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The inter-section of political history and health policy in Asia – The historical foundations for health policy analysis

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ABSTRACT

One of the challenges for health reform in Asia is the diverse set of socio-economic and political structures, and the related variability in the direction and pace of health systems and policy reform. This paper aims to make comparative observations and analysis of health policy reform in the context of historical change, and considers the implications of these findings for the practice of health policy analysis. We adopt an ecological model for analysis of policy development, whereby health systems are considered as dynamic social constructs shaped by changing political and social conditions. Utilizing historical, social scientific and health literature, timelines of health and history for five countries (Cambodia, Myanmar, Mongolia, North Korea and Timor Leste) are mapped over a 30–50 year period. The case studies compare and contrast key turning points in political and health policy history, and examines the manner in which these turning points sets the scene for the acting out of longer term health policy formation, particularly with regard to the managerial domains of health policy making. Findings illustrate that the direction of health policy reform is shaped by the character of political reform, with countries in the region being at variable stages of transition from monolithic and centralized administrations, towards more complex management arrangements characterized by a diversity of health providers, constituency interest and financing sources. The pace of reform is driven by a country's institutional capability to withstand and manage transition shocks of post conflict rehabilitation and emergence of liberal economic reforms in an altered governance context. These findings demonstrate that health policy analysis needs to be informed by a deeper understanding and questioning of the historical trajectory and political stance that sets the stage for the acting out of health policy formation, in order that health systems function optimally along their own historical pathways.

1. Introduction

1.1. Background to health reform and social transition

Despite rapid economic growth, the Asian region has been beset by policy challenges of persisting inequities in health care access and health outcomes, and major health sector governance challenges presented by macro-level reforms in politics, economics or civil administration. In *China*, institutional reforms have failed to keep pace with broader development policy that was linked to free market macro-economic reforms in the 1980s (Bloom, 2011). In *Mongolia* during the post-Soviet neo-liberal reforms in the early 1990s, measures were put in place to decentralize health care systems to family group practices (FGPs) and institute health financing models based on capitation based funding for primary care (Hindle and Khulan, 2006). In *Cambodia*, during the post UN-sponsored election period from 1993, the socialist model of governance was dismantled and replaced by a more complex diversified management arrangement, including the scale up of demand side financing initiatives and the expansion of health contracting models and of the private medical sector (Grundy and Moodie, 2008). Similar pathways have occurred in *Indonesia* (Ghani, 2012) and the *Philippines* (Lakshminarayanan, 2003), where policy makers have developed responses to the administrative challenges of decentralization and devolution.

A common theme in these observations of health and social change is the policy and development challenge related to transition from centralized political orders in the 1980s and 1990s towards more diverse and open pluralist models of administration.

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The highly diverse pattern of political and economic history contributes to an equivalently diverse set of organizational structures, institutional arrangements and methods of financing of health care systems, requiring countries to tailor policy implementation for universal coverage according to the specificities of national context (Carrin et al., 2008).

1.2. Theories of policy change

But the question remains as to what combination of social theories can best explain the varying pace of policy and system change across national settings, and how this can inform a more consistent and comprehensive approach to policy analysis. Bourdieu (1977) makes reference to the notion of "*habitus*" in order to emphasise the durable dispositions of behaviours that provide national institutions with their particular continuity of character. Similarly, Huntington (2006) defines institutions in terms of stable, valued and recurring patterns of behaviour. This durability and continuity of institutions and their related behaviours contributes to what others have referred to as the trajectory (Walt et al., 2008) or path dependence (Altenstetter and Busse, 2005) of health policy.

The concept of "path dependence" has common features including the observations that early events in sequence matter and that later events have an inertia related to the earlier sequence (Mahoney, 2000). Despite the presence of historical inertia, path dependence does not rule out the availability of policy choice, although the band of choice is conceptually narrowed based on context (Kay, 2005). The related idea of "process sequencing" is that trajectories are not random but are outgrowths of earlier trajectories(Howlett 2009). Policy activity can also be reactive in transforming the wider policy context and directions. In accounting for the changing of trajectories, analysts have put forward the ideas of "critical junctures" (Kay, 2005) or "policy turning points" (Abbott, 1997), whereby periods of crisis are reported to contribute to ideational change and subsequent re setting of policy directions.

1.3. Analytic framework

The historicism of policy formation (policy turning points) demonstrates that policies do not operate in a vacuum but in contrast originate from past time and are contextualized in place (Capano, 2009). This being the case, the formation of managerial ideas is located within a wider field of social and political ideas and institutions that are subject to periodic historical transformations. This concept of health care as forming part of an "ecosystem" is related in part to the limitation of systems analysis, which emphasizes elements of the internal organization and management of health care systems. This limitation presents major challenges for comparative systems and policy analysis, whereby a predominance of hybrid forms seems to defeat efforts for a consistent set of health system classifications or ideal types (Freeman and Frisina, 2010).

The metaphor of ecosystem is also relevant in so far as health policy and systems change demonstrates an adaptive, organic and evolutionary quality, as it periodically shifts directions, responds to shocks or crises, and seeks to re-establish system equilibrium in response to fundamental changes in a wider field of economic, social and political relations. Feedback processes, including institutional rule adaptation and behavioural changes, allow policy and systems to re-adjust to changing circumstances, leading to the establishment of new and longer term equilibriums (homoeostasis) in policies and systems (Howlett, 2009). This re-establishment of policy and systems equilibrium in a new order responds to the need to reset patterns of institutional behaviours (Huntington, 2006), as systems struggle to re-align with higher level economic and political reform. The phenomenon of policy dis-equilibrium can be defined as the delayed policy or institutional response to political or economic change, as institutions struggle to adapt their traditions of management or "habitus" (Bourdieu, 1977) to a radically altered governance context.

From this standpoint, rather than viewing health systems simply as technical constructs engineered by technical planners and decision makers, health systems can also be viewed as dynamic social constructs shaped by the control parameters of changing political and social conditions (Glass and Mc Atee, 2006).

Through illustration of case studies in health system development from the Asian region, this paper aims to make comparative observations and analysis of health policy reform in the context of historical change, and considers the implications of these findings for the practice of health policy analysis. The main variables of interest is macro-political change, as defined by major shifts in the exercise of political or economic power, in terms of free market reform, decentralization and constituency emergence. The variable of interest is the health policy turning point, which is defined as the critical juncture at which health policy is reformed in the direction of this political or economic transformation.

2. Methods

2.1. Target countries and sources of data

The country cases were selected based on the authors' published observations and analyses in the five countries under study. As an observer and participant in the policy and planning environment in these country settings for variable periods of time between 1993 and 2013, the opportunity was provided to observe the influence of history and politics in reshaping the health policy landscape in each national setting and to access the grey health systems and policy literature. These observations and analyses were detailed into published country case studies of health system strengthening in the cases of Myanmar (Tin et al., 2010), North Korea (Grundy and Moodie, 2008), Cambodia (Grundy et al., 2009) and the Philippines (Grundy, 2003).

We reviewed literature in *Pubmed* data base, using the search terms "universal health coverage" as a title search (122 responses). As noted by Walt et al. (2008), we found limited reference to historical analysis of the evolution of health policy. The literature on theories of "policy change" (Title search) returned 198 responses, of which only two were relevant to an Asian setting, and of which there were no systematic attempts to analyse policy change across country health systems. The search terms "History" and "Health system" (Title search) returned 21 responses, but with no responses for Asia. Literature has been reviewed on systems thinking, complexity theory and theories of policy change. The literature on social and political history in each of these countries is quite extensive, so historical sources were not systematically searched, but were sourced selectively in order to construct a broad outline of the historical timelines outlined in Figs. 1–5.

As a work of comparative analysis and synthesis incorporating both historical and health systems analysis, we note here the limitations that are the characteristics of any trans-disciplinary study, particularly with regard to challenges of validity related to a complex web of causation. But here we would also stress that this complex web of causation represents a model of the health policy analysis in the real world, and is a means by which to tackle the problem of "the considerable gap between normative accounts of how health systems operate and realities on the ground." (Bloom et al., 2008 Page 2076–77). We have attempted to manage these limitations through testing and posing of a single research question, and to consistent reporting of the variables of interest – namely, historical trajectory and political transformation, health