



World Health  
Organization



# The Political Economy of Health Financing Reform: analysis and strategies to support universal health coverage

Susan Sparkes, Jesse Bump, Ece Ozcelik, and Michael Reich

WHO Symposium on Health Financing for UHC: managing politics and assessing progress  
Liverpool, 9 October 2018

## Objectives of the afternoon

1. Discuss how to incorporate political economy analysis into health financing reform
2. Share experiences in health reform: political economy factors and strategies to address them
3. Consider future research and policy agenda to advance health financing reforms in support of UHC objectives



NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA  
TOWARDS UNIVERSAL HEALTH COVERAGE



GENEL SAĞLIK SİGORTASI

- Why are some technically sound health financing policies adopted and implemented and others not?
- What political economy factors influence health financing reform adoption and implementation?
- How can political economy analysis help develop effective adoption and implementation strategies?

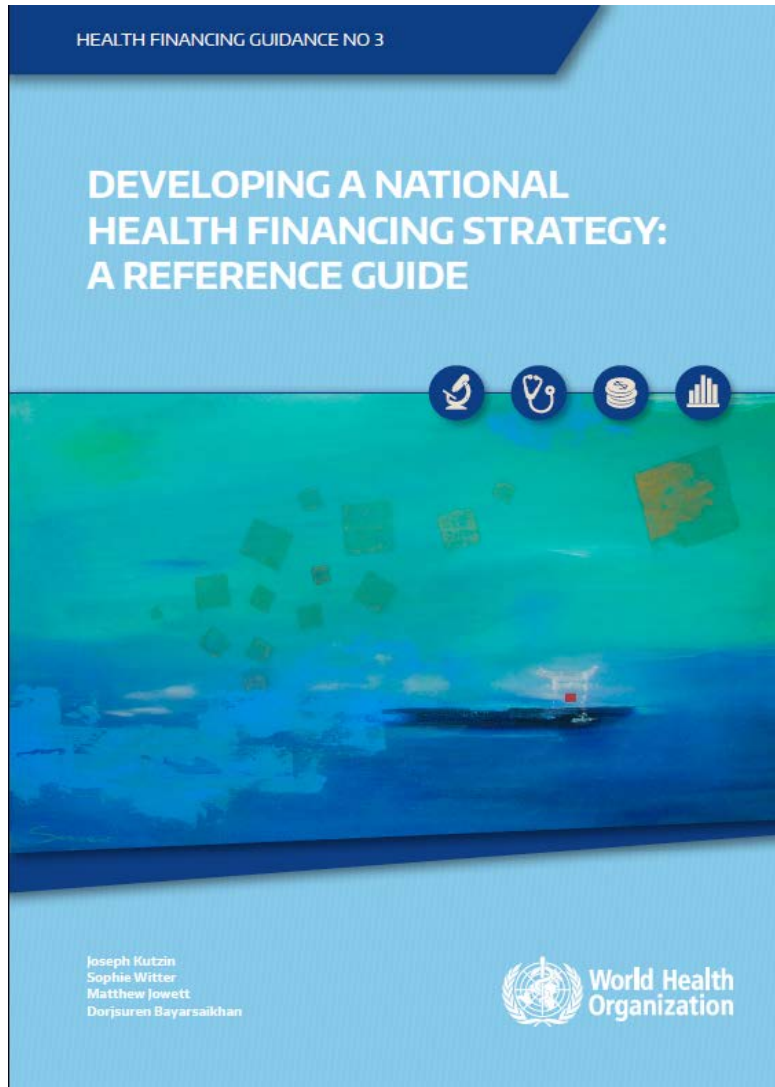


*"I'd like to stall this project into the ground—hand it over to one of our action committees."*

# Why focus on political economy analysis?

- Political economy directly affects adoption and implementation processes.
- By better understanding political economy dynamics, policymakers can improve their strategies for adoption and implementation.

# Health financing and UHC: guiding principles



1. Move towards predominant reliance on **public, compulsory funding** for UHC
2. **Reduce fragmentation** to enhance re-distributional capacity (more prepayment, fewer prepayment schemes) and reduce administrative duplication
3. Move towards **strategic purchasing** to align funding and incentives with promised services, promote efficiency and accountability, and manage expenditure growth to sustain progress

Why is political economy so important for health financing reform?

1. Redistribution
2. Government intervention and dealing with ministry of finance
3. Important political issue within countries
4. Reflects core social values

## Use of approach

- Analyse political economy factors related to health financing
- Develop strategies to improve development, adoption and implementation of health financing strategies
- Real-time, rapid appraisal to support decision-making
- Intended primarily for reform teams

# What's new about this approach?

- Explicitly recognizes that moving to UHC is a political process.
- Provides practical guidance for national decision makers who seek to adopt and implement health financing reforms that move towards UHC.

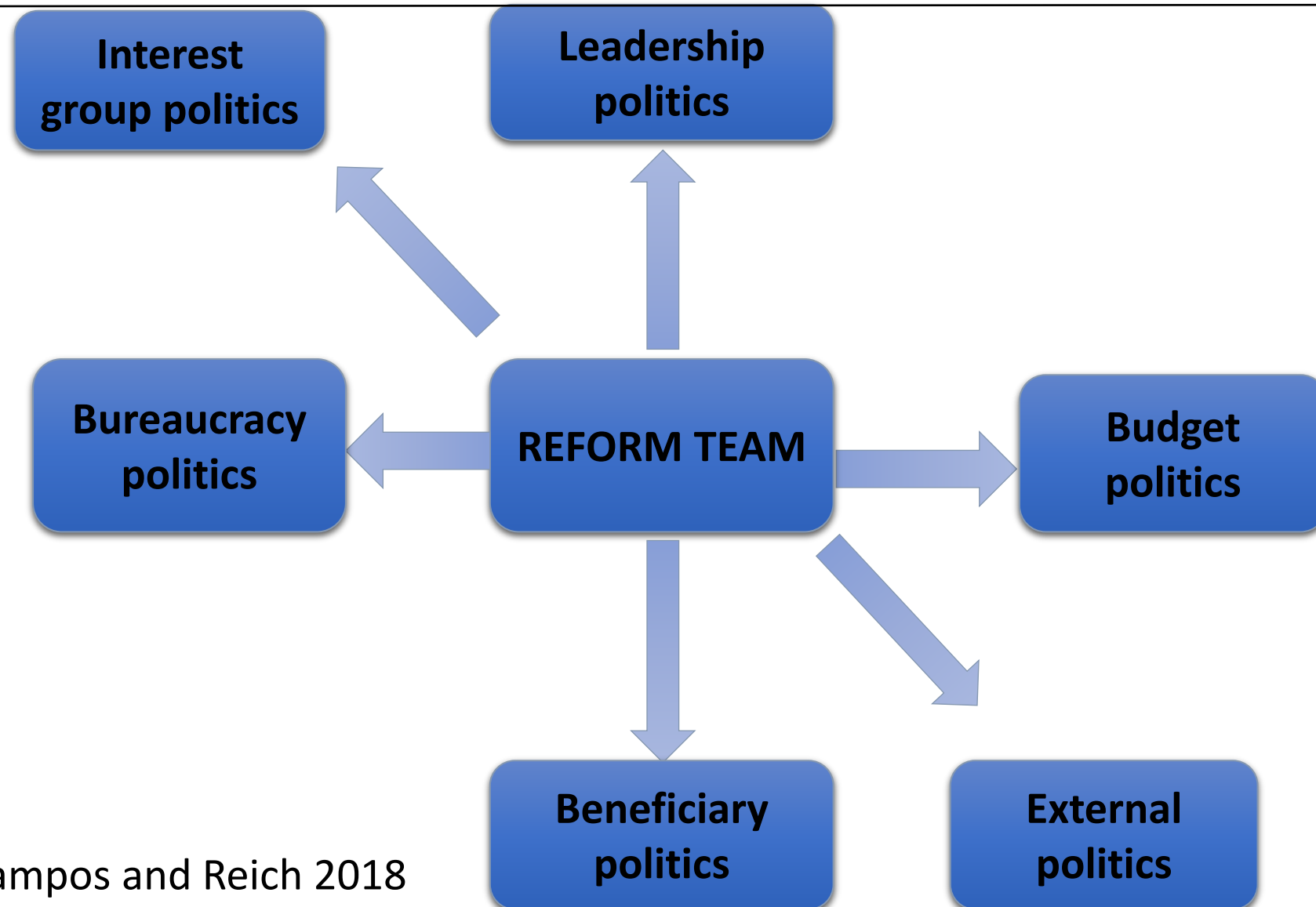
So we had this idea...

# Now what?

# Our vision

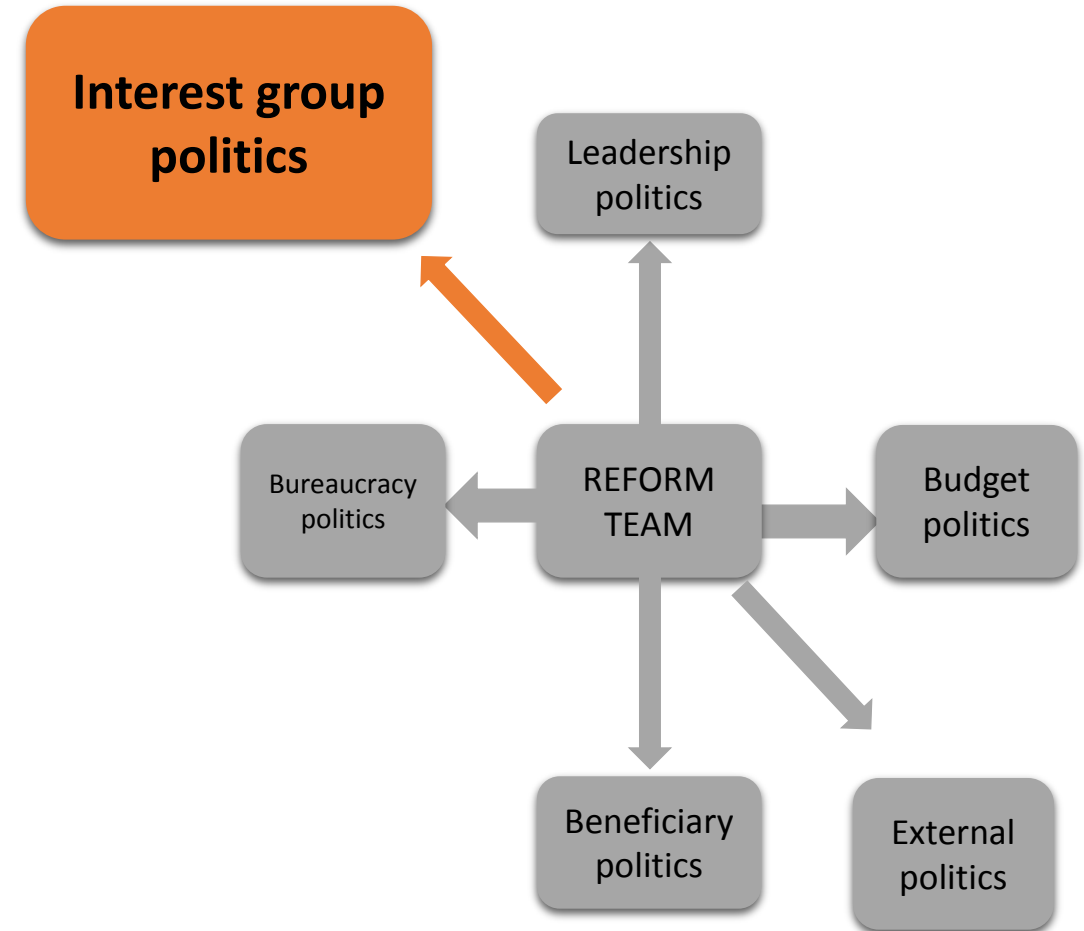
	Revenue Raising	Risk Pooling	Purchasing	Benefit Design
<b>Political Economy Typology?</b>				
<b>Typical Stakeholders?</b>				
<b>Policy Cycle Stages?</b>				
<b>Institutional Stages? (veto points)</b>				
<b>Other theory?</b>				
<b>Political Economy Area 51?</b>				

# Empirical Experience and literature review



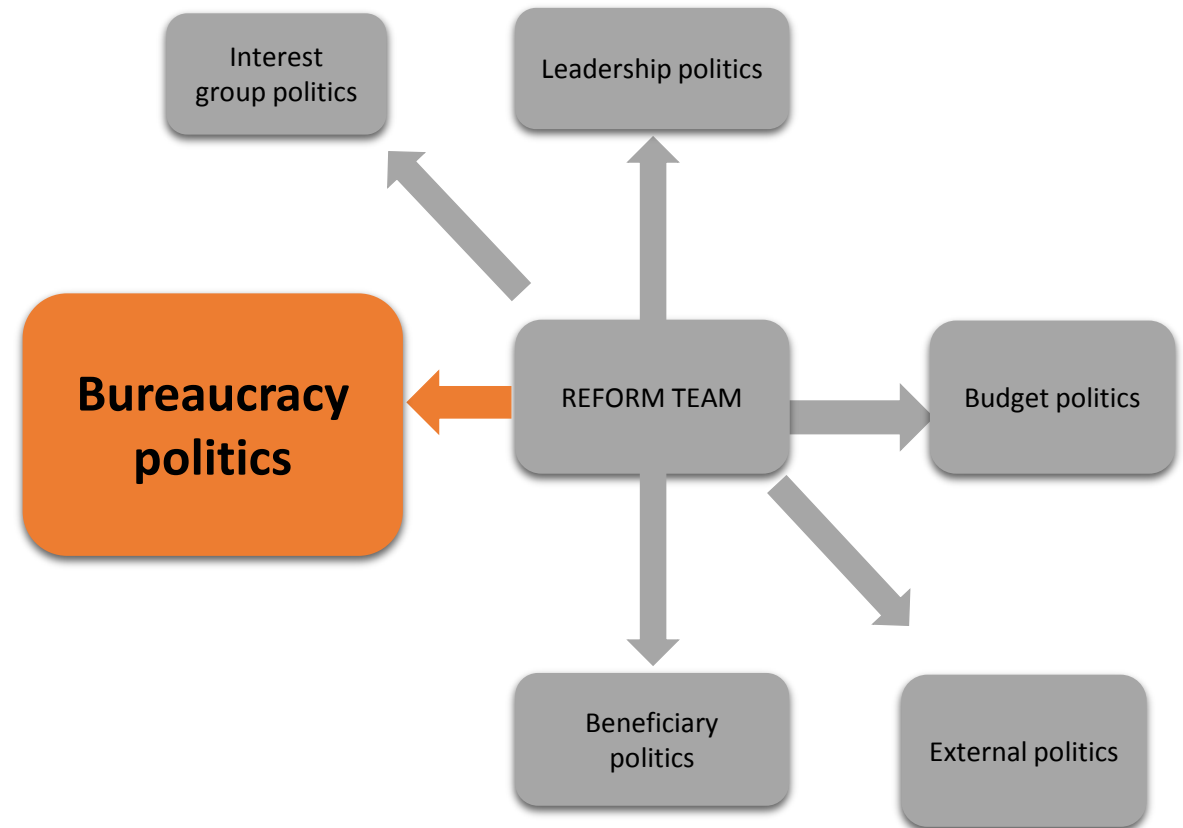
# Interest group politics

- Seek to minimize losses, maximize gains from reform
- Common stakeholders:
  - Providers and their unions
  - Industry groups
  - Insurers and employers' groups
  - Specific consumer groups



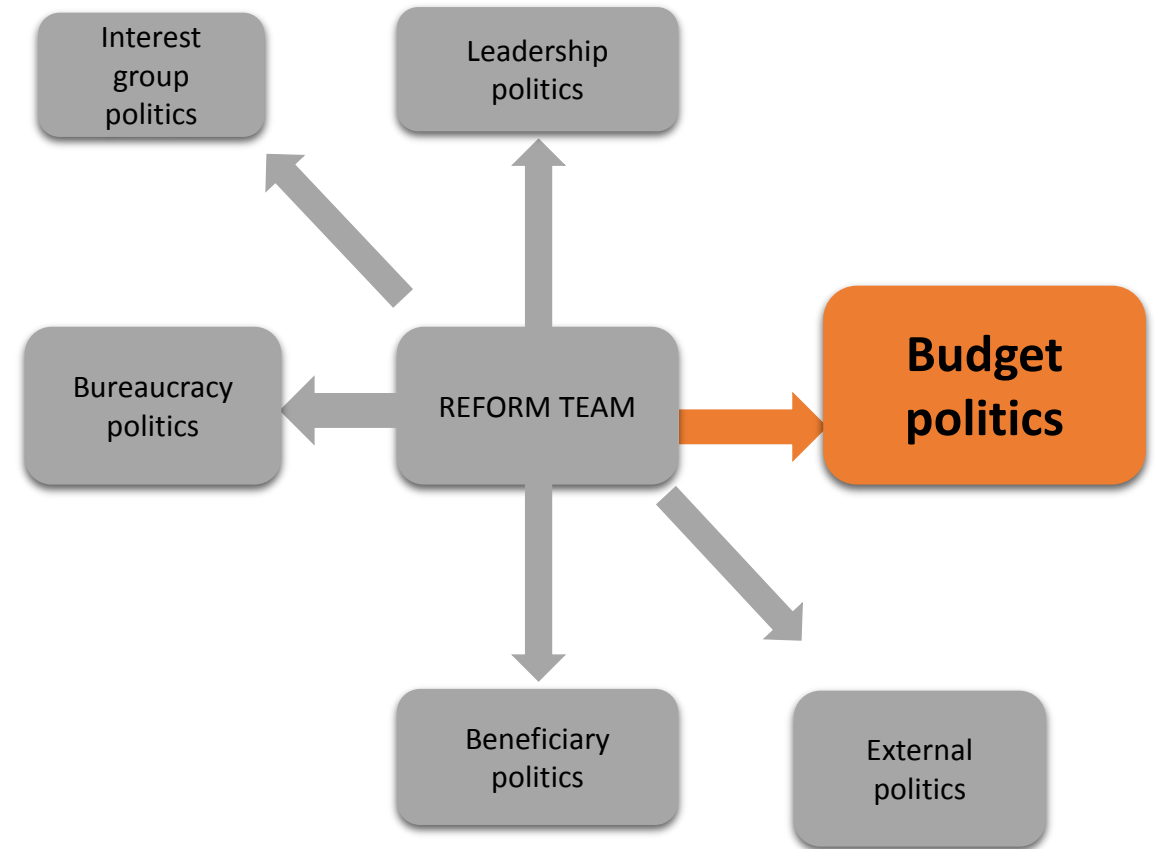
# Bureaucracy politics

- Ministries and other governmental units
- Contest reform to protect or expand authority, interests, budget, personnel, or influence.
- In federal and decentralized settings, complex central-subnational power dynamics are complex and may be influenced by party politics



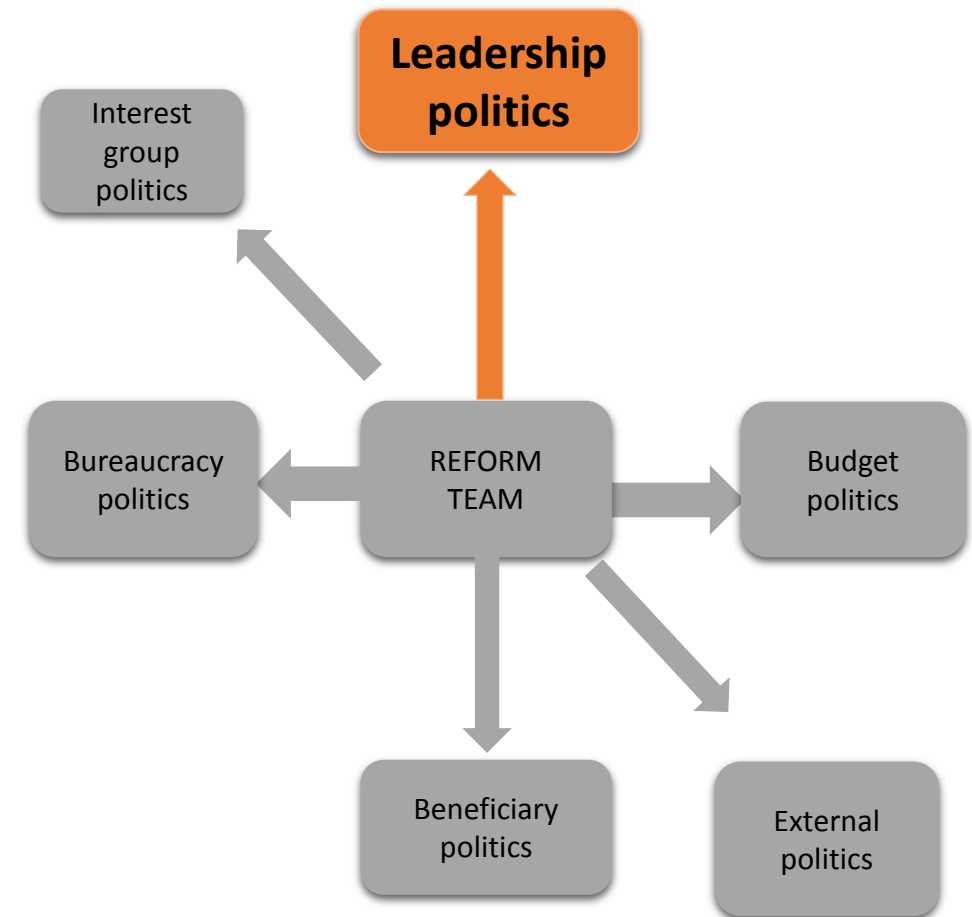
# Budget politics

- Overall tax administration and collection, revenue allocation typically lie with finance authorities
- Budget allocation and expenditure mechanisms can deeply influence reform



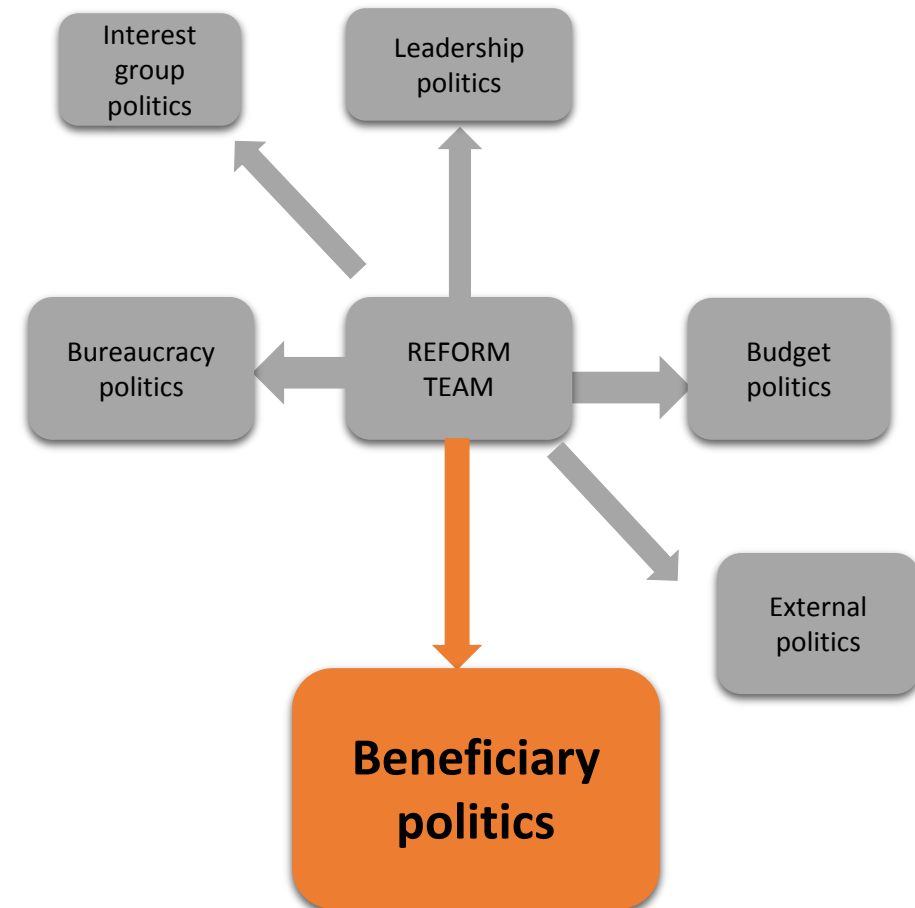
# Leadership politics

- Political leaders: executive and legislative
- Priority of reform relative to other national-level issues
- Influences perceptions of the benefits and costs of reform, thereby changing feasibility
- Electoral cycles, party politics, and context shape opportunities for reform

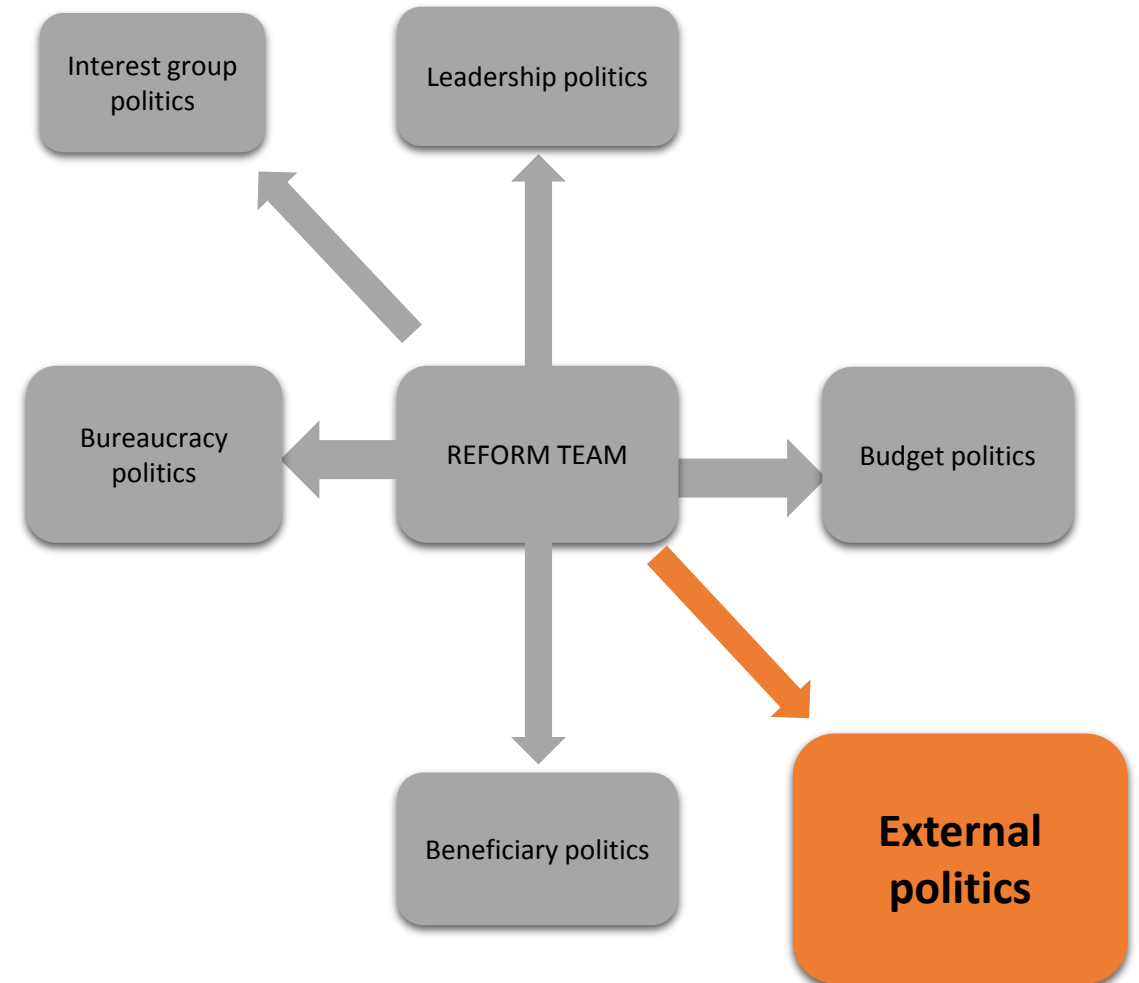


# Beneficiary politics

- Citizens
- Behaviors, preferences, and political activities of end users
- Considers ideas and ideologies
  - Alignment of reform with national values, identities, worldviews
  - Public opinion
- Reform success may require changing the behavior of end users
- Social mobilization, democratic participation of existing or potential beneficiaries



- External actors can be very influential:
  - Bi- and multi-lateral agencies
  - International financial institutions
  - NGOs, private companies, foundations
- Managing, coordinating donors is complex
- External donors can distort priorities, undermine country ownership



# Methods Conclusions

- Moving from a cloud to clarity
- Intended to identify common challenges and solutions—not as a theory of everything
- Focused on political strategies for reform teams
  - Other users would have other options
- Developed with retrospective evidence, but intended for prospective use
- Integral to policy development; not intended as a separate stage

## User perspective

- The approach takes the perspective of those working to develop and implement health financing reform:
  - Reform teams
  - Ministry of health officials
  - Practitioners, development partners and researchers supporting government officials

# Practical application of the framework



# ILLUSTRATIVE EXAMPLES OF STRATEGIES TO REDUCE FRAGMENTATION IN POOLING

Dimensions	Political economy factors	Strategies used by reform teams	Examples
Interest group politics	Advocates for reform are not well organized and too weak to adopt and implement pooling reform	Build coalitions for reform favouring political leaders and other supporting civic groups, professional associations, labour unions to influence the design of reform proposals, garner public support and support implementation Solidify the legitimacy of the pooling reform by showing public support for its technical aspects Mobilize public support by linking the reforms to the broader social and political context	Mexico, Korea
	Opposing interest groups organize against consolidation	Undermine legitimacy or replace opposing workers with those from labour unions in support of the reform agenda	
	Internal opposition from within the Ministry of Health	Settle interdepartmental conflicts in support of a single, unified view/message within the Ministry of Health Use favourable personal relationships with the Head of the Cabinet and other key Ministries and relevant institutions to garner support and block opposition's ability to influence the Legislature	Mexico, Turkey, Ghana
Bureaucratic politics	Existing social security institutions or line ministries block consolidation of revenue pools due to concerns over reduction in resources to their own institutions	Directly involve leaders from across other bureaucratic agencies to link reform with other policy priorities and to enable broad-based ownership of reform plans Support the policy development process by drawing in on the knowledge of the domestic and international technical experts Create a new independent agency with new rules and regulations Mobilize support from healthcare providers who is in favour of the new agency	
	Lack of clear delineation of responsibilities across government agencies, as consolidating pools requires redefinition of responsibilities	Form an intergovernmental task force before the pooling reforms are discussed in the Legislature to coordinate reform related policy matters	
	Uncertainty over budgetary concerns	Use societal/party values to highlight the normative importance of undertaking the reforms Build a reform team comprised of experts with strong technical knowledge, political skills and favourable personal relations with the heads of influential technical and political institutions, as well as politicians Enable a public policy making process that will allow participation of interest groups in the design of the reform	Mexico, Turkey
Budget politics	The Ministry of Finance controls the government budget and has the capacity to block consolidation of pools due to concerns over increased budgetary pressures and the expectation of rising costs	Use societal/party values to highlight the normative importance of undertaking the reforms Build a reform team comprised of experts with strong technical knowledge, political skills and favourable personal relations with the heads of influential technical and political institutions, as well as politicians Enable a public policy making process that will allow participation of interest groups in the design of the reform	
	Minister of Health is too weak to address opposition from within the ruling political party to pooling reform	Engage the top-level political leadership's influence to enforce strict party discipline among party members in support of the reform Position the reform as a central policy issue to garner votes and political support by directly tying policy with individual benefits	Mexico, Turkey, Korea
	Leadership politics	Resistance from the opposition parties to the ruling party's vision for the consolidation of pools	Use the President's election campaign platform to increase public visibility of health policy reforms Use the party values/ideology/President's personal values (e.g. social solidarity) to inform the underlying approach to pooling reform Sequence health reforms such that easily implementable-high visibility changes are adopted in the earlier reform stages to garner public support Incorporate supporting interest groups into the policy development process by using their technical expertise and influence in the public sphere Exert strong political will of the top-level politicians, including the President or the Prime Minister, to pass the pooling reform agenda Use party majority in the Legislature to pass laws
General public is disengaged from the highly technical pooling reform		Use the President's election campaign platform to increase public visibility of health policy reforms Reframe the public debate on the pooling reform as a crucial component of good governance, modernization of the nation, and benefits to individuals Set up hot lines for citizens to address questions, concerns and complaints Direct engagement with public through ministerial forums and town halls Highlight pooling reform as a political priority in the political manifesto and in the government's political agenda Use favourable media coverage to mobilize support for the proposed pooling reforms from among the most disadvantaged groups of the population	Ghana, Korea
Opposition parties garner public support for their vision of the pooling reforms		Rapidly pass reforms in the Legislature before the new election cycle to pre-empt the efforts of the opposition Use media coverage to create a negative perception of the opposing political actors in the eye of the public	
External actor politics	The existing pooling arrangements are perceived as the legacy of external actors	Collaborate with international organizations with high technical expertise to demonstrate the deleterious impact of the existing pooling arrangements on health service utilization and financial risk protection Use funding from international organizations to pilot different models of revenue pooling to determine which one works better given the country context	Ghana, Turkey
	International organizations favour a different model of pooling reforms compared to the reform team	Facilitate an open dialogue with various international organizations that can contribute to the design, financing and development of the reform plans	

# Practical application of the framework

- We tested the approach by conducting a retrospective analysis of international experiences in reducing fragmentation in pooling

## References

1. Alin, R., Y. Hwang, and M. Quiñanes. The Evolving Functions and Organization of Finance Ministries. *Public Budgeting & Finance*, 2005, 30(4): p. 3-25.
2. Anderson, L, et al. How can health ministries present persuasive investment plans for women's, children's and adolescents' health? *Bulletin of the World Health Organization*, 2016, 94(6): p. 468-476.
3. Blanchet, N., G. Fink, and I. Osh-Akiba. The Effect of Ghana's Health Insurance Scheme on Health Care Utilization. *Ghana Medical Journal*, 2012, 46(2): p. 76-84.
4. Bump, J.B. and Political Economy of Turkey's Health Programme. *30 Washington, D.C.*
5. Cahlin, C., et al. Financing public health and health systems. *Health Affairs*, 2017, 36(10): p. 1743-1748.
6. Oh, Y.-I. and J. Bump. Resource allocation process in global health: a review of health policy and planning. *2018, 33(suppl. 1): 14-18.*
7. Fox, A.M. and R. Reich. The politics of universal health coverage in low and middle income countries: a framework for analysis and action. *Journal of Health Politics, Policy and Law*, 2015, 40(5): p. 1023-1060.
8. Gómez-Dantés, O., M.R. Reich, and F.M. Knaul. The democratization of health in Mexico: financial innovations for universal coverage. *Bulletin of the World Health Organization*, 2009, 87: p. 543-548.
9. Gómez-Dantés, O., M.R. Reich, and F. Garrido-Latorre. Political economy of pursuing the expansion of social protection in health in Mexico. *Health Systems & Reform*, 2015, 1(3): p. 207-216.
10. Kwon, S., J. C. Cahlin, and M. Jochims. Approach to understanding health policy making in Korea. *Journal of Health Politics, Policy and Law*, 2015, 40(3): p. 195-219.
11. Kutzlin, J., C. Cahlin, and M. Jochims. Implementing Health Financing Reform: Lessons from Countries in Transition. 2010. *European Observatory on Health Systems and Policies.*
12. Kwon, S. Healthcare financing reform and the new single payer system in the Republic of Korea: Social solidarity or efficiency? *International Social Security Review*, 2003, 56(3): p. 75-94.
13. Kwon, S. and M.R. Reich. The changing process and politics of health policy in Korea. *Journal of Health Politics, Policy and Law*, 2005, 30(5): p. 1003-1026.
14. Lakin, J.M. The possibilities and limitations of insurgent technocratic reform: Mexico's Popular Health Insurance Program, 2001-2005. 2008. *Harvard University: Cambridge.*
15. Lakin, J. The End of Insurance: Mexico's Seguro Popular, 2001-2007. *Journal of Health Politics, Policy and Law*, 2010, 35(3): p. 353-378.
16. Mahmood, S.A., et al. Making Politics Work for Development: Harnessing Transparency and Citizen Engagement. 2016. *World Bank: Oxford, UK.*
17. Olson, M. The Logic of Collective Action: Public Goods and the Theory of Groups. 1965. *Cambridge MA: Harvard University Press.*
18. Roberts, M., et al. Getting Health Reform Right: A Guide to Improving Performance and Equity. 2014. *New York: Oxford University Press.*
19. Sparkes, S., J. Bump, and M. Reich. Political Strategies for Health Reform in Turkey: Extending Veto Point Theory. *Health Systems & Reform*, 2015, 1(4).
20. Sjaastad, J.L. Negotiating change: an analysis of the origins of Ghana's national health insurance act. 2006.

## Bureaucratic politics related to reducing fragmentation in pooling

---

Existing **social security institutions** or **bureaucratic agencies** may express concerns over policies to consolidate pools

Perceived threat that the consolidation plans could **reduce benefits to their own beneficiaries**

---

Influx of new beneficiaries into existing pools could overwhelm the capacity to deliver services

### Examples

**Turkey**

**Mexico**

---

# Navigating bureaucratic politics

---

Use **favourable personal relationships** with top political leaders to strengthen support and reduce opposition to the proposed consolidation

---

Form an **intergovernmental task** force before the pooling reforms are discussed in the Legislature to coordinate plans across bureaucratic agencies

---

Support the policy development process by **drawing on the knowledge of domestic and international technical experts**

---

## Concluding remarks

- We applied the approach in a retrospective analysis of international experiences in reducing fragmentation in pooling
- Intended use: reform teams can use this approach to improve the political feasibility of a desired health financing reform

Thank you

# Acknowledgments

- We gratefully acknowledge:
  - All participants of the 2-3 July 2018 expert consultation on *The Political Economy of Health Financing Reform: Analysis and Strategy to Support Universal Health Coverage*
  - Harvard T.H. Chan School of Public Health, in addition to the authors, research assistance from Claire Chaumont and administrative support from Emily Cole
  - Financial support from the United Kingdom's Department for International Development (Making Country Health Systems Stronger programme)

# References

- Campos PA, Reich MR. Political Analysis for Health Policy Implementation (DRAFT). Rockville, Maryland: Health Finance and Governance Project, Abt Associates; 2018.
- Frenk J. The global health system: strengthening national health systems as the next step for global progress. *PLoS Med* 7 2010; 1: e1000089.
- Berlan D, Buse K, Shiffman J, Tanaka S. The bit in the middle: a synthesis of global health literature on policy formulation and adoption. *Health Policy Plan* 2014; 29(Suppl 3): iii23-iii34.
- Brinkerhoff DW, Crosby B. Managing policy reform: concepts and tools for decision-makers in developing and transitioning countries. Bloomfield, CT: Kumarian Press; 2002
- Gilson L. Everyday Politics and the Leadership of Health Policy Implementation. *Health Systems & Reform* 2016; 2(3): 187-93.

# Thailand Universal Coverage Scheme: Political Economy Factors

Walaiporn Patcharanarumol, PhD.  
International Health Policy Program (IHPP),  
Ministry of Public Health, Thailand

9 October 2018

Liverpool, UK

# Thai Universal Health Coverage, since 2002

**68 million Thai populations**

UC Scheme	Civil Servant Scheme	Social Health Insurance
Act 2002	Royal Decree 1980	Act 1990
48 mln pop (reside in rural areas; Q1-2; children, elderly, informal wk)	9 mln pop (urban; Q4-5; children, elderly, public sector wk)	11 mln pop (city; Q4-5; only adult workers in private sector)
Tax funded	Tax funded	Tripartite cont
National Health Security Office	Comptroller General Dept, MOF	Social Security Office, MOL

**Public (75%) & private (25%) health facilities**

# Functions of UC Scheme's manager

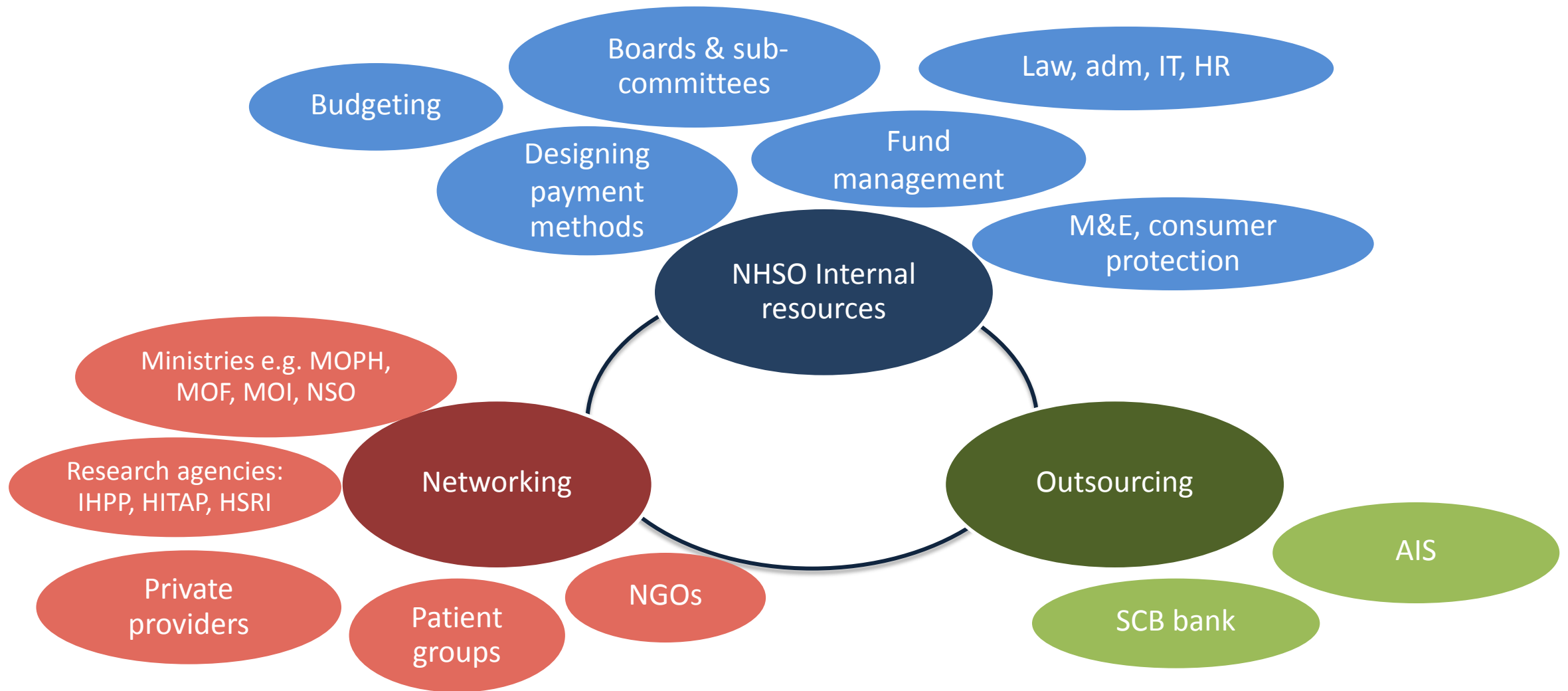
UHC in real actions: (a) ensure access & (b) financial risk protection

## 1. Managing the Boards / committees – Good Governance

2. Budgeting	3. Designing payment methods	4. Fund management	5. M&E, consumer protection
<ul style="list-style-type: none"> <li>• Beneficiary registration (CRVS)</li> <li>• Benefit package</li> <li>• Cost of service</li> </ul> <p><b>Adequate funding</b></p>	<ul style="list-style-type: none"> <li>• Provider registration &amp; beneficiaries' allocation</li> <li>• New idea for improvement</li> </ul> <p><b>Efficiency, equity and quality</b></p>	<ul style="list-style-type: none"> <li>• 70% of UCS budget by capitation &amp; DRG</li> <li>• 30% by reimbursement (claim – high cost, special payment)</li> <li>• Audit</li> <li>• Payment</li> </ul> <p><b>Accountability &amp; transparency</b></p>	<ul style="list-style-type: none"> <li>• Call Center</li> <li>• Public hearing</li> <li>• Satisfaction survey</li> <li>• Report to the Board, Cabinet &amp; public</li> </ul> <p><b>Right protection</b></p>

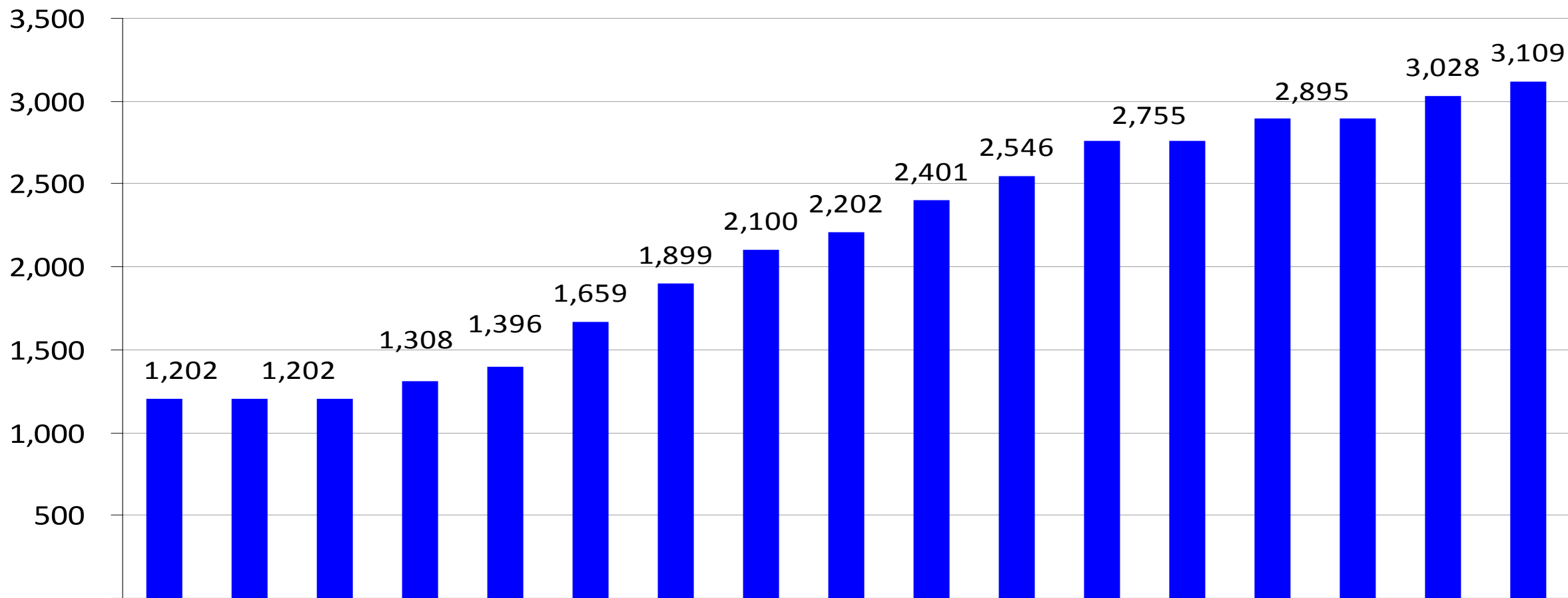
## 6. Fundamental issues: law, administration, IT, HR

# Implementing UC Scheme



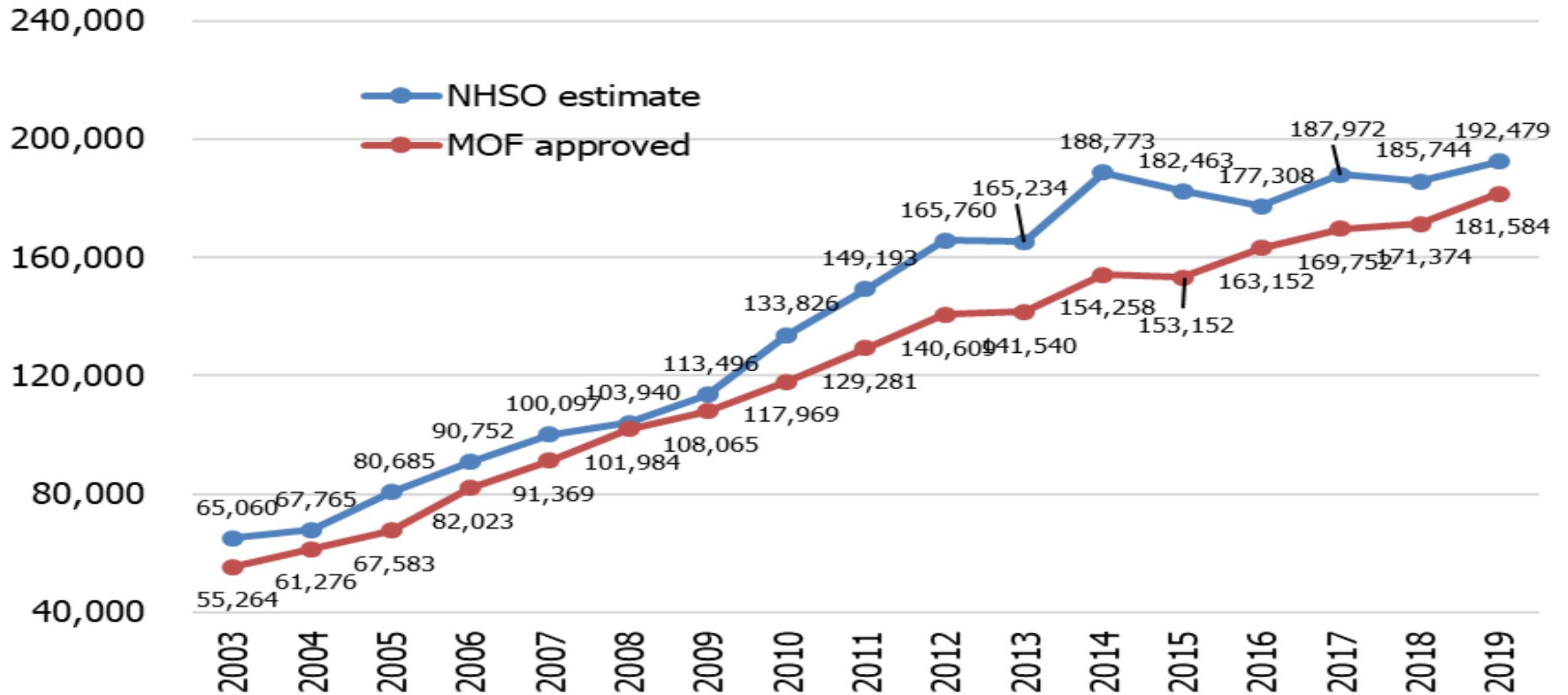
# Continued political commitment to UC scheme, despite 8 rival governments, 13 health ministers and 11 permanent secretaries

Baht / person / year



2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
G 1				G 2		G 3	G 4, 5	G 6		G 6, 7	G 7		G 7, 8	G 8		
M 1				M 2	M 3	M 4	M 5-7	M 8	M 9	M 9	M 10	M 11	M 12	M 12	M 13	M 13

# UC Scheme budget (million Thai Baht)



Source: data from National Health Security Office

## Political economy factors

- **Triangles that Move the Mountain: political-social-intellectual powers**
  - Different actors in moving towards UHC: government, MOPH, providers, CSO, academia, public media etc
  - Home grown capacities to generate evidence and meet emerging challenges
- **Peace and economic growth** allowed larger fiscal spaces for social protection
  - Health budget gradually moved up to around 16% of government budget
- **Health system strengthening:** PHC based equitable Health Systems since 1978 vs tertiary care hospitals

## Remaining challenge

- Fragmentation of three schemes

# WHO symposium on health financing for UHC

## Political Economy Outline of Peru's Health Reform



**Midori de Habich**  
**Liverpool, October 2018**

# Purpose

Can we learn from the past trajectory to jump start the next phase of the health reform?

# Overview of Peru's Health Reform

<i>Period</i>	2004-2005	2006-2007	2009	2009-2010	2013-2016
<i>Policy cycle</i>	<b>Agenda setting</b>	<b>Policy design</b>	<b>Approval</b>	<b>Implementation I</b>	<b>Implementation II</b>
<i>Key milestones</i>	Approval of the Political Parties' Agreement on Health	Multiple legislative proposals from diverse political parties	Approval of the Universal Health Insurance Law (UHI)  Approval of the Benefit Package - PEAS	Approval of the UHI by-law  Implementation of UHI pilots	<b>Scaling -up (*)</b>  Expansion of population coverage  Extension of PEAS nationwide  Strengthening of SIS (Public Health Insurer)  Creation of SUSALUD (National Health Superintendency)

2006 Presidential election

2011 Presidential election

2016 Presidential election

(\*) 24 Legislative Decrees

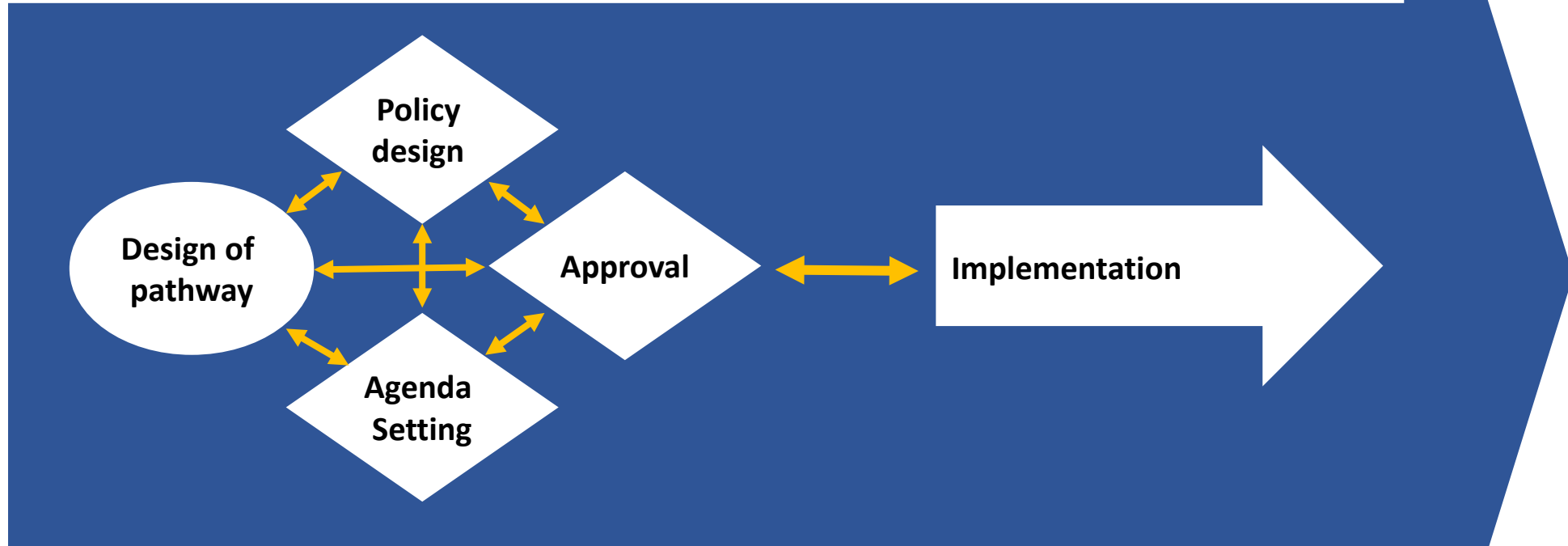
<b>Period</b>	<b>2004-2005</b>	
<b>Policy cycle</b>	<b>Agenda setting</b>	
<b>Milestone</b>	<b>Approval of the Political Parties' Agreement on Health (PPAH)</b>	
<b>Opportunity</b>	Post-Fujimori democratic transition. Revival of political parties and movements.	
<b>Key dimensions:</b>	<b>Political economy factors</b>	<b>Strategies</b>
Interes groups Leadership Politics	Health and health reform not a political priority.  Potential advocates and political leaders not well informed and not organized	Facilitation of a consensus building process with wide participation of 16 political parties, ahead of the election period ( <i>"veil of ignorance"</i> ).  Knowledge sharing on health sector indicators, particularly health financing  Support discussion by drawing on international techno-politicians /high level practitioners
Bureaucratic Beneficiary Politics	Little awareness or involvement.	No strategies for engagement.

<b>Period</b>	<b>2007-2009</b>	
<b>Policy cycle</b>	<b>Policy design and Approval</b>	
<b>Milestones</b>	<b>Multiple legislative proposals from diverse political parties Approval of the Universal Health Insurance Law (UHI)</b>	
<b>Opportunity</b>	Political parties incorporated (some notion) of health reform as a priority.	
<b>Key dimensions:</b>	<b>Political economy factors</b>	<b>Strategies</b>
Interes groups Leadership Politics	Need for differentiation (after the broad consensus) of political actors.  Resistance of MOF to UHI reform due to fiscal constraints.	Technical support to the President of Congressional Health Committee (of the governing party and member of the PPAH).  Facilitation of a convergence process of most of the multiple proposals.  Movilization of the members of the PPAH to achieve support in Congress to pass the UHI Law.
Bureaucratic Politics	Resistance of MOF to UHI reform due to fiscal constraints.	Support from the President and empowerment of the Minister of Health.
Beneficiary Politics	Little involvement.	No strategies for engagement.

<b>Period</b>	<b>2009-2010</b>	
<b>Policy cycle</b>	<b>Implementation: initial phase</b>	
<b>Milestones</b>	<b>Approval of the UHI by-law, Benefit Package (PEAS) and pilots</b>	
<b>Opportunity</b>	Economic growth, Presidential support.	
<b>Key dimensions:</b>	<b>Political economy factors</b>	<b>Strategies</b>
Interes groups Leadership	Resistance of MOF to UHI reform due to fiscal constraints.	Implementation of pilot experiences in 3 poor regions. ( <i>"What doesn't happen in Lima, doesn't happen"</i> )
Politics	Resistance from left wing parties and related civil society organizations.	Emphasis on pro-poor orientation of the reform
Bureaucratic Politics	Resistance (pasive) from sub sectors (Social Security, private sector, etc. ) to accept MOH stewardship role	Creation of the National Committee for the implementation of UHI, lead by the Minister of Health
Beneficiary Politics	Little awareness or involvement.	No national strategies for engagement.

<b>Period</b>	<b>2013-2016</b>	
<b>Policy cycle</b>	<b>Implementation: scaling up</b>	
<b>Milestones</b>	<b>Extension of population coverage, extension of PEAS nationwide, Strengthening of SIS (Public Health Insurer), Creation of SUSALUD (National Health Superintendency), wage reform, investment reform.</b>	
<b>Opportunity</b>	Economic growth, Presidential support.	
<b>Key dimensions:</b>	<b>Political economy factors</b>	<b>Strategies</b>
Interes groups Leadership Politics	<p>Resistance from providers (public hospitals) and unions.</p> <p>Resistance from left wing parties and related civil society organizations.</p>	<p>The President's request to the National Health Council for a health reform package</p> <p>Delegation of Legislative Faculty to the MOH for the approval of the health reform package (24 Legislative Decrees)</p> <p>Agreement of health policy framework MOH-Regional Governments</p> <p>Coordination of policy implementation MOH-Regional Health Directorates.</p>
Bureaucratic Politics	Resistance of MOF to UHI reform due to fiscal constraints.	Support from the President and empowerment of the Minister of Health.
Beneficiary Politics	Little awareness or involvement.	Short-route: Creation of Citizens Juries (Juntas de Usuarios)

# Going forward



Adapted from *Facilitative Leadership*.



[mdehabich@iages.com.pe](mailto:mdehabich@iages.com.pe)