



Political settlements and pathways to universal health coverage

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Abstract

With the recent ratification of Sustainable Development Goal Target 3.8, universal health coverage (UHC) has consolidated its position atop the global public health agenda. However, as a growing body of technical and political analysis reveals, uncertainties remain over the ability of all countries to achieve UHC, and the pathways they should take to get there. This paper reviews some of the existing political economy analysis (PEA) of UHC, before presenting political settlements analysis (PSA) as an alternative, yet complementary, approach. It outlines a model that links political settlement type to UHC progress via political commitment, policy pathways, funding and governance arrangements, and provides some hypotheses about how fast progress to UHC will be under different political settlement types. It also argues that UHC champions should adapt their ways of working to fit the political settlement, distinguishing between ‘government-supporting’, ‘government-substituting’ and ‘government-connecting’ strategies. It then presents case study evidence from six low- and lower-middle-income countries to help assess these claims. It concludes that, while the evidence of a relationship between political settlement and UHC progress is quite strong, the hypothesis about political settlement type and ways of working requires further research.

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Introduction

On 25 September 2015, the UN General Assembly ratified the 2030 Sustainable Development Goals (SDGs). As had been expected, the SDGs included a target (number 3.8) to ‘Achieve universal health coverage including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.’¹

As the culmination of a long campaign to make universal health coverage (UHC) the overriding goal of global health policy, Target 3.8 was greeted with enthusiasm by UHC advocates. Despite the upbeat mood, questions remain over whether or not UHC is economically and politically viable everywhere, and over how different countries should best attempt to make progress towards it. The World Health Organization (WHO) has recognised that the transition to UHC will be incremental, and has suggested each country’s path will be unique.² The mantra of uniqueness, however, provides scant guidance for policy-makers who might wish to understand different countries’ potential for UHC progress, or how best to advance it in different contexts.

Fortunately, a body of evidence is beginning to emerge on the nuts and bolts of implementation. There is also an emerging political economy literature, some of which focuses on the deep structural underpinnings of UHC, and some on the rather more fluid and contingent policy coalitions that surround it.

In this paper, we explore the potential of a variant of political economy called political settlements analysis (PSA) to add another, complementary, dimension. A political settlement is understood here as the balance of power and institutions that underlies the political order (Di John and Putzel, 2009; Khan, 2010; Laws and Leftwich, 2014), and PSA focuses on this balance to help explain the basic forms of political commitment that, at a very fundamental level, are likely to shape a country’s willingness and ability to adopt and effectively implement UHC reforms.

As such, PSA can provide a reality check on a country’s professed commitment to UHC and the ambitiousness of its efforts to achieve it. Further, it can provide some very broad pointers for the kinds of partners and ways of working UHC advocates should focus on in different types of country. And finally, it can provide a guide to the places in which policy-makers are most likely to find transferrable lessons.

We hope the paper will be of interest to three main audiences: first, UHC champions working in and with developing countries, especially those interested in the governance and politics of UHC; second, UHC researchers, especially those interested in the political economy of UHC;

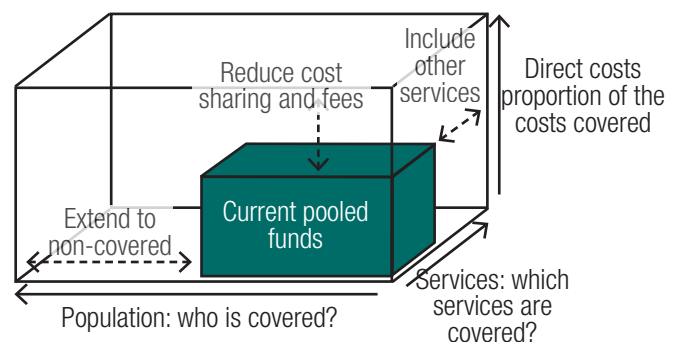
and third, the growing number of political settlements analysts, interested in seeing PSA applied to new fields.

We proceed by providing some background to UHC, an overview of some existing political economy studies of the topic and then a discussion of PSA. Here, we outline a causal model that links political settlement type to UHC progress, and also provide some hypotheses about how UHC champions ought to work best under different types of political settlement, distinguishing between ‘government-supporting’, ‘government-substituting’ and ‘government-connecting’ strategies. Using published sources, we then provide a discussion of progress towards UHC in Vietnam, Kyrgyzstan, Myanmar, the Democratic Republic of Congo (DRC), Indonesia and Bangladesh. We find broad support for the idea that UHC progress is typically stronger in ‘dominant’ political settlements, and some support for the idea that UHC progress is optimal when policy strategies are designed to fit political settlement type. On this second question, however, we argue that more research of a different design is required before confident conclusions can be drawn.

Background

The basic idea underlying UHC is that everyone should receive the health care they need without incurring levels of expenditure that would cause financial hardship (WHO, 2015). Progress towards universal coverage is typically measured on three dimensions: the services covered, the costs covered and the proportion of the population covered (WHO, 2010). This has become known as the ‘coverage cube’.³ Advocates of UHC regard it as ‘the single most powerful concept that public health has to offer’ (Chan, 2012). As

Figure 1: The WHO UHC cube



Source: WHO (2010).

1 <https://sustainabledevelopment.un.org/?menu=1300>

2 ‘There is no one-size-fits-all model. Countries must take into account their historical development, their health system capacities and also their ability, in terms of the speed and scope of coverage to move over time’ (Margaret Chan: <https://www.youtube.com/watch?v=s8w8RUZhV-8>)

3 For an attempt to improve on this cube, see Roberts et al. (2015).

we see below, progress towards UHC began to be made in Western European economies as early as the late 19th century. Here, growing industrialisation lent political salience to the demands of organised labour groups for more effective and accessible health services. These demands accelerated after World War II, concurrently with the creation in 1948 of the WHO and the formal incorporation of health assistance in post-war reconstruction efforts. By the mid-20th century, UHC systems in various forms had been established in a number of high-income countries, including Australia, Canada, Israel, Japan and New Zealand. Proceeding under the auspices of a very different political trajectory and ideology, the Soviet model of UHC pioneered certain practices of extending basic health services to widely dispersed populations following the communist advance into Eastern Europe (McKee et al., 2013: 40).

The 1978 Alma Ata conference and its accompanying declaration was the first international statement on the importance of primary health care (PHC) for all. A key milestone in the emergence of the ideal of UHC, the conference proceedings underscored the importance of public health as a driver of economic and social development and the responsibility of governments for the health of the general populace (Bump, 2010). The PHC strategy, backed by WHO and the UN Children's Fund (UNICEF) and signed by representatives from 143 countries, was defined as essential health care made universally accessible to communities at an affordable cost. The sweeping vision of the conference declaration of 'health for all' – which built on earlier progressive ideals on public health expressed by philanthropic organisations such as the Rockefeller Foundation – became condensed in the following decade into a more limited set of cost-effective interventions that could be implemented in low-income settings through the centralised bureaucracy of international aid organisations (Bump, 2010; Stuckler et al., 2010). Selective primary health care (SPHC) aimed to maximise the effectiveness of resources by focusing on specific diseases, creating the core of a fuller PHC system that could be built on over time (Bump, 2010).

Greater equity in health services has remained a consistent theme in global health discourse and has gained momentum in recent years. The 1993 World Development Report made the case for health spending as an investment, reaffirmed by the 2001 Report of the WHO Commission on Macroeconomics and Health. In addition, the Millennium Development Goals (MDGs) had a strong health emphasis, with three out of the eight goals focusing on health issues. The first decade of the 21st century has been called the 'golden age for health development', as financing for health tripled, new programmes – the President's Emergency Plan for AIDS Relief (PEPFAR) – and new institutions – the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Gavi Alliance – were founded (Chan, 2012).

Although much of this additional financing focused on 'vertical programmes' targeting specific diseases, the limitations of these programmes have fuelled a growing concern with 'health system strengthening' as a whole (Fox and Reich, 2015). In 2005, the WHO member states endorsed UHC as a central goal. The 2010 World Health Report focused on how UHC could be financed, and led to the concept gaining a higher profile. In 2012 the UN General Assembly adopted a resolution emphasising the responsibility of governments to 'urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services'. In 2014, Universal Health Coverage Day was established to mark the anniversary of the UN General Assembly resolution, with the support of a 'global coalition of more than 500 leading health and development organizations' led by the Rockefeller Foundation, the World Bank and WHO.

As the idea of UHC has grown in prominence, so has the amount of research around it. In the PubMed database, Bump (2010) finds that the phrase 'universal health coverage' appears in the title or abstract of papers three times in the 1980s, 16 times in the 1990s and 56 times in the 2000s. An annually updated annotated bibliography on UHC details 97 publications for 2014 and 98 for 2015 (Kickbusch et al., 2014, 2015). The 2013 World Health Report was dedicated to research around UHC, with chapters on building research systems, defining and measuring progress towards UHC and translating research evidence into policy and practice, while *Going universal*, a recent World Bank report, identified over 6,500 studies attempting to evaluate UHC impact (Cotlear et al., 2015).

Going universal itself summarizes the findings of research into 24 countries that have taken a 'bottom up' approach to UHC, deliberately addressing a history of inequality in the provision of and access to health care. It focuses on the technical nuts and bolts of different UHC programmes, including whether they are improving the service delivery 'supply-side', or enrolling individuals and households in 'demand-side' approaches, how to phase the expansion of coverage, how to enrol the non-poor, which services to add, how to improve health care provision, and how to strengthen accountability (Cotlear et al. 2015).

The political economy of UHC

While technical knowledge is essential to running an effective UHC programme, the international community has increasingly come to recognise that technical solutions to development problems will have little practical effect if they are not also attuned to political economy concerns (Fox and Reich, 2015). However, researchers and practitioners have only recently begun to apply political economy frameworks to global health issues. The bulk of the analysis of health in the developing world focuses on technical issues such as disease prevention and

policy design, with comparatively little attention paid to the political and economic dynamics that influence the adoption, implementation and on-going progress of health reforms (Participants at the Bellagio Workshop on Political Economy of Global Health, 2015).

Nevertheless, there are signs of a growing appreciation of the importance of political economy issues to health coverage among theorists and key international organisations. For example, although WHO tends to avoid entanglement in its members' domestic politics, it has acknowledged that progress towards UHC is at least in part political: 'All countries can do more to raise funds for health or to diversify their sources of funding, to reduce the reliance on direct payments by promoting prepayment and pooling, and to use funds more efficiently and equitably, *provided the political will exists*' (our emphasis) (WHO, 2010: 17).

Stuckler et al. (2010: 2) claim 'adopting UHC is primarily a political rather than a technical issue'. They argue successful transitions to UHC have all involved 're-framing the debate, identifying and creating political opportunities, and mobilizing resources' (ibid.: 4). According to Fox and Reich (2015), UHC reforms inevitably involve political trade-offs, conflicts and negotiations because these reforms redistribute resources in the health sector and across households. Similarly, Bump (2010: 40) argues that UHC is 'intensely political' because it involves 'a renegotiation of the social contract and changes who gets what and who bears financial responsibility'.

These more overtly political approaches to the analysis of health reform acknowledge that, in any given context, the current system of health financing can often be difficult to change, not just because of the technical or financial demands involved but also because any such change has implications for the interests of powerful stakeholders (WHO, 2010: 94). As the participants at a recent workshop on the political economy of health argue, 'Health system reform, including current efforts to move toward UHC, usually entails the allocation and redistribution of a society's resources, which creates winners and losers. It is thus a profoundly political and economic process' (Participants at the Bellagio Workshop on Political Economy of Global Health, 2015: 20). In particular, in moving towards UHC, questions arise over how to compel individuals, particularly wealthier individuals, to contribute to shared health financing pools when it may run contrary to their individual interests to do so (Reich et al., 2015). Moreover, introducing UHC reforms typically involves advocating on behalf of the poor and marginalised in society, who may lack effective political representation (WHO, 2010: 25).

In summary, then, making progress towards UHC means engaging with deeply political issues. First, government capacity to raise revenues has been the most significant factor in explaining reductions in the share of out-of-pocket (OOP) health spending over 1995–2009 (Fan and

Savedoff, 2012) and investing in government fiscal capacity to raise revenues is ultimately a political decision (Besley and Persson, 2013). Second, when people are incorporated into pooled funding arrangements – whether insurance schemes or tax-funded publicly provided care – these redistribute from the healthy to the sick and from the rich to the poor. Introducing mechanisms that involve taxes can be politically sensitive and will invariably be resisted by particular interest groups (WHO, 2010, 28). Third, improving the standards of care and service delivery is also a deeply political undertaking (Harris et al., 2013; World Bank, 2003). Finally, at the implementation stage, reforms for UHC in low-income countries often encounter the familiar political obstacles of weak institutions, poor infrastructure, deep-seated relations of patronage and rent-seeking and limited time horizons imposed by the electoral cycle (Fox and Reich, 2015: 18–21). The move towards UHC therefore demands both technical knowledge as well as pragmatic political strategies that are sensitive to the national political economy context.

Responding to this challenge, recent years have seen the emergence of a number of political economy studies of UHC and frameworks for understanding progress towards it. For example, Stuckler et al. (2010) put forward four key interrelated political economy factors that influence the trajectory towards UHC: individuals, institutions, events and context. Individuals advocating for UHC are more likely to find success if existing institutions are supportive of their efforts, if the wider political and cultural context is conducive to redistribution for health and if it is possible to take advantage of windows of opportunity. McKee et al. (2013) identify similar factors and also highlight the importance of organised labour and left-wing parties, adequate economic resources and an absence of societal divisions.

Fox and Reich (2015) provide a forward-looking framework organised around four stages in the policy cycle: the initial placement of the issue on the policy agenda, the technical design of the reforms, the legislative process involved in adopting the reforms and the implementation of the policy. Four variables influence policy at each of the four phases: interests, institutions, ideas and ideology. In order for UHC reform to make it onto the national policy agenda, a number of factors need to come together at the right moment, representing 'a convergence of an ongoing problem with a political window (occasioned by political and economic transitions) and an available policy solution' (ibid.: 1).

Indeed, most studies of the politics of UHC agree on the importance of contingent events that provide windows of opportunity to push forward reform. Such a window is often provided through a change in the political leadership, a political, economic or social crisis or a major exogenous shock. Such events can provide an opportunity for major social reforms by reshuffling political competition in ways that enable advocates to push for policy change. The precise nature of the window varies: financial

crises were the impetus for UHC reform in Indonesia, Thailand and Turkey; in Brazil it followed a period of re-democratisation; France and Japan undertook reforms during the reconstruction efforts post-World War II (Reich et al., 2015: 1).⁴

Another common theme is the importance of domestic political context. Bump (2010: 3) observes that all countries that have made substantive progress towards UHC have done so through ‘organic, domestic processes, which necessarily reflect local historical, cultural and institutional legacies’. The elevation of health reform on to the national political agenda clearly depends on the preferences of governments for health improvement as opposed to other activities (Participants at the Bellagio Workshop on Political Economy of Global Health, 2015). Although there are notable counter-examples, public health coverage is often regarded as a priority by governments with effective ties to labour groups and trade unions (McKee et al., 2013: 41).⁵ Broadly speaking, right-wing parties tend to support a more gradual expansion of health coverage based on insurance, whereas left-wing politicians tend to support a more immediate, far-reaching expansion of coverage as an expression of political ideology (Stuckler et al., 2010: 6). Fox and Reich (2015: 5) point out that the prevailing political ideology in a country also affects the degree to which the private rather than the public sector is used as the vehicle for health financing and service delivery.

The presence of democratic institutions appears to have some bearing on the political dynamics surrounding UHC reform, although authors are divided on their importance. According to Stuckler et al. (2010: 33), the experiences of Germany, the UK and South Korea all bear out the observation that democratic pressure on policy-makers can be an important factor in determining the allocation of tax resources for public health. On the other hand, Fox and Reich (2015: 7) contend that democratisation does not necessarily lead to greater probability of expanded health coverage through popular pressure from newly enfranchised voters. On the basis of the experience of health reform in Mexico, Korea and Taiwan, they assert that, although health reforms are often preceded by a transition to democracy, the actual expansion of UHC is typically led by elites and politicians rather than mass demands (see also Grindle, 2001).

A range of studies note that political struggles to establish UHC can also play out across different parts of government and different tiers of the public administration. WHO (2010: 35) acknowledges that many administrations, in both high- and low-income countries, still award low

priority to health in the allocation of departmental funds. Ministries of health therefore need to be equipped to negotiate with ministries of finance and planning in order to push for adequate resources (Borgonovi and Compagni, 2012; Fox and Reich, 2015; Stuckler et al., 2010).

Notwithstanding the significance of individual political leaders at both national and local level with the necessary vision and commitment, the support or opposition of specific interest groups and social movements can be the deciding factor in shaping the success or failure of UHC reforms. Key stakeholders tend to be drawn from the medical profession, organised labour, government officials, political parties, insurance and pharmaceutical companies, leading industrialists, the media and the general public.

Stuckler et al. (2010: 6) characterise the groups that support UHC as ‘challengers’ against those maintaining the *status quo*. They point out that one tends to find a typically informal coalition of medical, pharmaceutical and insurance stakeholders that is resistant towards publicly financed UHC. Moreover, in highly divided societies (along the lines of, e.g., ethnicity, religion, language or age), it is expected that the drivers of redistribution will be weaker and UHC reform will encounter greater resistance (McKee et al., 2013, 41; Stuckler et al., 2010: 33). Those groups in favour of public health financing tend to be drawn from trade unions, nursing and community health worker associations. Support for public redistribution towards health through taxation tends to be stronger when labour groups and representatives are well organised, where there are union representatives who understand the interest of impoverished groups and where those groups have access to public policy channels.

However, the political influence of organised professional associations of health workers can also complicate efforts to expand effective coverage. For example, research by Harris et al. (2013) has found that the dominance of organised and influential professional groups and health workers’ unions in Nepal has undermined efforts to improve access to qualified health workers in remote rural areas. Politically affiliated unions systematically facilitate transfers to preferred postings or further training in the Kathmandu Valley for their members. Patronage networks in human resource management thereby undermine the expansion of effective health services in the more remote areas of Nepal.

Reich et al. (2015: 2) use Turkey’s recent experience to illustrate the importance of managing the pressures that emerge from interest group politics in the drive to UHC. The government’s initial roadmap to reform involved

4 Stuckler et al. (2010: 22) point out that opportunities for social reform can follow not only from exogenous shocks but also from particular moments in the political or electoral cycle. In the US, for example, newly elected presidents are said to have a honeymoon period that makes it possible for them to push through contentious aspects of their campaign agenda.

5 The experiences of Mexico, Turkey and Ghana provide counter-examples to this generalisation. In Mexico, serious opposition to national health insurance came from the left-wing opposition Partido de la Revolución Democrática, whereas trade unions in all three countries were opposed to health coverage reform. We are grateful to Michael Reich for pointing out these cases.

identifying those interest groups likely to be opposed to it and developing an understanding of their motivations and potential effects on the political process. On the basis of this initial scoping exercise, strategies were developed to manage opposition from groups drawn from the civil service, trade unions and the social security and health sectors. At the same time, the government sought to increase public support for the reforms by doing away with the practice of holding patients to ransom for past-due hospital bills, by improving the facilities for patient care and by expanding emergency services. Additionally, they sought to undermine the support base of the existing health workers' association by establishing a new union along with pay-for-performance incentives.

Moving on to consider the pace and trajectory of UHC reform, it is expected that the number of veto players and veto points in the legislative process will be key factors in determining the way health reforms are adopted (Fox and Reich, 2015: 14). Veto points are the 'junctures in the legislative and policy design process where reform can be blocked' whereas veto players are the 'individuals or collective actors whose agreement is required to make a policy decision' (ibid.). When there is a large number of veto players, far-reaching policy changes are harder to achieve because of the greater potential for conflicts of interest. Where there is a high number of veto points, lobbyists and interest groups have more opportunity to influence the policy process. In these cases, an incremental, 'bottom-up approach' may be more feasible than rapid, systemic development imposed by government (ibid.: 14–15).

The politics of UHC is clearly complex, with a variety of ideas, actors, interests and institutions, not to mention contingent factors such as windows of opportunity contributing to whether or not UHC policies are adopted, how pro-poor they are and whether the transition to UHC is designed to be fast or slow.⁶ Drawing on the aforementioned political economy analysis (PEA) literature, Table 1 summarises some of the factors likely to enable and disable rapid progress to UHC. As we see in the next section, the interaction of these 'policy domain' factors with the deeper power relations of the political settlement combine to shape a country's progress to UHC.

Political settlements analysis and the study of UHC

PSA is a relatively recent political economy approach to the study of UHC. At the heart of PSA is the idea that a society's institutional structure and the policies that flow from it reflect the interests of powerful groups in society, echoing the insights of classical political economists and early 20th century elite theorists, including Marx, Mosca,

Pareto and Michels. One of the first traceable uses of the concept is in Joseph Melling's study of industrial capitalism and the welfare state (1991), while it was first used in a development studies context by Mushtaq Khan (1995), to explain why similar institutions perform differently in different developing countries. The idea subsequently caught on in the development community, with several notable contributions (Di John and Putzel, 2009; Hickey, 2013; Jones et al., 2012; Khan, 2010; Laws, 2012; Laws and Leftwich, 2014; Levy and Walton, 2013; Lindemann, 2008; Parks and Cole, 2010; Rocha Menocal, 2015; Whitfield and Therkilsden, 2011). Much of this work has been funded by aid agencies, and some has found its way into policy documents and, to a lesser extent, programming. From 2015, the UK's Department for International Development (DFID) began to fund a Political Settlements Research Programme at the University of Edinburgh.⁷

As this is an evolving field of study, there is considerable variation in the way different authors use the term 'political settlement'. Di John and Putzel (2009: 4) describe it as 'the balance of power between contending social groups and social classes, on which any state is based'; an early DFID paper (2010: 22) refers to the 'expression of a common understanding, usually forged between elites, about how

Table 1: Enabling and disabling factors in the transition to UHC

Enabling factors	Disabling factors
Political transition or crisis	Strong coalitions of medical, pharmaceutical and insurance stakeholders
Left-wing or populist government	Politically weak health ministries
Strong labour movement	Large number of veto points in the political system
Strong presence of pro-UHC 'technopols'	Relatively heterogeneous social structure
Strong international health actor presence	
Relatively homogeneous social structure	

power is organised and exercised'; whereas Khan (2010: 4) calls it 'a combination of power and institutions that is mutually compatible and also sustainable in terms of economic and political viability'. For Levy (2012: 5), it is 'the set of institutional relationships through which a

⁶ Note that 'fast' is not necessarily 'better'. We can only assume this in contexts where the policies are likely to be well designed and implemented.

⁷ <http://www.politicalsettlements.org/>

country restrains violence'. Despite the variation, all these authors use the term to imply a condition of minimal political stability, as opposed to pervasive anarchy or civil war: a political settlement exists when powerful groups have agreed to stop fighting and pursue their aims through peaceful politics. There is also an explicit focus on the role of economic rents in securing the conditions for political stability; in other words, political settlements are formed and peace reigns when a society's institutions distribute rents in a way that is acceptable to powerful groups.

The identification of political settlements with peace and political stability has led some authors to equate them to peace deals or agreements. Laws (2012), however, argues convincingly that, although political settlements are typically inaugurated by discrete events such as peace deals, elite pacts or regime change, they are better understood as on-going political processes. He argues further that, while some political settlements may be characterised by a common understanding of the rules of the game, it is more normal for them to involve on-going bargaining, manoeuvring and negotiation. This takes place not just among elites but also between elites and their followers in wider society. Laws and Leftwich (2014: 1) conclude that PSA is about understanding 'the formal and informal processes, agreements, and practices that help consolidate politics, rather than violence, as a means for dealing with disagreements about interests, ideas and the distribution and use of power' (see also Lavers and Hickey, 2015).

PSA comes bundled with a number of assumptions. The first is that, in the absence of a political settlement, sustainable or inclusive development is impossible. A second is that the way societies solve the problem of violence, in other words the nature of the political settlement, creates powerful path dependencies for future development, strongly influencing the ability of the state to raise revenue through taxation, to hire and fire competent civil servants, to privilege certain sectors for economic development or to advance the position of different social groups, among other things. A third is that political settlements tend to evolve gradually until such a time as a tipping point is reached, after which change can be dramatic and discontinuous. A fourth is that institutions and policies are most likely to take root or be implemented effectively where they are aligned with the underlying political settlement.

From our discussion so far, it should be apparent that PEA and PSA share in common the starting premise that, in order to understand development outcomes and the varying trajectories of change in different countries, we must go beyond formal policies, structures and institutions and look to more fundamental political dynamics. Both schools maintain that development, and political change

more broadly, is not only about government capacity or technical expertise in policy design, but is also a function of power relations and the structure of ideas, interests and incentives between individuals and groups. PSA typically pays greater attention than other types of PEA, however, to the *underlying distribution of power* that shapes the trajectory of political and economic processes. By this, we mean PSA is more centrally concerned with understanding the formal and informal power relationships between elites, and between elites and their respective groups of followers.

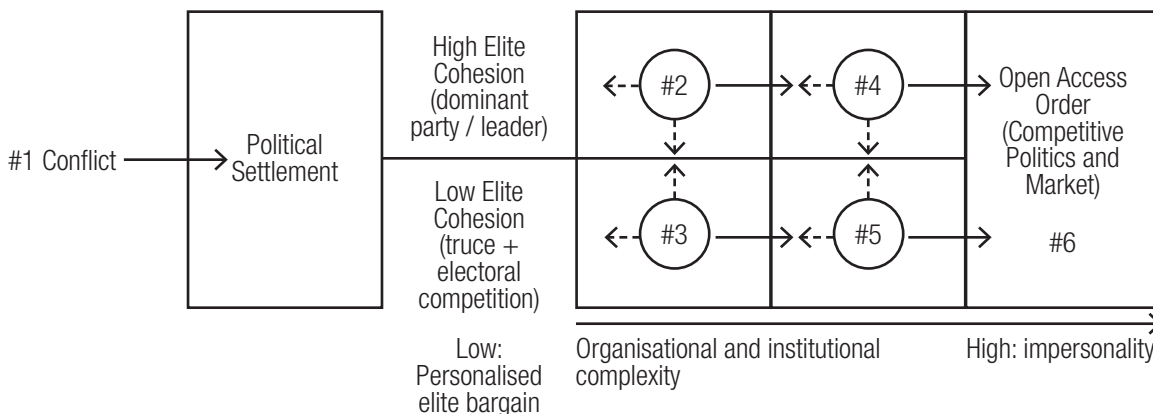
PSA has also generated a number of typologies and theories that hypothetically link different political settlement 'types' to differences in development outcomes, or, to be more precise, some of the more proximate causes of development outcomes, in particular political will and state capability. This has permitted further hypotheses about such things as how successful different types of political settlement are likely to be in implementing development policies, and also what kinds of policies, especially governance policies, are likely to work best where.

To date, most PSA work has taken the form of small-n comparative case study analysis, in which cases are chosen on the independent, political settlement variable and analytical narratives are told that try and link the political settlement to political will, state capability, the success or failure of various policy initiatives and, ultimately, development outcomes (Chopra, 2015; Hickey et al., 2015; Kelsall and Heng, 2016; Khan, 2010). In the main, PSA has been used here as an interpretive framework to help us understand how different countries have achieved the development outcomes they have. At the same time, and to the extent that the narratives confirm the hypotheses the typologies generate, PSA can be said to have predictive power. In principle, policy-makers can extrapolate from what has worked well in countries with one political settlement type and apply it to countries with similar types, and vice versa. While social complexity ensures there is no guarantee this will work, PSA can at least help policy-makers place their first bets (Kelsall, 2016).⁸

PSA remains a relatively young field in considerable ferment, throwing up new models and modifications in response to intellectual debates and research results. A major centre of gravity is the Centre for Effective States and Inclusive Development at the University of Manchester (ESID). Research for this paper, for example, began using a model created for ESID by Brian Levy and Michael Walton to help explain the politics of service provision (Levy and Walton, 2013). As the research was in progress, Tom Lavers and Sam Hickey released a new paper using a different political settlements framework inspired by Mushtaq Khan and applied to the politics of social protection, including UHC (Lavers and Hickey, 2015).

⁸ To our knowledge, nobody has yet attempted to study the results of using PSA in this manner; nor have there been many attempts to apply PSA to a large dataset. For an exception, see Levy (2014). Unsurprisingly, nobody has used PSA to try and predict the future in the manner of a Popperian falsification experiment.

Figure 2: Levy's developmental trajectories



Source: Levy (2012).

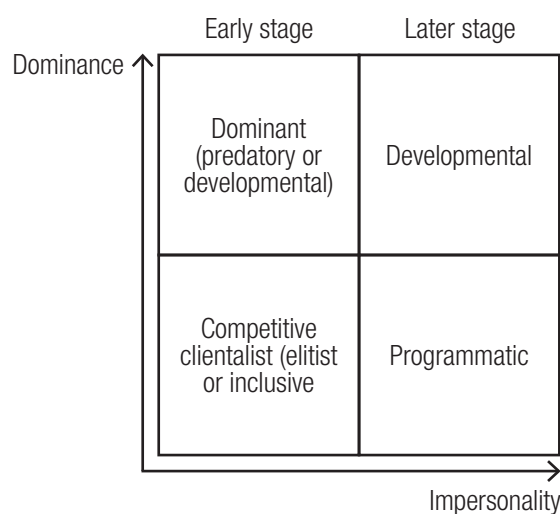
Shortly thereafter, David Booth released another typology, which was later adopted and extended by Kelsall (Booth, 2015; Kelsall, 2016). In this paper, we focus on the Levy typology, with which we started our work and which drove our case selection, while enriching the analysis with insights from the other approaches.

The Levy framework⁹ is inspired by the work of Douglass North et al. on ‘limited’ and ‘open access orders’. For North et al., society’s natural condition is violence, but some societies solve the problem of violence by creating ‘limited access orders’ (LAOs): ‘personalised elite bargains’ in which powerful groups or elites are granted privileged access to land, markets, employment, tax revenues and the like, inducing them to support the political order. According to North et al. (2009, 2013), most societies in human history, as well as most contemporary developing countries, are LAOs. They are to be distinguished from ‘open access orders’ (OAOs): ‘impersonal’ societies in which peace is underpinned by the openness of the political order and the political subordination of the military, and in which the main rents are generated via processes of technological innovation and creative destruction, as occurs in most advanced industrial countries. North et al. contend that transitioning from LAO to OAO status involves increasing organisational complexity via the progressive *impersonalisation* of institutions. Levy has added to this the notion that there are different trajectories from LAO to OAO, based on the degree of elite cohesion in the polity. In high-cohesion settlements, a particular leader, organisation or party is *dominant* in the sense of having consolidated its grip on power. In low-cohesion settlements, the elite is divided but has agreed to *compete for power* peacefully through elections. This can also be expressed as a measure of the disparity in violence

potential between the leaders and their opponents: in dominant settlements, it would take an enormous effort and considerable sacrifice for opponents to remove the leaders from power; in competitive settlements, this is much easier (Levy, 2014).

Levy argues that different political settlement types have different governance characteristics, and hypothesises that the transition from LAO to OAO status will be smoothest when development policy ‘works with the grain’ of these. In other work, Levy and Walton (2013: 12) refine the approach to include additional types at the early, personalised stage of development: ‘dominant-predatory’, ‘dominant-developmental’, ‘inclusive competitive clientelist’ and ‘elitist competitive clientelist’ (see Figure 3).

Figure 3: Levy's political settlement types



Source: Adapted from Levy and Walton (2013).

⁹ This framework has actually been through a number of iterations (While drawing on all three, for simplicity’s sake we refer throughout to ‘Levy’).

In dominant settings, the leader or leadership group (the principal) has a great deal of discretion over the performance of the bureaucracy. In consequence, where the leadership is inclined for one reason or another towards predation, public sector performance is likely to be poor. However, ‘on occasion, dominant political leaders can emerge with a strong developmental orientation. In such settings, even at an earlier stage of the broader transition from personalised to impersonal institutions, the potential may be high for unexpectedly strong bureaucratic performance’ (Levy, 2012: 8, 2014).

In competitive settings, the challenges are likely to be different. By definition, the polity is more open, but the performance of the public bureaucracy is likely to be more problematic:

[...] whereas along the dominant trajectory, there exists the possibility (though by no means the certainty) of the early emergence of a political leader committed to strong public sector performance, in early stage competitive settings, the centrality of politics implies that bureaucratic performance generally is likely to be poor: Political time horizons are likely to be short, so there is little incentive for political leaders to invest in the long-term task of building bureaucratic capability. Moreover, with no one faction having a clear monopoly of power, there are unlikely to be clear signals as to how to deploy whatever bureaucratic capability may be available [...] decisionmaking is constantly contested; narrow interest-seeking and even individual corruption are ubiquitous; political incentives to supply public goods are limited. Conflict continually threatens to spiral out of control (Levy, 2012: 9–10, 2014).

In other work, Levy and Walton (2013: 19) advance several hypotheses about what types of governance arrangements work best under different types of settlement, drawing a basic distinction between what they call ‘hierarchical’ and ‘multi-stakeholder’ governance, where the former involves classic top-down principal-agent relations and the latter refers to a situation in which ‘there is a politically salient coalition of external stakeholders that is working in concert with an organization’s management...with a mutual interest in pursuing the organization’s goals’. They hypothesise that progress in dominant-developmental settings is most likely to come from technocratic initiatives, together with improved stakeholder involvement ‘to help solve internal agency problems’ (ibid.: 20). In dominant predatory settings, little generally can be done, although even here there may be areas where the leadership has an interest in better developmental performance, in which ‘islands of effectiveness’ might be built. In competitive clientelist settlements, progress is most likely to be made ‘through external stakeholder mobilisation, political connectivity and links to internal organisational stakeholders’ (ibid.: 21).

Levy’s work is complemented by that of Lavers and Hickey (2015: 9). The latter hypothesise that, in potential developmental coalitions (which overlap with Levy’s ‘dominant-developmental’ settlements), ruling elites are likely to be under little pressure from lower-level factions, and may resist international and domestic attempts to bring about more progressive social policies which, via higher taxation demands, would reduce their enjoyment of rents. In other situations, potential developmental coalitions may decide to initiate the expansion of social protection, ‘as a means of securing the acquiescence of groups that might otherwise threaten political stability or economic growth in the future or to undermine political opponents’ (ibid.).

By contrast, competitive clientelist coalitions (overlapping with Levy’s ‘competitive clientelist’ category) are likely to face strong redistributive pressures from lower-level factions, which may lead to an early commitment to UHC but result in policies targeted at those groups that are better organised, and more of a political nuisance, than those most in need of social protection.

The nature of the political settlement will also affect the state’s implementation capacity. In potential developmental coalitions, the ruling coalition is likely to have a long time horizon, and thus the ability to carefully design policies that will pay off in the medium and long term. By contrast, competitive clientelist settlements are more likely to create *ad hoc* policies that deliver quick benefits to politically important groups, especially around election time (Lavers and Hickey, 2015: 10). In settlements where there is little elite interest in social protection, transnational actors, particularly in aid-dependent countries, may play a greater role. However, ‘it seems unlikely that social protection will become institutionalised, as opposed to merely project-based, in contexts where there is little to no national elite commitment’ (Lavers and Hickey, 2015: 10). Moreover, in ‘weak dominant party’ (akin to Levy’s dominant-developmental but with strong internal factions) and competitive clientelist settings, policy implementation is likely ‘to become heavily politicised and distributed according to the logic of patronage, rather than according to needs or rights’ (ibid.).

Lavers and Hickey also discuss the role ideas have in underpinning political settlements and in influencing policy agendas within political settlements. Potential developmental coalitions, they argue, are likely to be grounded in strong ideological orientations, and therefore more resistant to external ideas. Social protection agendas, including UHC, will need to be painted in congenial ideological colours to gain acceptance. By contrast, in competitive settlements, social protection may need to be framed to appeal to broad and diverse constituencies, slowing the process of policy adoption and implementation. Alternatively, ruling coalitions in competitive clientelist or weak dominant party settlements may adopt external

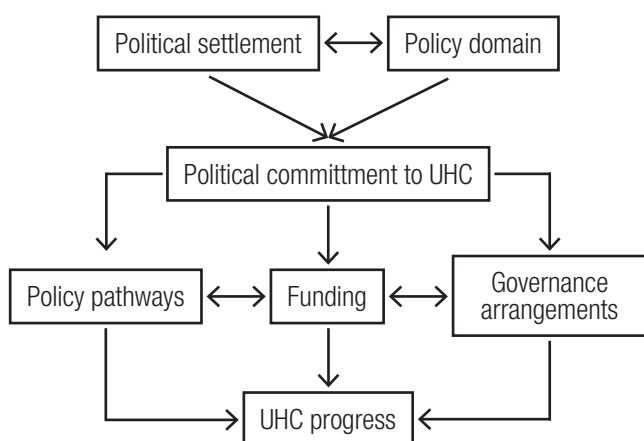
policy ideas as a means of securing funding for rent distribution, making ideological fit less important.

Understanding whether and what type of social protection policies, or any other policy for that matter, a country ultimately adopts involves attention to what Lavers and Hickey (2015: 18) call ‘policy coalitions’, which help explain how policy processes play out in specific *policy domains* within particular political settlements. Where social protection is deemed ‘key to political stability or thick enough with rents to support the distributive requirements of the ruling coalition’, the interests and ideas of the ruling coalition are likely to be strongly reflected in social protection policies. Where, by contrast, it is deemed marginal to regime survival, foreign donors will have greater scope to drive policy content (ibid.).¹⁰

Political settlements and UHC progress: a model

Summarising the discussion above, Figure 4 sets out what we believe to be the main variables in the causal chain linking the political settlement to UHC progress.

Figure 4: Political settlements and UHC progress



In this causal chain, *the political settlement* is the underlying balance of power and institutions on which the political order is based. *The policy domain* is the realm of ideas, interest groups and coalitions concerned specifically with health. These two variables interact to drive a certain level of *political commitment to UHC*, which manifests in a variety of *policy pathways* to UHC, for instance whether to go with a taxation- or insurance-based model; the choice of which population groups to incorporate and when; the composition of the service package; and the mix of public, private and non-state provision. It also drives a certain

level of public *funding*, and also particular *governance arrangements*, such as how insurance and exemption schemes are managed and how service providers are monitored and held accountable – all of which will affect implementation, and ultimately *UHC progress*.

It is important to note that UHC champions, whether in government, civil society or the development community, have little to no influence over the political settlement itself, at least in the short term. They *are* able to influence UHC outcomes, however, through the policy domain. Knowing how the political settlement affects political commitment to UHC should help them design *strategies* that result in policy pathways, funding solutions and governance arrangements that not only complement each other but also either *build on the strengths* of the political settlement or *help mitigate some of its weaknesses*. The journey to UHC is then likely to be as fast and smooth as possible, given the nature of the political settlement and other forces in the policy domain. Very simply, we categorise these different strategies as ‘*government-supporting*’, ‘*government-substituting*’ and ‘*government-connecting*’.

Building on this, Table 2 sets out some hypotheses about how political settlement *type* affects political commitment to UHC at early stages of development, the most likely policy pathway to UHC under the circumstances, the adequacy of funding arrangements (for the poor) and the probable effectiveness of public governance. On the basis of these, the sixth column suggests some policy *strategies* that actors in the policy domain might profitably adopt, either to build on the strengths of the settlement or to mitigate its weaknesses. The next column provides some predictions about strength of UHC progress under different settlement types, with the rider that progress will be modified by the nature of the policy domain.

As mentioned earlier, PSA can be used as an interpretive framework to provide rich and nuanced analytical narratives about how countries get the development results they do. Here, however, we reduce that richness to a set of simple variables for the sake of creating a relatively parsimonious theory that can generate clear hypotheses. Political settlements are reduced to Levy’s four early-stage types: *dominant-developmental*, *dominant-predatory*, *elitist competitive clientelist* and *inclusive competitive clientelist*. Policy pathways are reduced to those that are, broadly speaking, *state-centred*, *market- and non-state actor-dominated* and *pluralistic*. Funding can be *adequate* or *inadequate*. Governance can be *effective* or *ineffective*.

Here, then, are our hypotheses. In dominant developmental settlements, the government is likely to be strongly committed to UHC (once it has accepted the need for it) and to have relatively high funding capabilities

10 Booth (2015) and Kelsall (2016) have recently attempted to realise PSA’s potential further, first by undertaking a conceptual cleaning-up exercise and second by trying to marry PSA with recent ideas about ‘thinking and working politically’ (Leftwich, 2011; Wild et al., 2015). Although we believe this framework may ultimately supersede the other two, it is currently less well developed than they are. We do, however, draw on some of its insights in our hypotheses linking political settlement type to UHC strategies.

and effective governance arrangements. It should be able to 'own' UHC policies and take the lead in designing and implementing them. That does not mean it will have enough expertise or funds to do everything it wants, or that it will get things right all of the time. The best-fit strategy for UHC champions in this context is likely to be *government-supporting*: providing technical support and funding for what will be a predominantly state-centred pathway, even if elements of non-state provision and financing remain. In these circumstances, progress to UHC should be strong.

In dominant-predatory and elitist competitive clientelist contexts, the government is likely to have weak commitment to UHC and little ability to effectively fund or govern it. State structures will be highly dysfunctional. The best-fit strategy for UHC champions in this context will be *government-substituting*. Champions should attempt to build 'islands of effectiveness' in the administration that can accomplish the absolute essentials required of a public health bureaucracy, while substituting much state provision and financing with non-state and market solutions, often in an ameliorative way. UHC progress is likely to be weak to moderate.

In inclusive competitive clientelist contexts, the state may have a strong ostensible commitment to UHC and some financial capability (fluctuating, probably, with the electoral cycle), but policy design and adoption is likely to be diluted or undermined by vigorous interest group politics, and implementation is in constant danger of being undermined by weak or chaotic governance and patronage pressures. Parts of the state may work well where committed leaders, managers and service providers have been able to insulate themselves from or find a way of working with the politics around them, but many parts will work poorly. At the same time, the more pluralistic political context is likely to imply a more diverse, although not necessarily more effective, range of health actors in the private sector and civil society. We describe the best-fit strategy for UHC champions working in this context as *government-connecting*. What we mean by this is a more

politically savvy role, whereby UHC champions help connect the more effective parts of the state and polity with the more effective elements of the market and civil society, supporting local ownership and multi-stakeholder initiatives that can trump patronage politics and create solutions that work for the poor. UHC champions, especially external players, may need to be especially experimental, adaptive and politically smart here, with a greater role in convening actors around UHC issues, building coalitions and brokering solutions, rather than supplying solutions themselves.¹¹ In these circumstances, UHC progress should be moderate.

We also need to say something about the policy domain. Policy domains vary greatly, but, when it comes to understanding UHC progress, what is most important for us to know is whether the balance of forces is, very broadly speaking, *enabling* or *disabling*. There may be forces in the political settlement pushing for a fairly rapid transition to UHC, but if the balance of power in the policy domain is disabling, these may get bogged down. Conversely, there may be no strong commitment to UHC from the political settlement, but an enabling politics of the policy domain may induce a reasonable degree of progress nonetheless. Whatever the inherent balance of forces in the policy domain, our argument is that, if UHC champions adopt the best-fit strategies identified above, progress towards UHC will be easier.

By now we should be able to see some of PSA's distinctive contribution. Where existing political economy approaches have tended to focus either on the long-term structural drivers of UHC or else on the political dynamics of policy adoption, PSA approaches provide something that is complementary, yet slightly different. In short, they provide an insight into some fundamental features of political commitment that are likely to condition progress towards UHC. Further, they provide a means of categorising different countries and providing pointers to the broad policy strategies UHC champions should adopt in different places.

11 Note that, in all political settlements, UHC champions should be politically smart and flexible and should eschew blueprint approaches, but in competitive clientelistic settlements this is especially so.

Table 2: Political settlement types and UHC progress

Political settlement type	Political commitment to UHC	Policy pathways	Funding	Governance	Good fit policy strategies	UHC progress
Dominant (developmental)	Strong, if aligned with the ideas and interests of the dominant group	State-centred role feasible though not necessary	Adequate, though can be improved with donor supplements	Moderate to highly effective	Government-supporting	Strong, provided policy domain is enabling
Dominant (predatory)	Weak, although may be adopted for appearance's sake	Non-state-/market-dominated preferable	Highly inadequate, so will need to be donor-dominated	Ineffective	Government-substituting	Weak to moderate
Eliteist competitive clientelist	Weak, although may be adopted for appearance's sake	Non-state-/market-dominated preferable	Highly inadequate, so will need to be donor-dominated	Moderately effective for elites but not the poor.	Government-substituting	Weak to moderate
Inclusive competitive clientelist	Pressures for early adoption of UHC policies, but more pluralistic polity means commitment likely to waver, or provision to be captured by patronage	Pluralist strategies preferable	Fluctuating, so may need to be donor-supplemented	Ineffective to moderately effective	Government-connecting	Moderate, although may be improved or worsened depending on policy domain. Likely to plateau somewhat later than in dominant predatory and eliteist competitive clientelist settlements

Country case studies

In this section, we set out six case studies of low- and lower-middle-income countries. We selected cases on the independent variable of political settlement type, the aim being to choose a diverse selection of types. Working with what we already knew about how ‘dominant’ the ruling parties or coalitions were in these countries, together with their basic orientations, we chose two countries we felt would be dominant-developmental (Vietnam and Kyrgyzstan), two that were dominant-predatory (DRC and Myanmar) and two that were competitive clientelist (Bangladesh and Indonesia).¹² On closer inspection, Kyrgyzstan and Myanmar appeared to have experienced different types of political settlement over the past two decades, Kyrgyzstan moving from dominant-developmental to competitive clientelist and Myanmar from dominant-predatory to dominant-developmental. Bangladesh has also become more ‘dominant’ of late, although for most of the period under consideration it has been competitive. The studies were conducted using desk-based methods, with materials identified in the UHC annotated bibliographies (Kickbusch et al., 2014, 2015), supplemented by literature searches on Google and Google Scholar. Budgetary constraints prevented a more in-depth trawl of the literature and country visits. Nevertheless, for most countries we felt we were able to build a reasonable picture of the political settlement and the politics of the policy domain, and how these interacted to create a certain degree of political commitment to particular UHC pathways, governance arrangements and funding, as illustrated below. In a later section we also provide a quantitative analysis.

Vietnam

The Vietnamese political system is characterised by an authoritarian one-party state under the control of the Communist Party. Political opposition is not tolerated and there is an absence of independent civil society organisations. There have been no serious challenges to Communist Party rule since 1975, and the leadership group has a dominant grip over the polity. Its orientation is also to a large extent developmental, recognising that its continued legitimacy rests to a large degree on delivering benefits to the mass of the people.

In the 1970s and early 1980s, a fully subsidised public health system was part of this bargain. But, in the face of economic stagnation from the late 1980s, Vietnam began experimenting with reducing public spending and encouraging market reforms to stimulate private sector growth. The first decade of what were called the Doi Moi reforms, from the late 1980s to the mid-1990s, saw a drastic reduction in central government spending on

Table 3: Political settlement types, countries and UHC progress

Political settlement type	Country
Dominant-developmental	Vietnam
Dominant-developmental > competitive clientelist	Kyrgyzstan
Dominant-predatory	DRC
Dominant-predatory > dominant-developmental	Myanmar
Competitive clientelist > dominant	Bangladesh
Competitive clientelist	Indonesia

hospitals and the introduction of user fees, drug sales in public facilities and private medicine (World Bank, 2009).

Since economic recovery in the mid-1990s, however, there has been a greater emphasis on service delivery and the passage of bold UHC reforms, facilitated by ‘strong national ownership, sustained political commitment and leadership, and active legislative regulation’ (World Bank, 2014b: 6). With the launch of its national health insurance programme in 1993, Vietnam’s health sector evolved from a government revenue-based system to one based on multi-source financing, and successive reforms have driven undeniable progress in expanding health coverage since then. The scheme initially covered specific groups employed in the formal sector, including government officials, state employees and the staff of foreign invested companies, and certain social categories such as war veterans and their dependants (Forsberg, 2011). In 2003, a Health Care Fund for the Poor (HCFP) was created, which was later merged with the national insurance programme in 2009. By 2010, nearly 60% of Vietnamese had health insurance, up from 10% in the early 1990s, and OOP spending had fallen to below 50%. In 2012, the government approved a roadmap to UHC, with a goal of achieving 70% coverage by 2015 and 80% by 2020 and of reducing OOP payments to less than 40% of total health care spending by 2020. The government has now expanded health coverage to approximately 90% of the poor and 60% of the near-poor through state subsidies and financial protection (World Bank, 2014b).

Nevertheless, according to Forsberg (2011), the Vietnamese government still regards public health as a cost rather than an investment. Despite the huge strides towards UHC, it remains the case that access to health care in Vietnam for many patients depends on their ability to pay higher prices in the context of health institutions governed by informal fees. In Levy’s terms, Vietnamese

¹² Note that we did not have enough information to distinguish between ‘elitist’ and ‘inclusive’ competitive clientelist countries.

Table 4: Demographic and health financing data, 2013–14*

	Bangladesh	DRC	Indonesia	Kyrgyzstan	Myanmar	Vietnam
Demographic and health data						
Population	159.1m	74.9m	254.5m	5.8m	53.4m	90.7m
Life expectancy at birth	71	58	69	70	66	76
Maternal mortality ratio (per 100,000 live births)	188	717	133	77	184	54
Mortality rate, under-5 (per 1,000)	39.5	101.7	28.2	22.6	51.7	22.3
Prevalence of HIV, total (% of population aged 15–49)*	0.10	1.00	0.50	0.30	0.70	0.50
Health financing data						
GDP per capita (current \$)	954	414	3,624	1,282	1,107	1,909
Health expenditure per capita (current \$)	32	16	107	87	14	111
Health expenditure, total (% of GDP)	3.73	3.51	3.07	6.67	1.77	5.95
Health expenditure, public (% of GDP)	1.31	1.86	1.20	3.94	0.48	2.49
Health expenditure, private (% of GDP)	2.41	1.64	1.87	2.73	1.29	3.46
OOP health expenditure (% of total expenditure on health)	60.23	32.70	45.81	36.36	68.20	49.41

Note: *Health data are for 2014, financing data for 2013.

Source: World Development Indicators.

health institutions appear to operate according to highly personalised norms. According to Forsberg (2011: 6), ‘uncontrollable informal fee arrangements exist at all levels of healthcare services in the form of bribes or paying commissions to cover the service costs and salary deficiencies of medical staff’. Insured patients are often required to pay ‘envelope costs’ to medical staff to access the services to which they are entitled free of charge.

In addition, the commercialisation of health services combined with pervasive corruption has allowed pharmaceutical companies to profit in ways that undermine coverage. The drug market in Vietnam has been dominated by state-owned enterprises operating a monopoly, which forces community health centres to purchase supplies from them. Pharmaceutical companies are able to lobby or pay

bribes to ensure their products are included on official insurance lists. Drug prices are often then increased by upwards of 30% over the market prices and doctors are encouraged to overprescribe medications and laboratory tests. The prevalence of ‘kick back’ payments from pharmaceutical distributors to medical staff perpetuates the abuse of medical practices (Forsberg, 2011). In addition, although the health insurance programme has been nominally opened up to the informal sector, enrolment remains low at 10% of the population group (Vietnam Ministry of Health, 2011; World Bank, 2014b).

Despite these problems, our analysis of the data indicates that, since 2005, the country has achieved rising service coverage with falling – though still high – OOP expenditure, and now appears well on course to achieve

its 2015 health coverage target. Vietnam therefore displays some contradictory trends. On the one hand, the success of the government in achieving progress in some key areas of health coverage and service delivery matches the performance that would be expected from a country with a dominant developmental political settlement. However, as might be expected in an 'early stage', personalised settlement, problems of rent-seeking and corruption remain, which retard somewhat the progress to UHC, especially with respect to reductions in OOP spending.

Kyrgyzstan

Kyrgyzstan, also known as the Kyrgyz Republic, declared independence from the Soviet Union in 1991 under the leadership of President Askar Akayev. Head of a dominant party, Akayev was able to withstand various challenges to his rule, before being toppled from office in 2005's 'Tulip Revolution', animated by concerns about corruption and vote fraud. In 2010, Akayev's successor, Kurmanbek Bakiyev, was also swept from power. Since 2011, Almazbek Atambayev has led a turbulent parliamentary republic. From 1991 to 2005, then, Kyrgyzstan is best described as a (weakly) dominant settlement, which switched to another weakly dominant settlement in 2005. Both, as we shall see, appear to have been at least partially developmental. After 2010, the settlement appears to have become more genuinely competitive, with hard-fought and comparatively fair parliamentary elections in 2015 (Marat, 2012; Standish, 2015).

As with most other Central Asian republics of the former Soviet Union, Kyrgyzstan was blessed at independence with a much more highly developed health sector than would be expected for its income level. Independence and the switch to a market economy disrupted this system, but, early on in his rule, President Akayev, supported by influential interest groups in the health sector, made health financing reform a priority.

The Manas plan, implemented between 1996 and 2006, and the Manas Taalimi programme, 2006 to 2010, redesigned the financing and delivery of health care with a focus on primary care, maternal and child health and communicable and non-communicable diseases. The Kyrgyz State Guaranteed Benefits Package (SGBP) was introduced as part of the reform process and is regarded as a successful example of a UHC initiative in the context of a low-income transition economy. The SGBP is available to all citizens and includes a basic set of health services that is publicly funded. All citizens are entitled to free primary and emergency care while referral care carries a flat co-payment with various exemption categories (World Bank, 2013).

The plan has benefited from consistent presidential support, effective leadership in the health sector, and strong top-down governance combined with a culture of accountability in decision-making (Balabanova et al., 2011). Although much of Kyrgyz public bureaucracy and politics has been described as 'clannish', pockets of the

health ministry have been insulated from the instability of the wider political settlement, as restrictions on firing civil servants have allowed key health system personnel to remain in post to oversee the reform process in the long term (ibid.).

A second notable feature of the reforms is that they have been carried out incrementally over an extended period of time, with changes being piloted in one locality before gradually being implemented nationally. For example, the first health insurance project was started in Issyk-Kul oblast in 1994, and full implementation of the Single Payer reform did not take place until almost a decade later after a number of programme changes (Falkingham et al., 2010: 436).

Finally, successive governments have pursued multi-stakeholder engagement, effective donor coordination and strong partnerships with non-governmental organisations (NGOs) and international organisations. From an early point in the reform process, the Manas programme has been the umbrella project for all the various actors in the health sector, which has meant that their activities have focused on achieving the same set of goals.

Today, the country provides a higher coverage of a range of basic health services than comparable low- and lower-middle-income countries and there is only a negligible difference between the rich and the poor in terms of the utilisation of PHC and hospital services. The reform process has led to a marked downward incidence of catastrophic health payments (ibid.). According to the World Bank (2013), in 2001 11% of patients who needed care did not seek it for reasons related to finance or distance; this dropped to 3.1% in 2006.

Democratic Republic of the Congo

The political settlement in DRC bears all the hallmarks of the dominant predatory model identified by Levy and Walton (2013), with the substantive orientation of the settlement driven by the rent-extracting motives of elites. The practice of political office being used for personal gain became entrenched during the long regime of Mobutu Sese Seko, who ruled the country as a personal dictatorship from 1965 to 1990, and has persisted through the transition to democratic rule and the current, electorally dominant government of Joseph Kabila (USAID, 2012). Patrimonialism and the capture of state resources for private accumulation of wealth are central to the DRC settlement; corruption is 'not so much an affliction of the Congolese system as it is the system itself' (USAID, 2012: 22; Waldman, 2006). A more recent trend is for political power to become increasingly concentrated in the executive branch of government, which further facilitates corruption and rent-seeking, with predictable consequences for state commitment to public service delivery. In addition, although Kabila faces strong factional challenges from excluded elites, opposition political parties in DRC are for the most part dominated by an individual politician without a clear political agenda. The result is that 'competition of ideas and responsiveness of government

to the people are not part of political culture and political practice in the DRC' (ibid.: v).

Unsurprisingly, the result has been a lack of clear political commitment to expanding effective health coverage or UHC, in terms of either policies, funding or governance. Although its public health system was once regarded as a model for the continent, with a well-organised district PHC and referral system, it suffered near total collapse between 1995 and 2001 owing to protracted civil war (Stasse et al., 2015; Waldman, 2006). This deterioration was compounded by government mismanagement and neglect, the temporary withdrawal of foreign assistance and a chronic shortage of skilled health staff (Waldman, 2006). More recently, Stasse et al. (2015) find widespread, poorly regulated fee-for-service payments by patients render the cost of health care unpredictable. Direct payment is requested for every health intervention and access to quality care is poor, especially in district hospitals, which often have higher costs than health centres.

In 2006, the DRC government published its Health Systems Strengthening Strategy, which recognised the poor budgetary allocation to the health sector and partly attributed the problems in health coverage and service provision to ineffective leadership in the Ministry of Health. As a result of poor governance, chronic staffing problems and under-financing, the ministry was said to have lost the power to make independent decisions, to have difficulties in coordinating the activities of funding agencies and to be unable to control the financing of the health sector or the planning framework of health zones in the face of external initiatives.

Since then, donors have begun to play a much more active role, with increased funding for the sector and schemes to strengthen local health zones and in some cases to contract out public services to NGOs (Stasse et al., 2015). A considerable amount of donor assistance has been focused on re-establishing health services in conflict-affected areas (Waldman, 2006). There is also evidence that experiments in performance-based contracting have helped create efficient partnerships between government and private sector providers that have led to improvements in both access to health care and health care quality (Soeters et al., 2011; Waldman, 2006). These experiments build on a long tradition of public-private partnerships in the Congolese health system (Waldman, 2006). The introduction of a Basic Package of Health Services has provided a degree of policy coherence and uniformity in service delivery in an otherwise uncoordinated system (ibid.). Public spending on health has risen substantially, from an average of under 0.2% of GDP in 1995–99 to an average of just under 2% in 2010–13, with external resources rising from just 4% of total health spending in 2001 to 52% by 2013. This increase in external resources does appear to be associated with some significant increases in service coverage. For example, immunisation rates improved from 18% in 1998 to 80% in 2014, while OOP expenditures have remained fairly constant in real

terms but have fallen significantly as a share of overall expenditure as external resources have risen.

This perhaps confirms our earlier predictions that the right kinds of donor interventions can lead to significant progress, even in dominant predatory settlements. However, we would expect the rate of progress to at some point plateau, unless the ruling elite itself comes to identify its own self-interest with increases in the health of the population, thanks to an evolution in or even transformation of the political settlement.

Myanmar

From 1962, Myanmar was governed as a militaristic, single-party state, pursuing the 'Burmese way to socialism'. It is best described as a (weak) dominant settlement, surviving repeated insurgencies, riots and abortive transitions to democratic rule. Despite its professed socialist credentials, the regime was widely regarded as one of the most predatory on the planet, presiding over very low levels of economic and human development. However, following elections in 2010, the military began to retreat from an active role, placing General Thein Sein at the head of a nominally civilian government. In 2015, there was a more genuine transition to democracy, in which Aung Sang Suu Kyi's National League for Democracy swept to power in elections. In the interim, the regime appears to have acquired a more developmental outlook, illustrated by its relation to the health sector below.

As mentioned above, a historic lack of government investment in health care under the military combined with foreign sanctions barring NGO provision of health services has resulted in a poor public health system (Shobert, 2013). In 2000, WHO ranked the country's health care system the second worst in the world and in 2009 the government spent the least amount of money on health as a percentage of gross domestic product (GDP) of any country worldwide. Basic health services and health centre infrastructure have failed to keep pace with population growth, resulting in poor services and inequitable access, particularly in rural areas (WHO, 2014). At present, approximately three quarters of Myanmar's citizens have very limited access to essential health services, and OOP payments account for the majority of health care expenditure (Evans, 2014; Van Minh et al., 2014).

Nevertheless, there are grounds for cautious optimism. With a shift in the political settlement in 2010 from a military dictatorship to an elected government and the creation of a new constitution, the country and its systems are liberalising and health coverage reforms are under way (Shobert, 2013). The Myanmar government has established a goal of achieving UHC by 2030 as part of a drive to end extreme poverty. According to Evans (2014), alongside the newly established democratic political institutions, there is a range of public, private and civil society actors in the health sector who are working towards strengthening Myanmar's health system and realising the goal of UHC. Moreover,

there is a shared political consensus in favour of UHC and a desire across the political spectrum to address the current gaps in health equity. There is also evidence that the quality of governmental decision-making more generally has improved in recent years, and that institutions have become less personalised. For example, a recent report from the International Crisis Group (ICG, 2012: 6) found that ‘the new climate of political openness means that there is now greater transparency in decision-making [...] Decisions are now more likely to be made by technocrats on the basis of their merits rather than by generals, and there is the prospect of a more level playing field emerging.’ However, considerable progress remains to be achieved, both in terms of consolidating democratic and rule-governed institutions and in terms of promoting better health coverage, particularly for poor and marginalised groups.

Recent gains in effective health coverage in Myanmar appear to be the result of top-down, technocratic governance initiatives and the influence of developmentally oriented leadership. In August 2014, the government launched a wholesale reform of the Ministry of Health with a view to increasing effective health coverage in local communities. In 2014, a delegation from the Center for Strategic and International Studies (CSIS) found discussions were underway between national and regional government health officials on how to converge their activities more efficiently with a view to strengthening basic health services. Furthermore, the Myanmar government has shown ‘pragmatism and flexibility’ in enabling the UN and local and international NGOs to expand health programmes in the country. The delegation report expresses confidence that, if the re-structuring of the Ministry of Health is successful, the latter will be able to manage directly the increasing resources coming into the country from the Global Fund, the World Bank, the US Agency for International Development (USAID) and other donors (Morrison et al., 2014). Top-down governmental commitment to comprehensive development can also be seen in the Framework for Economic and Social Reform (FESR) 2013, which prioritises the allocation of greater resources for rural PHC and innovation in health financing. According to a recent WHO country cooperation strategy report (WHO, 2014), the inter-ministerial National Health Committee takes a leadership role and gives guidance in implementing country-wide health programmes ‘systematically and efficiently’.

In recent years, there have been gains in HIV/AIDS prevention, treatment and care; control of malaria; effective tuberculosis treatment; and maternal, newborn and child mortality rates (Morrison et al., 2014). The country has seen a modest fall in OOP spending on health from 2006, whereas public health spending has doubled since 2009. At the same time, it must be remembered that these are advances from a very low starting point: Myanmar still has the highest percentage of OOP expenditure of any country in our sample.

Myanmar thus seems to us to fit the picture of a dominant-predatory settlement with a weak policy domain, morphing recently into a dominant-developmental settlement, with a supportive policy domain. Years of stagnation have been superseded by a period of quite rapid progress, at least on the service coverage front. It is too early to say whether the National League for Democracy will form part of a new, dominant (albeit more democratic) settlement, or whether the settlement will become competitive in nature. The outcome may well shape the rate at which progress to UHC can be maintained.

Indonesia

The Indonesian political settlement has become more competitive in the past two decades as the country has transitioned from a centralised authoritarian regime to democratic rule. After the death in 1998 of President Suharto, who ruled the country as a dictatorship for 32 years, the constitution was amended and new laws were passed to introduce democratic institutions. Since then, the electoral process has led to regular turnovers in government, indicating the presence of a stable elite agreement on peaceful rules for political competition.

The central government has committed to achieving UHC by 2019 through integrating the various existing insurance schemes under a single-payer umbrella. This commitment builds on a trajectory of reform that stretches back to the Suharto era and has accelerated with the move to democracy. Since the 1970s, the government has constructed more than 9,500 health centres, 22,000 auxiliary health centres and 800 public hospitals (World Bank, 2014a).

Between 1995 and 2011, health insurance coverage increased rapidly, from 15% to 40%, delivered through three national programmes; government health expenditure has grown in both absolute and relative terms. The largest national insurance programme, Jamkesmas, covers approximately one third of the population; Askes and Jamsostek cover approximately 6% and 2.4%, respectively. Since 2006, the country has seen a steady increase in government expenditure on health. In 2011, OOP payments as a percentage of total health expenditure were relatively high at 47%; however, incidence of catastrophic spending on health is low by comparison with regional trends. Health service delivery is split between public and private providers but weighted towards public provision, especially in rural areas (World Bank, 2014a).

The movement towards legally codifying UHC in Indonesia was met with resistance by a range of interest groups. Employment associations and business groups argued that the mandatory nature of the scheme would contravene human rights; private sector employees were opposed to the sharing of contributions between employers and employees; certain bilateral aid organisations criticised the government monopoly over the administration of the system; and employers expressed concern over the level of contributions they would have to meet. Despite these

objections, the political process of establishing UHC was eventually formally embodied in the National Social Security System Law in 2004 (World Bank, 2014a).

Alongside the transition to democracy, the country has pursued an aggressive programme of decentralisation. While the central government has strengthened the legal foundations for free health care, district governments have since 2001 had primary responsibility for implementing health policy. As a result, the performance of institutions in Indonesia is shaped heavily by the competitive character of political settlements at the subnational or sectoral level. District leaders, or *bupati* – who are often themselves drawn from the bureaucratic, military, business or criminal elite – commonly regard political power as a means to capture rents and distribute patronage favours to supporters (Rosser et al., 2011).

A study by Rosser et al. (2011) finds considerable variance in the degree to which district governments have supported the provision of free health services. Numerous districts have used their political and financial authority to enrich local elites rather than pursue pro-poor reforms. But there are notable exceptions. For example, the district government of Jembrana has pursued an extensive policy of local health insurance to supplement the national programme, developing innovative methods to minimise user fees. By contrast, in the neighbouring district of Tabanan, the local government has shown little interest in promoting pro-poor health services or infrastructure. The main argument in Rosser et al. is that this variance can be accounted for primarily by the different career strategies for political advancement adopted by *bupati*. In other words, the competitive clientelist setting can generate different outcomes in terms of health coverage and provision depending on the type of political support the heads of local governments court. Where *bupati* have sought to advance their political careers by developing a base of popular support among voters from lower-income brackets, they have been more inclined to promote free public services, including health, than where leaders have focused on developing patronage networks.

In cases where leaders are independent of predatory interests, they have followed a strategy of ‘political entrepreneurship’ in order to generate the popular support needed to promote and sustain their political careers. In these districts, free public services are used as a tool to build a popular support base. By contrast, where *bupati* are embedded in personal networks through which they receive the backing of predatory interests (both business and criminal), they have been more likely to pursue strategies of patronage distribution because their political careers depend on distributing favours to their supporters. This in turn means the provision of public services such as free health care is neglected, as resources are used to service predatory interests.

This case study fits the observation in Lavers and Hickey (2015) that, in competitive clientelist settlements,

there is likely to be a strong inclination on the part of ruling elites to use social protection policies as a form of patronage to secure the support of lower-level factions or constituents. In summary, then, the structure of incentives stemming from the character of subnational political settlements in Indonesia helps explain the variation in the performance of districts in the effective expansion of health care to their populations. The combination of national interest group politics and subnational political settlement dynamics appears, then, to have retarded somewhat the progress of UHC.

Bangladesh

In the past two decades, the Bangladeshi political settlement has displayed many of the characteristics of the competitive clientelist model proposed by Levy. Democratically elected political parties have governed the country since the 1990s, save for a short period of military rule between 2006 and 2008, and there have been frequent turn-overs in the ruling party via democratic elections in 1996, 2001 and 2008. Up to that point the electoral competition was effectively split between the Awami League (AL) and the Bangladeshi National Party (BNP). However, the AL has maintained an overwhelming parliamentary majority since 2008 and, against a backdrop of alleged vote rigging and escalating political violence, the BNP boycotted the 2014 parliamentary elections. With the AL having recently completed its second year in office in its second successive term, the indications are that a more dominant political settlement is becoming entrenched.

The right to health care was established in the 1972 constitution and a commitment to public health has been a stable feature of the political agenda of successive ruling parties. Since then, the country has achieved what the World Bank (2005) described as a ‘spectacular rate of progress’ on health indicators. Advancement in health delivery has occurred alongside substantial growth in health infrastructure, from virtually no health facilities at independence to a network of district hospitals and local community clinics. Successive health reform plans have seen the system evolve from an urban-based delivery structure to a more broad-based rural programme that is capable of reaching vulnerable groups (McCloughlin and Batley, 2012).

The persistence of the commitment to health reform across numerous changes of government since independence, and the consensus among elites to promote pro-poor development policies, is perhaps surprising in the context of a competitive clientelist political settlement, where it is anticipated that the expectation of electoral turn-over will lead parties to pursue ‘quick-win’ policies that service the immediate interests of specific, politically important groups (Lavers and Hickey, 2015: 10). According to McCloughlin and Batley (2012), the presence of strong competitive pressures in the political settlement has in fact meant that successive ruling parties have upgraded their health programmes in order to outbid

their predecessor and secure political support. Health policy resonates strongly with the electorate in Bangladesh: the current government under Prime Minister Sheikh Hasina rose to power partly on the strength of an electoral promise to re-establish community health clinics in rural areas (Harmer, 2011).

In May 2011, the government of Bangladesh announced a commitment to achieve UHC by 2032. The goal of the government's strategy for UHC is to create a universal Social Health Protection Scheme (SHPS). It is estimated that OOP spending will decrease from the present level of 64% of total health expenditure to 32% once SHPS has been implemented fully (World Bank, 2015).

Nevertheless, there are some doubts over the ability of the country to achieve this goal. Notwithstanding the presence of elite coordination around welfarist development strategies, Bangladeshi state institutions are subject to a high degree of clientelist pressure, with rent-seeking and patronage distribution seen as accepted features of the political environment (Hassan, 2013; Khan, 2011). Moreover, the power of lower-level factions in the health sector is relatively high, which can disrupt the state's capacity to implement reforms. A notable feature of the politics of Bangladeshi health services is the influence of the main professional association representing doctors. The Bangladesh Medical Association (BMA) is informally divided into two branches, which are affiliated with the two main electoral parties: Shwadinata Chikitshak Parishad, supported by the AL, and the Doctors' Association of Bangladesh, supported by the BNP. When the party affiliated to a particular branch is in power, association members receive access to rents in the form of procurement contracts, transfers, promotions and jobs (Hassan, 2013).

The BMA as a whole is regarded as the most powerful interest group in the health sector and is routinely consulted in the formation of health policy. In the past, the BMA has influenced the trajectory of reform by opposing efforts to decentralise the health system and by lobbying against policies that would have limited doctors' private practices. The common practice of public sector-employed doctors pursuing private practices in the afternoon and the clustering of private hospitals in urban areas directly reduces equity of access on the part of poor citizens. More generally, the private health sector is thriving, accounting for 80% of hospitals, whereas the public sector suffers from over-crowding, a shortfall of doctors and nurses and poor infrastructure. The pattern of health financing is indicative of the government's complicity in the trend towards greater privatisation. According to the World Development Indicators, between 1997 and 2006 the government's share of total expenditure on health fell from 43% to

37%, whereas OOP payments as a share of total health expenditure grew from 56% to 59% over the same period.

While the pressures of democratic competition can encourage parties to court voters by making bold commitments to health reform, the competitive political settlement in Bangladesh also generates institutional barriers that can obstruct the capacity of elites to implement those reforms. In contrast with dominant political settlements characterised by authoritarian or single-party rule, where strong centralised governments can exercise tight control over decision-making procedures, Levy and Walton (2013: 18) assert that service delivery in more competitive clientelist settings can be hampered by a 'combination of multiple, competing interests, often spread across different ministries, and weak impersonal accountability mechanisms'. In addition, Levy (2012: 40) suggests parties governing in the context of competitive personalised settlements may have little incentive to undertake the long-term process of strengthening bureaucratic capacity and improving efficiency because of the short timeframes during which they are likely to rule.

This is consistent with aspects of health sector governance in Bangladesh. A World Bank report (2015: 32) provides an instructive example of how the health system is burdened by fragmented and inefficient decision-making. The procedure involved in establishing a new physician post in the Ministry of Health and Family Welfare requires the approval of five other ministries or institutional bodies – a lengthy process subject to a range of political pressures that can take up to two years to complete. Once the post has been established, the process of filling the vacancy involves nine stages across a similarly diverse range of public bodies and can take up to three years. The multitude of government entities required to sign off on decisions means there is a lack of clear accountability lines, which can frustrate the implementation of decisions. It is therefore unsurprising that problems in human resource management in the health sector constitute significant obstacles to effective health coverage in Bangladesh.

Quantifying progress towards universal health coverage

In order to supplement our qualitative case study analysis with some quantitative data, we build on recent literature that seeks to quantify progress towards universal health coverage.¹³ As set out above, an influential way of conceptualising UHC is the WHO's UHC 'coverage cube'. Progress towards UHC is measured on three dimensions: the services covered, the costs covered and the proportion of the population covered (WHO, 2010). WHO and the World Bank have recently proposed indicators to track these

13 The first UHC global monitoring report was released in 2015 (WHO, 2015). Wagstaff et al. (2015a, 2015b) seek to quantify UHC in a single indicator. In contrast, studies such as Atun et al. (2015) and Reich et al. (2015) provide narrative descriptions of progress, assessing through a mixture of policy reforms and health coverage indicators.

dimensions of health coverage: a definition of what counts as the services to be measured for ‘universal health coverage’, what proportion of the population is covered by these health services and whether these services can be accessed without payments that would cause financial hardship. It is proposed that health service coverage be measured by means of six indicators,¹⁴ covering health interventions from which every individual in every country should benefit and that have

relevant population. As only three (DTP3 immunisation coverage, effective tuberculosis treatment coverage and percentage of people living with HIV who are currently on antiretroviral therapy) out of the six indicators are available in every year, with the other three indicators (contraceptive prevalence, at least four ANC visits and proportion of births attended by a skilled birth attendant) available only irregularly, the index was calculated as

Table 5: A summary of UHC progress in six countries

Country	Political settlement	Type of progress
DRC	Dominant-predatory	Rapid progress since the end of war in 2003. There has been a large increase in donor funding for health, which by 2013 accounted for over half of all spending on health and largely financed the recorded increase on government expenditure on health. Progress is thus more likely the result of external assistance than improvement in government health systems.
Vietnam	Dominant-developmental	Strong progress in service coverage since 2000, with 80% of births attended by skilled health staff and 80% immunisation coverage, and OOP financing reduced significantly from over 60% to below 50%.
Bangladesh	Competitive clientelist	Weaker progress than other countries because of a poor score on the index of service delivery owing to low antenatal care (ANC) coverage rates (25%) and low coverage rates for births attended by skilled health staff (31%). However, it performs much better in health outcomes (e.g. life expectancy, under-five mortality, maternal mortality).
Indonesia	Competitive clientelist	Progress only on service coverage, which remains disappointing for its income level, which is considerably higher than the other cases. Little progress on financing, although it started at a comparably lower level of OOP financing than the other countries.
Kyrgyzstan	Dominant-developmental>competitive clientelist	Strong progress in service coverage, with immunisation and maternal care above the 80% threshold the WHO considers amounts to universal coverage, and in financing, with OOP payments accounting for less than 40% of total health expenditure.
Myanmar	Dominant predatory> dominant-developmental	Strong progress on service coverage since 2000 from a very low base, with especially fast progress on increasing tuberculosis treatment. Health financing remains dominated by OOP payments, which account for over 70% of total health expenditure.

recent, comparable data for the majority of countries. These are shown in Table 6 (WHO, 2015).

The second dimension of UHC, protecting people from financial hardship when accessing health care, is measured through estimates of the incidence of catastrophic health expenditures (e.g. health expenditures above 25% of total expenditure or 40% of subsistence/food expenditures), and incidence of impoverishing health expenditure (i.e. health expenditure that pushes households into poverty or deepens their poverty).

To provide a single measure of progress on the service coverage dimension of UHC (the ‘service coverage index’), the six health service coverage indicators shown in Table 7 are averaged¹⁸ into a single indicator, based on data from the World Development Indicators¹⁹ and WHO.²⁰ All these indicators are expressed as percentage coverage of the

averages for five-year periods to ensure there was at least one data point for each indicator for each five-year period (indicators with more than one data point in each five year period were averaged).

The UHC monitoring report (WHO, 2015) was able to calculate incidence of catastrophic or impoverishing health expenditure for only 37 countries with nationally representative, publicly available and comparable survey data with information on both total consumption and on health OOP. Thus, instead of this, a more basic measure of financial protection has been used: the proportion of health expenditure *not* financed from OOP payments.²¹ WHO (2010) estimates that only when OOP payments are reduced to around 15–20% of total health expenditures does incidence of financial catastrophe and impoverishment fall to negligible levels. The average of

14 Their UHC global monitoring report (WHO, 2015) includes two further indicators, for improved drinking water coverage and improved sanitation coverage. However, these are not included here as water and sanitation infrastructure is not the responsibility of the health sector.

the proportion of health expenditures not financed from OOP payments and the service coverage index is taken to produce the 'UHC index'.

Figure 5 shows UHC progress for our six countries along two axes: service coverage and OOP expenditure. Table 8 shows the results for these countries when the data points from the two axes are averaged, providing a composite UHC progress score. Table 9 ranks the countries by level and (absolute) rate of progress. Taken together, the data provide further support for the idea that UHC progress is likely to be stronger in dominant settings. Specifically, Vietnam and Kyrgyzstan (dominant-developmental for most of the period under discussion) both outperform Bangladesh and Indonesia (competitive for most of the period under discussion), in terms of both level and rate of progress to UHC. More surprisingly, perhaps, DRC (dominant-predatory) outperforms Indonesia and Bangladesh on both level and rate of progress, and Myanmar (dominant-predatory>dominant-developmental) also outperforms Bangladesh on both, while outperforming Indonesia on rate.

Table 6: UHC health service indicators

Health service	Indicators
Reproductive and newborn health	Percentage of demand for family planning that is satisfied with a modern method among married or in-union women ^{15<?>} ANC coverage, at least four visits with any care provider during pregnancy ^{16<?>} Proportion of deliveries attended by a skilled health provider ^{17<?>}
Child immunisation	Percentage of DTP3 immunisation coverage
Infectious disease	Proportion of tuberculosis cases detected and successfully treated (effective coverage) Percentage of people living with HIV who are currently on ART

Source: WHO (2015).

The differences are not large, but both the numbers and the narrative support the idea that dominance permits

Table 7: UHC financial protection indicators

Measure	Indicators
Catastrophic health expenditure	Share of population spending less than 25% of their total expenditure on OOP Share of population spending less than 40% of their non-subsistence expenditures on OOP Share of population spending less than 40% of their non-food expenditure on OOP
Impoverishing health expenditure	Share of population not pushed into poverty, i.e. with expenditures net and gross of OOP above an international poverty line/level of subsistence food consumption/multiple poverty lines Share of population not further pushed, i.e. with expenses below an international poverty line/level of subsistence food consumption/multiple poverty lines and no OOP Share of population neither pushed nor further pushed into poverty

Source: WHO (2015).

a comparatively rapid implementation of UHC reforms thanks to strong principal-agent relations and effective governance, once the political leadership has acknowledged the need for them (as in Myanmar) or else surrendered the health sector to external actors (as in DRC). By contrast, progress in competitive clientelistic settings tends to be somewhat impeded by interest group politics and implementation failures. This is not to say that DRC and Myanmar have 'better' health care than Indonesia and Bangladesh, or that they will continue to outstrip them in terms of UHC progress. The results for DRC are nevertheless somewhat spectacular, and illustrate what a donor-dominated health sector can achieve at low levels of development, even in predatory settings. That said, we would expect progress in DRC to plateau more quickly than in Indonesia and Bangladesh, unless the political leadership comes to relate its own survival to the reforms. What about our other hypothesis, that, in order to make optimal progress, UHC champions should choose a strategy or work in a way that is a 'good fit' with the political settlement? This is arguably the more interesting of our hypotheses, since it is pregnant with implications for what UHC champions should do.

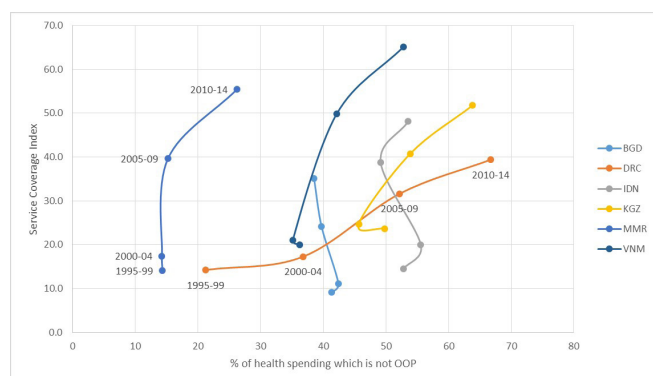
18 A geometric rather than arithmetic mean is used as this gives countries with higher dispersion on the measures of health care a worse score for a given arithmetic mean.

19 The following indicators were obtained from the World Development Indicators (<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>): contraceptive prevalence (percentage of women ages 15–49); births attended by skilled health staff (percentage of total); immunisation, DPT (percentage of children ages 12–23 months); and antiretroviral therapy coverage (percentage of people living with HIV). An indicator for the effective coverage of tuberculosis was constructed from the product of the tuberculosis case detection rate (percentage, all forms) and the tuberculosis treatment success rate (percentage of new cases).

20 Data for ANC coverage (at least four visits) is from WHO: <http://apps.who.int/gho/data/view.main.321>

21 This measure is used so an increase in the score (a reduction in the proportion of total health expenditures finance from OOP payments) is an improvement.

Figure 5: Service coverage and OOP health spending for six countries, 1995–99 to 2010–14



why these countries have progressed as they have, and while we could posit that strategies have been government-supporting in Indonesia, when in fact a government-connecting approach would have been preferable, in truth we do not have clear enough indicators for our categories to know whether UHC champions have really been behaving in a good-fit way for each case.

There is also the perplexing question of the relevant counterfactual. What do we mean by ‘optimal rate of progress’ or ‘better results’? Better relative to what? The answer is that the ‘good-fit’ strategy is better than another strategy that UHC advocates *could* have taken in the same country, at the same time, with all other factors constant. The universe being what it is, it is impossible, unfortunately,

Table 8: UHC progress for six countries, a composite index, 1995–2014

UHC index	1995–99	2000–04	2005–09	2010–14	Change	% Change
Bangladesh	19.41	21.69	30.98	36.80	+17.39	90%
Myanmar	14.24	15.78	24.57	38.17	+23.94	168%
Indonesia	27.75	33.34	43.68	50.76	+23.02	83%
DRC	17.41	25.24	40.61	51.27	+33.87	195%
Kyrgyz Republic	34.34	33.61	46.84	57.47	+23.13	67%
Vietnam	26.96	27.19	45.84	58.68	+31.71	118%

While it might plausibly be argued that the strategy has been government-supporting in Vietnam, Kyrgyzstan and Myanmar, government-substituting in DRC and government-connecting in Bangladesh, helping explain

to know whether strategies are better in this way or not.

A case study approach that would nevertheless give us some leverage over this question would have to provide clear grounds for specifying political settlement type, and then clear

Table 9: UHC ranking and political settlement type

Country	UHC progress by level (2014)	UHC progress by absolute change (1995–2014)	UHC progress by % change (1995–2014)	Average ranking across 3 indicators	Political settlement type
Vietnam	1st	2nd	3rd	2nd	Dominant-developmental
Kyrgyzstan	2nd	4th	6th	4th	Dominant-developmental>competitive clientelist
DRC	3rd	1st	1st	1st	Dominant-predatory
Indonesia	4th	5th	5th	5th	Competitive clientelist
Myanmar	5th	3rd	2nd	3rd	Dominant-predatory>dominant-developmental
Bangladesh	6th	6th	4th	6th	Competitive clientelist>dominant

criteria for identifying ‘government-following’, ‘government-substituting’ and ‘government-connecting’ strategies. Holding political settlement type constant across countries, we would then have to choose cases that contrasted on the ‘goodness of fit’ variable. Even then, any attribution of UHC progress to the fitness variable would need to account for the role of the policy domain, which, because it co-determines outcomes, is liable to muddy the water.

Another approach, presumably, would be to test whether what we take to be ‘good-fit’ cases perform better or worse than the average country with the same political settlement type, with a similar level of income. Whether there would be good enough data, and enough data points to be able to draw meaningful conclusions from such an exercise, would require additional research.

Another option would be to conduct a controlled experiment within countries that are currently undertaking UHC reforms. Reformers would have to agree to adopt different ways of working, perhaps in different geographic areas, or for different population groups or service dimensions, some of which mimicked what we predict to be ‘good-fit’ strategies, and some of which took a different approach. The results could then be monitored over time. Doubtless this would present certain ethical and practical difficulties, not to mention attribution problems, and would also mark something of a stretching of the boundaries of PSA, since its injunctions tend to be pitched at a ‘whole country’ level. Notwithstanding these challenges, we feel this is probably the most promising direction in which to take PSA and UHC research.

Progress towards universal health coverage in a larger sample

Returning to our findings on political settlement type and UHC progress, it is important to note that the quantitative differences in progress were not large, and, moreover, that the small size of our sample could have biased our conclusions. Had we chosen different countries, our conclusions might have been different. We consequently tried to test the findings against a larger sample. To do so, we utilised Levy’s (2014) typology of dominant, intermediate and competitive regimes, constructed from a modified version of the democracy indicator from the Polity IV dataset.²² This has two major disadvantages, however. First, it reduces regime type to a single dominant-competitive dimension, and introduces an intermediate category for regimes that do not clearly fall into either. This does not capture the differences in regime type within the dominant, intermediate and competitive types, whether between predatory and developmental dominant settlements or between elitist or inclusive settlements.

Second, the Polity IV indicator primarily provides a measure of how formally ‘democratic’ a country’s institutions are, whereas the ‘dominant-competitive’ dichotomy is actually supposed to be a measure of ‘elite cohesion’, or the level of ‘how easy or difficult it is to remove an incumbent regime’. As such it is an imperfect proxy. Moreover, it is important to remember that development results are not intended simply to be ‘read off’ from political settlement type. Outcomes are co-determined by the politics of the policy domain, one aspect of which concerns the different ‘strategies’ we have been discussing. Since the policy domain is semi-autonomous from the political settlement it is difficult to predict outcomes on the basis of knowledge of political settlement type alone. Unfortunately, we do not have cross-national data for the composition of the policy domain or the strategies UHC champions choose; until we do, we cannot expect our hypotheses to be reflected in large-n datasets. As such, the results from this analysis can be at best suggestive.

Data are available to calculate the UHC index for 62 countries for 2010–14, shown in Figure 6, again with the service coverage index on the y-axis and the financing measure on the x-axis. Countries towards the top right-hand corner are those performing well on both service coverage, and on reducing OOP payments.

PSA predicted that dominant regimes are likely to be under less pressure to expand social services, and may thus have little interest in more progressive provision of social services, which would imply high taxation upon the elite. However, there may be cases where a dominant regime does decide to expand access to services as a means of securing political stability or undermining opponents, and, where it does so, a long time horizon will mean the regime has the ability to carefully design policies for the long term. We can thus expect some dispersion of results across dominant regimes depending on whether or not service delivery has been prioritised. Where it has, we could expect substantial progress towards UHC, but little or no progress where it has not.

Competitive settlements, especially those that are more inclusive, are likely to face stronger redistributive pressures, meaning service delivery will be higher up the political agenda. However, the pressure is likely to be for *ad hoc* policies to deliver patronage to specific groups, rather than to deliver systematic improvement in services. These political pressures additionally mean bureaucratic capability to deliver policies is also likely to be poor. Politicians with short time horizons have few incentives to embark on the long-term building of bureaucratic capacity, and competition may also imply a lack of a clear prioritisation of policies.

²² This indicator involves assessment of the competitiveness of political participation, the openness and competitiveness of executive recruitment and the constraints on the chief executive. See Levy (2014) Chapter 7.

Figure 6: UHC index, 2009–14

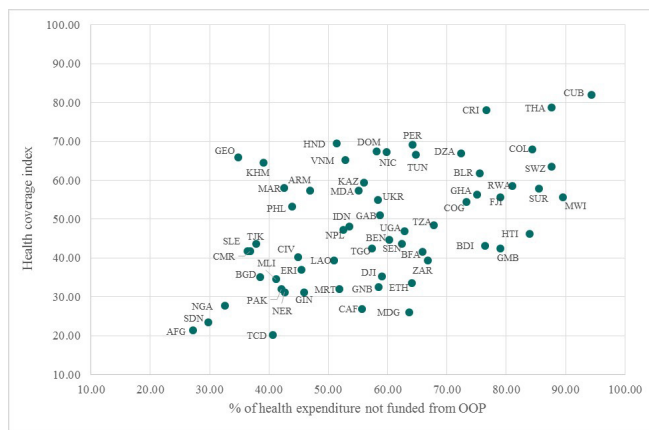
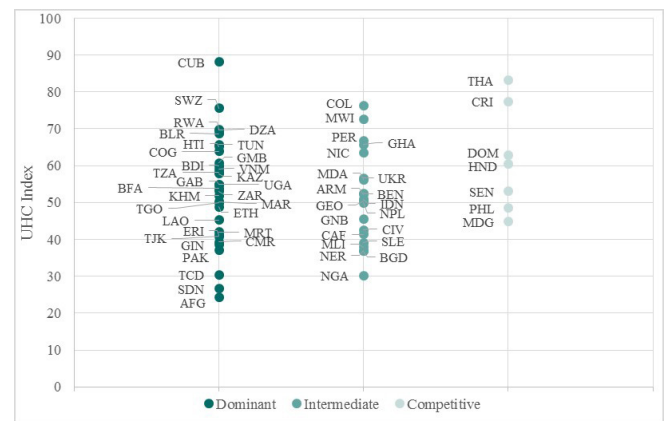


Figure 7: Political settlement and UHC



However, we find little support for these predictions in the cross-country relationship between political settlement and progress on UHC, as Figure 7 shows. As theory would predict, there is substantial variation in performance among dominant political settlements, containing both the best (Cuba) and worst (Afghanistan, Sudan) performers. However, performance is otherwise indistinguishable from intermediate regimes. While the average for competitive regimes is higher, it is not statistically significant. This lack of relationship seems to bear out concerns over the measurement of regime type. However, another possibility is that the simple UHC index we have calculated does not capture several important aspects of UHC. The variables included are predominantly those for prevention and primary care interventions that were the focus of the MDGs. As such, these indicators are not necessarily reflective of national burdens of disease, or what health budgets are typically spent on. Organisation for Economic Co-operation and Development countries typically spend only around 5% of health spending on preventative services (Wagstaff et al., 2015a). No indicators are included for non-communicable diseases, which now account for 55% of the global burden of disease (WHO,

2015), but for which there are not yet widely comparable data across countries. This is problematic as the index as it stands would not give countries credit for progress made on developing a more advanced health system that treats conditions that may account for the majority of the burden of disease, or for ensuring a large part of health expenditure contributes to effective service coverage. Running an effective referral system is more complex (and less amenable to external support not dependent on domestic bureaucratic capacity) and may thus be considered a better test of the extent to which a domestic political settlement is able to provide health services.

Put differently, there may not be a big difference between dominant and competitive regimes when it comes to supplying some of the ‘easier’ health services that are the focus of the UHC index, especially when development partners are heavily involved in the sector. However, we would expect these differences to manifest themselves when it comes to supplying more complex forms of curative care that require greater state capacity and coordination. At present, however, we do not have the data to determine this.²³

23 Note, however, that running the data against an alternative index created by Wagstaff et al. (2015a, 2015b) did not return results that were any more supportive of our hypotheses.

Conclusions

In this paper we have discussed some of the background to UHC and reviewed some of the existing political economy literature on it. In particular, we have examined different theories of the kinds of long term structural change, contingent events and interest group politics that are likely to enable or disable a smooth and fast transition to UHC.

We have also discussed PSA as an alternative, complementary, approach that focuses on the deeper balance of power on which politics is based. We have provided a model that links the political settlement, in combination with what we call the policy domain, to UHC progress through the mechanism of political commitment, policy pathways, funding and governance arrangements. We have hypothesised that, other things being equal, progress will be stronger in dominant-developmental settlements and weaker in dominant-predatory and elitist competitive clientelist settlements, with inclusive competitive clientelist settlements lying somewhere in between. We have also hypothesised that, in dominant-developmental settings, progress will be optimised when UHC champions play a government-supporting role; that in dominant-predatory and elitist competitive clientelist settlements, it will be optimised when UHC champions play a government-substituting role; and that in inclusive competitive clientelist settlements, it will be optimised when they play a government-connecting role.

Case studies of six low- and lower-middle-income countries have provided broad support for the hypotheses connecting political settlement type to UHC progress, with dominant-developmental Vietnam and Kyrgyzstan outperforming competitive clientelist Indonesia and Bangladesh. More surprising is the strong performance of dominant-predatory DRC and to a lesser extent Myanmar.

We have argued that it may be easier to achieve early results in a donor-driven health sector in a dominant-predatory settlement than in a more nationally owned health sector, thick with local politics, in a competitive clientelist settlement. Myanmar, meanwhile, suggests progress in dominant settings can rapidly improve if the settlement switches from predatory to developmental.

We also tested the hypotheses against a larger dataset to see if the putative advantages of dominance were confirmed. In fact they were not, but we suspect this may have more to do with problems of measuring political settlement type, the absence of proxies for intervening variables and limitations of the UHC progress data, as opposed to invalidity of the hypotheses themselves. More work on indicators and measurement would be welcome to assess whether relationships do hold, and, if so, how significant they are.

Our case studies also provided some support for the arguably more interesting idea that UHC progress is optimised when policy strategies are a good fit for the political settlement. In truth, however, the evidence is a little vague here. More work would be needed on indicators, and a different research design, to draw conclusions with any confidence. Thanks to the elusive nature of the counterfactual, designing an appropriate study is challenging. However, we would recommend that researchers concentrate their efforts on quasi-experimental action research in which in-country UHC champions run different parts of their programmes according to different strategies, with the results monitored and analysed. In the meantime, we think PSA still provides a promising framework for rich PEA of particular country contexts, and intuitively plausible ideas about how to strategise in them.

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