

1

Introduction

Health Policy Design

“Nobody knew healthcare could be so complicated,” quipped President Donald Trump in November 2017. His comments echo the frustrations of governments across the world struggling to come to grips with the intractable challenges of health policy. The fundamental question that all governments face is how to organize, finance, and pay for health care so that the entire population has access to necessary care at an affordable cost. Answering this question is hard, as governments have learnt all too well after decades of policy reforms and trillions of dollars in spending.

The need to find ways to expand access to health care at affordable cost became urgent following the adoption of the Sustainable Development Goals (SDGs) by all members of the United Nations in 2015. SDG Target 3.8 explicitly commits governments to achieve Universal Health Coverage (UHC) – defined as ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them” (WHO, 2020) – by 2030. This is an ambitious goal considering that nearly half of the world’s population lacks access to essential health services, and each year about 100 million people are pushed into ‘extreme poverty’ due to out-of-pocket (OOP) payments for health care. Based on current trends, it is projected that more than one-third of the world population will continue to be deprived of essential care in 2030, the deadline for UHC (New, 2019). While the most severe deprivations are concentrated in low-income countries, significant pockets of hardship persist in middle- and high-income countries. Even in countries that have succeeded in largely achieving the UHC goal, governments are faced with organizational and financial challenges of maintaining services. Sustaining UHC is, thus, as much of a challenge as achieving it requires sound health policies to succeed in the long run.

We define the goal of health policy as ensuring that the entire population has access to necessary services at costs affordable to both

households and the society as a whole. While households are rightly the primary focus of health policy, fiscal considerations cannot be ignored if the programmes are to be sustainable in the long run. By focusing on necessary care and affordability, we attribute primary importance to health and financial protection, and secondary importance to other health system goals such as efficiency and consumer choice. What is ‘necessary’ and ‘affordable’ of course varies across societies, shaped by a range of factors, including national income, household characteristics, and social values. It is also possible for societies to seek more than the minimum suggested here, but policy-makers need to be mindful of the additional difficulties in the form of extra spending as well as policy incoherence and weaker accountability associated with expanded goals. Americans, for example, place strong emphasis on provider autonomy and consumer choice, which involves additional financial and administrative costs that must be accounted for in affordability calculations.

The objective of this book is to describe the health policies of six governments in Asia – China, Hong Kong, India, (South) Korea, Singapore, and Thailand – and assess their performance with respect to achieving, maintaining, and improving UHC. It focuses particularly on the policy tools that these governments use to address critical health system functions. As we will see in the subsequent chapters, all governments studied here show an increasing comprehension of the intricacies of the health policy problems they face and are developing a design strategy to deal with them. Overall, while Hong Kong and Singapore enjoy the best health policy record, it is Thailand and, to a lesser extent, China that show the most improvements in progress towards UHC. The dominance of private providers in India and Korea makes it difficult for their governments to employ the policy tools necessary for sustaining UHC, reflected in their continued high incidence of OOP payments.

The analysis presented in this book shows that while there has been notable progress in strengthening governance, financing, and payment arrangements, some critical functions remain overlooked. Particularly, many governments have paid insufficient attention to deficiencies in public hospitals and their management. Similarly, governments have made inadequate efforts to establish and deploy a regulatory framework for the health sector which is especially vital in systems with a large share of private providers and payers. A well-run public hospital

1.1 Perspectives on Health Policy

3

system and an effective framework for regulating private providers are essential tools to support the governance, financing, and payment reforms undertaken in the six health systems studied in this book. This serves as a timely reminder to governments and international organizations who obsess over improvements in financing and payment issues and overlook ownership and regulatory concerns.

1.1 Perspectives on Health Policy

One of the steepest hurdles in health policy is that neither scholars nor policymakers fully appreciate the enormity and complexity of the sector. Without fully appreciating the difficulties, they propose solutions – such as tighter regulations, increased competition, or enhanced expenditure – which often aggravate rather than ameliorate problems. The sources of the healthcare problem are not only complex – rooted as they are in myriad biological, economic, ethical, political, and social issues – but also often intertwined in unfathomable ways. It is for good reasons that reforming health care is often likened to shaping a balloon: squeeze in one place and it pops up in another.

The complexity of the healthcare sector stems from several interlinked characteristics which are somewhat unique. First, the pervasive information asymmetry and moral hazards that characterize healthcare goods and services give rise to a series of interrelated market and government failures that are difficult to manage (Blomqvist, 1991, 2011; Zweifel and Manning, 2000). Second, the key agents in a health system – the patients, the healthcare providers, and the insurers – create multiple principal–agent relationships that aggravate these failures (Brinkerhoff et al., 2014; Bali and Ramesh, 2015a; McGuire, 2000). Third, these agents have fundamentally differing interests and incentives. For example, healthcare providers prefer unfettered autonomy in both medical and financial matters, while insurers or third-party payers face incentives to insure only healthy patients or pass on costs across the risk pool. Users, for their part, want access to the most sophisticated care available, regardless of need, and seek some third party to pay for it. Fourth, the material interests of the key stakeholders – especially healthcare providers, who largely determine the distribution of resources in the sector – are difficult to reconcile with those of the government or the society at large, especially around issues of supply and affordability (Pauly, 2009; Fuchs, 2011; Ramesh et al.,

2013). Fifth, health systems and their constituent institutions have evolved gradually in a path-dependent manner that locks in existing practices and stymies reform (Roberts et al., 2003; Hsiao and Shaw, 2007; Pierson, 2000; Haeder, 2012; Beland, 2016). Sixth, these policy challenges in health care are intertwined and cannot be addressed in isolation: they need to be targeted individually but in a coordinated manner (Bali and Ramesh, 2017). Moreover, these challenges are ubiquitous across all modes of governance – hierarchical or otherwise – as they stem from the innate characteristics of the health system and are not an extension of a particular governance arrangement (Ramesh et al., 2015; Wu and Ramesh, 2014).

Attitudes towards health policy challenges and how to deal with them have changed over the years. Initially, health policy problems were seen essentially as a supply-side issue rooted in insufficient medical facilities, personnel, and financial resources. With this understanding, policy efforts understandably concentrated on increasing supply of health services and mobilizing financial resources to pay for them. It was subsequently realized that households' potential demand for care was almost endless, as was the providers' enthusiasm to meet it, so long as some third party was paying for it. Healthcare expenditures rose rapidly and were projected to grow yet faster with ageing populations and rising expectations. It was also realized that many were unable to access services despite their availability for a variety of reasons which raised critical issues of access and equity. Furthermore, the expansion of the middle class and the corresponding rise in demand for comfortable and prompt services drew attention to the requirement for more responsiveness to users' needs.

Thus began the search for reforms that not only provide needed health services to all but do so in an economical, equitable, fiscally sustainable, and user-friendly manner. But the way they have gone about it has differed according to their training and professional experiences, as we will see in the following section.

Economists have engaged with these questions in health care largely conceptualizing the problems afflicting the sector as a series of market and government failures related to moral hazard, information asymmetry, and adverse selection (for example, see Pauly et al., 2012; Culyer et al., 2000). As early as the 1990s, there was a consensus among mainstream economists that the optimal response to the failures was market-based tools such as competition and the use of financial

1.1 Perspectives on Health Policy

5

incentives. Policy reforms inspired by this line of thinking include managed care in the United States and GP Fundholding in the United Kingdom launched during the 1990s (Blomqvist, 2011; Glied, 2000). In Asia, many governments similarly liberalized the health sector and introduced market relationships between providers and patients. Contemporary economic analyses of health care focus more on providers' behaviour, particularly how they respond to different payment tools such as diagnosis-related groups (DRGs) and capitation. This line of scholarship, however, does not adequately recognize the policy context in which these tools exist and work (Fox and Reich, 2017). For instance, measures to correct malfeasance produce different results in different countries due to the different social and ethical contexts (Ramesh, 2013; Nguyen et al., 2017).

Political scientists, on the other hand, have engaged with these questions largely through the lens of historical institutionalism. This line of scholarship conceptualizes policy problems in terms of the actors, ideas, and institutions in a given sector (Esping-Andersen, 1996; Moran, 2000; Harris and Milkis, 1989; Jochim and May, 2010). Political competition and its impact on health policy has also been a focus of studies by political scientists (for example, see Haggard and Kaufman, 2008; Ramesh and Asher, 2000; Wong, 2006). Studies from this perspective offer keen insights into the evolution of health systems but stop short of offering recommendations for improvements, except for reiterating the importance of institutional and political factors in constraining policy choices.

In a similar vein, scholars in social policy and development studies explain policy developments and outcomes with reference to the state and non-state actors involved in the sector (Wendt, 2009). They tend to focus heavily on the amount of fiscal resources spent on a policy problem and its equity implications, ignoring the efficiency and sustainability dimensions of spending. While easy to measure, levels of spending on health is a poor indicator of performance, as it is easy to spend a lot on health without a corresponding improvement in outcomes, as the case of the USA reminds us. Similarly, many countries in Southeast Asia, including Singapore and Thailand, enjoy admirable health outcomes at relatively modest levels of spending (Ramesh and Wu, 2009; Wu and Ramesh, 2009). Health spending is a political decision only secondarily related to improving the population's health (Ramesh and Asher, 2000; Wong, 2006). Spending as a policy

tool is useful only if it is accompanied by other complementary tools (Ramesh et al., 2013).

Over the past fifteen years, there has been a proliferation of works by international organizations such as the World Bank and the World Health Organization (WHO) focusing on ‘health system’, defined as “organizations, people and actions whose primary intent is to promote, restore or maintain health” (WHO, 2010). With long experience on the frontlines of healthcare reforms, these organizations are acutely aware of the multifaceted nature of health policy and the range of considerations that go into its design. They have accordingly developed concepts such as ‘building blocks’ and ‘control knobs’, which are now widely used in health policy discussions. The WHO’s ‘building blocks’ of health systems comprise six components: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance (WHO, 2010). In a similar effort, the World Bank has conceptualized health policy in terms of five ‘knobs’ that it argues policymakers can use to effect change in the health system: financing, payment, organization, regulation, and persuasion (Roberts et al., 2003). While the two frameworks represent a worthy effort to systematize health policy thinking, they are essentially descriptive labels for different functions in the sector that offer little insight into the relationships among them or their relative importance (Mounier-Jack, 2014; Witter et al., 2019).

Another body of works produced by international organizations centres on the concept of ‘governance’. However, the word has been defined in so many fundamentally different ways that it is hard to generalize about its meaning or usefulness. The WHO Glossary entry for ‘governance’, for example, offers three distinct definitions (WHO, undated). Broadly speaking, one body of works concentrates on institutional relationships in health policy, while another espouses normative principles – ‘good governance’ – that they would like to see embodied in health systems and policy. Discussions on health governance are thick with references to collaboration, participation, transparency, and accountability. While these ideas are logically cogent and intuitively appealing, there is little empirical evidence showing that they make health care accessible on a sustainable basis.

There are also various analysts associated with the WHO and the World Bank who have produced sophisticated ‘how-to’ manuals on design of financing and payment systems for health care

1.1 Perspectives on Health Policy

7

(Langenbrunner and Somanathan, 2011; Langenbrunner et al., 2009; Langenbrunner and Wiley, 2002). While this body of work is directly relevant to strengthening health systems and building UHC, it lacks the problem-centred approach necessary for understanding and addressing the underlying causes of the problems afflicting health systems. Dealing with health policy problems requires an understanding of not only its technical dimensions but also the political and social contexts within which they exist and are addressed (Bali and Ramesh, 2019; Chindarkar et al., 2017). Only Roberts and his colleagues (Roberts et al., 2003) come close to taking the broad yet detailed approach necessary to address contemporary health policy challenges.

International organizations and researchers affiliated with them conceptualize the challenges of UHC too narrowly to be helpful. The World Health Report 2010, for example, posits three ‘fundamental problems’ that hinder the achievement of UHC.

The first is the availability of resources The second barrier to universal coverage is an overreliance on direct payments at the time people need care The third impediment to a more rapid movement towards universal coverage is the inefficient and inequitable use of resources. (WHO, 2010)

For solutions, the Report proposes, “Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity.” The conception of both problem and solution is narrow to the point of being unhelpful. Removing barriers to access is critical, but issues of financial sustainability cannot be ignored if the programme is to be viable in the long run. Securing financial viability goes beyond ‘promoting efficiency and eliminating waste’ through accountability and transparency. It also requires corollary structural measures, related to provision, financing, and payment and the different imperatives faced by public and private health systems. More importantly, the issue of financing cannot be divorced from production and delivery of health services because it is on the supply side that many of the root causes of financial unsustainability lie. Inefficiencies in hospitals and insurance funds, for example, are a major problem and must be dealt with before additional public funds are allocated to them.

To achieve UHC on a sustainable basis, policymakers need to adopt a problem-solving approach to the entire system. They need a

comprehensive understanding of the barriers to UHC and, more importantly, their root causes with the purpose of uprooting them. In other words, they need to engage in collective problem-solving to remove the conditions that stymie access to health care and threaten viability. Since the lack of universal access to health care is the result of a range of related but distinct underlying conditions, it is imperative that they are dealt with individually but in a concerted manner. And this is what we propose to do in our study of the six Asian countries' experience with achieving UHC.

1.2 The Policy Design Approach

The theoretical framing of this book draws on the policy design literature, particularly the 'new' design orientation within the policy sciences. Policy design describes the activities related to addressing the causes of a public problem with the purpose of eliminating them or at least reducing their adverse effects. Reiterating one of the fundamental tenets of problem-solving, it emphasizes the means (i.e. policy tools or instruments) most able to potentially address the targeted problem. The proliferation of market- and network-centred governance reforms in the 1990s and early 2000s caused a decline in the popularity of the design approach as it limited the range of choices available to governments (Howlett and Lejano, 2013). This in turn encouraged analysts to focus on broad institutional arrangements to organize economic and social activities rather than specific tools to address the key problems. Recent years have seen a resurgence of interest in policy design and policy tools as the shortcomings of the undiscerning efforts to promote deregulation, marketization, and privatization became increasingly apparent (Peters, 2018a).

The 'new' design orientation re-emphasizes the role of a policy tool or a collection of tools in addressing policy problems (Howlett et al., 2015). Policy tools or instruments – defined as the means by which governments implement policies and achieve goals (Howlett et al., 2009) – have been a central concern in the policy sciences since the 1950s (Dahl and Lindblom, 1953; Hood, 2007). While early works dwelled on individual policy tools and substitutability among them, recent works have focused on how they work together as 'policy mixes' or 'portfolios' in attaining specific policy goals (Howlett and Rayner, 2013; Schaffrin et al., 2014; Howlett, 2019). The changed emphasis of

1.3 Health Policy Design

9

recent works reflects the increasingly complex and multifaceted problems that policymakers are called upon to solve on one hand and the limited ‘degrees of freedom’ they enjoy in solving them on the other (Chindarkar et al., 2017; Howlett et al., 2015). This approach highlights issues of coordination, coherence, and consistency within mixes of policy tools used to address collective problems (Peters, 2015; Howlett and del Rio, 2015; Bali and Ramesh, 2018).

The design approach to public policy offers insights as well as a framework for understanding the challenges within the health sector and how they can be addressed. We argue that, in health care, the root of the problem lies in the inherent characteristics of the service which give rise to a series of interrelated market and government failures that result in rising costs and restricted access. To reduce the incidence of such failures and mitigate their adverse effects, policymakers need to purposefully search for tools matching the problem and apply them diligently. What is the specific problematic condition and its root cause that needs to be tackled? What are the choice of tools available to deal with it? In what combination and to what extent are the different tools to be used to address the problem? These questions point to not only the need for assessing the intrinsic usefulness of each tool but how it complements and contradicts the other tools in use. The mix of tools, and the synergies and contradictions among them, is as important as their individual characteristics and uses. No less important is the policy context including policy legacies, and the entrenched interests of stakeholders who can be expected to support or resist changes to tools used depending on their self-interest.

1.3 Health Policy Design

Health policy is about eliminating or mitigating the causes of problematic conditions that impede the achievement of universal health care, here defined as availability of health care to the entire population at cost affordable to households as well as the society. Health policy design, it follows, is about selecting and deploying policy tools to remove or, more realistically, ameliorate the adverse effects of the critical problems that prevent the achievement of universal health care. Health policy tools are the specific means by which health care is organized, financed, and delivered to the population.

Table 1.1 *Health system functions, policy tools, and principal resources*

Health system function	Policy tool	Principal resource base of the tool
<i>Governance</i>	Stewardship and coordination	Organization and nodality
<i>Provision</i>	Public and private ownership	Organization
<i>Financing</i>	Risk pooling	Treasure and authority
<i>Payment</i>	Retrospective and prospective payment	Treasure and authority
<i>Setting standards</i>	Regulation	Authority

Sources: Adapted from Hood, 1983; Roberts et al., 2003; Howlett, 2019.

From health systems perspective, there are five critical functions that policymakers need to attend to in order to achieve universal health care: *governance, provision, financing, payment, and setting standards* (Table 1.1). *Governance* is an overarching function comprising of providing direction to the sector and coordinating the disparate public and private activities that affect health care. The vast financial, personnel, information, and other resources that go into health care require a robust governance framework in which the roles and responsibilities are allocated thoughtfully and enforced diligently (Brinkerhoff and Bossert, 2008). *Organizing* the delivery of health care through public or private providers – or a combination of the two, as is more commonly the case – is another critical function that requires attention. *Financing* the healthcare system in an equitable yet sustainable manner through pooling of financial resources is the third critical function in health care. The fourth critical function requires policymakers to pay attention to how healthcare providers are paid. Without a *payment* system that sets out right incentives, users will be either poorly served or over-served at excessive costs to the society. Finally, to function effectively, health systems need to ensure the *safety and quality* of medications, treatments, and services delivered to patients. Health systems with significant private provision and financing also require governments to set the terms of market exchange with the goal of protecting patients. While these five functions are distinct and involve separate sets of actors, they overlap and are closely related and, as result, need to be approached holistically (de Savigny and Adam, 2009; Roberts et al., 2003).