



POLITICAL MOTIVATION AS A KEY DRIVER FOR UNIVERSAL HEALTH COVERAGE

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Recommended citation:

Venkateswaran, S., Slaria, S., Mukherjee, S., (2022). *Political Motivation as a Key Driver for Universal Health Coverage* (CSEP Working Paper 32). New Delhi: Centre for Social and Economic Progress.

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POLITICAL MOTIVATION AS A KEY DRIVER FOR UNIVERSAL HEALTH COVERAGE*

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*We are grateful for the comments we received on earlier versions of this paper from Michael Reich, Nachiket Mor, Owen Smith, Philipa Mladovsky, Rakesh Mohan. Any errors or shortcomings remaining are entirely ours.

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Abstract

There are vast variations across countries in terms of public investments in health, health outcomes, and progress towards universal health coverage. However, neither economic status nor knowledge of solutions has borne out to be binding constraints to health improvements. The drivers of universal health coverage surpass the macro-economic context of a nation, and as pointed out by scholars (Atun et. al., 2013; Yilmaz 2017), are deeply linked with the extent of political prioritisation of healthcare. Low public investments in health in India, and the slow movement towards universal health coverage, underline the need for greater political prioritisation of health in the country.

While the role of politics in policy reforms has been established by several scholars (Reich 1995; Walt 1994; Bambra et al 2005), this paper seeks to identify the intrinsic motivations or incentives that drive political priorities. Drawing on the experience of nine countries, this paper seeks to contribute to the discussion on the political incentives for prioritisation of healthcare in countries like India and how these may be shaped or strengthened.

The paper finds that healthcare reforms happen in (at least) two stages: the existence and recognition of a national context and a problem, followed by the emergence of political opportunities and motivations that lead political leaders to address the identified problem. This paper distinguishes motivation as a crucial factor for analysis because, in the absence of strong incentives, not every political opportunity leads to an issue receiving attention. Our paper also finds that reforms are motivated by an incoming regime's need to gain political legitimacy, its political ideology, or a combination of the two.

Importantly, political motivation does not always arise by itself, but it is often driven by external factors and stakeholders who contribute to creating or strengthening incentives for political attention. A more proactive role played by citizens and other actors who question the status quo and highlight the schisms in the social contract between a political regime and citizens may contribute to shifting the source of legitimacy for leaders.

Introduction

The world has made significant strides in healthcare in terms of eliminating disease, improving health indicators, and working toward the Sustainable Development Goals. Several countries are now aspiring for universal health coverage. However, approximately half of the world's population is still unable to obtain essential healthcare services. Every year, about 100 million people are pushed into extreme poverty globally because of healthcare-related expenditures (WHO, 2017).

There are vast variations in public investments in health, health outcomes, and progress towards universal health coverage across countries, but neither economic status nor a lack of understanding of solutions has borne out to be binding constraints to health improvements. With the sharing of global knowledge and expertise, a lack of understanding no longer limits health improvements at the country level. Given the rate of progress in low- and lower-middle-income countries such as Indonesia, Vietnam, Brazil, Turkey, and Thailand, economic status is also not a factor holding back health improvements. Mor (2019) notes that total health expenditure (as a proxy for economic status) alone explains only about 50% of DALY rates.¹ Several countries across the world that face economic challenges and high inequality in terms of access to healthcare have successfully managed to prioritise healthcare and move towards efficient universal health coverage. A key driver for universal health coverage, as has been pointed out by several scholars, is the influence of political attention and prioritisation on improving healthcare (Shiffman & Ved, 2007; Yilmaz, 2017; Sparkes et al, 2019). Attention from political leaders and policymakers increases the probability that policy reforms and public investments needed for progress on health reforms are implemented. Public investments in health have remained low in India, and movement towards universal health coverage has been slow, indicating a need for greater political prioritisation of health in the country.

While the role of politics in policy change has been established by several scholars (Reich, 1995; Walt, 1994), this paper seeks to identify the motivations that drive political attention and prioritisation of health policy by country leaders. Through the experience of several countries, we attempt to inform the analysis for slow progressing countries like India (in terms of universal health coverage countries such as India and others (where progress towards universal health coverage remains slow) of the political incentives for prioritisation of healthcare and how these may be shaped or strengthened.

There is a vast body of literature on the solutions to many of the healthcare challenges across countries and the nature of the reforms undertaken. Our paper does not focus on these. Because the scholarship on the political motivations for reform and health prioritisation is limited—especially in the context of competing national priorities—this constitutes the focus of our paper.

Research question and methodology

The considerable scholarship on how the attention of political and other leaders drives policy reform and public investments raises a deeper question concerning the forces that lead to such attention. Much has been written about external drivers (Gilson et al 2018, Kingdon 1984, Berger and Luckmann 1966, Buse et al. 2012, Cobb and Elder 1972, Edelman 1988, Shiffman and Smith 2007, Campos and Reich 2018, Sparks et al 2019)²; however, we hypothesise that some intrinsic motivations and incentives draw the attention and commitment of political leaders to an issue, in this case, health. The focus of our analysis is on identifying the motivations that drive country leaders and policymakers to prioritise health and the factors that contribute to these motivations.

¹ Disability-adjusted life years

² External drivers to policy reforms have been explored in detail in Venkateswaran, Slaria & Mor (2021)

This analysis should not be interpreted to suggest that the process of formulating health priorities and health sector reforms is entirely driven by the intrinsic motivation of country leaders. Building on political economy frameworks developed by numerous scholars, policy entrepreneurs have contributed in various forms to facilitate and promote the processes of reform initiation. However, it can be argued that all such efforts are successful when there is a clear incentive for country leaders, who need to weigh choices and priorities across multiple national competing demands and needs, to implement reforms. It is precisely this motivation or incentives that is the focus of this paper, in addition to the external factors, stakeholders, and processes that play a role in creating these incentives.

In our paper, we use political attention and political prioritisation of health as interchangeable. Building on a definition by Shiffman and Smith (2007), referred to in Schmidt et al (2010), we view political priority as the degree to which (1) political leaders actively pay attention to health and prioritise interventions needed for progress on health, (2) political decisions lead to system reforms and programmes that address the problem, and (3) reforms and programmes are supported by financial and other resources.

Since the research question is aimed at the motivation driving attention to health, this paper focuses—in a limited manner—on the initiation of health reforms distinct from their outcomes. While this is not to minimise the criticality of impact, the outcomes of reforms, or their specific design, which are a function of multiple factors, it is not the intent of this paper to examine these aspects.

We analysed the incentives for health prioritisation across nine countries—Turkey, Mexico, Brazil, Argentina, Indonesia, Philippines, Thailand, Vietnam, and China. Two sets of criteria influenced the selection of these countries. One, that they had undertaken health reforms with the country leadership demonstrating a prioritisation of health. Two, the countries were selected to represent different economic levels, political systems, and geographic regions.

As per the first criterion, the countries were selected because they demonstrated political prioritisation of health during a specific time period, which, in this case, was determined by the aforementioned factors. All of the countries selected had undertaken health reforms³ and initiated programmes to address health-related challenges at a specific time.

- Turkey—until the early 2000s—faced inequities in health outcomes across regions and segments of the population, shortages and inequitable distribution of infrastructure and human resources, and inequitable financing of the health system. These were addressed through the Health Transformation Plan in 2003, which introduced a single purchaser model to address these inequities.
- Thailand had an uninsured population of 30% in 2001, with significant private expenditure on health, leading to the introduction of a tax-financed programme (the 30-baht scheme) in 2002. The scheme provides healthcare at the point of service for a co-payment of 30 bahts (equivalent to US\$ 0.87).
- In Argentina, the economic crises—led unemployment resulted in a large proportion of the population losing their health insurance cover and consequently deteriorating health outcomes. This was addressed through Plan Nacer in 2005, focused on expanding insurance cover for basic services amongst citizens who were not insured.
- A large proportion of Mexico's population, specifically the lowest-income group, lacked health insurance—leading to high out-of-pocket expenditures and catastrophic financial events. Reforms in the form of Seguro Popular were introduced in 2003 to address the unequal distribution of financial, physical, and human resources in health services.

³ Elaborated in later sections in the paper

- Brazil had different health rights for workers and poor populations working outside the formal economy, which were addressed through a unified health system enshrined in the constitution in the 1990s to ensure equal access to health services for all citizens.
- In Vietnam, out-of-pocket expenditure on health increased significantly with a shift to a market economy. A state-financed health insurance was introduced in 2003, along with citizens being provided a legal right to health protection.
- The Philippines healthcare programme was not successful in addressing the healthcare needs of its poor due to poor governance and accountability. The PhilHealth-sponsored programme was extended to focus on the poorest population, with premiums paid for by the government.
- Indonesia experienced an increased cost of healthcare input and diminishing purchasing power after the financial crisis. A constitutional amendment in 2000 made the state responsible for ensuring health service provision for all citizens, leading to the national government paying for in-patient services for all poor people.
- China witnessed a shift to a market-based system, resulting in inequalities in health access and increased private health expenditure. A basic health insurance scheme was introduced in response in 2003.

As per the second criterion, the country selection was aimed at obtaining a representative sample of diverse economic, political, and geographic contexts. On the economic front, countries were chosen among low-income, lower-middle-income, and upper-middle-income countries to gauge the interaction of economic circumstances with the motivation to reform domestic healthcare sectors. The rationale for different economic contexts stems from the need to explore hypotheses pointing to stronger economic contexts being more amenable to the introduction of reforms. The chosen countries represent significantly different economic contexts with per capita GDP ranging from about US\$430 to US\$7,500 at the time of initiating health reforms (World Bank, 2021). At the time of the launch of countries' healthcare reforms (as detailed in later sections), the World Bank classified Vietnam and Indonesia as low-income countries; the Philippines, China, Brazil, Turkey, and Thailand as lower-middle-income countries; and Argentina and Mexico as upper-middle-income countries (World Bank, 2021).

The dynamics of engagement between political leaders and citizens could vary according to the type of political regime driving principal-agent relationships and political incentives. It is for this reason that the political context could be viewed as another variable for issue prioritisation, where different political regimes—democratic and authoritarian—may respond to citizen needs differently. This could then suggest that very different factors lead to political attention to an issue across political systems. On the political front, therefore, countries were selected to represent varied political systems (democratic regimes, single party-led countries, and those moving towards democratisation) to examine if and how the political system influences the motivation for and priority accorded to health issues.

Geographic regions have experienced economic and/or political transitions: structural shifts emerging from the Washington Consensus, and the transition from authoritarian rule in much of Latin America and the Asian Financial Crisis in South-East Asia, to name a few. These processes shaped the autonomy and priorities of countries in the region. This analysis, therefore, includes countries across regions—in Latin America, the Middle East, and Asia—to examine how the regional contexts influenced the rationale and motivation for attention to health.

In our study, we utilised a mixed methodology of extensive secondary literature analysis and a limited set of stakeholder interviews. The secondary analysis focused on specific reforms introduced in the respective country over the last few decades (recognising that several countries have undertaken

multiple reforms across years). It examined contexts pre- and post-reforms—combining historical, political, economic, and social aspects to trace the trajectory of the processes that led to the reforms. Interviewed stakeholders included former bureaucrats, researchers, and officials from multilateral organisations who were engaged with these countries in varied ways. Our analysis is limited to the study of the priority given to health by political and other leaders and the resulting initiation of sector reforms rather than their actual implementation.

Results

This paper rests on the basic premise that healthcare reforms happen in (at least) two stages. The first is the existence and recognition of a national context and a problem, which in most analysed countries was high poverty and/or inequality, of which a tangible component is an unequal access to quality healthcare services. This is followed by political opportunities and motivations that lead policymakers and political leaders to address the national context/problem. Through our paper, we separate motivation as a distinct factor for analysis because not every political opportunity may lead to sectoral attention in the absence of strong incentives. Elections, as a political window, underline this fact—as not every change in political leadership leads to a shift in a sector's priority.

The experiences across the nine countries analysed also underline the roles of other factors and stakeholders in influencing agenda setting—such as civil society organisations, social workers, activists, social movements, citizen demand, and international organisations—as identified by many political economy scholars (Kingdon, 1984; Walgrave & Vliegthart, 2010; Ağartan, 2008; Armada, Muntaner, & Navarro, 2001; Lloyd-Sherlock, 2006).

The paper explores motivations to address specific economic and socio-political contexts and the nature of incentives that move leaders from recognising a situation to acting on it. Despite similarities in economic contexts, we examined if and how incentives varied for different leaders.

The goals of reducing poverty and inequality or seeking national development or increased growth are seen across several countries. The pathways to these, however, vary and are often built around perceived incentives by leaders. Incentives could be viewed in different forms; it is precisely this interrogation that led to identifying the foundational motivation for leaders.

Buchanan (2002) points to actions of leaders that are aimed at lending credibility to their governance and in turn leading citizens to provide validity to the government's administrative decisions. This is seen in various political regimes to appease the electorate in democratic systems and validate the performance of autocratic systems.

A different pathway is based on ideology, as defined by several political theorists (Erikson & Tedin, 2019; Parsons, 1951; Jost, 2009), built on philosophies of life which set about ideals about structuring the proper order of society and processes to achieve the same.

To understand how these and possibly other pathways influenced the political prioritisation of health in these countries, it is important to understand the national and political contexts in each.

Economic context

At the time of reform, all nine countries were experiencing high rates of poverty or inequality or both, along with high levels of out-of-pocket expenditures on health. Healthcare reforms were largely introduced to address systemic inequities constraining universal health coverage.

When reforms were undertaken in the early 2000s, Turkey had a Gini coefficient of 0.43, with only almost 40% of the population uninsured (Atun et al, 2013). The 1990s witnessed coalition governments which were weak, resulting in unstable and unsustainable economic development

and the country witnessing economic cycles of boom and bust. As a result, Turkey witnessed a contraction in its real GDP during the 1990s, rampant inflation, and high rates of unemployment leading to increased inequality in the early 2000s. The political economic and social instability led successive governments in the 1990s to de-prioritise the health sector. At the time, the health sector in the country faced several issues—the adequacy and distribution of health financing, physical infrastructure and human resources for health, and inequities in outcomes across income groups and regions (Atun et al, 2013).

Until the early 2000s, Mexico had a Gini coefficient of 0.50 with out-of-pocket expenditure at 54% before the reforms (Atun et. al, 2015). The Mexican health system was designed to provide episodic and acute care. However, a declining fertility rate and increasing life expectancy brought about an epidemiological transition in the country, increasing the burden of non-communicable diseases and chronic illnesses that the health system was ill-equipped to deal with (Atun et. al, 2015). By the mid-1990s, approximately half of Mexico's population lacked health insurance, including those whose access was limited to “very basic community and preventive health interventions included in the poverty alleviation programme *Oportunidades*” (Frenk et al, 2006). Consequently, more than half of the total national health expenditure was out of pocket. These high levels of out-of-pocket expenditure were exposing Mexican households to catastrophic financial events; in 2000, approximately 3 to 4 million Mexican families (approximately 4% of the total population) incurred impoverishing health expenditures (Frenk et al, 2009). Several financial imbalances prevented the healthcare system from focusing on population health, including (1) low health spending levels; (2) skewed public investments across states and between those that were insured and those uninsured; (3) the inequitable contribution of states to finance healthcare, with significant differences in expenditure per head across states; and (4) chronic under-investment in health infrastructure (Secretaría de Salud, 2001; Frenk et al, 2006).

When the 30-baht reforms were introduced in 2002, Thailand had a Gini coefficient of 0.42, and 34% of the health spend was paid out of pocket (World Bank, 2021). While Thailand had always focused on providing healthcare to its citizens, including the launch of the Low-income Scheme in 1975, 30% of the country's population remained uninsured in 2001. Kuhonta (2017) argues that the macro context for the introduction of Universal Health Coverage (UHC) in Thailand included the introduction of the 1997 Constitution and the Asian Financial Crisis. While the need for social equity emerged as a result of the Asian Financial Crisis, conditions for government stability, leading to policy sustainability emerged from the constitution created.

The Philippines has seen improvements in economic growth since 2001, but this has not translated into inclusive development and a reduction in poverty. The country had a Gini coefficient of 0.46 with out-of-pocket health expenditure reaching about 56% in 2009 (one year before the health reforms were initiated) (World Bank, 2021). Inequalities persisted, of which, access to quality healthcare was reflected through high out-of-pocket health expenditures, a major factor leading to the impoverishment of poor households (Cabalfin, 2016; Chakraborty, 2013). The Gloria Macapagal Arroyo administration (2001–10) did little to address this and several allegations of corruption and human rights abuses had been levelled against it (Amnesty International, 2007).

Brazil had a Gini coefficient of 0.61 when it underwent the democratisation process in 1988 (World Bank, 2021). The country underwent industrialisation and urbanisation from the 1930s to the 1980s. This led to a change in demographic patterns due to an increase in incomes, lower fertility, declining mortality, and increasing life expectancy (Machado & Silva, 2019). Consequently, Brazil witnessed an epidemiological transition marked by a rise in cardiovascular illnesses, cancer diseases, and other non-communicable diseases (Machado & Silva, 2019). At the same time, the 20 years of military rule from 1964 to 1985 were characterised by an increased focus on economic development as opposed to social welfare. The private sector grew, including from the social security provisions

where publicly financed care was provided through the private sector; those working in the informal sector and the urban and rural poor were largely excluded from the same. Consequently, public sector healthcare was also concentrated in the developed parts of the country and excluded the urban and rural poor (Collins et al, 2000). When the country prepared for a transition from an authoritarian to a democratic regime after 20 years of military rule, “health sector reform became a fundamental feature of the fight to re-democratise the society and the political regime” (Collins et al, 2000: 115).

In Indonesia, democratisation occurred after the Asian Financial Crisis, when the percentage of people living under the \$1.90 poverty line (2011 PPP) was as high as 63%, with out-of-pocket health expenditures comprising 44% of total health expenditure (World Bank, 2021). The Asian Financial Crisis of 1997, citizens’ protests, and political instability acted as catalysts for the reform in Indonesia’s healthcare system. Before the crisis, Indonesia’s health outcomes were relatively better than that of its peer countries (Hotchkiss & Jacobalis, 1998). After the economic crisis, two events impacted the poor in a big way. First, Indonesia faced a devaluation of its currency and inflation, leading to an increase in the prices of healthcare inputs, especially those of imported pharmaceutical products. Reduced tax revenues led to reduced health expenditure by the government, in turn leading to a shortage of medicines and equipment in government health facilities. This impacted the usage of government-run facilities, worsening the health status of the population (Waters et al, 2003). Second, the crisis pushed an additional 36 million Indonesian people into absolute poverty (Aspinall, 2014). This led to an adverse impact on poor households who had to simultaneously contend with diminishing purchasing power as well as increased costs of treatment at Indonesian government health centres (government facilities charged user fees from patients).

Like in other countries in the region, Argentina’s health sector agenda was developed in the 1990s at the same time the country was experiencing “profound economic and social restructuring, along neoliberal lines” (Llyod-Sherlock, 2005: 1896). It is important to understand health sector reforms in Argentina vis-à-vis the wider context of neoliberal restructuring and governance. Between 1989 and 1999, in collaboration with the World Bank and the International Monetary Fund (IMF), the Carlos Menem administration adopted neoliberal reforms that involved trade liberalisation and privatisation, which were also reflected in the country’s healthcare reforms (Machado, 2018). The reforms, however, failed to bring about substantial results and the hyperinflationary economic crisis from 1999 to 2002 led to a public health emergency. The GDP of the country fell by 18.3% between 1998 and 2002, the number of poor grew by 20 percentage points, and inequity worsened (Cortez & Romero, 2013). As unemployment increased and more people were laid off from their jobs, approximately 12% of workers lost their health insurance cover; the sharp fall in employment rates resulted in 60% of the total population falling outside the social health insurance system (Cortez & Romero, 2013). The crisis resulted in deteriorating health indicators, including child and maternal mortality rates, especially in the poorest regions.

Vietnam, being a communist one-party state, had an inherent mandate to provide access to healthcare to all its citizens as part of its socialist agenda. Despite this, 37% of the population lived under the \$1.90 poverty line in 2002, a year before the health reforms were carried out (World Bank, 2021). In the late 1980s, Vietnam was hit by a socio-economic crisis after the collapse of the Soviet Union—which reduced foreign aid (Bui T.T. Ha et al, 2014). This affected the government’s ability to solely fund healthcare activities and ushered in a market economy policy with a socialist government structure (Bui T.T. Ha et al, 2014). This led to high out-of-pocket expenses on healthcare at 37% of total healthcare expenditure as of 2002 (World Bank, 2021).

As of 2002, in China, out-of-pocket expenditure was at 64% of the total health expenditure while 32% of the population lived under the \$1.90 poverty line just before the health reforms were implemented (World Bank, 2021). The health privatisation policies of a market-led system (discussed later in this

paper) followed by the Deng Xiaoping administration led to a reduction in government regulations within the healthcare sector and the re-orientation of public hospitals into for-profit entities. These shifts led to health inequalities between rural and urban residents, poor quality of healthcare, and increasing private health expenditure (Yip & Hsiao, 2015).

The following table summarises the change in public health expenditure and the population covered across these countries as a result of the reforms.

Table: Pre- and post-reform status in public health expenditure and population coverage

Country	Reform timeframe	Pre-reforms		Post-reforms	
		Population covered	PHE as % of the total budget	Population covered	PHE as % of the total budget
Turkey	2003 onwards	69.8%	7.46	98.8%	10.7 (2007)
Thailand	2001	70% ⁴	12.7	100%	14.8 (2006)
Argentina	2004/05	NA	18.5	NA	15 (2006)
Mexico	2003–19	51%	10.4	85%	10.7 (2007)
Brazil	1988–2020	22.8%	8.4 (1995)	75%	10.3 (2017) ⁵
Vietnam	1992 onwards	20% (2003) ⁶	6.6	80% (2016) ⁷	7.5 (2006)
Philippines	2010–16	52.6 Households	6.6	63.2 Households (2015) ⁸	7.3 (2015)
Indonesia	1999–2014	less than 50 % ⁹	3.9	82 % (2014)	4.5 (2007)
China	2002–12	20% (early 2000) ¹⁰	5.6	98% (by 2015).	7.9 (2007)

Source: Authors' analysis

⁴ Tangcharoensathien, V., Patcharanarumol, W., Kulthanmanusorn, A., Saengruang, N., & Kosiyaporn, H. (2019.) The political economy of UHC reform in Thailand: Lessons for low- and middle-income countries. *Health Systems & Reform*, 5(3), 195–208, doi: 10.1080/23288604.2019.1630595.

⁵ <https://countryeconomy.com/government/expenditure/health/brazil>.

⁶ Tran, et al. (2021). Getting to universal health coverage in China and Vietnam. Brookings. Retrieved from <https://www.brookings.edu/blog/future-development/2021/02/03/getting-to-universal-health-coverage-in-china-and-vietnam/>.

⁷ *ibid*

⁸ Bredenkamp, et al. (2017). Expansion of health insurance in the Philippines: Evidence from panel data. World Bank. Retrieved from <https://openknowledge.worldbank.org/bitstream/handle/10986/27669/116647-WP-ExpansionofHealthInsurance-PUBLIC.pdf?sequence=1&isAllowed=y>.

⁹ Sparrow, R., Budiyati, S., Yumna, A., Warda, N., Suryahadi, A., & Bedi, A.S. (2017). Sub-national health care financing reforms in Indonesia, *Health Policy and Planning*, 32(1), 91–101, <https://doi.org/10.1093/heapol/czw101>.

¹⁰ Li, Y., Malik, V., & Hu, F.B. (2017). Health Insurance in China: After declining in the 1990s, coverage rates rebounded to near-universal levels by 2011, *Health Affairs*, 36(8), <https://doi.org/10.1377/hlthaff.2016.1658>.

Political context

As with the economic context, similarities in political context across the nine analysed countries were evident from the political transitions they went through, although the nature and extent of political change were quite different. Some countries witnessed the initiation of a democratic process (such as Brazil and Indonesia), while others merely witnessed a change of political leadership (Turkey, Thailand, Mexico, Argentina, China, and the Philippines).

Democratisation

In Indonesia, the aftermath of the economic crisis led to widespread social unrest and citizen protests. This unrest was instrumental in forcing the then autocratic ruler, President Suharto, to step down in 1998. While his successor, B.J. Habibie, tried to mitigate the effects of the crisis and increase the acceptability of the ruling party by strengthening education, nutrition, and health services for the poorest, these did not prove effective in saving Suharto's party (Aspinall, 2014; Hotchkiss & Jacobalis, 1998; Asian Development Bank, 2006; Pisani et al, 2016).

To counter Suharto's autocratic policies, multiple student movements unified into a political party known as the Indonesian Democratic Party of Struggle (PDI-P party), formed by Megawati Sukarnoputri (daughter of the former president, Suharto) as a government dissent faction in 1998. Although this party did not have an inherent welfarist agenda, it capitalised on citizen protests against President Suharto. As demands for democratisation increased, they highlighted the social ills brought about by the Suharto regime, campaigning on a platform for increased equity, leading to their election to power in 1999. They leveraged the focus on social welfare and equity as a political tool to gain legitimacy among a public that was already protesting Suharto's policies. After the electoral success of the party, the Megawati administration amended the constitution in 2000 to include "the right to receive medical services" (Pisani et al, 2016: 270) highlighting the state's responsibility in ensuring health service provisions and seeking to develop a social security system for all citizens (Pisani et al, 2016; Agustina et al, 2018).

In Brazil, it was the process of democratisation and the promulgation of the constitution which led to the prioritisation of healthcare and the social sector more broadly. Brazil experienced a period of military dictatorship from 1964 to the late 1980s. The last phase of the military dictatorship (1985–90) marked the process of re-democratisation in the country, wherein a regime (Brazilian Democratic Movement Party) opposed to the dictatorship came into power (1986), a new constitution was promulgated (1988), and the popular presidential elections were carried out (1989) (Codato, 2006).

It was within this backdrop—with pressure from the Brazilian *sanitarista* (public health) movement (discussed in detail in the next section)—that Brazil witnessed increased attention to the health sector. Amidst the economic crisis and democratisation in the 1980s, the country witnessed the emergence of healthcare reforms which led to healthcare being recognised as a citizenship right and also the introduction of the public Unified Health System (SUS) enshrined in the constitution (Machado & Silva, 2019). During the Constituent Assembly in the late 1980s, when Brazil was moving towards re-democratisation, the left-oriented parties and the liberal sections of other parties agreed upon the need for a public health system (Davidian, 2021). Thus, in the new constitution, "it was the health sector that presented the most complete proposal both in terms of governing principles and in the organization of the system" (Elias and Cohn, 2003: 45).

Change in regime

The reforms in Turkey were situated in the political context of a change in political leadership, with the election of the AK Party in the early 2000s. The party came into being 15 months before coming into power in 2002, borne out of a separation from the major political Islamist movement,

presented as a “conservative democratic” party aiming to bring together various streams of centrist and rightist parties. In the 2002 general elections, the AK Party won by a majority and “ended a decade of poorly functioning coalition governments” (Atun et al, 2013: 71). While the party adopted a neo-liberal approach to the economy, it did prioritise the role of the state in social and healthcare policy (Yilmaz, 2017). The AK Party had seven main components in its party programme, one of which was dedicated to social policies—which included healthcare.

Consequently, when the AK Party came into power on a populist mandate, to appeal to its significant voter base of rural poor and urban slum dwellers, it focused on a pro-poor narrative. Yilmaz (2017: 154) finds that “Healthcare was key in the AKP’s quest for power, and that the AKP used healthcare to influence people”. Yilmaz (2017) argues that the AK Party focused on social policies and healthcare reform specifically to distance itself from the political Islamist movement it had emerged out of, as all parties affiliated to the movement had been shut down.

Health reforms, in the form of the well-implemented Health Transformation Plan (HTP), contributed to the electoral success of the AK Party over the years; in turn, continuing the priority to healthcare through which the party was able to leverage greater political legitimacy. Over a ten-year period, the percentage of the population satisfied with the healthcare system in Turkey increased from 40% in 2003 to 75% in 2013 (Atun et al, 2013; Yilmaz, 2017). Public opinion surveys indicated that the general public considered healthcare reforms to be the party’s most successful achievement (Yilmaz, 2017).

Patton (2006) argues that the party was able to push for reforms and deliver successfully on them due to a combination of factors including greater stability in the government of the AK Party, improved financial management, and improved demand for better healthcare from working-class citizens. The World Bank provided technical and financial assistance in introducing the reforms, with the relations between the Turkish government and the World Bank strengthened with the AK Party. Yilmaz (2017) argues that the release of the World Bank’s report on Turkey’s healthcare system in 2003 was “influential in setting the main parameters of the political debates on Turkey’s health-care system” (Yilmaz, 2017: 132) and served as a reference point for the AK Party which was already motivated to reform the country’s healthcare system.

Mexico witnessed the Vicente Fox-led National Action Party (NAP) coming into power in the early 2000s after breaking the Institutional Revolutionary Party’s (PRI) hold on presidential power for over 70 years. A new party and the political ideology of the health minister, Dr Julio Frenk, when the party came into power, led to the initiation of health reforms in Mexico, largely termed a minister-driven reform. Since the 1980s, the minister had surfaced challenges confronted by the Mexican health system, through his focus and leadership on multiple academic efforts, and built on his expertise along with the support of the president and other stakeholders to drive the reform process from beginning to end. The System of Social Protection in Health (SSPH) and its healthcare insurance component, the Seguro Popular, was a culmination of this process (Frenk et al, 2006).

Argentina witnessed one of the greatest economic and unemployment crises in the country’s history in 2001, leading to disappointment with the political and economic situation in the country, and citizens re-evaluating the presidency of Carlos Menem of the Peronist party in the 2003 general elections (Sanchez, 2005).

In the run-up to the elections, Néstor Kirchner (who won the elections) ran on a centre-left platform and addressed the social exclusion legacy of his predecessor by a focus on production and (Sanchez, 2005). Upon coming into power, President Néstor Kirchner focused on the expansion of social rights for the country’s population, including increased coverage of public health programmes. The government of Argentina prioritised healthcare and invested in the health sector as part of its poverty alleviation programme (Cortez & Romero, 2013). Various programmes were introduced including Plan Nacer, a Maternal and Child Health Insurance programme targeted at expanding insurance coverage for basic services among those not insured (CGD, 2015; Gertler et al, 2014).

In Thailand, the push for reforms came from the newly elected, reform oriented political party, Thai Rak Thai, led by Thaksin Shinawatra who campaigned for a pro-poor agenda in the lead-up to the January 2001 elections (Kuhonta, 2017). Thaksin Shinawatra, leader of the Thai Rak Thai party, taking note of the rural discontent against the incumbent of the pro-market democrat party collaborated with a large and vocal civic group with rural roots (Baker, 2000) and promised universal health coverage in his campaign. This was subsequently implemented in the form of the 30-baht Reform¹¹ when the party came into power. Political actors and bureaucracy played an instrumental role in the introduction of universal health coverage in Thailand, leading to its successful implementation in 2002.

Like Brazil (discussed later in this paper), healthcare professionals came to occupy important positions in the government in Thailand, playing a significant role in pushing UHC on the agenda and ensuring its implementation. Two senior members of the party, including the future deputy prime minister, were members of the Rural Doctor's Society (RDS)—a society formed in 1978, instrumental in driving healthcare reforms in Thailand (explained in detail in the next section) and strong supporters of universal health coverage. Mor (2021) argues that the victory of the TRT party and its pro-poor agenda focusing on healthcare was seen as a window of opportunity by members of the RDS who seized the opportunity and pushed for UHC in the country. United in their “deep core beliefs” (Mor, 2021: 1) around the importance of UHC, the doctors were crucial in driving the reform process. As senior members of the political party in power as well as in the Ministry of Public Health, they were able to bring healthcare to the political agenda. Kuhonta (2017) argues that the new constitution introduced in 1997 increased the power of the prime minister to a significant extent and allowed political dominance for Thaksin and TRT, with the context of the Asian Financial Crisis and the resulting economic hardships further helping to bolster the popularity of the party.

In the Philippines, the Benigno Aquino III presidency (2010–16) followed the Gloria Macapagal Arroyo regime (2001–10). The latter saw high inequalities in healthcare, reflected through high out-of-pocket health expenditures and the impoverishment of poor households. Despite healthcare being free for poor households during the Arroyo regime, poor implementation led to inefficiency and corruption in the public healthcare systems (Cabalfin, 2016; Chakraborty, 2013). Consequently, the Benigno Aquino III presidency sought to introduce radical change compared to his predecessor by focusing on the effective implementation of social and economic welfare programmes such as those relating to healthcare, education, and employment. This focus was also motivated by his mother's (President Corazon Aquino (1986–92)) legacy and influence on his voter base (Cabato & Branigin, 2021). It was during the presidency of Corazon Aquino that healthcare saw an initial impetus with the implementation of the Local Government Code (1991), providing local government units the power to manage region-specific health systems. This laid the foundation for the National Health Insurance Act (1995), later establishing PhilHealth as a national health insurance body. This legacy played a key role in several health reforms undertaken by the Aquino III administration (Dayrit et al, 2018; Silfverberg, 2014).

The conditions during the Arroyo regime changed significantly with the Benigno Aquino III administration undertaking several health reforms to strengthen the roadmap towards universal healthcare. The commitment of the Aquino III presidency was instrumental in establishing a strong social contract with the Filipino people.

Healthcare prioritisation in China saw a shift in the mid-1970s when it moved from a government-led socialist economy to a market economy brought about by the privatisation policies of the Deng Xiaoping administration (1978–91). The shift to a market-based system started in 1978, after the policies of the centrally planned socialist system had led to severe underemployment, low productivity,

¹¹ A government-funded health programme aimed at universal coverage that required a co-payment of 30 baht per visit.

poverty, and famines. The shift to a market economy was envisioned as a means to produce rapid economic growth, which also saw an effect on the health sector, with a greater push towards individual self-reliance. This change resulted in a significant reduction in government regulations within the healthcare sector, which led to an increased mark-up on drugs and re-orientation of public hospitals into financially independent entities. These health practices led to health inequalities between rural and urban residents, poor quality of healthcare, and increasing private health expenditure. The high healthcare costs and lack of insurance coverage in the 1990s prompted high public discontent and protests, picked up through media coverage (Yip & Hsiao, 2015).

At the same time, two other policy windows contributed to the change—the Severe Acute Respiratory Syndrome (SARS) outbreak and a transitional political leadership (Yip & Hsiao, 2015). The tumultuous time of the SARS outbreak and public unrest over high healthcare costs coincided with the national political transition (between November 2002 to March 2003) within the Chinese leadership, which led to the start of the regime of President Hu and Premier Wen. The Hu–Wen administration had a different set of social values than their predecessors (Deng Xiaoping administration), gave a higher priority to the health needs of Chinese rural and urban residents, and considered a health safety net as crucial for people’s well-being.

While healthcare is one of the core agendas of China’s communist party ideology as part of its social welfare system, the healthcare reforms that took place in 2003 were influenced in large part by a need for the Chinese Communist Party to demonstrate good governance, and also as a means to control the citizens’ protests and reduce focus on the state’s failure to provide access to quality healthcare (Zhu, 2011). Thus, external pressures, citizen demand, as well as the ill-effects of the SARS pandemic prompted the Hu–Wen government to provide basic insurance programmes and catalysed the change for the 2009 reforms, which led to the establishment of universal healthcare for all Chinese residents (Yip & Hsiao, 2015; Eggleston, 2010).

Our analysis suggests that while political transitions have been a common factor in shifting priority to social policy, it is not a necessary condition. The experience of Vietnam points to the initiation of healthcare reforms even in the absence of political transitions.

Vietnam, being a one-party-led communist state, had an inherent mandate to provide access to healthcare to all its citizens as part of its socialist agenda, though, as pointed out earlier in this paper, 37% of the population lived under the US\$1.90 poverty line (in 2011 PPP¹²), with high out-of-pocket expenditures on healthcare (World Bank, 2021). In the late 1980s, Vietnam was hit by a socio-economic crisis after the collapse of the Soviet Union, which reduced foreign aid. This affected the government’s ability to solely fund healthcare activities and ushered in a market economy policy with a socialist government structure. While this led to the privatisation of healthcare, the government was careful to protect the interests of its people through the Law on People health protection (1989) (Bui T.T. Ha et al, 2014) and socio-economic development plans and budgets. The law signified the commitment of the Vietnamese government to the universal right to healthcare.

Social context

The social context, in terms of citizen demand, social movements, and the influence of policy actors, constitutes the third pillar, which not only brings visibility to the issue but establishes it as a key national agenda. Agenda setting and political prioritisation are influenced by various factors. Policy actors—including NGOs, civil society organisations, and social workers and activists—can be key in influencing agenda setting and policy choice (Kingdon, 1984). Similarly, social movements can influence national agendas (Walgrave & Vliegthart, 2010), as can demands from citizens for reforms. The presence of such social drivers and their interaction with the political process was

¹² Purchasing power parity

visible in most of the countries studied, in their contribution to the creation or strengthening of incentives for political leaders in prioritising healthcare.

Brazil saw policy actors playing a key role in the prioritisation of healthcare reforms in the country. “Brazil’s *sanitarista* (public health) movement had long advocated for more equitable health reforms and played a critical role in institutionalizing principles of universalism in the 1988 constitution, following the transition to democracy in 1985, and for the 1990 Unified Health System Law” (Maeda et al, 2014: 24). Various actors came together to give rise to a healthcare movement which sought to transform a segmented, fragmented, inefficient, and exclusive healthcare system. These included public health academics, administrators and experts from various government ministries and health professionals (Machado & Silva, 2019). Collaborations between them and social movements and progressive politicians led to the development of a reform agenda. In 1986, for example, at the Eighth National Health Conference, the right to health was advocated by a large group (about 4,000) comprising academics, administrators, health professionals, social movements, and ordinary citizens. This led to the formation of the National Committee for Health Care Reform, which presented a proposal in front of the 1987–88 National Constitutional Convention (Machado & Silva, 2019). The same health experts and members of the healthcare movement came to occupy important positions in the Ministry of Social Security and Assistance and the Ministry of Health, which enabled them to push for healthcare reforms (Elias & Cohn, 2003).

While health experts and social movements drove the healthcare agenda in Brazil, Turkey entered the new millennium with the population having increased expectations from the government including a demand for “decisive policies that would advance citizens’ democratic rights; improve health and education services” (Atun et al, 2013: 70). Citizen dissatisfaction with the socio-economic conditions of Turkey was visible through their discontent with the health system, which came to light through the findings of a satisfaction survey by the Turkish Statistical Institute. The survey found that 40% of the population was satisfied with the health services in the country. This was lower than social insurance (40%), legal and judiciary (46%), and public security and order services (58%) (Atun et al, 2013).

China witnessed large citizens’ protests following increasing health inequities due to the SARS outbreak and private healthcare costs. The citizens’ demand for healthcare was highlighted in 2005 when a national poll of over 3,000 people ranked healthcare systems to be the topmost problem in China. International media picked up this issue and highlighted it, resulting in greater political focus (Yip & Hsiao, 2015).

In Indonesia, the introduction of the 2011 Badan Penyelenggara Jaminan Sosial (BPJS) law—which mandated social security protection for all Indonesians—saw several organisations like labour unions and NGOs coming together to form the Social Security Action Committee (KAJS) to ensure that the BPJS funds were directed into health insurance for all (Aspinall, 2014). Citizen protests and student movements in Indonesia played a critical role, with the student movements culminating in the form of a political party.

Political attention to health in Thailand can be traced back to the times of King Rama VI (1910–25), which saw early investments in health system infrastructure (Tangcharoensathien et al, 2019). By the 1980s, a few policy elites in the Ministry of Public Health had started working on universal health coverage. This included former student leaders who had fought against military rule in the 1970s and leaders of the RDS—a society formed in 1978 that was instrumental in driving healthcare reforms in Thailand. The RDS was formed by a group of doctors from elite medical universities in the country in support of doctors working in rural areas, eventually becoming the institutional base for progressive reforms in the Thai healthcare sector (Kuhonta, 2017). Over time, doctors came to occupy important positions in the Ministry of Public Health, civil society and non-governmental organisations, and political parties, including in the Thai Rak Thai party, which came into power in 2001.

Discussion

Our analysis of the nine selected countries reveals that healthcare reforms emerged in a context where economic systems were marred by high rates of poverty and/or inequality, leading to high out-of-pocket expenditures on healthcare. At the time of the reforms, most countries witnessed growth contraction, unemployment, inequality and citizen dissatisfaction with healthcare access, and the rising costs of healthcare emerging from the privatisation of healthcare in some cases. Regional contexts were contributing factors: the impact of the Asian Financial Crisis on Thailand and Indonesia, the collapse of the Soviet Union on Vietnam, and the transition from autocratic regimes in Brazil and the Philippines.

Elections and the formation of new governments proved to be the catalyst for reforms in most countries. Turkey, Thailand, Mexico, Argentina, Philippines, China, Indonesia, and Brazil witnessed the start of reforms when new governments came into power. Whether the political transitions were a result of a democratisation process or a change in leadership resulting from elections, our analysis found that healthcare reforms were invariably motivated by a need to gain political legitimacy on the part of the incoming regime, the political ideology of the new regime, or a combination of both.

Where a new regime was yet to establish its legitimacy and form a social compact with citizens, the motivation was borne out of a perceived need to earn political legitimacy by addressing a key and felt need amongst citizens and hence reap electoral benefits from the political capital formed. Seeking political legitimacy was a driving motivation for reforms in Turkey, the Philippines, Indonesia, Brazil, and China, all of which witnessed new political regimes rising to power. The AK Party in Turkey prioritised healthcare to differentiate itself from the previous political Islamist movement and to gain credibility as a new party. Aquino III sought legitimacy when he came to power in the Philippines by countering the corruption-ridden regime of his predecessor and simultaneously building on his mother's legacy (during whose regime healthcare received considerable attention) by focusing on social policy. The PDI-P party in Indonesia that replaced Suharto's rule sought political legitimacy by responding to citizen protests against Suharto and focused on social policy and equity, areas where Suharto's regime had failed. In the case of Argentina, Néstor focused on a centre-left campaign to distinguish himself from Menem and implemented social equity programmes, including healthcare reform, upon coming into power. China, despite being an authoritarian regime, felt the need to garner political legitimacy for the new leadership, given the large citizen protests against rising healthcare costs, leading to the prioritisation of healthcare. Reforms in China were influenced by both, a need to seek political legitimacy as well as an ideology of social welfare and equity.

On the other hand, certain new political regimes came into power with a foundational ideology of social welfare and equity, which formed the motivation and base for health reforms, as revealed by the experience of Brazil and Argentina. The motivation for healthcare reforms in Thailand was driven both by the ideology of bureaucrats who had long engaged with healthcare and the new political regime's need to establish political legitimacy through improved healthcare. In the case of Mexico, the ideology of the health minister (Julio Frenk) played a key role in the prioritisation of health. Vietnam is an outlier, where the introduction of reforms did not align with a new political regime. However, even then, it was the political ideology of social equity, which was the driving force for the existing regime, which led to the prioritisation of healthcare in the country.

Achieving tangible improvements in benefits established the legitimacy of political regimes in two ways. One, it contributed to the political legitimacy needed to sustain the government itself; second, it provided the regime the legitimacy needed to undertake further reforms. This was then a reinforcing cycle, where key reforms, which were well implemented and effective in addressing critical needs, sustained governments, which in turn contributed to sustaining reforms. The experience of Turkey illustrates this well. Well-implemented reforms fuelled the expectations of

citizens (at the very least, of those benefiting from the reforms), which led to increased citizen demand, creating the space for further reform.

While the experiences of the countries examined in this paper point to ideology and/or the need to establish legitimacy as a driving force for prioritising health and initiating reforms, the obvious question that emerges is what happens in contexts where neither of these can be a driving factor? In some country contexts, neither political ideology nor political legitimacy may be centred around issues of social equity. Would that then suggest the absence of political motivation to prioritise social sectors in such cases? It does not have to, as our analysis of select countries reveals. The political motivation outlined above does not necessarily take root by itself. On the contrary, it is often driven by other factors and stakeholders, such as varied policy entrepreneurs and advocates, who contribute to creating and strengthening incentives for political attention. The experience of some of the countries studied shows that internal and external advocacy play a key role in ensuring that key issues get highlighted.

In the case of Brazil and Thailand, social movements and networks of doctors and public health professionals (the *Sanitarista* movement and Rural Doctor's SocietyS) played an important role in the prioritisation of healthcare by bringing visibility to a felt need and positioning health as a high-level priority. Citizen mobilisation and a strong push by bureaucrats combined to create a context where health was viewed as a potential means of establishing political legitimacy. In countries such as China, in addition to the ideological position on social welfare, citizen protests contributed significantly to the political regime viewing health as a pathway to strengthening legitimacy. Similar citizen protests were seen in Indonesia.

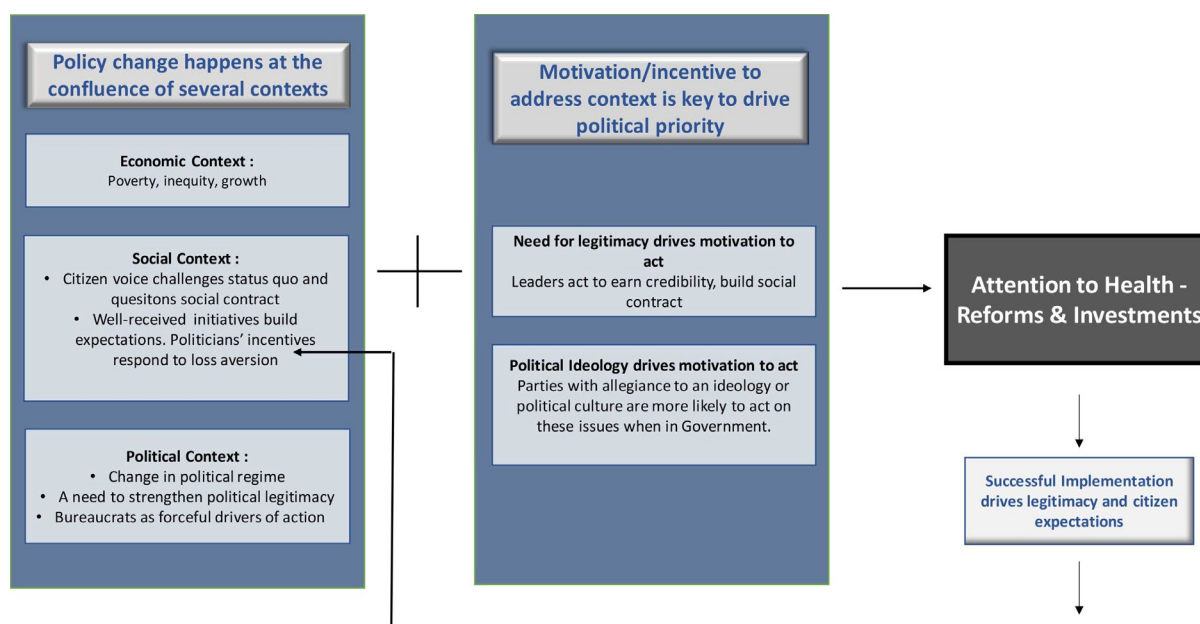
Research by Levitsky (2016) outlines the importance of citizen awareness, voice, and politicisation in 'removing the political cover for maintaining the status quo'. Social movements and other advocacy actors can play a critical role in challenging the notion that existing policies may be aligned with citizen choice or be acceptable to citizens. Public questioning and expression of dissatisfaction with policies lift the mask off what may be viewed as a minor problem and offers the platform to form a social contract with citizens by addressing the issue.

Mobilisation by citizens and social movements, and the advocacy of policy entrepreneurs internal to the system, can be a key factor in influencing the motivation for political regimes, especially when such motivation is based on seeking political legitimacy. It is for citizens and movements to create the platforms that underline what would constitute or contribute to political legitimacy for a particular regime. Citizen voice by itself may not be enough, as evident from the experience of countries such as Brazil. Instead, what is required is clear pathways to, and full proposals for, reforms that complement citizen movements.

Based on the preceding analysis, we offer the following framework to understand political attention to, and action on, health.

What are the implications for India and similar countries where progress towards universal health coverage has been slow? Analysing the experience of key health reforms in India shows that India is not an outlier in this framework. The National Rural Health Mission (NRHM) was introduced in 2005, soon after a new government, the Congress-led UPA (United Progressive Alliance) government, came to power in 2004. The coalition government forged a Common Minimum Programme, focusing on the needs of India's poor. The UPA government's focus on addressing not only the basic unfulfilled needs of India's citizens but also their rights to human development, translated to a social equity-oriented politics, in contrast to the prior regime's politics, which promoted an "India shining" narrative.

Pathways to Political Attention to Health



Source: Authors' analysis

The National Rural Health Mission, a key reform in the health sector, was introduced soon after the formation of the UPA government, as was a health insurance scheme for the poor, Rashtriya Swasthya Bima Yojana (RSBY). These, combined with other social policy measures introduced during the UPA regime—such as employment, food, and education guarantees—all of which were seen to emerge at the confluence of the UPA's rights-based ideology, their need for differentiating themselves from the previous regime (criticised for ignoring social welfare and equity issues), and their quest for political legitimacy by addressing structural needs.

A second significant reform in India was a tax-funded health insurance programme for 40% of India's population—in the form of what is now called Pradhan Mantri Jan Arogya Yojana (PM-JAY)—introduced by the Bhartiya Janata Party (BJP) government during its 2014–19 term. While this could be viewed as a mere expansion of the previous insurance programme (RSBY), it is important to consider the context. Several states had already launched state-specific insurance programmes, and the national government did not have a health programme that conveyed its commitment to social policy. The need to take a stewardship role and be associated with a key health intervention that could counter the previous regime's NRHM could have been the possible driving force for the reform. The BJP regime that came to power in 2014 also sought legitimacy through welfare schemes,¹³ which largely took the shape of welfare handouts. This was quite distinct from the previous regime's focus on rights-based entitlements. These strengthened their identity of being welfare-oriented, contributing to their political legitimacy; and PM-JAY fit well with such a policy focus.

Importantly, neither of these reforms took place in themselves. Other stakeholders played a key role: civil society in the case of the UPA regime and bureaucrats—to some extent—in the BJP case. The need to build an identity distinct from the previous government prompted UPA leaders to engage extensively with civil society leaders (through the National Advisory Council formed by Sonia Gandhi), which contributed to the setting of a social equity agenda. UPA leaders were also influenced by the global discourse on the macro-economy and health,¹⁴ which contributed to driving attention to health. Bureaucrats and institutions such as NITI Aayog, similarly, played a key role in the launch of PM-JAY.

¹³ The provision of a cooking gas connection, agricultural cash transfers etc.

¹⁴ WHO commission on Macro Economics and Health, 2001.

In conclusion, in contexts where neither political ideology nor the social contract centres on notions of social equity with health as a key element, a more proactive role played by citizens and other actors, questioning the political legitimacy of the regime in power and highlighting the schisms in the social contract between the two, may contribute to shifting the source of legitimacy for leaders. Voices, through electoral and other platforms, combined with clear pathways to address felt challenges, have a role to play in building deeper social contracts and accordingly shifting the incentives of political leaders.

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