Post Graduate Certificate Course in Health System and Management - 2013

Module 2: Chapter 1

HEALTH POLICY

Indian Association of Preventive and Social Medicine
Gujarat Chapter

HEALTH POLICY

Learning Objectives:

At the end of this chapter participants will be able to:

1. Understand how a health policy is formed
2. Decisive factors in formation of health policy
3. Comment on health policy of India

What is Policy? ……..

Policy is a system which provides logical framework and rationality of decision making for the achievement of intended objectives.

It is a guide to action, a decision about allocation of resources in relation to priorities.

It is a statement of intension.

It may be set by heads of Govt., Legislatures, regulatory agencies empowered by constituted authorities.

Ministry of Health and Family Welfare, Govt. of India evolved various policies from time to time in India with aims and objectives of better health status of India. The main objective of policy is to achieve an acceptable standard of good health amongst the general population of the country. Govt of India has declared certain policies related to population policy, nutrition policy, drug policies, HIV testing policy, Health policy etc.

Concept of Health Policy:

The prime aim of health policies worldwide has been the maintenance and improvement of the health status of populations. This implies an understanding of human health and disease in order to determine the major biological, political, social, environmental, and lifestyle factors influencing health status and the burden of disease. The risk factors which influence health differ between countries. Thus policies for health will be influenced by different factors in each country and region.

Whilst the least developed countries are still struggling to provide basic health services, the more advanced countries are endeavouring to meet the rising expectations and demands of their population for the most up-to-date high technology diagnostic tools and treatments. Much of the debate on health policy in developing countries revolves around this central issue of making the best use of limited resources in environments in which there is a wide gap between needs and resources, expectations and performance.

The process of policy-making for the health sector has become increasingly intricate. Health practitioners, policy-makers, and planners have to contend with three main issues: diversity, complexity, and change.

Diversity

There is often great diversity within countries, as well as between and within different geographical areas. Ecological and geographical factors account for some of the variation in the pattern of distribution of health and disease but economic, social, and cultural determinants also contribute to the diversity.

Complexity

The explosion of new knowledge and innovative health technologies have markedly increased the complexity of health care. The expanding scope of prophylactic, diagnostic, and therapeutic options demands an increasing range of specific programmes with the associated need for specialist personnel, new categories of support staff, high-technology equipment, and infrastructure.

The complex interaction of medical and non-medical factors in the dynamics of health and disease calls for a critical analysis of needs and opportunities as the basis of designing and managing health programmes. To complement medical inputs from the health sector it is necessary to mobilize intersectoral action because of the important influence of non-medical factors on health, such as: i). agriculture (food security and nutrition), ii). education (especially women's education), iii). waterworks and sanitation, iv). labour and industry (health of workers, pollution).

Change

Policy-making in developing countries has to be fluid and dynamic to adapt strategies and programmes to the many changes that are occurring in the environment.

Epidemiological transition

As in developed countries, developing countries are undergoing epidemiological transition. The traditional health problems, such as childhood diseases and communicable diseases, are declining, whilst chronic diseases, such as cancers, cardiovascular diseases, diabetes, etc., are becoming increasingly prominent causes of morbidity and mortality. Many developing countries present a mixed picture with the persistence of infectious diseases compounded by malnutrition and the emergence of chronic diseases especially among the urban élite.

Epidemics and other emergencies

In addition to this slowly evolving epidemiological transition, more rapid changes occur in the form of epidemics and other acute problems, for example natural disasters (floods, drought, etc.).

Socio-economic variables

Changes in the economic and social situation in the country may have a profound effect on the health sector. Health policies have had to be modified in the light of rapid development in some countries and economic recession in others.

Major challenges and issues:

Policy-making in the health sector of developing countries involves many complex problems. This chapter highlights seven critical issues:
(1) health reform with special emphasis on structural reform and decentralization;
(2) tools for policy-making—assessment of burden of disease, cost-effectiveness, and health accounts;
(3) financing health care—cost recovery schemes, user fees, and private insurance;
(4) public–private partnerships in the delivery and financing of health care and in drug policy;
(5) health research;
(6) international agencies such as the World Health Organization (WHO), the World Bank, the United Nations International Children's Emergency Fund (UNICEF), and bilateral donor agencies;
(7) equity in health.

Health reform: special emphasis on structural reform/decentralization

The rapid advances in health technologies, the increasing demands and expectations of populations, and the escalating costs of health care are challenging governments in both developed and developing countries.

Health reform has been defined as 'sustained purposeful change to improve efficiency, equity and effectiveness of the health sector' (Berman 1995). Governments cannot efficiently manage the delivery of health care in large countries with dispersed populations.

Models of decentralization

The exact details of decentralization vary from country to country. Decentralization involves allocating functions to provincial and local governments as well as defining their relationships with each other and with the central government.

Certain important issues need to be addressed as follows:

a. autonomy
b. financial resources
c. professional and technical capacity
d. information system
e. other health-related sectors
f. relationship with other health-care providers.

Autonomy

In federal states, constitutional authority may provide provincial governments with higher degrees of autonomy than is given to regional health authorities in unitary states. Provincial and local health authorities in unitary states may have the responsibility of implementing services under the direction of the central government with little authority to make changes in the programmes.

Financial resources

Decentralization of health services is generally accompanied by resource flows from the central government to peripheral authorities. The subvention from the central government may represent the bulk of the resources available to the local health authority but some authorities supplement central funds with revenue derived from local taxes and user fees. In general, local authorities that can raise funds through taxation and/or can retain revenue derived from user fees tend to have more autonomy in making decisions and fine tuning health policies to suit local needs.

Information system

Up-to-date information is an essential tool for the management of health services for identifying needs, designing services, and for monitoring performance as well as changes in health status (Rosen 1999). Ideally, the data should be disaggregated by the standard demographic indicators—age, sex, and marital status—but also by variables that may be relevant locally, for example ethnic group, race, religion, etc.

Professional and technical capacity

Local professional and technical capacity is an important issue in decentralized health systems. In order for the devolved services to function efficiently, the peripheral health authorities must have appropriate capacity for planning, implementing, and monitoring services. In particular, they must be able to gather and analyse relevant data as the basis for decision-making and monitoring. Many developing countries are in the process of building such capacity that is available in long established local authorities of developed countries. In any event, even in the most advanced countries, the resources of regional authorities and central government are sometimes required to fill the gaps in local capacity.

Other health-care providers

In addition to the public sector, private providers, both for profit as well as non-profit agencies, are involved in health care. In developing countries, traditional healers still play a prominent role and as in developed countries, practitioners of alternative medicine are also increasingly popular. Local health services relate vertically to regional and central authorities, which provide support for supplementing local capacity both for dealing with emergencies as well as for long-term interventions. They must interact

horizontally with other local health authorities especially those that serve neighbouring areas. By sharing information, they can reinforce their programmes by learning from each other and they can also achieve economies of scale by sharing resources.

Other health-related sectors

The well-known effects of socio-economic and environmental factors on health dictate the need for intersectoral action. National policies in such sectors as education, agriculture, welfare, and environment are translated into action through provincial and local authorities. Decentralization of these health-related sectors would facilitate interaction with their colleagues in the health sector.

Tools for policy-making

Previously, policy-making in developing countries was largely determined by the dictates of influential experts rather than by objective analysis. In the immediate post independence period, some developing countries copy models of health services in developed countries with particular emphasis on the construction of large tertiary hospitals. The high cost of maintaining such establishments often distort the national health budget leaving very little resources for supporting less expensive but highly effective community-based services. Because of severe resource constraints, developing countries should set clear priorities, and adopt policies that would help to achieve maximum improvement in health in return for minimum expenditure.

It was relatively easy to establish priority lists in the traditional epidemiological situation where a few major conditions, mainly acute infectious diseases, accounted for a high proportion of deaths. In such situations, it was possible to rank priorities by considering the mortality rates from specific acute infectious diseases or the prevalence of chronic disabling diseases like onchocerciasis (river blindness). As major epidemic and endemic conditions come under control, the process of priority setting has become more complex. The increasing pressure on policy-makers to base their decisions on sound evidence has led them to use three new types of tools: measurement of 'burden of disease' assessment of the cost-effectiveness of interventions analysis of national health accounts.

Burden of disease

Objective decisions in setting priorities require measurements of the impact of individual conditions and risk factors, and their amenability to control. What is required is an index that would summarize the impact of specific health problems in terms of disease, disability, and premature death. Early attempts to develop a summary index were based on the calculation of the number of useful days of life lost from premature death (mortality) and from disability (morbidity). This approach was further refined to a new measure, the disability-adjusted life year (DALY) which combines losses from death and disability but also makes allowance for: a discount rate, so that future years

of healthy life are valued at progressively lower level) age weights, so that years lost at different ages are given different values .

The WHO and the World Bank collaborated in a venture to measure the global burden of disease . Individual countries are being encouraged to measure their national burden of disease. Measurement of burden of disease using DALYs is proving a valuable tool but is rather a complex operation, particularly difficult in developing countries that lack reliable data about the frequency and distribution of various health problems. In such situations, estimates of DALYs are based on extrapolations from limited studies and rough approximations. However, attempts to calculate the national burden of disease draw attention to gaps in information that can be filled by improvements in the national health information systems. The DALY is proving a useful tool but more work is required to refine and simplify it.

The DALY is used to:

- rank diseases and conditions by the burden of disease;
- estimate the cost-effectiveness of interventions by comparing the cost of averting a DALY.

Cost-effectiveness analysis enables policy-makers to compare different interventions for the same condition and select the interventions that give the largest gain in DALYs per unit cost. It also allows comparison of diseases and conditions by the availability of cost-effective interventions. It may provide clues on how modifications of interventions could make them more cost-effective.

National health accounts

Previously, policy-makers concentrated mainly on spending within the public sector, ignoring private spending through insurance, corporate arrangements, employees' schemes, and out-of-pocket expenditure. Health economists now obtain a more comprehensive view of health expenditures by compiling national health accounts. These analyses attempt to obtain an overview of health spending from all sources—public and private, corporate and personal—into comprehensive health accounts. The results affect the choices made within the public sector but also influence the public role in providing guidelines to the private sector and communities on the most cost-effective uses of their personal expenditure.

Financing health care

The wide margin between the public resources for health and the demands and expectations of the population is a common challenge to health authorities in developing countries. Governments should ensure that there is an adequate level of financing from public and private sources to develop and sustain the essential components of the health services. Macroeconomic policies advocated by the International Monetary Fund and other funding agencies have forced many

governments to trim public spending on health and to reassess the allocation of their limited resources. Under these circumstances, policy-makers are exploring approaches to increase the resources available for health, allocate the limited resources to target priority conditions and groups, and promote equity.

Redistribution of resources

User charges enable the public sector to reallocate the resources by withdrawing subsidies from those who can afford to pay and redirecting the savings to expand cost-effective public health services to the poor.

Public–private partnerships

The crisis in the health sector has induced governments in many developing countries to review the relationship of the public sector to the private sector. Specifically, policy-makers are exploring mechanisms to promote complementary involvement of the private sector in particular with regard to the delivery of health care and the provision of medical supplies. The WHO now strongly supports the promotion of public–private partnerships with the caveat that such partnerships should be mutually beneficial and must always benefit health

Equity

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

Although equity in health is intuitively understood to reflect a sense of fairness and justice, the term is used to refer to related but non-identical concepts covering three main issues:

1. health status of families, communities, and population groups
2. allocation of resources(Vertical Equity)
3. access to and utilization of services(Horizontal Equity)

Health status

Inequalities in health status occur commonly and are regarded as prima-facie evidence of inequities in the health-care system. Significant inequalities in health status are found even in the most affluent developed countries, with long traditions of national health services that are designed to provide universal coverage.

A consistent finding is the strong association between poverty and poor health status as defined by such indicators as the expectation of life, the incidence of acute diseases and injuries, and the prevalence of chronic diseases and disabilities. This consistent association of poverty with poor health strengthens the case in favour of programmes for the alleviation of poverty as important strategies for health promotion.

Allocation of resources

Equity is also examined in terms of the allocation of resources to different sections of the population. On moral and ethical grounds, the objective of allocative equity is for public resources to be shared out in a fair manner.The simplest formula would be a uniform per capita allocation. However, if large differences in health status already exist, an equal allocation would tend to perpetuate the inequalities. It can be argued that it is the responsibility of governments to perform a redistributive function by allocating resources from the more affluent sector of society to meet the needs of lower-income individuals and families, so-called 'vertical equity'.

Access and utilization

Another view of equity is that everyone should have an equal opportunity of receiving care. This so-called 'horizontal equity' proposes that individuals in like situations should be treated in like manner. Access is often defined in terms of the availability of services and its geographical coverage but experience has shown that the potential access, that is the services are within geographical range, does not necessarily correspond to real access as measured by the utilization of services.

Marked disparities are often found in the geographical distribution of health facilities: between regions, between urban and rural areas, between rural areas, and within urban areas. The differential ratios of people per facility—hospital beds, nurses, and doctors—are used to measure the disparities. The distribution of health centres and other institutions in relation to the population—how far people have to travel to reach such facilities—are also used to indicate the uneven distribution of resources.

Optimization of equity

Optimization of equity requires conscious attention to a number of important issues:

1. political commitment
2. policy formulation
3. allocation of resources
4. intersectoral action
5. community involvement
6. information system
7. monitoring of equity.

Political commitment

The political commitment of the government is the essential basis for promoting equity in health . The objective of equity in health fits well with the political philosophy in welfare states that have the clear goal of providing universal coverage of comprehensive health care for the entire population from birth to death. Political commitment is also required to correct the inequities that result from discrimination on the basis of gender, race, ethnic group, and religion. Often, inequalities in health status reflect the marginalization of disadvantaged groups.

Policy formulation

In weighing policy options, a good guideline would be to examine critically the expected impact of the selected option on equity. The formulation of health policies has to contend with a variety of pressures including the increasing demands of populations for more services, the desire to achieve maximal improvement in health of the populations served, and the need to contain costs. Reforms of the health sector aim at improving efficiency, effectiveness, cost-effectiveness, and equity. It is not always easy to reconcile these goals. For example, the delivery of care to the populations in remote areas is relatively expensive and less cost-effective than services to dense urban areas. However, in the interest of equity, health services should reach the underserved populations even in remote settings.

There is increasing recognition of the role of health policy and health systems research in identifying and solving problems on the planning and operation of health services. The Global Forum for Health Research, a new independent entity, focuses specifically on promoting health research with particular reference to the problems that affect the poor.

Allocation of resources

One aspect of equity is that the government should allocate financial resources fairly to the entire population. A simple demographic formula that allocates funds simply on population size may need to be adjusted to take note of the special needs of particular regions; otherwise, the uniform allocation may tend to perpetuate inequalities.

Within the health budget, there is the difficult task of allocating resources to the needs of the various groups within the community. With finite resources, even the most affluent nations have to accept limits to the services that the public sector can provide.

Intersectoral action

The health sector must provide the leadership for mobilizing intersectoral action to achieve these three objectives:

1. policies and programmes to alleviate poverty and social deprivation
2. ensuring that people have the basic requirements for maintaining good health—food, safe and adequate water supply, sanitation, and housing
3. Guaranteeing access to affordable health care.

Community involvement

Decentralized health services need to devise mechanisms for obtaining informed opinions from the whole community through credible representatives of civil society. The involvement of communities in decisions that affect their health care is widely recommended: it does not often work effectively in practice. Even in developed countries, the communities are often unable to participate effectively in decision making because:

- authorities may not consult them
- they lack relevant information
- the society may not be well organized.

Information systems

In order to design services that are equitable and to monitor performance of health services, each health authority needs an appropriate management information system which must include measuring inequalities in health status and inequities in access to health care. The data-collecting instruments must be designed to take note of groups and subgroups especially vulnerable groups whose access to services is restricted by geographical, economic, social, and cultural factors. It should include the usual demographic indicators of age, sex, and marital status, as well as socio-economic indicators like race, ethnic origin, occupation, residence, and other social variables.

Monitoring and evaluation

The health system should include mechanisms for monitoring equity objectively. Interest in measuring equity has generated some useful tools and some valuable experience is accumulating. In the first instance, monitoring equity is the responsibility of health authorities at each level of care. They must build into their service sensitive indicators that would inform them of their performance with regard to equity and access to care.

With its strong commitment to this goal of equity and its accumulated knowledge and experience, the WHO may provide useful guidance to the national programme. Because some of the issues involved are politically sensitive, many governments would not welcome the direct involvement of external agencies in the review process.

National policies related to Health:

1. National Health Policy 2002
2. National Population Policy 2000
3. Nat. AIDS Prevention & control policy 2002
4. National Blood policy 2002
5. National policy for empowerment of women 2001
6. National policy & charter for children 2003
7. National youth policy 2003
8. National policy for old person 1999
9. National policy for person with disabilities
10. National nutrition policy 1993
11. National health research policy draft
12. National policy on education
13. National pharmaceutical policy
14. National policy on ISM & H 2002
15. National water policy
16. National environment policy 2006
17. National housing & habitat policy 1998
18. National conservation strategy & policy statement on environment & development 1992
19. National policy on resettlement & rehabilitation for project affected families 2006.