at the program level (rural FPP) in Iran; its implications were further identify, especially as regards enhancing our current understanding of FPP, which was previously informed by western contexts. After explaining the method, we analyzed the contextual background of Iran's rural health system regarding FPP. Next, the results from the analysis on the dominant discourses on rural health and the rural FPP were presented. This was followed by a discussion and a conclusion regarding the reconstruction of these discourses to change the way in which rural health is currently understood.

Methodology

Approach

This study adopted a discourse analysis (DA) to examine how well-intentioned effort to advance equity policy may unintentionally maintain discourse and practices that reinforce inequity. In agreement with Malatzky and Bourke (2016), the status of rural health and by extension, rural health practitioners, is undermined by the discourses that currently dominate the field. Discourse analysis is conducive to observing how power relations produce dominant discourses and marginalize others in the process of problem framing (Hewitt 2009). Typically, dominant policy-embedded discourse is normalized to such an extent that it is barely called into question. Consequently, policy problems are often accepted at face value and solutions predicated upon those problems often address the symptoms rather than the sources of the problem (Allan 2008; Allan et al. 2009). Discourse analysis necessitates that the researcher view the problem from the “outside” in order to recognize the hidden assumptions and practices that form the discourse formation rules (Hidding et al. 2000; Hewitt 2009). Locating problems in particular discourses helps us see rural places as separate from the problems that beset them. That is, not to locate problems as residing in the lack of resources and distance but in discourses. Employing discourse analysis facilitates an examination of how problems and policies may be so coupled that resonates with the prevailing assumptions of knowledge legitimacy in a particular context (Lennon 2015).

Our approach in this paper was informed by Foucault’s work (Carabine 2001; Parker 1992). According to Foucauldian thinking, discourse is defined here as a ‘group of related statements that are productive (Carabine 2001) they accumulate to produce both meanings and effects in the real world’, or in Foucauldian terms, they have ‘power outcomes or effect’ that define the ‘truth’ of what lies behind an issue (Carabine 2001, p. 268). Discourse refers to the production of knowledge and evolution of practices through language and interaction, with policy embracing a set of tacit assumptions determined by its relationship to a particular situation, social system or ideological framework and representing a struggle over ideas and values (Foucault in Bacchi 2000; Shaw 2010). Here, Foucault is describing the constructive nature of discourse which creates hierarchies that categorize, institutionalize, and dictate the role of people within institutions (Foucault 1972). Discourse analysis in Foucault’s work is less a method and more a series of engagements with historical events and documents that identify techniques and structures through which power is captured, intensified, and directed toward certain productive and profitable ends (Day 2005). Indeed, discourse analysis is deemed as an appropriate approach to illuminating how certain definitions and interpretations of problems and solutions gain influence, not just through linguistic practices but also by being embedded in power/knowledge relations which form a social framework through which ideas are converted into political realities (Hajer 1995; see also Carabine 2001). Four strengths can be discerned from Foucauldian discourse analysis (FDA) of policies and interventions (Hewitt 2009):

(1) it clarifies the mechanisms of governments, institutions, and governance without making any assumptions about institutional boundaries/roles of actors; (2) it uncovers the diverse influences that define a policy problem; (3) it suggests ways of studying the detailed dialogue of policy making and its implementation in order to understand the manifest practices of resistance, collaboration or co-operation; and (4) it exposes the contingent nature of the policy process through debunking the rationality of policy making. We assumed a combined view of FDA of policy making, a perspective that allows for the identification of the policy mechanisms, actors and their opinions, and the dominant discourses through which the power relations are being constructed and integrated into rural FPP in Quchan.

Data collection

Data were gathered from 25 documents, 31 interviews, and 21 observations. Focusing on the current Iranian rural FPP context, this paper examined a selection of key national/provincial documents (legislation and service plans and guidelines) in order to identify the rural health's problems; this was followed by the analysis of a sample of FPP service policies to consider translation at the local level (Appendix 1). To achieve our overall research purpose, the following two questions guided document collection and analysis: (1) How does the Iranian government address rural health's problems in rural FPP? (2) Have the guidelines contributed to the provision of quality healthcare in rural Iran? These documents include guidance, annual work reports, policy papers, and strategic plans by the available websites of the Ministry of Health and Medical Education (MoHME), the Ministry of Co-operatives, Labor and Social Welfare (MoCLSW), Islamic Parliament of Iran (Majlis), Government News Database, Department of Health and Provincial Health Center/Mashhad (DHPHCM), and the Network Health and Nursing Quchan (NHNQ). The findings in these documents were complemented and accompanied by interviews with rural FPP staff members.

The study was conducted in Quchan's rural districts and townships in Khorasan Razavi province, north eastern Iran. The study area was purposively selected as it was among the few 'early adopters' of rural FPP. Moreover, this case study is located within the administrative boundaries of Mashhad city, which has the most optimal healthcare facilities in Iran and the regions. It provides access to a broad range of health services. Typically, Quchan residents spend 2 h commuting in each direction to receive a better service in the city center, where health facilities are concentrated. Due to its proximity to Mashhad city, Quchan can be considered as a notable example of health inequalities. We purposefully identified all of the 19 units offering the primary service levels in Quchan, including 14 rural health houses and 5 rural health centers to represent the diversity of the districts and townships (Appendix 2). Two executive institutions were further selected from the provincial and district levels (Appendix 3).

31 semi-structured interviews were conducted with rural FPP staff members (family physicians, physician assistants, midwives, nurses, pharmacists, and social

workers) and provincial/district executive managers participating in the study. Purposeful and snowball sampling was used to identify the research participants. Interviews are well-suited to discourse analysis since they allow us to examine language in use and draw out the links between texts (in this case the interviews) and societal and cultural processes and structures. The main points of the questions which only served as an interview guide were “Please describe your experience of working within a rural practice context as an FPP staff member/executive manager”, which gradually moved to more specific topics (Appendix 4). The duration of interviews ranged from 20 to 40 min.

Data analysis

We followed the analytic steps outlined by Carabine (2001) to analyze the data generated by documents, interviews, and observations. This approach was underpinned ‘in essence’ by the criteria identified by Parker (1992), hence in accordance with the critical realist position within FDA. The purpose of analyses of such ilk is to identify/describe the particular elements contained within the discourse (which are constituted through text in documents/interviews) and the potential effect that they have (Silverman 2006). Carabine (2001) suggests that locating normalization strategies is an important aspect of discourse analysis because normalization illustrates how power/knowledge operates to inscribe certain thoughts and behaviors within the realm of the normal and the good to direct both the population and the individuals. To assist FDA, Carabine (2001) codified 11 steps (cited in Keller 2013: 54), among which mention can be made of document review (and re-review), identifying discursive strategies and themes, looking for inter-relationships, identifying absences and silences, and continued attention to observations that may emerge during the process. While the process was not followed in a linear fashion, many of the steps identified by Carabine were observed in this study. The analysis was assisted by thematic analysis method (Braun and Clarke 2006). The steps are (modified for this study):

1. Knowing the data and drawing out the discourse:
 - Select your topic-identify the possible data sources;
 - Know your data-read and reread. Familiarity aids analysis and interpretation;
 - Identify the themes-categories and objects of the discourse.
2. Analyzing the nature of the discourse:
 - Look for evidence of the inter-relationships between discourse;
 - Look at absences and silences.

We then interpreted and discussed the integrated finding themes of the data sets through applying Powers’ analytic framework (2013). Powers has described a genealogy to explain the historical and social circumstances of emerging discourses, followed by an analysis of how the discourse functions presently. Similarly, Rawlinson (1987) makes an important distinction, stating that *how* a discourse has *arisen* and *why* its *functions* should be encompassed. Guided by Don’s work (2019), the

gathered data were pulled together into an overall summary and further analyzed for consolidation. The phases are:

- i. *Familiarization* skim reading over the texts in the archive to get the gist;
- ii. *Segmenting the text* using the tools outlined above, the selected texts were read discursively and coded segments were made;
- iii. *Analytic summary* an analytic summary was generated to consolidate the series of text segments. Preliminary themes and subthemes were identified through systematically aggregating the coded segments which were conceptually similar.
 - a. *Summary Analysis of Genealogy* aspects of the analytic summary pertinent to the history, or emergence, of the rural health discourse were summarized;
 - b. *Summary Analysis of Functions* aspects of the analytic summary pertinent to the effects of the rural health discourse were summarized;
- iv. *Interpretation* dominant discourses were identified and within a Powers' framework of analysis, were then subjected to interpretation and discussion. The interpretation was situated within the relevant power relations, both historical and contemporary.

The next section introduces the discourses of emergence through a phased process of analysis. Aligned with the conceptual framework—and in connection with the research purpose, the effects of dominant discourses on rural health were examined. All the phases of an analytical process were performed manually (Saldana 2009).

Results

What was most revealing was how the process of discourse analysis uncovered two contradictory goals. The first reflects the current theories of health and is consistent with implementing health promotion principles in rural healthcare practices. However, these accounts oscillated between second goal which is more representative of a political ideology (see Andersen et al. 2011): equity and social justice. Typically, it particularly focuses on the dominant health promotion discourse strategy when it comes to the description of the rural FPP, but the deficit discourse showed through. Especially, we observed that the rural FPP in Iran does not reflect the promotion of health principles and instead, access to more resources tends to become prioritized. The deficit discourse is originally constituted to create the political artifice of rural health in order to draw attention to the health needs of people living in rural areas and to attract resources to meet these needs (Malatzky and Bourke 2016). Malatzky and Bourke (2016) suggest that it has led to the systematic reinforcement of rural health as the poor cousin of 'normal health', against which it is always 'less than'.

The deficit discourse also intersects with other themes and discourses in this case. Relying on the same theme, a second discourse on rural health has emerged in the rural FPP decisions and the primary care of Iran's ruling. This discourse is characterized by relatively poor working conditions, and it is generally inferior or demeaning social status. Many health workers prefer to work in urban areas due to higher incomes, better living conditions and better educational opportunities for their children.

The rural FPP to achieve the government's ideological purposes about justice and equality/the discourse of deficits

An important dimension of discourse deficits in Iran is its powerful and clear association with the revolutionary motto of enhancing the life quality of the poor and those in rural areas. This discourse is institutionalized in many policies and policy instruments. Former Health Minister Vahid Dastjerdi's speech in 2012 at the unveiling ceremony of the FPP (Document 15), which illustrates the government's ideological purposes to achieve justice and equality (Takian et al. 2011), is a key policy text that establishes an important background for the current discourse.

Before analysis, we briefly present the background of FPP in the context of Iranian medicine history. In line with the Alma-Ata 1978 Declaration and the current global trends in health promotion, the current government announced that it would implement training and education programs for rural communities by achieving the highest academic and professional goals. In her speech introducing the rural FPP, Vahid Dastjerdi called for the need to reform the health care system based on expanding primary care, stating that:

FPP have been implemented in 50 developed countries around the world and have resulted in people's satisfaction, so we are determined to implement it. We have not paid enough attention to global trends in health promotion issues. (Document 15)

This program aims to provide support, help with personal health issues, and enhance the quality of patient care and public safety by promoting health and well-being for the medical profession that cares for all Iran (Document 1). This shift has caused tension in the government because it has traditionally adopted a physical development model of state-run healthcare facilities for distributive justice, where its main task involves equity in access to health services (Khodayari-Zarnaq et al. 2020). A former senior health official stated:

The parliament approved a budget for equipping the rural health system with the aim of reducing the differences between urban and rural areas, and between the public and private sectors. The funding aimed for justice and equal access to health care facilities, rather than the rural FPP or referral system. (Document 24)

The parliament was concerned that if the health system was not upgraded to global standards, it would not be able to meet the emerging needs of the community

Fig. 2 Ministries and organizations involved in the rural FPP in Iran

in a sustainable manner in the future (Document 13). To help ensure the continued progress of the health system, the old mechanisms urgently need to be converted into global trends in health promotion issues (Document 13). A member of parliament stated:

We are currently trying to provide the basics of justice in the health system by implementing the rural FPP and the referral system with a health-oriented approach and paying attention to all aspects of health while improving the health of the family members and the community. (Document 13)

In 2005, the rural FPP was one resulting strategy the government adopted; however, its implementation was delayed due to fiscal constraints and lack of coordination between different departments within the government. Despite these challenges, parliament opened a policy window via rural insurance for all funding (Behbar: rural insurance for all rural residents) and coupling the streams (Takian et al. 2011). This was a crucial measure to revitalize FPP; however, because of the conservative tendencies of the parliament, just as it had in the past—as the driver for physical health approaches and equity in access to health services—was implemented (Fig. 2). Accordingly, redefining rural insurance into rural FPP as a new plan in the health system is critical to ensuring such a transformation. The parliament's decision clearly reflects the ideology of social justice and poverty alleviation, a central principle espoused in health policy perspectives (Document 18, Document 21). Since the announcement of the rural FPP vision, the government has been required by politicians to develop a specific program to address rural health problems (Document 20, p. 12). This new-found 'status' along with the evidence of what rural areas/services lack compared to urban areas/services, reproduced a discourse that rural health is problematic in and of itself (Bourke et al. 2013). By normalizing, the program's output was limited to issuing insurance cards and referring patients to the city to take advantage of professional and private services.

To explore the discourse functions, we relied on the analysis of data from Quchan and written reports that we had elicited and tagged ourselves. As mentioned earlier, these categories are health unit closures, workforce shortage, and lack of access to healthcare services.

According to several interviewees, the rural FPP is in an invalid and suspended status and through guidelines issued by insurance companies are currently being followed. Interviewee #12 stated:

since health service package was defined, most units dedicated to the program are badly equipped and the quality of medical services is poor. This is against the rural FPP standards of practice. (Nurse, rural health center, N 12)

The main purpose of parliament was to achieve the ambitions of an organization in a short and simple fashion; it is necessary that all rural populations uncovered by medical insurance freely enroll with their local FP where their premium is fully paid by the government to the rural insurance fund. Instead of developing primary care in rural areas, insurance providers seek to compensate for the lack of access to healthcare services through transferring villagers to the cities. Interviewee #8 confirmed this image:

Although early disease detection and medicine prescription are within the scope of FP health team practice (first level of services). Lack of some basic equipment in the rural health house has led to otherwise unnecessary referrals. At the same time, after referral to specialized hospitals, most individuals do not report the result to be recorded in their health files. However, given the absence of electronic health records, the order was never fully implemented. (Physician assistant, rural health house: N 3, 8)

The two program implementers have conflicting interests. First, the rural FPP is a task led by the MoHME. It follows an extensive set of rules as part of the National Planning, Programming, and Budgeting framework, in which mobility and accessibility objectives are translated into distinct state-funded infrastructure projects (National PHC Network). The implementation of these projects is commissioned by the Ministry to its operating health networks. The MoHME seeks to promote health through the development of primary care in rural areas. Second, rural insurance is implemented by the MoCLSW through insurance providers in MSIO. MoCLSW aims at filling the gap in access to healthcare in rural areas reflected in facilitating the use of health services in cities through the issuance of insurance cards. Consequently, rural insurance is very much project-based, whereas the rural FPP is performance-based. A district health manager (#25) explained:

Due to a conflict of interest, the FP team has never been fully deployed in rural care settings while Behvarzes (as former employees of the rural health system) only stamp insurance cards to refer villagers to the city. The rural FPP is followed by insurance providers. [Network Health and Nursing Quchan (NHNQ): N 2]

The rural FPP is considered as a stranger in the midst, caught between both conflicting approaches. The current methods implemented ignore the main features of rural FPP, namely health promotion and primary prevention. To resist constraints that have degraded service quality, health workers have to meet other patients' needs beyond their assigned tasks so that public confidence in the program does not diminish. A provincial health expert (#29) mentioned:

The rural FPP is considered as the poor cousin when witnessing the support, equipment, and staffing of urban health centers. The villagers who had fair access to the program's services, complained about the poor quality of the services compared to their peers. Beyond the scope of the program, we have to meet all their needs to satisfy the residents, despite the lack of resources and limited staffing. [Department of Health and Provincial Health Center/Mashhad (DHPHCM): N 1]

In sum, we can conclude that the rural FPP is defined by a deficit discourse, where it is characterized as a facilitator—rather than a direct provider—of health-care services for which insurance companies are responsible.

The rural FPP to align with the urban-oriented medical curriculum/the discourse of career disadvantages

We also found out how deficit discourse makes its way into the “hidden curriculum” of medicine as an implicit understanding that working in the rural FPP is a disadvantageous career pathway (Document 7). The hidden curriculum is defined as a set of influences that function at the level of organizational structure and culture to impact learning (Hafferty 1998). It is comprised of processes, pressures, and constraints which fall outside the formal curriculum and are often unarticulated or unexplored (Stanek et al. 2015). In the hidden curriculum, students learn through what they read, see, and hear about the difficulties of practicing in rural areas (Malatzky and Bourke 2016).

There have been increasing trends in Iranian medical education regarding rural influence on medical universities and the postgraduate training program owing to free medical education and the entry of students from different social backgrounds through a national competitive examination, where all rural areas in Iran benefit from doctors who originally came from that area (Tavakol et al. 2006). Nevertheless, the medical curriculum in Iranian medical universities is traditional; it encourages learning extensive factual knowledge with focus on hospital-based and disease-centered medicine that is deficient in problem-solving skills (Sankarapandian and Christopher 2014). It further provides students with all related theoretical knowledge and clinical skills (Dashash 2013). Generally, graduates are not well prepared to provide primary level healthcare (Document 7, Document 8, Document 9). For instance, the following is an excerpt from an annual work report on the need for medical curriculum reform:

Medical students are unprepared for rural practice. Although these students have been trained in urban environments possibly equipped with the neces-

sary knowledge and skills, there is no substitute for personal experience in rural medicine. Medical universities should generally develop rural training experiences for their students who are considering practice in rural areas. (Document 19, p. 74)

Unfortunately, attention to improvement in general health in government agencies does not seem to match the attention to the improvement of the undergraduate medical curriculum (Tavakol et al. 2006). The medical curriculum generally tends to a curative healthcare model, detached from the larger social, economic, cultural, and political context of people's lives, which largely determines their health (Document 6, Document 7, Document 9). A national health expert stated:

Changes in medical education are important. At present, the primary concern of medical universities is to prepare students for treating patients in specialized hospitals. The addition of community-based education into medical training, where students can be equipped with multidisciplinary skills, should be a vital part of this effort. (Document 11)

General practice is the strongest in small towns and rural areas, where the absence of specialists has created a demand for general practitioners with a broader range of competencies compared with the typical urban general practice (Hays et al. 1997). However, for various reasons, relatively few general practitioners live outside the urban centers (Document 25). A provincial health manager argued:

The rural FPP has multiple care levels, so it needs a team-based organization that can create synergies to provide comprehensive service. The FP team has never been fully deployed in rural care settings, where we witnessed a heavy workload with a low FP-to-resident ratio. (Document 25)

In comparison to hospital-based teaching, FP training is based on problem-solving skills in primary care environment with rational use of investigations and cost-effective management (Raghavendran and Inbaraj 2018). Through FP training, students are bound to learn to apply their clinical knowledge gained in tertiary care to primary and secondary care context and fathom the importance of FP (Sankarapandian and Christopher 2014). For instance, executive guidelines of the rural FPP describe that:

The rural FPP provides specialized education, training, and tools to better prepare students for service in rural, underserved areas. The goal of the program is to provide students with enriched community health experiences away from the academic setting. (Document 2)

To further discuss the discourse of "career disadvantage", we investigated the direct effects of discourse patterns on what medical students deem as rural practice and what it means to go rural through the hidden curriculum.

A strong theme in our interviews was recognition by participants that either felt unprepared or were initially unaware of the special characteristics of rural practice. Interviewee #15 explained:

We came here because of the scholarship. We were not prepared to work in rural care settings, this is inevitable". (Pharmacist, rural health house: N 1)

Interviewee #4 further mentioned:

We never received a formal orientation for the rural FPP by the university. (Midwife, rural health house: N 10)

Most of the practical courses are presented in hospitals and for students unfamiliar with the rural FPP practices. Medical students have been drawn to rural areas through national authorities who want to reinvigorate the existing policies to attract and retain doctors in rural areas in Iran. Indeed, there was a lack of communication among the university, the faculty, and the students in terms of activities during the internship. A provincial health manager (#31) argued:

The medical students understand their own responsibility as future healthcare workers to handle patients in specialized hospitals. They should, therefore, be seen as a resource to use in hospital service delivery. [Department of Health and Provincial Health Center/Mashhad (DHPHCM): N 1]

Medical students are generally united in their perceptions of what constitutes medical professionalism and good medical practice. They usually prefer characters who display technical and empathetic abilities, maintain a balance between work and leisure, and work primarily in direct patient care rather than administration (Weaver et al. 2014). Interviewee #7 stated:

We were trained in specialized clinics and hospitals that provide in-patient care. While a rural resident requires a unique set of skills to attend to the diverse needs, we lack these skills. (Family physician, rural health house: N 2)

They argue that such terms associate rural medicine with a lack of sophistication, as if working in the rural FPP means avoiding complicated medicine.

Many interviewees held that going to rural FPP was entry into the lowest level of care with little growth and specialization. This is problematic for practitioners who are trained in an environment that assigns more value, status, and respect to performing medical interventions. Interviewee #9 explained:

Due to the lack of resources, we provide more primary care at this center-people treat us as inferiors. We only refer rural residents to higher levels of the program in metropolitan areas and confirm their insurance cards to urban professionals. (Social worker (Behvarz), rural health house: N 16)

Interviewee #19:

Prior to signing our contracts, we had different suppositions, I assumed I would have some responsibilities, but now we play the role of a receptionist who confirms the insurance cards and introduces patients to a specialist in district health centers. (Family physician, rural health center: N 19)

In conclusion, the discourse of career disadvantages is expanded with a deficit discourse that argues for what rural health lacks compared to urban health. In

general, these arguments well fit with the established disadvantageous career discourse, seen in the urban-oriented medical curriculum for instance.

The rural FPP to represent discipline perceptions about rural communities, rural life, and rural residents/the discourse of rural inferiority

The government promotes its notion of rural FPP to serve ideological purposes, including outreach to the poor and social justice (first theme) by defining it as a facilitator of patient transfer to urban care centers to compensate for the rural health deficit alignment with the urban-oriented medical curriculum (second theme). Therefore, it is clear that failure to achieve the expected results in providing more resources, improving health outcomes and a larger health workforce and repeating the same text in the following plan indicate the government's poor commitment to some plan aspects provision, especially at a particular time (see Michielsen et al. 2011; Khodayari-Zarnaq et al. 2020). Beyond primary care goals, political attention to developing a specific format of the program to fill the gap between urban and rural areas in access to services along with patient transfer to care centers in cities to compensate for deficits have created an inferior discourse that shape health professionals' thoughts and decisions in relation to working and living conditions in rural areas (Document 23).

People living in rural communities in Iran have a poorer health status and inferior health services compared to those living in metropolitan centers. Iranian-Islamic outreach to the poor and social justice ideology, together with the urban–rural divide, enforces the dichotomy of urban superiority versus rural inferiority (Document 24). Nevertheless, endeavors to employ approaches to equal distribution of health services have normalized the inequality between the urban and the rural rather than fix the problem. Through normalizing dominant discourses, people who live rural areas are constructed as clients to whom it is difficult to provide healthcare (Malatzky and Bourke 2016). They are primitive, uneducated, unsophisticated, disabled, and do not actively engage in healthcare. This is clear when examining health workers' decision and motivations to work in rural areas. A national health expert stated:

Attracting and retaining health professionals to rural and remote areas is the biggest challenge facing our rural FPP today, which makes distributing health care more difficult given the goal of universal primary health care coverage. Looking to advance their careers, health professionals avoid working in the rural community. (Document 5, Document 6)

The proportion of elderly and low-income people in rural areas is higher than in urban areas due to their physical inability and the migration of young rural population to cities. Elders living in rural communities are at a disadvantage in terms of available services, resources, and activities. There is a common assumption that people living in rural communities tend to be similar to each other and not a diverse group in general. For policymakers, rural populations are increasingly older and are less diverse (Document 13, Document 14, Document 16). A senior policymaker stated:

Iranian parliament, together with MoHME and MoCLSW, has a clear responsibility for meeting the health care needs of the increasing number of older people, as 90% of referrals are related to this age group. We should emphasize older people but not neglect the needs of other groups. (Document 20, p. 84)

However, there are also challenges to living and staying in a rural area, such as the healthcare of rural residents. The living conditions in rural areas are worse than those in urban areas, thus it makes it difficult to accept work in rural areas. For example, the policy texts on rural FPP confirm that:

Improving the living conditions for health workers and their families and investing in infrastructures and services are important factors that influence their decisions to move to and remain in rural areas. (Document 4, Document 5)

The absence of direct evidence as to improved rural health infrastructure and living conditions contributes to the increased retention of health workers in rural areas, which is mainly because of the manner in which policies were formed (Takian et al. 2011). On the other hand, there is no ample evidence to support the authorities' contention about the ideological purposes of the Islamic Republic, including alleviating poverty and improving people's standards of living in rural areas.

In what follows, we describe these conditions and their implications at the local level to address the problem of recruiting and retaining health workers in rural areas.

Most interviewees pointed out the difficulties associated with recruiting and retaining health workers, notably doctors, due to concerns about isolation, limited health facilities, or a lack of employment and education opportunities for their families. A district health manager (#27) explained:

Our doctors don't want to come back and work here after their mission is complete, they want to work in the city where life is easier for them and their families. [Network Health and Nursing Quchan (NHNQ): N 2]

For those living in rural areas, these concerns are exacerbated by the geographic isolation that requires them to travel greater distances to obtain services. Additionally, many believe that rural people are unresponsive, non-compliant, and old, which leads to rural practice being deemed as an unattractive prospect for practitioners. Interviewee #1 said:

In line with rural FPP guidelines, we have been working at this unit to provide services at first level and refer clients to second/third level and specialized hospitals; however, the problem is that people that don't want to work with us either don't come to us or they don't register their information when they are referred to the city. In fact, most of the clients here are elderly and uneducated, so it's really hard to discuss these things with them. (Family physician, rural health house: N 9)

In this respect, interviewee #18 stated:

The rural people are also confused about our role in the rural FPP. They refer directly to higher levels and specialists without our referral/or they refer to specialists and specialized hospitals for access to primary care and outpatient services, which is within the scope of our responsibilities at the rural health house. (Physician assistant, rural health center: N 14)

As a consequence, the rural FPP through inferior discourse is caught in a normative model of healthcare that disguises the unique needs of rural communities. While the rural FPP could produce an image of diverse and challenging health practice, rural communities are constructed as homogeneous rather than complex.

Interpretation and discussion

Rural Iranians experience significant health disparities compared to their urban-dwelling counterparts. Health disparities are differences in health outcomes that stem from unequal distribution of or access to the resources that promote good health. To counteract this disadvantage, the Iranian government has established healthcare decentralization programs that have been closely linked to health care reforms and promoted as part of primary health care since 1978. Despite efforts in improving rural access to care, urban populations continue to reflect a higher proportion of access to healthcare services. However, dominant discourses play critical roles in maintaining such challenges and thus health disparities (Malatzky and Bourke 2018; Garneau et al. 2019). Therefore, we focus on the relations of power operating through discourse to construct knowledge of rural health (Malatzky and Bourke 2016, 2018).

Unlike the observations of many other countries that urban vs. rural health inequity is closely associated with uneven distribution of economic and social resources, the rural–urban maldistribution in Iran is more rooted in the slogan of the Islamic Revolution (equity and social justice). After the revolution of 1979, it inherited economic and social infrastructures that were extremely uneven in favor of urban areas; however, the past 40 years, a system of coordination and outreach has been developed to reduce poverty in rural and underserved areas (Of note, the implementation of land reform in the 1960s was the first step in eliminating rural–urban division, but urban-based economic policies in the 1970s stopped well short of closing this goal). The shift toward pro-rural and pro-poor (populist) approach under the Islamic Republic included expanding the infrastructure and basic services—such as electricity and clean water—from cities to the countryside (Salehi-Isfahani 2009; Maloney 2020). The poverty rate declined to less than 10% in 2014 from 25% in 1970s. Iran's ambitious rural health program in the 1980s, which was expanded to include family planning in the 1990s, is widely acknowledged as a successful program and a model for the developing world to reduce infant and maternal mortality and fertility (Salehi-Isfahani et al. 2010). Today, most rural Iranians enjoy access to basic services and infrastructures, whereas the population has almost doubled

and most of the country is urbanized. Pro-poor policies of the Islamic government have expanded basic infrastructures in rural areas; however, these policies have not been as effective in reducing inequality, which, after an initial decline following the Revolution, has remained basically constant in the post-Revolution period (Salehi-Isfahani 2009). This can be explained by some compelling reasons: the Iranian government's overall emphasis on redistribution much more health through cash transfers, such as insurance payments has left the more fundamental determinants of inequality untouched. The various payments have been influenced by the assumption that a shortage of health workforce, infrastructure, and essential medicine causes rural beneficiaries to receive fewer healthcare services than their urban counterparts; therefore, with insurance coverage, they will be able to come to cities to get better services. The government of Iran has demonstrated a groundswell of interest in reducing the unfair distribution of health by investing in health centers in rural areas but keep telling people that the services in health centers are unrighteous and make contacts with health centers and the private sectors in cities. Despite adopting a relatively egalitarian approach to health distribution with the expansion of health networks, access to health opportunities has remained highly unequal. The functionality and utilization of the existing health infrastructure has been sub-optimal or poor. In fact, the normalized dominance of approaches to equal distribution of health services and deficit discourses manifested in health needs and attracting more resources have recreated rural health problems. Therefore, rural health is still considered as devalued, marginalized, or urban's poor cousin. However, the pro-rural and pro-poor rhetoric of the Islamic Revolution was quite distinct from the former regime it replaced, but its actual policies could be found in the toolboxes of most developing countries and international organizations (Salehi-Isfahani 2009; Maloney 2020). The privilege of deficit knowledge in health programs pertaining to the rural health workforce, broader dominant discourses of generalism, and the nature of rural communities has contributed to the persistent health disparities between rural and urban areas (Malatzky and Bourke 2018). In conclusion, the mainstream of the urban health system continues to play a critical role in setting policy directions while also representing the state's discursive position (at a particular point in time) in relation to the rural health system.

Furthermore, there an irreconcilable conflict of interest in relation to the private sector's co-operation with the rural FPP, in which the policymakers have private-capacity interests which could improperly influence the performance of the reforms. In other words, the principal problem of the rural FPP is that people involved in public policymaking receive benefits simultaneously in the private sector. The slogan of the rural FPP and its implementation are two completely different issues: It is often observed that politicians make many slogans regarding the rural FPP, while their behavior shows something else. Specialist doctors, particularly ones who are involved in importing high technology medical equipment, are against the rural FPP, believing it would endanger their profits. They assume that the referral system discourages using such technologies, and as a result their patients would eventually be reduced (Takian 2009). Chain clinics do not agree with this policy due to the huge revenues from the large number of rural people who come to these centers. Furthermore, politicians who are supposed to defend the public sector, behave as though the

quality of services is lower in the public sector, which has led to the destruction of public confidence (Takian et al. 2011). Despite access to free services through insurance coverage, villagers prefer to go to private clinics at a higher price.

By encompassing both the historical (rural–urban divisions in the health system) and the contemporary (private-capacity interests’ policymakers in the health system) dynamics of conflict, this section illustrates that power relations are centralized and coordinated by government agencies and the private sector in commonly cited problems rural health and the rural FPP in particular. In general, power imbalances between the rural and the urban and the related conflicts of interest can hinder the proper functioning of this policy, which is usually in favor of urban claims on rural space.

Conclusions

The purpose of this paper was to understand more about what governs the rural health and rural FPP. Therefore, we started out by presenting the structure of discourses and how they various elements have been articulated through mainstream urban health (Bourke et al. 2010, 2012, 2013; Malatzky and Bourke 2016; Nimegeer and Farmer 2016). Afterward, we demonstrated how these discourses functioned to construct rural practices as deficits and disadvantages, and inferior compared to urban practices (Bourke et al. 2013; Malatzky and Bourke 2016); thus, claiming that rural FPP and overall rural health is undermined by discourses. We treated this academic and political construction of rurality as an exercise of power (Ghaffar et al. 2016; Garneau et al. 2019). To disrupt the operations of power that underscore the deficit knowledge and undermine other knowledge, we need to change the way in which rural health is currently constructed and understood (Malatzky and Bourke 2018). It goes without saying that rural health needs re-production. This will be achieved by a more comprehensive understanding of rural health that is not devalued, marginalized, or urban’s poor cousin (Malatzky and Bourke 2016). Medical schools and residency programs need new approaches to encourage learners to enter and stay in rural practice (Thach et al. 2018). Case-based learning can be used to highlight the unique challenges of rural medicine, particularly when working with limited resources (Hays and Sen Gupta 2003). In addition, allowing medical students to visit and spend time in rural areas and resource-limited environments during their academy and clinical work can help both competence and confidence to thrive in a rural environment. Those working not only in rural health, but also politicians and policymakers have to promote other realities concerning rural health. As demonstrated, rural practice can be challenging and complex, but can have positive outcomes (Veitch and Battye 2008).

The general message of this paper is that a select experts’ strategy, not along with urban concepts, can contribute to adapting rural health programs to the structure and location of their training program. The way we structure rural health policies today is very much restricted by discourses. Understanding the way discourses function and what they take for granted can contribute to generating alternative knowledge such that we can develop rural upbringing and rurally located training.

Appendix 1: Document data

No.	Name of the document	Source	Type
D1	18 versions of the rural FPP	MoHME	pdf document
D2	Executive guidelines of the rural FPP	MoHME	booklet
D3	Expansion of health units' guidelines	MoHME	webpage
D4	Enabling health networks in rural areas	MoHME	webpage
D5	Improving the quality of health services/ Improving living standards	MoHME	webpage
D6	Health work growth model fact sheet	MoHME	webpage
D7	Medical education system	MoHME	webpage
D8	Internship for medical students	MoHME	webpage
D9	In-service training of health workers	MoHME	webpage
D10	The rural FPP recruitment flowchart	MoHME	brochure
D11	Coordinating ways to provide health services	MoHME	webpage
D12	Memorandum of understanding between MoCLSW and MoHME regarding the implementation of the rural FPP	MoCLSW	webpage
D13	Summary of preliminary recommendations of the parliamentary health commission	ICANA (Islamic Consultative Assembly News Agency)	press release
D14	Memorandum of understanding on first level of services between MoHME and Medical Services Insurance Organization (MSIO)	MoHME	webpage
D15	The unveiling ceremony of version 01 of the rural FPP	Government News Database	speech
D16	A review of the rural FPP and referral system	MoCLSW	webpage
D17	Efforts to expand the rural FPP in the country's provinces based on the results obtained in Fars province	Shiraz university of medical sciences	speech
D18	The rural FPP is completely justice-oriented	Government News Database	speech
D19	Annual work reports of the rural FPP	MoHME	report
D20	Policy papers/Critical inquiry in the rural FPP development	MoHME	report
D21	Recognizing the core reasons rural FPP problems	Tabnak Professional News Site	press release
D22	The rural FPP-13 years later	The Islamic Republic of Iran Medical Council (IRIMC)	press release
D23	Publish the results of the rural FPP/Why did the program fail?	Iranian Students' News Agency (ISNA)	press release
D24	Is the rural FPP a priority?	The online version of the Iranian daily Hamshahri	press release

No.	Name of the document	Source	Type
D25	The rural FPP in Khorasan Razavi Province	DHPHCM	webpage

Appendix 2: An overview of rural FPP in Quchan

N	The name of rural and urban health centers and houses	Number of staff members	Number of populations covered	Distance to district health centers	Rural health house	Rural health center
1	Almajugh	4	9835	22	*	
2	Elahian	3	3216	50	*	
3	Imam Gholi	2	2975	40	*	
4	Beyglar	3	2951	30	*	
5	Bajgiran	3	1674	80	*	
6	Daghiyan	2	2827	35	*	
7	Doghayi	3	3900	30	*	
8	Dizadiz	3	5371	18	*	
9	Rahvard/Bajgiran	2	2228	35	*	
10	Sharkohnezh/Mazrag	4	6277	10	*	
11	Quchan Khomeini	6	8616	0		*
12	Quchan Beheshti	6	3012	0		*
13	Quchan Seyyed-o-Shohada	6	4931	0		*
14	Quchan Valiasr	6	4938	0		*
15	Aliabad	3	3969	8	*	
16	Molla Mohammad	2	3758	22	*	
17	Farkhan	2	5225	19	*	
18	Yazdanabad	2	4979	12	*	
19	Quchan Motahari	6	5135	0		*
Total	–	68	85,817	–	14	5

Source Network Health and Nursing Quchan (NHNQ)

Appendix 3: Provincial and local-level administrative health system

N	The executive provincial/district management
1	Department of Health and Provincial Health Center/Mashhad (DHPHCM)
2	Network Health and Nursing Quchan (NHNQ)

Appendix 4: Interview guide

Date and venue
Name and position of interviewee
1. For the purposes of this study, we will let you define what “rural” means. Can you describe it?
2. Is there any component of your learners’ training dedicated to preparing learners for what rural practices like? and also what rural life like? Can you describe them?
3. Are there ways you help learners identify as rural practices? Can you describe them?
4. What elements for rural practices that you think are important? What?

Appendix 5: Coding process

Codes	Categories	Themes
<ul style="list-style-type: none">- The government’s ideological purposes about justice and equality- Transformative view/ pay attention to global trends in health promotion issues- Problematising the health situation of rural areas/normalizing rural–urban health disparities Policy support the rural public insurance program	<ul style="list-style-type: none">- Government ideology/ outreach to the poor and social justice- The rural FPP is defined by a deficit discourse, where it is characterized as a facilitator—rather than a direct provider—of healthcare services for which insurance companies are responsible	<ul style="list-style-type: none">- Combination of ideological views with global trends <ol style="list-style-type: none">1. The rural FPP to achieve the government’s ideological purposes about justice and equality/the discourse of deficits2. The rural FPP to align with urban-oriented medical curriculum/ the discourse of career disadvantages3. The rural FPP to represent discipline perceptions about rural communities, rural life, and rural residents/ the discourse of rural inferiority

Codes	Categories	Themes
<ul style="list-style-type: none"> - Urban-oriented medical curriculum - Hospital-based teaching - The medical curriculum detached from the larger social, economic, cultural, and political context of the people's lives - The recruitment and retention of quality health professionals - The medical students are unprepared or not performed for rural practice - The medical students unfamiliar with rural practice - The medical students are united in their perceptions of what constitutes medical professionalism and good medical practice - The dominant perception that going rural is an entry into the lowest level of care with little growth and specialization - The government's ideological purposes/urban-rural divide - A dichotomy between urban = superior, and rural = inferior - older people/a homogenous picture of rural communities - Health workers notably doctors because of concerns about working and living conditions for themselves and their families/Rural places non-progressive and backward - Rural people are old, stoic, uneducated and do not actively engage in healthcare 	<ul style="list-style-type: none"> - Working in the rural FPP is a disadvantageous career pathway - The government's ideological purposes/urban-rural divide - Urban-rural Inequality in working living standards 	<ul style="list-style-type: none"> - Combination of ideological views and professional view - Homogenous view/apply a normative model of healthcare

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