Research Article

Political Economy Analysis for Health Financing Reform

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Abstract—Health financing reform is an inherently political process that alters the distribution of entitlements, responsibilities and resources across the health sector and beyond. As a result, changes in health financing policy affect a range of stakeholders and institutions in ways that can create political obstacles and tensions. As countries pursue health financing policies that support progress towards Universal Health Coverage, the analysis and management of these political concerns must be incorporated in reform processes. This article proposes an approach to political economy analysis to help policy makers develop more effective strategies for managing political challenges that arise in reform. Political economy analysis is used to assess the power and position of key political actors, as a way to develop strategies to change the political feasibility of desired reforms. Applying this approach to recent health financing reforms in Turkey and Mexico shows the importance of political economy factors in determining policy trajectories. In both cases, reform policies are analyzed according to the roles and positions of major categories of influential stakeholders: interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics. The strategic responses to each political economy factor stress the connectedness of technical and political processes. Applying the approach to the two cases of Turkey and Mexico retrospectively shows its relevance for understanding reform experiences and its potential for helping decision makers manage reform processes prospectively. Moving forward, explicit political economy analysis can become an integral component of health financing reform processes to inform strategic responses and policy sequencing.

INTRODUCTION

Expanding equitable access to quality health services through health financing reform is a priority for many countries. As highlighted in the 2010 World Health Report, health financing reform has important implications for advancing Universal
Health Coverage (UHC), i.e., effective service coverage with financial risk protection, as well as the related goals of health status and customer satisfaction. Achieving these goals requires effective strategies coordinated across many functions of the health system including governance, regulation, and the organization of service delivery.

Financing issues underpin many aspects of health system performance. Financial incentives are important for changing the behavior of both providers and patients. Those incentives also influence stakeholders who seek to shape health policies and thereby affect overall system performance. Expanding effective access to health services depends on generating more resources for health as well as increasing the efficiency and equity with which resources are used. Health financing reforms directly affect equity by changing how resources are allocated across income and age groups. They also affect welfare because health expenditures are a common cause of household impoverishment, and the expected costs of treatment can be an important barrier to seeking care.

Also, the sheer magnitude of resources in the health sector (about 10% of the world economy in 2016) creates vast economic interests in its organization and operation, with important political implications. Experience shows that health financing reform carries important ethical implications and involves both technical and political decisions that require substantial negotiation. Often, decisions about health financing alter the distribution of entitlements, responsibilities, and resources within the health sector and beyond. These changes affect a range of stakeholders and institutional processes with varying interests, power, and influence, which can create political opportunities and tensions.

Agreement on the importance of health financing reform for UHC, however, has not translated easily into implementation at the national level. Countries have adopted different policies related to health financing for UHC, with each case influenced by demographic, epidemiological, and socioeconomic factors as well as cultural, historical, and political economy considerations. Some reforms have been comprehensive (e.g., introducing a national health insurance scheme) while others have been directed at specific areas of health financing (e.g., changing provider payment methods). Reforms have been connected with other parts of the health system (e.g., service delivery models) and have been embedded within larger governmental reform processes (e.g., decentralization).

The political economy of health financing reform is a critical determinant of both the design and implementation of efforts to improve health system performance. Analyzing the political economy of reform can help explain the broader forces that affect the distribution of health and resources within and across populations. In this article, political economy analysis is used to assess the power and position of key political actors, as a way to develop strategies to change the political feasibility of desired reforms. Incorporating political economy analysis (PEA) into reform processes can help policy makers develop more effective approaches to navigate the political challenges that arise when seeking to introduce policy change.

This article proposes an analytical approach to guide policy makers and practitioners on how to identify and address key political economy challenges in health financing reform. We include two national reform examples to show how targeted strategies can be used to manage political economy challenges in the design, adoption, and implementation of reform. We use these cases as a retrospective illustration of our approach. However, we intend the primary use of this approach to be in real-time to assist national policy makers and others adopting and implementing health financing reforms that promote UHC. Although we do not provide a comprehensive mapping of all the potential political economy factors and strategies related to health financing reform, we do provide a structured way of thinking that we hope will assist practitioners in making difficult decisions in this policy arena. Key messages from the article are presented in Table 1.

1. Health financing reform is an inherently political process and therefore political economy analysis and strategies should be incorporated into policy design, adoption and implementation.
2. Political economy analysis provides a structured way to assist practitioners in navigating key areas of contestation.
3. Keeping reform objectives as central to the analytical approach and development of technical and political strategies is critical to ensure compromises do not undermine policy goals.
4. The framework used to approach the political economy of health financing reform recognizes that different actors seek to influence reform at different stages of the policy cycle to minimize losses and maximize gains.
5. Political economy factors have been key determinants of the trajectory and strategic approach taken by leaders to move health financing reform forward to implementation.
6. Sequencing adoption and implementation of components of the reform process based on political economy factors, as well as engagement with beneficiaries, are critical factors in moving reforms forward.

TABLE 1. Key Messages
The article is organized as follows. First, we provide a description of the methods used to develop the political economy of health financing approach. Second, we discuss technical dimensions and related normative principles. Third, we present our framework for assessing political economy factors in health financing reforms. Fourth, we discuss the intended use of the approach. We then illustrate the application of the approach using two prominent health financing reforms from Turkey and Mexico. Finally, we discuss some conclusions on incorporating political economy analysis into health financing reform processes.

DEVELOPMENT OF THE FRAMEWORK

We developed our ideas for incorporating political economy analysis into health financing reform through an iterative process of literature review and expert consultations. We first conducted two systematic reviews of published literature. One focused on the technical dimensions of health financing reform; the second examined political economy and political analysis of health reform. The papers identified in the health financing search focused primarily on the technical aspects of health financing reforms, with very little information about the political economy of the process. The search on political economy and health policy similarly did not lead us to an existing framework or model that would serve our purposes.

We then expanded our search to reports by development agencies. We reviewed the Drivers of Change and Politics of Development frameworks, both offered by the UK Department for International Development, and used by that agency in many countries,20 Problem-Driven Political Economy analysis, originally developed by the World Bank,21 and the Dutch Foreign Ministry’s Strategic Governance and Corruption Assessment.22 We found that these approaches could be useful for collecting information about political economy conflicts, and offered ways of categorizing these conflicts. But they provided limited practical guidance to help policy makers manage the political economy challenges of health financing reform.

To address this gap in the literature, we decided to draw on a paper on the political economy of health policy implementation written in the summer of 2018 by Campos and Reich (and included in this special issue of Health Systems & Reform), which we have adapted for the approach developed in this article.23 We used this political economy framework to analyze specific health financing reform experiences in Turkey and Mexico, presented below, as illustrative examples of analysis.

The approach was discussed at two international meetings. Feedback and comments from both meetings were used to revise and improve the concepts and methods in the approach.

HEALTH FINANCING REFORM

Health financing involves four health system functions and policies: revenue raising, pooling, purchasing, and benefit design.24 Raising revenues for health refers to policies for mobilizing financial resources from households, businesses, and external sources to pay health system expenditures.16 Pooling refers to the accumulation and management of pre-paid revenues to spread financial risk for paying for certain health services across a group so that the pooled funds can be used to help pay for health care.1 Purchasing relates to the arrangements used to pay for health services, including health workers and other providers, on behalf of the population.25 Benefit design is a policy choice that refers to the services covered by pooled funds, and commonly also includes specifying eligibility groups, point of service costs, and patient cost sharing.3,4 While the specific content will differ across countries, these four functions can be used to characterize health financing in any country.

Health financing reforms are highly sensitive to context, reflecting institutional settings, culture, politics, history, and other factors particular to individual nations. Recognizing this diversity in policy responses, the World Health Organization (WHO) developed normative principles to guide countries considering health financing reforms to promote UHC (see Table 2 for a selection of these principles).3,26,27 Depending on the nature of the reform, these principles can be adopted

| Health financing function | Principle |
|---------------------------|-----------|
| Revenue raising           | Move towards predominant reliance on public (i.e., compulsory and pre-paid) revenue sources |
| Pooling                   | Enhance redistributive capacity by reducing fragmentation across pools or mitigating the consequences of fragmentation |
| Purchasing                | Move towards more strategic purchasing of health services |
| Benefit design            | Specify and improve the population’s awareness of their legal entitlements and obligations as beneficiaries. |

Notes: See Katrin et. al (2017) for more information.4

TABLE 2. Guiding Principles for Health Financing Reform
individually or as a package. These principles can help guide strategic negotiations and compromises during UHC reforms.

**THE POLITICAL ECONOMY FRAMEWORK**

The political economy framework used in this paper builds on the methods of applied political analysis and strategies presented in the article in this issue on the politics of implementing health policy and on prior work by the senior author. This framework recognizes that stakeholder analysis of actors along with strategies to change the political landscape (including the distribution of power) are key components of an applied political economy analysis. Campos and Reich propose six major categories of stakeholder groups that are likely to influence health reform: interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics. We use these categories in our analysis of the political economy dimensions of health financing reform.

The organization of analysis around stakeholder categories recognizes that different actors seek to influence reform at different stages of the policy cycle, each seeking to minimize losses and maximize gains. This approach assesses the role and position of stakeholders, as well as the power dynamics between them and their relationship to politicians and policy makers. These power dynamics can be shaped by institutional context, which we do not attempt to characterize here, although it is an important part of the contextual knowledge needed to apply our approach. All six dimensions are not necessarily engaged by every type of health financing reform or in every reform setting since the involvement of stakeholders is conditional on circumstances and context. Similarly, reform proponents need to consider which stakeholders are most likely to be engaged when assessing the political feasibility of a specific reform. The strategies that work in one national context may not be effective elsewhere (or at another time in the same country). The idiosyncrasy of reform requires both careful empirical analysis as well as creative strategic thinking—all grounded in local knowledge and practice. However, we suggest that the six stakeholder groupings are broadly applicable and can be used to analyze most reforms. We describe each category as follows:

**Interest group politics** refer to stakeholders organized around certain shared interests, such as health provider associations, unions of health workers, industry groups (including hospitals and pharmaceutical companies), insurers, employers’ groups, and consumer organizations. These groups have different kinds and levels of power, which they use to influence politicians and policy makers and the adoption and implementation of policies. As is well known, different interest groups are not equally organized or powerful.

**Bureaucratic politics** examine the relationships among different agencies within the government related to health financing reform. Different agencies may attempt to capture the reform as a way to protect or expand their authority, interests, budget, personnel or general influence. As a result, conflict, negotiation and compromise between different government agencies can influence government policies and actions on health financing. This dynamic can also push for shifts in governance arrangements regulating the relationships between those agencies. In federal and decentralized settings, these conflicts can also involve tension and conflict between central and subnational government authorities, which can be further complicated by the role of different political parties.

**Budget politics** focus on budget allocation and expenditure mechanisms, and their impact on policy implementation. This area explicitly acknowledges that resource mobilization and allocation at national and local levels are inherently political processes. One of the most important political relationships for a minister of health is with the minister of finance. The essential and prominent nature of financing for any health policy reform justifies the separation of budget politics from the category of bureaucratic politics, although these are linked closely. Issues related to tax administration, collection, public financial management, and revenue allocation generally sit within the purview of finance authorities. As a result, the relationship between the health and finance ministries becomes a critical factor in shaping and enabling health financing reform, as well as competition with other sectors that are vying for their own budget allocations. Budget politics within the national legislature and within subnational legislative bodies can also have a critical influence on health financing reforms.

**Leadership politics** include the commitment of political leaders—typically in the executive or legislative branches of government—and the position of financing reform relative to other policy issues. It explicitly recognizes that commitment by political leadership (such as the head of state) changes perceptions of the political benefits and costs of actions and results associated with a policy, and thereby changes political feasibility. This category includes consideration of electoral cycles and party politics, at the national and sub-national levels, including the role of constitutional factors and federal structures that can influence the proposal and adoption of reforms and can help explain resistance to reform efforts.

**Beneficiary politics** consider the behaviors, preferences, and political activities of the end users of the health system.
This category relates to ideas and ideologies in promoting a health financing reform, including, for example, how health financing reform aligns with national values, identities, or worldviews, or the role of public opinion. It also acknowledges that access to care is not equivalent to service utilization, and the behavior of end users will likely have to change to meet intended reform objectives. For example, a reform intending to increase the use of facility-based deliveries would require that pregnant women actually report to facilities to give birth. It also includes the social mobilization (or non-mobilization) of existing or potentially new beneficiaries, which can affect the political feasibility of reform proposals.

External actor politics recognize that funds and ideas for the health sector can come from external sources and therefore decisions on health policy can involve external actors—often designated “donors” or “partners”—including bilateral and multilateral agencies, and international financial institutions, as well as external non-state actors such as non-governmental organizations, foundations, and private for-profit entities. These external actors can affect policy decisions depending on the financial conditions, incentives, and intellectual influence related to their contributions, and the broader context of relative power and geopolitical circumstances. External actor political influence on reform processes can also depend on the domestic politics of a country, including competition among political parties at the national and sub-national levels. This is especially true in fragile situations where external actors have extensive influence over policy decisions. Therefore, aligning funding and other assistance with national objectives can be complicated by domestic political dynamics and interests.

These political economy dimensions align with the categories of commonly identified stakeholders involved in and affected by health system policymaking, including the 2004 World Development Report, which referenced policymakers, providers, and clients as key groupings to understand service delivery dynamics. Bureaucratic, leadership and budget politics all relate to state functions and interests. Providers as an organized entity are an important interest group, and the beneficiaries of health financing policy are usually the citizens of a country (raising important questions about non-citizen residents within a nation). One addition to these dimensions in relation to health financing reform is the influence of external politics, both through financial and technical interests, on policy outcomes.

**APPLYING THE APPROACH**

This analytical approach provides a structured framework to identify and assess political economy challenges and opportunities associated with health financing reforms, and then to devise strategies to address them. Ultimately, the approach is intended for prospective, iterative use, so that decision makers and other officials can develop targeted strategies to navigate the political economy constraints and opportunities of the reform process. While the approach is grounded in academic research, it is intended for use by those working to develop and implement health financing reforms. Users can include: (1) national officials in a ministry of health (MOH); (2) health financing reform team members from other governmental ministries (e.g., ministry of finance, ministry of labor, or the office of the President); and (3) development partners, researchers, and practitioners (including civil society organizations) who seek to influence health financing reform efforts. Ministries of health will likely be involved in most health financing reforms, although leadership and support may also come from other agencies, such as the office of the President. We have developed a step-by-step guide for these users, which will be released separately.

We structured our approach to political economy analysis around stakeholder groupings informed by theory and experience as a useful starting point. However, the role of contextual factors must also be considered. These vary from setting to setting, reflecting the prevailing historical factors, cultural norms, national values, institutional structures, and immediate political considerations. Addressing these factors requires consideration of influences relevant to health policy, including electoral cycles, historical experiences such as colonialism, economic and institutional constraints, organizational capacity, recent political events and social disasters, and cultural norms.

**ILLUSTRATIVE APPLICATIONS**

In this section we apply our approach to political economy analysis to two national health financing reforms: Turkey’s Transformation in Health Program (2002–2012) and Mexico’s Seguro Popular (2000–2006). These brief retrospective examples do not present a full analysis of the political economy of either reform. Rather, they are selective applications to show how our approach can be used to identify political economy challenges and opportunities, and how these challenges can be addressed using political strategies to advance the adoption or implementation of reform.

These two countries were selected based on the following three criteria: (1) each country introduced a national health financing reform to expand effective coverage and improve health system outcomes by seeking to reduce fragmentation in pools, increasing the share of public revenues for the health
sector, and adopting strategic purchasing aligned to promised benefits, (2) each reform experience has been analyzed in peer-reviewed research articles and grey literature, including political economy aspects, and (3) our research team included expertise on the reform experiences of the two cases.

Turkey

Context

Following the 2002 national elections, a new government came to power in Turkey with a health system reform platform to promote equitable access to health services, reduce disparities in health outcomes, and improve overall population health. Compared with other countries at a similar income level, Turkey recorded high infant and maternal mortality rates, low satisfaction with health services in the public sector, and high impoverishment rates due to health expenditures. Between 2002–2012, the government implemented a series of reforms known as the Transformation in Health Program (THP) that sought to expand the supply of health services, while overhauling financial arrangements to increase effective coverage, reduce fragmentation between various insurance schemes, and increase public revenues in the health sector. The THP sought to unify diverse financing and social security plans under a single national insurance scheme providing comprehensive coverage for all Turkish citizens.

Political Economy Factors and Related Strategies

Before embarking on the reforms to establish a unified, single payer health insurance scheme, the Minister of Health and his reform team conducted a prospective political analysis that assessed the interest and power of many stakeholders. This analysis examined various stakeholders with interests in the reform and provided recommended strategies to manage those interests to improve adoption and implementation feasibility. In early stages of the reform, supportive stakeholders included domestic national leadership and external actors: the Prime Minister and the political party in power, plus the World Bank, WHO, and other development partners that were committed to the success of the reform.

The reform team used supportive leadership and external actor politics strategically to overcome opposition within the interest group, bureaucratic, and beneficiary politics spheres, including from the Turkish Medical Association, the Ministry of Labor and Social Security, and the Ministry of Finance, and resistance from various beneficiary groups concerned with their own entitlements. One strategy was to include technocrats from the Ministry of Labor and Social Security and Ministry of Finance as members of the reform design and implementation team. These technocrats helped shape the reforms and worked with the leadership of their own ministries to broaden support for adoption and manage resistance during implementation. This bureaucratic politics strategy helped link the health financing reform with other government priorities, including pension reform and fiscal sustainability.

Beneficiary politics were also crucial in the design and sequencing of the reforms. Some prominent groups, such as civil servants, believed that the reforms could diminish their entitlements. These concerns were allayed with assurances and explanations that the entitlements of existing beneficiaries would not be reduced, and promises that government revenues would be increased to subsidize the newly enrolled, and that the quality of health service delivery would improve more generally. Favorable macroeconomic conditions greatly facilitated Turkey’s strategic policy progress. The newly elected ruling party’s political base included rural and low-income households, which stood to benefit the most from the reforms. Delivering on the campaign promise to expand coverage benefited the health sector and was also an advantageous political strategy to reward these supporters and gain votes in future elections.

Interest group politics were also addressed, as the Ministry of Health worked to assure most providers that their compensation and employment conditions would not suffer because of the creation of a single, unified health purchaser. This was done by introducing substantial performance incentives that dramatically increased the pay of providers, which was facilitated by overall economic growth, and the dedication of a greater share of the government budget to health. Technical expertise provided by external development partners played an important role in the development of actuarial models and other analytical products that were used in discussions with finance authorities.

These political economy strategies were employed before attempting the contested merger of various pools to create a single national health insurance scheme. This legal and administrative merging took place at the end of the reform process in 2012, after benefits had been unified, provider pay had been increased, supply conditions had improved, general government revenues had increased, informal sector beneficiaries had been enrolled, and the Ministry of Health had accumulated additional political power from its successes. This process demonstrates the importance of strategic sequencing to ensure technical systems and policies are in place, and that the largest political hurdles have been overcome.

This brief analysis of Turkey’s THP (see Table 3 for summary) shows the influence of political economy factors on the
reform process and on the technical design and implementation of health financing policy. Each of the political economy dimensions influenced policy decisions, both in terms of the content and sequencing of reforms. The Minister and his health reform team analyzed the situation and responded with carefully thought-out political strategies to manage the THP process over many years. These strategies addressed the institutional constraints and opportunities that existed and were facilitated by Turkey’s centralized political system. While the Minister and his team did not fully achieve all objectives of the reform, they did succeed in implementing policies to establish a unified, single-payer national health insurance system, increase general government revenue for the health sector, and introduce performance-based payments to providers that contributed to improved outcomes.

**Mexico**

**Context**

In 2000, Mexico’s newly elected government under President Vicente Fox (and the Partido Acción Nacional or PAN) began plans for a nation-wide health financing reform to expand financial protection and access to health services for the non-salaried population, under a new program designed and promoted by the Minister of Health. The public insurance program, known as *Seguro Popular*, was targeted at more than 45 million people, primarily in the informal sector and without social security, and the approximately three to four million people with high-cost health expenditures annually. The new program was passed by the Mexican Congress in 2003 and implemented in 2004 to provide subsidized insurance for an explicit set of healthcare interventions and coverage for a limited set of high-cost illnesses. The reform sought to create a purchaser-provider split and give state ministries of health more resources to improve the health system. The major source of funding was federal taxes, with complementary contributions from states, and individual premiums based on a progressive scale, with broad exemptions for the poor.

**Political Economy Factors and Related Strategies**

On coming into office in 2000, the Minister of Health initially intended to establish a unified health insurance scheme that would bring together the formal employed sector covered by social security with the rest of the population into a single pool. This plan, however, met strong opposition from *interest group politics*, namely the Mexican Social Security Institute (IMSS), including its strong and influential union, which provided health services to approximately 40% of Mexicans, and therefore was dropped. Instead, the health financing reform was designed to focus only on the population not covered by social security in Mexico.

To support development of the new plan, the Minister of Health worked within the *budget politics* sphere to create an

| Dimension                  | Political economy factor                                                                 | Strategy used by reform team                                                                 |
|----------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Proposed policy:           | Reduce fragmentation in pooling by merging insurance schemes                             | Reduce opposition by increasing provider pay                                                  |
| Interest group politics    | Opposition from the medical association due to concerns over pay changes                 | Directly involve relevant ministries in the reform process early on, cede control of some aspects of purchasing function to labor ministry, link reform with other non-health reform priorities, and grandfather current civil servants into previous scheme |
| Bureaucratic politics     | Tension between ministries and civil servants over control of new financing scheme       | Directly involve relevant ministries in the reform process early on, cede control of some aspects of purchasing function to labor ministry, link reform with other non-health reform priorities, and grandfather current civil servants into previous scheme |
| Budget politics           | Opposition from finance authorities based on fiscal sustainability                       | Directly involve relevant ministries in the reform process early on, cede control of some aspects of purchasing function to labor ministry, link reform with other non-health reform priorities, and grandfather current civil servants into previous scheme |
| Leadership politics       | Highest level support and pressure for reform success from top political leaders         | Strategically leverage high-level support to overcome critical opposition                      |
| Beneficiary politics      | Concerns from current beneficiaries of insurance schemes about reduction in benefits and subsidization of poor | Gradually increase benefits to align with highest level and ensure no reduction for current enrollees, and increase public satisfaction by investing in the health system |
| External politics         | Interest by external partners to provide financial and technical support                 | Leverage external actors to provide financial support and technical analyses to underpin reform efforts |

TABLE 3. Summary PEA for Turkey’s Transformation in Health Program (2002–2012)
economic analysis unit inside the ministry. This unit provided technical analysis that helped convince the Ministry of Finance that the proposed increase in government health expenditure (one percent of gross domestic product) would be financially sustainable and was better than other options. This analysis helped reduce opposition to the reform from the Ministry of Finance. Finally, however, presidential support to the Minister of Health (leadership politics) was crucial to convince the Ministry of Finance to support the reform. Also, between 1999 and 2004 global oil prices increased considerably, a situation that benefited Mexico as an oil-exporter, and this trend also helped overcome Finance’s resistance to reform. In addition, the Minister of Health met frequently with legislators from different political parties and with governors from many states, to help move the reform through legislative processes, leading to its approval in 2003.

Mexico’s federal structure and increasing decentralization provided additional political economy challenges to adopting and implementing Seguro Popular. Two leadership politics strategies used to persuade states to support the reform proposal was the promise to increase federal resources sent to states for the health sector and the promise of significant flexibility in allowing states to decide on how those resources would be used. Reflecting the principle of expanded decentralization, states were required to allocate financial resources for the health sector and were responsible for enrolment and implementation of the public insurance program. A National Commission for Social Protection of Health was established at the federal level, and agreements were reached with each of the 32 states to transfer resources from the federal to state level based on per capita enrolment (which served as an incentive for states to encourage enrolment in the new program). States were then each responsible for establishing the State Protection Regimes (REPSS) to pool federal and state funds and purchase services on behalf of enrolled populations. Furthermore, the Ministry of Health established a separate federal-level Fund for Protection against Catastrophic Expenses that provides coverage for an explicit package of tertiary, high-cost services.

Implementation of Seguro Popular, however, encountered various problems related to state responsibilities and accountability, including delays in funds transferred between the various levels of government, several states not complying with negotiated expenditure targets, inappropriate uses of Seguro Popular funds in some states, and problems in the operations of the REPSS, which remained a part of state ministries of health and not operating as a separate purchaser. In addition, while the plan required premium payments adjusted by income level, in practice almost no premiums were collected, because the enrollment process did not provide means testing and almost all enrollees declared they belonged to the lower income groups that were exempt from payment.

The Seguro Popular reform experience highlights the importance of strategic compromise and targeted negotiation to move reform processes forward (see Table 4 for summary). The existing social security system in Mexico served as a strong institutional constraint to the reforms as proposed initially. When the effort to create a single, unified national health insurance program failed, the PAN-led government decided to expand coverage to Mexico’s large informal sector separately by mobilizing support for the reform through several political parties and a decentralized, federal structure that included an array of stakeholders. That system is now being re-reformed by the government of President López Obrador (elected in 2018) as it works to transform Seguro Popular and the broader national health system, seeking to centralize control over implementation at the federal level, constrain the discretionary power of the states, and contain corruption by cutting expenditures; the changes underway, however, are creating widespread confusion and reductions in service delivery throughout the Mexican health system.

DISCUSSION

This brief analysis of health financing reform experiences in Turkey and Mexico highlights the importance of political economy factors in shaping what happens in reform processes. Applying our approach retrospectively shows the relevance of political economy analysis for understanding reform experiences and its potential for helping decision makers manage reform processes prospectively. While both countries introduced health financing policies that influenced progress towards UHC, their reform trajectories were distinct. One important difference is that while Turkey achieved a single, unified national health insurance system, Mexico did not. This different outcome can in part be explained by political economy factors and related strategic compromises that were made to move reform policies forward. The differing institutional contexts—Mexico as a federal state and Turkey as a centralized state—played an important role in reform outcomes. In many respects, the institutional contexts set the operating environment and constrained potential choice sets for the reform team as they
addressed stakeholder dynamics related to reform. The analysis above also reveals some common political economy themes relevant to health financing reform.

First, in both cases, newly-appointed Ministers of Health used political economy analyses early on to pursue health financing reform when a political window of opportunity opened in their countries and to push their reforms to the top of the policy agenda. Both Ministers of Health worked to create strong support from the top executive leadership in their respective countries. Both Ministers of Health sought to incorporate health reform as an integral component of the political platform of the respective governments. Therefore, party leadership in both countries had a vested interest in moving reform forward. As a result, health financing reform was not just viewed as a health sector priority, but also as a national priority. The respective Ministers of Health were able to strategically leverage this interest and power to overcome particular points of opposition during the reform process.

Second, both cases involved major reform efforts that created significant political economy challenges and required political strategies to adopt and implement the financing reforms. In Turkey, the Minister of Health was able to overcome resistance from existing social security institutions and beneficiaries by gradually increasing benefits for the informal sector and low-income individuals. Legislative action to merge the various schemes was delayed until benefits were harmonized, supply was improved for all Turkish citizens, and patient satisfaction with service delivery was enhanced. By contrast, in Mexico, the Minister of Health was able to achieve legislative approval across several political parties to get the reform adopted and implemented, although he could not overcome opposition from IMSS and its labor union to create an integrated health system, and he could not effectively promote a purchaser-provider split in the system’s operations at the state level.

Third, both reforms were supported by technical analysis conducted by experts with a range of specialties, including economics and finance, and the analyses were used in negotiations with key stakeholders, in budget politics, leadership politics, and interest group politics. Health authorities used these economic analyses to negotiate with finance authorities and build political support for the reform proposals. In Turkey, the reform team used external support to conduct analyses that

| Dimension             | Political economy factor                                                                 | Strategy used by reform team                                                                 |
|-----------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Proposed policy:      | Reduce fragmentation in pooling by merging insurance schemes                             | Take advantage of enabling conditions to move reform forward                                 |
| Interest group politics | Relatively weak organization of physician groups and lack of mobilization of civil society | Abandon idea of merging IMSS and other social security programs into a single organization |
| Bureaucratic politics | Strong opposition from existing social security institutions and their unions to merging health insurance schemes | Establish economic analysis unit in MOH to conduct technical analysis for use in negotiations with Ministry of Finance |
| Budget politics       | Concerns over fiscal sustainability related to increased number of enrollees and objective to increase spending on health | Present health insurance plan as part of President’s vision of democratization |
| Leadership politics   | Support from newly elected president                                                      | Incorporate financial matching conditions into federal program and ultimately allocate additional federal funds to compensate low state-level allocations |
| Beneficiary politics  | Resistance by certain states opposed to national legislative agenda                       | Give states flexibility in allocating the increased federal funds they received            |
| External politics     | Support for the minister and his reform plans from international organizations           | Publish articles about implementation and impacts of Seguro Popular in high impact journals with international readership |

Notes: See Gómez-Dantés et al. for more information.

TABLE 4. Summary PEA for Mexico’s Seguro Popular (2000–2006)
highlighted fiscal sustainability. These expert advisers were in a position of authority to advise on the reform trajectories and to negotiate with key stakeholders. Mexico, on the other hand, relied more on domestic resources and domestic experts in conducting these analyses. Technical analysis was critical in both national cases, but ultimately the policy impact depended on embedding these analyses in political strategies to advance adoption and implementation of the reforms.

Fourth, the reform teams adapted reform proposals when confronted with opposition in seeking politically feasible and acceptable policies. In Turkey, the gradual expansion of benefits and harmonization of different plans over the course of almost ten years eventually yielded a single, unified national insurance scheme. In Mexico, the reform team abandoned plans for a single, unified insurance plan early in the process. They then offered substantial federal funds to improve state health systems, which provided an incentive for states to agree to the legislative reform proposal in the Mexican Congress. This strategic sequencing of interventions was critical to incrementally move reform objectives forward.

This approach to analyzing the political economy of health financing reform expands on previous related literature in three ways. First, it focuses on the array of political dynamics and interests involved in seeing a policy through from design to adoption to actual implementation. Second, the approach goes beyond identifying specific stakeholder interests, institutional constraints, or veto players, to focus on how PEA can be used as a tool to develop political strategies for policy makers and practitioners. Third, the approach adopts a specific point of view related to how PEA can be used to advance reform. The approach and its application consider how a reform team or leader can practically navigate complex political economy dynamics to achieve reform objectives. In this way, it seeks to strike a balance between usability and comprehensiveness. There are some limitations to this approach, notably that it does not explicitly account for contextual factors, including the institutional settings in which reform is shaped. We make this tradeoff between abstraction and specificity in an attempt to characterize political contestations that we believe to be common to most settings globally. At the same time, we suggest that potential users of the framework draw on their contextual knowledge to adapt the ideas to local settings.

**CONCLUSION**

This article lays out an approach to incorporate political economy analysis and related strategies into the design, adoption and implementation of health financing reforms that move countries towards UHC. The Turkey and Mexico examples demonstrate the role of political economy factors in influencing feasible policy solutions that moved reform forward in both countries. There are limitations to generalizing from the two illustrative examples we presented. However, some lessons on political economy analysis do emerge for teams working to advance health financing reform (as we summarize in Table 1). As shown by these two examples, the political and the technical are closely intertwined. Just as politicians need to understand the technical implications of policy choices, technical experts and practitioners need to address the political implications of reform policies. Analyzing interests and points of contestation relevant to key stakeholder groupings serves to highlight the political economy factors relevant to specific policy objectives. Incorporating political economy analysis into health financing reform efforts, however, also requires strong leadership to create comprehensive reform teams that can effectively move countries towards UHC. While political strategies are influential in any health financing reform effort, reform proponents need to keep their ultimate objectives in mind to ensure that strategic compromises and sequencing decisions do not undermine overall policy goals. This strategic approach to health financing reform is a way to enable successful design, adoption and implementation of policy changes that move countries towards UHC.

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