Commentary

Political Context and Health Financing Reform

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INTRODUCTION

The articles in this special issue make two particularly valuable contributions to understanding health financing reform. First, through historical case studies, they provide rich empirical evidence showing that reform is more than a technical matter: it is also a heavily political undertaking. Second, they provide guidance to reformers on political management, illustrating the utility of a framework that identifies groups of actors who facilitate and obstruct change, including interest groups and political leaders.

A focus on political management highlights the role of human agency in health financing reform. Reform is shaped not only by agency but also by political context—enduring political and social arrangements not easily altered by the actions of individuals. For instance, the adoption and smooth implementation of reform may be more likely in a country with a government that has a unitary political structure that limits the ability of anti-reform groups to block change.

Several scholars warn against excessive analytical focus on the actions of individuals, as doing so may mask the role of structural forces and long-term social processes in explaining political and social outcomes, including social welfare policy adoption and implementation.

The articles in this special issue attend to political context but highlight individual agency. In this commentary, I do the reverse. I do so with a view to calling attention to some of the larger and more enduring factors pertaining to nature of the political system and party rule, features of civil society, and the global political environment—that alongside human agency may explain why major health financing reforms advance in some national settings but not others.

REFORM IN THE UNITED STATES

Blake and Adolino examine why, among a group of 20 industrialized countries, the US historically has struggled more than the rest to enact national health insurance. Their analysis illustrates the potential influence of political context
on health policy reform, pointing to factors explaining the adoption of national health insurance—and other health financing reforms—that may apply beyond the US.

They begin their analysis by considering explanations that have focused on factors connected either to culture, the economy, institutions, or politics. They reject these explanations, arguing that a confluence of factors is at work, pertaining to the structure of the political system (numbers 1 and 2 below), nature of party rule (3), and features of civil society (4 and 5). Their argument, laid out below, is that unique among this group of countries, the US lacks all five:

1. **A unitary rather than federal political system:** Federal political systems—ones in which national and sub-national governments share power—provide a greater number of veto points that potentially can obstruct reform than unitary systems which afford sovereign power solely to central governments.

2. **A political structure with a dominant executive:** Parliamentary systems—fusing executive and legislative power in one body—offer fewer veto points than presidential systems, which disperse power across different branches of government, limiting that of the executive.

3. **A tradition of leftist party rule:** Leftist parties are more likely to embrace social welfare-oriented concerns such as universal health coverage than conservative parties, as the former are more inclined to support a strong state role in redistributing resources to benefit economically disadvantaged population groups.

4. **A political culture that favors social solidarity rather than individualism:** Societies that emphasize individual responsibility are less likely to support the government taking on a central role in ensuring health care access and provision than those that value social solidarity.

5. **A corporatist rather than pluralist pattern of interest group activity:** Systems with pluralist interest group patterns—ones with multiple social groups competing for power—are more likely to present opposition to reform than corporatist systems—where society is organized into hierarchical interest groups that link and promote cooperation among business, labor, and government.

The special issue’s framework calls attention to several of these factors. For instance, the authors highlight the role of pluralist interest group activity, pointing out that groups such as medical professionals may seek to block policy reforms. And they note that federal political systems may make reform more cumbersome, as the center has limited capacity to direct action at lower levels.

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**REFORM IN THAILAND, TURKEY, MEXICO, AND NEW YORK STATE**

We see some of these factors potentially at work in four of the primary cases considered in the articles in the special issue—Thailand, Turkey, Mexico, and New York State. Financing reform appears to have proceeded furthest in Thailand and Turkey, facilitating near-universal health coverage in both countries. Mexico represents an intermediate case, with the passage of universal health coverage laws but problems in implementation at sub-national levels. Meanwhile, New York State has yet to ensure health coverage for all its citizens despite repeated attempts by pro-reform legislators to do so.

With respect to the structure of the political system, for much of their modern history, Thailand and Turkey have had unitary, parliamentary systems and vacillated between semi-democratic and authoritarian rule, with frequent military intervention in politics. By limiting the number of veto points, this centralization of power may have made reform adoption easier in these countries than in New York, which is situated in a country with a federal system and whose state government divides executive and legislative power. In New York, the need for laws to be approved by three entities—the Senate, the Assembly, and the governorship—has made reform adoption particularly difficult. In addition, the structure of the political system may also have affected implementation in some of these settings: in Mexico, for instance, a country with a federal political system, state governments have slowed implementation of the national health insurance program, Seguro Popular.

With respect to features of civil society, as compared with many Western European countries, US political culture prioritizes individual responsibility and places much less emphasis on social solidarity, leading many to oppose a strong government role in ensuring health care coverage—a point that applies to many citizens of New York State. Moreover, unlike several Northern European and Latin American countries, the pattern of interest group activity is pluralist, not corporatist, providing space for interest groups such as medical associations and the insurance industry to obstruct reform.

The cases considered in the special issue challenge some of Blake and Adolino’s contentions concerning how political context may shape reform. Reform in Thailand, Turkey, and Mexico followed the election of new ruling parties in each: The National Action Party (PAN) in Mexico in 2000, the Thai Rak Thai Party in Thailand in 2001, and the Justice and Development Party (AKP) in Turkey in 2002. And the new ruling coalition of Mexico (Morena—the National Regeneration Movement) is seeking to dismantle reforms. Interestingly, both PAN and
AKP are conservative parties, and Mexico’s present ruling coalition includes a leftist labor party, challenging Blake and Adolino’s proposition, derived from comparison of industrialized democracies, concerning the relationship between a history of leftist party rule and prospects for health reform. Also, despite barriers posed by its federal, presidential political system, in 2010, the US government under the Obama administration passed the Affordable Care Act, a comprehensive health care reform program. The US experience suggests that while political systems with multiple veto points make reform cumbersome, even in such systems, reform may advance if effective leadership and favorable political conditions emerge.

Blake and Adolino focus on political dynamics at the national level. Features of the global political context may also shape national health financing reform prospects. For instance, Tangcharoensathien and colleagues argue that investments from the 1970s in local health infrastructure helped build a foundation in the 2000s for universal health coverage in Thailand. They note that this early investment was influenced by geopolitics: the need during the Cold War to foster development and preempt disaffection from rural populations as a means of countering communist infiltration in the Indochina region. More recently, the inclusion of universal health coverage as a target in the Sustainable Development Goals may be placing normative pressure on national governments to address this issue.

CONCLUSION
The discussion above points to a number of factors pertaining to political context that may shape health financing reform outcomes. These concern the nature of the political system, party politics, civil society, and global political context. Just as we can identify the groups of stakeholders who need to be managed to advance health financing reform—an undertaking that implies the power of human agency—so, too, can we lay out the contextual factors that may hamper and facilitate reform. The factors identified in this commentary may or may not be the most relevant in explaining cross-national differences in health financing adoption and implementation outcomes: detecting those factors constitutes a larger research agenda. The deeper point is that the most robust explanations for health financing reform outcomes, such as the enactment of laws on universal health coverage, likely will be ones that consider interactions between human agency, on the one hand, and the contextual forces that facilitate and constrain action, on the other.

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REFERENCES
1. Campos PA, Reich MR. Political analysis for health policy implementation. Health Syst Reform. 2019;5(3):224–235. doi:10.1080/23288604.2019.1625251.
2. Kim HJ, Sharman JC. Accounts and accountability: corruption, human rights, and individual accountability norms. Int Organ. 2014;68(2):417–448. doi:10.1017/S0020818313000428.
3. Pierson P. Big, slow-moving, and invisible: macrosocial processes in the study of comparative politics. In: Mahoney J, Rueschemeyer D, editors. Comparative historical analysis in the social sciences. Cambridge, United Kingdom: Cambridge University Press; 2003. p. 177–207.
4. Blake CH, Adolino JR. The enactment of national health insurance: a Boolean analysis of twenty advanced industrial democracies. J Health Polit Policy Law. 2001;26:679–708.
5. Fox AM, Choi Y. Political economy of reform under US Federalism: adopting single-payer health coverage in New York State. Health Syst Reform. 2019;5(3):209–223. doi:10.1080/23288604.2019.1635414.
6. Sparkes SP, Bump JB, Özelik EA, Reich MR. Political economy analysis for health financing reform. Health Syst Reform. 2019;5(3):183–194. doi:10.1080/23288604.2019.1633874.
7. Tangcharoensathien V, Patcharanarumol W, Kulthananusorn A, Saenguang N, Kosiyaporn H. The political economy of UHC reform in Thailand: lessons for low- and middle-income countries. Health Syst Reform. 2019;5(3):195–208. doi:10.1080/23288604.2019.1630595.
8. Frenk J, Gómez-Dantés O, Knaul FM. A dark day for universal health coverage. Lancet. 2019;393(10169):301–03. doi:10.1016/S0140-6736(19)30118-7.