The politics of health sector reform in developing countries: three cases of pharmaceutical policy

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Revision received 20 January 1995; accepted 24 January 1995

Abstract

This paper examines the political dynamics of health sector reform in poor countries, through a comparative study of pharmaceutical policy reform in Sri Lanka, Bangladesh, and the Philippines. The paper first reviews five reasons why policy reform is political. It then presents three political economic models of the policy reform process: the political will, political factions, and political survival models. Next, the paper describes the three cases of national pharmaceutical policy reform, and identifies common conditions that made these reforms politically feasible. The paper’s analysis suggests that health sector reform is feasible at certain definable, and perhaps predictable, political moments, especially in the early periods of new regimes. The most important and manipulable political factors are: political timing, which provides opportunities for policy entrepreneurs to introduce their ideas into public debate, and political management of group competition, which allows leaders to control the political effects of distributional consequences and protect the regime’s stability. A strong and narrow political coalition improves the capacity of political leaders to resist the pressures of concentrated economic costs (both inside and outside national boundaries). The paper argues that for reform to succeed, policy-makers need effective methods to analyze relevant political conditions and shape key political factors in favor of policy reform. The method of Political Mapping is briefly introduced as a technique that can help policy-makers in analyzing and managing the political dimensions of policy reform and in improving the political feasibility of reform.

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SSDI 0168-8510(95)00728-B
Key words: Health policy reform; Political model; Developing countries

1. Introduction

Policy reform is a profoundly political process. Politics affects the origins, the formulation, and the implementation of public policy, especially when significant changes are involved. In the health sector as well, policy reform requires political skill, in both rich and poor countries, as President and Hillary Clinton have discovered [1]. Yet these political dimensions are seldom analyzed systematically for health sector reform in poor countries. The tendency in public health is to portray policy reform as a technocratic or economic process. Both economists and health policy analysts tend to provide detailed prescriptions on what should be done, but without clear instructions on how to do it and without good explanations of why things go wrong. A similar pattern has been observed for economic policy-making. As noted by Robert H. Bates, ‘Politics is rarely placed at the center of economic research’ (Ref. [2], p. 272). Decision makers in most instances are expected to rely on their intuition in managing the politics of reform.

The 1993 World Development Report (WDR), on ‘investing for health’, exemplifies the downplay of politics. The report provided seven chapters on what countries should do to improve the allocative efficiency of health expenditures in poor countries, but only five paragraphs on the process of health sector reform, under the heading of ‘directions and prospects for reform’ (Ref. [3], pp. 164–165). And these paragraphs provided few concrete or specific ideas about how to manage what the report called the ‘continuous and complex struggle’ of health sector reform. The report largely ignored the significant problems of implementation. A similar pattern exists for the more general efforts to promote structural reform in poor countries. Miles Kahler identified a tendency on the part of external agencies (such as the World Bank and the International Monetary Fund) to avoid an explicit analysis of politics, even for major economic policies and even when political factors were recognized as critical to success; instead, these agencies engaged in implicit or ad hoc political analysis (Ref. [4], pp. 157–158).

The 1993 WDR seems to rely on a model of policy reform that assumes right action will naturally follow from rational analysis. In presenting its conclusions, the WDR (Ref. [3], p. 15) cautioned, ‘At first glance, it might appear that adoption of this Report’s major recommendations will be easy’ (although the report did not suggest why one might believe that the proposed policy changes would be easy to achieve). The report then continued to say that ‘in reality, change will be difficult, since an array of interest groups may stand to lose — from suppliers of medical services to rich beneficiaries of public subsidies to protected drug companies’. But the report still discussed policy reform according to a simple model of political economy: ‘Broad reforms in the health sector are possible when there is sufficient political will and when changes to the health sector are designed and implemented by capable planners and managers’ (Ref. [3], p. 15).

In short, political analysis by economists tends to underspecify the political conditions under which health reform is likely to succeed. The WDR, for example,
did not provide any evidence to support the assertion that 'sufficient political will' is a necessary condition for health reform; nor did the report define the concept of political will in a succinct or explicit manner — a pattern I have criticized elsewhere [5]. It might have been helpful, at least for some readers, if the report had included this political concept in the introductory section on 'definitions and data notes', along with explanations of such economic concepts as cost-effectiveness, allocative efficiency, and disability-adjusted life year (Ref. [3], pp. 10–12). Other economists, in their analyses of health sector reform, have recognized more directly the ways in which the current problems and policies in the health sector are 'the outcome of a political process' and concluded that significant policy reform is only likely to occur 'if there is a corresponding change in the distribution of political power' (Ref. [6], p. 25). But they similarly provided few indications of how power should be redistributed (either the proposed reconfiguration or the preferred process) in order to achieve the desired policy reform.

In emphasizing the political dimensions of health sector reform, I do not mean to suggest that technical analysis (of the economic and health aspects) is unnecessary. Rather, the main point is that technical analysis is necessary but not sufficient to make the reform process succeed. While some observers might recommend that multilateral agencies such as the World Bank should stick to technical analysis, I would argue (along with Kahler [4]) that these agencies could improve the quality of their technical advice and the feasibility of their policy proposals by more systematic analysis of the political and organizational factors that affect policy reform.

This paper examines the politics of health sector reform in poor countries in four steps. The paper argues that for reform to succeed, policy makers must develop methods to understand, analyze, and then manipulate the political conditions in favor of policy reform. I suggest that the method of political mapping can help policy-makers in analyzing and managing key aspects of health sector reform [7]. This method provides a systematic procedure to analyze and improve the political feasibility of policy reform and is briefly described in the conclusion.

2. Why is policy reform political?

Policy reform is inevitably political because it seeks to change who gets valued goods in society. Five specific reasons can be proposed to explain the political dimensions of policy reform: (1) reform represents a selection of values that express a particular view of the good society; (2) reform has distinct distributional consequences in the allocation of both benefits and harms; (3) reform promotes competition among groups that seek to influence the distributional consequences; (4) the enactment or non-enactment of reform is often associated with regular political events or with political crises; and (5) reform can have significant consequences for a regime's political stability or longevity.

2.1. Values

No single definition of the substance of policy reform is universally accepted in the health sector, or in other sectors either. Indeed, the substance of policy reform
represents a value-laden choice of political philosophy, even when (or especially when) the choice is presented as a technical decision. Three broad value systems, reflecting fundamentally different visions of the good society, are commonly called into play to provide the philosophical foundations for policy reform: the utilitarian, communitarian, and libertarian perspectives. While these three systems are not the full set of possibilities (another example would be Rawlsian liberal egalitarianism), they do represent three major philosophical approaches applied to health sector reform.

Perhaps the most common value system today for policy reform is the utilitarian perspective. This approach employs a consequentialist calculation and comparison of policies to determine which option will achieve the most results for the least inputs. As Kymlicka observed, consequentialism 'seems to provide a straightforward method for resolving moral questions. Finding the morally right answer becomes a matter of measuring changes in human welfare, not of consulting spiritual leaders, or relying on obscure traditions' [8]. To carry out this calculation for health sector reform, the WDR adopted the metric of cost-effectiveness, using Disability Adjusted Life Years. While this metric may not be the only standard used by the WDR, it certainly stands head and shoulders above all others. The report is titled 'Investing in Health' and the dominant concern is how to obtain the most 'health gain per dollar spent'. The WDR's recommendations generally assume that if an action is cost-effective, then it should be done.

The WDR also proposed to protect equity through health sector reform, seeking to increase efficiency and increase equity at the same time. The report did not make clear whether both must increase, the relative importance of the two objectives, or what to do when cost-effectiveness and equity are in conflict. Efforts to combine efficiency and equity can be politically hazardous. Joan Nelson warned, 'While efficiency and social justice argue for targeting benefits to the poor, political incentives point toward broader targeting that reaches some of the more politically influential middle deciles. Tight targeting of more than compensatory benefits may be a realistic option only for governments that do not need political support' (Ref. [10], p. 110). The WDR recognized this point, suggesting a gradual shift in resources rather than sudden changes, in order to maintain the support of middle classes and urban groups (Ref. [3], p. 165). The report implicitly recognized the potential dangers of making policy recommendations in a political vacuum, but left unexplored the implications of compromising cost-effectiveness and equity to create political feasibility.

A second value system is the communitarian perspective, which emphasizes an empirical social contract (whether explicit or implicit) that exists within some actual community. This philosophical approach can provide a community-based notion of the common good, to justify and guide the redistribution of resources through health sector reform. The international movement toward primary health care can be viewed as a communitarian argument to provide health care resources for rural residents of poor countries. The movement for 'community-oriented primary care', which seeks to improve primary care in poor communities, is similarly based on principles of grounding health policy and health services 'in communities, for communities, and with communities' [9]. A communitarian ap-
proach to allocating health resources would not necessarily be concerned about the
cost-effectiveness of maximizing health within a particular society; it would instead
seek to improve health within a particular segment of the society, as part of a
community-based vision of the common good, regardless of whether those actions
were the most cost-effective. It might differ from one community to the next,
making it difficult to construct a single substantive metric for this approach.

The third main value system used to guide policy reform is the libertarian
perspective. This approach emphasizes the principle of individual liberty, that one
is entitled to use one’s natural endowments to make whatever deals and choices
one can, as long as the action does not infringe on the life and liberty of others.
The state’s role, in this perspective, is limited to the protection of individuals
against unjust appropriation, in what Robert Nozick called the ‘minimalist state’
[11]. This theory is non-consequentialist, based on the belief that liberty alone will
produce a moral society, without any efforts by the state to redistribute goods in
society. The libertarian approach enshrines the market, with its free exchange of
goods and labor, as the key to policy reform. Health sector reform based on
libertarian values would be measured by a process metric, reflecting the degree of
state intervention in the economy, with the assumption that if an action reduces
state intervention then it generally should be done.

Libertarian values, and the role of the market, provided the foundation for many
policy reform efforts in poor countries in the 1980s, especially for economic policy.
(Some market-oriented reforms, however, were more consequentialist and utilitarian
in emphasizing the greater effectiveness of the market compared to state
intervention.) These reforms typically sought to reduce the degree of state inter-
vention in the economy, through, for example, privatization, competition, reducing
regulation and limiting public expenditures. In the 1980s, a major international
debate arose over the health and nutrition consequences of structural adjustment
policies, with UNICEF in particular calling for efforts to protect the poor and
vulnerable groups in poor countries and to place ‘the human dimension’ at the
core of economic policy reforms [12]. This debate led to some backing off from
strong libertarian positions and promoted efforts to strengthen the state’s capacity
to protect social welfare, a more utilitarian view.

The choice of a value system to explain and justify a major policy reform
represents a political choice, not only because of the philosophical ambiguities
about how to defend one system over another (the problem of meta-ethics), but
also because the choice has real consequences for the distribution of resources
among different groups in society.

2.2. Distributional consequences

Policy reform can produce predictable patterns of distributional consequences
across different social groups; indeed, reform is often intended to produce a
particular redistribution. Reform can redirect benefits from urban to rural, or from
rich to poor, or from organized to non-organized, or from one ethnic group to
another, depending in part on the philosophical assumptions of the reform. In
short, policy reform is political, because it seeks to affect who gets what and, as
discussed below, it affects group competition in society over who gets what.
The distributional consequences of policy reform can have a significant impact on the ease of implementation. For example, according to Nelson, ‘The political difficulty of pro-poor measures increases to the extent that the resource transfer from privileged groups is obvious, long-term, and large (relative to the incomes of these same privileged groups)’ (Ref. [10], p. 100). Experience with economic reform suggests that targeting the poor encounters significant political obstacles, as noted above. Nelson reported that ‘the poor usually benefit to the extent that their priority concerns overlap with those of the somewhat better off. If their interests diverge, the poor are not likely to gain much, and they may even lose ground’ (Ref. [10], p. 99).

On the other hand, policy reform that promises to benefit more powerful groups in society, or that is perceived as regressive in placing additional burdens on the poor, can elicit protest from domestic groups as well as international agencies. The distributional consequences of structural adjustment reforms, in the economic sector, resulted in street protests in some countries (especially when subsidies were abruptly removed from specific commodities) and also produced a campaign from UNICEF to alter the adjustment policies [12], even though some economists continued to question the strength of the evidence on health and nutritional consequences [13]. And, indeed, the call for ‘adjustment with a human face’ did result in revised efforts by multilateral banks to protect the more vulnerable groups in poor countries from adverse consequences of economic policy reforms. Distributional consequences thus can affect the politics of international agencies, and thereby produce changes in reform strategies.

The tendency for policy reform to have potentially regressive consequences is reinforced by a classic problem of collective action: that concentrated effects on more powerful groups in society tend to have more influence on government decisions than dispersed effects on more powerless groups [14]. For example, policy makers may be more willing to take the risk of offending the relatively powerless poor, because of dispersed costs, lack of strong social organization, physical distance from the national capital, and low voting turnout, rather than offending the relatively powerful middle class, because of more concentrated costs, availability of strong social organization, physical proximity to the seat of government, and high voting turnout — even when the aggregate costs are likely to be higher for the poor than for the middle class.

A key political question for policy reform is when and how this problem of collective action can be overcome. What are the political conditions under which reform can have distributional consequences that do not simply reinforce the existing skewed distribution of economic and political power? Two provisional answers are provided by the literature on economic reforms: political alliances and compensatory benefits. Nelson reported that in many situations where governments give higher priority to the needs of poor people, ‘Political salience increases where the poor are actually or potentially allied with groups in a position to threaten the government’s security’ (Ref. [10], p. 97). Second, progressive distributional consequences are more likely to be politically feasible when other groups also receive some benefits, or as noted above, when the interests of the poor overlap with the interests of the more powerful. How much inefficiency is needed, in order to make
pro-poor policies politically palatable, will depend on other political circumstances, including the existing patterns of group competition.

2.3. **Group competition**

Policy reform affects the interests of groups in society, including interest groups, bureaucratic agencies, and political parties. Simple-minded pluralism would postulate that different groups will compete to protect their interests, and that the ‘stronger’ group will win out and thereby affect the substance and implementation of the policy adopted. The pluralist predictions do not always work out in practice, however, due to political biases that affect the relative power of groups, the transaction costs of creating new groups, and the dilemmas of collective action associated with the dispersion and concentration of costs and benefits.

Political leaders are particularly concerned about the differential impacts on groups in the government coalition. Every regime has its allies and partners, arranged in various types of coalitions, to provide support for the government and its policies. As John Waterbury wrote, ‘The crucial challenge for political leadership is to avoid injuring the interests of all coalition members simultaneously’ (Ref. [15], p. 39). Similarly, ‘political leaders must gauge when injuring the interests of specific groups will trigger a disruptive response’ (Ref. [15], p. 46). The strength of the governing coalition, and the confidence of leaders in their ability to control different groups in the coalition, affect the willingness of leaders to assume the political risks of reform (Ref. [16], p. 328). Weak and divided governments are most likely to procrastinate about reform, even when confronted with the sticks and carrots wielded by international agencies (Ref. [16], p. 330).

For economic policy, Waterbury argues that it is possible and highly desirable to construct the reform agenda in phases in order to spread the burdens of adjustment across coalition members and avoid harming all allies simultaneously (Ref. [15], p. 52). The timing of the reform process, as discussed below, thus can affect group competition and regime stability. Waterbury warns that ‘only under the most dire circumstances’ should all elements of economic reform be introduced at once. While a large literature exists on the questions of appropriate sequencing of economic reform policies (cited by Waterbury), little exists for health sector reform.

In managing the reform process, political leaders are advised to use both compensation and obfuscation: ‘Compensatory payments may help to mitigate the impact of adjustment and to sequence the distribution of pain among coalition members and large segments of the population. Forthright declarations of policy intent, the laying out of timetables, and the public targeting of specific interests may well leave leaders without room to maneuver and lead to the defection and opposition of groups vital to regime maintenance’ (Ref. [15], p. 55). Outside agencies that require strict accounting, accountability, and transparency may contribute to undermining the success of policy reform. Political leaders need to control group competition in policy reform through a two-table bargaining game [17]. The bargains reached with external actors, including international agencies and multinational corporations, must be politically acceptable and sustainable in
the domestic political game, in what Putnam described as a two-game politics of international negotiations.

Managing the politics of group competition in policy reform requires a good understanding of who is for the reform, who is against it, and who is not mobilized in one direction or the other. A political strategy for policy reform needs to consider the interests or objectives of key stakeholders, and how important those interests are in the group’s priorities. The direction of causation between groups and policies, however, may not always be clear. In some cases, a new policy creates an organized interest group out of the beneficiaries — a pattern observed in both rich and poor countries (Ref. [18], p. 207). In other cases, enactment of a new policy requires an existing interest group that is both well organized and highly mobilized. A policy maker’s ability to mobilize quiescent groups and to quell activated groups can affect the political success of policy reform [19]. As Nelson observed, ‘If benefits of structural changes are often delayed and accrue to individuals and groups who are not politically organized and may not even recognize their potential gains when the policy is launched, prospects for coalitions in support of the reforms are poor’ (Ref. [16], p. 359). Managing these processes of group competition must include consideration of timing.

2.4. Timing

The opportunity to achieve policy reform is often affected by external events. Reform is usually more feasible at the beginning of a regime than at the end of a regime (although some political leaders at the end of their time in power may introduce reforms to prolong their power or reap some last-minute benefits). Major concurrent events (either real or symbolic) can open up political windows for reform, in democratic as well as non-democratic systems. Disasters, both natural and human-created, provide policy entrepreneurs with an occasion to push for long-desired ideas. An ability to recognize and exploit those transitions that open windows for reform — before the windows slam shut — thus can affect whether reform is achieved.

Horowitz argued that timing (‘the simultaneity of events’) is an important explanation for when policy change occurs and how it occurs, in both positive and negative senses (Ref. [18], p. 204), because of the many constraints that affect policy making in poor countries. He observed that, ‘a disproportionate number of policies are adopted at exceptional times — times of crisis, times when there is a strong demand for change, times when unusual events have immobilized obstacles to new policy or drastically changed the composition of decision making bodies. At such times, organized interests are frequently ineffective. Ideas for policy become important forces, and elites have a good deal of freedom to put their ideas into operation’ (Ref. [18], p. 205).

Moments of regime transition provide an important opportunity for policy reform. These transitions are generally accompanied by a delegitimization of the previous government, which makes it easier to dismantle existing policies and structures, and an increased executive autonomy or legitimacy for new government in the ‘honeymoon’ period, which makes it easier to introduce new policies and structures (Ref. [20], p. 75). Keeler showed a similar pattern for major policy
reforms in a study of established democratic polities (Britain, France, and the United States), demonstrating that the size of a government's mandate (measured by a mandate index), along with the severity of the crisis confronted, are good predictors of the size of the window for reform and the scope of legislative achievement [21]. Waterbury noted two different electoral strategies of political timing for democratic regimes: pushing through an adjustment package just after receiving a popular mandate in an election; or starting to implement the adjustment package and then calling an election, hoping that beneficiaries will support the government in the election (Ref. [15], pp. 52–53).

Regime transitions are critical for non-democratic as well as democratic governments, in overcoming the forces opposed to reform (Ref. [15], p. 55). Of course, the importance of timing depends in part on the substance of the reform. Radical changes require careful consideration of timing, while minor incremental changes are not as dependent on timing. Moreover, the nature of the reform may depend on the nature of concurrent events; natural disasters may create opportunities for certain types of reform, but not for others. Efforts to enact sudden changes in policy, without propitious concurrent events, can challenge the legitimacy of governments, including authoritarian regimes.

2.5. Regime stability

Finally, policy reform is political because it can pose significant political risks and can provide significant political benefits for regimes in power (and for opposition groups out of power). In some cases, efforts to enact policy reform can affect the stability and longevity of governments. One prominent example in health is Mrs Indira Gandhi's aggressive family planning policy in India in 1976–77, which created coercion and chaos, and in 1977 contributed to her resounding electoral defeat [22]. Most political leaders have a strong sense of self-interest and a strong instinct of survival; consequently, they are reluctant to carry out reforms that have a high probability of disrupting the government and ending their rule.

Whether policy reform affects regime stability, in turn, is influenced by various factors. The country's broader political economy provides the context within which policy reform occurs and thereby shapes its political consequences for the regime. Relevant factors include the regime type, especially the degree of democracy or state control over society, as reflected in factors that affect public participation, such as literacy, freedom of association and speech, social activism, and income differentials. If a policy reform can be symbolically connected to an ongoing political struggle within a country, then it can become threatening to regime stability. In extraordinary situations, efforts to push through policy reform can contribute to a government's downfall, especially when opposition arises from previously quiescent sectors or from former allies.

Regime transitions to democracy provide opportunities for policy reform, and indeed often require policy reform. But these systemic changes also create vulnerabilities due to the emergence of new political competition [20]. Expanded pluralism can produce a form of policy gridlock, in which decisions are blocked through democratic processes. And in extreme situations, as in some of the new countries
of Eastern Europe, political liberalization can unleash ethnic hostilities that obstruct efforts at policy reform and undermine regime stability.

This review of why policy reform is political remains incomplete, but I hope that the main point is persuasive. This point, which is gaining wider acceptance, stresses the importance of a political economic perspective in assessing the prospects for policy reform and in explaining the successes and failures of the reform process [5,23–25]. Perhaps better political models could persuade sceptics (should they still exist) about the unavoidable importance of politics in the policy reform process.

3. Political models of policy reform

Policy reform usually involves a complex package of significant changes, while incremental changes in policy involve fewer and simpler alterations. The distinction made by Peter S. Cleaves between ‘less problematic’ and ‘more problematic’ changes in policy provides a good description of the characteristics of policy reform [26] (Table 1). All policy changes that fit on the ‘more problematic’ side may not be reforms, but it seems likely that all reforms would fit on the ‘more problematic’ side. As suggested by Table 1, policy reform usually does involve complex technical issues, a comprehensive change from the current situation, multi-actor targets, and multiple goals, often ambiguously stated, and of long duration.

In searching for good political models of policy making processes in developing countries, one soon discovers that the literature is rather sparse. ‘Comparative public policy is a young field, even younger than the systematic study of politics in the developing countries of Asia, Africa, and Latin America. The hybrid of these two fields — comparative public policy in developing countries — is younger still’ (Ref. [18], p. 197). The comparative analysis of health policy processes in developing countries is even more underdeveloped. Many studies exist of health policy from epidemiologic and economic perspectives; but few address the political aspects of health policy in developing countries. The literature on the political economy of policy reform, on the other hand, mostly examines economic policies, especially in the stabilization and trade arenas. Various models are proposed, including political as well as economic variables, and involving different assumptions about how and why policy reform works (or does not work) in poor countries.

Table 1
Characteristics of policy affecting its implementation

<table>
<thead>
<tr>
<th>Less problematic</th>
<th>More problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple technical features</td>
<td>Complex technical features</td>
</tr>
<tr>
<td>Marginal change from status quo</td>
<td>Comprehensive change from status quo</td>
</tr>
<tr>
<td>One-actor target</td>
<td>Multi-actor target</td>
</tr>
<tr>
<td>One-goal objective</td>
<td>Multi-goal objective</td>
</tr>
<tr>
<td>Clearly stated goals</td>
<td>Ambiguous or unclear goals</td>
</tr>
<tr>
<td>Short duration</td>
<td>Long duration</td>
</tr>
</tbody>
</table>

Source: Cleaves [26], p. 287.
This section represents a brief foray into the field of comparative health policy in poor countries, to suggest clusters of political conditions when reform is possible. When can political leaders overcome the constraints of group competition and the demands of political survival and introduce significant reforms in policy? In addition, what can leaders do to shape political circumstances to enhance the probability of significant change? Even when analysts try to explain the factors leading to success or failure of reform, they often fail to address the possibilities of changing the balance of power or managing the politics of policy-making processes in order to improve the probability of success. The literature provides little practical advice on how to identify opportunities for change, or how to assess the positive and negative factors that cannot be changed, in order to determine whether success is likely.

I propose three political mechanisms for consideration: political will, political factions, and political survival. These three categories may seem, to some, rather odd choices for policy-making models. They correspond roughly to three models described by Alberto Alesina in his review of political models of macroeconomic policy and fiscal reform — but with new names [25]. I have chosen these names to emphasize the political dimensions of reform. In doing so, I have retreated from my previous critique of the concept of political will, and sought to give it some substantive content and utility [5]. These three mechanisms, I believe, represent three clusters of political conditions under which policy reform can occur.

3.1. The political will model

The political will model assumes that decisions by political leaders are both necessary and sufficient for major policy change. This model resembles the benevolent dictator in a Platonic state, similar to the traditional public administration view of how policy is made. The model posits a technocratic approach with a rational actor model of decision-making, and assumes a strong state, good institutional capacity, and adequate political capital. On the other hand, the model tends to ignore the political constraints to policy reform, and can be politically naive. This model is what Alesina called the ‘social planner’ model, in which rational analysis is used and implemented by politicians to make the ‘right’ choices, to enhance the public interest of society, regardless of the consequences for particular constituencies or for political futures¹ [25]. In this model, decision makers seek to maximize (or at least increase) the public interest. Empirically, this model may operate under certain political circumstances, such as a strong mandate, strong

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¹As Bates noted, Kenneth Arrow in his book on Social Choice and Individual Values long ago dispelled the notion of a state that adopts policies to maximize some social welfare function, unless there is a dictator who can make the appropriate decisions without compromise and despite opposition. And, as Bates emphasized, the world’s experience with dictators on both the right and the left shows otherwise. The policies adopted by these governments (and others) ‘do not represent the preferences of some single actor. They represent the outcome of a political struggle, in which competing interests with rival visions of the social good seek the power to impose policies that are consonant with their preferences upon the collectivity’ (Ref. [2], p. 265).
state, narrow coalition, and strong leadership. The model also shows striking similarities to the concept of the developmental state, which is seen as underlying the successes of the East Asian countries [27]. According to this model, policy reform occurs when political leaders exercise their ‘will’ to further the public interest. And if reform does not occur, then leaders have not shown sufficient political will (as suggested by the WDR of 1993).

3.2. The political factions model
The political factions model assumes that politicians seek to serve the desires of different groups, including interest groups, bureaucratic agencies, and political parties. This model subsumes the interest group approach to policy making, with its emphasis on the political competition of groups and ideas, and also the bureaucratic politics approach, with its emphasis on how government organizations seek to protect and promote their narrow sectarian interests. In this model, rational analysis serves mainly as a means to promote and serve organizational interests. This model resembles what Alesina called the ‘partisan’ model in the economic literature, in which aggregate policies (such as fiscal and monetary measures) are used to achieve significant redistribution of income and wealth, in order to reward specific constituent groups. In this model, decision makers seek to serve the interests of their constituencies and can redistribute goods to fit with ideological principles. Some versions of the model assume pluralist principles about the free competition of groups to determine policy. According to this model, reform occurs when it corresponds to the preferred distribution of benefits to specific constituent groups of government leaders. And if no reform occurs, then the preferred constituencies have not received sufficient benefits.

3.3. The political survival model
The political survival model assumes government officials seek to protect individual interests, as power-holders, whether elected or non-elected, in order to maintain or expand their existing control over resources. This model incorporates many of the principles of the public choice school, arguing that politicians operate on a logic of ‘opportunistic’ politics [25]. In this model, decision makers manipulate fiscal and monetary policies, for example, in order to achieve an expansionary economic period just before elections in hopes of increasing the probability of their political survival. Under non-democratic regimes, the logic of opportunistic politics would lead politicians to drain the public purse for personal gain, especially if it seemed their time in office might be coming to an end. According to this model, reform occurs when it serves the personal political survival or the personal pecuniary interests of political leaders. And if no reform occurs, then political leaders have not received sufficient personal benefits.

A full elaboration of these models of policy reform is beyond the scope of this paper. It is worth noting, however, that the three models are not necessarily mutually exclusive. All three forms of decision-making may coexist in some countries, although if one political model of policy reform is dominant, at least for
a limited period of time, then it would have distinct consequences for the likelihood of policy reform.\footnote{One could, for example, operationalize the three models and assign countries to the specific categories, in order to determine the degree to which the success of reform is explained by these clusters of political conditions. This methodological approach is not adopted here. For this type of analysis, which seeks to explain different choices in economic policy adjustment and implementation, in 13 nations, using five set of political economic factors, see Nelson [28].}

These three models, as with all models, have both advantages and disadvantages in the ways they simplify reality. I would suggest that the three models do reflect conventional wisdom about how the world works. From this perspective, the models of political will, political factions, and political survival are useful in articulating common assumptions about policy reform and in identifying dominant patterns of policy reform.

4. Pharmaceutical policy reform

The reform of pharmaceutical policy in poor countries represents one of the most important areas of health sector reform, as well as one of the most contested. Remarkably, pharmaceutical policy represents one of the few areas in the health sector for which both the World Bank and the World Health Organization agree that major restructuring is needed. Their agreement, however, emerges from different value orientations. The WDR, for example, cited the pharmaceutical sector as an important target for reform, with ‘substantial scope for reduction of waste and inefficiency in government health programs’, and ‘the most promising area for efficiency gains in the short run’ (Ref. [3], p. 159). The Bank called for improvements in the selection and quantification of drug requirements, the use of essential national drug lists, and competitive purchasing of drugs. The Bank thus stressed the utilitarian basis for improved pharmaceutical policies, in seeking to achieve maximal utility from limited resources, reflecting its traditional emphasis on the cost-effective use of health sector resources [29]. The World Health Organization has called for similar policy reforms, for the past decade, through its Action Program on Essential Drugs. But the WHO has justified its reforms to the pharmaceutical sector on the basis of achieving greater equity, through improved accessibility and affordability of basic drugs to poor people, and with hardly a mention of improved efficiency [30].

Pharmaceutical policy provides a good area to explore health sector reform for economic, political, and ethical reasons as well. First, pharmaceutical expenditures in poor countries typically account for between 10 and 30% of total recurrent costs of public sector health expenditures, ranking second after salaries (Ref. [3], p. 146). In many countries, pharmaceutical purchases account for an even higher proportion of private expenditures. These high expenditures make drugs a high priority issue for policy makers. Second, pharmaceutical policy usually involves both the public and private sectors, as well as domestic and international actors, in various political patterns of collaboration, competition, and conflict. It thus serves as a good example for other areas of health sector reform, such as the introduction of
user fees and the promotion of private sector activities, which also involve multiple actors in complex patterns of interaction (but are not considered in this paper). Third, discussion of pharmaceutical policy often elicits a debate about basic social values, including the roles of the market and the state, and the relative importance of efficiency and equity.

An analysis of pharmaceutical policy reform promises to hold important lessons that are relevant for other areas of health sector reform, especially those areas involving conflicts with the private sector or with the medical association (such as efforts intended to reduce private sector inefficiencies or increase government revenues). On the other hand, pharmaceutical policy reform may not be representative of all types of health sector reform, especially those focused on the government sector (such as the expansion of primary health care, or the promotion of immunization).

Three cases were selected for analysis of pharmaceutical policy reform: Sri Lanka, Bangladesh, and the Philippines. These three cases represent major policy reforms, including many of the characteristics shown in Table 1, and they stand out as successful instances of pharmaceutical reforms in the 1970s and 1980s. The three cases embody key elements of reforms recommended by both the World Bank and the WHO for the pharmaceutical sector, although they also involved more government intervention in market activities than considered desirable by the World Bank. The three cases also generated substantial controversy, at both domestic and international levels, concerning the passage and implementation of the reform packages. In all three cases, the reforms were passed even though the domestic market was dominated by multinational corporations (at least 75% of the private sector in Sri Lanka, 75% of the total market in Bangladesh, and at least 70% of the total market in the Philippines). Below, I present the substance of pharmaceutical reform in the three countries, and then compare the three experiences, in search of common patterns in the political feasibility of policy reform.

4.1. Sri Lanka

Pharmaceutical reform in Sri Lanka followed the landslide election in 1970 of the Sri Lanka Freedom Party (SLFP) and the inauguration of a strong coalition government consisting of the SLFP and two Marxist parties. Mrs Bandaranaike returned to power (following her previous stint from 1960 to 1965) as the head of a coalition government that, according to one observer, 'exhibited greater ideological coherence and sense of purpose than any previous such alliance. It also dominated Parliament more completely and was forcefully reminded that there was a constituency for thorough radicalism by the 1971 Insurgency (by the JVP, a radical Sinhalese party and unemployed rural youths)' [31]. These conditions spawned a transformation of the Sri Lankan economy, with a wave of nationalizations, expansion of the public corporate sector, and enlargement of the state's control of economic activities. Sri Lanka's pharmaceutical sector reforms occurred within this broad shift in government and political economy.

Following the inauguration of the new government, the Prime Minister set up a two-member committee, including a prominent university-based pharmacologist and a member of Parliament, to prepare a report on measures to rationalize the
pharmaceutical sector in Sri Lanka. Their report, issued in 1971, provided the basis for pharmaceutical reform [32].

In 1971, the Sri Lankan government established the State Pharmaceutical Corporation (SPC) to implement the reforms of the Wickremasinghe and Bibile report, under the Ministry of Industries and Scientific Affairs, instead of the MOH. The SPC soon began replacing the 134 private importers of pharmaceuticals, and by mid-1973 had become the sole importer. An international tendering system, with quality control requirements, was used to purchase low-cost generic products when available, to seek non-patent-observing sources for newer patented products, and to bargain with transnational sources for patented products that were not available elsewhere. The government's National Formulary Committee, established in 1962 to reform the list of drugs, had previously reduced the number of private sector drugs from 4000 to 2100 (3000 dosage forms). In 1971, this process continued, with the total number of drugs reduced from 2100 to 600. In addition, the usage of brand names was greatly reduced. Patent protection laws were not amended in Sri Lanka, but purchases from non-patent-observing sources were actively pursued. Overall, implementation was most successful in the areas of import, distribution, drug list reduction, and promotion, with little progress in amendment of patent law, promotion of local production, and improvement of local quality control facilities. The reforms thus contained some libertarian values (using the competitive international market for procurement), some utilitarian values (emphasizing cost-effective purchases of a limited list of generic products, ignoring certain property rights), and some communitarian values (emphasizing redistribution to poorer members of the community in order to support the common good).

Opposition to Sri Lanka's pharmaceutical reform came from both foreign and domestic sources. On 10 May 1973, Joseph Stetler, the President of the U.S. Pharmaceutical Manufacturers Association, wrote an aggressive and threatening letter addressed to Sri Lanka's Prime Minister (Ref. [33], p. 310). The letter vigorously attacked all of the major provisions of the country's pharmaceutical reform and argued that the policy would have counterproductive consequences — inhibiting the growth of local industry, discouraging high-quality companies from participating in the tenders, encouraging the purchase of low-quality products with poor health consequences, discouraging international companies from participation in the Sri Lankan market by reducing patent protection, reducing the therapeutic efficacy of drugs by relying on generics with problems in bioequivalence, and reducing the information available to pharmacists and physicians due to restrictions on promotion. Stetler backed up the USPMA's complaints about the reform with a broader economic threat, stating that 'the action calls into question the Government's position with respect to all foreign investment in Sri Lanka'.

Within Sri Lanka, opposition to the reform emerged from private medical practitioners and from local representatives of the international pharmaceutical industry (Ref. [33], p. 311). The domestically based opposition focused on criticism of the quality of SPC purchased drugs, alleging that the lower-cost generic products and the products procured from non-patent-observing sources were therapeutically ineffective. The medical profession resisted the change from brand to generic
names, due to qualms about the quality of generics and to habit of using brand names. In addition, some patients preferred well-known brand name drugs. According to Lall and Bibile (Ref. [33], p. 319, 13n), 'The SPC managed, by means of the gradual pace of change and some compromise, to avoid an all-out battle with local firms'.

These reforms were achieved in the early years of Mrs Bandaranaike's government, when the coalition was strongly united in its goals. During these years, the United Front government (as it was known) instituted a ceiling on land-holdings and houses, and imposed severe import restrictions. The pharmaceutical reforms thus fit with the redistributive, socialist, and statist strategies of the regime in power. The substantive elements of the pharmaceutical reform depended on strong support from progressive academic elites, characterized by Professor S. Bibile, who recognized the socialist government as an opportunity to implement long-desired reforms. (Similar academic entries into government efforts at policy reform occurred in other sectors as well.) The threat of the 1971 Insurgency provided a political impetus to reform, by demonstrating the existence of a radical sentiment in rural areas and justifying transformative policies that might coopt the potential for broad-based revolt. The severe economic conditions existing in Sri Lanka in the early 1970s provided an economic rationale for policy reforms that promised to reduce government expenditures while purchasing larger quantities and achieving greater health impacts.

As domestic political circumstances changed in Sri Lanka, pharmaceutical reform slowed down and was partially reversed. In 1975, the most radical party in the coalition, the Lanka Sama Samaj Party (LSSP), quit the government, and the Prime Minister 'moved distinctly to the right' (Ref. [33], p. 305), showing less enthusiasm for pharmaceutical reform. The shift in governmental position was accompanied by more vocal criticism of pharmaceutical policy by vested interests, including doctors and local representatives of multinational drug companies, resulting in some concessions by the SPC on the retention of brand name drugs (Ref. [33], p. 309). In early 1977, the Sri Lanka Communist Party quit the coalition government, followed by the resignation of the Minister of Industries, in protest of the Prime Minister's 'right-wing policies', including the refusal to nationalize multinational drug companies in Sri Lanka (Ref. [33], p. 326). In July 1977, after the SLFP government fell, elections were held, resulting in a resounding defeat for the SLFP and no seats in Parliament for the Marxists (the first time since the introduction of universal suffrage) (Ref. [31], p. 350).

The new government that assumed power in 1977 was based on the United National Party, with over 80% of the seats in Parliament. This party won with campaign promises of economic liberalization, market-oriented policies, and pro-Western geopolitics. The UNP regime reversed some crucial elements of Mrs Bandaranaike's pharmaceutical reform — as its own reform policy. In particular the State Pharmaceutical Corporation lost its monopoly on imports, as the private sector was allowed to import and distribute, and brand names became more prominent in the pharmaceutical market (but not the government sector). The partial privatization reportedly produced price competition between the SPC and the private sector, contributing to a market-oriented control over drug prices
through SPC decisions to import and distribute at low prices in the government sector those products considered to have excessive profit margins in the private sector (Ref. [34], p. 22). In general, the UNP government criticized the reported achievements of the previous regime's pharmaceutical policy and sought to improve the policy in areas of quality control, advertising, and efficiency of the SPC. Indeed, rather than a total reversal, the UNP policy retained some important aspects of the previous policy, such as the concept of essential drugs in registration and the role of the centralized state purchasing in the pharmaceutical system (for public institutions), but had little success in promoting domestic production, reflecting broader problems of economy policy\(^3\) [35].

4.2. Bangladesh\(^4\)

On 24 March 1982, Lieutenant-General and Army Chief of Staff H.M. Ershad overthrew the Bangladesh government and seized power, declaring martial law later that day [36]. Among the new government's top items for reform was pharmaceutical policy. Within about 4 weeks of taking over, Ershad had convened an eight-member expert committee to transform government policy on drugs, and 2 weeks later, on 11 May, the committee presented its report. The committee unanimously recommended 16 criteria as guidelines to reorganize the country's pharmaceutical sector. While 'keeping in view the health needs of the country', the report stated its overall objective as follows: 'Consistent with the declared guidelines of Government to provide basic needs of life to the majority of the people through austerity and to improve the economy of the country, wastage of foreign exchange through the production and/or importation of unnecessary drugs or drugs of marginal value have to be stopped' [37]. The report appended a list of drugs to be removed from the market, based on the committee's evaluation of all the registered and licensed pharmaceutical products manufactured and imported in Bangladesh. The report thus articulated utilitarian values (in maximizing the health benefits of drug purchases) and communitarian values (in seeking to improve the common good), and became the basis of the new national policy.

The Bangladesh Drug (Control) Ordinance of 1982 was issued soon thereafter, on 12 June 1982, as a declaration by Chief Martial Law Administrator Ershad. The policy applied the concept of essential drugs to both the private and public sectors for pharmaceuticals in Bangladesh (an essential drugs list had been used since 1978 for procurement by the government's Central Medical Stores). The policy's basic strategy was to exclude all non-essential drugs from the country, rather than to promote essential drugs in the public sector while allowing the coexistence of a broader private market. The policy created a restricted national formulary of 150

\(^3\) More generally, the post-1977 economic reforms by the United National Party did not promote exports very effectively, due to a substantial continuation of import controls [53], and did not involve a vigorous privatization program, consisting mainly of a slowdown in the creation of new state-owned enterprises, with only two sales completed by mid-1990 (Ref. [54], pp. 312–313). An analysis of Sri Lanka's post-1977 economic reforms, and its divergence from a 'classic' structural adjustment and stabilization program, however, is a separate story from the main thrust of this paper.

\(^4\) This section on the Bangladesh pharmaceutical policy draws on Reich [55].
essential drugs and 100 specialist drugs, with 12 at the health post level, 45 for primary health care, and the full list at tertiary hospitals. The act banned about 1700 drugs from production or sale in three categories: 299 harmful drugs that were to be destroyed within 3 months; 127 drugs that required reformulation within 1 year, due to unnecessary, unscientific, or harmful ingredients; and 1240 drugs that did not conform to the 16 basic principles and had to be withdrawn within 18 months [38]. The ordinance also included measures to promote local manufacture and to restrict the operations of foreign firms within Bangladesh. For instance, if products were produced by local firms, multinationals were not allowed to import similar drugs. The policy also imposed restrictions on transfer prices, requiring that they be similar to international competitive prices.

Ershad's rise to power had created favorable political conditions and incentives for pharmaceutical reform. First, the policy embodied a populist strategy of basic needs (reduced prices of essential drugs) to appeal to Bangladesh's rural poor, who continued to be bypassed by development efforts, despite nearly US$3 billion of aid funds committed in the country in the first decade after independence in 1971 (Ref. [39], p. 16). Second, the Drug Policy created a political alliance with one sector of local industry and also with a number of prominent left intellectuals, symbolized by Dr Zafrullah Chowdhury (a key architect of the new drug policy) as a development activist and a freedom fighter. Third, the policy articulated a vision of self-reliance and priority provision of basic national needs and an attitude of proud defiance against the multinationals — a stance of economic nationalism. Finally, the policy generated international legitimacy through its support by international agencies and nongovernmental development organizations.

The new drug policy received an immediate and hostile response from the pharmaceutical industry. Domestic firms in the Bangladesh pharmaceutical industry association (Bangladesh Ashad Shilpa Samity, or BASS) purchased full-page advertisements in the Bangladesh press to oppose the drug policy. International firms did the same, arguing that the new policy would discourage foreign investors, would result in more harm than good for public health, and would not achieve the goals of increased availability of medicines. Ultimately, the international industry argued, the policy would result in decisions by companies to halt all pharmaceutical production, including that of essential drugs, and to leave Bangladesh. Attacks on the drug policy continued from The Pulse, a medical newspaper in Bangladesh, which denounced the policy as 'unimaginative, ill-conceived and hasty', releasing 'evil forces' in the market, putting additional burdens on the common man, 'delaying recovery from diseases,' and 'prolonging suffering of the patients' [40].

Pressure on Ershad's government came also from foreign governments, which asserted that the policy would discourage private investors from entering or staying in Bangladesh. Ambassadors from the United States, West Germany, the United Kingdom, and the Netherlands individually visited the Health Minister and the Chief Martial Law Administrator to express their displeasure (Ref. [42], pp. 99–100). In addition, the U.S. ambassador helped to arrange for a visit of experts from the Pharmaceutical Manufacturers Association and from companies in July 1982. Given the importance of foreign aid in Bangladesh, the official complaints could not easily be ignored by the new government.
The Bangladesh Medical Association (BMA) also quickly emerged as a vocal opponent to the new drug policy. The BMA reportedly agreed with the policy's ultimate objectives but not with its formulation process, criticizing the committee's lack of consultation with the BMA [42]. The BMA criticized the methods used to review all drugs on the market in a 2-week period and also attacked the involvement of foreigners from NGOs in design of the drug policy. Because of these conflicts, the BMA refused to discuss the policy's implementation after its announcement in June 1982.

The World Health Organization and international consumer organizations, on the other hand, praised the drug policy. WHO Director-General Halfdan Mahler supported the policy during a visit to Dhaka in September 1982 [43]. In 1986, the International Organization of Consumers Unions published a document that commended the drug policy and the government leader who supported it [44]. Praise came as well from international medical journals, especially Tropical Doctor and the Lancet.

While the Bangladesh government persisted with the main thrust of its drug policy, some changes were introduced in response to complaints and pressure from industry and foreign governments [40]. These included: permitting some banned products back on the market, extending the time periods for implementation, introducing an appeals process, and altering the list of allowed products. With these compromises, the policy survived opposition from the international pharmaceutical industry, the Bangladesh Medical Association, and Western governments (Ref. [45], pp. 13–16).

Ershad achieved several domestic political objectives with his pharmaceutical reform. His goals included populist political objectives (providing lower prices on some common drugs for the poor), economic political objectives (winning support from the domestic pharmaceutical industry), symbolic political objectives (creating the symbol of an external enemy), and broader legitimacy (gaining domestic and international recognition for his innovative policy). The policy's continuity, however, depended on creating an additional constituency for the policy out of previous opponents. By 1986, the policy's benefits of increased local production became clear, the Bangladesh pharmaceutical industry association had reversed its initial opposition to the policy and had become a vocal and public supporter.

The fate of Bangladesh's 1982 pharmaceutical reform is uncertain in the post-Ershad political era. In early December 1990, senior army personnel in Bangladesh forced Ershad to resign, after several months of rising protests against the government. His fall from power resulted from a combination of economic distress, political instability, and increasing interest group mobilization, which persuaded the military to withdraw its support from Ershad. An important element in the political equation was increasing opposition from the Bangladesh Medical Association, in protest to Ershad's proposed health reform policy that was announced in July 1990. Following parliamentary elections in February 1991, a new government took office and announced that the drug policy would be reviewed and revised, responding to both domestic and international pressures. The nature of the revision, however, remains undecided in 1993.
4.3. Philippines

In February 1986, the Philippines underwent a dramatic political reversal and renewal, as the ‘People Power’ movement ended the 16-year regime of Ferdinand Marcos in a revolutionary atmosphere and installed a new government under the leadership of Corazon Aquino. In March of that year, Dr Alfredo Bengzon, a neurosurgeon with a Masters in Business Administration, assumed the helm of the Health Ministry, with a strong commitment to reform the country’s health system. In addition, Bengzon was fortunate to have a good political relationship with President Aquino, because of his role (along with others) in helping to persuade her to challenge Marcos in the election (Ref. [46], p. 33). The mood of revolutionary fervor that accompanied Aquino’s assumption of power created fertile conditions for systemic change in many sectors in the Philippines; while some reforms materialized (as in pharmaceutical policy), others remained unfulfilled promises (such as land reform).

According to Bengzon, he arrived at the issue of pharmaceutical reform ‘by serendipity’ (Ref. [47], p. 6). In April 1986, one month after taking over responsibility as Secretary of Health, he ‘became aware’ that pharmaceutical expenditures accounted for 18–20% of his Department’s annual budget. He responded by seeking to improve the cost-effectiveness of procurement, to use the Department’s purchasing power to obtain better terms and volume discounts, and thereby expand the government’s supply of drugs. In exploring the existing system, he discovered that the Philippines did not have a national pharmaceutical policy and that decisions on pharmaceutical production, trade, and information were dictated by the groups involved, heavily influenced by their own interests (Ref. [47], p. 6). Bengzon resolved to correct this situation, to improve the procurement problems in his agency, and to improve the availability of drugs to the populace. In presenting the policy, he subsequently emphasized the libertarian principle of providing consumers with greater choice.

To prepare a draft national drug policy, Bengzon followed a consultative and iterative process that involved all the interested parties, in both public and private sectors (Fig. 1). The Department’s top management (the secretary and two under-secretaries) served as the ‘initiators and task masters’ of the process (Ref. [46], p. 35). They created a task force to provide background information on pharmaceutical issues and to frame the rules and timing of the consultation process. Different social sectors were then requested to review the terms of reference for the policy and submit position papers, leading to the identification of seven key issues. Face-to-face meetings followed with 61 organizations and 99 individuals. The policy was then created during a live-in retreat by the Department’s Executive Committee with ‘appropriate consultants’, and was presented to President Aquino for review in early April 1987. She announced the new policy at the end of the month, just over a year after the Department started work on pharmaceutical reform (Ref. [49], pp. 6–7).

To provide a solid legal foundation for pharmaceutical reform, the proponents sought specific constitutional and legislative goals. The new Constitution of 1987 gave a strong mandate to cost-effectiveness, equitable distribution, and government
regulation of pharmaceuticals (in Article 13, Sections 11 and 12). Following the announcement of the new drug policy, the Congress unanimously passed the Philippine Generics Act in September 1988, giving the Department of Health the necessary authority and sanctions to implement key measures of the PNDP. The Generics Law included the following key provisions (Ref. [47], p. 9):
The use of generic name in labelling and advertising, prescribing and dispensing.

Development of an Essential Drugs List with a core list of 297 drugs and a complementary list of 263 drugs.

Information, education, and communication campaigns to various social sectors and to the public at large.

Provision for penalty, which ranges from reprimand for the first conviction to fines and suspensions of license to practice for repeated violations.

Contingency authority empowering the Secretary of Health to do the following: (a) issue rules and regulations to drug manufacturing companies to produce, distribute and make available to the public, medicines in the form of generic drugs, and (b) import raw materials when there is a shortage, for the use of Filipino owned or controlled drug establishments, to be marketed and sold exclusively under generic nomenclature.

Opposition to pharmaceutical reform crystallized around the Generics Law, emerging from sources both domestic and foreign, especially from US organizations. Kintanar and Robles [46] described the adversaries and their complaints:

The Philippine Medical Association filed a suit questioning the Generics Law; some multinationals also brought the issue of generic labelling guidelines to court; the president of the Drug Association of the Philippines — the organization of multinational firms — called the Essential Drugs List ‘extremely dangerous’; the head of the American Chamber of Commerce in the Philippines, Gordon Westley, expressed deep concern ‘over proposals to use government power to closely control, widely prohibit and minutely redirect private activities in the health sector’; two American senators (Allan Cranston and Richard Lugar) warned President Aquino to ‘look carefully at plans... to implement a National Drug Policy because... the task of stimulating new US investments may become more difficult’; lastly, the US State Department was supposed to have floated a document saying that ‘to avoid serious damage to the Philippine reputation as a place to invest, we urge... the government of the Philippines to implement the Generics Law in as non-discriminatory and non-compulsory manner as possible’ (Ref. [46], p. 42).

In addition, a small group in the Philippine Medical Association attacked the Generics Law as a violation of their human rights because of legal sanctions for physicians who disregard regulations on generic prescribing. A small number of newspaper columnists also criticized the Generics Law (Ref. [46], pp. 51–52).

Supporters of pharmaceutical reform employed various strategies to contain the opposition, including: continued political support from President Aquino; constituency building and alliances with the church, the media, academia, and health professionals; court decisions against the plaintiffs and in favor of the policy; public protests by ‘people’s organizations’ and consumer groups against the firms that filed court suits; public demonstrations in support of President Aquino and the Generics Law; and social marketing of the policy through the mass media to the public and health professionals (Ref. [48], pp. 42–43). The initiators of pharmaceutical reform anticipated opposition and prepared for it, collecting substantive documentation for court challenges and designing political strategies to mobilize
domestic and international support. They also implemented the policy in ‘relatively
easier areas’ first, in order to produce visible successes, and agreed to some
compromises in implementation, in order to receive cooperation from key organi-
zations such as the Philippine Medical Association (Ref. [46], p. 48).
Advocates of pharmaceutical reform in the Philippines recognized the impor-
tance of political timing, in passing and implementing the reform; they also
recognized that new political circumstances could permit a reversal of the policy.
The potential for reversal arose after changes in the executive and legislative
branches of government, following the election of Fidel Ramos as the new
President in May 1992, who appointed a new Secretary of Health, along with the
election of a new Congress. The head of the Philippine National Drug Policy
Programme, writing with a journalist, concluded in 1992, ‘Undoubtedly, opponents
of the PNDP are awaiting a propitious moment, one that will give them the
opportunity to turn back the clock’ (Ref. [46], p. 53). Their conclusion reflects a
basic principle, that reform is constructed and sustained through politics, and its
corollary, that reform is also dismembered and reversed through politics.

5. Discussion

The three case studies share a number of conditions that contributed to making
policy reform politically feasible. Below I review and compare these conditions, to
identify key political variables that affect the feasibility of pharmaceutical reform,
and to explore principles that may be generalized to other areas of health sector
reform. Table 2 provides a summary of the political dimensions of pharmaceutical
reform in Sri Lanka, Bangladesh, and the Philippines.

It goes without saying, almost, that three case studies do not constitute proof in
social science. Three cases can, however, provide the basis for a persuasive
argument, through the identification of commonalities and differences and through
contextual analysis (and three cases are usually better than one or two). The
limitations of this comparative method are well known, and do not merit repetition
here [48]. Various alternative analytical approaches could be adopted in future
research5. Despite these limitations, this essay does take several steps toward
identifying critical political conditions for health sector reform, briefly noted below.

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5Four alternative approaches are: (1) The number of cases could be expanded, and statistical methods
could be used to analyze correlations between the political conditions in a society and the political
feasibility of a reform. (2) The study could include cases where pharmaceutical reform failed, as in
Nigeria and Peru, to seek differences between feasibility and failure. (3) The study could explore other
successful cases of health sector reform, outside the pharmaceutical field, to seek commonalities. (4) A
series of papers could be commissioned on national pharmaceutical reform experiences, written by the
‘technocrat-politicians’ involved, as was done for economic policy by Williamson and which reached a
number of conclusions similar to this chapter [49]. According to The Economist’s review of the
Williamson book, the main conclusions were: ‘To sum up, you don’t need a dictator or a crisis. You
probably do need a leader with a vision, a strong political base, and, if possible, an advanced degree in
economics. And you pretty definitely need a team of economic advisers who are telling that leader the
same thing’ [56].
Table 2
The politics of pharmaceutical policy reform in three countries

<table>
<thead>
<tr>
<th>Reform politics</th>
<th>Sri Lanka</th>
<th>Bangladesh</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>— democratic election, socialist values, redistributive</td>
<td>— military coup, populist, anti-corruption</td>
<td>— democratic election, people's power revolution, social equity (C)</td>
</tr>
<tr>
<td></td>
<td>— for common good (C)</td>
<td>— basic needs for common good (C)</td>
<td>— efficient procurement (U)</td>
</tr>
<tr>
<td></td>
<td>— use internal market (L)</td>
<td>— reduced usage of unnecessary drugs (U)</td>
<td>— patient choice (L)</td>
</tr>
<tr>
<td></td>
<td>— cost effective (U)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distribution consequences</td>
<td>— pro-poor</td>
<td>— pro-poor</td>
<td>— pro-poor</td>
</tr>
<tr>
<td></td>
<td>— anti-MNC</td>
<td>— anti-MNC</td>
<td>— anti-MNC</td>
</tr>
<tr>
<td></td>
<td>— reduced benefits to urban elite</td>
<td>— reduced benefits to urban elite</td>
<td>— reduced benefits to urban elite</td>
</tr>
<tr>
<td></td>
<td>— potential benefits to local firms</td>
<td>— potential benefits to local firms</td>
<td>— potential benefits to local firms</td>
</tr>
<tr>
<td></td>
<td>— improved efficiency</td>
<td>— improved efficiency</td>
<td>— improved efficiency</td>
</tr>
<tr>
<td>Group competition</td>
<td>— policy change based on local academics and official report</td>
<td>— sudden change with little consultation</td>
<td>— consensus-building process through MOH, with mobilization of social groups</td>
</tr>
<tr>
<td></td>
<td>— persuasive power of common good</td>
<td>— coercive power of government plus concession</td>
<td>— opposed by medical association and USPMA</td>
</tr>
<tr>
<td></td>
<td>— opposed by medical association and USFMA</td>
<td>— opposed by medical association and USPMA and local firms</td>
<td>— opposed by medical association and USPMA</td>
</tr>
<tr>
<td>Timing</td>
<td>— post-election, party switch, strong socialist mandate</td>
<td>— post-military coup, as one of first government actions by Ershad seeking national and international legitimacy</td>
<td>— post-election in democratic revolutionary spirit</td>
</tr>
<tr>
<td></td>
<td>— economic difficulties</td>
<td>— trade embargo and pressure</td>
<td>— near start of Aquino government</td>
</tr>
<tr>
<td></td>
<td>— start of coalition government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political</td>
<td>— coalition government, when government weakened due to divisions, policy weakened</td>
<td>— able to withstand strong challenge by MNCs and Western governments</td>
<td>— able to withstand strong challenge by MNCs and Western governments</td>
</tr>
<tr>
<td></td>
<td>— partial reversal when new government elected in 1977</td>
<td>— head of state involved</td>
<td>— President involved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— concessions offered and opponents coopted</td>
<td>— strong Minister of Health</td>
</tr>
</tbody>
</table>

C, communitarian; L, libertarian; U, utilitarian; MNC, multinational corporation; USPMA, US Pharmaceutical Manufacturers Association.

5.1. Values
The three cases all relied on multiple values in justifying and explaining the policy reform. In each case, the reform involved a complicated package of policy
measures, which included different philosophical principles. All three cases promised more cost-effective results, invoking utilitarian values, as well as increased attention to the poor and vulnerable groups in society, suggesting communitarian principles. The reform in the Philippines was defended as improving patient choice, a libertarian objective, but it also was criticized for restricting physician choice at the same time. The reform in Sri Lanka relied upon a vigorous use of the international market to obtain the best products at the lowest price. This mixture of principles, often vaguely articulated, appeared in all three cases, and suggests that policy reform probably does not involve a one-to-one correspondence to a single philosophical axiom. Indeed, if reform is based on a single dominant value, which is explicitly stated and rigorously applied, it could have adverse consequences, making the reform more vulnerable and inflexible, and thereby more susceptible to opposition. A striking commonality is that political leaders in all three cases used the realm of values to distinguish the new regime sharply from the old and to appeal to specific constituencies (in these cases, the majority poor in each society). This commonality resembles the conclusion reached in Williamson's study of economic policy reform about the need for a leader with a vision [49].

5.2. Distributional consequences

In these three cases of pharmaceutical reform, the new policies were intended to have similar distributional consequences, as shown in Table 2. Benefits would accrue in the short term to the poorer groups of society, through improved access to lower priced drugs, with additional benefits emerging over time to local manufacturers that could replace imports. Costs, on the other hand, would be borne by multinational corporations that would lose markets or market share for specific products, and also by some patients who preferred or depended on products that were no longer allowed (including, for example, members of the urban elite who preferred certain brand-name products). Physicians would lose some degree of choice, through restricted lists of essential drugs, and could lose some income through sales of pharmaceutical products, but would gain through greater availability of basic products and improved efficiency in drug management. In all three cases, two groups of cost-bearers for the reform (multinational corporations, and physicians) were better organized than the presumed benefit bearers (poorer populations of the society) — yet it was possible for political leaders to design strategies that could overcome this collective action dilemma and manage the political aspects of these distributional consequences, as discussed next. This commonality indicates that political factors can outweigh the pressures of concentrated economic costs.

5.3. Group competition

The three cases showed distinctly similar forms of group competition, with different strategies adopted by the political leaders involved. For pharmaceutical policy reform, a predictable pattern of opposition emerged, with similar groups making similar arguments in each case. In all three countries, the national physicians association and various US private organizations (the US Pharmaceutical Manufacturers Association or the US Chamber of Commerce) became mobilized
in opposition to the reform. The governing coalitions, in all three countries, were sufficiently strong to resist the pressures mounted by both internal and external groups, although they adopted different approaches. In Sri Lanka, the government relied heavily on appeals to national interest and common good, bolstered by powerful inputs of technical expertise from national authorities. In Bangladesh, the policy reform occurred through an unusually rapid change, using the coercive power of government to squash some opposition, subsequent revisions in the policy as concessions to meet other complaints, and rewards to local manufacturers to transform their initial opposition into public support for the reform. In the Philippines, group competition was managed through a consensus-building process engineered by advocates in the Ministry of Health, along with efforts to persuade the physicians’ association to support the reform and other efforts to mobilize social pressure from presumed beneficiaries in the general population against the opposition. In the latter two cases, and possibly in Sri Lanka as well, policy sponsors adopted an initially extreme position that would allow concessions later as compromises with opponents.

The three cases illustrate the two-table political bargaining described by Putnam, and confirm his point that domestic political variables often count more than foreign political variables (such as MNCs and international banks) [17]. Even market domination by foreign firms (at 70–75% of the domestic market) did not obstruct pharmaceutical reform in these three countries. In short, for these cases, a strong political base and effective political strategies to manage group competition were more important than the economic structure of the market in determining the feasibility of reform.

5.4. Timing

The three cases confirm the general principle that opportunities for major reform have a better chance of success in the early periods of new regimes, in both democratic and non-democratic states. In all three countries, the pharmaceutical reforms occurred in the first years, when political leaders still enjoyed extra political ‘capital’ not yet expended, when coalitions were strong and supportive, when social problems could be blamed on the errors of the previous regime, and when the general public mood still looked optimistically on future prospects. The three cases suggest that the political will model may have some limited applicability at the start of a new regime, but not in a pure sense. Even Ershad, despite his power as a military dictator, needed to negotiate with different groups and provide concessions in order to gain support or non-interference (as suggested by the political factions model). And the political leaders in Sri Lanka and the Philippines similarly became involved in negotiations with different groups to assure the reform’s acceptance. The cases suggest that the political factions model is closer to reality, and that the political skill of leaders and the timing of reform critically affect the probability of success. Regimes may also move through these three political models over time, from a dominant mode of political will, to political factions, and then to political survival, as political debts accumulate and a regime’s end approaches.

The three cases also reflect the general principle that policy entrepreneurs seek
opportune moments to push their ideas [50]. In Sri Lanka, Dr Bibile had long sought to achieve a comprehensive pharmaceutical reform, and enthusiastically pursued the chance offered by Mrs Bandaranaike’s government. In Bangladesh, Dr Zafrullah had attempted to persuade previous governments to enact a pharmaceutical reform, without success, and had a major role in convincing Ershad to launch the reform process. In the Philippines, Dr Bengzon became the internal initiator of pharmaceutical reform, even though he had not previously advocated this reform, but a number of consumer groups outside the government strongly supported and pushed for the policy change. A similar pattern can be found in the United States, where the Jackson Hole group plotted and planned for years, with a special commitment from Dr Alain Enthoven, for an opportunity to get their proposal for ‘managed competition’ on the agenda for health sector reform. The US example shows that while political timing often affects when an issue gets on the agenda, it does not guarantee the issue’s translation into official policy.

5.5. Political stability

In these three cases of pharmaceutical reform, the governments successfully resisted strong opposition from domestic and foreign pressure groups. In short, the political leaders managed the policy reforms in ways that protected the regime’s stability. The challenge, however, is not only to protect the regime’s stability from being undermined by policy reform, but also to protect the reform’s continuity from being undermined by subsequent political change. As I noted above, political processes provide the means to achieve policy reform, but they also provide the means to unravel previous reforms. A policy reform is especially vulnerable to political reversal when it redistributes resources to relatively powerless and unorganized groups in society. A reform can be protected against full reversal if constituencies are created both inside and outside government, as has happened in Sri Lanka since 1977. The degrees of reversal for the pharmaceutical reforms in Bangladesh and the Philippines are still uncertain. A reform can also be protected if the marginal groups can become better organized and develop into an effective constituency for the redistributed system, or if they can ally themselves with more powerful groups in society; this is not easy to achieve in pharmaceutical reform, because of the collective action dilemmas, that is, the transaction costs that mitigate against organizing the unorganized [51].

5.6. Implications for health sector reform

Which lessons of pharmaceutical reform are relevant for other substantive areas of health sector reform? Based on the above analysis, several conclusions seem to apply to the politics of health sector reform more generally.

First, the cases suggest that at certain definable, and perhaps predictable political moments, major policy reform in the health sector is feasible. While health is often a relatively low national priority compared to economic issues, the three cases show that it is possible to catapult health sector reform onto the national political agenda and to change key elements of health policy in significant ways. The most important and manipulable factors are political timing, which provides opportunities for policy entrepreneurs to introduce their ideas into public
debate, and political management of group competition, which allows leaders to control the political effects of distributional consequences and protect the regime's stability. A strong and narrow political coalition improves the capacity of political leaders to resist the pressures of concentrated economic costs (both inside and outside national boundaries).

Fig. 2. The six steps of political mapping.
Second, the three cases suggest that some political patterns in health sector reform may be predictable, especially the role of physicians as an organized interest group. Any effort to reform the health sector must take into account the physicians' association, and must design strategies to coopt, neutralize, or mobilize this group. Studies in rich countries have similarly emphasized the political role of physicians' associations, and reached the general conclusion that a government can change the method of paying physicians only when the physicians agree [52]. This finding would suggest the possibility of future studies to examine the political conditions when physicians' associations are likely to promote or obstruct health sector reform.

Third, the cases suggest that the political conditions for policy reform can be shaped by skilled leaders, so that reforms can become politically feasible and politically sustainable. To assist decision-makers in managing the politics of health sector reform, I have developed an analytical method called political mapping (also available as computer software), which systematically assesses [7] (Fig. 2): (1) the consequences of policy reform efforts; (2) the positions of support and opposition taken by key players; (3) the analysis of stakeholders' objectives; (4) the relationship of players in a policy network map; (5) the transitions underway that create opportunities; and (6) the construction of strategies for change. The method of political mapping is designed to improve the political feasibility of policy reform. The method can improve various aspects of health policy, including: problem identification, by providing rapid identification and definition of obstacles; policy formulation, by assisting in communication among different organizations; implementation strategies, by proposing new ideas and strategies that can improve the political feasibility of health policy; and overall enhanced impact of health policy, by improving the chances that a policy will achieve its intended effects. If health sector reform is a profoundly political process, then applied political analysis, similar to the method of political mapping could help organizations that seek to promote or engage in reform (including multilateral agencies such as the World Bank), by providing strategies to enhance the feasibility of reform and the probability of success.

References


