# CHALLENGES IN POLICY IMPLEMENTATION

## A METHODOLOGICAL PERSPECTIVE

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## Introduction

Health policies play a crucial role in shaping healthcare systems and improving public health outcomes. However, the effectiveness of these policies depends not only on their design but also on their implementation patterns, which vary across regions and healthcare frameworks. Understanding these patterns from a methodological perspective helps in identifying the key factors influencing policy success or failure.

Methodologically, health policy implementation involves several interconnected components, including stakeholder engagement, resource allocation, evidence-based decision-making, and continuous monitoring. The challenges in implementing health policies often stem from issues such as inadequate institutional capacity, fragmented governance structures, socio-economic disparities, and resistance from healthcare providers or the general public. Additionally, external factors like global health crises—such as the COVID-19 pandemic—have demonstrated how policy responses must be adaptive and grounded in timely, high-quality data to be effective.

This study examines the patterns in health policy implementation, focusing on methodological challenges and real-world case studies that highlight successes and failures. By analyzing these patterns, we can develop a structured approach to improving policy effectiveness and ensuring better health outcomes.

Health policy implementation is a critical aspect of public health governance, determining the effectiveness of interventions aimed at improving healthcare access, disease prevention, and overall health outcomes. While well-structured policies provide a framework for addressing healthcare challenges, their success depends on effective execution, which varies across regions due to differences in infrastructure, governance, financial resources, and socio-cultural factors. A methodological approach to studying health policy implementation helps in identifying recurring patterns, assessing key challenges, and developing evidence-based strategies to enhance policy effectiveness.

## Challenges in health policy implementation

The implementation of a new health policy demands more than providing instructions around a policy document or designing a set of standard operating procedures. Implementation refers to the stage of the policy process immediately after the passage of a law. Implementation science, viewed broadly, means administration of law in which various organization, states, local authorities, procedures and techniques work together to put adopted polices into effect in an effort to attain policy or program goals to better understand the factors that impede or facilitate implementation. For our purpose, implementation can be conceptualized as a process, outputs and outcome. As a process, it is viewed as a series of decisions and actions directed toward putting a prior authoritative federal legislative decision into effect by the state or local authorities or organizations. As an output, implementation can be defined in terms of the extent to which programmatic goals are supported, such as the level of expenditures committed to a program or the number of violations issued for failure to comply with the implementation directive. Policy implementation can be conceptualized as some measurable change in the large problem that was addressed by the program, public law, or judicial decisions.

**Health policy implementations in developing nations**

Health policy implementation in developing nations is a complex and multifaceted challenge, requiring a nuanced understanding of the unique obstacles faced by these countries. Developing nations often struggle to attract and retain qualified medical personnel due to factors such as low remuneration, inadequate working conditions, and limited professional development opportunities. This scarcity undermines the capacity of the healthcare system to deliver quality services, resulting in overburdened facilities and reduced access to essential care. The developing nations faced the challenges such as:-

**Financial Constraints**

- Limited Funding for Health Programs
- Impact on Infrastructure
- Shortage of Medical Supplies
- Economic Factors Influencing Policy Implementation

**Infrastructure Deficiencies**

- Inadequate Road Networks
- Limited Access to Remote Areas
- Importance of Robust Infrastructure for Healthcare Facilities

## CASE STUDY I

### School Health Programme, Nigeria

School Health is defined as the promotion and maintenance of the highest degree of physical, mental, and social well-being of the school population.SH includes a healthy environment, nursing, and other health services that students need to stay in school, nutritious and appealing school meals, opportunities for physical activities that include physical education, health education that covers a range of developmentally appropriate topics taught by knowledgeable teachers, programmes that promote the health of students, school faculty and staff, and counseling, psychological, and social services that promote healthy social and emotional development and remove barriers to students' learning[1]. Schools are described as one of the most productive and least stigmatizing platforms for providing healthcare services for children and staff.[2]

There are 4 levels of prevention that can be facilitated in schools. They are Health Promotion, Disease Prevention, Early diagnosis and Prompt Treatment & Rehabilitation. Students spend a significant proportion of their lives in schools, 8 hrs. per day for 5 days a week, for 6 to 12 years. School health can lead to developing the human capital index of any country. SH is not just about classroom learning, it is about creating policies and programmes that promote a healthy school environment, reinforcing a healthful living.

SHP is a composite of procedures and activities designed to protect and promote the well-being of students and school personnel.[3]SHP is usually integrated with the activities within the homes and community with its success requiring the cooperation & collaboration of the vital functional sectors of the community. SHP can be one of the most cost-effective investments a nation can make to simultaneously improve education and health.[4]

Main objectives:

1) Obtain a rapid and sustained improvement in the health of school children
2) To ensure that children from pre-school age to adolescence are in optimum health at all times, so that they can achieve their physical and intellectual potential

[1] American School Health Association, 2023

[2] Mason Jones et al. 2012

[3] Akani et al. 2001

[4] Gro Bruntland, former Director General, WHO

3) To ensure that the students receive maximal moral and emotional benefits from health providers, teachers and the school environment.[5]

**Nigerian Context**

SH services were first established in the year 1929, by Dr. Isaac Oluwole. A scheme was proposed that would lead to school inspections by medical officers three times a year, throughout the duration of their schooling. It came to the attention of the Christian Council of Nigeria, that there was a high incidence of malnutrition among school children. It urged the Govt. To inaugurate the proposed medical service in schools. In 1952, the Gov. of Western Nigeria published a policy with a four-year plan wherein school medical services would be available and free for all school children. Special clinics were set up for school children and a school health service came up in the year 1971 at the federal Gov. level. A School Health service unit opened in the River's state which mainly did school inspections and health talks. Despite these efforts, there was no appreciable improvement in the health status of school-age children. It was so bad that a student sent a 'save-our-souls' letter to the Commissioner for Health of River's State in the year 1989. This led to the formulation of a proposal for improving SH services in 1990. Sadly, this project had not been implemented to a satisfactory level. An assessment of the SHP done in a local govt. area reported low levels of SH knowledge among the primary school teachers and an absolute lack of input into the SHP by physicians and healthcare professionals. It also gave a review that the primary school environment was hygienically unsafe and bad for the health of the children. No health instructions were taught to children as a subject. A short training of the teachers stimulated some of them to take initiatives towards implementing SHP rightly, i.e. not capital intensive. They started keeping the school health records, periodic examining of the children along with the introduction of the first aid boxes.

Oyo State SHP was launched on 28 March 2001, to ensure maximum mental and physical health development of the school children with a special focus on communicable and non-communicable diseases, and nutrition. An SHP Committee was set up to sustain the programme. They had to conduct regular health visits for inspection and routinely train the teachers and the 33 local govt. SHP officers. They had to introduce standard first aid boxes in all schools, design referral forms for sick pupils and encourage nutritious and hygienic meals for the pupils. The Committee also had to monitor and supervise all these activities to see that the set govt. goals were achieved. A collaboration with government organizations and NGOs was needed to carry out these goals. However, since the inauguration of this programme in the Oyo State, no assessment has been done to ascertain improvements or lack thereof.

[5] Okeahialam, 2003

## THE NIGERIAN SCHOOL HEALTH POLICY (NSHPo), 2006

NSHPo was launched by the Federal Ministry of Education to improve the state of SH services in Nigeria. Before the formulation of this policy, SHP was neglected. Before NSHPo adoption there were no healthcare services in most schools and those present were not optimal. Many head teachers did not know of the mandatory pre-admission medical checkups of the students and even if they knew, the families of the students couldn't afford them. Hence comes forward the first challenge of policy implementation which is **the non-allocation of necessary resources.** It is cheaper to invest in healthy childhoods than to engage in damage control later in life, finds health economics. Therefore, govt. should not hesitate to invest in SH and well-being programmes.

The main practices aimed under the policy were:

1) Standards for safety and sanitation
2) Adequate Food Services
3) Maintenance of teachers
4) Health
5) Promotion of the mental and emotional health of both teachers and pupils.
6) Health instruction in the curriculum
7) First aid for emergencies
8) Prevention and control of communicable diseases
9) Health appraisals, guidance and assistance
10) Emphasize the hygiene aspects of physical education
11) Adapt the SHP to individual needs
12) Designing education and care for handicapped students

These practices were pursued effectively in many countries, particularly developed nations. The policy in Nigeria was also like those of the developed countries but Nigerian educational institutions lacked poorly in its execution.

There are five operational components under the NSHPo framework provided by the Federal Ministry of Education, 2006.

1) **School Health Services (SHS)**
2) **Healthful School Environment (HSE)**
3) **School Feeding Services (SFS)**
4) **Skills Based Health Education and School (SBHE)**
5) **School, Home and Community Relationships (SHCR)**

### The main Problems of the NSHPo Policy Implementation

The Policy document has not been well positioned to influence the activities detailed for the implementation of the programme. Ever since the adoption of NSHPo, no monitoring of the implementation process nor evaluation of the objectives have been done. The five components mentioned earlier are to be ran as a series of harmonized activities. However, in the current scenario, only SFS has got some attention in a few states. There is a lack of interventions in the other four components and is not having much movement in Nigeria. According to a recent survey, SHP is a sleeping giant in Nigeria having minimal implementation.[6] The SHP copies are not even available in schools both rural and urban. Then how can it be formulated, coordinated and implemented effectively?

Nigeria struggles with the double burden of malnutrition with both undernourished and overweight children. SFS aimed at improving the nutritional status of school children. However, there is no baseline data for children, to compare their current nutritional status. So, it is difficult to ascertain if there is any improvement at all. A possible solution to this problem is to establish school admission anthropometric measurements. This will slowly furnish the lack of data.

There are certain Policy gaps too which has to be addressed in the current situation of Nigeria. A robust mental health or psychosocial component has to be included in the policy framework. References to mental health are sparse in the policy. It has no anti-bullying policies nor mentions about the use of positive disciplinary measures. Nigeria is a country with one of the highest rates of suicidal thoughts and attempts among in-school adolescents worldwide.[7] 8% of the children in primary schools are ADHD patients. Teacher's do not understand it and they describe such children as wicked, evil, witches and wizards. Still, the mental health is a marginalized component in the Nigerian SHPo when it should be a standalone component.

There is an absence of provision for children with disabilities when they also have an equal right to education and health. Silence about the health of school staff is a huge gap to be mended. It is only through them that the policy can reach children and work as it should. Ignoring their health is a huge blunder in the methodological perspective of this particular policy. A catalogue of stakeholders was listed in the NSHPo document for implementing the SHP. But it's not clear that which ministry should be held responsible for the failure of the implementation of the policy. Is it ministry of education or ministry of health? Here comes the need to define an organizational or administrative structure for the program. Each of the 36 states of Nigeria should review the implementation of the SHP based on NSHPo.

[6] Dania and Adebayo, 2019
[7] Omigbodun et al. 2008

## CASE STUDY II

### The National Health Service, UK

The National Health Service (NHS) in the UK has been facing an escalating crisis, with terms like “collapse” and “catastrophe” frequently used in media reports. After the COVID-19 pandemic, the NHS was expected to recover, but instead, it plunged into deeper problems, exacerbated by long-standing systemic issues.

Doctors had warned of an impending crisis during winter, which materialized as severe delays in patient care. Ambulances were stuck outside hospitals, unable to offload patients, leading to prolonged suffering for those waiting at home. Emergency department wait times exceeded 12 hours, with patients left in overcrowded hospital corridors. The Royal College of Emergency Medicine estimated that delays caused 300–500 deaths weekly. NHS workers, including ambulance staff, nurses, and junior doctors, went on strike due to poor pay and working conditions, resulting in hundreds of thousands of cancelled operations and appointments. The waiting list for specialist consultations has surged to over 7 million patients, up from 4.4 million before the pandemic. This backlog reflects deeper structural issues, particularly chronic underinvestment

### Key Causes of the NHS Crisis

The UK follows a “just-in-time” healthcare model, maintaining high hospital bed occupancy but with minimal spare capacity. The number of hospital beds per 1,000 people dropped by 10% between 2010 and 2020, making the system vulnerable to patient surges. The UK ranks second-lowest in hospital beds per capita among 24 European nations. Health expenditure rose from 7.0% to 9.8% of GDP between 2000 and 2009 but plateaued at 10.2% due to austerity policies.UK per-capita health spending is 18% lower than the median of 14 European countries. Additional funding in recent years has not significantly improved services, as much of it is diverted to expensive short-term fixes like locum staff.

“Bed blocking” occurs as elderly patients remain in hospital beds due to a lack of care home availability .In January 2023, one in seven acute care beds was occupied by patients who were fit for discharge but had nowhere to go. The social care sector is underfunded and struggles to retain workers due to low wages.

High rates of undiagnosed hypertension, hypercholesterolemia, and obesity contribute to increased NHS demand. A severe influenza season in winter 2022–2023 further strained the system.COVID-19 continues to affect hospital admissions, with more than 12,000 inpatients testing positive in early January 2023.The UK does not train enough healthcare professionals, relying on recruitment from abroad, which Brexit has disrupted. Nurses' real wages have fallen by 10% over a decade, leading to resignations and early retirements.

Junior doctors' wages have dropped by 25% in real terms, discouraging retention. The number of GPs per 1,000 people has declined, increasing workload pressures. A pension tax penalty has pushed experienced doctors into early retirement.

NHS staff feel undervalued, with exhaustion and low pay worsening morale. Public confidence in the NHS has plummeted as access to timely care has deteriorated. Despite dissatisfaction, most people support striking NHS workers, recognizing their struggle. There is no clear consensus on how to fix the NHS. Both major political parties agree that increased funding alone will not solve the crisis but disagree on necessary reforms. Some accuse the Conservative government of underfunding the NHS to push for privatization, though staffing remains a challenge. Key proposed reforms include integrating primary, hospital, and social care and improving medical record systems. The NHS is a model for publicly funded healthcare worldwide. If the NHS fails, it could undermine the broader argument for universal, tax-funded healthcare systems.

**Problems in the Implementation of UK's Health Policy**

Between 2010 and 2019, health system spending plateaued due to austerity policies, leading to a decline in hospital bed availability and overall capacity. The NHS has not trained sufficient healthcare professionals domestically, relying heavily on international recruitment. This approach has been disrupted by factors like Brexit, leading to staffing shortages. Additionally, bottlenecks in specialist training have left many doctors unable to progress to consultant roles, causing frustration and attrition within the workforce. Successive governments have failed to shift focus from hospital-based care to primary and community care, despite longstanding promises. This neglect has resulted in inadequate preventive measures and increased pressure on hospital services.[8]

Insufficient investment in social care has led to "bed blocking," where patients ready for discharge remain in hospitals due to a lack of community care options. This situation exacerbates hospital overcrowding and delays. Significant funds have been allocated to roles such as equality, diversity, and inclusion staff, with some positions offering salaries up to £122,000 annually. This expenditure has been criticized, especially when frontline medical staff face pays constraints and the system struggles with patient care delays.[9]

Frequent structural reforms without sustained long-term strategies have led to instability and inefficiencies within the NHS. The lack of consistent, long-term planning has hindered the development of a resilient healthcare system.

[8] End decades of primary care policy failures, says think tank | The BMJ
[9] NHS hires diversity staff on double the salary of junior doctors

# *Major problem in health policy implementations in Indian context*

The best known public policy framework is the **stages heuristic** (Lasswell 1956; Brewer and deLeon 1983). It divides the public policy process into four stages: agenda setting, formulation, implementation, and evaluation. Decentralization is better for implementing the policies because the community involvement increases the better solutions. admitting that bureaucrats may affect policy in implementation, but suggesting that all decisions are monitored to ensure they are not altered significantly.

## Key Points of Concerns

**Inadequate Secondary Care:** pushed more people towards costly private hospitals.

**Private Sector Dominance:** Publicly funded health insurance schemes like PMJAY benefit the private sector

**Weakened Primary Health System:** The focus on curative care has weakened primary health institutions that were once trusted for preventive and community health services.

## Major Challenges in India's Healthcare System

### Inequitable Access Healthcare:

- **Urban-Rural Divide:** Rural areas have inadequate healthcare infrastructure
- **Healthcare Workforce:** Shortage of doctors, nurses, and health professionals

### Weak Secondary and Tertiary Public Healthcare:

- **Underfunded Secondary Care**
- **Tertiary Care Reliance on Private Sector:** Tertiary healthcare is increasingly outsourced to the private sector under schemes like PMJAY

**Market Monopolization by Private Healthcare:** The PMJAY for primarily benefiting private hospitals

## Conclusion

India's public health system requires a balanced approach that prioritizes primary and secondary care, strengthens public sector infrastructure, and ensures equitable access across social strata. Without these changes, the gap between the public health needs and the policies designed to address them will continue to widen. Decentralization of health systems must be there.

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