

CHAPTER 15

Political Economy of Reform

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Over the last twenty years a growing number of developing countries have sought to transform their health financing mechanisms—with the goal of achieving universal coverage, often through national health insurance. Yet successful reform is the exception rather than the rule. If scaling up health insurance coverage is popular, can greatly improve access to care, and can potentially reduce costs through risk pooling, why is it so hard to adopt and implement?

INTRODUCTION: WHY POLITICAL ECONOMY?

Reforms are difficult because they involve a series of complex political exchanges, any one of which can stop the process short of its goals. To overcome these challenges, different political skills are required at different stages of the reform process. In short, the reform of health financing is difficult because of the political economy challenges embedded in each step of the policy reform process. Politics affects whether reform makes its way onto the national agenda, how the reform proposal is designed, the compromises needed to produce an acceptable agreement, and ultimately the implementation of reform (Reich 2002).

Health financing reform is often treated as a technical matter—designing the right policy to produce the intended effect. However, what is viewed as technically optimal is seldom politically feasible. Interventions often do not work in the intended manner. If reform teams wish to succeed, they need to give more attention to the political dimensions of the policy process together with the technical dimensions of policy development (Gilson and Raphaely 2007).

Health policy analysts and international development organizations are giving increasing emphasis to political economy analysis to provide the missing link between reform processes and policy outcomes. The World Bank has recognized the critical role of political economy for all sectors of development (World Bank 2008) and recently formed a “community of practice” within the Bank to promote political economy knowledge and analysis. This approach involves a deeper understanding of the political, institutional, social, and economic issues at play, the power relations among actors, and the incentives that affect change. Political economy analysis can help answer a series of questions crucial to scaling up access to health insurance, such as: Why have some countries been successful at

adopting national health insurance whereas others have failed? Why have leaders preferred particular policy designs over others? Why has the same reform produced the intended effect in certain settings, but not in others? What are the prospects for scaling up health insurance coverage in developing countries?

As this volume shows, few developing countries have adopted national health insurance, although the health insurance model is growing in popularity, and systemic reform is gaining momentum over vertical approaches. Nor is this trend limited to middle-income countries. Although traditionally viewed as a luxury only wealthier countries could afford, low-income countries are beginning to view health insurance as a means of increasing resources for health even in the absence of an expanding tax base. Ghana is perhaps the poorest country to attempt national health insurance. Rwanda's government is working to scale up national health insurance from local community-based financing schemes. Chile, Colombia, and Mexico are middle-income countries with large and enduring informal sectors that have instituted national health insurance. Most East Asian Tigers have adopted national health insurance systems in the context of rapid economic growth and shrinking informal sectors. East European countries have switched from a national health service model financed by general tax revenue and focused on salaried hospital-based specialists to a national health insurance model financed by payroll taxes with providers paid through fee for service (Wagstaff and Moreno-Serra, chapter 14, this volume). All advanced industrial countries (with the exception of the United States) have some form of universal health coverage—either through national health insurance or a national health service—although these systems are coming under increasing pressure for retrenchment. What can be learned from the experiences of scaling up health insurance in developing countries and from the historical experiences of now developed countries? What recommendations should policy makers and technocrats draw from the political economy of health reform?

Analysis of the political economy of health financing reform shows that there is no consensus about what constitutes a “good” reform, because of disagreement about underlying social values (Roberts et al. 2004). Different ethical assumptions result in different reform policies. A full exploration of the ethical underpinnings of health financing reform is not possible in this chapter, however, due to limitations of space and analysis.

This chapter highlights how the political economy of reform affects the agenda-setting, design, adoption, and implementation of national health insurance schemes by drawing on examples of health financing reform in both successful and unsuccessful cases. The challenges specific to scaling up health insurance in low- and middle-income countries that make health reform so difficult to achieve are assessed. It is argued that simply exhorting leaders to commit to national health insurance is insufficient to move countries to scale up coverage and that lack of political commitment to reform is inadequate to explain why some countries have been more successful than others. In addition, problems are explored with several other commonly asserted reasons to explain the failure or success of health insurance scale-up (such as economic growth,

democratization, and political culture). Instead, the authors focus on four variables they believe particularly affect the probability of successful reform: institutions, ideas, interests, and ideology. Although a deterministic account of which variables matter most is not provided, concrete examples of health reform are presented to illustrate the effects of each variable on the reform process. In addition, the authors suggest ways that policy makers may find these four variables useful in designing their health reform strategies.

There are many schematics of the policy cycle. For this chapter, the authors adapt the models of Kaufman and Nelson (2004) and Roberts et al. (2004) to distinguish four phases of the policy reform cycle: (1) the initial placement on the policy agenda (agenda setting); (2) technical design of the reform proposal (design); (3) legislative consideration and passage of the reform bill (adoption); and (4) implementation of the adopted policy (implementation). Different elements of political economy come into play at these four stages in the reform process, and different theories of political economy help explain what happens and why some proposals go forward while others founder. The objectives of this chapter are twofold: to introduce key theories of political economy that help explain why health financing reform is difficult and to present practical implications of understanding this perspective.

To illustrate, the authors draw on cases of health reform (Chile; China; Colombia; Ghana; Mexico; and Taiwan, China) as well as cases of nonreform or incremental reform (Canada, South Africa, and the United States). The examples were selected because they are relatively well studied, are known to the authors, and include both successful and unsuccessful cases. Although this chapter draws on evidence from various national contexts, the examples are not intended as a systematic review of countries scaling up health insurance. The authors propose hypotheses about the political economy of health reform and use evidence from country cases to support preliminary conclusions with theoretical and practical applications. The analysis reveals several paradoxes. Sometimes increasing democracy helps the reform process, and sometimes not. Sometimes prosperity drives health reform, and sometimes economic adversity. Sometimes decentralization can help by allowing experimentation, and sometimes it hurts by hindering implementation. These paradoxes lead to a more complex understanding of health financing and the reform process.

AGENDA SETTING: GETTING HEALTH INSURANCE ONTO THE NATIONAL AGENDA

What determines whether health insurance is prioritized on the national agenda and not education, pensions, or some other issue? Policy analysts often attribute low expenditure on health care as a share of GDP to a lack of “political will” to allocate more money to health (Scheil-Adlung, chapter 2, this volume; Hsiao and others, chapter 11, this volume). However, developing-country governments are faced with many pressing challenges and limited resources (Heller, chapter 5,

this volume). Some analysts explain the lack of national health insurance as a result of inadequate knowledge about the nature of insurance, inadequate trust in insurance companies, or lack of willingness or ability to pay an insurance premium (van de Ven, chapter 3, this volume). This question is viewed from a political economy perspective in this chapter, with particular attention to theories of agenda setting.

Agenda Setting: Coupling Policies with Political Windows

On its own, the problem of low coverage and limited financial risk protection is insufficient to place health insurance expansion high on the national agenda, due to various factors. According to Kingdon (2003), the process of agenda setting requires a combination of three streams: a window of opportunity in the *political stream*, with a ready-made solution (e.g., health insurance) in the *policy stream*, which addresses a persistent trouble (such as low access to health services) in the *problem stream*. Problems make it to the top of the national agenda for legislative enactment when there is a coupling of a problem window such as a crisis or major focusing event (e.g., an epidemic outbreak) with a political window (elections or some other political upset to the status quo). Whereas interest groups and lobbyists exert ongoing pressure for certain policy platforms, a combination of swings in national mood and elections are thought to be more important in affecting when certain issues are given a high priority (Kingdon 2003).

Problems need to be socially defined and politically supported through processes of mobilization in order to appear on the political agenda and be addressed by policy reform. Policy alternatives are narrowed by the policy process (bargaining and competition among political actors), and hidden participants or specialists (i.e., technocrats) get involved. Skilled politicians and policy entrepreneurs must recognize the potential to bring these three streams (problem, policy, and political) together to take advantage of an opportunity before it passes (Kingdon 2003). This requires attention to the roles of policy windows, the ambiguous effects of economic growth, and the influence of dominant political ideas and ideology, discussed next. The processes of problem definition and agenda setting, thus, are deeply political.

Policy Windows: The Role of Critical Junctures and Exogenous Shocks

In countries that have adopted some form of national health insurance, why did health reform make it onto the national agenda? Some policy analysts assume that if “a problem” exists, reform becomes inevitable once a breaking point is reached. However, experience with health reform shows that, even when patient dissatisfaction and cost inflation are high, reform does not automatically follow (as illustrated by the U.S. experience). Large political or economic shocks are often necessary to open a window of opportunity for change. These critical

junctures and exogenous shocks can reshuffle political competition in ways that allow advocates to push more effectively for policy change. Democratization, for example, can open a political window for health reform—allowing increased political competition, giving politicians and policy entrepreneurs new opportunities for change, and creating space for “big-bang” reform. Economic transitions can also open political space for reform.

Democratization and the Political Space for Reform

Several countries, for example, adopted national health insurance in the wake of democratization (e.g., the Republic of Korea; Mexico; and Taiwan, China). Under the prior authoritarian regimes health insurance expansion in Korea and Taiwan, China, moved in a gradual, piecemeal fashion, primarily benefiting economically vital coalitions and sectors. After democratization, increased political competition resulted in a more dramatic expansion of benefits (Wong 2004). In each case, the party in power used universal coverage as a political strategy to gain popular support (Wong 2004). In Mexico, the election of Vicente Fox as president in 2000 ended the 70 years in power of the Partido Revolucionario Institucional (PRI) and brought a new group of technocrats into the Ministry of Health (MOH); they pursued health reform with the president’s support and commitment (Lakin 2010). In Ghana, reform emerged out of an electoral strategy of the opposition party (New Patriotic Party) in Ghana’s first successfully contested multiparty election, in 2000. To galvanize the support of the rural poor, the New Patriotic Party used health reform as an election platform promising a big-bang approach that would replace the unpopular cash-and-carry system with national health insurance based on ability to pay (Rajkotia 2007; Agyepong and Adjei 2008). These findings are supported by a comparative study of education and health sector reform in eight Latin American countries, which showed that democratization increased the political salience of reform for government decision makers through the logic of political competition (Kaufman and Nelson 2004).

But democratization does not necessarily increase the probability of achieving health insurance coverage in the ways that are most commonly theorized, that is, through popular pressure from newly enfranchised, relatively poor voters (Meltzer and Richard 1981). In Mexico, for example, reform was driven by “insurgent technocrats” in the MOH seeking policy change, not by the popular demands of newly enfranchised voters lacking health insurance (Lakin 2008). Lakin (2008) stresses that a change in the nature of political appointments and a reduction of partisan discipline within the executive branch allowed a reform-focused change team to come to power and created a coincidence of factors that enabled reform from above. In other cases (such as Korea and Taiwan, China), there was more popular pressure from below for reform than in Mexico, but the expansion of health insurance was primarily politician-led (or policy-elite-led) (Lakin 2008; Lin 2002; Wong 2004). In the United States, popular pressure for

health reform on its own has been insufficient to catalyze universal health coverage for decades (Steinmo and Watts 1995).

Democratic transitions can also affect the ideological character of the reform, including the role of the state and the market. In Chile, for example, under 18 years of military rule, private health insurance was encouraged to proliferate, which might have been less likely under democratic circumstances. Following the elections of 1989 and Chile's return to democracy, public officials tried to restore equity in the health system. But their efforts were constrained by the "pacted democracy" institutions that were created in negotiations between the military regime and other political actors to end the dictatorship. As a result, reform in Chile has followed an incremental process of strengthening the public sector without directly confronting the political and economic interests opposed to reform (Bossert 2010).

Experience also shows that democratization does not guarantee that health reform makes it onto the legislative agenda. In South Africa, after the end of apartheid in 1994 the African National Congress gave health reform and social health insurance a prominent place on its policy agenda in the transition to multiracial democracy. But these reform ideas were not successfully transformed into national policy for consideration by the legislature (Gilson et al. 2003; McIntyre, Doherty, and Gilson 2003; Marks 1997).

In addition, autocratic regimes sometimes have incentives to provide social risk protection in ways that redistribute benefits. Health financing reform can serve as a political strategy to control social pressure for democratic change. For example, in the Middle East, some oil-rich "rentier" states that provide national health insurance for their citizens are beginning to expand insurance coverage to noncitizens (Ekman and Elgazzar, chapter 9, this volume). In these cases, the state may be using the expansion of social benefits as a carrot to contain popular pressure for greater political participation. Other health systems historically provided more benefits under nondemocratic circumstances. In Eastern Europe and the former USSR, for example, health benefits were more comprehensive under communism than after the fall of the iron curtain.

Nor does democratization always predict the direction or shape that reform will take. In the transitional economies, the move to a less generous social health insurance model occurred in political space created by the disintegration of the USSR (Wagstaff and Moreno-Serra, chapter 14, this volume). Health insurance financed through payroll taxes was introduced as part of a package of reforms aimed at supporting the transition from centrally planned to market-based economies. These reforms reduced public services in order to generate leaner, more liberal welfare states with protection decoupled from provision. This shock-therapy package spilled over into health policy, where 18 out of 28 East European and Central Asian countries adopted national health insurance to replace their faltering national health services and fee-for-service payment systems based on the North American model (Wagstaff and Moreno-Serra, chapter 14, this volume).

Thus, democratization (or the threat of democratization, as in the Middle East) can create a political window of opportunity and can precipitate the expansion of health insurance, but democratization is neither necessary nor sufficient to do so. Democratization does not automatically put health financing reform on the table, but it increases the probability that different reform options will be considered. Increased political competition and structural change in political institutions are what make reform more probable, not popular pressure per se. Nor does democratization necessarily translate into more risk protection; it can also be used as a window for retrenchment.

Economic Growth and Reform

Policy analysts often assume that economic expansion is a key factor in the scale-up of health insurance, as discussed in the chapter on East Asia (Hsiao and others, chapter 11, this volume). In Japan, Korea, and Taiwan, China, the rapidly expanding economies and large formal employment sector facilitated a significant expansion of government-mandated social health insurance—starting with formal sector workers and then including informal sector workers, rural farmers, and the poor.

Functionalist views of welfare state expansion have presented universal social protection as an inevitable by-product of economic growth and an expanded tax base (Wilensky 1975), but recent experience suggests otherwise. In contrast with the East Asian example, in some cases economic contraction can lead policy makers to promote the expansion of coverage to provide more social risk protection. For instance, in many Western countries, large expansions of health coverage came in the wake of the Great Depression of the 1930s (Steinmo and Watts 1995; Immergut 1990). In the United Kingdom, the National Health Service was established during the period of post-war recovery (Fox 1985). The case of the United States, however, provides some counter examples (as well as some support) for this pattern. The failure of health reform to pass in the United States during the New Deal came at a time when citizens were most vulnerable, and this marked the beginning of a series of failures at expansion (Steinmo and Watts 1995). The major expansion in coverage in the United States came with Medicaid and Medicare in the mid-1960s, which occurred during the post-war economic boom. Conversely, President Barack Obama's health reform finally passed in 2010, in the wake of a huge economic crisis.

Cycles of boom or bust can open a political space for reform but do not guarantee the passage of reform nor the direction the reform will take (greater expansion or retrenchment). Economic crisis in Latin America and Africa generated a wave of fiscal austerity measures including the introduction of user fees in the 1980s (Weyland 2004). Economic transitions in the former USSR moved in the direction of greater austerity as economic conditions deteriorated during the transition to a market system.

The recent introduction of national health insurance in several low-income countries further draws into question the notion that expanded health coverage

is an inevitable by-product of economic growth and an expanded tax base. Instead of waiting for economic expansion, some low-income countries with large informal sectors are viewing health insurance as a means to raise revenue for health, increase utilization of health services, and improve financial risk protection even for citizens outside the formal sector. A few low-income countries have substantially scaled up health insurance, even with large and enduring informal sectors and resultantly small tax bases. Rather than introducing top-down national health insurance, middle-income East Asian countries with large informal sectors, such as China, the Philippines, and Thailand, have targeted the informal sector and the poor from the outset by expanding community-based insurance, starting with rural populations and then gradually achieving universal coverage (Hsiao and others, chapter 11, this volume). Other lower-middle-income countries like Colombia and low-income countries like Ghana have adopted national health insurance and are finding ways to finance coverage incrementally over a 10-to-20-year period—even in the absence of rapidly expanding public funds generated through economic growth. There remain questions, however, about how to collect health insurance premiums from the informal sector in both low- and middle-income countries (discussed below). Despite these difficulties, health insurance expansion is increasingly on the policy agenda of developing countries over direct expansion of national health services through general taxation. This suggests that a similar political calculus regarding the introduction of health insurance prevails in low-income countries even though they potentially lack sufficient resources to sustain these programs.

This discussion suggests that having adequate economic resources is not a sufficient condition to place health reform on the national agenda, and it may not even be a necessary condition. Indeed, in some situations, financial instability can be a political motivator for the expansion of risk protection and help push insurance expansion onto the legislative agenda. Importantly, it is the shock of rapid economic growth or contraction that changes the political calculus of leaders, which can increase the probability of health reform's making its way onto national agendas, not popular or interest group pressure on their own. Although available economic resources differ, the political process for arriving at national health insurance may not differ substantially among countries at different levels of development.

Narrowing the Policy Scope: Why Some Issues Are Completely Off the Agenda

A country's dominant political ideas and ideology also shape which policy designs are given serious consideration. (Political scientists refer to this set of beliefs and values in a society as "political culture.") While resistance to scaling up social benefits like health insurance is frequently attributed to a country's political culture, this explanation can be circular (Smith 1996). Critics of cultural explanations note the endogeneity of this variable and its lack of explanatory

power (Steinmo and Watts 1995). For instance, unequal states produce fragmented welfare states, which feed back into the existing inequality and reinforce the antistatist narrative that the state should play a minimal role in social risk protection (Alesina, Glaeser, and Sacerdote 2001). While cultural explanations alone may have difficulty explaining the adoption of reform, they may help explain why certain design options gain political traction and how the range of possible options becomes narrowed down. As Kingdon (2003) notes, what gets selected for the national agenda depends not only on technical and financial feasibility but also must be congruent with the values of community members and general public acceptability.

Depending on a country's political culture, some policies may simply be "off the agenda." For instance, in the United States, a single-payer system has consistently been off the agenda, in part due to public resistance to "socialized medicine" (as well as opposition from insurance companies and the practical problems of removing private insurance plans from the health system).¹ Social health insurance rests on notions of social solidarity (Ly and others, chapter 8, this volume), suggesting that heterogeneous societies are more likely to resist plans that spread risk and subsidies across diverse social groups (e.g., Alesina, Glaeser, and Sacerdote 2001; Miguel 2004). Popular objections to social solidarity and popular acceptance of individual responsibility are commonly cited reasons for the U.S. failure to adopt national health insurance or a single-payer system or even get these options on the national agenda (Jacobs 1993). By contrast, some scholars argue that East Asian countries are solidaristic and defer to authority (e.g., Moody 1996), making health insurance expansion more culturally acceptable (Doh and Cole 2009).

In sum, the first step in scaling up health insurance is for the issue to make it onto the national policy agenda. Health reform appears on the national agenda when different streams come together at the right moment—a coupling of an ongoing problem with a political window and a policy solution (Kingdon 2003). Social mobilization and lobbying around a problem (like expanding health coverage) will not get far without a political opening that changes the policy equilibrium. Likewise, a political opening may pass unexploited if policy entrepreneurs are not promoting persuasive solutions. The authors' review of cases further suggests that major political and economic shifts can create opportunities for health financing reform, but that both democratization and economic expansion have ambiguous impacts since reform has also reached the national policy agenda in situations of nondemocracy and economic contraction.

TECHNICAL DESIGN: WHAT AFFECTS THE CONTENTS OF THE PROPOSED REFORMS?

During the design phase, policy proposals are hammered out. A complex negotiation process shapes what gets into the legislation and what is left

off the table. Although participatory approaches to policy development are sometimes promoted in the policy literature, experience shows that behind-the-scenes advising by technocrats plays an important role at this stage, as during the agenda-setting period (Kaufman and Nelson 2004). During the design stage, the policy space narrows as the preferred proposals of policy entrepreneurs become the focus of debate (Kingdon 2003). Design issues are typically considered to be a technical process of applying economic theory to the problems of health insurance (Glied and Stabile, chapter 4, this volume), but design is actually a profoundly political process as well.

Policy Diffusion and Learning from Foreign Models

As the introduction to this volume suggests (Preker, Lindner, Chernichovsky, and Schellekens, chapter 1), the health insurance model has recently gained momentum over the general revenues finance model of national health service (NHS). Why is this the case? Public policy has been observed to diffuse in a wavelike S-shaped pattern, sweeping across regions of the world and clustering geographically and temporally (Weyland 2005). Scholars of policy diffusion have proposed various explanations for the wavelike diffusion of policy ideas (e.g., Simmons and Elkins 2004):

- *Influence of external pressure.* Countries adopt policies due to pressure from international financial institutions or donors.
- *Symbolic or normative imitation.* Countries imitate trendsetter countries to stay on the frontier of policy experimentation.
- *Rational learning.* Countries learn from other cases where adequate information is available about what has worked.
- *Cognitive heuristics.* Countries adopt policies in the absence of full information and unlimited time to make decisions, by using “boundedly rational” inferential shortcuts and looking at other countries’ experiences.

The approach used in deciding on policy design has important implications for a policy’s impact, as suggested by the health reform experiences of various countries. The selection of the policy design approach is often conditioned by broader historical and political circumstances.

External pressure for policy design can take various forms. For example, as discussed in the chapter on Anglophone Africa (Ly and others, chapter 8, this volume), most former British colonies adopted Britain’s NHS model upon independence, as an institutional carryover from the colonial experience. With a small resource base and a high cost of care, however, these systems were chronically underfunded. In the 1980s and 1990s, in response to economic austerity packages and fiscal crisis, many African countries introduced user fees to make up for funding shortfalls. Critics have pointed to the role of the international financial institutions in pressing countries to adopt these cost-recovery schemes

(e.g., Kim et al. 2000). More recently, health insurance is increasingly being advocated by development agencies to overcome the gaps in coverage emanating from underfunded or fragmented national health services and the limited experiments with health insurance that have been undertaken in a number of developing countries.

But the ideas of development agencies are not directly transferred in cookie-cutter fashion to recipient countries; policy diffusion is mediated by domestic political processes. While external pressure is frequently invoked as an explanation for the convergence of policy across diverse countries, a number of studies find continued diversity and innovation in national social policy even amid general convergence (e.g., Murillo 2002). Nelson finds, for instance, that “external attempts to prompt specific actions had a rather limited impact [on health sector reform], despite the substantial influence [...] of broader international intellectual currents on reform debate and government agendas” (Nelson 2004: 32). Countries in very different parts of the world may adopt prevailing models from other parts of the world. For instance, Chile in the 1950s adopted a modified version of the British NHS even though it was not within the British sphere of influence. Whether policy makers are adopting a national health insurance model from external pressure and imitation or from some form of domestic learning (whether rational or bounded) remains for researchers to examine and explain.

In East Asia, the decision to adopt a national health insurance model appears to have occurred more through domestic learning than through external pressure or peer imitation. Japan was the first non-Western country to expand health insurance following the German social health insurance model (Hsiao and others, chapter 11, this volume). In contrast to the first-mover advantage that has been noted in the development literature (Gerschenkron 1962), in social policy late developers like Japan have the advantage of being able to learn from existing models rather than creating policy *de novo*. The ability to leapfrog existing models has enabled newly industrial countries to introduce universal health systems much more rapidly than “*la longue durée*” that characterized the development of the welfare state in the West (Singh 1999). In considering how to provide health coverage, Japan had foreign models to observe and evaluate. As a result, Japan decided to adopt Germany’s Bismarckian model of employee-based social health insurance in 1922, beginning with the coverage of blue-collar workers and then expanding coverage to other population groups (Hsiao and others, chapter 11, this volume).

Japan’s policy experience in turn set an example for other East Asian countries like Korea and Taiwan, China, which also adopted a social health insurance model. Korea and Taiwan, China, however, subsequently adopted a single government-run insurance model to provide universal coverage, unlike Japan, which has maintained multiple insurers (Hsiao and others, chapter 11, this volume). Recently, China has followed a rational learning process for health reform, surveying different countries’ health systems and experimenting before

deciding on a particular model (Blumenthal and Hsiao 2005). By developing after the West expanded welfare protections, newly industrializing countries can learn from these experiences and design their policies accordingly. In Mexico, for example, the design of national health insurance was driven by a technocratic policy assessment of the “evidence-based” merits of health insurance (demand-driven delivery) over a national health service (supply-driven delivery) (Frenk 2006; Lakin 2010).

Policy Entrepreneurs, Technocrats, and Change Teams in Policy Design

Policy diffusion is not simply the process of policy makers’ “learning from what works.” The role that technocrats and policy entrepreneurs play in diffusing academic ideas has been gaining increasing attention in the policy literature (e.g., Silva 1991; Dominguez 1998; Lee and Goodman 2002). The recent switch toward a health insurance model in developing countries appears to be driven by teams of policy experts or “expert epistemic communities” that endorse particular policy solutions (Dobbin, Simmons, and Garret 2007). According to Kaufman and Nelson (2004: 475), “specific proposals have generally been designed from the top, by reform or ‘change teams’ within or among the ministries.” Change teams of technocrats are the technical entities that design policies and build networks of support within government (Waterbury 1992). The assignment of policy design to technocrats takes some of the political pressure off politicians and allows politicians to claim some plausible deniability if the reform fails. Change teams were crucial to the success of attempted health reforms in Latin America during the 1990s (Bossert and González-Rossetti 2000).

Technocrats alone may lack the political skills needed to get their proposals accepted. The challenge is to make the policy design both palatable to politicians so that the legislation will pass and digestible to bureaucrats so that the policy can be implemented. Successful change teams often include both technocrats, concerned mainly with the technical design of policy, and “technopols,” who combine a technocrat’s technical expertise and training with a politician’s pragmatic expertise on how to produce change (Dominguez 1998).

Chile’s health sector reform under President Ricardo Lagos (2000–2006), for example, involved two change teams. The first included technical experts in public health, costing, law, and economics from the Ministries of Health and Finance, responsible for developing the details underlying health sector reform, which enabled the Lagos administration to generate internal support from the Ministry of Finance (MOF). The second change team was more political, with membership from think tanks associated with political parties like the Christian Democrats and right-wing interests. This team’s political affiliations enabled it to secure support from the far right in the legislative process (Bossert and Amrock n.d.). In Mexico, a politically astute change team in the Ministry of Health eventually abandoned the strategy of trying to convince the Ministry of Finance to

come on board through evidence of cost savings. Instead, in order to pass legislation for national health insurance, the change team sidelined the MOF, misrepresenting the MOF position to other government ministries so that the MOF could not effectively oppose the reform (Lakin 2010).

Good politicians possess practical political knowledge of how the policy process works. Politicians know which interest groups will oppose a particular design and the bargaining chips that may persuade fellow legislators to support an idea. The content of reform is often deliberately shaped to appeal to a particular coalition of actors. A failure to consult with relevant interest groups can lead to a policy design's being dead on arrival. For instance, President Bill Clinton's strategy of extensive consulting with technical experts while excluding groups seen as obstacles later led to legislative gridlock with politicians and resistance from groups he did not include. By contrast, Obama's willingness to negotiate with key interest groups up front helped reduce political obstacles in the legislative process even though it later raised some public concerns.²

While technocrats often present an air of value neutrality and objectivity, their ideological orientation is rarely far from the surface. In Chile and Colombia, technocrats pushing managed competition viewed themselves as apolitical, although they were ideologically in favor of changing the role of the state in the social sector through a greater reliance on the private sector by adopting targeting and demand subsidies over more comprehensive social risk protection (Bossert and González-Rossetti 2000). Likewise, Clinton's strategy of linking his reform to managed competition was not driven primarily by his belief in the soundness of Enthoven's theory, but rather by the political calculus that market delivery would synthesize the "liberal ends" of universal coverage with the "conservative means" of provision by private insurers (Oberlander 2007). This compromise, though ultimately unsuccessful, allowed Clinton to reach across the aisle to attract majority support in Congress and avoid antagonizing organized interests (Oberlander 2007). Obama eventually dropped his "public option" as this policy drew opposition from both moderate Democrats and Republicans. In Taiwan, China, the president ultimately decided not to accept the advice of technocrats to replace fee-for-service payment with capitation to control costs, because of anticipated political resistance to the change (Yeh, Yuang, and Hsiao forthcoming). Although some policies may diffuse globally, how the ideas are integrated into national policies is mediated by partisan political competition and domestic political calculations.

Technocrats shape reform, but their ideas still must go into the policy process. Designs are subject to institutional and partisan constraints and what is politically feasible in a given system. The assessment of what is politically feasible requires strategizing between technocrats and technopols who know the political context. Policy makers need to take into account the institutional and partisan landscape in designing reforms—if they wish to make policy.

Distributive Politics: Hard and Soft Budget Constraints and the Role of Finance Ministries

Financing represents one of the most contentious elements of policy design. Ministers of finance typically oppose the expansion of large social programs like national health insurance for fear of breaking the bank. In South Africa, expanding health insurance coverage was stymied by the MOF (McIntyre and van den Heever 2007; McIntyre, Doherty, and Gilson 2003). In many countries, the MOF acts as the gatekeeper of reform. As noted earlier, Mexico's technocratic supporters of health reform (Lakin 2008) purposefully built alliances within the government to work around opposition from the MOF. Similar opposition by the MOF to the expansion of social health insurance has been observed in Israel (Gross, Rosen, and Shiron 2001) and the Arab Republic of Egypt (Nandakumar et al. 2000).

Both Chile and Colombia managed significant budgetary increases for reform initiatives despite resistance from their respective Ministries of Finance. In Chile, the president succeeded in introducing a significant increase in the social security tax on the formal sector, and Colombia imposed a value added tax (VAT) to cover the transitional costs of reform. Sustained presidential commitment to reform and concerted efforts by the change team were necessary to overcome the resistance from the MOF. In Chile, a compromise with the MOF that the increases in the social security tax be accompanied by a ceiling on total government expenses in health ultimately contributed to the fiscal soundness of Chile's reform. In Colombia, however, the transitional costs became permanent, thereby contributing to subsequent fiscal crisis. As Glied and Stabile note (chapter 4, this volume), while MOFs generally oppose expansion of the public budget, politicians face soft budget constraints and incentives to run deficits. In the long term, those deficits can threaten the financial sustainability of a system or necessitate new funding streams, especially for a cost-inflationary good like health care.

Political Battles over Financing: Interests and Ideology

Financing is also contentious because it usually involves compelling the wealthy (who can afford to pay for their own insurance) to contribute resources to subsidize the poor and others who cannot pay for health insurance and compelling the healthy to subsidize the sick. This improves the welfare of the poorest and most vulnerable, while making society as a whole better off. However, as a risk-pooling mechanism, health insurance schemes generate collective action dilemmas—how to compel individuals (especially in high-income groups) to contribute to the pool when it is against their individual interests to do so. While it is often assumed that health insurance is redistributive, the actual design of a financing reform affects the degree of redistribution and the extent to which insurance is regressively or progressively financed (Glied and Stabile, chapter 4, this volume). Certain financing streams are politically more difficult than others, and the politically feasible financing streams may also be more regressive. For example, sales

taxes and sin taxes (such as taxes on alcohol and cigarettes) are politically less contentious but are also more regressive. Payroll taxes are easier to implement than income or corporate taxes, since the latter tend to be strongly opposed by business and the wealthy, but payroll taxes can also be more regressive.

If health reform is redistributive, the relevant political question is who benefits and who pays? Even where there is consensus that reform is necessary, political factions may disagree about the specific financing mechanism and its political implications. This disagreement shapes the type of system that is politically feasible to get through the legislature and the degree of redistribution. In short, the design of financing has a profound effect on political support for reform, and the political actors behind reform have a profound impact on the design of financing.

In Taiwan, China, the initial design of social health insurance called for 60 percent of the premium to be covered by the employer and 40 percent by the employee. But after deliberation within the planning commission, the government agreed to pay 10 percent of the premium for public and private sector workers to reduce the burden on workers without increasing costs for industry, and to lower the contribution of workers to 30 percent (Lin 2002; Yeh, Yuang, and Hsiao forthcoming). In addition, the initial plan proposed that family dependents should also have to make contributions to the premium to ensure fiscal soundness. The Council of Labor Affairs objected, arguing that, in the spirit of mutual assistance, dependents should be exempt since employers, who also are required to pay a portion of the premium, would discriminate against workers with many dependents (Lin 2002). A compromise was reached whereby the employer would pay for the average number of dependents and the insured would pay for the actual number of dependents. All of this deliberation took place between the ministries and the Executive Yuan before the bill was sent to the Legislative Yuan for a vote (Lin 2002).

Judging the equity in financing from different financing mechanisms is a complicated question. But taking into account equity in the design of financing is politically important because it affects which factions will support or oppose reform in the legislative phase. Whether the financing of national health insurance in developing countries is regressive or progressive depends in part on the capacity of the state to collect taxes and the size of the informal sector. Financing through general tax revenue, especially income taxes, is thought to be the most progressively redistributive in developed countries (Glied and Stabile, chapter 4, this volume). But due to low government revenues from general taxation in developing countries (and the difficulties of collecting income taxes in these countries), public health services in poor countries tend to be severely underfunded and consequently often low quality. As a result the wealthy may prefer to buy private health insurance (or pay out of pocket) rather than pay more to subsidize a weak system, which can generate separate tiers of care and undermine social risk pooling.

Health insurance financed through payroll taxes depends on an even narrower resource base—those employed in the formal sector—and therefore

may still require a large infusion of general tax revenue in poor countries. For premium-based systems, the degree of regressiveness in financing depends largely on the graduated cost of premiums and decisions on who qualifies as exempt. Cost-sharing and coinsurance spread the cost burden and generate a solidaristic notion that “everyone is paying something,” creating a “culture of prepayment” (Lakin 2010) that may offset some resistance to other financing mechanisms. However, like sales taxes, cost-sharing is regressive, and even small fees in developing countries can create large barriers to care for the poor.

Financing schemes in developing countries must struggle with how to raise money from a limited tax base while mediating conflict between the small but powerful group of urban elites that work in the formal sector and the large populace in the informal sector with limited ability to pay. In Ghana, the government’s attempt to deduct a 2.5 percent contribution from the formal sector pension funds to finance the health insurance scheme was met with sharp resistance by public sector workers during the design phase (Coleman 2010). Ultimately, the largest share of health insurance financing was designed to come from a VAT and the second largest from payroll taxes on formal sector workers and premium contributions from informal sector workers who are not otherwise exempt (Agyepong and Adjei 2008; Witter and Garshong 2009). How and why the New Patriotic Party (NPP) developed its financing scheme remain obscure. However, increasingly exemptions are being extended to additional populations not previously entitled to free care, such as pregnant women (Witter and Garshong 2009). In Mexico, the major opposition to national health insurance came from the left (the opposition Partido de la Revolución Democrática, PRD). The left objected to premium payments, which they saw as regressive, preferring “free” services financed through general tax revenues (Lakin 2010). In Mexico, as in Ghana, with few effective sticks to enforce means testing, the scope of who is considered exempt from premium payment has been widening.

In sum, multiple factors drive the recent popularity of the national health insurance model in the design of health reform. Those factors include the spread of ideas through increasingly global policy networks, change teams of technocrats, and the advice of aid agencies that seek to promote certain policy ideas, including social health insurance. Political institutions constrain the set of potential design options that are politically viable, as politicians anticipate what is possible to get passed, given the institutional and partisan circumstances at a particular political moment. Existing institutions further bind politicians in what is possible, since policy makers have to construct reform on existing institutions. Interest groups also influence the direction of reform to make sure their positions are protected. Policy makers often must act under uncertainty about what the actual impacts of the policy will be. Distributive politics is perhaps the most contentious element of design as the ideological orientations of the left and the right clash over preferences for redistribution, and groups with the most power often have the least interest in contributing.

ADOPTION: POLITICAL BARGAINING AND THE LEGISLATIVE PROCESS

Once on the agenda, there is no guarantee that the reform as designed will be adopted. In general, policy stability is thought to be the norm rather than the exception (Pierson 2004; Tsebelis 2002; Baumgartner and Jones 1993). Radical policy change, such as a large scale-up of a national health insurance program, is rare and difficult to achieve. Health reform is hard because new policy meets resistance from groups that stand to lose from a change in the status quo, and the future potential beneficiaries may not be mobilized or even organized. Policy change in the real world never achieves Pareto efficiency, where everyone is made better off without anyone's being made worse off. Health reform typically involves a complex redistribution of costs and benefits across society, and people who will be made worse off resist change. Inherently, reforms are conditioned by historical influences, and change is subject to increasing returns as interest groups become entrenched, and the relative costs of switching the current activity become higher when compared with once-possible options (Pierson 2004). Further, public policy constitutes an inherent collective action problem—coordination is essential, but the effectiveness of an individual's actions depends heavily on the actions of others. According to some observers, the creation of conditions for collective action is the principal object of political life (Pierson 2004; Stiglitz 1995). For this reason, the policy-making process has been described as unfolding in a "punctuated equilibrium": long periods of stability interrupted by infrequent and sudden upheaval, followed by a return to stasis (Baumgartner and Jones 1993).

Interest Group Influences and Policy Feedback

As recognized in many chapters in this book, interest groups often influence health financing reform via their influence on politicians (Marmor 2000). For national health insurance, these groups include private insurance companies, medical associations, and trade unions, among others. However, to understand the relative impact of different groups on health reform, one must look at how a group's power becomes institutionalized over time and how this power varies across countries. In the United States, the failure of the state to take a leading role at particular critical junctures allowed the insurance industry to assume a dominant position (Steinmo and Watts 1995). Once private insurance companies are established, it becomes increasingly difficult to constrain their power or reform them away. Colombia's health insurance reform institutionalized the power of private insurance companies inspired by Enthoven's "managed competition" model, and expanded a small prepaid private insurance industry into a formidable power that now covers nearly 70 percent of the population. The government's efforts to regulate private insurers, control spiraling health care costs, and equalize benefits packages have been unsuccessful at reducing

the influence of private insurance companies (Bossert 2010). Similarly, Chile has not been able to remove private health insurance entities (called ISAPRES), but it has incrementally strengthened the public sector without directly confronting the political and economic interests of the private insurance entities (Bossert 2010).

The legacy of union-based benefits packages can also make reform more difficult to achieve, especially if the goal is to pool previously separate benefit plans. In countries that have established benefits packages for public and private sector unions, introducing a uniform benefits package for all citizens, including the informal sector, can be difficult. Typically, unions have fought hard to win their benefits and legitimately fear losing their gains if public benefits are extended to previously excluded groups. In addition, a uniform benefits package that covers the poor, who may not contribute to the pool, implies higher taxes on the rich, which could place an additional burden on relatively well-off union members. In Mexico, the power of one of Mexico's largest unions, the union of the Instituto Mexicana del Seguro Social (IMSS), and its opposition to being pooled with the previously uninsured, resulted in the establishment of a separate national health insurance system for the uninsured (the Seguro Popular) administered through the Ministry of Health, rather than an integrated system, and has arguably reinforced a two-tiered benefits package (Lakin 2008). Countries with existing private insurers and multitiered health plans face more hurdles in generating a single-payer, uniform benefits plan than do countries without these existing institutions. The result can be the continuation of two-tiered systems, as has occurred in Colombia and Chile (Bossert 2010). One counter example is Japan, which has reduced differences in benefits and copayments among plans over time through incremental changes (Ikegami and Campbell 1999), but still confronts nearly 3,500 social insurance plans with varying premium rates.

Although national health insurance may be hard to introduce, once adopted and institutionalized, it can be even harder to remove or change. Even in a context of general retrenchment of the welfare state, health has been one area that the public has been reluctant to see cut (Kitschelt 2001). The bad news is that certain less desirable health system designs (such as cost-increasing fee-for-service and private, for-profit health insurance) can also become increasingly difficult to regulate or reform because interests become entrenched over time.

Political Institutions and Veto Players

Despite the critical power frequently assigned to interest groups in explaining health reform, health policy analysts have increasingly argued that "we have veto points within political systems and not veto groups within societies" (Immergut 1992: 391; also: Steinmo and Watts 1995; Hacker 1998). In other words, the demands of interest groups are mediated through political institutions that structure the kind of legislative change possible in a given system.

A critical determinant of whether a policy gets adopted is the number of veto players and veto points in the legislative process (Immergut 1992; Tsebelis 1995; Hacker 1998). Veto players are the individuals or collective actors whose agreement is required to make a policy decision (Tsebelis 1995). These include *institutional veto players* such as the president and legislative chambers in a federal system, which have formal veto power, and *partisan veto players* or parties in parliamentary systems, whose veto power can vary depending on electoral outcomes. A greater number of veto players increases the likelihood that policy stability (the status quo) will prevail and militates against radical, big-bang policy changes such as adopting national health insurance. Veto points refer to junctures in the legislative and policy design process where reform can be blocked. For countries with multiple veto points, big-bang reform is difficult, and incremental reform is more likely. Furthermore, as the number of veto points increases, lobbyists and interest groups have more access and control over the policy process (Immergut 1992).

The number of veto points may surpass the influence of interest groups in influencing health reform, and different reform strategies may be necessary in countries with a greater number of veto points. For instance, Immergut (1992) notes that differences in the development of national health systems in Sweden, France, and Switzerland cannot be explained by reference to the mobilization of medical associations, since each country had influential medical professions that had achieved a legal monopoly of medical practice by the outset of the 20th century. Rather, the influence of these political pressure groups operated through their institutionalized access to policy makers. In Switzerland, the political institution of the popular referendum provided a critical access point for the medical association to block reform efforts. At several points in Switzerland's history, health reform legislation was enacted into law by both chambers of parliament but subsequently vetoed through referendum challenges because higher income voters, who stood to lose from national health insurance or other forms of social protection, were far more likely to vote. As a result, even the threat of calling a referendum was enough to make legislators shy away from enacting large-scale reform (Immergut 2002). By contrast, in Sweden, with no institutional veto points and a majority support in parliament, comprehensive health reforms passed without substantial challenge in spite of lobbying by the powerful medical association (Immergut 1992). This example illustrates that the mobilization of interest groups is not sufficient to explain the reform process. In this comparative analysis, institutional differences in veto points better explain why a minority (the medical association) in one case had a more profound influence on policy proposals.

Certain political institutions further militate against large, redistributive social programs where the benefits are diffuse. Representatives elected in single-member majoritarian voting systems that represent small geographic constituencies (as in the United States) have a greater incentive to pass policies that benefit their particular constituent base (pork-barrel politics) rather than

support broadly redistributive social policy. The result is a welfare state based on local rather than national public goods provision (Cox and McCubbins 2001; Persson and Tabellini 2003). Majoritarian voting systems, as in the United States, are therefore likely to face more obstacles in adopting national health insurance coverage. The “veto-ridden” political institutions of the United States have been cited as a primary barrier to the adoption of national health insurance and for the country’s tendency to spend more on pork-barrel projects that are easily geographically targeted (e.g., schools, roads) than on transfer spending (e.g., unemployment benefits and old-age pensions) (Hacker 1998; Steinmo and Watts 1995; Milesi-Ferretti, Perotti, and Rostagno 2002). As highlighted in this book’s chapter on Europe (Maarse and others, chapter 12), in European countries with complex multiparty consensual political systems, such as Germany, social health insurance evolved through prolonged and fierce political battles over health reform. The resulting layered and fractured health system reflects the compromise and appeasement of diverse views and the battle wounds from a greater number of veto points. In addition, the countries that followed this Bismarckian path tend to view social insurance as an entitlement that is paid for rather than a universal right that is guaranteed to all, and free-riding is strictly monitored (Maarse and others, chapter 12, this volume).

Viewed from this perspective, incrementalism is less an approach to reform than a result of institutional design (multiple veto players). Federal states, for instance, with a greater separation of powers and devolution of authority, are more likely to engage in incrementalism. But when health reform in federal states is impossible at the national level, policy experimentation can be lively within subnational units (states or provinces or regions). This decentralized policy experimentation increases the likelihood of health insurance at the subnational level, since it can be achieved without a great deal of additional federal funds or cooperation but may create greater inequality as richer jurisdictions are better placed to experiment with reform without federal support. Decentralized policy success can then create incentives for others to follow, both at the subnational and national levels (Bossert 1998). For instance, in Canada, a federal state, political movements supportive of single-payer health reform first gained a political foothold in western provinces and enacted programs that served as an example, which subsequently spurred other provinces and the federal government to respond (Hacker 1998).

In veto-ridden states, incremental scale-up may at times be more effective than top-down big-bang approaches to reform. But incremental reforms can also create new interest groups that block more fundamental reforms (since those changes would make the groups’ services redundant). In the United States, there have been a number of policy innovations to create universal health coverage at the state level, some more successful than others. State-based policy innovation in the United States played an important political role in the debate over reform legislation in 2009–10. However, because the same veto-ridden political institutions are mirrored at the state level as at the national

level, incremental state-based reform has so far met with limited success at building universal coverage within states or in furthering universal coverage at the national level (Gray et al. 2005). Further, a number of federal constraints and reliance on federal funding impede experimentation within states, making incremental, bottom-up reform more challenging, even for more politically liberal states (Carter and LaPlant 1997). In recent battles over health reform in the United States, the small left-leaning contingent, after abandoning its hopes for more substantial single-payer reform, turned its energy toward protecting the right of states to experiment with more far-reaching reform options; this, too, however, was ultimately unsuccessful.³

Partisan Political Competition and Legislative Bargaining

The adoption of national health insurance is also influenced by the partisan policy preferences of vote-seeking political representatives. Although institutional structures incentivize and constrain politicians in different ways, politicians generally seek to maximize both their chances of reelection and their influence on public policy (Strøm 1990).

Politicians are considered responsive when they “adopt policies that are signaled as preferred by citizens” through “public opinion polls; various forms of direct political action [...] and, during elections, votes for particular platforms” (Przeworski, Stokes, and Manin 1999: 9). In terms of consulting the public at large, evidence suggests that politicians do not directly respond to current public opinion in formulating their preferred policy option or stance. Instead, politicians use informational shortcuts and make prospective judgments. They speculate about what the media will focus on at reelection and the likely positions of their constituents. For instance, in the case of the United States, Gelman, Lee, and Yair (2010) note the surprising disconnect between what politicians’ constituents have signaled as their preferences on health reform through polls and politicians’ actual voting records on the Obama health reform. Likewise, Shapiro and Jacobs (2010) note a form of “post-hoc representation” in the relationship between public opinion and the policy choices of U.S. representatives for health reform, whereby individual components of the reform are selectively spotlighted, which suggests that public opinion is a two-way street. Citizens do not simply communicate preferences and politicians respond; instead, politicians actively construct the preferences of their constituents through targeted messaging.

Party loyalty and discipline can sometimes determine how politicians vote on health reform proposals, depending on the institutional context. In Mexico, partisan political competition and ideology came into play during the negotiation of the health reform bill in the legislature. As the fate of the bill came down to the number of votes in the Mexican Congress, party discipline became a critical deciding factor in the passage of health reform (Lakin 2008). In 2003, in the absence of a majority for the governing Partido Acción Nacional (PAN),

a lack of party discipline among the PRI allowed passage of health reform. The PRI split between legislators associated with the IMSS union who opposed the reform and legislators who backed the reform even though it was spearheaded by the PAN. The left party (PRD), conversely, was fairly united in its opposition to the reform in the Mexican Congress, based on the party's view of the financing mechanism as not progressive enough (Lakin 2008).

During legislative bargaining, politicians may also seek to add personal legislative provisions or riders for their favored policy in exchange for a vote for a bill. This can result in the bill's substance being compromised and criticism if the rider is unpopular. For instance, during the 2010 health reform debate in the United States, pro-life Democrats added an executive order to the bill clarifying the existing law that federal funding would not be used to pay for abortion services. This angered pro-choice legislators and advocates.⁴ Further, once the "public option" and amendments for states wishing to adopt single-payer systems were dropped from the legislation, support among left-of-center Democrats waned. In the final vote, however, these Democrats felt pressured to vote in favor of the bill on the argument that some reform was better than no reform.⁵ In Mexico, as a deliberate strategy to prevent the passage of Seguro Popular, the MOF (unsuccessfully) attempted to add a fiscal reform rider to the health insurance bill that would have resulted in unpopular tax increases (Lakin 2010).

While parties on the left may seem more likely to propose and support national health insurance, reform does not always come from the usual suspects. When reform is proposed by a party that would not traditionally support a large state-driven fiscal expansion, the public may be more inclined to accept that there is a dire problem, and partisan wrangling may be reduced. This "Nixon-in-China effect" is partly what can account for the success of reform in Mexico where the PAN, a center-right party, put health insurance reform on the agenda and ultimately passed it with support from the traditionally centrist party, the PRI (Lakin 2008). In the United States, while health reform has typically been promoted by Democrats, in the 1970s Nixon put health reform on the agenda, even though it was ultimately defeated in Congress.⁶

This review of the political economy of adoption leads to a number of conclusions. First, a greater number of veto players and veto points makes it increasingly difficult to adopt a major reform. Incrementalism is often a by-product of veto-ridden systems. Reformers either propose an incremental reform, knowing that more thoroughgoing reform will be opposed from the start, or comprehensive reform slowly gets whittled down as it moves through legislative bargaining. In veto-ridden systems, reformers seeking to produce big-bang changes either need to wait for a major upset to the status quo (a critical juncture) or try to scale up reform gradually from more local experimentation. Second, political institutions such as federalism and majoritarianism incentivize politicians against broadly redistributive programs. Third, large-scale policy change is relatively rare because entrenched interests become increasingly "locked in" over time and the costs of

policy switching become steeper relative to the political gains from the status quo. Finally, ideology affects partisan competition and political bargaining strategies.

IMPLEMENTATION: OPERATIONALIZING THE REFORM

Implementation is the complex process of putting a policy into practice. In their classic book, Pressman and Wildavsky (1975: xv) define implementation as “the ability to forge subsequent links in the causal chain so as to obtain the desired results.” All implementation is hard. The politically attractive parts of the policy cycle are agenda setting, policy design, and adoption. The hard work occurs in implementation and producing tangible results. This is partly due to the large number of “decision points” that implementation has to go through and the “clearances” necessary for its success. A decision point is reached when “an act of agreement has to be registered for the program to continue,” and “each instance in which a separate participant is required to give his consent is called a clearance” (Pressman and Wildavsky 1975: xvi). Like veto points, more clearances in a system can generate additional obstacles to implementation.

In this section three dimensions of political economy that affect reform implementation are considered. First, how the structure of political institutions, especially federalism and majoritarianism, and political time horizons affect processes of implementation are examined. Next, the political economy of evaluation and targeting during implementation is explored. Third, how policy choices made in the design and adoption phases can produce unintended consequences in implementation is examined. These factors can shape implementation in ways that affect the ultimate functioning of the health insurance program.

Political Institutions, Delegation, and Executive Time Horizons

Whereas the political battle over adoption and design of reform normally occurs on the national stage, the battle over implementation plays out at the local level (Grindle 1980). The political institutions of federalism and majoritarianism play a key role in affecting implementation by generating a division of power between the central and local governments and by creating incentives for pork-barrel spending. One of the core questions facing the drafters of legislation concerns the degree of detail to include in legislation versus the amount of discretion to grant to implementers (Yeh, Yuang, and Hsiao forthcoming; Huber and Shipan 2002). As Grindle (1980) outlines, the central problem in implementation is that government officials at the top level seek to avoid conflict by trying to appease local elites and politicians responsible for implementation, who often have the most to lose from redistributive programs. This presents a common pool problem (Persson and Tabellini 2003): the beneficiaries who have the most to gain have limited power over implementation, whereas the opponents who have the most to lose have a great deal of power. Whereas corruption is often blamed for

implementation challenges, Grindle (1980) stresses that, contrary to the common view, bureaucrats are not inherently corrupt; rather, they face pressures on a number of fronts to avoid conflict.

One way to circumvent problems with government officials at the central level is through delegation, which has both advantages and disadvantages. Delegation can reduce resistance since it can encourage experimentation and innovation, tailoring programs to the diversity of local situations, but it can also increase opportunities for resistance to implementation and patronage (Bossert 1998; Faguet 2001). Delegation can also serve as a means of blame shifting and plausible deniability for implementation failures. In economically or ethnically diverse countries, however, the ability to experiment and adapt national legislation to the local context can also help reduce or avoid conflict (Miguel 2004).

Political systems where a higher degree of discretion is granted to regional and local political actors, such as in federal systems, have the potential to generate greater pressures for patronage through the targeting of public services for political gain. Where public goods can be targeted (as with local public goods), rational reelection-seeking politicians will in theory reward regions or groups of voters that have provided support in the past (Cox and McCubbins 1986), or target concentrations of swing voters that could go either way to maximize future votes (Armesto 2009; Dixit and Londregan 1996). But a problem arises with this kind of targeting if it is connected with the power of the local representative, to the detriment of the poorest regions or individuals within regions. Patronage can highlight the political forces behind unequal patterns of development and distribution that operate through machine politics. Through patronage, supporters of opposition groups may be systematically disadvantaged and punished for their views. But machine politics can also sometimes reward otherwise disadvantaged groups, under certain circumstances.

In Mexico, studies have shown that, in order to win back votes, local spending on the antipoverty program PRONASOL, a precursor to Seguro Popular, was targeted to districts that had defected to the opposition PRD as a reward (Molinar and Weldon 1994). Other studies have shown that spending on PRONASOL was targeted by the incumbent party, the PRI, to punish opposition municipalities by withdrawing resources, diverting resources to reward supporters, and targeting resources to swing municipalities that could vote either way (Magaloni 2006). Analysis of targeting of Seguro Popular benefits has similarly found evidence that its implementation occurred in ways that targeted swing voters in order to shore up support for the incumbent party, the PAN (Lakin 2008).

The effects of scaling up health insurance take a long time to unfold, like many other interventions. Politicians' time horizons, conversely, are short and regulated by election cycles (Pierson 2004). Parties that pass substantial social entitlement legislation often want to create a relatively permanent policy that will endure past the current government—in essence to “tie the hands” of their successors so that reform is not easily undone (King et al. 2007). Furthermore, politicians that oppose reform may nonetheless allow it to pass, banking on the

reform's not actually being implemented. This allows them to take credit for its passage, while avoiding the blame if implementation falters.

Electoral timing also affected implementation in Mexico. There, the president and other politicians who backed national health insurance faced a dilemma. They needed to affiliate as many citizens as legally possible to Seguro Popular in a short period to demonstrate the program's political appeal before the next election in 2006 (and build up political support for the program in case of a party change in government), but "opposition from providers and states was incompatible with speedy affiliation" (Lakin 2010). Although the evaluation found in the short term that the reform had increased access and reduced catastrophic expenditures for some people (King et al. 2009), over time questions have been raised about whether Mexico's reform can be considered health insurance and not simply a large infusion of funding into its existing public health service, since only around 5 percent of affiliates pay a premium (Lakin 2010). Thus, Mexico's bold experiment with health insurance has been portrayed as an extension of its previous system during implementation. In addition, the big-bang approach of the change team became increasingly threatened during implementation, as the problems with this tactic became apparent. Lacking the support of the MOH provider union (which saw the reform as producing more work with no pay increase) and with state governors opposing the requirement of state contributions, the central government found itself with limited leverage to enforce the implementation of a top-down reform in a decentralized system (Lakin 2010).

Similarly, within five years of implementation, Ghana faced increasing pressure to overhaul its health insurance system as the program was bordering on insolvency (Siadat 2010). This party, which preferred an incremental approach to national health insurance, lacked enough votes in parliament to oppose the reform at adoption but subsequently forged "horizontal" alliances during implementation, aligning itself with government agencies and organized labor, community-based health insurance schemes, donors, and other opponents of the big-bang reform strategy (Agyepong and Adjei 2008).

Political considerations also affected the timing of the implementation of National Health Insurance (NHI) in Taiwan, China. With legislative elections looming at the end of 1995, the same year that the NHI was adopted, the president ordered the implementation of the NHI within three months of adoption. Within only three months, the newly constituted Bureau of National Health Insurance would have to "enroll nine million people, clarify the insurance benefits, set standards and payment rates, contract providers, and prepare to pay more than twenty million claims per month" (Yeh, Yuang, and Hsiao forthcoming). This hurried roll-out resulted in suboptimal implementation.

Policy implementation thus creates new opportunities for opposition and criticism, even after a bill has been approved and signed into law. Pushing reforms through the legislature may be politically expedient and necessary to meet the short time horizons of election cycles before the political window of opportunity closes. But the compromises made to meet election deadlines can create serious

problems in implementation, which can sometimes undermine the objectives of the reform or raise the possibility of reversal.

In both Mexico and Ghana, parties and politicians have been punished at the voting booth in the election following the major reform efforts. Conflicts that existed at the beginning of the reform did not cease after reform. In Mexico, the left opposition (the PRD), which had opposed the introduction of Seguro Popular, continued to attack the program during implementation and substantially increased its number of seats in the 2006 election, nearly winning the presidential contest. In the United States, immediately after the adoption of the Obama reform, calls arose to reverse the new law and challenge its constitutionality.⁷ Political competition and deep societal divisions over expanded access do not cease after reform is passed into law and continue to influence the implementation of policy in ways that designers may not anticipate.

The Political Economy of Evaluation and Targeting

Technocrats may wish to evaluate health reforms to assess their impact. Politicians, however, may have mixed feelings about evaluation. Politicians who backed reform have an incentive to claim success even when a program is in serious trouble, and politicians who opposed reform have an incentive to paint the program in a negative light and assign blame. As a result, the truth of success or failure can be difficult (if not impossible) to discern. These processes of credit claiming and problem blaming make evaluation all the more challenging. “Politically robust” evaluations are difficult to achieve since politicians have an incentive to roll out reforms in a politically instrumental rather than scientifically sound manner (King et al. 2007). Furthermore, most politicians are reluctant to allow an arm’s-length evaluation, since the political risks are steep and personal. If the evaluation goes well, the payoffs are high, but if it goes badly, the risks are potentially disastrous, at least to one’s reputation and legacy and potentially to one’s political future as well.

Mexico is one of the few countries where evaluation was designed and conducted to protect randomization from political influence (King et al. 2007). Like many other policy evaluations, Mexico’s faced pressure from state-level leaders seeking to more rapidly extend program coverage to their areas. In an attempt to overcome this natural democratic incentive, the evaluation matched areas in pairs on background characteristics so that if one area was contaminated, the other area in the pair could be dropped, rather than contaminate the entire sample (King et al. 2007).

This strategy allowed for a scientifically strong evaluation of impacts. It also reflects the tensions between the evaluation of technical elements of design and an evaluation of the political economy of implementation. Political parties have a political incentive to target social spending to their constituents at the expense of providing broad public goods that benefit a wider set of beneficiaries (Persson and Tabellini 2003). Where this targeted spending harms or distorts the

effective roll-out of a program, such as when program benefits are captured by elites, preferred ethnic groups, or political partisans, this democratic incentive may negatively shape the implementation of health programs. In short, competitive politics produces incentives to implement policy in a nonrandom manner, which complicates the design of evaluation.

Although proponents of randomization try to control the roll-out of programs to protect against selection bias (Deaton 2009), it is precisely the non-randomness or purposive selection in take-up that political economists are interested in understanding. An evaluation of reform that includes political factors would assess why implementation unfolded in the manner it did. Who were the winners and losers from reform? Why were benefits targeted toward certain groups or areas at particular times? In the real world, take-up does not occur in a random manner. For instance, researchers of the welfare state have identified political “business cycles” in the tendency of government expenditure to increase according to the electoral calendar (Nordhaus 1975; Alesina, Roubini, and Cohen 1997). As a result, fiscal policies in electoral democracies are to a significant extent determined by electoral politics.

Governments also may have incentives to target national subsidies to “swing” provinces, in which electoral contests are competitive, to reward supporters or punish opponents. Targeting takes on a different significance from a political economy perspective than its technical meaning. Whether public programs should attempt to target the poor through means testing, or if this effort is more costly and less effective than simply making services available to all households, has been debated in the public policy literature (Besley and Kanbur 1993). In the political economy meaning of targeting, however, the important question is not how to better target the poor, but rather who gets targeted and why. Evidence of political business cycles and the targeting of swing districts and loyal supporters in the allocation of public goods is a pervasive issue considered by students of political economy (Diaz-Cayeros et al. 2002; Armesto 2009; Bardhan and Mookerjee 2006).

The capacity of the state can also affect the processes of implementation and evaluation of reform. The debate over means testing is pertinent to the scale-up of health insurance in developing countries where the state may lack the capacity to successfully implement means-tested targeting. As Hsiao and others (chapter 11, this volume) point out, the greatest difficulty in scaling up social health insurance in weak states (such as Cambodia, the Lao People’s Democratic Republic, and Pakistan) is the lack of adequate administrative and regulatory capacity to set up and oversee the organization of such a system. Successful implementation requires a competent administration to define the scope of the benefits package and to enforce a means-testing system. Where capacity is lacking, a larger number of implementation challenges arise.

In Ghana, while health insurance is mandatory *de jure*, there is no enforcement *de facto* and nonenrolment is not penalized (Blanchet 2010). Similarly, a graduated, means-tested premium has been abandoned in favor of a low, fixed

annual premium for all (the equivalent of about US\$7) (Blanchet 2010). While affiliation in Ghana has been growing rapidly, only an estimated 59 percent of the population has registered with the national health insurance service, and there is evidence that enrolment unequally favors the relatively wealthy (Asante and Aikins 2008; Mensah 2009; Sarpong et al. 2010). Yet, in contrast to the typical urban bias in the provision of public goods and services, higher enrolment rates in Ghana occur in poorer, rural regions that are the vote banks of the party that introduced health insurance (Witter and Garshong 2009). With a lack of means testing, however, few members contribute financially through premiums, a trend that may threaten the program's economic sustainability (Blanchet 2010).

Although state capacity is arguably stronger in Mexico, it too has faced challenges to enforcing means testing. One concession won by the MOF was that the program be rolled out gradually (affiliating only 14 percent of the eligible population per year) to make sure the program's budget did not exceed government revenues (Lakin 2010). While this gradual roll-out created an effective laboratory for program evaluation, the voluntary nature of affiliation reduced the social risk-pooling element of insurance and undermined the ability to do means testing. Even though states are required in Mexico's federal structure to subsidize the premiums of the informal sector workers, states have had a difficult time persuading residents to pay their premiums and have not used means testing in deciding on the income level of new members (Lakin 2010). With federal incentives to show progress in affiliation, the states turned a blind eye to residents who declared their incomes in the lower two deciles in the sign-up process so that they would not be required to pay a premium. Consequently, Mexico has a voluntary health insurance program that is in practice free for nearly all members, which has raised questions about the financial sustainability of the program without additional infusions of general tax revenue (Lakin 2010).

The terms "targeting" and "selection" have political connotations that differ from their common technical designations. In keeping with the classic definition of politics as "the social processes that determine who gets what, when, and how" (Lasswell 1936), a political economic analysis of implementation is fundamentally interested in the nonrandomness of public goods distribution and service provision.

Unintended Consequences of Policy Design Choices

Choices made for political reasons at the design and adoption phases can affect the implementation and future sustainability of national health insurance programs. The example of Colombia highlights the unintended consequences of policy reform that can appear in implementation. In adopting a new constitution in 1991 that guarantees Colombians a universal right to health care, Colombia sowed the seeds of a financial crisis for its health insurance system. The *tutela* (protection writ) system was originally designed to allow citizens to seek redress when they believe a denial of medical services violates their right to health.

However, this appeals process to protect a citizen's right to health has created a substantial burden on the country's health system. Tutela claims allow citizens to demand goods and services that fall outside their limited benefits packages. Much as abuse of the emergency room has become an option of last resort for people without insurance coverage in the United States, the tutela system in Colombia has provided individual patients with a reimbursement strategy for expensive health services, which over time has created financial problems and fairness questions for the health system (Yamin and Parra-Vera 2009).

In Ghana, political incentives to please a broad constituency during the design phase led to the bypassing of cost-control measures in favor of policies that appealed to the incumbent party's political base. As Witter and Garshong (2009) summarize, efforts to appeal to the party's rural base of voters resulted in: (1) NHIA revenues primarily growing with GDP rather than with membership; (2) an overly generous benefits package; (3) exemption schemes covering large population groups, but without a sufficient subsidy to cover exempt members; (4) little oversight of the diagnosis-related group (DRG) tariff or of overprescribing by providers; and (5) no cost-sharing for patients. The economic costs of these design features have become increasingly apparent with expanded implementation.

Implementation generally involves setting up a new institution or agency to administer the program, which can cause problems as each stakeholder jockey to capture the agency (Yeh, Yuang, and Hsiao forthcoming). There can also be pressure on governments to appoint representatives from a broad group of interests, and institutional appointments may involve patronage rather than a merit-based choice of leader.

In Taiwan, China, heated debates occurred among business leaders and labor and social welfare advocates over whether the agency to administer national health insurance should be a government agency, parastatal, or private nonprofit organization, with pro-government and pro-market groups sharply divided (Yeh, Yuang, and Hsiao forthcoming). Taiwan, China, ultimately decided to create a state-owned, semi-governmental enterprise to administer the NHI. Integration of the existing insurance schemes into a state-owned enterprise in Taiwan, China, was similarly controversial. Separate insurance schemes existed for labor, farmers, and civil servants, each group with a different premium base, different premium rates, and different benefits packages. One strategy the new NHI head adopted to resolve the resistance toward integration was to recruit the key staff from existing insurance programs, offering promotions as an incentive (Yeh, Yuang, and Hsiao forthcoming). Political factions and vested interest groups tried to influence the various appointments to leadership positions to ensure that representatives of their interests would hold positions that would give them political leverage (Hsiao and others, chapter 11, this volume). Ultimately, the president exercised his authority to make a unilateral appointment based on merit.

In Mexico, the development of a separate, single-payer agency to administer a new integrated social health insurance was impossible due to resistance from the powerful social security provider union of the IMSS. Integration could have led

to public contracting and competition for the IMSS with the MOH and potentially private providers (Lakin 2010). The IMSS effectively resisted integration during the adoption phase, resulting in a policy to administer Seguro Popular through the MOH, leading to continued fragmentation of coverage.

To summarize, politics influences implementation through the political pressures generated by electoral cycles and the short time horizons of politicians, patronage in local politics, and feedback from groups resistant to change. Countries where these tendencies are more explicitly built into the constitutional structure, such as federal or decentralized states with majority rule, have more institutional pressures to delegate discretion over implementation to the local level, which can increase difficulties in implementation. Likewise, geographic targeting of benefits may reward or punish areas that supported or opposed the incumbent party, or roll-out may be targeted toward swing voters. Interests, institutions, and ideology continue to impact the implementation of reform as different groups, parties, and politicians try to maximize the gains from the roll-out of social programs and distance themselves from the failures.

CONCLUSIONS

While it is well known that formulating, adopting, and implementing social policies occur through political processes, most of the literature on health financing reform focuses on the economic or technocratic design of policy—with little attention paid to how political dynamics affect policy design and outputs. Politics is treated as idiosyncratic, unpredictable, nonacademic, and as a barrier to be overcome in achieving the most technically optimal, utility-maximizing reform. As a result, in citing why so few countries have adopted systemic health reform like national health insurance, researchers often invoke a lack of “political will” or commitment to reform. The assumption seems to be that if leaders were so inclined, reform would be easy (Reich 2002; Roberts et al. 2004).

Politics needs to be viewed as the pathway to reform, the process by which technical plans are adapted to the preferences of different constituents in society. The structure of political institutions has a major influence on the distributive impacts of policy. As discussed, political systems with multiple veto points inhibit policy reform, and some systems are particularly adept at targeting political benefits in a nonrandom manner (Persson and Tabellini 2003; Cox and McCubbins 2001). Furthermore, political goals have a “lumpy” or “winner-take-all” quality to them. Unlike economic markets, where there is usually room for many firms, in politics second place often means no place at the table (Pierson 2004). Thus scaling up national health insurance in developing countries should not be expected to occur in the same way in different contexts. As U.S. politician Tip O’Neill put it, “All politics is local.” Nevertheless, trends and lessons can be drawn from studying the political economy of reform cross-nationally, with important implications for future reform efforts.

This chapter concludes by presenting a few practical implications about the political economy of health financing reform, drawing evidence from the chapter’s analysis and intended as advice for policy makers and policy analysts. These ideas will not provide a definitive answer to when universal health insurance will be successfully scaled up, but they can help policy makers judge when the timing is ripe for reform and how to design a politically feasible reform.

Health reform is a profoundly political process, and politics plays a role in all phases of the health reform process (Roberts et al. 2004). The specific political strategies and skills at each phase are different, although decisions made at each phase interact with one another. Health reform is not only a technical process. It is a political process characterized by trade-offs and influenced by ideology, ideas, interests, political calculations, bargaining, and strategizing within a particular institutional context. Each technical design component has a political calculation associated with it (table 15.1).

TABLE 15.1 Political Strategies to Manage the Political Economy of Health Financing Reform

<i>Policy cycle</i>	<i>Constraints and facilitators</i>	<i>Strategies</i>
<p>Agenda setting Getting health reform on the policy agenda</p>	<ul style="list-style-type: none"> • Critical junctures, focusing events, and opportunity windows • Partisan policy cycles • Political culture, ethnic and religious fractionalization, and heterogeneity of preferences 	<ul style="list-style-type: none"> • Recognize a political window of opportunity and exploit that opportunity (and know when the moment is not right). • Work with policy entrepreneurs to create political momentum for health reform. • Understand political culture and package messages accordingly.
<p>Policy design Crafting the technical design of reform in a political context</p>	<ul style="list-style-type: none"> • Trendsetters, international organizations, and external pressure • Technocrats and policy entrepreneurs • Finance Ministry • Interest group and partisan influences 	<ul style="list-style-type: none"> • Give different groups the feeling of participation while maintaining control. • Balance concerns of different stakeholders to reach a political equilibrium. • Design around major political and institutional obstacles. • Consider distributive consequences of policy and partisan support base.
<p>Adoption Getting health reform through the legislative process</p>	<ul style="list-style-type: none"> • Interest groups and existing institutions • Number of veto points and veto players • Political leadership and party discipline 	<ul style="list-style-type: none"> • Practice the art of legislative negotiation and bargaining. • Keep certain agreements nontransparent to maintain support of different interests. • Find allies within the legislature.
<p>Implementation Carrying out the reform</p>	<ul style="list-style-type: none"> • Federalism, decentralization, and delegation • Political time horizons • Existing institutions and positive feedback 	<ul style="list-style-type: none"> • Balance delegation with retention of oversight. • Appoint cabinet members and bureaucrats strategically. • Anticipate and manage partisan politics and the patronage of implementation. • Account for natural “democratic incentive” in the design of policy evaluation.

Source: Authors.

This analysis of health financing reform across the policy cycle identifies four political factors that commonly affect reform strategies and successful scale-up: (1) institutions; (2) ideas; (3) ideology; and (4) interests. The interaction of the four I's at each stage in the policy process is particularly relevant in managing the politics of reform.

- *Institutions.* A country's political institutions—whether they are veto-ridden or veto-few—affect the political calculations for reformers from the beginning. Politicians calculate what is politically feasible given the checks and balances they face and the support/opposition ready to mobilize for or against different reform options. Countries with more institutional and partisan veto points have a more difficult time passing big-bang reforms and may instead have to adopt an incremental approach. Insurgent tactics may also be used to manage the multiple veto points to achieve big-bang reform. However, costs are associated with this strategy as opposed to a more participatory approach. Insurgent tactics can lead to the emergence of more problems during implementation; participatory engagement, conversely, can force more compromises up front during design and adoption of the policy.
- *Ideas.* Health reform is heavily influenced by the prevailing ideas in society. Kingdon (2003) describes the policy-making process as a “primeval soup”—ideas float around, bumping into one another, encountering new ideas, and forming combinations and recombinations. These ideas are circulated waiting to be linked up with political opportunities. Thus, the ideas that are prominent at any given time have a greater likelihood of being taken up by policy makers. This explains why particular policies appear to cluster in time and space. Recently, national health insurance has gained popularity as a means of increasing access to health services and is diffusing rapidly through global policy networks. Technocrats can bring technical ideas to the policy table, but those ideas must be adapted to the local political palate.
- *Ideology.* Ideologically driven partisan competition also affects reform, but it is more mutable than the institutional rules of the game since the composition of political competition changes more frequently. In general, parties on the left of the ideological spectrum support more redistributive social policies, including financing through general tax revenue and publicly rather than privately delivered health services. Parties on the right prefer the status quo or more regressive forms of financing and more involvement from the private sector, often with limited government participation. Likewise, incumbent parties wish to show that their policies are working, whereas the opposition has an incentive to discredit the prior government's reform and propose alternatives. Thus, the content of reform bears the partisan imprint of parties backing the plan and reflects the political competition between different political factions and the constituents they represent. If compromise cannot be reached, the status quo (the present health system) usually prevails, which ironically may satisfy no one. Politicians should consider the political consequences of the policy designs they recommend.

- *Interests.* While policy makers are arguably the mediators of the various stakeholders' interests, the mobilization of these groups has a profound influence on policy makers' decisions and their political calculus. Organized interests, often representing a minority, have a disproportionate influence on policy makers. Medical associations and providers have resisted national health reforms that would limit free choice of doctors and their economic independence. Private health insurers fight tooth and nail to protect their independence and their incomes. Industry generally opposes the increased taxation that more progressive financing measures entail. Influential unions that have fought hard to achieve their benefits resist efforts to extend protection to the uninsured for fear it will compromise their own hard-won gains. Due to existing power structures, countries have frequently had to design reform around them instead of incorporating them into a single system, often further reinforcing inequality in an already fragmented welfare state. This discussion highlights the importance of taking into account the irreversibility of certain policy choices. Some policies are more difficult to undo than they were to do, and the dynamics of reversal may be different from the dynamics of adoption due to the rising costs of reversal over time (Pierson 2004). All policies, once implemented, build up networks of stakeholders and supporters who resist reforms that would reduce their benefits. In adopting policies that may be particularly difficult to undo, the potential unintended (but foreseeable) consequences should be considered.

These four variables—institutions, ideas, ideology, and interests—interact with each other at each stage of the reform process.

What does this mean for policy makers wishing to scale up health insurance in developing countries? This presents a strategic political choice: Should leaders ram through adoption of national health insurance in spite of large informal sectors and insufficient capacity for implementation, or should leaders incrementally scale up health insurance coverage by building on community financing schemes and the formal sector? As the experience of Mexico and Ghana illustrate, even if national health insurance fails to meet all the technical criteria to constitute health insurance, its introduction can infuse needed revenue into an underfunded public health system and expand health benefits for previously disadvantaged people. Further, having this architecture in place can serve as a means of gradually increasing coverage and institutionalizing insurance, making reversal of gains difficult over time. In short, in some situations, political logic trumps economic caution. However, where this big-bang approach is infeasible, either because a window of opportunity does not present itself or because the existence of multiple veto points makes radical reform infeasible, a gradual, bottom-up community health insurance model has worked to substantially expand coverage in Thailand and China, and is being experimented with currently in Rwanda, where the national government is steering the gradual increase in insurance coverage.

Technocrats who design reform are frequently interested in what works in a laboratory setting, but real reform has to work in real societies and requires grounding in both politics and economics. Evaluations of health policy designs

(like payroll tax–financed systems versus general taxation) focus on whether one financing design works better than another, while trying to control for existing background conditions or other immeasurables captured in the “error term.” Political economy analysis is interested in exploring the immeasurables and unpacking the error term to explain what happens in all phases of the policy reform process. We believe that political economy analysis has both theoretical and practical implications for making health financing reform work better.

NOTES

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