POLITICAL ECONOMY OF HEALTH FINANCING REFORMS TOWARDS UHC

Reflections across the Nepal and Thai case studies

Sophie Witter

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Queen Margaret University
INSTITUTE FOR GLOBAL HEALTH AND DEVELOPMENT

World Health Organization
REGIONAL OFFICE FOR South-East Asia

CONTEXT TRIGGERS FOR REFORMS: ROLE OF CRISES

In both cases, **crises triggered a new settlement which resulted in a strong impetus to extend equitable coverage** of health services, especially in rural areas.

- In the case of Thailand, the fall-out of the Asian financial crisis resulted in a reforming, populist government which used UHC as an electoral offer.
- The economic crisis did not affect the reformist climate and in fact activated demands for change and a sense of urgency to achieve this change in a rapid manner, becoming in fact a catalyst for reform.
- In the case of Nepal, the civil war led to a peace agreement in which the Maoist and alliance of seven political parties promoted health as a constitutional right.
- Interestingly, fear of communism spreading in the region was cited as a factor in investment in health care over recent decades in Thailand, while in Nepal, incorporation of formerly communist/Maoist leaders in the peace process equally drove a pro-equity agenda for the sector and beyond.
- Social inclusion and participation was also a shared theme across the two cases, promoted by the federalisation agenda in Nepal (also a fall-out of the new settlement) and the inclusion of participatory rights in Thailand, adding to grassroots pressure for reforms.

WINDOW OF OPPORTUNITY

Crises influenced all three of Kingdon's 'streams' (though especially the problem and politics ones)

- **problem stream**
  - deepened perception of difficulties for the public in access to healthcare and catastrophic expenditure in the aftermath of the financial crisis in Thailand
  - poor maternal health indicators, embedded in a context of poverty and rural exclusion in Nepal
- **policy stream**
  - technical solutions based on experience of other prepayment mechanisms and supported by research capacity in Thailand
  - specific studies commissioned in Nepal
- **political stream**
  - new government and push for radical political change in both contexts, with political dividends envisioned from the reforms

STAKEHOLDERS AND MANAGEMENT OF REFORMS: THE ROLE OF 'CHANGE TEAMS'

- One point of contrast between the two case studies was related to 'change teams' at the heart of the chosen focal reforms
- In the Thai case, the change team emerged as key to the design, adoption and implementation of reforms.
  - Technically strong, politically savvy and well-connected, the change team was ideologically committed to UHC, but seen as politically impartial and free from conflicts of interest
  - The change team was a close-knit group with key contacts inside and outside of the Ministry of Public Health
  - The change team demonstrated not only their technical skills and knowledge, but also their experience in navigating bureaucracy and governmental politics and their capacity to mobilise different sources of power at political, societal and international levels and use effective strategies to move the reform agenda forward. They saw themselves (and were in practice) **policy entrepreneurs** or "match makers" between evidence and politics
- By contrast, in Nepal, there was no clear change team, but rather a more diffuse set of actors supporting reforms over time, which may in part explain the more fragmented nature of these reforms

STRATEGIES IN RELATION TO OTHER ACTORS

- In both cases, **coalition building** and **mobilising support** was important
- Also **enhancing the legitimacy of the policy** (for example, by drawing on the MDGs and rights-based approaches in Nepal, and by connecting to traditional social values in Thailand)
- **Addressing opposition by meeting some of their demands** was identified in both settings, but appeared to be more significant in Thailand, perhaps because of the greater potential opposition (for example, from beneficiaries of existing schemes which feared dilution of benefits, from the MoHP because of changes to its role, and from private providers)

The role of externals

- In Nepal, the external actors (development partners) played a much more significant role, linked to Nepal's weaker economic situation and greater aid dependency of the health sector in particular, so building consensus amongst donors assumed a more prominent role
- The interaction with international players in Thailand differed – in this case, the change team drew on international learning early in the process, but also used international approbation to cement the reforms as the Thai experience was shared internationally and given a strong positive reaction

STRATEGIES (CONT)

- The Thai case study highlights more overt political adoption strategies, including **changing the decision-making processes** (for example, shifting budget decision to the Prime Minister to bypass challenges by the MoF)
- Some of these, such as the establishment of the National Health Security Board and later the National Health Assembly, not only increased supporters for these reforms but also likely changed the margins of manoeuvre for future reforms
- There was also more **dialogue on reform content to bring people on board** in Thailand – seeking common goals, and reflecting opposition demands in some elements of the reforms
  - The overall key elements of all strategies in Thailand, according to one KI, were compromise and negotiation, as well as strategic use of participation (listening to and respecting others), which were integrated within the open recognition of the importance and power of policy dialogue in itself
  - The approach to the policy dialogue remained flexible, adaptive, gradual and pragmatic and as much as possible the focus was on "win-win" narratives (pointing out to the gains for each group involved, rather than the potential losses)
  - This may only be effective, however, when the change team keeps its eye on the reform goals, such that pragmatism does not lead to drift

STRATEGIC USE OF EVIDENCE

- In Thailand, the change team made **strategic use of the evidence available and its capacity to generate locally-relevant knowledge**
  - The evidence-generators/knowledge managers were engaged directly in the political processes (or very close to them) and therefore politically savvy in the use of evidence.
  - This was reflected in how evidence was used - for example, ensuring that it was available rapidly for decision-making and at the same time ensuring that decision makers did not get 'bogged down' seeking too much detail, which can be paralysing at time when speed is needed in the pace of reforms.
  - This is a highly skilled role, requiring robust research, evidence synthesis, political, and policy dialogue skills, for example
- The Nepal Health Sector Support Programme aimed to provide a similar embedded, close-to-policy evidence generation mechanism, and has indeed provided important monitoring data to feed back into policy processes.
  - However, the NHSSP has not had the same independence, long-term stable funding and political connections of some of the groups that played a lead role in the Thai reforms.

PACE OF THE REFORMS

- In Thailand, the decision making and implementation of the UCS reform in 2001-2 happened at a rapid pace, described as "blitzkrieg strategy", which took advantage of the window of opportunity and avoided the consolidation of opposition to the reform
- After that, reform progress returned to a slower pace during implementation that was gradual and incremental, and characterised by flexibility
- The same time pressure does not seem to have been experienced in Nepal, which may be a reflection of the relatively less clear opposition from organised groups, as well as the less deliberate reform agenda (linking to the more diffuse 'change team')

TECHNICAL ELEMENTS OF THE REFORM

- The technical content of the reform is a key element in its political economy, of course – having implications for **who might gain or lose** (and so support or oppose) as well as **how challenging it may be to implement and to institutionalise**
- In both case studies, the **core reforms related to pooling, which directly affects the public and so can be more politically controversial** (but arguably, once enacted, harder to reverse as that would involve withdrawing benefits from often substantial population groups)
- The **increase in risk pooling was more extensive in Thailand** – in the case of Nepal, the step-wise extension of the maternity protection and later entitlements to free basic health care were more incremental and were undermined, especially for free basic health care, by implementation challenges
- It is notable that the policies have been maintained, even during later phases when social health insurance came into the spotlight in Nepal.
- In Thailand, **purchasing and provider payment reforms were also significant** and undertaken strategically
  - For example, the choice of capitation as the main provider payment mechanism was essential in an early phase as it is often difficult to bring this in when providers are used to fee-for-service payments.

Flexibility and adaptive learning

- "Adaptive learning" as shown in the flexible approach to implementation was a key element of success in both case studies but particularly in Thailand, where it **allowed room for continuous improvements and responses to criticisms** as well as new evidence emerging
- It also **avoided the process getting locked into mistakes made early on**, which might strengthen opposition to the reforms

REFLECTIONS ON STRATEGIES

Reform management strategies must of course reflect varying contexts and goals, but the case studies do highlight some preliminary insights, including:

- the value of a change team that is well-connected, clear in its goals and technically as well as politically savvy
- the benefits of speed when more organised opposition is anticipated
- the importance of connecting to social values to entrench reforms
- the strategic use of dialogue to create win-win situations
- changing decision rules to reduce the veto power of opponents
- iteration and flexibility, while keeping a clear goal in mind
- encouraging participation and transparency to mobilise the support of beneficiaries

SOURCES AND (VERY SELECTIVE) KEY READINGS

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