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Policy Making in Health-care Management: Issues and Challenges

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Abstract

Kerala has become a success and a model for the country, especially in increasing life expectancy as well as reducing infant and maternal mortalities. However, there exists a wide disparity in health-care spending in the country. This disparity can be mainly attributed to the social, political, and economic circumstances prevailing in the states of India. The contribution of Missionary hospitals in addressing this equity gap is noteworthy. An organized movement in health-care sector was initiated by the missionary churches by establishing a variety of health-care formats in Kerala. Among the various stakeholders, the policymakers and leaders have a very relevant and challenging responsibility in envisioning and innovating policies, strategies, and finding creative ways of management and sustainability. This is a descriptive cross-sectional study, done among the missionary hospitals under Catholic Church in Kerala which are registered under CHAI Kerala. The study is limited to ten hospitals from five zones. The data are collected through questionnaire from fifty policymakers of ten hospitals spread all over the State of Kerala. The study shows that there is a significant difference in the satisfaction of policymakers with the health-care management based on their age and association with the institution. There is difference in the leadership quality exhibited by policymakers based on gender. Moreover, there is a significant difference in service quality based on their tenure of association with the institution. Along with sociodemographics, policies, and regulations, social responsibilities were the other factors found as major challenges in health-care management for the policymakers.

Keywords: Health equity, Healthcare management, Leadership, Missionary health care, Policy makers

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Introduction

In the wake of the recent COVID-19 pandemic, UN Labour Organisation recently said, the ability to access affordable, quality, health care has become "a matter of life and death."[1] As a middle-income South Asian economy with almost 1.2 billion population, managing health care in India is a very complex yet important task. In India, health care is managed in state level. As a result, regional variations in health-care quality will happen, depending on the various elements and scenarios, which are area specific. Even though many Indian states have had varied levels of health outcomes, the state of Kerala with almost 33.3 million people, had consistent success rates and health outcomes over the past five to six decades. This has led many writers and economists including Amartya Sen, to call the Kerala state as a model in social development, especially in education and health care. In the recent Human Development Index published in the Ayog Annual Reports 2019–20, Kerala scored the highest score (0.625) followed by Punjab (0.569), based on the 23 health parameters.[2] An organized movement in health-care sector was initiated by the Missionary churches by establishing a variety of health-care formats in the remote areas of Kerala.[3]

Missionary hospitals have a unique way of rendering health-care service in Kerala. Health-care management has come to the forefront of societal life and global well-being, in the scenario of pandemic and other disasters. Economic development could not be perceived without proper health management systems and vice versa. In general, health-care management comprises various stakeholders; health-care policy makers, health-care professionals, hospitals, and patients. Besides, there are various contributors and services working along the system, making the health-care system as it is now. Among the various stakeholders, the policymakers and leaders have a very relevant and challenging responsibility in order to envision and innovate policies, strategies, and to find creative ways of management and sustainability. In this article, the various issues and challenges faced by the policymakers of health-care management of missionary hospitals in Kerala are analyzed and evaluated using scientific tools, so as to give more insights into better health management practices.

According to Deloitte 2020 Global Health Care Outlook, health care today faces challenges of four kinds: financial, strategic, digital, and talent related.[4] Maintaining financial sustainability in an uncertain and changing environment is a challenging task. The contributing factors for financial instability includes rising pandemic levels, aging population, increasing numbers of people with chronic, long-term conditions, rising costs for medical technologies and infrastructure, rising labor costs and shortage of trained health-care professionals, and demand for sustainable, holistic and long term ecosystem of services.[5] As in other aspects of life, the consumers are now demanding more transparency, convenience, access, and personalized products and services in health care. They are not passive as in traditional system, but

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active and informed participants, demanding better care, and involvement in decisions regarding their care plans. Hence, there is a need for innovating new care models, focusing more on prevention and wellbeing rather than cure.

Many scholars had attributed the role of Christian missionaries, especially in the education and health-care development of the state.[6] Along with the government and other social movements, Christianity and Christian missionaries had laid a solid foundation for this Health Care model, taking care of all the sections of the society, especially the poor and the marginalized.[7]

Health-care management of missionary hospitals today is measured using six dimensions; competency of management, multi-specialty care, technological advancement, medical insurance facility, holistic care, and quality of medical education. The challenges of policymakers of missionary hospitals are measured using six variables: policies and regulations, social responsibility, demographics, leadership, and service quality.

The current health system of the state is not equipped to respond to these negative trends, and therefore there is an urgent need for a new thinking and policy reform to take up these challenges so that the health status of the state could be improved. The leadership in health care organizations has the responsibility to bring the organization together and promote better coordination and team spirit. Even though the Christian churches had become one of the major health-care providers of the state, the challenges and impact on this sector had not been studied in detail. The policymakers need to address the issue of equity, access, and affordability, especially of the rural area.[8] Therefore, a study is initiated to analyze the challenges faced by the policymakers of the health-care management of missionary hospitals in Kerala.

Materials and Methods

This is a descriptive study done among the policymakers of the missionary hospitals under the Catholic Church in Kerala. All the hospitals registered under Catholic Health Association of India (CHAI) – Kerala Region, are included in the study. In the CHAI - Kerala region, there are five zones: Central zone, Kottayam zone, Trissur zone, Malabar zone, and Trivandrum zone, covering all the regions of the state. Primary data would be collected by administering structured questionnaires and secondary data would be collected from prior research studies and other existing reports. Two hospitals each from all the five zones were selected, one above 300 bed strength and one below 300 beds, respectively. Therefore, the study is limited to ten hospitals from five zones. Judgmental sampling method is being used or the study. The data are collected through questionnaire from fifty policymakers of ten hospitals spread all over the state of Kerala. The questionnaire for policymakers has emerged from literature review and exploratory study undertaken before the development of instrument.

Study Variables

Sociodemographic factors

Sociodemographic factors were designation, department, association with the institute, total experience, gender, and age. Descriptive statistics of health-care management include competency of management team, multispecialty care, technology updation, medical insurance facility holistic care, and quality of medical education. The descriptive statistics for measuring challenges of policymakers are divided in to five factors such as policies and regulations, social responsibilities, demographics, leadership, and service quality. These factors are evaluated by getting responses on cost of medical education, increase in the number of private hospitals, lack of proper regulatory framework, lack of political commitment, lack of financial support from government, discrepancies in following medical ethics, corruption in the system, less accessibility to rural areas, inadequate education and awareness programs, inequitable health-care costs, improper delivery of free service to the needy, lack of spiritual and emotional care, aging society, consumerism, lifestyle diseases, lack of professionals with management skills, improper succession planning, high expectations of patients, demand for cleanliness of hospital premises, and timely service.

Health-care management of missionary hospitals is characterized by competency of management, technological advancement, quality of medical education, multispecialty care, insurance facility, and the aspect of holistic care.

Competency of management

The health-care system in any country depends highly on how well its managers and administrators are constantly working with their employees to improve the quality of their services, which in turn helps in the improvement of the quality of the life of the citizens.[9] A competent management team is very essential for the effectiveness of the health-care system. The responsibility for managing the healthcare institutions rests with the top management. Most of the top institutions have three layers of top management structure: director, assistant directors, and nursing superintend/administrator.

Technological advancement

Information Technology (IT) has the potential to improve the quality, safety, and efficiency of health care. Complex information and data from different sources need to be integrated in order to provide quality health care. IT allows health-care providers to collect, store, retrieve, and transfer information electronically. IT-based decision support system could help doctors to learn about new treatments and also to understand rapidly changing state of medical knowledge.[10] Health IT allows comprehensive management of medical information and its secure and free flow of information between health-care providers and consumers. Commonly used IT data tools are Electronic Medical Records, Clinical Decision Support, Computerized Physician Order Entry, Electronic Prescribing, Health Information Exchange, Personal Health Record, Remote Monitoring, Telehealth/Telemedicine, Home monitoring of Patients, Clinical Data Processing, etc.

Quality of medical education

The development of good medical services in the country is almost entirely dependent on the medical education imparted in the various medical colleges of the country. In Kerala, Department of Medical Education plays an important role in improving health status of the society. The education and training of the medical students are given under Kerala University of Health Sciences which is instituted in 2010. Among other private medical institutions, the missionary medical institutions have a unique call and mission

to make the medical education affordable and accessible to the poor sections of the society, in the midst of ever increasing cost concerns, especially in terms of medical equipment, human resource, and other government regulations.

Multispecialty care

Kerala is one of the states where out of pocket expenses are very high compared to other states in the country. Major reasons for such a scenario are the higher levels of education, living standards, health awareness, exposure to international health services, and NRI remittances. Kerala offers multispecialty care in most of the health-care formats, and most of the tertiary mission hospitals are providing quality and specialized care which are even comparable to international standards. Kerala has the highest per capita expenditure on health in the country during 2013–14, at Rs.7636. In terms of money spent, the State's average annual expenditure on health is about Rs.25,000 crore, out of which the government's expenditure comes to about Rs.6000 crore, while the rest is private expenditure.[11]

Insurance facility

With globalization and widening up of a liberal economy, many health-care insurance providers offered their services. India is still a growing insurance market. Comprehensive Health Insurance Agency of Kerala, a nodal agency is constituted for the implementation of the RSBY-CHIS health insurance schemes in Kerala. *KARUNYA AROGYA SURAKSHA PADHATHI* is the health-care scheme which aims at providing a health cover of Rs.5 Lakhs/family/year for secondary and tertiary care hospitalization to over 42 Lakhs poor and vulnerable families (approximately 64 lakhs beneficiaries) that form the bottom 40% of the Kerala population. Both public and private insurance schemes and plans enable people to go for even expensive treatments.

Holistic care

Most of the time, people opt for missionary care services, because of the holistic care that those hospitals provide. WHO has also mentioned about the importance of physical, mental, and social well-being in health care. The mission of CHAI Kerala is to provide humanizing care, considering the dignity of the person, and the needs of society. The institutions also pledge to strive for the healing of the total person-physical, psychological, social, and spiritual well-being.

Data Collection Procedure

The data are collected through questionnaire from fifty policymakers of ten hospitals spread all over the state of Kerala. The questionnaire for policy makers has emerged from literature review and exploratory study undertaken before the development of instrument. Hence, the content validity was checked. The content validity is primarily judgmental and intuitive, made with consultation of panel of HR practitioners and management experts. The questionnaire was also reviewed by health-care management researchers to ensure content validity.

Results

In the survey, fifty policymakers from ten hospitals participated; questionnaires were given, filled, and returned. The respondents were divided into three categories with regard to their designation; director (20.0%), assistant director (54.0%), and administrator (26.0%) [Table 1].

The respondents were further categorized into two with regard to their Department: administration (42.0%) and nursing care (58.0%) [Table 2].

Table 3 depicts the sociodemographic characteristics of the respondents with regard to gender, age, experience, and association with the institute. Regarding gender, 60.0% of the respondents are male and 40.0% are female. Age is categorized into three: 31–40 years (28.0%), 41–50 years (66.0%), and above 50 years (6.0%). With regard to the year of experience, two categories are made; 5–10 years (44.0%) and above 10 years (56.0%). The respondents were further categorized into three based on their association with the institute; <5 years (28.0%), 5–10 years (56.0%), and above 10 years (16.0%).

The characteristics of health-care management with mean and standard deviation is depicted in Table 4.

By doing the mean difference of health-care management by policymakers, it is found that, among the demographic factors, only association with the institute sum of square 37.821, df 2

Table 1: Distribution of policymaker's designation

Designation of policy makers	*Number*	*Percentage*
Director	10	20.0
assistant director	27	54.0
Administrator	13	26.0
Total	50	100.0

Table 2: Distribution of policy maker's department

Department	*Number*	*Percentage*
Administration	21	42.0
Nursing care	29	58.0
Total	50	100.0

Table 3: Socio demography details

	n (%)
Gender	
Male	60.0
Female	40.0
Age	
31–40 years	28.0
41–50 years	66.0
Above 50 years	6.0
Experience	
5–10 years	44.0
Above 10 years	56.0
Association with institute	
Less than 5 years	28.0
5–10 years	56.0
Above 10 years	16.0

Table 4: Description of health-care management system with mean and SD

	N	*Minimum*	*Maximum*	*Mean*	*SD*
Competency of management team	50	2	5	3.64	0.749
Multi-specialty care	50	1	5	3.18	1.044
Technology updation	50	1	5	3.34	0.961
Medical insurance facility	50	2	5	3.24	0.847
Holistic care	50	2	5	3.36	1.102
Quality of medical education	50	2	5	4.34	0.717

mean sqaure 18.911, F3.308, and significance difference <0.005 *policymakers age are also having significant difference* [Table 5].

Challenges faced by policymakers in the missionary health-care management are analyzed by five dimensions: policies and regulations, social responsibility, demographics, leadership, and service quality. The mean difference of these five dimensions, only three dimensions were showing that policies and regulations, social responsibilities, and demographics with the institution are significant [Table 6].

Table 7 depicts other two factors are leadership and service quality which has no difference between the above three variables except gender with leadership qualities and service quality with number of years of association with institute.

Table 5: ANOVA Mean difference of health care management with policy makers

Description	*N*	*Mean±Sd*	*Sum of squares*	*df*	*Mean square*	*F*	*Sig.*
Designation							
Director	10	21.80±2.44	6.570	2	3.285	0.515	Ns
Assistant Director	27	20.85±1.96					
Administrator	13	21.08±3.50					
Association with the institute							
Less than 5 years	14	22.43±2.21	37.821	2	18.911	3.308	*
5–10 years	28	20.75±2.19					
Above 10 years	8	20.00±3.30					
Age							
31–40 years	14	21.71±1.82	46.794	2	23.397	4.234	*
41–50 years	33	20.55±2.50					
Above 50 years	3	24.33±2.89					

Table 6: ANOVA test

Institution	*N*	*Policies and regulations*	*social Responsibilities*	*Demographics*
		Mean±SD	*Mean±SD*	*Mean±SD*
ST	50	21.20±2.05	11.00±1.73	11.60±1.14
LF	50	22.40±6.19	9.80±3.35	12.60±3.44
AL	50	25.80±2.28	13.00±2.74	14.60±2.88
KR	50	28.60±.55	16.40±.89	16.00±.71
AM	50	24.00±2.24	14.00±1.41	13.40±.89
SJ	50	27.00±1.41	13.40±1.52	13.20±1.48
NR	50	25.20±1.10	13.80±2.05	12.20±.84
AS	50	22.40±6.19	9.80±3.35	12.60±3.44
HC	50	21.20±2.05	11.00±1.73	11.60±1.14
BZ	50	25.80±2.28	13.00±2.74	14.60±2.88
Sum of mean square		287.920	197.680	93.120
Df		9	9	9
Mean Square		31.991	21.964	10.347
F		3.079	4.168	2.201
Sig		**	**	*

Table 7: Difference of Mean

	N	*Mean±SD*
Leadership - Gender		
Male	30	7.30±1.56
Female	20	5.85±1.81
Service quality - Association with the institute		
Less than 5 years	14	12.86±1.61
5–10 years	28	11.75±1.04
Above 10 years	8	10.50±2.88

Leadership quality between gender Mean 7.30 ± 1.56 for male (30) and female (20) 5.85 ± 1.81, t 3.091, df 48 and it is highly significant <0.05**. According to the difference between service quality with number of years of association with institutions of policymakers, Mean 12.86 ± 1.61 for <5 year-association (14), 5–10-year association (28), mean 11.75 ± 1.04, and more than 10 years of association (8) mean 10.50 ± 2.88. ANOVA test was done for service equality, the mean difference sum of squares 29.056, df 2, mean square 14.522, F 5.645, and significant value is <0.05**.

Discussion

Health equity is a situation where physical, financial, and managerial resources are adequately available to enable every individual a healthy living. In order to achieve this, the resources need to be distributed optimally to cater to various determinants of health (nutrition, housing, water, sanitation, livelihoods, etc.) apart from health care.[12] The low level of public spending on health has been a widely discussed issue in India.[13-16] The private sector expenditure is more than double the government spending. When people are forced to remain dependent on more expensive private providers, missionary hospital plays a crucial role by providing poor population an advantage. The study shows that there is significant difference in the satisfaction of policy makers with health-care management system based on their age and association with the institution. There is a difference in the leadership quality exhibited by policymakers based on gender. Moreover, there is significant difference in service quality based on their tenure of association with the institution. Along with sociodemographics, policies, and regulations, social responsibilities were the other factors found as major challenges in health-care management for the policymakers. Missionary hospitals are characterized by health-care system that is well equipped to overcome these challenges by means of competency of management team, multispecialty care, technology updation, medical insurance facility, holistic care, and quality of medical education. The study suggests that the adoption of an approach to health care based on the health-care system in missionary hospitals in a structured and integrated way helps to narrow the gaps in health equity.

Conclusion

The state of Kerala has a remarkable advantage over other places in various health-care formats and the model of Kerala health-care system is exemplary. The health equity gap visible across India is addressed to a large extend in Kerala through a comprehensive, co-ordinated approach. The dimensions of health-care system followed in missionary hospitals, the sociodemographic characteristics of stakeholders in relation to leadership and service quality, and the challenges faced by policymakers in managing health-care system are analyzed. In terms of narrowing equity gap, the role of missionary hospitals in rendering health services is explored in this study.

Conflict of Interest

The authors declare no potential conflicts of interest with respect to research, authorship and/or publication of this article.

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