Health policy and COVID-19: path dependency and trajectory

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Abstract

The coronavirus disease (COVID-19) pandemic has tested the mettle of governments across the globe and has thrown entrenched fault lines within health systems into sharper relief. In response to the outbreak of the pandemic, governments introduced a range of measures to meet the growth in demand and bridge gaps in health systems. The objective of this paper is to understand the nature and extent of the changes in health systems triggered by the COVID-19 crisis. The paper examines changes in the role of governments in (1) sector coordination, (2) service provision, (3) financing, (4) payment, and (5) regulations. It outlines broad trends and reforms underway prior to the pandemic and highlights likely trajectories in these aspects in the future. The paper argues that while the pandemic has accelerated changes already underway before the crisis, it has made little headway in clearing the path for other or deeper health policy reforms. The reform window that COVID-19 opened has not been wide enough to overcome the entrenched path dependency and structural interests that characterize the sector.

Keywords: health policy; health systems; COVID-19; policy change; crisis

The coronavirus disease (COVID-19) has brought to the fore not only challenges around access and affordability to health care but also raised deep questions about health policy in the face of current and future pandemics. As the virus spread and infected vast populations around the world in early 2020, governments scurried to respond to it with ad hoc measures of varying scope and depth. To what extent were these responses new or did the pandemic merely advance or accelerate existing arrangements and trends? The purpose of this paper is to address this question by exploring the nature, extent, and long-term implications of changes in health policy triggered by the COVID-19 pandemic. It will focus particularly on the trends associated with changes in critical health system functions (Ramesh & Bali, 2021; Roberts et al., 2003).

Studying policy trajectories and unpacking change has been a key focus of studies in the policy sciences for the last three decades (Baumgartner & Jones, 1993; Birkland, 1998; Howlett & Cashore, 2009). These studies help highlight patterns of stability and infrequent change in public policy and explain the patterns with reference to surrounding ideas, interests, institutions, and feedback mechanisms. These factors collectively create lock-in effects and foster incentives to maintain the status quo and continue
policies’ current trajectory. Concepts within the policy sciences such as incrementalism, path dependency, policy styles, and policy paradigms are routinely used to describe such stability and explain why substantive policy change is uncommon. The health sector is particularly noted for its resistance to change due to vast information asymmetries and high financial stakes (Bali & Hannah, 2021; Béland, 2010).

Existing policy patterns are disturbed by what are described as “punctuations” or “focussing events” that open up opportunities for change (Birkland, 1998; Sabatier & Weible, 2007). Such events (or “windows of opportunity”) are often, but not always, precipitated by exogenous factors such as a crisis that serves as a “critical juncture” to change policy dynamics (Birkland, 1998; Kingdon, 2003). As Wilsford (2010) puts it: “on rare occasions a perfect storm arrives on the policy landscape, and a juncture of large-scale and exceptional character opens a window for something big and new.” When this equilibrium is disrupted, old routines may lose their force and existing institutional arrangements are disrupted, creating space for change to occur. However, as Hogan et al. in this issue suggest, not all focussing events result in or contribute to change (Hogan et al., 2022). Indeed, there are different policy pathways and causal mechanisms through which such events can effect change.

The COVID-19 pandemic—one of the largest public health crises to ever afflict the world—has all the makings of a large-scale mega “focusing event” or “critical juncture” with the potential to open policy windows and trigger deep policy change (Marsden & Docherty, 2021; Vlassis, 2021). Similar to other major crises in the past (see ’t Hart & Boin, 2022), it may be reasonably expected that the current pandemic would trigger a series of much-needed reforms in the sector (Ramesh & Bali, 2021). Moreover, given the proximity of the sector to the crisis, we expect the propensity of change to be extremely high (see Knill et al., 2022). To what extent has the current pandemic served as an “accelerator” or a “path clearing” event that will fundamentally shape the course of health policy development? What are the long-term implications of these changes for the role of governments in the health sector? To address these questions, we analyze emerging trends in health policy, especially with respect to governments’ key health system functions.

In the following section, we discuss policy change in health care with focus on systemic barriers to change. Next, we discuss the substance of the challenges to health systems posed by the COVID-19 pandemic in five crucial respects: governance, provision, financing, payment, and regulation. Finally, we analyze the nature and extent of changes brought by the pandemic and draw out their long-term implications. The paper concludes that while COVID-19 has accelerated changes that were already underway before the outbreak, it is unlikely to trigger fundamental changes, regardless of their need, due to deep path dependencies and entrenched vested interests.

**Health policy change**

The slow and episodic nature of policy change is manifestly evident in health care for a number of reasons. Health systems are highly interdependent, built on complex relationships among actors with very different interests (Altenstetter & Busse, 2005; Wilsford, 1994). For change to occur in the system, a large constellation of forces need to change, including the role of health professionals and different components of the medical and pharmaceutical industries (Béland, 2010). This is intrinsically difficult because the potential losers do everything in their power to block changes that adversely affect their interests. The resistance from the medical profession and the pharmaceutical industry, as extensively documented in studies on health-care reforms in the USA, has been particularly salient in impeding necessary reforms (Pierson, 1994; Steinmo & Watts, 1995).

The policy feedback literature also sheds valuable light on why fundamental change is rare in health policy (Campbell, 2020; Hacker, 2002). Large social programs such as Medicare in the USA create various feedback effects through material redistribution and cognitive interpretation that favor sustaining current policy logics. Similarly, the National Health Service in the UK has weathered demands for extensive privatization due to a combination of positive policy feedback and strong lock-in effects that block efforts to dilute the role of the government in the sector (Pierson, 1994). Similar positive feedback effects have been observed in the Chinese social health insurance system (He et al., 2021).

Another, and often the most important, reason for health systems’ resistance to change is its essential architecture comprising separate components centered on core health system functions: “governance, provision, financing, payment, and regulations” (Ramesh & Bali, 2021; Roberts et al., 2003). While these components are distinct with their own sets of actors, institutions, and processes, they...
overlap and are closely related in complex webs of relationships (Savigny & Adam, 2009). Changes in one part of the health system require complementary changes in other parts for them to be effective. This creates a system of policy inertia fostered by legacies and path dependency that is challenging to overcome (Greener, 2005). Orchestrating such large-scale reform efforts is an arduous and frustrating task as the US health-care reformers have repeatedly discovered.

Governance is an overarching function consisting 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 framework for providing stewardship to key actors and coordinating their efforts. Stewardship refers to setting a common goal and organizing collective efforts to achieve it. In health care, this consists of stating a vision and ensuring that the priorities and actions of different agencies at all levels of government are aligned and geared toward achieving it (Barbazza & Tello, 2014). The need for stewardship is paralleled by the need to coordinate policies through orchestration of efforts of actors with overlapping responsibilities (Cejudo & Michel, 2017). The objective of coordination is to develop coherence across programs such that they not only reduce contradictions but are also complementary and mutually reinforcing (Peters, 2018). There are various mechanisms for achieving policy coordination with different advantages and disadvantages (Peters, 2018).

Organizing the provision of health care through public or private providers, or a combination of the two, is another critical function that requires policy attention. The provision function is accomplished by organizing public and private providers in ways that lead them to serve the public rather than their own interest. For private providers, this means curbing opportunities for profit maximization at the expense of users, whereas for public providers, it usually involves motivating personnel to be cost-conscious and remain responsive to patients’ needs. In addition to ownership, a vital issue in provision is the relationship between primary and secondary health-care providers who typically operate separately despite the need for close collaboration. The separation undermines quality of care as well as cost control, prompting governments to launch efforts to integrate different components of health care (Nicholson et al., 2013). While all governments have expressed commitment to strengthening primary care and integrating it with secondary care, integration has been difficult due to historical legacies and the existing self-interests that benefit from fragmentation.

Financing health care in an equitable yet sustainable manner through pooling of financial resources is the third critical function in health policy. This involves establishing and managing risk pools either through government budget or insurance to ensure that households are protected from financial hardships caused by out-of-pocket payments without undermining the programs’ financial sustainability. While insurance—which may be compulsory and public or voluntary and private—offers many advantages, it is relevant only to those who can pay premiums on a regular basis. Insurance schemes are also strict in what they include or exclude which limits their usefulness for meeting unexpected needs, such as during a pandemic. Direct government expenditures from general revenues have their own advantages and disadvantages. It is an efficient mechanism because the pooling is at the national level which may lower unit costs. It is also an equitable mechanism if taxes are progressive. In addition, direct government spending affords the government levers to change providers’ and users’ behavior in desired ways by selectively paying for priority services which makes it particularly useful for meeting public health objectives. If public spending is substantial, the government can use its buying power to negotiate better prices and quality through “strategic purchasing” (Tangcharoensathien et al., 2015).

In addition, health systems require a viable system for paying providers (Roberts et al., 2003). To avoid both under- and oversupply of needed services, it is necessary for the payment system to establish right incentives for providers. For fee-for-service (FFS) payments, for example, this means dampening the motivation to over-service patients while the opposite is the case for prospective capped payment mechanisms such as capitation. Overall, however, there is no single payment tool that simultaneously achieves all objectives, necessitating a hybrid system as appropriate in the local context. The provision and financing arrangements—whether they are public or private—are particularly relevant to the effectiveness of payment arrangements.

Finally, health systems require a robust regulatory framework to function effectively. There are two broad targets of regulation: quality and safety of medical products and services, and the health-care market. Given that health interventions affect human body, regulations are necessary to ensure the professional credentials of health personnel and safety of drugs, therapies, and clinical practices
(Tuohy, 2003). While there is broad societal and political consensus on the need for safety of health products and services, there are considerable controversies over acceptable level of risk and cost compared to benefits. In comparison, regulation of health-care markets targets producers and insurers’ behavior with the purpose of protecting users from medical and financial hardships. Regulations are particularly needed with respect to private providers, whose core mission is to maximize profit, the pursuit of which incentivizes them to cut corners on safety issues and over-service and over-charge users. Public providers are less susceptible to these shortcomings, although they suffer from other flaws arising from public ownership and financing (Konisky & Teodoro, 2015).

The specific health system arrangements in place in any particular jurisdiction are largely the result of historical choices that set future path dependency and the ideas and interests of the key actors in the health sector (Bali & Hannah, 2021; Campos & Reich, 2019; Fox & Reich, 2013). For any meaningful change across these five key functions, at any given point in time, policymakers must therefore find ways to overcome path dependency and promote collaboration among diverse sets of actors. This is normally a difficult task, but internal or external crises open new windows of opportunity which make changes easier to adopt and implement. A pandemic may be seen as such an epochal event with the potential to open policy windows and clear paths to reforming health care (Auener et al., 2020). Later in the paper we will see the extent to which COVID-19 has shaped health-care reforms in Asia.

**COVID-19 challenges to health systems**

The sudden and widespread outbreak of COVID-19 has put governance capabilities of health systems around the world under extreme stress. Many health systems considered strongly prepared—in terms of infrastructure, manpower, and resource—for public health emergencies did not fare well in responding to COVID-19 (Razavi et al., 2020). The pandemic particularly tested the usefulness of decentralization and administrative autonomy during public health crises. In hindsight, centralized health systems such as China, Singapore, and South Korea produced more effective response to the pandemic in terms of lower infection and fatality rates (He et al., 2020; Woo, 2020). Common among these countries were rapid mobilization and allocation of resources and decisive stewardship in devising and executing a response strategy. This was stark in contrast to decentralized systems such as in Netherlands where local autonomy made the response slow and disjointed (Wallenburg et al., 2021). The decentralized health systems in the USA experienced a similarly disparate and uncoordinated response (Lal et al., 2021). Referring to Italy, Capano and Lippi (2021) point out that decentralization is a conducive factor to health system performance only when national-level preparation and coordination mechanisms are effective.

This pandemic has once again highlighted the shortcomings of fragmented health service delivery. Despite the widely promoted value of preventive and promotive care, most systems neglect primary care, the frontline component in the fight against pandemic. Primary care is a critical point of triage for sorting patients who require hospital care and the rest who can be treated within the community (World Health Organization, 2020). However, primary care providers are unable to perform this vital function if they are not adequately resourced and integrated with hospitals (Bali & Ramesh, 2021). In systems with weak primary care, all COVID patients proceeded directly to hospitals which overwhelmed the latter. The widespread outbreak of the virus in long-term care homes with devastating impact similarly revealed the limitations of fragmented health systems. The high mortality rate among COVID patients with underlying comorbidities further illustrated the importance of integrated health systems (Auener et al., 2020).

The COVID-19 pandemic has put health financing systems under extreme strains due to the high medical cost of treating a large number of COVID patients at a time when governments’ fiscal capacity was already stretched to the limit due to new and expanded fiscal support measures. The pandemic disrupted the provision of routine care and led patients to defer nonurgent elective services; this precipitous drop in demand for routine services has drastically reduced providers’ revenues and undermined their financial viability in many health systems (Blumenthal et al., 2020; Sorenson et al., 2020). Because some expensive functions such as intensive care unit services were often cross-subsidized from more profitable chronic and elective care services, hospitals experienced aggravated financial stress (Auener et al., 2020). It is arguable that the resulting weaknesses in health care for noninfectious diseases will have adverse long-term consequences when the pandemic is over (Auener et al., 2020; Sorenson et al., 2020).
The critical role of provider payment methods has once again been highlighted by the COVID-19 pandemic. The limitations of FFS and helpful potential of capitation payment in advancing public health has long been recognized and confirmed during the pandemic (Blumenthal et al., 2020; Fuchs, 2020). The problem was compounded by economic slowdown and the associated increase in unemployment which undermined households’ capacity to purchase health insurance or pay for health care. This was particularly evident in the USA where FFS coexists with voluntary private insurance (Blumenthal et al., 2020; Lal et al., 2021). The situation was slightly better in countries—such as China, Thailand, and Vietnam—with comprehensive public financing programs in place (Chua et al., 2020).

The COVID-19 has also exposed the shortcomings of private health care that has been aggressively promoted in many countries in recent decades (Sparke, 2020). Promotion of private health care that is poorly regulated and not fully integrated into national health systems has led to a situation in which private providers are difficult to deploy in fight against pandemic (Williams et al., 2021). Furthermore, due to weak regulations, unethical behaviors were widely observed in private health systems such as in India, Nigeria, and South Africa, including denial of services to COVID patients, sorting of patients based on the ability-to-pay, price gouging, and gaming government regulations on bed availability (Williams et al., 2021). These behaviors not only put the health of patients at risk but also significantly weakened the legitimacy of public–private partnerships.

**Health policy in a post-COVID world**

In this section we describe and discuss the nature and extent of changes precipitated by the pandemic and lay out their long-term implications across five crucial health system functions. Our discussion is framed by Cashore and Howlett’s (2007) policy elements framework which considers continuity and change in underlying ideas and governance arrangements (macro level), policy tools (meso level), and their settings (micro level) in a sector.

**Governance**

The current pandemic is likely to reinforce and accelerate many governance trends that crystallized two decades ago. After a vigorous move toward decentralized and market-led governance in the 1990s, policy discussions in the early 2000s turned to reasserting the role of governments, especially national governments, across many areas of public service delivery (Ramesh & Araral, 2010). Calls to rely on New Public Management techniques gave way to pleas for government direction and stewardship in public policy. In health care, central governments started to play a more active role in steering the sector and setting policy direction.

To promote vertical coordination, governments have been establishing arrangements for actively allocating tasks across agencies at different levels of government and ensuring that there were mechanisms to hold them accountable (Bali & Ramesh, 2019, 2021). This in turn has required implementing a national policy framework setting minimum standards for services across the country, while giving local governments and implementing agencies sufficient autonomy and discretion. These reforms, described as “centralized-decentralization,” seek to combine strong central oversight with opportunities for local initiative and innovation.

The trend promoting centralized governance while retaining the essence of decentralization accelerated during the fight against the pandemic. For example, national governments in Australia and India introduced a policy framework for disease containment measures but allowed state and local governments to manage movement controls and other restrictions (Taneja & Bali, 2021). Similarly, while local governments in China were given autonomy, key performance indicators of government officials were tied to the effectiveness of containing the pandemic (He et al., 2020).

Alongside efforts to improve vertical coordination, there has been an increasing emphasis on horizontal coordination of agencies, policies, and actors in the sector in response to frustration with fragmentations that undermine accountability and compromise quality of care. While there are various mechanisms for achieving policy coordination (see Peters, 2018), in health care this has largely been sought by creating central agencies. For example, in 2018, the Chinese government established the National Health Commission to steer the provision of health services and the National Health-care Security Administration for coordinating health financing and payment functions. In India, the
National Health Authority was established in 2018 to coordinate universal coverage reforms. Many governments in the region have also experimented with reforms to promote efficiencies through improved coordination in their purchasing functions (Tangcharoensathien et al., 2015).

The trend toward enhanced vertical and horizontal coordination of health care has accentuated during the pandemic. The innate features of the current pandemic—particularly its fast-spreading and transboundary nature—require a central authority to devise and execute a swift yet coordinated response (Boin et al., 2021). In countries as diverse as Australia, China, India, Singapore, and Thailand, governments established networks of public and private hospitals for coordinated delivery of COVID-19 care. Governments also quickly created high-level agencies to coordinate response to the crisis. For example, Australia established a National Cabinet consisting of state Premiers chaired by the Prime Minister while Singapore created Multi-Minister Taskforce on COVID-19 and Thailand created Centre for COVID-19 Situation Administration soon after the outbreak of the pandemic. In Taiwan, the Central Epidemic Command Centre, which was established after the 2004 severe acute respiratory syndrome outbreak, was charged with coordinating policy actions across ministries.

It is too early to comment on the future trajectory of the ongoing trends toward centralized stewardship and coordination while maintaining decentralized governance. On the one hand, the demands for centralized coordination are real and measures to promote it began to be adopted two decades ago and were only accentuated by the pandemic. Coexisting with the coronavirus in the “new normal” would inevitably require greater efforts to steer and coordinate the health system and various aspects of socioeconomic activities. On the other hand, the interests and objectives of different levels of government and their populations and agencies are diverse and hard to bring under a common framework. It is difficult to predict if the divergent governments and their constituents will continue to work toward common goals when the pandemic has ended.

**Provision of services**

Governments typically rely on a combination of private and public providers in the provision of health services. For decades until the 1980s, it was common for governments around the world to expand their role in direct provision of health care. The tides turned in the 1990s when governments in Asia—including China, India, Indonesia, Malaysia, and Thailand (Ramesh & Wu, 2008; Ramesh et al., 2015)—began to gradually expand the role of private provision. Private provision is attractive to governments not only for fiscal but also political reasons because voters tend to prefer private services when given a choice. More importantly, private provision is supported by powerful stakeholders in the sector, including pharmaceutical companies, private health-care providers, and commercial insurers.

The outbreak of the Asian financial crisis in 1997 interrupted and even halted the efforts to privatize health care in the affected countries, including Indonesia, Malaysia, and Thailand (Ramesh & Bali, 2021). In some other countries, including China and Singapore, privatization was slowed down due to realization of its adverse effects. The realization that private hospitals were inaccessible to vast sections of the society led to course correction, as governments began to strengthen their public hospitals and health centers (Baru, 2003; Wu & Ramesh, 2009). Thailand was one of the first to reverse course as it established universal health insurance anchored around public hospitals and health centers in 2001. China and India introduced similar reforms to strengthen public hospitals and clinics in the following years.

In parallel, governments launched efforts to improve the performance of public health-care facilities, following the realization that public hospitals and clinics suffered from structural flaws that promoted inefficiencies and stifled responsiveness. Low motivation on the part of managers was found to be particularly deleterious to public hospitals’ performance. In response, governments introduced financial and nonfinancial incentives to promote managers’ performance (Bali & Ramesh, 2021). The latter were also given expanded operational autonomy to boost morale and to encourage them to take more responsibility. Accountability mechanisms were also strengthened in tandem.

The emerging trend of strengthening public provision that began in the mid-2000s is likely to accelerate in the future for a variety of reasons. First, the pandemic has reiterated the importance of a strong public provision system. Private hospitals are simply not incentivized to invest in public health-related services such as infection control. At the same time, private providers lack the incentive to invest in “excess” or “slack” capacity necessary for dealing with public health crises (Woo, 2020). Second, the pandemic has re-emphasized the central role of the government in delivering public services during crises.
When COVID-19 broke out, public health-care facilities were the first responders and point of care in many countries despite acute shortage of resources. In contrast, many private hospitals took advantage of the crisis and charged exorbitant prices for COVID-19 treatment, making health care inaccessible and pushing patients to the public system (Williams et al., 2021).

Yet, significant challenges remain in the way of the public sector realizing its full potential in provision of health care. The substantial increase in resources channeled to public health-care facilities in recent decades has yielded only marginal results. There is no evidence that the facilities’ efficiency or the staff’s morale has increased as a result of the reforms. The reforms have also done little to address organizational weaknesses in public hospital system. The daunting challenge is how to correct the perverse incentives that lie deep in the public system (Barber et al., 2014). Civil service laws and regulations in many countries—including China, India, and Indonesia—are rigid and provide strong protection to incumbents: they are unlikely to be exposed to flexible work practices and rewards based on performance. Moreover, private providers in some countries, such as India and South Korea, are simply too numerous and powerful to allow the public sector to grow significantly larger at their expense.

Similar to stewardship and coordination, the pandemic did not contribute to a change in the underlying ideas, actors, or tools used to organize the provision of services. It merely accelerated changes already underway. It is too early to tell if the pandemic has forestalled experiments with private provision and accelerated strengthening of public hospitals. After the end of the current pandemic, it is quite likely that middle classes will revive their clamor for more personalized and attentive services, the forte of the private sector. More capable governments, however, will continue to strengthen the public sector by not only devoting extra fiscal resources but also introducing measures that improve their accountability and responsiveness. In countries with less capable government, on the other hand, private providers will continue to expand to fill gaps left by the public sector.

**Financing**

Most countries use a combination of sources for financing health care: government budget, social insurance, private insurance, and out-of-pocket payment (OOP). In recent decades, there has been substantial increase in health financing from government budget and social insurance, although OOP continues to form an unusually large source in many Asian countries. Private insurance plays a growing but still a small role despite governments’ efforts to promote them because of the poor value for money they offer (Ramesh & Bali, 2021).

Governments in Asia began to expand health-care financing through government budget and social insurance in the late 1990s. China launched new social insurance schemes in the late 1990s although it was not until a decade later that they became a major source of funds. Thailand introduced a new government-funded Universal Coverage Scheme in 2001, India expanded the National Rural Health Mission in 2004, and Indonesia “launched Jaminan Kesehatan Nasional” in 2014. In parallel, there was increased spending from government budget, especially after the mid-2000s. This followed the realization that contributory insurance programs, while fiscally appealing, did not cover large parts of the population in the informal sector. Many governments—including those of China, India, Indonesia, Vietnam, and Singapore—subsequently introduced reforms to subsidize insurance premiums for poorer households.

Government spending on health care increased further following the outbreak of COVID-19. For example, public spending on health doubled in India and Indonesia in 2020–2021 (Bhatia & Singh, 2021). Most of this increased spending was on public health interventions such as strengthening pandemic preparedness, ensuring access to vaccinations, and filling gaps in public health infrastructure. The trends around increased public spending and expanded reliance on noncontributory financing for health services are likely to accelerate further in the years to come.

It is to be expected that the massive fiscal expansion in the wake of the pandemic will be rolled back at some point because the current debt levels are untenable in the long run. Yet, there are a variety of reasons why direct government expenditures on health care will continue to increase beyond the crisis. First, the rising health expenditures associated with population aging and improvements in medical technology that have been ongoing for some decades will continue and accelerate in the coming years. The rising financial burden will have to be borne largely by governments, due to limited capacity of households to shoulder more expenses (Barasa et al., 2020). Second, many of the targets of enhanced
expenditures during the pandemic—vaccination drives, shoring up infrastructure, strengthening disease surveillance and reporting, etc.—are enduring needs that are unlikely to change in the near future. Third, health expenditures tend to be “sticky” once they have been increased due to the political economy of health systems wherein providers and users collude to resist changes that undermine their interests (Wu & Ramesh, 2009).

Finally, and most importantly, the pandemic has highlighted the weaknesses of contribution-based health financing and reiterated the need for governments to directly finance essential health services. Insurance schemes, public or private, tend to focus on curative care which makes them ill-prepared for tackling public health crises, which are expected to increase in frequency and severity in the future (Lal et al., 2021). Private insurance, in that they are guided primarily by profits, failed to provide the needed risk pooling in the fight against COVID-19. In many instances, private insurance companies refused to pay for treatment or required large co-payments (Williams et al., 2021). Yet, there are powerful sections in the society that prefer private hospital care and demand subsidized private insurance which cannot be ignored by governments.

We expect the pre-crisis trend of increased government spending, particularly through noncontributory government budget, to continue in the future. However, governments are unlikely to be able to do away with private insurance or OOP. Not only does private insurance continue to appeal to sections of the society, it is deeply entrenched in many health systems through generous tax incentives which make it politically difficult to reduce.

**Payment**

Different health-care systems use different combinations of mechanisms for paying providers: FFS, capitation, global or line-item budgets, diagnostic related groups (DRGs), etc. Historically, private providers have been paid on FFS basis while public providers have been paid on global budget basis. In the 1980 and 1990s, there were widespread efforts to promote FFS payments, in conjunction with efforts to expand private provision. The change was inspired by the belief that FFS payment promotes efficiency and responsiveness by tying the remuneration providers receive to the amount of services they provide. Although known, it was not fully appreciated at the time that the key strength of FFS—its responsiveness to users—was also its main weakness in that it incentivized them to supply more services than needed, the result of which was increased overall expenditures. By the 2000s, many governments—including China, Japan, and South Korea—began to make efforts to reign in FFS by introducing fee schedules and limits on the volume of services.

Over the past two decades, there have been concerted efforts to move away from FFS and introduce prospective payment arrangements such as capitation, DRGs, and global budget (Bali & Ramesh, 2021). This was largely driven by the realization that total expenditures were lower in health systems that employed prospective payments for paying providers (Tangcharoensathien et al., 2015). However, while prospective payments are helpful in dampening health expenditures, they create systemic incentives to under-provide services in terms of both quality and quantity. They are also difficult to implement due to technical challenges in setting appropriate rates as well as opposition from both providers and users who broadly prefer FFS. More astute governments and insurers have been able to layer prospective payments with FFS to address these contradictory challenges (Yip, 2020).

The trend toward expansion of prospective payments, particularly capitation and DRGs, are likely to expand in the wake of the pandemic for several reasons. First, the uncertainties associated with treatment protocols for COVID-19 infections make relying on FFS arrangements financially untenable due to their vast scope for overservicing. Many insurance companies that rely on FFS were forced to introduce caps on payment for COVID-19 treatments. Second, increased government spending on healthcare during the pandemic was based on existing payment arrangements because of the need to quickly disburse funds in the face of a rapidly spreading pandemic. For example, the federal government in Australia allocated lump-sum funds to subsidize costs incurred by hospitals and state public health authorities to treat COVID-19 patients. Similarly, the federal government in the USA used existing mechanisms such as Medicare to allocate additional funding for vaccinations and treating COVID-19 patients. Allocation for public health and infection control in the future may follow this trend owing to path dependency. Lastly, many governments have already developed standard protocols for treating COVID-19 patients, which has facilitated the development of set DRG rates which may be extended to treatment of other infectious diseases. For example, India introduced the treatment of COVID-19 into
benefits offered under its universal coverage program, Pradhan Mantri Jan Arogya Yojana or PM-JAY. Similar arrangements were made in Philippines, Thailand and Indonesia. While specific details are uncertain, it is likely that DRG payments will become more widespread in the treatment of infectious diseases.

Here again we see the pandemic accelerating move toward prospective and noncontributory payment approaches already underway and no significant change in dominant ideas. However, governments are unlikely to be able to do away with FFS completely, given its inherent advantages in ensuring that providers remain responsive to patients. Furthermore, governments are likely to use it to incentivize providers to deliver certain services such as vaccinations. At the same time, the increasing reliance on prospective payments is likely to continue given the pressing need to contain health expenditures. The certainty it offers in paying for treatment of known diseases will also continue to facilitate a broader adoption of prospective payments.

Regulations

While governments have regulated the safety of drugs and medical equipment, accreditation and licensing of medical professionals, and hygiene and sanitation standards for over a century, the scope and depth of regulations have grown rapidly in recent decades. This in part reflects broader resurgence in the use of regulations to pursue policy priorities in social policy (see e.g., Haber, 2011; Levi-Faur, 2014). Deploying regulations in health care is challenging, however. Health-care providers—usually the principal target of regulations—resist them because of the limits they impose on professional and business autonomy and the additional costs they typically impose (Tuohy, 2003).

Notwithstanding resistance from health-care producer groups, the current pandemic has enhanced the need for tighter regulations and at the same time created favorable conditions for their implementation. At the outset of the pandemic, it became clear that governments would need to rely on more coercive measures than nudges and suasion to protect citizens’ health and safety. Public health agencies across the world quickly introduced a variety of regulations to prevent the spread of the virus. Common examples included mandating social distancing and density requirements, face masks, quarantine, and movement and travel restrictions among others (Goyal & Howlett, 2021). Regulations were also introduced in many countries to expedite approval of vaccines. Many countries have introduced extensive regulations governing who can or must get the vaccines and the type of test certificates they need to show in order to visit public spaces and travel. While there has been some resistance to the restrictions in some countries, most societies have largely complied with them. The unprecedented imposition of restrictions is likely to have spillover effects on other aspects of health care in the future.

In addition to targeting public health, regulations have also sought to shape the functioning and outcomes of health-care markets. Prices of drugs and medical services have been the subject of regulations in many countries for a long time, which have been extended to other aspects of health-care markets. In Australia, similar to many other countries, the Pharmaceutical Benefits Scheme requires cost-effectiveness evaluation before they are included in the scheme for subsidization. In the USA, private insurers were required to waive cost of testing and vaccinations, or that they be provided at “reasonable costs.” Similarly, recent regulations in Singapore require private health insurance to impose a certain minimum co-payment with the objective of curbing moral hazards of complete insurance. In the Philippines, regulatory tools were used to require private providers to expand capacity to deal with increase in COVID-19 cases. In India, state governments introduced price ceilings and required hospitals to publish their bed occupancy ratios to discourage rent-seeking by private providers (Taneja & Bali, 2021).

1 Ministry of Health and Family Welfare, Government of India, Treatment of COVID-19 patients under PM-JAY. Press release, 6 August, 2021, retrieved from https://pib.gov.in/PressReleasePage.aspx?PRID=1743156.
2 Bangkok Post, “Private hospitals urge state to cover costs,” 13 July, 2021, retrieved from https://www.bangkokpost.com/business/2147683/private-hospitals-urge-state-to-cover-costs; The Jakarta Post, “Government commits to full BPJS Kesehatan coverage for COVID-19 patients,” 24 March, 2020, retrieved from https://www.thejakartapost.com/news/2020/03/24/govt-commits-to-full-bpps-kesehatan-coverage-for-covid-19-patients.html.
3 “The lightning-fast quest for COVID vaccines: and what it means for other diseases?” Nature News Feature, 18 December, 2020, retrieved from https://www.nature.com/articles/d41586-020-03626-1.
4 “Biden-Harris Administration increases Medicare payment for life-saving Covid-19 vaccine”, Center for Medicare & Medicaid Services, USA, 15 March, 2021, retrieved from https://www.cms.gov/newsroom/press-releases/biden-harris-administration-increases-medicare-payment-life-saving-covid-19-vaccine.
5 “DOH to private hospitals: admit more COVID-19 patients,” Philstar Global, 19 April, 2021, retrieved from https://www.philstar.com/headlines/2021/04/19/2092130/doh-private-hospitals-admit-more-covid-19-patients.
The growing use of regulations to protect health and safety of the population as well as improve the functioning of health-care markets is likely to continue in a post-COVID world. However, in countries where the private sector is dominant—such as India, South Korea, and the USA—private providers are simply too large and powerful to allow regulations that significantly undermine their profits. For example, in the USA, private insurers initially waived deductibles for treating COVID patients but have since returned to requiring higher co-payments. Similarly, medical professionals in most countries enjoy unparalleled autonomy and would be loath to allow themselves to be subjected to strict supervision. However, their capacity to resist regulations may have been blunted somewhat by the pandemic. This is likely to have legacy and threshold effects which would facilitate use of regulations to achieve health policy objectives. The importance of stronger regulations will especially grow if governments succeed in promoting private provision of health care.

Conclusion

There is consensus in the literature that major changes in public policy are challenging and infrequent due to a confluence of existing dominant ideas, interests, and institutions that impede change. These are reinforced by the existence of feedback mechanisms that create lock-in effects favoring the continuation of the status quo. Epochal crises and other focusing events are said to temporarily remove or lower the barriers that impede change as they enhance societal attention to problematic issues and galvanize actors to do something about them (Kingdon, 2003; Wilsford, 2010). The central aim of this paper has been to examine these propositions with reference to the health sector—a policy sector most proximate to the crisis and one of the most contentious policy areas with a myriad of actors and interests with conflicting interests. Our analysis focused on five key aspects of health systems for evidence of continuity and change in the face of the pandemic: coordination, provision, financing, payment, and regulation.

Contrary to expectations that the pandemic would clear the path for reforms or foster change given its proximity to the crisis, our analysis offers a sobering account of recent changes in the health sector. In most functional areas of the health system, we find that the pandemic merely accelerated or advanced ongoing reforms that started well before the crisis. For instance, we saw governments playing a more active role in steering and coordinating the sector—a trend crystallized a decade earlier across health systems. Similarly, governments expanded public provision and financing in the face of the pandemic, a trend which, again, began much earlier. Furthermore, governments quickly marshaled additional resources for the sector but continued to rely on existing payment mechanisms for allocating them. Most of the changes that have occurred can be characterized as recalibration of existing policy settings and tools rather than introduction of major policy changes. The only area where there has been a marked change is with respect to speedy approval of vaccines and treatments and somewhat tougher regulation of private providers.

The account of health policy changes offered in this paper points to the need to carefully distinguish terms used to describe and explain the impact of the crises on policy change. Using Cashore and Howlett’s (2007) distinction between macro, meso, and micro policy changes, it may be concluded that the changes described in this paper are at the micro or meso levels, involving changes in existing policy tools, such as increased public provision, public financing, and coordination as well as more intrusive regulation of private providers. There has been limited, if any, notable change at the macro level in terms of new ideas, actors, or institutions in the health sector. Thus, while crises may accelerate some changes and remove obstacles to change, in health care these have been confined to micro and meso levels (Knill et al., 2022).

The reasons for the limited changes triggered by the Covid-19 pandemic are not hard to fathom. While the pandemic drew stark attention to the shortcomings of health-care systems and created favorable political conditions for addressing them, they were not sufficient to overcome the forces that entrench the status quo. These include not only policy legacies and path dependencies but also the confluence of interests of key stakeholders that benefit from existing arrangements which continue to operate during and across critical junctures such as crises (Evans, 2005). Crises alone are insufficient to overcome their resistance, unless there are policy actors and entrepreneurs who take advantage of the window of opportunity and push through desired reforms (Mintrom, 2019). The onset of the Covid-19

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6 “Some health insurers ending waivers for Covid treatment fees,” NBC News, 27 April, 2021, retrieved from https://www.nbcnews.com/health/health-news/some-health-insurers-ending-waivers-covid-treatment-fees-n1265422.
The pandemic was too abrupt to allow policy entrepreneurs to seize the opportunities it offered. Thus, while the current crisis has all the features of a path-clearing event, it has succeeded in only accelerating policy changes already underway rather than initiate new substantial reforms.

**Conflict of interest**
None declared.

**References**

Altenstetter, C., & Busse, R. (2005). Health care reform in Germany: Patchwork change within established governance structures. *Journal of Health Politics, Policy and Law*, 30(1–2), 121–142.

Auener, S., Kroon, D., Wackers, E., van Dulmen, S., & Jeurissen, P. (2020). COVID-19: A window of opportunity for positive healthcare reforms. *International Journal of Health Policy and Management*, 9(10), 419–422.

Bali, A. S., & Hannah, A. (2021). Policy styles in healthcare: Understanding variations in health systems. In M. Howlett & J. Tosun (Eds.), *The Routledge handbook of policy styles* (pp. 105–122). Routledge.

Bali, A. S., & Ramesh, M. (2019). Assessing health reform: Studying tool appropriateness & critical capacities. *Policy and Society*, 38(1), 148–166.

Bali, A. S., & Ramesh, M. (2021). Governing healthcare in India: A policy capacity perspective. *International Review of Administrative Sciences*, 87(2), 275–293.

Barasa, E., Bennett, S., Rao, K., Goodman, C., Gupta, I., Hanvoravongchai, P., James, C., Maceira, D., Witter, S., & Hanson, K. (2020). Health financing in response to COVID-19: An agenda for research. Working Paper, Health Systems Global. [https://researchonline.lshtm.ac.uk/id/eprint/4661945/](https://researchonline.lshtm.ac.uk/id/eprint/4661945/).

Barbetta, E., & Tello, J. E. (2014). A review of health governance: Definitions, dimensions and tools to govern. *Health Policy*, 116(1), 1–11.

Barber, S. L., Borowitz, M., Bekedam, H., & Ma, J. (2014). The hospital of the future in China: China’s reform of public hospitals and trends from industrialized countries. *Health Policy and Planning*, 29(3), 367–378.

Baru, R. V. (2003). Privatization of health services: A South Asian perspective. *Economic and Political Weekly*, 38(42), 4433–4437.

Baumgartner, F. R., & Jones, B. D. (1993). *Agendas and instability in American politics*. University of Chicago Press.

Béland, D. (2010). Policy change and health care research. *Journal of Health Politics, Policy and Law*, 35(4), 615–641.

Bhatia, M., & Singh, D. P. (2021). Health sector allocations in India’s Budget (2021–2022): A trick or threat? *International Journal of Community and Social Development*, 3(2), 177–180.

Birkland, T. A. (1998). Focusing events, mobilization, and agenda setting. *Journal of Public Policy*, 18(1), 53–74.

Blumenthal, D., Fowler, E. J., Abrams, M., & Collins, S. R. (2020). Covid-19: Implications for the health care system. *New England Journal of Medicine*, 383(15), 1483–1488.

Boin, A., McConnell, A., & t Hart, P. (2021). *Governing the Pandemic: The Politics of Navigating a Mega-Crisis*. Springer Nature.

Campbell, A. L. (2020). The Affordable Care Act and mass policy feedbacks. *Journal of Health Politics, Policy and Law*, 45(4), 567–580.

Campos, P. A., & Reich, M. R. (2019). Political analysis for health policy implementation. *Health Systems and Reform*, 5(3), 224–235.

Capano, G., & Lippi, A. (2021). Decentralization, policy capacities, and varieties of first health response to the COVID-19 outbreak: Evidence from three regions in Italy. *Journal of European Public Policy*, 28(8), 1197–1278.

Cashore, B., & Howlett, M. (2007). Punctuating which equilibrium? Understanding thermostatic policy dynamics in Pacific Northwest forestry. *American Journal of Political Science*, 51(3), 532–551.

Cejudo, G. M., & Michel, C. L. (2017). Addressing fragmented government action: Coordination, coherence, and integration. *Policy Sciences*, 50(4), 745–767.

Chua, A. Q., Tan, M.M.J., Verma, M., Han, E.K.L., Hsu, L.Y., Cook, A.R., Teo, Y.Y., Lee, V.J. & Legido-Quigley, H. (2020). Health system resilience in managing the COVID-19 pandemic: Lessons from Singapore. *BMJ Global Health*, 5(9), e003317.

Evans, R. G. (2005). Fellow travelers on a contested path: Power, purpose, and the evolution of European health care systems. *Journal of Health Politics, Policy and Law*, 30(1–2), 277–294.
Fox, A. M., & Reich, M. R. (2013). Political economy of reform. In A. S. Preker, M. E. Lindner, D. Chernichovsky, & O. Schellekens (Eds.), Scaling up affordable health insurance: Staying the course (pp. 395–434). The World Bank.

Fuchs, V. R. (2020). Health care policy after the COVID-19 pandemic. JAMA, 324(3), 233–234.

Goyal, N., & Howlett, M. (2021). ‘Measuring the mix’ of policy responses to COVID-19: Comparative policy analysis using topic modelling. Journal of Comparative Policy Analysis, 23(2), 250–261.

Greener, I. (2005). The potential of path dependence in political studies. Politics, 25(1), 62–72.

Haber, H. (2011). Regulating-for-welfare: A comparative study of “regulatory welfare regimes” in the Israeli, British, and Swedish Electricity Sectors. Law and Policy, 33(1), 116–148.

Hacker, J. S. (2002). The divided welfare state: The battle over public and private social benefits in the United States. Cambridge University Press.

He, A. J., Ratigan, K., & Qian, J. (2021). Attitudinal feedback towards sub-national social policy: A comparison of popular support for social health insurance in urban China. Journal of Comparative Policy Analysis, 23(3), 350–371.

He, A. J., Shi, Y., & Liu, H. (2020). Crisis governance, Chinese style: Distinctive features of China’s response to the Covid-19 pandemic. Policy Design and Practice, 3(3), 242–258.

Hogan, J., Howlett, M., & Murphy, M. (2022). Re-thinking the coronavirus pandemic as a policy punctuation: COVID-19 as a path-clearing policy accelerator. Policy and Society, 41(1). https://doi.org/10.1093/pol soc/puab009.

Howlett, M., & Cashore, B. (2009). The dependent variable problem in the study of policy change: Understanding policy change as a methodological problem. Journal of Comparative Policy Analysis, 11(1), 33–46.

Kingdon, J. W. (2003). Agendas, alternatives, and public policies (2nd ed.). Longman.

Knill, C., & Steinebach, Y. (2022). What has happened and what has not happened due to the coronavirus disease pandemic: a systemic perspective on policy change. Policy and Society, 41(1). https://doi.org/10.1093/pol soc/puab008.

Konisky, D. M., & Teodoro, M. P. (2015). When governments regulate governments. American Journal of Political Science, 60(3), 559–574.

Lal, A., Erondu, N. A., Heymann, D. L., Gitahi, G., & Yates, R. (2021). Fragmented health systems in COVID-19: Rectifying the misalignment between global health security and universal health coverage. The Lancet, 397(10268), 61–67.

Levi-Faur, D. (2014). The welfare state: A regulatory perspective. Public Administration, 92(3), 599–614.

Marsden, G., & Docherty, I. (2021). Mega-disruptions and policy change: Lessons from the mobility sector in response to the Covid-19 pandemic in the UK. Transport Policy, 110, 86–97.

Mintrom, M. (2019). So you want to be a policy entrepreneur? Policy Design and Practice, 2(4), 307–323.

Nicholson, C., Jackson, C., & Marley, J. (2013). A governance model for integrated primary/secondary care for the health-reforming first world: Results of a systematic review. BMC Health Services Research, 13, 528. https://doi.org/10.1186/1472-6963-13-528.

Peters, G. B. (2018). The challenge of policy coordination. Policy Design and Practice, 1(1), 1–11.

Pierson, P. (1994). Dismantling the welfare state? Reagan, Thatcher and the politics of retrenchment. Cambridge University Press.

Ramesh, M., & Bali, A. S. (2021). Health Policy in Asia: A Policy Design Approach. Cambridge University Press.

Ramesh, M., & Araral, E. (2010). Reasserting the role of the state in public services. In M. Ramesh, E. Araral & X. Wu (Eds.), Reasserting the public in public services: New public management reforms (pp. 1–16). Routledge.

Ramesh, M., & Wu, X. (2008). Realigning public and private health care in Southeast Asia. The Pacific Review, 21(2), 171–187.

Ramesh, M., Wu, X., & Howlett, M. (2015). Second best governance? Governments and governance in the imperfect world of health care delivery in China, India and Thailand in comparative perspective. Journal of Comparative Policy Analysis, 17(4), 342–358.

Razavi, A., Erondu, N., & Okereke, E. (2020). The Global Health Security Index: What value does it add? BMJ Global Health, 5(4), e002477.

Roberts, M., Hsiao, W., Berman, P., & Reich, M. (2003). Getting Health Reform Right: A Guide to Improving Performance and Equity. Oxford University Press.

Sabatier, P. A., & Weible, C. M. (2007). The advocacy coalition framework: Innovations and clarifications. In P. Sabatier (Ed.), Theories of the policy process (pp. 189–222). Westview.

Savigny, D. E., & Adam, T. (2009). Systems thinking for health systems strengthening. World Health Organization.
Sorenson, C., Japinga, M., Crook, J., & McClellan, M. (2020). Building a better health care system post-Covid-19: Steps for reducing low-value and wasteful care. NEJM Catalyst. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0368.

Sparke, M. (2020). Neoliberal regime change and the remaking of global health: From rollback disinvestment to rollout reinvestment and reterritorialization. Review of International Political Economy, 27(1), 48–74.

Steinmo, S., & Watts, J. (1995). It’s the institutions, stupid! Why comprehensive national health insurance always fails in America. Journal of Health Politics, Policy and Law, 20(2), 329–372.

’t Hart, P., & Boin, A. (2022). From crisis to reform? Exploring three post-COVID pathways. Policy and Society, 41(1). https://doi.org/10.1093/polsoc/puab007.

Taneja, P., & Bali, A. S. (2021). India’s domestic and foreign policy responses to COVID-19. The Round Table, 110(1), 46–61.

Tangcharoensathien, V., Limwattananon, S., Patcharanarumol, W., Thammatacharee, J., Jongudomsuk, P., & Sirilak, S. (2015). Achieving universal health coverage goals in Thailand: The vital role of strategic purchasing. Health Policy and Planning, 30(9), 1152–1161.

Tuohy, C. H. (2003). Agency, contract, and governance: Shifting shapes of accountability in the health care arena. Journal of Health Politics, Policy and Law, 28(2–3), 195–215.

Vlassis, A. (2021). Global online platforms, COVID-19, and culture: The global pandemic, an accelerator towards which direction? Media, Culture and Society, 43(5), 957–969.

Wallenburg, I., Helderman, J., Jeurissen, P., & Ball, R. (2021). Unmasking a health care system: The Dutch policy response to the Covid-19 crisis. Health Economics, Policy and Law, 1–10. https://doi.org/10.1017/S1744133121000128.

Williams, O. D., Yung, K. C., & Grepin, K. A. (2021). The failure of private health services: COVID-19 induced crises in low- and middle-income country health systems. Global Public Health, 16(8–9), 1320–1333.

Wilsford, D. (1994). Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. Journal of Public Policy, 14(3), 251–283.

Wilsford, D. (2010). The logic of policy change: Structure and agency in political life. Journal of Health Politics, Policy and Law, 35(4), 663–680.

Woo, J. J. (2020). Policy capacity and Singapore’s response to the COVID-19 pandemic. Policy and Society, 39(3), 345–362.

World Health Organization. (2020). Coronavirus disease (COVID-19) technical guidance: Patient management. http://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/patient-management.

Wu, X., & Ramesh, M. (2009). Health care reforms in developing Asia: Propositions and realities. Development and Change, 40(3), 531–549.

Yip, W. C. M. (2020). Health care policy in East Asia: A World Scientific reference. World Scientific.