

MENAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	HEALTH POLICY ANALYSIS AND DEVELOPMENT
Module: 2.4	ECTS: 0,5
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Keywords	Health policy, health priorities
Learning objectives	<p>After completing this module students and public health professionals should:</p> <ul style="list-style-type: none"> • Understand the steps in creating a health policy (problem identification, research design, research plan, and/or policy paper); • Compare and contrast alternative approaches to health policy development; • Explain the concept and process of health policy development; • Define and illustrate elements of the health policy; • Learn how to assess, in real-life situations, the need for change and the scope for change; • Prepare policy brief/policy paper for arguing certain health policy issue.
Abstract	<p>This module examines the health policy development and in particular the functions of health policy analysis in the policy-making process. The module starts with a short overview of the historical background of policy analysis, which shows that the aim of policy analysis, today as in the past, has been to provide policymakers with information that can be used to solve practical problems. The module continues with a description of the policy development in the health sector. Although policy analysis is an intellectual activity, it is also embedded in a social and political process known as policymaking. Health policies are important because it is what gives content to the practices of the health sector. Policies are expressed in a whole series of practices, statements, regulations and even laws which are the result of decisions about how we will do things.</p> <p>This module contrasts and compares several models of health policy development, each of which captures an important aspect of the complex process of policymaking.</p>

Teaching methods	<p>An introductory lecture gives the students first insight in elements and process of health policy analysis and development. The theoretical knowledge is illustrated by a case study.</p> <p>Before/After introductory lectures students carefully read the recommended advanced readings. Afterwards they discuss the elements of health policy and the process of HP development with other students, especially the designing and planning phase (problem identification, policy options, etc.). In continuation, they need to identify a policy issue, find published materials (e.g. papers), write a short assignment/seminar paper (policy brief, including all its elements) and present their findings to other students.</p>
Specific recommendations for teachers	<ul style="list-style-type: none"> • work under teacher supervision/individual students' work proportion: 40%/60%; • facilities: lecture room; • equipment: LCD projection equipment; • training materials: recommended readings or other related readings; • target audience: master degree students according to Bologna scheme
Assessment of students	Structured essay (policy brief with all elements)

HEALTH POLICY ANALYSIS AND DEVELOPMENT

Neda Milevska-Kostova, Elisaveta Stikova, Doncho Donev

THEORETICAL BACKGROUND

Policy analysis in the policy making process

Public policy and policy analysis

Even though the roots of the policy as science and the policy analysis lay in the political sciences, over the past several decades, public policy has developed in a separate scientific discipline, with policy analysis as its tool aimed today as in the past, at providing policymakers with information that can be used to solve practical problems.

The main purpose of policy analysis is to improve policy making. This is not an easy task, especially when we consider that many of the most important policy changes are gradual, disjointed and incremental; large discontinuous changes are relatively rare and they stem from shocks that are exogenous to the policy-making process, not from a relatively marginal influence of analyses conducted within the process (1).

Among the policy analysts there is an unwritten rule that good policy analysis often yields better policies. In order to make good policy analysis, it is essential to know its rules, elements and procedures that combine it. This module essentially deals with the elements and procedures, but also with the whole context in which the policy analysis would take its place in a most efficient way to give informed and timely positions and opinions to the policy-makers during the process of decision making.

Policy-making and the policy cycle

The process of policy-making is often solely related to the actions of preparation, adoption and implementation of policies; it is associated with policy makers or decision makers as the ultimate power holders to adopt political decisions. But, this complex process is much more than a "galvanistic twitch" (2) - it embraces some hidden aspects of agenda setting through a systematic approach as well as through mobilization of interest groups around particular issue; it involves advocacy and lobbying for stakeholders' most preferred policy alternative at one, and the evaluation and monitoring of the implementation at the other end of the spectrum.

Some authors describe the policymaking as a *reiterative process* often called *policy cycle*. The policy cycle has defined steps which can be repeated, depending on the level of achievement of the goals or satisfaction of the stakeholders; it can also be repeated as many times as the policy process requires in order to establish effective policy, which in reality does happen, even though it is not resource-wise an efficient way of policy making.

Elements of policy cycle

In search for geometric and logical explanation of the otherwise fairly intuitive process, the researchers have proposed a model of policy cycle with defined steps that lead into effective policy making.

Basically, the policy cycle consists of 4 to 6 steps, depending on the level of fragmentation of the steps by various authors. The cycle opens with: a) policy agenda setting; b) issue identification; c) formulation/specification of the policy alternatives; d) decision on the most acceptable/optimal policy alternative; e) policy implementation; and f) monitoring and evaluation of the policy implementation. Additionally, some authors (3) propose that the segment of policy maintenance, succession or termination be separated from the last step, as it is recognized as very important part embedding another round of decision making.

But, the cycle does not have to be started at the agenda setting; it can also commence from the evaluation of previous policy, or it can continue from any given point at which the process has once stopped for various internal or external reasons. Thus, it is very important to understand that policy cycle is a “messy order” of events and actions that eventually lead to applicable solution of the chosen policy problem.

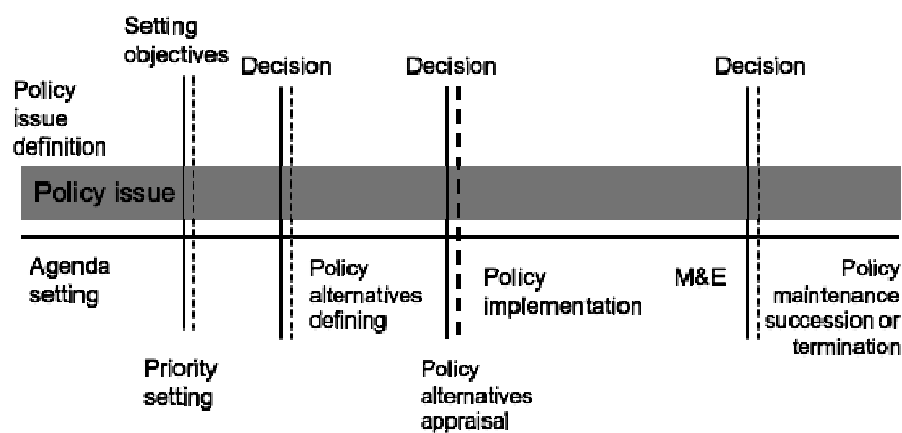


Figure 1. Policy process stages - simplified timeline

Policy agenda setting

The policy agenda setting is by far the most delicate step of all in the policy making process; here, all stakeholders have an open arena for putting forward issues, alternatives and solutions in front of the political power holders. It is often thought that this step is closed and exclusive to the decision makers, but in reality we experience much more interference from other, usually very influential parties, such as the business sector or strong civil society movements.

The importance of this step in furthering one's policy issue higher on the agenda is closely related to the significance of the timing chosen for pushing certain policy issue; there are more and less suitable times for introduction and advocating for certain policy issue. For example, it is very unlikely that the pro-abortion policy will be adopted during a conservative party ruling; it is highly inefficient to push an environmental issue during a nation-wide security crisis at the border, etc. Thus, it is up to the advocates of the policy issue/alternative to assess and wait for an appropriate time to seed it and to expect fertile soil for their position to be grown. These so-called *policy windows* are times when we can expect wide acceptance from both politics and general public, and those are judged and forecasted by experienced policy analysts.

Public interest alone does not guarantee that an issue will be placed on the policy agenda. To be placed on the agenda, policy makers must consider the issue within the purview of government action and deserving of public attention. Many different approaches are used to place an issue at the forefront of the policy agenda.

Enormous influence in the process of agenda setting can be expected from the powerful business sector, depending on the relevance of the issue to their operation(s). However, one should not underestimate the power of the opinion leaders in the society; those are sometimes influential researchers and professionals, think-tank organizations, international community, and of course - the media. As a major source of political information, the media help shape the public's perception of the reality. These perceptions constitute a basis for the public's political activity.

It's very important to emphasize that political parties serve as linkages or intermediaries between the citizens and their government. As Edmund Burke said in 1770 (4), a party is a body of man united, for promoting by their endeavours the national interest, upon some particular principle in which they are all agreed. Regarding his statement, officially and unofficially political parties have a major role in agenda setting process. Party leaders have major role in determining the agenda of the party in advance of an election and than balancing the conflict priorities of various interest groups between elections (5).

Issue identification/specification

Once the issue is set sufficiently high on the political agenda, policy makers must develop a broad policy agenda into specific policy option. It is the process of policy formulation. Policy formulation involves developing alternative proposals and than collecting, analyzing and communicating the information necessary to assess the alternatives and begin to persuade people to support one proposal or another. Policy formulation involves compromising and bargaining in order to satisfy various interests and build a coalition of support. The decision makers are themselves becoming the moving force for solving the policy problem; they seek analyses, opinions and advice from their own or external sources that they find relevant and reliable. It is not unusual for the policy and decision makers to look for several positions before making a decision. Even though, in the newer democracies this process is often ended by selection of the issue among the peers of the ruling government.

This is also a stage at which researchers and professionals should exhibit their views and findings, as the issue identification and its formulation can give way to improper understanding or misleading outcome for the policy.

In policy formulation, information is assembled, arguments developed, and alternatives shaped towards winning the approval of policy makers.

Analysis and specification of policy alternatives

Issue identification requires tough decision by the decision makers; the policy analysis and specification of policy alternatives puts this burden on the shoulders of policy analysts and researchers. Any given issue can be solved in an infinite number of ways, which are dependent on different social, economic, but also political factors. This part of the policy process is very much relying on understanding of the national context and specificities, legal framework and economic potentials of the country, as well as on the degree of political will, mentality of the people and readiness of the social and physical infrastructure.

For example, there may be a significant political will to introduce a smoking ban in the country, but other factors may impede its implementation, such as the willingness of people to understand and accept, potentials of the commercial sector to adapt to the needed standards, and sufficiency of the inspection services to implement the measures

so that the policy will become fully effective. Since, if any of the given factors and pre-conditions are not met, the created *leak of policy* will lead to further anarchical behaviour, lined with diminishing of trust in the government institutions and disbelief in their capacity to implement any policy in the future.

Another important factor when choosing the most optimal policy alternatives to be presented to the decision makers is the forecasted or calculated (in case of sufficient data) fiscal implication of the alternative. It is highly unlikely that the decision makers will choose even a more effective policy solution that places big budgetary burden over another, maybe not as effective but which requires minimal or no budget spending for implementation.

Choosing the most suitable/optimal policy alternative

Any decision maker would not like to be placed in front of one policy solution that has to be taken for granted, based on the judgment of the policy analyst(s). Knowing this, experienced policy researchers will often present at least 2 - most often 3 - policy options on the table; of them, almost without exception the "zero" alternative or the "status quo" policy option is one, as it shows what would happen if the situation of the selected policy remains unaltered, while other circumstances inevitably change with time. An illustrative example would be the analysis of the introduction of electronic health cards, in which the zero option of continuing the practice of paper health records is matched against the developing IT society, in terms of funds consumed by paper use, possibilities for abuse of data, time consumption for communicating health data among institutions, storage space, etc.

In this part of the work, as can be seen from the example, the analysts offer social, economic and political analysis (and forecast!) to the decision makers for each offered policy alternative, while at the end proposing the most preferable one against all mentioned criteria.

In the real world, however, sometimes it happens that the decision makers already have their own preferred solution, even before the analysis is done. This kind of "pre-commissioned" work is referred to as *garbage bin* policy approach (1), in which the solution is known before the problem is identified, or simply - the solution is attached to a problem, for reasons such as political image building, pushing certain group's vested interests instead of public interests, etc. Once the policy has been formulated, statements of government policies and programs are promulgated.

Policy implementation

After another round of difficult decision-making, finally the policy comes to the stage of implementation. Here, the decision makers should be aware (and maybe made aware by the policy analysts) of the necessary infrastructure for proper implementation, or the actions that should be taken to strengthen or enlarge it. Those actions become priority and take immediate execution. This is the test for both the political willingness and the potentials for success of the selected policy alternative.

Implementation involves three activities directed towards putting a policy into effect. The three activities required for implementation are:

- interpretation;
- organization; and
- application.

Interpretation means the translation of the programmatic language into acceptable and feasible administrative directives. These can be laws, regulations, decisions and resources allocation.

Organization requires the establishment of administrative units and methods necessary to put a program into effect. Resources like money, building, staff, equipment are important for implementation of the formulated policy issues.

Application requires the services to be routinely administered.

The process of interpreting and organization to implement policy goals it is often termed *strategic planning*. Strategy planning must be then followed by operational planning and management as a part of the application phase of the implementation.

Yet, putting certain policy in the daylight should go hand in hand with its monitoring and evaluation - for the simple reason of knowing its effects, but also gaps and challenges, as well as possibilities for improvement, once they are identified. The policy analyst again here plays crucial role in walking hand-in-hand with the decision makers, using its forecasting and policy adaptation skills.

Monitoring and evaluation

Each policy-making authority in the country should consider monitoring and evaluation as its integral part, and thus always make sure that there are sufficient resources for their execution. This is often not the case in the newer democracies, so usually even good policies suffer in their implementation, as there is no corrective mechanism to alarm about the faults in the system.

Essential part of the monitoring is setting realistic performance indicators, measuring them and evaluating each one against the expected outcomes of the policy, set during the issue identification and policy analysis stages. The results obtained will serve as feed into the next step, which will be made fairly easy to perform, once the necessary decision-making data is in place.

Deciding the Policy fate: maintenance, succession or termination?

Under the condition that the monitoring and evaluation stages have been properly performed (and this is not to be considered a one-time action!), the decision on whether the chosen policy alternative is to be continued, modified or completely ceased is relatively easy to adopt; if, of course, other political interests are not interfering with the decision. As the later is often the case, the role of monitoring and evaluation is thus more important, as it can strengthen the position against the decision made solely on the political interest base.

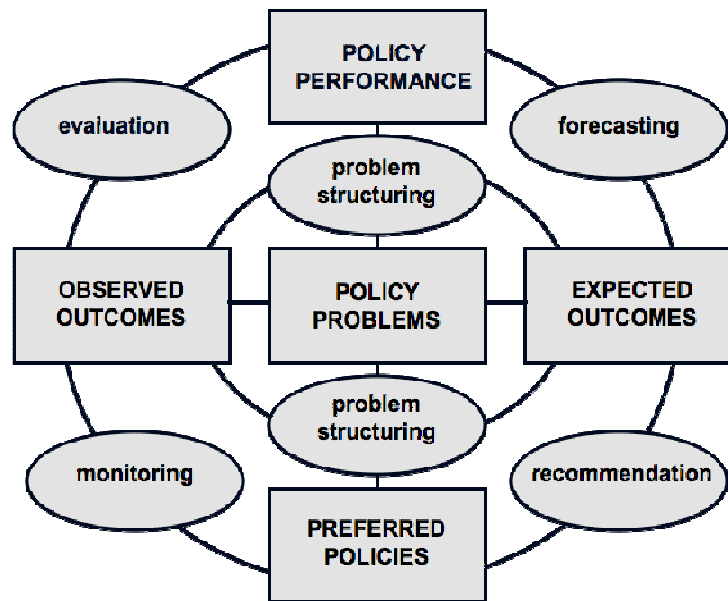


Figure 2. The Process of policy analysis (adapted from Dunn W.N, 2004)

Health policy development

Health policy agenda

In the health sector, the ultimate goal of the policy and decision makers is expected to be the wellbeing of the population, universal access to health services and/or providing better healthcare at optimal budget spending. As this is a very broad definition of a mission of health authorities, it includes infinite number of issues that need to be solved, addressed or improved. So, it is of quite an importance the order by which they are addressed, or the timing at which they are put onto the table. For example, the issue of propagating breastfeeding is not an unimportant one, but it has lower priority over providing health access to the whole population (including the rural areas); not that the healthy diet and nutrition programs are less important, but the vaccination preventive program will certainly be given a higher priority on the government policy agenda; etc. Yet, one should be aware that sometimes some apparently “less important” issues are put on the agenda for different reasons (among which e.g. the political rating improvement), and those policy windows should be used to push forward particular policy alternative(s), ideally optimal for the general public or the vast majority of population.

Major role in setting the health policy agenda is played by the international community, especially in the developing countries. This very noble intention, can sometimes be motivated by the objectives of solving the macroeconomic situation in the country, rather than by the goals of establishing a good system that would provide high quality healthcare; other times, it is related to a trend in the world, that would not necessarily be of high value if applied to an unprepared national context. Thus, it is very important to judge the source of the policy agenda setting, in order to be able to react upon it according to the national priorities and needs in this very sensitive social service sector.

Health policy analysis

In a not much different way from other areas in the society, the health policy analysis is using the methods and procedures as explained above for informing health policy-makers and decision-makers. The political consensus over the importance of a certain issue is much easier to obtain in the health sector rather than, for example in the sphere of national security; thus, here a much bigger challenge is the issue selection, together with the choice of the preferred policy alternative. Health sector being one of those in which there is always relatively higher demand than supply, or much bigger need than resources available, the choice is often difficult to make from the aspect of financial or human resources and infrastructure availability. For example, there is no government that will not agree with the importance of providing equal access to high quality healthcare for all citizens, but the financial limitations will certainly play crucial role in navigating the process.

To this end, the key criteria for the health policy analysis are bound to financial constraints of the country's economy, and overcoming these constraints is elaborated below and in the case study, given at the end of this module.

Key criteria in setting priorities, health policy formulation and alternatives

As said before, one of the key criteria in health policy making is related to the financial constraints or possibilities of the country's economy. Taking into consideration the fact that still the health sector is predominantly perceived as "resource spending" (spending on healthcare) rather than as "resource generating" (building a healthy workforce), this criterion will have the last word in deciding the most optimal health policy alternative (Box 1).

Another, not less important criteria, is that most of the policy makers would like to see in the policy analysis the outreach and the scope of population that would benefit from the given policy. To each policy maker that considers fulfilment of the mission of his/her organization would ask on the magnitude and effects of the policy if applied as priority in the system; he/she will certainly understand a comparison between a policy on drug abuse prevention and vaccination, for example. Choosing one over the other will have to give good arguments and justification for making such choice, in terms of holding themselves accountable in front of the citizens that voted for them.

Last but not least, among the key criteria is the timeframe of achievement of results or visibility of the policy implementation. Short-term objective are always preferred, but a good argumentation of a long-term and strategic goals can lead to choice of a far better solution over just another "headline for this month's journal".

Major players in health policy formulation

Regardless of the efforts of the governments in developing countries, it is an often seen scenario that the major players in setting the policy agenda and health policy formulation are the governments of developed countries or the international community. This is sometimes deliberate, but many times also unintended outcome of bilateral or multilateral agreements and relationships. Offering international or own solutions for local problems heavily bound to national contexts is a common practice among different health sector consultants, projects or programs. Even though made with good intentions, such applications of unadjusted policy solutions can lead to major damages to the health system in one country - and, as health sector is vitally dealing with human lives, such

damages by faulty health policy decisions can have unforeseeable consequences to the nation's economy as well.

<p>Box 1. Criteria for setting priorities in health policy and planning</p> <p>Medical criteria:</p> <ul style="list-style-type: none">◆ Frequency of the disease (prevalence and incidence)◆ Disease duration◆ Seriousness of the disease (consequences, complications)◆ Disease lethality and fatality (rabies, AIDS, tetanus)◆ Needs for problems solving according to professionals' evaluation <p>Economic criteria:</p> <ul style="list-style-type: none">◆ Financial expenses regarding the disease (for doctor service delivery payment, medicaments, rehabilitation etc.);◆ Permanent incapability for work (disability);◆ Temporary incapability for work (absence/absenteeism);◆ Economic rationality and sustainability of investments in finding decision for certain health problem (e.g. construction of water supply and drainage systems, immunization);◆ Financial constraints or possibilities of the country's economy <p>Social criteria:</p> <ul style="list-style-type: none">◆ Particular socio-medical importance of certain population groups (children, students and youngsters, women, workers, elderly people etc.);◆ Possibilities for practical solution of the problem;◆ Possibility for encompassing certain population groups (compactness of the group, for e.g. school children, workers);◆ How much the solution of one problem is independent from the solution of another problems;◆ Timeframe of achievement of results and visibility of the policy and program implementation <p>Human criteria:</p> <ul style="list-style-type: none">◆ Number of people that will benefit from the solution of a certain problem or from the given health policy;◆ Population's requests for finding solution regarding a certain problem;◆ The effects that will be achieved when the problem is resolved (more effects together).
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Thus, it is very important that the health policy is created and structured by researchers and analysts that have profound knowledge of the national context and specificities; imported solutions may be a good base for change, but only if matched against the local background, needs and possibilities.

Advocating health policy

In every policy issue or problem there are a number of stakeholders that have their positions, interests and knowledge or information, and therefore an environment of different pressures is created. In the case of health policy, not only the pressure from the professional community or government can be very high, but also the patients or users of the health system can have strong positions about a certain case, since the health policy is directly influencing their life, lifestyle or living standard.

In the process of advocating for certain health policy, in most of the cases, the first issue that should be addressed is the common misunderstanding of the standing of the patients and medical professionals within the system; as often seen, the medical profession finds itself opposed to the patients, and in fact this is major misinterpretation of the roles of both; the doctors and the patients are on the same side of the coin, as they both work and aim at - better health and prolongation of human life - each in their own role and own way. Once having planted for this, through the selected health issue that is advocated for, the health policy process will much easier move through the labyrinths of its own development.

There are different ways of doing advocacy; it can be both formal and informal, with or without written documents. It can take several months to several years, depending on the readiness of the stakeholders to take into account the opinion of others and listen to their arguments. But, whichever pathway is selected, the key to successful advocacy is to be ready to give up the ownership of the idea (something not very typical in the scientific and research community), to be prepared to hear others advocating for the idea (which helps the process, as it shows acceptance and raised awareness on the issue) and to be open for dialogue objectively accepting other positions and alternatives.

CASE STUDY: PATIENTS RIGHTS AS POLICY ISSUE - CASE OF MACEDONIA

Introduction

In most of the countries of South Eastern Europe prior to the transition there was no single legislation regulating the rights of patients, but those rights were stipulated in several healthcare and healthcare insurance laws and bylaw documents. One of the activities of some of the new EU member-states during the process of preparation for accession in the EU was the adjustment of the health care legislation towards the European legislation and standards. Such was the case with Hungary that in 1997 enacted the New Health Care Act, in which most of the patients' rights are regulated, such as: the right to healthcare, right to be treated with dignity, right to information, right to refuse treatment, right to information privacy, right to leave the health care institution, right to complaint, right to die with dignity, right to participation in decision-making in health care, etc. (6).

Further, the dramatic changes that have taken place in the past decade in Central and Eastern Europe have caused the large inequalities in health to grow even bigger, not only between but also within the countries in the region. This statement can be well backed up with the national health statistics, which "give a stark illustration of the effect of economic crisis and widespread pollution of the environment on the health of whole populations are revealing a growing health divides" (7).

The process was driven by the common health and social policy in the EU, which despite the differences of the national health systems, is placing the same rights of

patients, consumers, users, family members, weak populations and ordinary people at risk. As described in the Preamble of the European Charter of Patients' Rights, "financial constraints, however justified, cannot legitimize denying or compromising patients' rights. The Nice Charter of Fundamental Rights will soon be part of the new European constitution. It is the basis of the declaration of the fourteen concrete patients' rights currently at risk: the right to preventive measures, access, information, consent, free choice, privacy and confidentiality, respect of patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain and personalized treatment, and the right to complain and to receive compensation" (8).

As this process has not been completely undergone by the candidate countries for EU membership, among which the Republic of Macedonia, we have decided to start the process of preparation of the terrain for endorsement of a single legislative document, which will consolidate all existing and newly introduced rights.

The process

Prior to the transition, in the Republic of Macedonia there was no single legislation regulating the rights of patients, but those rights were stipulated in several healthcare and health insurance laws and bylaw documents.

The previously existing healthcare legislation (Health Law of 1970; Law for Healthcare of 1983) has regulated the patients' rights and duties to certain extent. The currently governing Law for Healthcare (1991) is more extensive in regulating these rights. However not all of the rights described in the European Charter of Patient's rights have been regulated.

The Health Care Act of 1991, regulates the functioning of the healthcare system in the country, and consists of the following chapters: (a) the health insurance; (b) rights and responsibilities of the healthcare users; (c) the rights and responsibilities of the healthcare providers; (d) organizational structure of the healthcare system, and (e) financing of the healthcare (9). According to the existing legislation, 8 of the 14 rights were regulated, in one of the mentioned documents.

However, the analysis of the existing legislation regarding the exercising of rights and duties of the patients and of the implementation practices in the country; the following conditions have been identified (6):

- Lack of appropriate and systematized legislation directly regulating patients' rights;
- Insufficient level of implementation of the existing legislation;
- Lack of knowledge and ignorance of patients regarding their rights;
- Non-transparent attitude of the healthcare authorities regarding information of the citizens for their rights (but also duties) as patients;
- Lack of technical support in the healthcare facilities for complete implementation of certain rights of patients, such as the right to privacy and confidentiality of personal and medical data.

The team decided that a health policy in R. Macedonia should be developed following the identified conditions.

Methodology

The first step taken after the situation analysis in R. Macedonia in 2005 was the screening of the legislation and practices in the neighbourhood and in the EU, as ultimate reference for the country's governance. The similar laws adopted in these countries have been taken as samples to start the drafting process of the law.

The questionnaire was prepared based on several sample questionnaires used for surveying of patients' satisfaction in different healthcare facilities. Bearing in mind the

local mentality, practices and the level of trust in the institutions of the system, a number of general questions have been put in the first part of the questionnaire, in order to get the patients' confidence and sense of real involvement in the survey. In order to collect more data for construction of case studies database of this project, the participants have been interviewed by a group of trained interviewers (6).

The sampling technique was the one of multistage sampling; this included the selection of healthcare facilities (the so-called series of clusters), based on the target group (e.g. facilities to which certain ethnicities gravitate), from each of which a random sample of patients has been selected (e.g. patients visiting the healthcare facility on the day of the survey).

Results

Despite the different but very high levels of regulation of patients' rights in the legislation, the implementation levels have been expectedly similar. The interviews reported a situation with the physician-patient relationship even expressed as "the father-physician taking care of the child-patient".

The reasons can be searched in the previous system, but can also be found in the ignorance of the patients regarding their rights. The only survey that was undertaken under this research (conducted in Macedonia on 282 individuals) shows that over 80% of the interviewed are not aware of the benefits from or the mere existence of most of the patients' rights. The most commonly heard of (but not often exercised) is the right to compensation for treatment received abroad; next to it is the right to compensation for the medications on the positive list (heavily subsidized), which have been purchased for a full price in a private pharmacy. The main reason why the 85.8% of the interviewees were not exercising these rights is the complicated and lengthy procedures administered by the Health Insurance Fund, as well as the unclear method of reimbursement.

Apart from these two, the other rights are mostly looked at as obligations. For example, the right to free choice of physician in the primary healthcare (the so-called "maticen lekar", with similar functions as the family physician) is considered an obligation imposed by the law; on the other hand, the more general explanation of the right to free choice of physician is almost prejudicially linked to the visit of a private physician's office (most of which have no contract with the Health Insurance Fund, charging the full price for the health services provided), which can be done without any referral and upon free judgment of the individual. Closely resembling to this is the attitude for signing the informed consent, which for over half of the interviewed patients is just another "administrative procedure".

The survey has confirmed the general notion and the acceptance by the patients of the paternalistic approach in the physician-patient relationship. Among the interviewees, 90.8% are satisfied (56% very and 34.8% averagely) from the services received; over 60% have never intentionally been to another physician or asked for a second opinion. Furthermore, 86.5% are convinced that the physician is prescribing them the best possible medications/therapy that they need, and 93.6% comply, as much as they can afford, with the recommendations and advices given by the doctor.

Even though the right to complain is regulated and guaranteed in the legislation, an astonishing 84-86% has never had any questions or complaints regarding the medical services received or healthcare facility procedures undergone. The background to this is more likely the decreased confidence in the institutions of the system, or ignorance regarding the mechanisms and institutions in which the legal advice or cure can be sought.

The reasons for such high level of satisfaction may be partly related to the structure of the interviewed group; namely, 60.9% have no official job or no job at all, of which 92.2% are covered with basic health insurance through the unemployed benefits system - the basic health insurance which is in no way different than what a regularly employed person receives by regular payment of taxes and payroll contributions to the state budget and to the single Health Insurance Fund (Note: the Macedonian system of health insurance still being in a very initial stage of healthcare reforms, does not have different health insurance policies and health insurance institutions which employees or employers can choose from for better health care coverage).

The comparative analysis of the legislation and regulative instruments in the countries of Southeast Europe and the survey of the level of implementation of the legislation in the Republic of Macedonia, two approaches for improvement of protection and promotion of the patients' rights impose, both involving changes in the legal environment (in terms of improved implementation of the current legislation or introduction of new instruments and mechanisms for exercising patients' rights), combined with other advocacy and public awareness raising activities involving the civil sector.

Alternatives

Following the health policy development process, the results were then transformed into policy alternatives that were offered to the policy maker - the Ministry of Health.

Alternative 1: Improved implementation of the current legislation

This alternative includes changes in the implementation mechanisms of the legislation, but also assuming undertaking public awareness raising activities. One of the main components to protection of patients' rights is the understanding of their violation by both the patient and the physician or the institution.

Moreover, as the patients are usually treated by a team of physicians, nurses, and technicians in a complex, unfamiliar, and sometimes frightening setting, they are often being treated as non-person and thus raising feelings of anonymity and isolation. Because of this the institution-patient relationship is almost equally important as the doctor-patient relationship.

Significant aspect in the improvement of the implementation of the legislation is the enhanced knowledge and perception of the general public but of the health professionals as well, in which the civil sector is expected to play major role - through awareness raising campaigns, offering legal advices and assistance in understanding and utilizing the mechanisms of the system.

The main portion of the costs for implementing this alternative will be related to the public awareness raising campaigns. Yet, a significant portion shall be considered for providing technical support (computers, database servers, software development) for enabling the implementation of certain rights, such as the right to confidentiality, but also the right to information about the medical condition of the patient.

Alternative 2: Improvement of the legislation

A far more complex alternative is the one requiring changes in the current legislation. This means restructuring of the existing healthcare acts for better presentation of the patients' rights in one place (commonly in one chapter of a single law, as seen from the

experiences of the countries in the region), but possibly introduction of new mechanisms for implementation and monitoring of the level of exercising of patients' rights.

One such idea, vastly debated in the health and legal professional communities is the introduction of a separate system of Healthcare Ombudsman, under which patients can sought legal advice and assistance through recommendations for the institutions of the judiciary system. In some countries, like Hungary, and since recently Serbia and Montenegro, each health care setting has an appointed "advocates" responsible for receiving and advising upon patients' claims or complaints. This approach provides first-hand legal aid on the existing mechanisms, but can also serve as a filter for the unjustified claims, thus contributing towards the more efficient implementation of the legislation regarding this very neglected but important legal sphere.

The costs incurring from implementing this alternative are mostly in the setting up and maintaining the newly proposed institutional settings and mechanisms; however, in this alternative as well, some public health education campaigns will be required, mostly in the direction of increasing the knowledge and awareness of the general public both of the existing rights but of the novelty in the system as well. With the current level of reforms in the healthcare system, but in the judiciary as well, it is hard to expect that additional funds can be provided for the implementation of this alternative. Rather, the existing Ombudsman office and its infrastructure can be used for engagement of a specialized health law professional. Also, another low-cost intervention is the public reporting of the Ombudsman about the number and types of claims, which will encourage the patients in a more aware way to accept and exercise their rights, but duties as patients as well.

The process - continued

Based on the results of this initiative from the civil sector, the alternatives offered and the EU directives, in November 2006 the Ministry of Health established a Task Force for preparation of Law on protection of patients' rights, inviting key experts, government and professional community representatives, NGOs and patients' organizations, as well as media representatives to participate in this process.

After almost one year of polishing the differences in the stakeholders' opinions and positions, at professional meetings and public debates and finally in November 2007 the Government adopted the Law and passed it on to the Parliament for final endorsement. In the Parliament, more than 100 amendments were made by the Members of the Parliament; the relevant ones were adopted, and the ones that were not of essential importance or were in collision with other legislation were rejected with sufficient and justified explanation. In February 2008, the Draft-Law was put on the Parliament Agenda for voting.

Advocating Health Policy

The process of advocacy for this health policy was not very different from the one explained in the theoretical part of this module. The issue was perceived as such, that it required strong commitment from the government, but also large support from the professional community; the level of understanding the patients' rights and duties to a point of being able to convert them as the rights and duties of the health professionals was not present, and this needed to be advocated for. Instruments such as policy briefs, informal communication with Doctors' Chamber, Medical Association and other professional organizations were made, together with formal presentations of the concept at scientific meetings.

However, the end result of this health policy development is not the endorsement of this law. It is yet to be confirmed and monitored how it is implemented, whether it should be maintained, improved or simply terminated if it does not show results comparable to the fiscal implications it may have. In other words, this and any other health policy is a continued process with constant need of evaluation and adjustment according to the changing needs and demands of the society and all its segments.

EXERCISES

Task 1

Read the recommended readings before the class. In-class exercise will be to discuss the case study and to determine which part represents which element of the policy cycle.

Task 2

Based on the case study above, select a similar issue on which you might like to make a case for development of health policy. Write a policy paper that would include all elements of the policy cycle. The teacher will use this paper for student assessment.

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RECOMMENDED READINGS

1. Dunn W.N., *Public Policy Analysis* Pearson Prentice Hall 2004, Ch. 2: Policy Analysis in the Policy-making Process, pp. 33-64.
2. Walt G., *Health Policy: An Introduction to process and Power*, ZED Books, London and New Jersey, 2004
3. Milevska-Kostova N. (2006) Patients rights as policy issue in Southeast Europe, Centre for Policy Studies, CEU, Budapest (available at: http://pdc.ceu.hu/archive/00003122/01/kostova_f3.pdf).