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## Perspective

### Politics and Universal Health Coverage — The Post-2015 Global Health Agenda

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When the United Nations summit for the adoption of the post-2015 development agenda begins on September 25, the attainment of universal health coverage (UHC) is expected to garner sub-

stantial attention. Bolstered by increasing evidence that UHC improves health outcomes,<sup>1</sup> countries are seeking to build health-related goals around the concept of health care for all. Yet many lower- and middle-income countries (LMICs) have not created UHC systems (see map). How can the global community translate vision into policy, especially in the face of complicated politics?

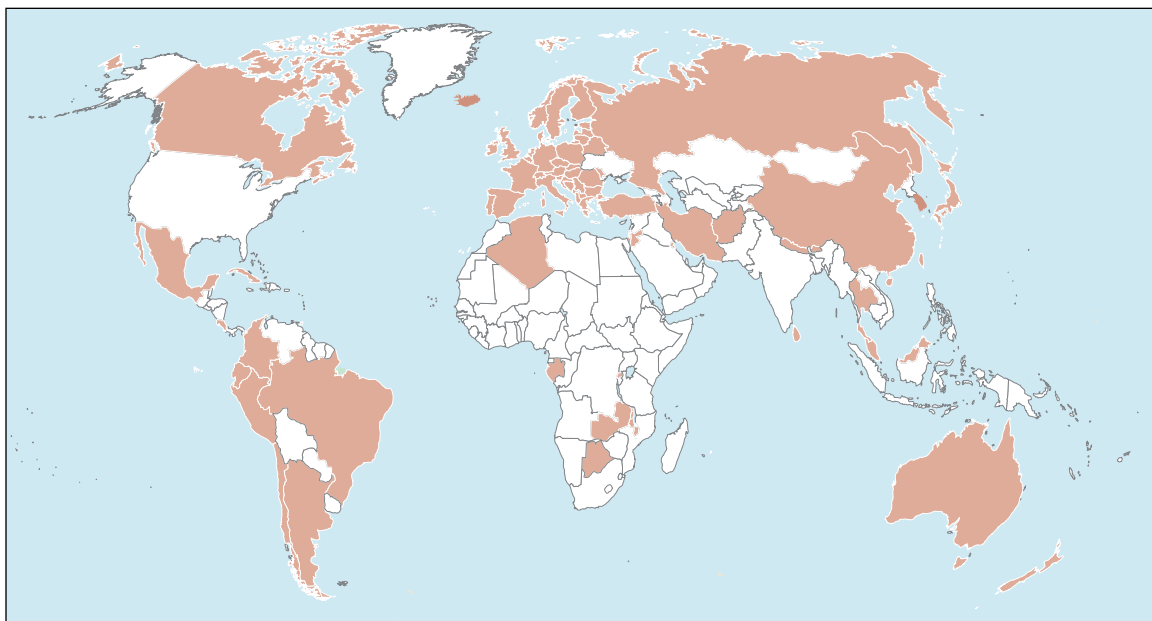
To elucidate some of the political dynamics involved, we developed a conceptual model describing sociopolitical factors that have helped catalyze reform in selected countries. We focused on trends over time in these variables during the lead-up to major health care legislation. Based on interviews with high-level former policy-

makers, civil-society members, and academics who oversaw the successful implementation of UHC initiatives in LMICs, our framework draws on information from Chile, Mexico, China, Thailand, Turkey, and Indonesia — countries with emerging economies that have recently instituted UHC schemes.

We sought to understand how each country's political landscape evolved to support UHC, examining how key factors had changed in the years preceding health care reform. We aimed to highlight the dominant sociopolitical forces that influenced debates on welfare expansion, rather than including all potential variables. Moreover, since several of these variables are challenging to define quantitatively, we tried to

characterize patterns of change — whether the condition or characteristic was increasing or decreasing during the years immediately preceding reform. We hope that illumination of these political roadmaps can help other LMICs address complicated domestic politics and relevant social ills in pursuing legislative change.

The first variable we identified, social solidarity, is perhaps the hardest to measure; it reflects the willingness of a citizenry to support expansion of the welfare state (see chart). Historically, quantitative metrics have been used to show that greater social cohesion is associated with low levels of income inequality, crime, government corruption, and rising per-capita gross domestic product. By such measures, Chile would appear to have the most cohesive society of the six countries we studied, since it has used its comparative wealth to nurture an educated citizenry with free



**Countries That Have Adopted Reforms toward Universal Health Coverage.**

The shaded countries have passed legislation that provides at least a basic set of health services (generally preventive) that is largely publicly financed and broadly accessible without limitations. Information is from the World Health Organization and the World Bank.

access to media, information, and other resources. Turkey and Mexico are also comparatively affluent countries with moderate income inequality and growing rates of literacy and skilled labor as measured, for instance, by the Knowledge Index (see the Supplementary Appendix, available with the full text of this article at NEJM.org).

We found no evidence, however, that economic strength necessarily translated into strong societal solidarity. Representatives of Chile, Mexico, Turkey, and China note that the heterogeneity of their peoples' political beliefs, cultural values, and religious affiliations create clear societal fault lines that would be expected to hinder expansion of a public good such as UHC. Assessments based on formal metrics such as the Global Peace Index, which measures societal cohesion, corroborate these observations.<sup>2</sup> Indeed, expansion of social welfare programs is often viewed as a zero-sum proposition: the quality of

medical care is expected to decline, or budgetary resources to be sapped, as health coverage expands. Chilean officials cite the frequency of protests against the governing regime, and experts on Turkey and Mexico note racial, sex-based, and socioeconomic disparities that have resulted in fractious societies. In China, authoritarian policies are considered the primary cause of poor social solidarity. By contrast, observers in Thailand and Indonesia perceive considerable social harmony attributable to the near-universality of Buddhism and Islam, respectively, in those countries; religion is a socially unifying force despite their relative poverty.

The second factor, economic growth, was present in all six countries when they adopted UHC in the early-to-mid-2000s. Julio Frenk, Mexico's minister of health during its implementation of *Seguro Popular*, told us how strong financial health not only permitted the government to finance welfare expansion but tempered objections

from members of the finance ministry who favored greater austerity.

The third variable, legislative decorum, is meant to capture the relative ease of ensuring that the political agenda of an incumbent party or regime becomes law. This variable depends on the functionality and power of a country's legislature. In Thailand, for example, the executive and legislative branches unwaveringly support extant UHC schemes despite an otherwise contentious political climate. Most of the other countries may face disagreements on implementation but no ongoing efforts to repeal UHC policies. In China and Turkey, the lack of opposition may be attributable to political systems that thwart opposition of any kind. In Mexico and Indonesia, health care reform efforts have been spearheaded by popular presidents such as Vicente Fox and Joko Widodo. Although Fox didn't run on welfare-state expansion nearly to the extent that Widodo did, his appointees pushed UHC forward aggressively in the

Politics and Universal Health Coverage*					
Country	Social Solidarity	Economic Growth	Legislative Decorum	Public Disaffection	Transformative Political Figure
Chile	↓	↑	↑	↑	↑
Mexico	↓	↑	↑	↑	↑
China	↓	↑	↑	↑	↓
Thailand	↑	↑	↑	↓	↑
Turkey	↓	↑	↑	↑	↑
Indonesia	↑	↑	↑	↓	↑

\* Arrows indicate the direction of the trend.

early 2000s, and *Seguro Popular* arguably became his most enduring legacy. Populism holds strong appeal in emerging democratic economies, and supporting expansion of social welfare policies such as UHC is a proven electoral strategy.

The final two variables may be the most vulnerable to change over time. Public disaffection refers to a consensus that an incumbent regime is not competent to provide government services such as health coverage or social assistance. In an interview, Harvard's Rifat Atun, an expert on Turkey's path to UHC, described how a decade of dysfunctional governments and social outrage after the 1999 Marmara earthquake precipitated the election of a populist, Recep Tayyip Erdoğan, who promoted UHC as a central campaign promise. In Mexico, Frenk helped to cultivate public outrage in the rural provinces by drawing attention to the inequities of the Mexican health system. In China, according to Harvard's William Hsiao, fears of grassroots revolution contributed to the Communist Party decision to expand the welfare state.

Finally, five of the six countries had a transformative leader who was elected with a populist mandate; only China lacked such a leader. The near-universality of this factor suggests that countries require charismatic and committed leadership to attain UHC. (Indeed,

even UHC systems in high-income countries in Europe and North America have been associated with political champions — Bismarck in Germany, Obama in the United States, Douglas in Canada, and Bevan in the United Kingdom.)

We offer this model as a first step in elucidating the politics that have shaped some UHC movements. We focused on trends, not current status alone, among sociopolitical conditions that have promoted reform. Elements of the model have been considered by others. For example, U.S. Senators Ron Wyden (D-OR) and Michael Bennett (D-CO) have described the importance of both popular will and a functional legislature working in a bipartisan manner to pass UHC.<sup>3</sup> European health policy experts have remarked on the importance of charismatic and committed leadership in bolstering European UHC movements.<sup>4</sup> Perhaps the most well-established factor is the influence of mass media and the Internet in framing debates on a regime's welfare policies.<sup>5</sup> As experience in Mexico and Turkey highlights, mass-media campaigns using powerful language to define a UHC movement can rally the public behind an otherwise failing and unpopular incumbent.

Of course, it is difficult to determine the extent to which each variable contributed to successful legislation, what the most crucial

ingredient was, and to what degree it was modifiable; further work is needed to elucidate these subtleties. We hope, however, that the framework generates discussion within LMICs such as Bolivia, Nigeria, Turkmenistan, and Venezuela, which have some of the necessary political ingredients to pursue UHC but have thus far failed to achieve it. What gaps exist in these countries, and are the relevant conditions changeable? As the global health and development community embarks on new goals, a better understanding of the links between health and politics could help foster durable changes that increase access to health care.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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