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## *Health policy processes in Asian transitional economies*

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### *Abstract*

This paper draws on studies of current knowledge on health policy processes in Cambodia, China and Lao PDR by a number of researchers in the POVILL Consortium. They are based on reviews of international and national literature and of policy documents, interviews with key informants and preliminary findings of small studies in a selection of rural localities. It explores why policy makers have become increasingly interested in strategies for helping households cope when a family member develops a serious illness and the reasons for their preference for demand-side approaches. It looks at, amongst other things, the influence of policy networks and stakeholder interests on policy formulation. It then explores factors that affect implementation. It concludes with a discussion of the questions that ongoing field studies are addressing.

### *Introduction*

The governments of China, Cambodia and Lao PDR have become increasingly interested in health and are at different stages in the formulation and implementation of major reforms to improve access to health care and reduce the impoverishing impact on households of major illness. The translation of broad intentions to address a problem into specific policies and changes on the ground is a complex process subject to many influences. This paper presents a preliminary analysis of these influences by a group of health policy analysts in two consortia: POVILL and Future Health Systems (in the case of China). It draws on publications by this paper's authors, based on reviews of international and national literature, studies of policy documents, interviews with key informants and small studies in a

selection of rural localities. The conclusions are preliminary, since its authors are in the midst of field studies.

## *The Development Context*

The three countries share a number of characteristics. All are in the midst of a transition to a market economy, although they are at different stages in the process. In China this has involved a shift from collective to household agricultural production and in all three countries it has implied the spread of market relationships to most sectors, including health. Another similarity is that each country has a decentralised government structure, although there is a much greater gap between central and local political and administrative structures in China (World Bank 2002). All are ruled by a Communist Party, or an offshoot of one, and there are close inter-relationships between party and government.

There are also differences, which provide important points of comparison. China has experienced many years of rapid economic growth and agriculture accounts for a diminishing share of total output. Cambodia and Lao PDR are still largely agricultural economies, which have experienced much slower growth and less poverty reduction. There are differences in the demographic structure. China has a growing proportion of elderly people and many rural households have one or more member in an urban area. Demographic transition and urbanisation are much less advanced in Cambodia and Lao PDR. This has led to a divergence in patterns of disease, with non-communicable diseases playing an increasingly important role in China. All three countries have been affected by the epidemic of HIV and AIDS, although the prevalence rate is higher in Cambodia.

One factor behind these differences is the long history of conflict from which Lao PDR has been recovering since around 1975, when the Lao People's Revolutionary Party came to power, and Cambodia since 1993 when the first multi-party election took place under the auspices of the United Nations. This historical legacy has affected their level of economic development and the robustness of their institutional arrangements. The state is much less "strong" in these two countries than in China. In addition, the continuing importance of multi-lateral organisations and international NGOs in Cambodia, reflects patterns established during the period of the United Nations Transitional Authority. The three countries differ in

political structure. China has been characterised as a party-state in which the structures of the ruling party and the government are intertwined, although it is implementing measures to increase the separation between the roles of Party and State (Saich 2001). The ruling party continues to dominate the political system of Lao PDR. The state is the major provider of health services, although several mass organisations and international NGOs play a role (Annear *et al.* 2008). Cambodia has competitive multi-party elections. It has permitted non-government organisations to play an important role in the delivery of health services and, increasingly as participants in policy debates (this will be discussed further below).

The countries also differ in the degree to which they are influenced by outside actors. The health sectors of Cambodia and Lao PDR depend heavily on funding from donor agencies and international organisations, while these sources contribute a tiny proportion of public health finance in China. Consequently, the Cambodian and Lao health sectors have been more exposed to external ideas than China (Jönsson 2002). A recent example is the focus on poverty reduction and the achievement of the Millennium Development Goals, which has influenced health strategies in both Cambodia and Lao PDR (Jönsson 2008). In exploring the relative influence of external actors it is important to differentiate between decisions that largely concern the allocation of donor resources and those implying long term commitments of political capital to particular health system strategies. China's policy process is almost entirely endogenous, but China has used partnerships with international agencies to introduce ideas from outside (Bloom, Liu and Qiao 2008). For example, it built on links with the World Bank Institute to import methods and ways of thinking associated with health economics (see below).

### *Health policy processes in China, Cambodia and Lao PDR*

There is a large international literature about policy and policy processes. Understandings of policy have expanded from "what governments do" to "what governments do in association with other actors". Policy processes have been conventionally understood as a progression through agenda-setting, policy formulation, implementation and evaluation and feedback.

Reality deviates a great deal from this linear process (Walt 1994; Tomson *et al.* 2005; Pulz and Treib 2006; Hyder *et al.* 2007). Complex institutional arrangements tend to be sticky so that many changes are incremental, with periodic tipping points when major reforms take place (Pierson 2000). There is a constant iteration between the different phases of the policy process and there may be a gradation of policy statements from the symbolic and aspirational through to strong government commitments to allocate public funds and exercise regulatory powers. Many factors influence the policy process including changing needs and capacities to meet various demands, competing interests, the influence of networks of experts and interested stakeholders, the emergence of new understandings from a variety of sources and challenges associated with the management of radical economic, social and institutional change. Thus the different policy phases only serve to organise our discussion. Our aim is not to propose a new way to view the policy process, or to develop an alternative analytical framework, but rather to highlight the complexity of the process by focusing on agency in relation to context and institutional capacity.

There has been relatively little scholarly interest in the study of policy processes in China and Southeast Asian ex-command economies, and even less interest in health policy development and implementation. Nonetheless there is a literature upon which we can build. Understandings of China's management of transition have been dominated by studies of elites and the roles of leaders, patronage networks within the political system and negotiations between different elements of the bureaucracy (Lampton 1992; Lieberthal and Oksenberg 1988). Liu and Bloom (2002) focus on inter-bureaucratic negotiations in their study of the simultaneous design of a large rural health reform project and formulation of new health policies. There is a growing interest in actors outside the small circle of political elites and in the consequences of the spread of market relationships, government decentralisation and globalisation. Zhang, Fang and Bloom (2008) argue that participation in health policy processes has widened, over the years, to include researchers and policy analysts and, to some extent, public opinion and the media. For example, since 2005 the media have been very active in highlighting problems in the health sector and in 2007 the government invited five Chinese academic institutions, the World Health Organisation and the World Bank to contribute to its review of options for reform.

A recent book by North (2005) contrasts the experiences of China and

the former Soviet Union, arguing that the former is successfully providing incentives that encourage economic growth. Oi (1999) and Oi and Walder (1999) demonstrate how this works in rural areas. North (2005) suggests that China will need to formalise these incentives in a legal framework if it wishes to create increasingly complex arrangements. Yang (2004) describes how government policy elites are responding to emergent problems in the financial sector by gradually creating quite sophisticated regulatory arrangements. Tsai (2007) argues that the evolution of "adaptive informal institutions" has had an important influence on national policy and the design of formal institutions. She is referring to the way that local informal regulatory arrangements adapt to new needs through day to day interactions between managers of enterprises and government officials. One can apply a similar understanding to the health sector. Several analysts argue that there are parallels between the health and financial sectors in the need to construct rules-based and trusted institutional arrangements and in a policy process that combines local adaptations and national policy changes (Bloom 2005; Bloom and Meessen 2007; Fang 2008; Pei 2007). These authors suggest that the creation of appropriate institutional arrangements for an effective health system is a major challenge for the next phase of China's transition. Cambodia and Lao PDR face a similar challenge.

There is a limited literature on policy development in Cambodia and Lao PDR. Gottesman (2004) focuses on the stabilisation of regimes in the immediate post-conflict period and the transition to a market economy. These regimes have remained intact during the subsequent involvement of the international community (Bourdet 2000; Hughes 2003 and 2006). In Cambodia, there are disputes about the impact of competitive multi-party elections and the major role of international and local NGOs on policy processes. In Lao PDR, the focus has been largely on the evolving relationship between the state and market actors (Rosser 2006). This has been reflected in studies of the evolving role of government as a regulator of the pharmaceutical sector (Paphassarang *et al.* 1995 and 2002; Stenson *et al.* 2001). The paper by Jönsson (2008) provides much more detail on health policy development in these countries.

Until recently government priorities in all three countries included the avoidance of civil disorder, the management of a rapid transition to a market economy and the encouragement of economic growth. Policy-makers paid much less attention to the health sector. However, health-related problems

are rising up the policy agenda. This is partly a consequence of the transition process which has been associated with the emergence of new patterns of economic inequality and the shift to households of the burden of financing medical care. This has created financial barriers to access to care and it has led to an increasing link between the illness of a family member and household poverty. These problems have been exacerbated by the emergence of a costly style of medical care in the weakly regulated markets for health-related goods and services.

Several factors pushed China's political leaders to pay more attention to these problems. One was growing public concern about the high cost of medical care as revealed in media stories and the findings of opinion surveys. Another was the SARS epidemic and the perceived failure of government to protect the public during its early stages. The fact that the epidemic affected Beijing, and that government officials and political leaders had a direct experience of the potential consequences of a breakdown of public health, may have been influential. The Deputy Prime Minister was made acting Minister of Health and played a key role in alerting political leaders to the need for reform. A third was the coming to power of a new leadership, which recognised the need to spread the benefits of economic growth. The decision to make the construction of a "harmonious society" the overall development objective created a favourable environment for those advocating improvements in access to health services. These changes opened a major window of opportunity for reform.

There have been no similar turns in government priorities in Cambodia and Lao PDR and no big health-related shock, except for Cambodia's HIV epidemic. Jönsson (2008) argues that the policies of donor agencies in favour of pro-poor health system development have influenced public policy announcements and the allocation of donor-supplied resources. The degree to which the governments of these countries are under domestic pressure to address health-related problems is less clear.

The following paragraphs take the growing willingness by governments and donors to invest in health as a given and focus on why all three have chosen demand-side interventions rather than increasing the budgets of government health facilities. This was a major departure from their previous practice. We argue that this responded to a desire by government policymakers and, in some cases, officials of donor agencies to push health service providers to pay more attention to the needs of the population they serve,

the influence of ideas generated by networks of national and international policy actors and the changing economic and institutional context associated with the ongoing transition to a market economy.

#### INTERESTS

Stakeholder interests are becoming increasingly important as the transition to a market economy leads to increases in social segmentation. However, it is not clear how they influence policies. In China, government departments are believed to "represent" the interests of different stakeholders in inter-bureaucratic negotiations. Liu and Bloom (2002) and Wang (2008) show how these interests have been reflected in health policy debates. The Ministry of Health is believed to be most concerned about the financial problems of its health facilities and the income of its employees. The Ministry of Agriculture is seen to represent the interests of farmers and the Ministry of Civil Affairs the government's responsibility to the very poor. During the early debates about rural health insurance the Ministry of Health strongly supported its introduction influenced by the serious financial problems of its rural health facilities. One sign that interests played an important role is that schemes tended not to direct many resources to village facilities, which were not part of the government system. The Ministry of Agriculture, on the other hand, opposed compulsory health insurance because they saw it as an earmarked tax, which might not benefit the population (Du 2000). This was consistent with a general government effort to reduce the burden of local taxes and levies on rural residents.

The interests of different levels of government influence policy development. The size of fiscal transfers to poor counties reflects the outcome of discussions about the proportion of their revenue that rich localities should transfer to the central government. There are tensions between national and local interests in the enforcement of regulations. For example, the Food and Drug Regulatory Agency has arranged for county-level inspectors to be employed by the next higher level of government to reduce the risk that they will be unduly influenced by the interests of local governments in enforcing drug safety regulations. More generally, the incentives that local leaders face in terms of nationally set targets and local pressures strongly influence policy outcomes.

There are signs that interest considerations have influenced the design of policies to meet health-related needs in China. In some localities, farmers

refused to contribute to voluntary schemes, reflecting a lack of trust in these schemes to operate in their interest (Wang *et al.* 2001; Lora-Wainwright 2007). There have been many newspaper articles about self-serving behaviour by health care providers - particularly those selling too many drugs and there have been reports of physical violence against health workers (Harris and Wu 2005). In the late 1990s, the government asked the anti-corruption agency of the Communist Party to review unprofessional activities by health workers, such as asking for informal payments from patients and kickbacks from drug wholesalers (Bloom and Fang 2003). The deterioration of trust culminated in speeches in recent years by the most senior political leaders, calling on health workers to change their attitude towards the public. This distrust was also reflected in government decisions to assign responsibility for organising urban health insurance and health safety nets for the poor to the Ministries of Labour and Social Security and Civil Affairs, respectively, in the hope that they would counteract the tendency of health service providers to act largely in the interests of their employees. The government has given responsibility for rural health insurance to the Ministry of Health, but has established supervision committees that include representatives of several ministries, the anti-corruption arm of the Communist Party and local representative bodies.

Complex patterns of interest are emerging in Cambodia with the increasing marketisation of health services, on the one hand, and the significant role of international and national NGOs, on the other. During the early years of reconstruction health facilities had to cope with major shortages of skilled personnel and very low government budgets. Health workers developed livelihood strategies that included informal charges. NGOs have played an important role in renegotiating contracts with health workers to include a more formalised charging regime. The managers of these facilities need to generate enough income to meet the expectations of their employees.

One reason for the great interest in the potential role of health equity funds, demand side approaches that fund the cost of hospital care for the poor, is the perception, amongst donor agencies, that formal and informal user charges were creating a major financial barrier to access by the poor. It was in the interest of the officials of these agencies to demonstrate that the poor were the major beneficiaries of the funds they made available. One option would have been to increase government funding of health facilities. However, there was concern that these funds would be used largely to benefit

health workers and the better off people who could afford to seek hospital care. Also, a supply-side approach would have been inconsistent with parallel initiatives to give health facilities more autonomy and establish mechanisms of performance-related pay. The design of health equity funds, with local NGOs answerable to international NGOs, which, in turn are accountable to donor agencies, was an attempt to shift the balance of influence in favour of the needs of the poor. Lao PDR is also experiencing a rapid spread of market relationships in the health sector. There has been little written about how that country is managing competing interests regarding the finance and provision of health-related goods and service.

#### POLICY NETWORKS

All three countries have looked abroad for organisational models they could implement while adapting their health system to a market economy. Networks of experts have emerged in each country, with significant influence on policy interventions.

China provides an example of an increasingly important policy network. It began with an agreement between the Ministry of Health and the World Bank Institute in 1991 to strengthen training in health economics. The Chinese Health Economics Institute established a World Bank flagship course and a national network of health economists. This network of researchers and government officials regularly organised meetings and played an active role in policy debates. Zhang, Fang and Bloom (2008) document how a combination of research studies and small local pilots built a body of shared knowledge and experience. In a 1997 policy statement the Ministry of Health acknowledged the seriousness of the health sector's problems and called for the creation of rural health insurance schemes to address them. This reflected a previous emphasis in the research of the health economics network on rural health insurance. The change in policy stimulated a big increase in research activities and the volume of published scientific papers on rural health finance rose dramatically after 2001, providing additional evidence to advocates of health insurance (Wang 2008).

There are several explanations for the focus on a demand-side intervention. The first is the inheritance from the period of the command economy, when the collective medical system (CMS) provided an important source of health finance. The policy problem was posed in terms of the adaptation of CMS to the emerging market economy. The second is the

interest of health economists in the potential role of social health insurance. There was a tendency to conflate the CMS with social health insurance. This reflected the large gap between theoretical understandings and the reality of transition management. The debates between ministries were largely caught up in a larger set of discussions about the role of earmarked taxes and other kinds of levy in financing local services. This was associated with the limited capacity of central government to ensure that local governments used tax revenues in the interest of the general population. The problems of accountability underlay a third reason for a focus on demand-side interventions: the commonly held view that health facilities operated largely in the interest of their employees. The major problem for government was to devise some mechanism to ensure that household contributions and transfers from higher levels of government could be translated into improved health services. This was to be the role of new CMS. The government has gradually increased its contribution to these schemes from 20 yuan per beneficiary in the first pilots to 80 yuan in 2008, while keeping household contributions at 10 yuan per person.

The 1997 policy statement was largely confined to the level of line ministries and contained no major commitments of money or political capital, which would have required a decision by the political leadership. This partly reflected the prevalent development priorities in the mid to late 1990s, which gave priority to economic growth and opposed large fiscal transfers to fund recurrent budgets of poor counties. It also reflected a concern about the feasibility of the available policy options.

China's approach to transition management is to test interventions before making major policy commitments. The Ministry of Health organised this kind of test by designing a large rural health development project to be funded jointly by the government, the World Bank and DFID. It is relevant that the lead department in the Ministry of Health was the Department of Planning and Finance, the same department that linked to the health economics network. That network strongly influenced project design, but over time their relatively simple vision of a future health system funded by social health insurance had to confront the difficulties of managing change and the construction of new institutions in poor counties (Liu and Bloom 2008; Bloom, Liu and Qiao 2008). This raised major issues about the sequencing of reforms and the creation of institutional arrangements to foster trust between providers, users of health services and health financing

schemes. The efforts by the project to implement voluntary health insurance highlighted the need to ensure that schemes used the available resources in the interests of beneficiaries and were seen to do so. The project also demonstrated the feasibility of establishing a health safety net for the very poor and built a wider constituency of academic experts and local health system managers in favour of reform. This represented a spread of the policy network to include other understandings of the challenge of reform and many more local government officials. The demonstration that certain health reforms were feasible meant that when the political leadership decided to prioritize meeting the needs of the poor, the health sector had effective interventions available (Zhang, Fang and Bloom 2008).

The relevant policy network in Cambodia had its origins in the international NGOs, which have played an important role in the reconstruction of the health sector since the period of the United Nations Transition Authority. The government's priority was to maintain civil peace and encourage economic development and it allowed NGO officials a lot of scope for innovation. These officials established informal networks with each other, key government officials and personnel in bilateral aid agencies and international organisations that funded health activities. They had a shared interest in finding ways to achieve objectives agreed by government and donors to meet the health-related needs of the poor. Ir and Biggeli (2007) describe how this informal network strongly influenced the flow of donor funds by publicising evidence from a few health equity projects that successfully channelled resources to pay for hospital care for the poor. Only a few years after the first experimental funds were established, the government announced a national policy in favour of covering the entire population. One way to view this success is as the achievement of an alliance between a network of foreign actors and the Ministry of Health to influence the allocation of donor funding. This leaves big questions about the stability of the policy and the sustainability of local institutions. For example, an overlapping network of a new cohort of experts, who took up posts since the initial experiments with health equity funds, has become increasingly interested in social health insurance. The relatively short term contracts that many international experts and officials receive may encourage them to prioritise innovation over consolidating established interventions. The Cambodia case raises questions about how policy-makers balance these two objectives.

There have been relatively few publications on policy processes in Lao PDR (Stenson *et al.* 2001; Tomson *et al.* 2005) Jönsson (2002) describes how the links between the Ministry of Health, the Swedish Agency for International Development Cooperation (Sida) and an academic institution with an international reputation for expertise in drug policy influenced the introduction of a policy on the regulation of pharmaceuticals. Annear *et al* (2008) report that the first health equity funds in that country were established by international NGOs and that plans for extending them more widely have taken place in the context of the World Bank and Asian Development Bank-funded projects.

#### IMPLEMENTATION AND THE MANAGEMENT OF INSTITUTIONAL DEVELOPMENT

It is difficult to distinguish between policy formulation and implementation in China and other transitional economies (Bloom, Lin and Wu 2008). This is because of the great importance of local adaptations and informal institutional arrangements for testing potential policy reforms (Xu, Zhang and Zhu 2008; Tsai 2007). Fang and Bloom (2008) illustrate the importance of local adaptations in a study of two successful township hospitals. They show the influence of a variety of local institutional arrangements on facility performance. These studies have identified several transition management issues.

The first is the sequencing of changes. Several authors have documented the multiple problems that have led to the poor performance of China's rural health system. These include overstaffing with poorly trained personnel employed during the Cultural Revolution, underdeveloped institutional arrangements for a market for health workers, problems with systems of management of public finance and problems with the accountability of local governments (Zhao, Killingsworth and Bloom 2008). The possibilities for health system development have been influenced by these contextual factors. For example, in the 1990s many health facility employees had little formal education. There were strong political and ethical reasons for government to keep them in post. However, the need to pay their salaries limited the capacity of health facilities to attract better qualified people. Meanwhile, urban health facilities attracted skilled personnel away from rural ones. In this context, increased health finance might have raised the incomes of unproductive workers without providing

much benefit to the population. This changed a lot soon after the turn of the Century, when many unskilled personnel reached retirement age and investments in training facilities meant that the supply of doctors rose markedly. The average age of rural hospital employees fell substantially and their levels of skill rose. This created very different possibilities for reform.

The second is the role of local government in the implementation of reforms. China has followed the pattern of other transitional economies in assigning to local governments the responsibility for service delivery, but not transferring similar control over public funds. Wang (2008) describes how local governments resist commitments not accompanied by resources. The problem is most acute in poor counties, where, there are scarcities of skilled personnel to implement complex changes and where there may also be problems with their accountability to the population. These factors contributed to popular discontent with high taxes and levies in poor localities, which ultimately led to the abolition of agricultural tax. This removed an unpopular financial burden but it also eliminated an important source of finance for local services. Viewed in this context, the decision by government to provide financial support to new CMS in poor counties, can be understood as the introduction of a new form of local levy and fiscal transfer earmarked for health.

The third, is the need to foster trust between actors and build commonly held values and beliefs about good and bad behaviour. Bloom, Standing and Lloyd (2008) argue that an important aspect of institution-building in the health sector is the negotiation of "social contracts" between key actors that include both rights and entitlements and obligations to other actors. We need to gain a better understanding of how the values underlying these social contracts have changed and how they have influenced policy. We also need to understand how the process of implementation may influence values and beliefs and, thereby, influence the construction of effective institutional arrangements.

The implementation of new CMS has illustrated a number of strategies for building trust. The first is the focus during the first years on the establishment of financial audit and transparency concerning the distribution of benefits. The aim was to answer doubts in the population about whether governments would use these funds for the defined purpose and whether benefits would be distributed fairly and according to rules. Another innovation was the decision to pay household contributions into a

“household account” which could be used to reimburse any health-related expenditure during the year. This arrangement was not consistent with a risk-sharing scheme, but it provided reassurance to suspicious rural residents that they would not lose their money. The schemes may eventually persuade people to contribute to risk-sharing schemes once they have greater trust in how they will be run.

Another measure to make schemes more accountable has been the establishment of supervision committees with representatives from a number of government departments including health, finance and audit, from the anti-corruption agency of the Communist Party and from local representative bodies. According to the relevant government document, these committees should include representatives of the beneficiaries (State Council 2003), but this is often not the case. These committees have mostly focused on the issues summarised above and preliminary findings of field studies by some authors of this paper have revealed that these committees may not be very active. Nonetheless, they have the potential to address a number of conflicting interests between types of providers (level of care and relationship to government) and between beneficiaries in terms of ability to make co-payments, proximity to a health facility, type of health problem and age and sex). Some authors of this paper are involved in concerning the construction of trust-based institutional arrangements for improved performance of rural health services, as part of the POVILL and Future Health Systems Consortia.

The Cambodia Government has focused its scarce human and financial resources on ensuring social stability and supporting economic development. It has permitted international NGOs a lot of scope for innovation in the health sector. One area of innovation has been in the design of health equity funds. These NGOs have established relationships with local NGOs, who have undertaken tasks under their supervision. In many cases these local NGOs have recruited personnel from government. They now play an important role in the health systems of a number of districts.

The successful pilot interventions have attracted a lot of money from bilateral and multi-lateral donor agencies to extend the experience nationwide. This raises major questions about the best way to construct sustainable institutional arrangements for translating large amounts of money into health-related services for poor people. For example, what are the relative roles of local government offices and local NGOs in the

management of health equity funds? Will international NGOs continue to ensure that funds are accountable to the agencies that provide them, or will other arrangements take over this role? Are local NGOs developing the management capacity and governance arrangements to account for large amounts of money themselves, following the precedence of local NGOs in other countries, such as BRAC, in Bangladesh? Since many local NGO personnel were recruited from government, what will be the future relationships between government and NGOs? Has the use of NGOs been a temporary expedient, while government focused on higher priority tasks, or, have NGOs established a long-term role in the Cambodian health system? To what extent has the leadership of local NGOs become a significant stakeholder in policy debates? We are studying these questions as part of the POVILL project.

The Lao Government has focused on strengthening basic health services in a context of severe financial and human resource constraints. One government response was to introduce user charges and request health facilities to exempt the poor. The government did not compensate facilities for the revenue foregone in implementing the exemption policy and relatively few poor people benefited from exemptions. Boupha *et al.* (2005) show that 83 percent of the people provided with free care by the second central hospital in 2005 were hospital staff or their families, while 12 percent were poor people. The government recently introduced a new Law on Health Care with proposals for the establishment of local funds to finance exemptions for the poor or specific organisational arrangements such as a health equity fund or local health insurance scheme (Government of Lao PDR 2006). The law identifies possible sources of finance as contributions from the government, individual, community, national and international organisations and foreign countries. However, these funds are just becoming established. The law provides little detail on the accountability arrangements and the design of schemes to ensure that services are competent and fairly priced. The POVILL study will explore variation between localities in the design of these funds including the governance arrangements.

## *Conclusions*

The governments of the three countries have become increasingly aware of growing popular concern about the high cost of medical care and they are seeking ways to address this concern. In Cambodia and Lao PDR the international agencies providing financial support to the health sector have become concerned to demonstrate that the resources they provide reach the poor. The common response has been to develop demand-side approaches for channelling additional public funds to the health sector. This has reflected a concern that health facilities would not necessarily utilise additional budget allocations in the interest of the community, particularly the poor. This was particularly due to previous reforms that gave health facilities a great deal of autonomy, particularly in China and Cambodia. It also reflected a perception by policy-makers that the relevant government agencies might not have sufficient incentives to ensure that health facilities act in the interests of the poor. In each country, a network of policy experts and government and donor officials influenced the design of demand-side interventions.

This paper presents preliminary ideas on policy processes in the three countries. These processes remain quite opaque and many issues remain to be clarified. The authors are currently studying these issues and their findings will contribute to our understanding of the development of health-related institutions and of the transition management process, itself.

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