Political Economy of Primary Health Care: A Comparison of Health System Reforms

This Doctoral Thesis, *Political Economy of Primary Health Care: A Comparison of Health System Reforms*, presented by *Anuska Kalita*,
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Abstract

This doctoral thesis examines the political economy of primary health care (PHC) reforms across nine countries—the Democratic Republic of Congo, Dominica, Egypt, Kazakhstan, Kenya, New Zealand, Thailand, Tunisia, and Uruguay—which represent diverse political, economic, and health system contexts. Addressing a gap in the literature where the political economy of PHC remains underexplored, the study investigates: (1) How have political economy factors driven PHC reforms? and (2) What are the distinct political economy factors of PHC reforms, and how do they differ across different types of PHC reforms—those focusing on financing versus organization?

Employing historical institutionalism alongside the Control Knob Framework, this thesis analyzes how political economy factors interact to shape reform trajectories. The research draws on primary qualitative data from 324 respondents via interviews, focus groups, and expert consultations across the sampled countries, complemented by an extensive review of literature and policy documents. Using the Framework Method, both deductive analysis for theory application and inductive approaches for theory building were applied. Process tracing provides an in-depth analyses of each reform, while the Comparative Sequential Method examines reform trajectories across health systems.

The findings reveal that political economy dynamics operate at multiple interrelated levels. Temporality is critical—historical legacies and path dependencies can constrain and enable reforms, while political upheavals or economic crises create windows for transformative change. Institutional contexts—political systems, electoral rules, constitutional provisions, and bureaucracies—significantly influence reform outcomes. Interest groups such as physicians, civil society, donors, and citizens actively shape reforms, while the politics of ideas affect public support and sustainability.

This research identifies six distinct domains of political economy tensions in PHC reforms: (1) public versus private sector, (2) hospital versus primary care, (3) physicians versus non-physicians, (4) centralized versus decentralized administration, (5) expanding versus limiting citizens' choice, and (6) selective versus comprehensive changes. Moreover, the chosen reform entry point—whether financing or organization—shapes how these tensions unfold. Understanding these dynamics can help policy actors anticipate resistance and devise strategies to navigate reforms. To build resilient health systems, countries must strengthen local capacities for political economy analysis and engage diverse stakeholders.

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CHAPTER 1: INTRODUCTION

Primary health care (PHC), as defined by the World Health Organization (WHO), is a whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and wellbeing closer to communities (1,2). PHC aims to optimize both the level and equitable distribution of health and wellbeing through three core components: primary care and essential public health functions as the backbone of integrated health services; multisectoral policy and action; and the empowerment of people and communities (1,2).

The concept of PHC and the global movement supporting it emerged in the late 1960s and 1970s, culminating in the International Conference on Primary Health Care held in Alma-Ata in 1978, in the former Soviet Union (now Kazakhstan). The movement gained momentum, although with criticism of the vertical health approach used in malaria eradication by U.S. agencies and the WHO since the late 1950s and the hospital-centric model of the U.S., many Western European countries, and the former Soviet Union (3–5). The experiences in developing countries, especially in the then-newly independent nations across Asia and Africa, showed that the conventional health care model was not suited for population wellbeing and equitable health outcomes for large segments of the populations living in rural areas at that time, and with the burden of disease dominated by infectious diseases. This acknowledgment led to recognizing the need for a paradigm shift in health systems. Experiencing the drawbacks of overspecialization, overreliance on hospitals, and the dominance of physicians, policymakers began to emphasize a model where nurses, midwives, and community health workers played a central role, focusing on prevention, community-based care, and health promotion. Health was no longer seen merely as the absence of disease but as intrinsically linked to development (3,6).

However, the concept of PHC faced significant challenges in the years following Alma-Ata. In the 1980s, the introduction of ‘selective PHC’—focused on a limited set of cost-effective interventions such as immunization, infectious diseases, and maternal and child health—narrowed the original vision of

comprehensive PHC (7). This shift was driven by financial and political pressures, particularly from international donors and development agencies, leading to a dilution of the broader, more holistic approach outlined at Alma-Ata (3). Additionally, low- and middle-income countries (LMICs) faced severe fiscal crises, starting with slowed growth during the 1950s and ‘60s, followed by the oil shocks of the 1970s. As a result, the momentum for comprehensive PHC waned, and the movement lost traction in many regions, where vertical programs regained prominence. Vertical programs received a further push by donor agendas in the early 2000s, especially with the emergence of global health institutions focusing on disease-specific funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi (the Vaccine Alliance) focused on vaccines, and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

Despite these setbacks, the global health community began to rediscover the importance of comprehensive PHC in the 2000s, driven by a growing recognition of the limitations of selective approaches. Significant international efforts, such as the World Health Report of 2008, titled “Primary Health Care: Now More Than Ever,” (8) and the 2018 Global Conference on Primary Health Care in Astana (1), marked a resurgence in the commitment to PHC. The 2018 Astana Declaration reaffirmed the principles of Alma-Ata while adapting them to the current global health context, placing renewed emphasis on integrated, people-centered health systems and multisectoral action. This resurgence reflected a global shift toward the ideals of equity, access, and sustainability central to the original PHC vision, one that has gained even more salience in the wake of the COVID-19 pandemic.

The value of orienting a health system toward PHC is well-documented. Effective and high-quality PHC enhances efficiency and equity and reduces dependency on specialist and hospital services (9,10). By fostering continuity through sustained relationships between physicians and patients, PHC encourages more appropriate care utilization and lowers health care costs (11,12). It is pivotal in improving access to quality services by ensuring continuity, comprehensiveness, and care coordination (13). In the long term, PHC has been shown to improve population health outcomes, particularly in areas such as mental health,

child health, and the prevention and management of non-communicable diseases (14,15), and is associated with higher patient satisfaction and improved self-reported health, as it delivers care within a trusted setting that takes into account patient, family, and community contexts (16). Additionally, PHC enhances health system resilience and emergency preparedness by emphasizing preventive care, a multidisciplinary approach, and the strong connections it fosters between individuals and communities (17).

In recognition of these advantages, over the years, major global health institutions have underscored PHC as a critical component of efforts to achieve Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs), especially goal three to ensure healthy lives and promote well-being for all at all ages (1). Countries around the world have engaged in multiple reform efforts toward this vision of PHC, addressing different aspects of the health system. However, these reform efforts have yielded varied results across countries (18). Some nations have successfully embraced PHC reforms, while others have struggled with adoption and implementation or even seen reforms reversed. These challenges are not simply the result of technical design flaws or implementation gaps, though these factors play a role. Rather, the crux of success or failure often lies in the context of political economy (18–20).

These varied experiences reinforce a key argument made by several scholars: health reforms are not merely technical adjustments to improve outcomes, but are deeply embedded in the political and economic contexts in which they are conceived and implemented (20,21). PHC reforms are inherently political, as they inevitably involve the redistribution of resources among various stakeholders to achieve just and equitable access to affordable and high-quality health care. These reforms involve changes across multiple dimensions of the health system—financing, provider payment, governance, organization, and persuasion. Consequently, they require engagement with a wide array of public-private and health and non-health stakeholders, each with distinct and sometimes competing interests. For example, PHC reforms often require the reallocation of financial and human resources from hospitals to primary care; they involve role-redefinitions in which community health workers or nurses begin to assume functions

traditionally performed by physicians or result in personnel from different clinical and non-clinical backgrounds start working together in multidisciplinary teams. These realities mean that PHC reforms involve different stakeholder groups and, fundamentally, a redistribution of resources among various levels and, importantly, from more well-resourced groups to lower-resourced ones, inevitably touching on entrenched interests and political economy dynamics.

Given the inherently political nature of PHC reforms, it is unsurprising that political economy factors frequently determine why these reforms gain or lose traction, why some stakeholders support or resist changes, and how reforms are sustained or reversed over time. Without this understanding, many reforms risk failure, regardless of their technical merits (20,22). Yet, despite its importance, most policy and research attention has focused on the technical design or evaluation of PHC initiatives, leaving political economy factors under-researched and under-theorized—often treated as a black box.

In this thesis, I unpack this black box to understand how political economy factors influence PHC reforms across different health systems and examine how these factors differ among varying types of PHC reforms. Specifically, I answer two research questions:

> ***Research question 1:*** How have political economy factors driven PHC reforms across countries?
>
> ***Research question 2:*** What are the distinct political economy factors of PHC reforms, and how do they differ across different types of PHC reforms—those focusing on financing versus organization?

Through my involvement in a collaborative initiative with the WHO, I draw on data from nine countries – the Democratic Republic of Congo (DRC), Dominica, Egypt, Kazakhstan, Kenya, New Zealand, Thailand, Tunisia, and Uruguay – and extensively supplement this data. I use political economy analysis to explain the trajectories of PHC reforms in these health systems, primarily via a historical institutionalist approach that examines how institutions, understood as enduring rules, norms, and

structures, shape interests and ideas over time. I explicitly examine the links between wealth and power, politics and economics, and states and markets in the reform process (22,23), and how formal and informal institutions in countries form and perpetuate interest groups, determine the bases of support or opposition to PHC reforms, and eventually, how these forces shape reform trajectories (23,24). Importantly, I extend the analysis into theory building by proposing a set of political economy factors that are distinctly relevant to PHC reforms and by examining the differences among various types of health system reforms. To the best of my knowledge, this is the first analysis of its kind.

While this thesis aims to contribute to and advance the literature on health systems and the political economy of health reforms, my broader doctoral work has a related goal to translate this research into practice by informing practitioners and policy actors on potential political economy factors they might face in navigating the reform process and equipping them with essential resources and capacities to analyze and address these factors. In addition to broader dissemination efforts and consultations to generate dialogs on political economy, I undertake this 'translation' through two concrete areas: (1) designing and teaching a module on "Navigating the Political Economy and Culture of Change" for the Course on *Leadership for PHC* intended for senior policy actors and reform leaders at the WHO Academy in Geneva, and (2) co-authoring a resource book designed as a policy actors' manual on political economy analysis for PHC reforms.

The remainder of this thesis is organized as follows. Chapter 2 starts with the theoretical frameworks and operational definitions of the fundamental concepts that form the analytical foundation of the study. It then presents a literature review drawing on three related but distinct strands: political economy and historical institutionalism, the political economy of health and development, and political economy analyses of health reforms. Chapter 3 outlines the data and methodology employed, including the limitations of the research. Chapter 4 sets the context by presenting the key characteristics of the political-economic environments of the nine countries (with details in Appendix 1), detailing their health systems, and describing the PHC reforms analyzed in this thesis. Chapter 5 then presents and discusses the findings

for the two research questions. First, by applying a historical institutionalist approach, it examines the various political economy factors that have driven PHC reforms across the countries. Next, it offers a novel exploration of the distinct domains of political economy dynamics specific to PHC, highlighting differences between various types of health system reforms. Finally, Chapter 6 summarizes the main findings and explores their implications for policy and practice.

CHAPTER 2: DEFINITIONS, THEORETICAL FRAMEWORKS, AND LITERATURE REVIEW

Definitions and theoretical frameworks

In this section, I define the foundational terms I use in this thesis. I clarify what I mean by health system reforms, how I operationally define political economy analysis, and discuss the theoretical approach and concepts of historical institutionalism.

Health system and health system reforms

At its core, this thesis is concerned with health systems and their reforms. Various frameworks have offered differing definitions and conceptualizations of health systems (21,25–28). Similarly, it is challenging to define "health reform" precisely, as the term is subject to multiple interpretations. To define both these terms – *health system* and *health system reforms* – I draw on one of the pioneering frameworks in this field, the Control Knob Framework, developed by Roberts and colleagues (21). This framework conceptualizes the health system *as a means to certain ends*, where "the means" of *health financing*, *provider payments, organization of the health care delivery system, regulation,* and *persuasion* act as interrelated policy levers that, when changed, lead to "the ends" – easier *access,* high *quality* of care delivered with *efficiency* (intermediate outcomes) and better *health status*, *financial risk protection* to prevent economic hardships to those seeking health care, and high *public satisfaction* (final outcomes) (21). Figure 1 provides a diagrammatic representation of the Control Knob Framework. The policy levers are interconnected, meaning that changes in one almost inevitably produce intended or unintended effects in others. Similarly, intermediate and final outcomes are linked—strong or weak performance in one outcome usually impacts performance in other outcomes and even overall system performance.

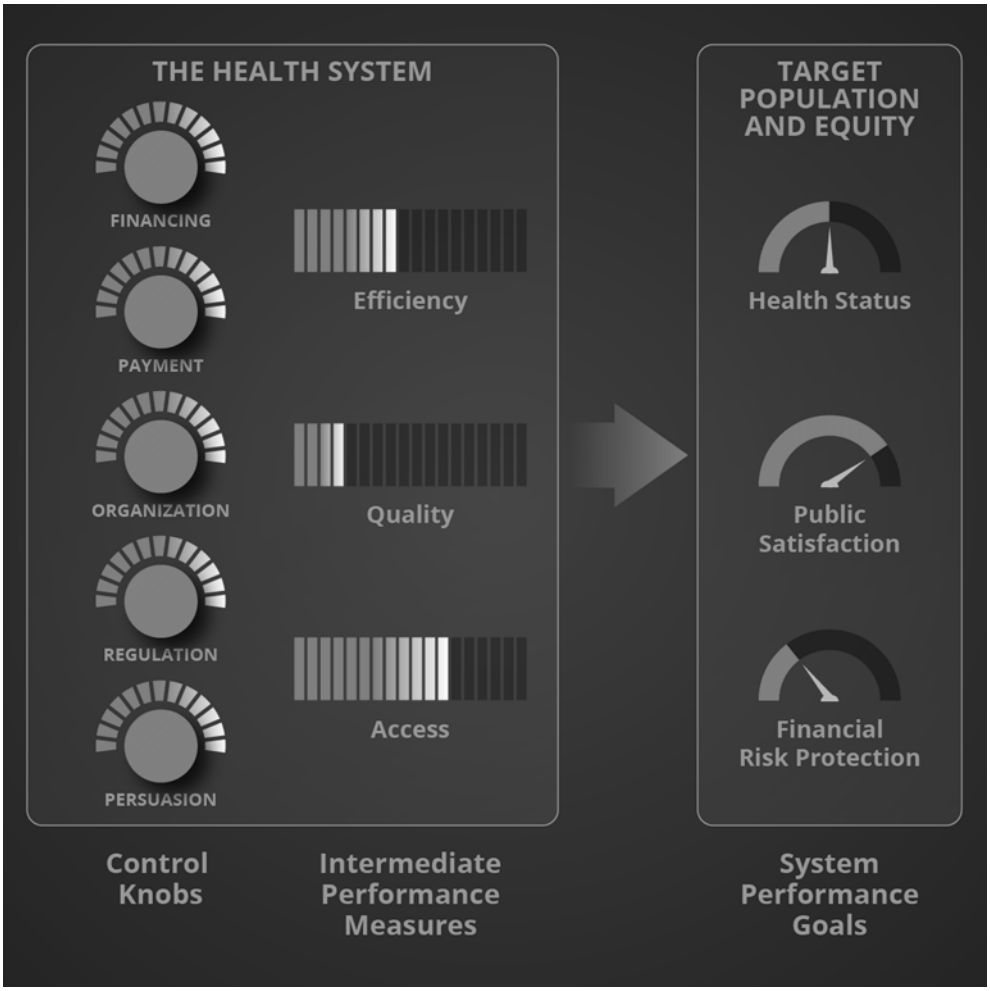

Figure 1: The Control Knob Framework

Source: Reich, Campos, Kalita, Guyer and Yip, 2024 (29). Adapted from Roberts, Hsiao, Berman, and Reich, 2004 (21).

The definition of health reform emerges from this conceptualization of a health system as a complex and dynamic system comprising a set of resources, actors, and institutions whose primary intent is to promote, restore, or maintain health. Roberts and colleagues posit that a reform implies sustained, purposeful, and fundamental changes and often involves several, if not all, aspects of a health system, such as how it is financed, how health care services are delivered, how providers are paid, how it is governed or regulated, and how different stakeholders are persuaded (21).

For the purposes of this thesis, it is essential to clarify what I mean by "reform." Drawing on the Control Knob Framework and subsequent work by Reich and colleagues (21,29), I differentiate between incremental changes or interventions (what I call "small 'r' reforms") and transformational changes (what I call "big 'R' reforms"). Small 'r' reforms refer to operational or incremental changes typically seen in individual health service organizations. While these reforms can undoubtedly lead to improvements, they generally target only one aspect of the organization to resolve specific concerns. In contrast, health system reforms, or big 'R' reforms, aim to reshape the entire health system and address factors that lead to widespread, systemic changes (21,29). This thesis is concerned with these big 'R' reforms.

Therefore, drawing on the aforementioned concepts, a PHC reform – the focus of this project – would mean changes in any of the *means* (described by the Control Knob Framework), such as financing or organization of the service delivery system, to achieve the *ends* or goals of PHC, such as better health status, including prevention of disease and promotion of wellbeing, ensuring that people can access high-quality, comprehensive health services when and where they need them without facing financial hardships and that these services are acceptable and people-centered.

As discussed in later chapters, the PHC reforms analyzed in this thesis used two primary policy levers as their entry points: financing (including provider payments) and organization (Figure 1). However, consistent with the conceptualization of big 'R' reforms, each PHC reform involved changes across other policy levers beyond their initial entry points.

Why the Control Knob Framework? There are several reasons why I chose the Control Knob Framework over others to conceptualize health systems and PHC reforms. First, the framework emphasizes the interconnections among various health system elements and acknowledges the inherent complexity of health reforms. This approach also recognizes that health reforms are deeply political, providing a strong foundation for the political economy analysis central to this thesis. Importantly, the Control Knob Framework highlights the role of policy actors as key change agents, shifting focus from

system inputs (as seen in frameworks like the Building Blocks Frameworks (28)) to the dynamic actions of those driving reforms. As discussed in Chapter 1, one of my core goals in this doctoral project, which aligns with the DrPH program's emphasis, is to bridge research and policy by strengthening the capacity of policy actors to analyze and navigate the political dynamics surrounding their reforms. This goal is closely aligned with the agentic perspective of the Control Knob Framework.

Political economy analysis

Political economy analysis is an analytical tool for understanding the incentives, power dynamics, interests, behaviors, and constraints in a system and how they influence resource distribution, policy, and programmatic decisions over time. I draw on Collinsion's definition for this thesis: "*Political economy analysis is concerned with the interaction of political and economic processes within a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time*" (30). It builds on broader literature from the academic disciplines of political science and economics. Political economy embraces the complex political nature of decision-making to investigate how power and authority affect economic choices in society.

Questions of power and authority come to the fore when heterogeneity of interest leads to conflicts among different stakeholders (or interest groups) in society. Political economy analysis investigates the interaction of political and economic processes in a society comprising heterogeneous stakeholders. This entails comprehending (1) the power and authority of groups in society, the interests they hold, and the incentives that drive them; (2) the role that formal and informal institutions play in allocating scarce resources; and (3) the influence that values and ideas, including culture, ideologies, and religion, have on shaping relations and interactions among these societal actors and groups (31). Whereas technical and informational approaches focus on the "what" of reform design, political economists begin by asking "why" and then "how," accounting for the complex rationale and contextual dynamics behind reforms.

Why a political economy analysis? Health systems are embedded in broader political and economic contexts, where power dynamics, interests, and institutions influence decisions about health policy. This means that health reforms cannot be understood or evaluated purely as technical interventions; they are deeply political processes shaped by the distribution of resources, competing priorities, and the ability of various stakeholders to influence policy choices (23,32). Political economy analysis helps uncover these underlying dynamics, providing a more comprehensive understanding of reform trajectories and why and how reforms succeed or fail. One of the central arguments for political economy analysis is that health reforms inherently challenge existing distributions of power and resources among different interest groups —such as health care providers, patients, and governments—which may have conflicting preferences, leading to contestation over changes (33,34). These groups may support or resist reforms depending on how they perceive their interests will be affected. Political economy analysis helps map these interests and understand their origins (35). Such analysis draws attention to the role of institutions in influencing decision-making processes and shaping reform trajectories.

Additionally, political economy analysis can significantly enhance the capacity of policy actors to navigate and manage the complexities of health reforms. By illuminating the power dynamics, interests, and institutional constraints that shape policy decisions, political economy analysis equips policymakers, advocates, and reform champions with a deeper understanding of the political landscape. This allows them to identify potential allies and opponents, anticipate resistance, and build coalitions that can support reform initiatives (35). Moreover, political economy analysis provides insight into the timing and sequencing of reforms, helping policy actors align reforms with windows of political opportunity or manage incremental changes when more transformative reforms are politically unfeasible. In this way, political economy analysis empowers policy actors to design more effective health reforms and enhance their ability to influence and guide reforms in complex environments, ultimately increasing the likelihood of reform adoption, implementation, and sustainability.

Historical institutionalism

Within political economy analysis, I chose the specific analytical approach of historical institutionalism for this thesis. Historical institutionalism is an approach in political science that emphasizes the role of institutions and their development over time and explores how and why change occurs in these institutions (36). It is rooted in the belief that institutions—the formal and informal rules, norms, and structures that govern behavior—significantly impact political processes and outcomes. This approach emerged in response to rational-choice institutionalism, which often neglected the importance of historical context in shaping political processes (37). Historical institutionalists argue that institutions structure political behavior by both constraining and enabling the choices available to actors and interest groups. However, unlike other institutionalist approaches, they emphasize the temporal dimension, focusing on how decisions made at critical moments in time can shape the long-term trajectory of political and social systems, often in ways that are difficult to reverse, where initial policy choices create path dependencies that lock in particular trajectories and limit future options. In health policy, this means that early decisions in a reform process—such as the structure of financing or the role of private providers—can have long-lasting effects, shaping the direction of the entire health system. A historical institutionalist approach helps illuminate these long-term dynamics, showing how past policies constrain or enable future reforms and provides a framework for assessing the sustainability of reforms over time.

Below, I define the key concepts used in a historical institutionalist approach.

Institutions refer to the formal and informal rules, such as constitutions, legislation and regulations, political systems, governance structures, and regime types (formal institutions), as well as norms, social networks, culture, ideologies, and power structures (informal institutions), that govern political, economic, and social interactions. They play a crucial role in structuring political processes, influencing the distribution of power, and mediating the outcomes of reforms. North (1990) defined institutions as "the rules of the game" that reduce uncertainty in human interactions by establishing predictable frameworks for political and economic exchanges (38). In this sense, institutions are not neutral but are

often designed to benefit certain groups over others, thus becoming sites of power struggles (36,38). Certain institutional structures enhance the authority of government actors, providing them with both the capacity and incentive to make decisions and act accordingly.

In contrast, other structures render governments more open and susceptible to the influence of specific actors whose interests may align with supporting or obstructing various policy actions. Historical institutionalism also strongly emphasizes the interaction between institutions and power. Once established, institutions can reproduce existing power relations by benefiting some actors over others. This helps explain why some reforms that aim to alter the status quo are met with resistance from entrenched interests that benefit from existing institutional arrangements (33,39,40).

A large body of political science literature is dedicated to studying the role of formal institutions in policy decisions. One of the most common topics of interest is regime type – democracy and authoritarianism. The Meltzer-Richard model theorizes that in democratic societies, the median voter (who has a median level of income) determines the level of redistributive taxation. As income inequality rises, demand for redistribution increases because the median voter earns less than the average income (41). Additionally, according to the median voter theorem, majority-rule voting systems tend to produce policies that align with the preferences of the median voter, as this position maximizes electoral support (42). Institutions also differ between parliamentary and presidential systems. Parliamentary systems consolidate power within the executive, while presidential systems are characterized by a separation of powers with checks and balances (43,44). Another distinction is between biparty and multiparty coalition systems, which create different political incentives (44). Similarly, provisions for direct democracy and proportional representation have been shown to shape electoral dynamics differently than single-member-district representation (45,46).

A country's constitution, judiciary, and legislative framework constrain political action (39,47), while federalism and decentralized governance create new dynamics among different levels of government and

between politicians and bureaucrats (48). In systems where regional and local political actors have greater discretion, such as in federal systems, there is a higher potential for patronage. This occurs when public services are strategically targeted for political gain (49). Where public goods can be targeted (as with local public goods), rational reelection-seeking politicians will, in theory, reward regions or groups of voters that have provided support in the past (50) or target concentrations of swing voters that could go either way to maximize future votes (51). Politicians in systems with single-member constituencies, such as the United States, have more incentive to focus on local, geographically targeted benefits (50), complicating the passage of national health reforms. Such systems provide multiple access points and numerous "veto points"—mechanisms through which interest groups can exert influence over redistributive policies (52,53). Historical institutionalist scholars use the concept of veto point to systematically look at how different groups and institutions interact closely and how different configurations of institutions may empower specific groups and allow them to exercise veto power (54,55). For example, veto-ridden systems like the United States face more obstacles to comprehensive reform, as seen in the long struggle for national health insurance, where pork-barrel politics dominate spending priorities. In contrast, countries with fewer veto points, such as the UK and Canada, have been able to implement national health systems and insurance through a more incremental approach. (45,56).

Interest groups – Organized groups that attempt to influence public policy to further the interests of their members (23) are another critical concept. Actors or groups vary in their power, resources, and influence on policy, often representing specific sectors, professional organizations, or advocacy coalitions. Related to interest groups is the crucial point of collective action, i.e., the ability of groups to organize themselves and take political action, determining whether an interest group can affect change and protect its interests. Multiple factors determine the strength of collective action. Notably, the group's size, membership, and cohesion determine its scope for collective action (57). Usually, the bigger the size and the more heterogeneous the membership is, the less powerful the group is and the less able it is to take concerted action. Other important factors include the group's knowledge, access to financial resources, and access

to political leadership (23). For example, physician associations with strictly controlled membership, highly technical and specialized knowledge, financial resources, and often power over politicians have more decisive collective action than more heterogeneous groups such as citizens or patients (23).

Different actors seek to influence reform at different stages of the policy cycle, each seeking to minimize losses and maximize gains or align policies with their ideas and ideologies, and political tussles may take place within distinct stakeholder groups. Specifically in the context of PHC reforms, physician associations, nurses, hospital groups, private sector providers, bureaucrats, politicians, global health agencies, donors, and citizens (or the beneficiaries of PHC reforms) have different interests, levels of power, and the ability to take collective action. Further, these abilities would be conditional on the institutional circumstances and shaped by the macro-economic contexts (for example, high-, middle- or low-income economies); the country's political regime and institutions (for example, democratic versus authoritarian regimes, and multiparty versus biparty systems); and the type of health system (for example, a mixed health system with public and private sectors versus a predominantly public sector system).

The influence of interest groups in health reform has often been considered critical, but scholars like Immergut (1992) argue that political institutions, rather than interest groups alone, play a key role in determining the success of reforms. Political systems contain veto points, or junctures where policies can be blocked, and veto players—individuals or groups whose agreement is needed for legislative change. The number of veto players in a system, such as presidents, legislative bodies, or political parties, can increase the likelihood that reforms will be stalled, especially for radical changes like national health insurance (58). More veto points also give interest groups more opportunities to influence outcomes. Immergut highlights how veto points within political systems—such as the ability of certain actors to block reforms—are shaped by institutional structures, explaining variations in health reform outcomes across different countries (52,59). For example, in Switzerland, the referendum process has allowed wealthy voters and medical associations to block health reforms, whereas in Sweden, where fewer institutional veto points exist, reforms have passed despite lobbying (59).

The concept of ***ideas*** refers to the historically constructed beliefs and perceptions of individual and collective actors. In historical institutionalism, ideas and ideational analysis are essential to explaining how and why institutions develop, adapt, and endure over time (54). Rather than viewing institutions solely as structures that constrain behavior, historical institutionalists emphasize how ideas shape the development and evolution of these institutions by framing actors' perceptions, defining problems, and influencing policy responses (60). Ideas are closely related to interest groups (or actors) and institutions because actors' beliefs and perceptions, especially those of powerful actors, can become institutions (i.e., rules of the game) over time, which in turn both constrain and empower different actors (61–63). For instance, as Hall (1993) argues, "policy paradigms" — the dominant ideas or beliefs that shape the goals and tools of policy — play a critical role in institutional stability and change, influencing how actors interpret institutional rules and how they respond to new challenges (60). Ideas operate at multiple levels—from "programmatic" ideas that shape specific policy frameworks to broader "public philosophies" that define overarching institutional purposes (64). Through this lens, ideational shifts are seen as precursors to institutional change, as emerging ideas help legitimize reform efforts and weaken established institutional logics. This perspective aligns with Thelen's (2004) work, which emphasizes how ideational shifts facilitate "gradual institutional transformation" (discussed later) as actors reinterpret existing institutions in light of new ideas, leading to incremental but transformative change over time (65).

Furthermore, ideational analysis in historical institutionalism underscores the role of discourse and framing in shaping institutional agendas and coalitions. Research has studied the role of ideas in health and public policy. For example, scholars have examined the role of neoliberalism and transnational organizations in driving the privatization of social security reforms (66). Others have studied the introduction of user fees for health care services across Asia and Africa during the Structural Adjustment Program (67). Additionally, research has explored how issue framing and global health goals shape national health priorities (68–70).

A core concept in historical institutionalism is ***critical junctures***—moments when significant shifts in political or economic conditions create opportunities for major institutional changes. Critical junctures are periods when institutional change is more likely because the usual constraints are weakened (37,71). These junctures, such as democratization of countries or change in political leadership after long periods of being governed by the same political party or war and economic recessions, can set systems on new paths, leading to long-lasting effects. There is a substantial body of work on critical junctures in health reforms. For example, the role of World War II was a critical juncture in the development of different health systems and social safety net programs (72–74). Likewise, democratization in Latin American and East Asian countries (75) has been seen as critical junctures for several reforms, including health (76). In South Korea and Taiwan, increased political competition and expansion of electoral rights after democratization led to a dramatic expansion of health insurance as a political strategy to gain popular support (77).

Related to this is the concept of ***path dependence,*** which refers to the idea that the decisions taken during critical junctures often determine how certain institutional arrangements get established, how they shape up, which interest groups emerge, and how they sustain power. These institutions are usually resistant to change, and future reforms often follow the same trajectory, even if they do not always yield the desired welfare results. This resistance to change is largely due to self-reinforcing mechanisms of power—how interest groups form around a policy decision, how every policy creates winners and losers, and how the winners often resist any change that threatens the favorable status quo. Pierson emphasizes that "increasing returns" can lock systems into particular paths, making future changes costly or politically challenging (33,39,40). For example, once a particular health system reform, such as a publicly funded insurance scheme, is introduced, it can create vested interests and expectations that make dismantling or radically changing the system politically untenable.

Another key concept in historical institutionalism is ***gradual institutional change***. While path dependence might suggest that institutions resist change, scholars highlight that institutions can undergo

significant transformation over time through slow, incremental changes rather than sudden breaks (78,79). Thelen introduces the concept of "institutional layering," where new rules or structures are introduced alongside existing ones, leading to a gradual shift in how institutions function (65). In health systems, for example, reforms might initially appear as minor adjustments to financing or organization, but over time, they can fundamentally alter the structure and performance of the system.

Why a historical institutionalist approach? The rationale for adopting a historical institutionalist approach for the political economy analysis in this thesis lies in its ability to capture the complex, time-bound nature of health system reforms. Unlike rational choice institutionalism, which focuses on individual actors making decisions based on strategic calculations of costs and benefits (80), historical institutionalism provides a more comprehensive understanding of how institutional structures, historical trajectories, and critical junctures shape policy outcomes over time. Health reforms are seldom the result of isolated, short-term decisions. Instead, they are deeply embedded within political and institutional contexts shaped by historical events, power dynamics, and the cumulative effects of past policies. This approach allows for a better account of the path-dependent nature of reforms and the broader institutional constraints that either limit or facilitate change (40).

Historical institutionalism also facilitates the examination of both continuity and change within health systems. While sociological institutionalism emphasizes how cultural norms and cognitive frames influence behavior (81), it may not fully address the power dynamics and conflicts inherent in health system reforms. In contrast, historical institutionalism recognizes that institutions are not just structures of social meaning but also arenas of power contestation (36). This perspective is particularly relevant for health reforms, where conflicts often arise between entrenched interests—private providers, government agencies, and civil society organizations—and emerging actors seeking to reshape the system. Its emphasis on gradual institutional change and the role of critical junctures offers valuable insights into how long-standing institutions are incrementally reconfigured in response to political pressures and external shocks, while still acknowledging the constraints imposed by historical legacies (78).

A review of the literature

As is evident from the previous sections in this chapter and in Chapter 1, while the literature on the political economy analysis of PHC reforms is scarce, there is a vast body of relevant work in political science (discussed above), the political economy of development and the welfare state, and the political economy of health that has deep relevance to my topic. Therefore, in this section, I present a review of the literature from these key fields.

Political economy of development and the welfare state

The political economy of development, service delivery, and the welfare state has generated a rich body of literature rooted in the intersection of political science and economics. Scholars in this field explore how political institutions, power relations, and economic structures shape the processes of development and the provision of public services, including health, education, and social protection. A central concern of this literature has been the role of institutions, including regime types, political parties, and institutional arrangements in shaping the provision of a country's social services and development outcomes. Esping-Andersen's (1990) seminal work classifies advanced democracies into three models—liberal, conservative, and social democratic—each characterized by distinct political economy logics (82). These models determine the extent of state intervention in providing social welfare, including health care and education. Social democratic states, for instance, prioritize universal coverage and state-led service delivery, while liberal regimes rely more on market mechanisms. This typology has been instrumental in understanding the variations in welfare state structures across countries and their implications for development and inequality. This typology is crucial for understanding variations in welfare provision, particularly regarding health and social protection. Huber and Stephens (2012) extend this analysis to the political origins of social protection in Latin America, emphasizing how political coalitions, partisan ideology, and regime types shape social policies (83). Similarly, McGuire (2018) builds on these ideas by exploring the political economy of health care in Latin America and East Asia, emphasizing the role of political regimes in shaping health outcomes (84,85). The work of Acemoglu further emphasizes how

historical legacies shape inclusive political institutions critical for long-term economic development, as they allow for broad-based participation and the protection of property rights, which, in turn, foster service delivery and innovation (86). More recently, Kaufman and Haggard (2020) examine how political regimes, democratization processes, and economic crises shape the expansion and retrenchment of social policies across regions. In their historical comparative analysis of Latin America, East Asia, and Eastern Europe, they highlight how different types of political regimes and levels of political competition influence the development of social protection systems, including health care (75,87). They argue that democratic transitions often facilitate welfare expansion as political elites seek to secure electoral support through redistributive policies. However, economic crises can lead to retrenchment as governments prioritize fiscal consolidation over social spending (75).

Scholars have also examined how political economy and power influence the delivery of essential services, a key role of the welfare state, and a prerequisite for development (88). Levy and Walton (2013) highlight how political institutions and governance structures affect inequality and service delivery, stressing the importance of state capacity in reducing poverty and improving access to health and education in the Global South (89). Other scholars argue that weak political institutions and electoral incentives often lead to the under-provision of essential services, as politicians prioritize targeted benefits to secure votes rather than broad-based service improvements (90–93). Similarly, Stokes (2005) and Kitschelt (2007) show how patronage networks mediate access to public goods, creating disparities in service provision. These dynamics are further complicated by the interaction between local and national political actors, as highlighted by Hicken (2011), who examines how different party systems and electoral incentives shape the quality of service delivery in low- and middle-income countries. These relate to the theories of political institutions, clientelism, and pork-barrel politics discussed earlier in this chapter (50).

Additionally, Gerring et al. (2012) emphasize the importance of local political structures in shaping public service delivery, particularly regarding accountability and governance (94). Their work suggests that local institutions can sometimes buffer against weak national governance, helping to improve service delivery

outcomes in certain contexts. Nelson (2007) also contributes to this debate by exploring how political elites in developing countries shape health policy, showing that sustained political commitment is essential for effective service provision, especially in health and education (87).

International institutions and global economic forces further shape the political economy of service delivery in developing countries. Scholars have examined how Structural Adjustment Programs imposed by international financial institutions in the 1980s and 1990s dramatically reshaped welfare states in the Global South by reducing state capacity and public sector spending, especially in health and education (66,95). In response, new forms of welfare provision, such as conditional cash transfers, have emerged instead of direct service provision by governments.

The literature on the political economy of development and service delivery is highly relevant to my thesis on the political economy of PHC reforms. It provides essential insights into how political institutions, power dynamics, and governance structures shape the delivery of public services, including health. By understanding the political and institutional factors that influence service provision, this body of work informs my analysis of PHC reforms, particularly in terms of how state capacity, political coalitions, and institutional legacies affect the implementation and sustainability of health system changes aimed at improving access and quality of care. This literature helps ground my exploration of PHC within broader frameworks of service delivery, redistribution, and state-building, offering a political economy lens to analyze the drivers and barriers to effective reform.

Political economy of health and health policy

The intersection of political and economic processes has long been recognized as crucial to understanding health and health policy. Rudolf Virchow laid the foundation for this perspective, asserting that "*medicine is a social science, and politics is nothing but medicine on a larger scale*" (Virchow, 1848). Navarro (1976) expanded this view in *Medicine Under Capitalism*, arguing that health systems in capitalist societies are shaped by class struggles, reflecting the interests of powerful economic and political groups

rather than being neutral (96). Gill Walt's *Health Policy: An Introduction to Process and Power* (1994) further emphasizes that health policy results from the complex interplay of actors, processes, and power relations (23). Walt and Gilson's *policy triangle framework* (1994) captures these dynamics by focusing on four components—context, content, process, and actors—highlighting that health reforms are profoundly political and shaped by various stakeholders at local, national, and international levels (97). In his early works, Reich discusses the importance of the politics of reforming health policies and identifies the need for political will, political analysis, and political strategies to increase the success of reforms (32). Using cases of countries undergoing transition and modernization, Reich's analysis has also focused on how political forces and economic interests shape health policy decisions, particularly in developing countries (98), and analyzed how the influence of interest groups has implications for health policies. He identified external interest groups (international agencies and multinational corporations) and internal groups (local non-governmental organizations) as well as domestic and international phenomena (such as decentralization and marketization) (99). Recent studies have further underscored the need for political economy analysis in health reforms (22,100) and emphasized the political determinants of health outcomes (101).

Of different types of health reforms, health financing and insurance reforms have received the most attention in political economy analysis. This body of literature includes the political economy of UHC, as most research limits the definition of UHC as coverage of financial risk protection for health. Based on a recent systematic narrative review published in 2020 (102), this literature includes comprehensive reviews (103,104), and several single and comparative case studies of countries. Savedoff (2004) compares political systems, arguing that democracies are more likely to pursue inclusive health reforms due to voter pressures, whereas authoritarian regimes may prioritize other areas.

Studies on health financing reforms, particularly national and social insurance systems, have examined the political economy factors influencing the adoption and sustainability of UHC across countries, analyzing barriers and facilitators (105–109). Research on Mexico's social health insurance program, for

instance, illustrates how powerful actors leverage political opportunities and effective strategies to drive reform even without broad beneficiary mobilization (76,110,111) and the politics of the reversal of the Mexican insurance program (112). In Turkey, leaders have successfully employed strategic political maneuvers to overcome institutional veto points, facilitating the adoption of health financing reforms (113,114). Similarly, in India, various studies analyze how political processes and institutional factors impact the agenda-setting, design, and adoption of health insurance programs (115–119). The politics of Thailand's UHC reforms have been analyzed by Tangcharoensathien and colleagues (2019), and notably by Harris (2015), who studied the critical role of bureaucrats and proposed the concept of 'developmental capture' (contrasting with regulatory capture) of state agencies by networks of reformist bureaucrats within the state who seek to promote inclusive social and developmental policies of benefit to the broader populace (120). Several studies have focused on health insurance reforms across African countries, highlighting national insurance programs in Ethiopia (121), Ghana (122), Kenya (123,124), Rwanda (125), South Africa (126,127), and Uganda (128).

A key takeaway from this literature is that UHC uptake and implementation are primarily driven by political rather than purely technical considerations. Key factors influencing UHC reforms include the interplay of ideologies, stakeholder interests, and institutional arrangements. Research emphasizes that ideologies shape the narrative around UHC. At the same time, diverse stakeholder interests, ranging from government entities to private sector players and civil society organizations, can facilitate or hinder policy adoption. Furthermore, institutions play a critical role in the implementation process, with existing infrastructure and political dynamics significantly affecting the progress toward UHC. The review underscores that national ownership and political will are essential for successful UHC reforms, often requiring adaptation to local contexts and existing political landscapes.

A few works that have used a historical institutionalist view to compare health reforms in different countries are particularly relevant to this thesis. Immergut's influential article, *Institutions, Veto Points, and Policy Results* (1990), examines how political institutions and veto points shape health policy

outcomes. Using case studies of Switzerland, France, and Sweden, she shows that institutional structures—especially veto points where actors can block or modify proposals—significantly impact reform success. Immergut (1990, 1992) argues that institutions and veto points shape how interest groups gain and exercise power and that systems with more veto points face more significant challenges in enacting comprehensive health reforms due to the need for consensus, often leading to compromise or policy stalling. Her work underscores the importance of institutional design in determining health policy paths within varied political contexts (59). Similarly, Hacker's (1998) comparative analysis of the UK, Canada, and the US explores how institutional structures and historical sequences affect the development of national health insurance. Hacker demonstrates that centralized systems, like those in the UK and Canada, facilitated coordinated health policies, while the fragmented US political system, marked by numerous veto points, hindered universal health coverage efforts. He emphasizes the influence of institutional legacies and early policy decisions, which create enduring path-dependent effects that shape future reform trajectories. Hacker's work illustrates the value of historical and institutional contexts in explaining distinct national approaches to health reform (56). Maioni (1998) examines the evolution of health insurance in the United States and Canada, beginning with the rise of health care as a political concern in the 1930s and leading up to federal health insurance legislation in the 1960s. Emphasizing the role of political institutions in shaping policy, she argues that Canada's federal structure and parliamentary system fostered a social-democratic third party instrumental in proving the viability of universal health insurance. In contrast, the limitations within the US political system compelled health care reformers to moderate their proposals to gain broad support within the Democratic party (45).

One of the other popular topics of political economy analysis has been specific health conditions and outcomes like maternal, neonatal, and child mortality; communicable diseases and epidemics; and vertical programs to address them. Shiffman and colleagues have studied the agenda-setting processes for maternal health and newborn survival across different countries and identified the prominent roles of international agencies and global health goals like the Millennium Development Goals, financial and

technical support, cohesive national policy communities focused on safe motherhood or newborn survival, the presence of influential national advocates to champion the cause, and the presentation of credible evidence to policymakers, highlighting the existence of the problem, along with offering clear policy solutions (70,129–131). Analysis of the politics of the rise and fall of disease priorities in global health has highlighted the importance of issue framing and policy communities—the network of individuals and organizations concerned with the problem—and how they establish institutions to maintain this narrative. This research underscores the power of ideas, challenging interpretations that objective, material factors such as mortality rates or the availability of cost-effective interventions are the basis of reforms (69,132,133).

While most of these studies have focused on the agenda-setting and adoption phases of the respective health policy issues, Croke's (2012) work comparing the decline in child mortality through malaria control in Uganda and Tanzania takes a historical institutionalist approach and discusses the role of political institutions over time and more recent political events in producing different policy choices and outcomes for the two countries (134). Scholars have also studied the effect of regime type on health outcomes. A large body of evidence suggests that democracies fare better on health outcomes than autocracies (94,135–137). However, other studies have found that while democratic governance may lead to higher overall social spending, which can improve health outcomes of the general population, it does not necessarily guarantee that these services reach the poorest individuals (138,139). Wigley and colleagues (2011) use a panel of 153 countries and find that democratic governance improves life expectancy, even when controlling for redistributive spending on health, education, and welfare, suggesting that democracy has a non-distributive, pro-health effect that goes beyond resource allocation (140). Four pathways are proposed for explaining the positive effect of democracy: autonomy (people having more control over their lives), social capital (stronger social networks), collective action (greater ability to organize for change), and information diffusion (more accessible health information through media freedom). A similar analysis using infant mortality rates across countries shows that the

relationship between democracy and good health outcomes is a time-dependent, historical phenomenon and depends on the "democratic stock" or the time a country has had democratic institutions (94).

Scholars have examined the political economy of epidemics such as HIV/AIDS (141–143), Ebola (144), and COVID-19, highlighting how political institutions and economic contexts shape national responses. Studies on HIV/AIDS reveal that press freedom boosts political commitment to tackling the epidemic, but high levels of income inequality in society often weaken government responsiveness, and political priority is typically highest in countries with severe epidemics (141,143). Political institutions and economic context influence reform leaders' incentives and ability to act on health crises, illustrating that epidemic responses do not occur in a political vacuum. Ethnic politics, in particular, hinder AIDS responses in divided societies, where elites are reluctant to present the epidemic as a collective threat, fearing damage to their group's reputation. This results in lower public demand for action and weaker government response, with cross-national studies showing that ethnic fragmentation reduces AIDS-related spending, linking ethnic competition to poor public health outcomes (142).

Maffioli's (2021) research on Ebola further emphasizes the impact of political incentives on epidemic responses, showing that the government focused on epidemic-hit villages but misallocated resources toward swing regions (144). Consequently, voters in these areas tended to support the incumbent party, indicating how electoral motivations affect resource distribution in health crises. In the context of COVID-19, the role of interest groups, institutions, and political structures became even more prominent. Early in the pandemic, business pressures in many countries delayed lockdown measures as governments weighed economic impact against public health (145). Differences in policy choices and, consequently, outcomes were observed in regime types (democracies versus authoritarian countries), partisanship and political ideologies, and the extent of federalism and centralization of governance (145–147). Taken together, these studies reveal that pandemic responses are heavily influenced by institutional structures, historical legacies of power, and interest groups, showing that pandemic policies often depend on navigating complex political and economic landscapes (148,149).

Political economy of PHC

Out of the different topics in health reforms, PHC remains one of the least systematically studied areas in political economy research despite growing recognition of how political factors shape these reforms (150). Most writings on the topic of the politics of PHC were conducted around the time of the Alma-Ata Declaration (1978), which put PHC as a global priority (see Chapter 1), but most of this is now more than 40 years old (4,5,151–153).

However, some more recent works are noteworthy. Croke (2021) has studied the role of political institutions and past policies in shaping PHC reforms in Ethiopia (154). His article examines how structural determinants intersect with individual agency, focusing on Ethiopia's historical and political developments over the past generation that drove leaders to prioritize PHC investments. It explores the ideas, institutional decisions, and innovations that facilitated the effective implementation of these investments (154). Another study on PHC reforms in Nigeria concludes that while health leaders developed evidence-based policies and managed stakeholder dynamics to achieve adoption, implementation was obstructed by institutional fragmentation and political challenges. Horizontal and vertical divisions within the health sector hindered coordination, while electoral cycles and leadership turnover impeded continuity, and the shift from client- to policy-focused politics met with resistance (155). A comparison of PHC in the U.S. and Bangladesh found that the quality of PHC in both countries is shaped by broader political economy factors, including colonial legacy, political competition, economic structure, and social inequality (156). A study by Kringos et al. (2013) explores the role of political, cultural, and economic factors (akin to formal and informal rules discussed earlier in this chapter) in shaping PHC across 31 European countries. The study highlights that wealthier countries often have weaker PHC structures and reduced access, as they tend to prioritize specialized care, satisfying public expectations despite increased costs (157). However, countries governed by left-wing parties typically exhibit stronger PHC, aligning with equity and access priorities through policies that reduce financial barriers and ensure wider service availability. Countries with a national health service system were more

effective in implementing these reforms compared to those with social health insurance systems, which generally show lower accessibility and continuity due to co-payment structures and less centralized coordination. Additionally, cultural values significantly influence PHC strength, with greater governmental involvement in welfare associated with improved accessibility, although often at the expense of coordination and service comprehensiveness (157).

In a recent commentary, Rajan and colleagues (2024) identify key political economy dichotomies within PHC, underscoring a disconnect between where health investments are directed and where needs are greatest (18). Despite policy emphasis on front-line, generalist-led care, investment continues to favor specialized, hospital-based services, reinforcing public perceptions that equate quality care with high-tech, specialized treatments. This has perpetuated underinvestment in PHC, thereby eroding public trust in PHC. Additionally, the paper critiques the "pro-poor" approach, arguing that it has stigmatized PHC as low-quality care primarily for impoverished populations (18).

Key takeaways

The literature review underscores both the strengths and gaps in the current body of knowledge on the political economy of PHC reforms. While substantial research has illuminated the role of political and economic factors in shaping development, public service delivery, and health policies, especially health insurance, fewer studies have systematically explored the political economy specific to PHC. The literature on the political economy of development and health policy provides essential insights into how power dynamics, institutional configurations, ideas, and temporality could influence PHC reforms. However, there is limited focus on the unique characteristics and challenges of PHC reforms within these broader frameworks.

This review identifies several gaps. First, more studies are needed that apply a political economy lens specifically to PHC, examining how political institutions, interest group pressures, sequence of reform efforts, and historical legacies shape these reforms. Second, there is little literature comparing the political

economy of different types of health reforms. Lastly, understanding how path dependencies influence PHC trajectories could illuminate why certain reforms continue while others are reversed and inform strategies for sustainable reform.

This thesis seeks to address these gaps in the literature. I draw on the extant theoretical and empirical evidence from political science, political economy of development, and health and take a historical institutionalist approach to offer a nuanced understanding of the causal mechanisms behind the barriers and facilitators to effective, equitable, and sustainable PHC reform.

CHAPTER 3: DATA AND METHODOLOGY

This thesis draws on multiple data sources and conducts analysis at two levels: the country level and the cross-country synthesis. First, as part of a collaborative, multi-country research initiative—the *Political Economy Dynamics of PHC Reforms*—supported by WHO's Special Program for Primary Health Care team, I conducted research to develop country case studies about the political economy dynamics of their respective PHC reforms. This process involved comprehensive document reviews and primary data collection through key informant interviews, focus group discussions, and expert consultations in each of the nine countries described below. Second, I conducted in-depth reviews of documents, secondary data, and published literature to synthesize findings using deductive analysis—guided by a historical institutionalist approach—and inductive analysis for theory building, which forms the core of this thesis. Each element of the research methodology is described in detail below.

Background of the research study

The WHO's Special Program on Primary Health Care launched the Primary Health Care Implementation Solutions (PHC-IS) initiative to explore how countries successfully scale up PHC-oriented health systems. The initiative aims to identify, document, and share learnings from diverse country contexts by examining the experiences of policy actors and practitioners directly involved in leading these reforms. A key objective of the PHC-IS initiative is to understand how political, economic, and institutional factors influence the prioritization, design, adoption, and implementation of PHC reforms. To address this objective, the initiative launched the *Political Economy Dynamics of PHC Reforms*, a collaborative research effort among WHO-Geneva, all six of its regional offices and nine selected country offices, and researchers from Harvard University (Kevin Croke and Anuska Kalita). This collaboration explicitly focuses on the political economy dynamics underpinning PHC reforms.

Sample

The sample for this thesis consists of nine countries, a diverse sample representing each of the six WHO regions. These countries were selected based on their positive response to the call for collaboration with WHO Headquarters in Geneva on the *Political Economy Dynamics of PHC Reforms* initiative, as well as other organizational considerations. The nine countries and their respective WHO regions are Dominica and Uruguay from the Americas Region (AMRO); the Democratic Republic of the Congo and Kenya from the African Region (AFRO); Kazakhstan from the European Region (EURO); Thailand from the Southeast Asian Region (SEARO); New Zealand from the Western Pacific Region (WPRO); and Egypt and Tunisia from the Eastern Mediterranean Region (EMRO).

For this thesis, I synthesize data from all nine countries rather than treating each as a standalone case study. The work of this thesis extends beyond the five in-depth country cases undertaken as a part of the WHO collaboration, published elsewhere (158–162).

Data collection

This thesis draws on data from multiple sources. First, it draws on data collected for the country case studies. In collaboration with country teams, we conducted a comprehensive review of both published and grey literature, as well as national policy, strategy, and guideline documents. We identified these documents through keyword searches on PubMed, Google, and Google Scholar, as well as consultations with health policy experts in each country. Additionally, we accessed databases from the WHO, the World Bank, and respective national governments to gather relevant information. Where necessary, documents published in local languages – reviewed by the country teams – were included to ensure a comprehensive understanding of each country's PHC reform efforts.

Following the document review, we identified key stakeholders in the selected PHC reforms. This process was informed by the policy documents and reports we reviewed and consultations with senior policy actors who had been directly involved in the reform processes in their respective countries. We collected

primary data through stakeholder consultations, focus group discussions (FGDs), and semi-structured in-depth interviews with key informants representing a broad range of stakeholders in each country. These stakeholders included government officials, health care providers, community representatives, and civil society members, among others.

I led the design of the interview and FGD guides and conducted coaching sessions with the country teams. The country teams adapted and finalized these guides in their local languages to ensure cultural and contextual relevance. Informed consent was obtained from all study participants before their involvement, and, where permitted, interviews and FGDs were audio-recorded to ensure accuracy. The confidentiality of all participants was strictly maintained, and the local teams de-identified all data before sharing it with the study team.

In total, 324 respondents participated in the study. This included 109 key informant interviews, 32 FGDs (each involving 4-6 participants), and four larger expert consultations, which included 10-20 participants per session. These primary data collection efforts are summarized in Table 1. These data formed the basis for developing five in-depth country case studies (Kazakhstan, Kenya, New Zealand, Thailand, and Uruguay), the analysis of which I will describe in the next section.

Table 1: Primary Data Collection Efforts Across the Nine Countries

Country	Interviews	Focus Group Discussions	Expert Consultations
DRC		3 (4 participants each)	
Dominica			1 (10 participants)
Egypt	12		
Kazakhstan	20	27 (4-6 participants each)	
Kenya	25	2 (6 participants each)	
New Zealand			1 (12 participants)
Thailand	15		
Tunisia	20		2 (20-15 participants each)
Uruguay	17		
Total (324 respondents)	**109 (109 respondents)**	**32 (158 participants)**	**4 (57 participants)**

Source: Author

For the synthesis central to this thesis, I went beyond the five-country case studies and expanded my data collection for all nine countries. I undertook an extensive review of published and grey literature on the political economy of health reforms, as well as the historical, economic, and political contexts of the selected countries. I supplemented these with document reviews, including translating several documents from local languages to English. Consultations with experts from different countries, as well as with health system experts and political scientists, helped validate the data and confirm the findings and interpretations.

Ethical approvals for the primary data collection were obtained from each country's relevant Institutional Review Boards (IRBs). Additionally, the research for this thesis, which uses data from the country case studies, was deemed exempt by Harvard University's IRB.

Data analysis

Data was analyzed at two main levels to develop both the country case studies and a synthesis. The detailed steps and methods for analysis for each level are described below.

Country case studies

To develop the country case studies, the first step was to analyze the published and grey literature to identify stakeholders of the respective country PHC reforms. Using the stakeholder analysis framework developed by Reich and Cooper (1996) and Reich et al. (2023), I collaborated with the country teams who assessed stakeholders' resources, interests, and relationships and evaluated the positions taken (support, opposition, or non-mobilized), and roles played by each stakeholder in relation to the reform (29,163). Stakeholders were defined as any relevant groups or individuals interested in or affected by the PHC reform. Data collected from the document search and interviews were organized into a spreadsheet matrix. Wherever possible, we considered both tangible resources (e.g., funding and personnel) and intangible ones (e.g., organizational legitimacy and access to decision-makers). These stakeholders were approached for the primary data collection efforts described above.

The data from the stakeholder interviews, focus group discussions, and consultations were analyzed using the Framework Method, which allows a combined approach to analysis, enabling themes to be developed both inductively from the accounts (experiences and views) of research participants and deductively from existing literature (164). For the deductive analysis, I used the Control Knob Framework (21) and a historical institutionalist approach (see Chapter 2). I apply the Control Knob Framework to characterize each country's PHC reform to identify the entry point (or the main focus) of the reform based on the different policy levers.

To form the basis of the synthesis, I triangulated the primary data and the findings from the document review. Using process tracing, I developed case studies for each country to provide a "thick description" of the phenomena, identify mechanisms through close observation of causal processes, and generate

hypotheses for further exploration—rather than testing them or estimating statistical relationships (165). These were theory-motivated case studies, i.e., historical institutionalist concepts are applied to each country's PHC reform. These case studies are published as a WHO series (23,24,36,39,59,78).

Synthesis of country case studies

For this thesis, I undertook a synthesis grounded in a historical institutionalist approach to examine the political economy dynamics of PHC reforms across the nine countries. Historical institutionalism focuses on how institutions—understood broadly as formal and informal rules, policies, and structures—shape political behavior and outcomes over time. This approach is particularly useful for understanding health system reforms, as it emphasizes the path-dependent nature of institutional change and highlights the influence of historical legacies on contemporary policy choices. I use the comparative sequential method to synthesize the historical institutionalist analysis. This approach systematically analyzes each country's reform process in sequence, with particular attention to the timing and sequencing of reform efforts. By examining reforms sequentially, I could trace how earlier policy choices or institutional arrangements influenced subsequent reforms and assess whether countries that undertook reforms in a particular order (e.g., beginning with financing reforms before addressing organization) experienced different outcomes compared to those that followed a different path. The comparative sequential analysis, commonly used in comparative politics, is particularly valuable in identifying whether similar reforms, when implemented in different contexts or at different points in time, yielded varying results (24,166,167). It also allows for a deeper understanding of how the broader political and institutional environments evolved as reforms unfolded, contributing to the overall understanding of the political economy dynamics that shaped PHC reforms.

The data analysis involved several stages. First, I conducted an in-depth review of each country's data, focusing on the historical development of its health system, the political economy of its PHC reforms, and the broader institutional context. I trace the trajectory of PHC reforms within each country's specific political and economic context, identifying how institutional structures have emerged, evolved, and

contributed to the creation, maintenance, or dissolution of different interest groups in response to critical junctures and institutional constraints, and ultimately, how these have influenced the design, adoption, and implementation of PHC reforms over time. This included examining key reforms, stakeholder interactions, and external influences such as international organizations or global health trends. I analyzed each country individually, focusing on historical patterns, institutional legacies, and the evolving interactions between political actors and institutions. By comparing countries with diverse political and health system characteristics, I examine how differing institutional arrangements and historical contexts have shaped reform outcomes, offering insights into why certain reforms succeeded, stalled, or were reversed across the nine cases.

Next, I compared the cases based on the political and institutional conditions under which reforms were initiated, the nature of interest groups that have emerged to support or oppose the reforms, and the outcomes achieved. Using historical institutionalism as an analytical lens, I link specific reform trajectories to broader institutional configurations and how different reforms lead to the mobilization and empowerment (or the opposite) of particular interest groups and actors. The comparative sequential method allowed me to categorize countries by the types of PHC reforms they undertook, such as financing-focused or organization-focused reforms, and to explore how similar institutional structures produced varying outcomes across different contexts.

Throughout this process, I remained attentive to the interplay between structure and agency, examining how individual actors or coalitions navigated existing institutional frameworks to influence reform outcomes. This multi-layered analysis provided a nuanced understanding of how historical and institutional factors shaped the political economy of PHC reforms in each case, ultimately contributing to the broader understanding of health system reform processes.

Study limitations

The research for this thesis has several limitations. A significant portion of the study was conducted within the framework of a large multi-country collaboration, in which the sample countries were selected based on WHO's organizational processes and priorities. While this approach has provided a diverse sample of geographical, political, and economic contexts, the sampling could have been strengthened methodologically. A more systematic approach—such as matching countries based on independent variables or explicit attention to variation on the dependent variable, i.e., the outcomes of their PHC reforms—would have enhanced the comparative strength of the analysis. The current sample limits the ability to conduct comparative case study analyses since the countries share few common characteristics. Comparative case study approaches are only valid if the countries in question are similar in the relevant independent variables (168). However, upon analysis (presented in Chapter 4), the countries have similar entry points for their reforms, allowing the comparison between financing-focused and organization-focused reforms. The countries also converged into three distinct groups in terms of their reforms' outcomes – countries with comprehensive and sustained reforms, those with mixed results, and others where reforms failed to be adopted or were reversed. These similarities provided a foundation for comparing their political economy dynamics.

Additionally, inherent limitations exist due to the qualitative nature of the research. The findings are context-specific to the countries studied, meaning that while they may offer transferable insights for other health systems or reforms, they are not broadly generalizable. The reliance on self-reported data from interviews, focus groups, and expert consultations introduces the possibility of recall or social desirability bias, potentially influencing participants' responses. The identification of participants through document reviews ensured the inclusion of a broad range of stakeholders with different levels of support (or opposition) and power vis-à-vis the PHC reforms. However, it is likely that certain perspectives were more represented than others. Power dynamics and positions of the stakeholders—such as community representatives, civil servants, or political opposition members—may have influenced their willingness to

share views candidly. For instance, beneficiaries of the reform or lower-level civil servants may have hesitated to express critical opinions due to fear of repercussions from more powerful officials or ruling authorities. Data from certain categories of respondents—such as frontline health workers, politicians, and citizens—were limited. Efforts were made to reach data saturation. However, as with any qualitative study, a larger or more diverse sample could have potentially uncovered additional perspectives and insights that were not captured in this analysis. Furthermore, the positionality of the in-country research teams—composed of WHO employees and consultants—must be considered. Their professional roles and the institutional relationships with respective country governments may have influenced data collection and interpretation, introducing a degree of subjectivity or bias.

In reflecting on my own positionality, I acknowledge that my background inevitably shaped the way I approached, interpreted, and presented the findings. I am not a citizen or resident of any of the sampled countries, nor do I speak the local languages of several of them, which may have limited my ability to fully grasp the cultural and linguistic nuances in the data. While I have taken steps to ensure rigor and objectivity throughout the research process, my “outsider” status may have introduced certain blind spots or assumptions that influenced my interpretation of the reform processes and the stakeholders' experiences. Additionally, my position as a researcher affiliated with Harvard adds another layer of complexity, as it may have impacted how WHO country and regional research teams viewed me and the nature of the information they chose to share. My reliance on local research teams also means that I depended heavily on their interpretations of the data, which may have been influenced by their positionality and relationships within their country contexts and the capacities and resources to collect and synthesize the data. In acknowledging these limitations and my positionality, I have aimed to apply critical reflexivity throughout the research process, remaining conscious of how my background and affiliations may have shaped the research outcomes. This awareness is essential in acknowledging the partiality of any qualitative research and the importance of understanding the power dynamics that influence the data and its interpretation.

CHAPTER 4: FINDINGS AND DISCUSSION: A DESCRIPTION OF THE COUNTRIES AND THEIR REFORMS

In this chapter, triangulating primary and secondary data, I first present the key characteristics of the health systems of all the nine countries and then briefly describe their PHC reforms analyzed in this study. I use the Control Knob Framework (see Chapter 2) to describe the health system and the reforms around the key policy levers (21). The sample includes a mix of high-income (HIC), middle-income (MIC), low-middle-income (LMIC), and low-income countries (LIC). It encompasses small island nations, countries with varying political systems and regime types, and nations facing diverse challenges such as conflict, civil unrest, and climate-related disasters. I summarize the key political and economic characteristics of the nine countries in Table 2 and describe each country's political and economic contexts in Appendix 1.

Table 2: Comparison of the sample countries across key economic and political characteristics

Country & WHO Region	Income Level (GDP per capita)	GINI Coefficient	Population (in millions)	Human Development Index	Freedom & Regime Type	Key Characteristics of the Political System
Africa						
DRC	Low (US$649)	0.45	102.3	0.481 (Low)	19 (Not Free) Authoritarian	Majoritarian, semi-presidential, bicameral legislature, multiparty system, dominated by single party, devolved governance
Kenya	Low-middle (US$1950)	0.39	55.1	0.601 (Medium)	52 (Partly Free) Hybrid Regime	Majoritarian, multiparty presidential, bicameral legislature, devolved governance
Americas						
Dominica	Upper-middle (US$7,860)	0.47	0.07	0.740 (High)	Free (93) Democracy	Majoritarian, parliamentary republic, unicameral legislature, unitary state
Uruguay	High (UD$22,564)	0.41	3.42	0.830 (Very High)	Free (96) Democracy	Proportional representation multiparty, presidential, bicameral legislature, unitary state
Eastern Mediterranean						
Kazakhstan	Middle (US$10,374)	0.29	19.9	0.802 (Very High)	5 (Not Free) Authoritarian	Proportional representation, presidential republic, bicameral legislature, unitary state, multiparty system dominated by a single party
Egypt	Low-middle (US$3,513)	0.32	112.7	0.728 (High)	Not Free (18) Authoritarian	Majoritarian, presidential system, bicameral legislature, unitary state, multiparty system, dominated by a single party

Table 2: ***Comparison of the sample countries across key economic and political characteristics (Continued)***

Tunisia	Low-middle (US$3,895)	0.34	12.6	0.732 (High)	Partly Free (51) Authoritarian	Proportional representation, multiparty parliamentary system, bicameral legislature, unitary state
Europe						
Kazakhstan	Middle (US$10,374)	0.29	19.9	0.802 (Very High)	5 (Not Free) Authoritarian	Proportional representation, presidential republic, bicameral legislature, unitary state, multiparty system dominated by a single party
Southeast Asia						
Thailand	Middle (US$7,182)	0.35	71.8	0.803 (Very High)	36 (Partly Free) Hybrid regime	Mixed system with majoritarian dominance, constitutional monarchy, multiparty parliamentary system with bicameral legislature, unitary state; periodic military rule
Western Pacific						
New Zealand	High (US$47,072)	0.31	5.2	0.939 (Very High)	Free (99) Democracy	Proportional representation, multiparty parliamentary system with unicameral legislature, unitary state

Sources:

Income Level – International Monetary Fund, 2024 (169)
GINI Coefficient – The World Bank, 2024 (170)
Population – The World Bank, 2024 (171)
Human Development Index – World Population Review, 2022 (172)
Freedom Score – Freedom House, 2024 (173)
Regime Type – Economist Intelligence Unit, 2023 (174)

The countries also differ in their health system structures, offering a rich spectrum for analysis. For each country, I focus on a specific reform initiative and time period. However, I also consider the historical antecedents and post-reform period developments in undertaking the political economy analysis. The specific reforms were selected by the collaborating country teams.

Before I proceed, it is important to clarify that this study does not evaluate the impact of the PHC reforms on health system outcomes. This is beyond the scope of this study. Instead, the "outcome" studied here is the comprehensiveness of the reforms (how many policy levers they addressed), whether they were implemented at scale, and their sustainability over time. This includes examining whether the reforms were successfully adopted, scaled, and strengthened, or if they failed to be implemented or scaled up, or were reversed. Table 3 summarizes the nine countries' health system characteristics and outlines the reforms under study.

Table 3: Key health systems features, PHC reforms, and their policy levers across the nine countries

Country	Key Health System Characteristics	Name of the Reform (Years)	Policy Lever Used as the Reform Entry Point	Other Policy Levers Used	Reform Outcome
Dominica	**Financing:** 4.2% of GDP; predominantly public financed (OOPE=22.9% of THE) **Organization:** Mixed health system, public sector dominated. Majority of health personnel employed by public sector. Private sector is for-profit **Provider payment:** Most physicians are paid salaries	PHC Reorientation in Response to Climate Events (2017-2023)	Organization	NA	Mixed results
DRC	**Financing:** 4.3% of GDP; predominantly financed through OOPE (OOPE= 39.4% of THE) **Organization:** Private sector dominated. Private sector is a mix of for-profit and not-for-profit Majority of health personnel employed by private sector. **Provider payment:** Fee-for-service	Provincial Health Reforms (2012-2023)	Organization	Governance	Failed to take off or reversed
Egypt	**Financing:** 1.4% of GDP; predominantly OOPE financed (OOPE=59.3% of THE) **Organization:** Mixed health system. Private sector is for-profit Majority of health personnel employed by public sector. **Provider payment:** Salaries in public sector, fee-for-service in private sector	Family Health Model (2000-2021)	Organization	Financing, Provider Payments	Mixed results

Table 4: Key health systems features, PHC reforms, and their policy levers across the nine countries (Continued)

Kazakhstan	**Financing:** 2.1% of GDP; predominantly public financed (OOPE=27.5% of THE) **Organization:** Mixed health system, public sector dominated. Majority of health personnel employed by public sector. Private sector is for-profit **Provider payment:** Mix of salaries, capitation	Multidisciplinary Teams (2010-2020)	Organization	Financing, Provider Payments, Governance	Comprehensive and sustained over time
Kenya	**Financing:** 2.1% of GDP; predominantly public financed (OOPE=24.1% of THE) **Organization:** Mixed health system (almost equal public and private sector provision). Private sector is for-profit **Provider payment:** Salaries and capitation in public sector, fee-for-service in private sector	Primary Care Networks (2019-2023)	Organization	Financing, Governance	Mixed results
New Zealand	**Financing:** 7.8% of GDP; predominantly public financed (OOPE=11.6% of THE) **Organization:** Mixed health system, private sector dominated for primary care, public sector dominated for hospital care **Provider payment:** Salaries and capitation	PHC Strategy (2001-2024)	Financing	Financing, Provider Payments, Governance	Failed to take off or reversed
Thailand	**Financing:** 2.9% of GDP; predominantly public financed (OOPE=10.5% of THE) **Organization:** Public sector dominated, very small private sector. Majority of health personnel employed by public sector. Private sector is for-profit **Provider payment:** Mix of salaries, capitation, global budgets/DRGs	Universal Coverage Scheme (2001-2020)	Financing	Organization Provider Payments, Governance	Comprehensive and sustained over time

Table 5: Key health systems features, PHC reforms, and their policy levers across the nine countries (Continued)

Tunisia	**Financing:** 4.7% of GDP; predominantly public financed (OOPE=36.4% of THE) **Organization:** Mixed health system. Private sector is for-profit **Provider payment:** Salaries and capitation in public sector, fee-for-service in private sector	Family Practice Model (2015-2023)	Organization	Provider Payments	Failed to take off or reversed
Uruguay	**Financing:** 6.9% of GDP; predominantly public financed (OOPE=15.4% of THE) **Organization:** Mixed health system, public sector dominated. Majority of health personnel employed by public sector. Private sector is not-for-profit **Provider payment:** Mix of salaries, capitation	*Sistema Nacional Integrado de Salud* (SNIS) and *Redes de Atención Primaria* (RAPs) (2005-2020)	Financing	Organization Provider Payments, Governance	Comprehensive and sustained over time

Source: Policy levers and reform outcomes are based on author's analysis. Financing data are from WHO, 2023 (175).

1. Dominica - PHC Reorientation in Response to Climate Events (2017-2023)

1.1. Overview of the health system and its outcomes

Dominica's tax-funded health system provides free primary care through a nationwide network of clinics and health centers (176). Out-of-pocket expenditure (OOPE) accounts for 23% of total health spending, creating financial barriers for those needing specialized or private care (175), particularly low-income groups, especially for advanced care that often requires travel abroad (177).

Service delivery is predominantly public-sector led, with health centers staffed by multidisciplinary teams providing primary care. The private sector fills gaps in diagnostics and specialist care but primarily serves wealthier individuals, exacerbating inequities in access (178). Providers in the public sector are salaried, while private providers operate on a fee-for-service basis, often increasing costs and fragmenting care. Historically, the health system has prioritized hospitals and health facilities, with limited emphasis on comprehensive primary care. The devastating Hurricane Maria in 2017 destroyed health facilities and disrupted services, bringing the gaps in the system to sharp relief (179,180). Table 3 presents the key features of the health system.

1.2. Brief overview of the reform

Dominica launched a set of reforms after Hurricane Maria in 2017. They are the focus of this study. Key aspects of the reform under the main policy levers are presented below.

Organization: In response to post-hurricane personnel shortages, Dominica—together with the Pan American Health Organization (PAHO)—trained a new cadre of Community Health Workers (CHWs) in 2018 (179). These CHWs were instrumental in delivering people-centered care within community settings, reinforcing the PHC approach. Prior to the reforms, primary care services were largely clinic-based and focused on routine curative care. Outreach to underserved or remote areas was limited, and community engagement in health planning and service delivery was minimal, relying heavily on

centralized management. The introduction of CHWs marked a shift toward a people-centered model, emphasizing outreach and care delivery within communities (179). Before Hurricane Maria, Dominica's health system relied on paper-based records and lacked technological integration. Remote care options, such as telemedicine, were almost non-existent, limiting access for residents in isolated areas. The reforms introduced telehealth and digital transformation initiatives to enhance diagnostic and treatment capabilities. Telemedicine enabled residents in rural and remote areas to access specialized care without requiring extensive travel (179). Additionally, digitizing health records enhanced health service efficiency, enabling better coordination across facilities and ensuring continuity of care, adding resilience in the face of Dominica's frequent climate disasters.

1.3. Reform outcome

Dominica's reforms have had mixed progress on PHC. While CHWs and digital health technologies remain integral to the health system, the PHC focus of the reforms has waned. Government priorities have shifted toward hospital infrastructure—evident in initiatives such as the Dominica Hospitals Authority Bill (2020), the Dominica-China Friendship Hospital, and the construction of new polyclinics to expand secondary care (177). Investments in hospital infrastructure have bolstered resilience, but areas such as primary care quality, community engagement, and public health surveillance have seen limited institutionalization and scale-up (181). Sustaining the PHC orientation of the reform remains a challenge amid competing health sector priorities.

2. DRC - Provincial Health Reforms (2012-2023)

2.1. Overview of the health system and its outcomes

The DRC experiences some of the poorest health outcomes globally, with an under-five mortality rate of 75.6 per 1,000 live births (2021) and a life expectancy of 60 years (171). The health system is under-resourced, fragmented, and heavily reliant on international donors, with external assistance accounting for 38% of health expenditure in 2021 (175). Households bear 43% of costs through OOPE, creating

significant financial barriers (175). Access to care is constrained by geographical, economic, and infrastructural barriers, especially in rural and conflict-affected areas (182).

Public health facilities are underfunded and lack essential resources, while secondary and tertiary services are concentrated in urban centers—limiting access to specialized care for those unable to pay (182). The private sector, including faith-based organizations, plays a critical role in underserved regions, while traditional healers and informal providers are often the primary caregivers in rural areas (182). Table 3 presents the key features of the health system.

2.2. Brief overview of the reform

In 2012, the DRC introduced Provincial Health Reforms to decentralize health care administration, in line with the 2006 Constitution's commitment to decentralization (see Appendix 1). The reforms aimed to address inefficiencies, inequities, and a lack of responsiveness in the centralized health system. The key aspects of the reform under the main policy levers are presented below.

Governance: The reforms devolved authority and resources to Provincial Health Administrations (PHA) in the DRC's 26 provinces and District Health Management Teams (DHMT) in 516 health zones. PHAs were tasked with planning, managing, and overseeing health services, while DHMTs handled local implementation. Fiscal decentralization granted provinces autonomy to allocate resources based on regional priorities, supported by integrated health planning to align national and district-level priorities (183–185).

Organization: The reform prioritized strengthening primary care facilities to serve as the first point of contact for most health care needs. Rather than offering comprehensive PHC, this level focused primarily on essential health services such as maternal and child health, immunizations, and infectious disease control. A tiered system referred more complex cases to general hospitals to improve efficiency and avoid

overburdening higher-level facilities. Standardized packages of essential health services were introduced to ensure consistency across health zones (183).

2.3. Reform outcome

Despite their ambitious vision, the reforms remain incomplete. PHAs often lack financial, human, and technical resources, which undermines their ability to function effectively (185,186). Governance challenges, vague policy frameworks, inadequate resourcing, and limited political commitment have stalled the transition from centralization to decentralization—leaving many pre-reform issues unresolved (186). Although the reforms promised transformative change, their practical impact has yet to fully materialize (186,187). Table 3 presents the key features of the health system.

3. Egypt - Family Health Model (1999-2021)

3.1. Overview of the health system and its outcomes

Egypt has made significant progress in reducing maternal and child mortality; however, disparities between urban and rural areas persist (188). The health system is financed through a combination of government funding, private-sector contributions, donor aid, and household out-of-pocket payments (175). OOPE accounts for about 60% of total health spending, placing a substantial financial burden on households (175,189). The Universal Health Insurance Law (2018) aims to expand coverage and reduce financial risks, funded through mandatory contributions, taxation, and co-payments. However, implementation is phased and faces fiscal and administrative hurdles. Although it is the primary provider of services, the public health sector is often criticized for inefficiency and poor quality, prompting many to rely on private-sector providers, particularly in urban areas, while non-governmental organizations (NGOs) and faith-based organizations supplement services, especially in underserved regions (190). Table 3 presents the key features of the health system.

3.2. Brief overview of the reform

In 1999, Egypt launched the Family Health Model as part of its broader Health Sector Reform Program to strengthen the existing primary care service delivery system and bring about focused improvements in maternal health outcomes to align with global goals like the Millennium Development Goals and later with the Sustainable Development Goals (191). Key aspects of the reform under the main policy levers are presented below.

Organization: Prior to the reform, primary care was fragmented and episodic. The Family Health Model established Family Health Units (FHU) and Family Health Centers (FHC) as the first point of contact for standardized, comprehensive care, focusing on antenatal, safe delivery, and postnatal services. Targeted efforts in rural and underserved areas aimed to reduce reliance on untrained birth attendants. Multidisciplinary teams were introduced to ensure a holistic approach to care and a structured referral system linking primary care to higher levels of care, addressing the inefficiencies of uncoordinated service delivery. Training programs for midwives, nurses, and doctors emphasized managing complications such as hemorrhage and infections, thereby improving the quality of maternal care (192). Family planning services were expanded to include a broader range of contraceptive options, reducing unintended pregnancies and improving reproductive health outcomes (191).

Financing: The reform rechanneled funds from direct facility financing through line-item budgets to contracted financing through the Family Health Fund at the governorate level – administrative units in Egypt. It also envisioned affiliating uninsured individuals with an FHU, requiring a one-time registration fee and a co-payment for each visit (193).

Provider payment mechanisms: In the pre-reform system, provider payments were based on rigid line-item budgets, offering little incentive for efficiency or quality improvement. The reform introduced performance-based payments, combining capitation with pay-for-performance schemes through the

Family Health Fund. These measures were designed to improve service quality and efficiency by linking payments to performance indicators, thereby incentivizing higher-quality care (190,194).

3.3. Reform outcome

By 2021, the FHUs and FHCs had become critical to ensuring access to skilled birth attendants and essential maternal services. The reforms have been associated with Egypt's reduction in maternal mortality rates, especially in rural areas (195). Nevertheless, regional disparities persist, driven by poverty, inadequate infrastructure, and cultural barriers. The Family Health Fund has faced considerable challenges over time. The fund was intended to be similar to an independent insurance scheme, combining private and public funding. However, it functioned primarily as a provider financing mechanism and did not significantly reduce OOPE for families (194).

Furthermore, the fund's operations often relied on time-limited international donor support rather than sustainable domestic resources (194). Additionally, persisting gaps in the availability and quality of the public sector have continued to drive people to access private sector services, which are costly and poorly regulated (194). More recently, the Universal Health Insurance system, launched in 2018, absorbed the pooling and purchasing functions of the erstwhile Family Health Fund while maintaining the Family Health Model as a cornerstone of care delivery (196).

4. Kazakhstan - Multidisciplinary Teams (2010-2020)

4.1. Overview of the health system and its outcomes

Kazakhstan has achieved notable progress in health outcomes—particularly in maternal and child health, life expectancy, and access to services—and ranks among the highest in human development indicators among its former Soviet and Central Asian peers (172). However, disparities persist between urban and rural areas, with non-communicable diseases (NCD) as the leading causes of death (188).

The health system is financed predominantly through public funding, supplemented by mandatory social health insurance established in 2016 (197). The Social Health Insurance Fund, acting as a single purchaser since 2020, contracts public and private providers to ensure equitable access. Primary care is prioritized, accounting for 52.4% of health spending in 2020; however, OOPE remains significant at 33.9% in 2019, underscoring persistent financial barriers (175,198).

The public sector remains the dominant provider of health services in Kazakhstan, especially for PHC and essential services. However, the private sector plays an increasing role in specialized and tertiary care and diagnostics, often catering to urban and higher-income populations (199). Regional (oblast) health departments manage primary, secondary, and tertiary care, while private providers also deliver services under contracts with the Social Health Insurance Fund. Provider payment mechanisms have shifted from traditional line-item budgets to capitation-based and performance-based models (197,198). See Table 3 for additional details.

4.2. Brief overview of the reform

As the birthplace of the 1978 Alma-Ata Declaration and the 2018 Astana Declaration (2,200), Kazakhstan has a long-standing commitment to PHC. Since its independence in 1992, Kazakhstan has embarked on policies to reorient its health system toward PHC by moving away from the Semashko-style model inherited from the Soviet era, which was characterized by fragmented, curative-focused, and hospital-centric care (201). Kazakhstan's shift toward multidisciplinary teams began with the *Salamatty Kazakhstan* program (2011–2015), which aimed to transform primary care delivery (158,201). Subsequent initiatives, including the State Policy for Public Health Development (*Densaulyk*) (2016–2019) and the State Program for Health Care Development (2020–2025), further strengthened the multidisciplinary team model (158). The key aspects of the reform under the main policy levers are presented below.

Organization: Previously fragmented and disease-focused, primary care was restructured through multidisciplinary teams. Each team comprises a family doctor, three nurses, a social worker, and a

psychologist, and is responsible for a defined catchment area, serving as the community's entry point to the health system. This approach integrates preventive, curative, and psychosocial care, addressing clinical and socioeconomic health determinants (202). Multidisciplinary teams were piloted in 17 "Best Practice PHC Centers," serving as hubs for broader implementation. Services expanded to include management of NCDs, mental health care, and home- or remote-based consultations, promoting comprehensive, community-oriented care. This aimed to address the pre-reform problem of widespread bypassing of general practitioners (GP) in favor of specialists, resulting in inefficiencies, higher costs, and inadequate preventive care (158). The *Densaulyk* program (2016–2019) further solidified the multidisciplinary team model by building capacity for collaborative care. Extensive training programs led by the National Association for PHC (established in 2018) upgraded clinical education to Western standards and empowered nurses with expanded roles in patient care. Facility managers received leadership training to professionalize health services management, while the 2020–2025 policy emphasized digital technologies to enhance primary care. These tools supported the multidisciplinary teams with public health surveillance, data collection, and improved care coordination (158).

Financing: Government financing for PHC increased from 40% of public health expenditure in 2007 to 56% in 2022, with plans to reach 60% by 2025 (202). In 2016, Kazakhstan introduced mandatory health insurance through the Social Health Insurance Fund, which serves as the single purchaser of publicly financed health services, contracting both public and private providers. Funds are pooled from three sources: government contributions for socially vulnerable groups mandatory contributions from employers and employees. The benefits include both the state-guaranteed benefits package and the social health insurance package, covering an extensive range of primary care services (198).

Provider payment mechanisms: The reforms aligned provider payment mechanisms with PHC goals, transitioning from line-item budgets to capitated payments based on population enrollment in 2011, and subsequently, in 2015-19, an addition of a pay-for-performance component based on a set of performance

indicators, rewarding care continuity and reducing unnecessary referrals (198). By 2015, capitation and additional performance-based payments were allocated for psychologist and social worker services.

Governance: Decentralization empowered regional and local governments to implement national policies, manage resources, and tailor primary care to local needs, bolstered by the 1995 Law on Local Self-government and constitutional amendments in 2016. Oblast (regional) administrations obtained authority over managing and licensing health facilities. In light of the Declaration of Astana (2018), there was a wider understanding of multistakeholder engagement, with an increased role for local government as an implementing agent. Facility autonomy was expanded, with some public facilities transitioning to more autonomous state enterprises, enabling them to manage budgets and charge fees (203).

4.3. Reform outcome

Kazakhstan's PHC-oriented multidisciplinary team reforms have reshaped primary care delivery, transitioning from a fragmented, specialist-driven model to a comprehensive, team-based approach (202). By broadening service packages, empowering health workers, and leveraging digital tools, the reforms have improved access, care continuity, and efficiency, while also addressing key health challenges such as NCDs and mental health, and reducing hospitalizations (202,204). These reforms have not only been sustained but have also been systematically strengthened over time through aligned and reinforcing policies.

5. Kenya - Primary Care Networks (2019-2023)

5.1. Overview of the health system and its outcomes

Kenya has made significant progress, particularly in maternal and child health outcomes, infectious disease control, and the scaling up of anti-retroviral treatment coverage (205,206).

Health care is financed through a mix of government allocations, OOPE, donor funding, and insurance contributions. Government spending on health remains low, constituting about 5% of GDP, and OOPE

accounts for 27% of total health expenditure, posing significant financial barriers for many households (175). Donor funding plays a critical role, particularly in vertical programs targeting infectious diseases. The transition from the National Health Insurance Fund to the Social Health Insurance Fund in 2023 aimed to pool resources more effectively, expand coverage, and reduce reliance on OOPE; however, implementation remains a work in progress (207,208). Both national and county budgets remain skewed toward curative services (61.9%), with only 14.7% allocated to promotive and preventive care (209).

Both public and private sectors play significant roles in health care delivery. The private sector, including for-profit organizations, faith-based organizations, and non-governmental organizations, complements public services by filling gaps, especially in underserved areas (210). Traditional healers and informal providers—including unlicensed practitioners—also operate within the health care landscape, often due to gaps in formal service provision (210). While they may offer accessible services, concerns about the quality and safety of care persist. Public sector primary care facilities are under-resourced, with shortages in human resources, infrastructure, and essential medicines (211). These gaps negatively impact the quality of care and reduce trust in primary-level facilities. The curative-focused approach and poor-quality primary care services, coupled with a fragmented health care delivery system, lead many people to bypass primary care facilities in favor of higher-level hospitals or delay or forego care (212). This lack of timely access impedes disease prevention, early detection, and management—worsening health outcomes and exacerbating financial hardship (213). The inefficiency caused by scarce hospital resources used to manage conditions that could be addressed at the primary care level poses systemic challenges, particularly in resource-constrained settings like Kenya (214). Table 3 presents additional details about the health system.

5.2. Brief overview of the reform

To address persistent challenges in PHC, Kenya introduced the Primary Care Networks (PCN) in 2019, piloting the approach in Garissa and Kisumu counties before announcing its national scale-up in 2021 (211,215). The key aspects of the reform under the main policy levers are presented below.

Organization: The PCN model uses a "hub-and-spoke" structure, with sub-county hospitals serving as hubs for health centers, dispensaries, and community health units (CHU), which function as the entry point to the health system (211,215). Each CHU covers approximately 5,000 people (1,000 households) and is staffed by community health promoters (CHP) who deliver community-based care, promote preventive health practices, and facilitate referrals (211,215). CHUs connect patients to health centers and dispensaries for more complex care, while sub-county hospitals manage referrals to higher-level facilities, ensuring streamlined care pathways and addressing the fragmentation of the previous referral system. The PCN model introduced multidisciplinary teams led by family physicians to coordinate primary care delivery. The teams consist of diverse health professionals, including medical officers, nurses, nutritionists, pharmacists, and community health assistants, tailored to meet local health priorities. Counties and the Ministry of Health have also prioritized the recruitment and training of CHPs to support community-level services (215).

Governance: PCN governance is structured across national and subnational county levels, following the devolution after the 2010 constitutional amendments. At the national level, the Primary Health Care Advisory Council and the Ministry of Health oversee implementation, while at the county level, PHC committees coordinate activities (215).

Financing: Financing for PCNs is sourced from national treasury grants, county contributions, and donor funds, with health budgets increasing since 2018-19. The Facility Improvement Fund allows primary care facilities to retain and directly manage revenues, such as reimbursements from the National Health

Insurance Fund (now Social Health Insurance Fund) for services to improve operational autonomy (207,215).

5.3. Reform outcome

Following the initial success of demonstration projects, the government called for the national scale-up of the PCN model in 2021. As of 2024, the country had established 191 PCNs out of a target of 315 PCNs (216). Early results suggest improved care coordination and teamwork among health providers. However, staffing challenges—especially in remote areas—have prompted adaptations such as deploying clinical officers with family medicine training to lead teams and expanding scopes of practice for existing personnel (217).

6. New Zealand - Primary Health Care Strategy (2001-2024)

6.1. Overview of the health system and its outcomes

New Zealand has made significant progress, with many of its health indicators ranking among the best globally, particularly among HICs in the Organisation for Economic Cooperation and Development (OECD). In 2022, life expectancy at birth was 83 years and rising (218); maternal and child health indicators remain strong, and in 2020, 86% of adults rated their health as good, very good, or excellent—well above the OECD average of 68% (219). However, significant disparities persist—particularly for Māori and Pacific peoples—who continue to experience poorer access to care, worse health outcomes, and higher rates of chronic diseases (220). The health system is predominantly financed through general taxation, with government health expenditure accounting for approximately 7% of GDP, and OOPE remains low, at about 13% of total health spending (175). Public funding covers comprehensive primary care services, hospitalizations, and public health programs, while private insurance and user fees contribute to elective surgeries and certain specialist services (221).

Health services are delivered through a mix of public and private providers. The public sector has traditionally dominated, with District Health Boards (DHBs) historically managing hospitals and community health services (221). In 2022, the DHBs were replaced by a centralized agency, Health New Zealand *(Te Whatu Ora)* (160). Primary care is primarily delivered by private GPs subsidized by public funding, while hospitals and specialist services are predominantly public. A referral system ensures coordination across levels of care, from primary care to secondary and tertiary hospitals. NGOs and Māori health providers play critical roles in delivering culturally appropriate care to address health inequities among Māori and other underserved groups. GPs are paid through a combination of capitation (based on patient enrollment) and co-payments from patients. Hospital-based providers are salaried, with funding allocated through national budgets (221). As of 2025, governance of New Zealand's health system is centralized, with Health New Zealand overseeing national service delivery and resource allocation. The Māori Health Authority (*Te Aka Whai Ora*) (dissolved in 2024) worked alongside Health New Zealand to ensure Māori health equity and uphold the principles of the Treaty of Waitangi in health care. The Ministry of Health sets policy direction and monitors system performance (222). (See Table 3 for additional details.)

6.2. Brief overview of the reform

New Zealand's PHC reform, initiated through the New Zealand Health Strategy (2000) and the Primary Health Care Strategy (2001), marked a transformative shift toward equity, integration, and community-focused care (223). These comprehensive reforms aimed to address longstanding disparities in access and health outcomes for lower-income households, Māori, and Pacific Islander populations (223). The key aspects of the reform under the main policy levers are presented below and summarized in Table 3.

Organization: The reform introduced Primary Health Organizations (PHO) as the central entities for delivering integrated services. PHOs, mandatorily not-for-profit entities, coordinated care for all enrolled persons through public and private multidisciplinary teams. These PHOs, comprising GPs, nurses, Māori

health workers, and other allied professionals, focused on preventive care, chronic disease management, health promotion, and contracting private GPs to provide curative services (224–226). Māori and Pacific providers could form PHOs in their communities. PHOs acted as care coordinators, maintaining patient records and linking patients to appropriate services. This marked a shift from the pre-reform system of episodic, curative care, primarily delivered by physicians, to a more comprehensive PHC approach delivered through multidisciplinary professionals, including Māori health providers. PHOs were the main point of contact for both primary and secondary care providers and were responsible for maintaining health records for care continuity and coordination. PHOs were required to coordinate and manage resources for the services they are responsible for to ensure the best use of the workforce and associated diagnostic and therapeutic services. The reform also undertook health personnel planning to determine the appropriate and equitable distribution of providers and skill mix. It focused on recruiting and building capacity for community health workers, Māori and Pacific GPs, and PHC nurses.

Governance: Prior to the reforms, governance was centralized, with minimal community involvement or regional adaptation of health services. Māori and Pacific representation in decision-making was limited, and services often lacked cultural responsiveness. The reform established 20 DHBs, introducing a decentralized governance structure. These DHBs became responsible for aligning national health goals with regional priorities by working through and funding PHOs for essential primary care services for their enrolled populations. PHOs were required to involve diverse providers and engage communities—including Māori and Pacific leadership—to ensure culturally responsive care (227,228). This governance structure reflected a commitment to the principles of the Treaty of Waitangi, particularly in improving equity for Māori communities. DHBs and PHOs collaborated with Māori Development Organizations to improve funding and service delivery through both Māori and mainstream providers, building capacity to deliver comprehensive and culturally responsive care to Māori communities.

Financing: Prior to the reforms, New Zealand was unusual among HICs in funding only about 40% of first-contact services, despite having a predominantly publicly funded health system (224). Cost posed a

barrier to accessing primary care services, especially for people from lower-income households, Māori, and Pacific Islanders (224). The reforms expanded essential primary care to include population services, first-contact care, pharmaceutical management, diagnostic testing, and referred services. The reform involved a substantial financial investment, doubling PHC funding with an additional NZ$ 2.2 billion allocated over seven years starting in 2002 (229). This investment expanded subsidies, improved affordability for vulnerable populations, and enabled PHOs to focus on health promotion and community engagement (229).

Provider payment mechanisms: A key change introduced by the reform was the transition from fee-for-service to capitation-based funding (230). Under this system, PHOs received funding based on the number of patients enrolled, adjusted for population characteristics such as age, ethnicity, and socioeconomic status. This shift incentivized providers to prioritize preventive care and long-term health management, rather than focusing on high patient volumes. Capitation also enabled targeted investments in health promotion, outreach, and chronic disease programs. However, concerns later emerged that capitation created financial challenges for some providers—particularly in areas with limited resources or high unmet health needs—resulting in variations in service quality and availability (227,230,231).

6.3. Reform outcome

New Zealand's PHC reform initially achieved significant improvements in access, affordability, and equity, reducing disparities in service coverage—particularly for Māori and Pacific Islander populations (229). However, as political priorities shifted in later years, austerity measures curtailed PHC funding growth, limiting the capacity of PHOs to expand services or sustain equity-focused initiatives (160). In particular, regional funding inequities began to emerge, undermining the reform's original aim of equitable access (232–234). Governance challenges—including the fragmented relationship between DHBs and PHOs—further weakened the reform's effectiveness (234). In 2022, New Zealand dissolved the DHBs in favor of a centralized health authority, Health New Zealand, and established the independent

Māori Health Authority (which was subsequently dissolved in 2024) (235), signaling a retreat from the decentralized governance model introduced by the 2001 reform.

7. Thailand - Universal Coverage Scheme (2001-2020)

7.1. Overview of the health system and its outcomes

Thailand's health system is widely recognized as a model of success in achieving universal health coverage (UHC). It is designed to ensure equitable access to health services for all Thai citizens while maintaining efficiency and sustainability. As of 2023, life expectancy at birth was approximately 77 years—comparable to some HICs and significantly above the Southeast Asian average (171). Infant mortality has declined to 7 deaths per 1,000 live births, and maternal mortality to around 20 per 100,000—both substantially lower than regional averages (171). Health care financing in Thailand is predominantly public, with about 71% of total health expenditure funded by the government. An additional 20% is covered through social and voluntary health insurance, while OOPE remains low at 9% (175). Financing is structured through three main public health insurance schemes. The Civil Servant Medical Benefit Scheme (CSMBS) covers government employees and their dependents, offering comprehensive benefits. The Social Security Scheme (SSS) targets private-sector employees and is funded through tripartite contributions from employers, employees, and the government. The Universal Coverage Scheme (UCS), introduced in 2002, covers the remaining population and ensures access to essential services without financial hardship (236).

Health care services in Thailand are delivered through a well-structured network of public and private providers operating across various levels of care. Sub-district health-promoting hospitals and health centers serve as the first point of contact, offering preventive and basic curative care. District hospitals provide specialized services and function as referral centers for primary care facilities. Provincial and regional hospitals deliver advanced medical treatments and specialist care. The public sector, overseen by the Ministry of Public Health, dominates service delivery. Private providers play a limited,

complementary role—particularly in urban areas and among those with private insurance coverage. Public services emphasize equity and accessibility, whereas private facilities tend to serve individuals who can afford OOPE or hold private insurance.

Providers are paid through different mechanisms across the different financing schemes: the CSMBS uses fee-for-service and diagnosis-related groups (DRG); the SSS uses capitation for outpatient care and DRGs for inpatient care; and the UCS uses capitation for outpatient care and a mix of DRGs and global budgets for inpatient care. Thailand's health system governance involves multiple institutions. Noteworthy are the Ministry of Public Health, which oversees policy formulation, regulation, and the operation of public health care facilities, and the National Health Security Office (NHSO), responsible for strategic purchasing for the UCS, designing payment mechanisms, contracting providers, developing benefit packages, and ensuring accountability through performance monitoring (237). Table 3 presents additional details about the health system.

7.2. Brief overview of the reform

Thailand's UCS was a landmark reform introduced in 2002 by the newly elected Thai Rak Thai party. It aimed to extend health coverage to previously uninsured populations—especially informal sector workers and rural communities (236). Key aspects of the reform under the main policy levers are summarized in Table 3 and presented below.

Financing: Thailand's UCS introduced transformative changes in health care financing. Prior to its implementation, approximately 30% of the population was uninsured and faced significant financial barriers to accessing care (175). Existing schemes such as the CSMBS and the SSS catered only to specific groups, leaving informal workers and the poor underserved (238). The UCS is financed through general tax revenue, enabling universal entitlement to a comprehensive benefit package without co-payments. Initially, the scheme included a 30 Baht enrollment fee, which was later abolished. These changes substantially reduced financial barriers to care and contributed to a dramatic decline in OOPE—

from 34.2% of total health spending in 2000 to 9% in 2021 (175,236). The government allocates an annual per capita budget to the NHSO, adjusted for inflation, demographic trends, and service needs.

Organization: The UCS leveraged Thailand's existing district health systems—comprising district hospitals and subdistrict health centers—to provide comprehensive primary care. These systems were reorganized into Contracting Units for Primary Care (CUPs), tasked with delivering preventive, curative, and rehabilitative services. This restructuring strengthened collaboration between hospitals and health centers and fostered integrated care within defined catchment areas (239). Prior to the reform, service delivery was unevenly distributed: a small, well-resourced private sector primarily served urban elites and expatriates, while an underfunded public sector provided care to the majority. This urban–rural divide limited access to essential health services for rural and low-income communities (236,240). The UCS prioritized public sector delivery while incorporating private providers—particularly in Bangkok—through contractual arrangements. Primary care was emphasized, with a focus on prevention, promotion, gatekeeping, and care coordination (237).

Provider Payment Mechanisms: The UCS introduced capitation payments for primary care and global budgets with DRGs for inpatient care, a shift from the erstwhile fee-for-service and salaries. Under the capitation model, CUPs received fixed payments based on the number of registered beneficiaries, incentivizing cost-efficient care and prioritizing prevention. This mechanism replaced the previous passive line-item budgets, shifting financial risk to providers and encouraging better health outcomes through proactive management (238,239).

Governance: A major governance shift was the establishment of the NHSO to serve as the purchaser of health services. This separated the purchasing function from the Ministry of Public Health, which continued to oversee service provision. The purchaser-provider split reduced institutional conflicts and enhanced accountability. Community participation was embedded through representation in NHSO governance structures, ensuring responsiveness to local health needs (238). Governance reforms under UCS emphasized participatory and inclusive decision-making. The NHSO engages various stakeholders,

including local governments, civil society, and health care professionals, ensuring that policies reflect diverse perspectives (238).

7.3. Reform outcome

The UCS has led to near-universal population coverage, improved health outcomes, and significant reductions in financial hardship from health care expenses. The reform strengthened PHC as the foundation of Thailand's health system by integrating district health systems and adopting progressive financing mechanisms. The UCS has been widely recognized as a model for achieving UHC in resource-constrained settings (161). The reform has been sustained over two decades—despite several political upheavals—and has been strengthened through congruent additions and adaptations.

8. Tunisia - Family Practice Model (2015-2023)

8.1. Overview of the health system and its outcomes

Tunisia has relatively strong health indicators compared to its regional peers. Life expectancy at birth is approximately 76 years, higher than the average for North African and Middle Eastern countries (218). The infant mortality rate stands at 12.6 deaths per 1,000 live births, and the maternal mortality ratio is 43 deaths per 100,000 live births, both significantly lower than the regional averages (218). Tunisia faces a rising burden of NCDs, which are the leading causes of morbidity and mortality (188). Disparities in health access and outcomes persist, particularly between urban and rural areas (241).

Tunisia's health system is a mixed model combining public and private sectors, delivering a range of preventive, curative, and rehabilitative services. The public sector, managed by the Ministry of Health, plays a dominant role, particularly in primary care, provided through a network of primary health centers, district hospitals, and regional or tertiary hospitals (241). These public facilities often face overcrowding, resource shortages, and uneven distribution of health care workers (241). As a result, many Tunisians bypass primary care facilities in favor of hospitals, further straining the health system. The private sector, meanwhile, focuses on specialized and hospital-based care, serving primarily urban and wealthier

populations, and remains fragmented and poorly integrated with public services, reducing system-wide efficiency (241).

Health financing relies on general taxation, social health insurance, and OOPE. The National Health Insurance Fund (*Caisse Nationale d'Assurance Maladie* or CNAM), established in 2004, covers about 70% of the population, primarily formal sector workers and their dependents (242). However, rural and informal workers often lack adequate financial protection, with OOPE accounting for nearly 40% of health expenditures (175,242). This reliance on OOPE creates barriers for low-income households and exacerbates inequities in access. Private voluntary insurance remains minimal, supplementing coverage mainly for higher-income groups seeking private care (175). Public sector funding is predominantly input-based through line-item budgets, which limit flexibility and efficiency. Private providers are reimbursed fee-for-service, incentivizing high-volume care but contributing to cost inflation and inequities (243).

8.2. Brief overview of the reform

Tunisia's Family Practice Model, launched in 2015, sought to reorient the health system from a fragmented, hospital-centric model to an integrated, person-centered PHC approach. The reform aimed to improve efficiency, equity, and care continuity by embedding family practice as the foundation of PHC (244). The key aspects of the reform under the main policy levers are presented below.

Organization: Before the reforms, primary care was limited to curative services, with GPs operating in isolation. Patients often bypassed primary care facilities in favor of specialists, overburdening hospitals and fragmenting care (243). The reform introduced family medicine as the cornerstone of PHC, emphasizing comprehensive, preventive, and promotive care. Family physicians, supported by multidisciplinary teams (nurses, midwives, and allied professionals), became the first point of contact and gatekeepers, coordinating care and managing referrals. These teams integrated previously siloed preventive services like immunizations and antenatal care, improving early detection and management of

NCDs such as diabetes and hypertension. Family medicine residency training and bridging programs aimed at enabling GPs to transition into family physicians. Tunisian medical schools partnered with local and international institutions to standardize family medicine curricula and equip health care professionals with the necessary skills (241,245).

Provider payment mechanisms: Public sector funding shifted from rigid line-item budgets and salaries to performance-based payments, incentivizing quality care and continuity (245). Family physicians were compensated based on outputs such as preventive services, chronic disease management, and follow-ups. CNAM contracted with private-sector GPs, designating them as gatekeepers for insured patients to reduce unnecessary referrals and control costs (242). However, the implementation of performance-based payments in the public sector has faced delays due to limited infrastructure for monitoring and evaluation (245).

8.3. Current status of the reform

The implementation of Tunisia's Family Practice Reforms faced considerable resistance and challenges. Health care providers, accustomed to the existing hospital-centric, curative model, were particularly resistant to changes in roles and responsibilities. The reforms, which granted family medicine physicians greater autonomy and redistributed responsibilities to family health teams, were perceived as disruptive to established hierarchies and workflows. This resistance was compounded by financial and administrative hurdles, including the transition from traditional line-item budgets to performance-based or capitation payment models, which proved difficult due to inadequate infrastructure for monitoring and evaluation. The Ministry of Health was slow to recognize family physicians as specialists, leading to unequal remuneration compared to other specialties. This disparity discouraged interest in family medicine and created dissatisfaction among practitioners. Ironically, while family physicians were set to receive higher payment rates than GPs, this led to opposition from the existing generation of GPs, who were also tasked with mentoring the newly trained family physicians. These tensions further strained the implementation

process. Financial constraints added to the difficulty of recruiting and retaining family physicians, particularly in rural areas where workforce shortages and limited resources were already significant barriers. Moreover, patients were hesitant to embrace the gatekeeping model, preferring direct access to specialists and hospital care, which they perceived as superior quality. These obstacles, combined with insufficient political and financial commitment, slowed the pace of reform (245,246).

9. Uruguay - Sistema Nacional Integrado de Salud and Redes de Atención Primaria (2007-2020)

9.1. Overview of the health system and its outcomes

Uruguay's health system is widely regarded as inclusive and effective, achieving near-universal health coverage and some of the strongest health outcomes in Latin America (171). Life expectancy is 77.8 years, among the highest in the region (171). Maternal mortality stands at 17 per 100,000 live births, and under-five mortality is 9 per 1,000 live births, both significantly lower than regional averages (171). NCDs, such as cardiovascular diseases and diabetes, are the leading causes of mortality (188).

Structured around a combination of public and private sectors, the system is designed to ensure equity and access through integrated service delivery and comprehensive health financing mechanisms. The National Integrated Health System (*Sistema Nacional Integrado de Salud*, SNIS), established in 2007, serves as the backbone of Uruguay's health system. It is funded through a mix of mandatory social health insurance contributions from employers and employees, along with general tax revenue. This structure minimizes financial barriers to care, with OOPE accounting for 17% of total health spending (175). The SNIS allows citizens to choose between public services offered by the State Health Services Administration (*Administración de los Servicios de Salud del Estado*, ASSE) and private providers, primarily mutual aid societies (mutualistas). Service delivery is centered on PHC and integrated with secondary and tertiary care to provide comprehensive and continuous services (247). The public sector, managed by ASSE, operates an extensive network of hospitals and clinics, primarily serving low-income and rural

populations. Meanwhile, the private sector, led by mutualistas, caters to middle- and upper-income groups, emphasizing quality care and prevention.

Provider payment mechanisms differ across sectors. In the public sector, facilities receive funding through global budgets allocated by the government, focusing on providing essential services to underserved populations. In the private sector, mutualistas operate on a capitation-based model, receiving per capita funding to manage the care of their enrolled populations (248,249). Table 3 provides additional details about the health system.

9.2. Brief overview of the reform

Uruguay's 2007 health reform, spearheaded by the Frente Amplio government, introduced the National Integrated Health System (*Sistema Nacional Integrado de Salud*, SNIS) to address deep-seated inefficiencies and inequities in the country's health system. The reform consolidated the previously fragmented public and private subsystems under a unified framework to provide comprehensive, equitable health coverage to all citizens. The SNIS prioritized PHC through significant changes in financing, organization, provider payments, and governance, as summarized in Table 3 and described below.

Financing: Prior to the reform, health insurance was fragmented into multiple small-risk pools, each with separate contributory mechanisms and coverage models. This structure created financial instability and inequities in access to care (249). The reform established the SNIS, consolidating risk pools and ensuring comprehensive UHC under a single benefits plan. Financing came from mandatory contributions based on income and household size, pooled into the National Health Fund (*Fondo Nacional de Salud*, FONASA), which manages and redistributes public health funds. This consolidation improved financial protection and reduced OOPE, benefiting low-income households (248,249).

Provider payment mechanisms: The reform shifted provider payment mechanisms from automatic line-item budgets (in the public sector) and fee-for-service models (in the private sector) to capitation-based payments adjusted for the epidemiological and risk profiles of enrolled populations (248). Providers were

incentivized to prioritize prevention, early detection, and chronic disease management through performance-based payments tied to nationally defined health goals, such as NCD screening rates. This approach aligned provider incentives with the PHC-oriented goals of the health system, emphasizing efficiency and improved health outcomes (248,250).

Organization: The SNIS unified public and private health service providers under a single-payer system. Citizens could choose between public providers, managed by ASSE, or private nonprofit providers, such as Collective Medical Assistance Institutions (*Instituciones de Asistencia Médica Colectiva*, IAMCs) (249). ASSE expanded its reach with over 900 facilities across Uruguay's 19 departments, organized into primary care networks (*Redes de Atención Primaria*, RAPs) to deliver community-focused services (251).

Governance: Governance reforms introduced a purchaser-provider split to streamline roles and responsibilities. FONASA was established as the strategic purchaser, responsible for managing funds and overseeing provider contracts (249). The Ministry of Health transitioned to a stewardship role, focusing on policy, regulation, and system oversight. ASSE, as the main public provider, was decentralized to improve responsiveness at the local level. Key legislation, such as the 2007 Law 18.211, guaranteed the right to health protection and ensured equal access to a standardized benefits package, solidifying equity and universality as core principles of the health system (252).

9.3. Reform outcome

Uruguay's health reform achieved significant milestones, including realizing UHC with equitable access to a comprehensive benefits package for all residents. By eliminating fragmentation in insurance and service delivery, the reform reduced inequities in financing and care (250)**.** The reform embedded PHC principles throughout the system, explicitly prioritizing health promotion, prevention, early detection, and management of chronic diseases. By reallocating resources and redesigning provider incentives, the system shifted from a physician- and hospital-centered model to one emphasizing community-based, cost-effective interventions (248). However, challenges persist, such as rising health care costs driven by an

aging population, the increasing burden of NCDs, and the need for sustainable financing and workforce distribution (250). Uruguay's reform has been consolidated and strengthened over time and remains the foundation of the country's health system, even following the change in political leadership in 2020-24.

This chapter has outlined the health system contexts of the nine countries in this study and the specific PHC reforms they have undertaken. When read alongside with the diverse historical, socioeconomic, and political contexts presented in Appendix 1, this analysis demonstrates that the selected countries reflect a wide spectrum of income levels, regime types, and health system structures, offering valuable comparative insights into the political economy of PHC reforms. While some reforms have shown sustained progress, others continue to face major implementation challenges, and some have even been reversed or failed to be successfully adopted. The contextual diversity highlighted in this chapter underscores the multifaceted nature of health system reforms, where historical legacies, political configurations, and institutional arrangements shape both their design and trajectory. By setting the stage with this comparative overview, the subsequent analysis in Chapter 5 will examine how political economy dynamics influence PHC reforms—and the conditions under which they succeed or falter.

CHAPTER 5: FINDINGS AND DISCUSSION: A POLITICAL ECONOMY ANALYSIS OF THE PHC REFORMS

In this chapter, I address the two central research questions of my thesis: (1) How have political economy factors influenced the trajectory of PHC reforms across countries? and (2) What are the distinct political economy factors that pertain to PHC reforms, and how do these factors differ between types of reforms—those focusing on financing versus the organization? Using a historical institutionalist approach (see Chapter 3), I present the findings as a "moving picture" rather than a "snapshot," drawing on Paul Pierson's well-known metaphor (40). This approach emphasizes the dynamic, process-oriented evolution of institutions, showing how past events and policy decisions shape the design and outcomes of current health reforms. In contrast to static analyses—common in the political economy of health reform literature—that view reforms as isolated moments, my approach integrates the enduring influence of historical welfare and health policy legacies, the role of temporality, institutions, and interest groups, along with the proximate, ongoing developments that continue to shape reform trajectories.

This chapter is organized around the main themes that emerged from the data analysis in response to the two research questions. For Research Question 1, I focus on theory application. Using a deductive approach, I analyze PHC reforms through a historical institutionalist lens, examining the role of temporality, institutional context, interest groups, and ideas in shaping the adoption, design, and outcomes of reforms. For Research Question 2, I shift to theory building. Using an inductive approach, I explore the political economy dynamics that emerge from the PHC reforms themselves. I explain how these dynamics differ between financing- and organization-focused reforms, arising primarily from how interests and power within health systems shape—and are shaped by—the technical design of the reforms. I discuss these findings in detail along the thematic lines outlined above.

1. Temporality: historical legacies, path dependence, and critical junctures

Temporality emerged as a critical factor shaping health reforms. As theory suggests, the findings show that historical legacies and path dependencies constrain the range of feasible policy options, with past

decisions creating structures that shape current choices (40). This was most evident in New Zealand, Tunisia, and the DRC, where path dependency led to policy inertia. However, these legacies also set positive precedents for reforms in Uruguay and Thailand. Continuity of political leadership—either by the same leader or the political party that introduced the PHC reform—helped to strengthen and sustain the reform in Uruguay, Kazakhstan, and Egypt. In contrast, frequent political changes contributed to reform instability, as seen in New Zealand, Kenya, Tunisia, and the DRC. Thailand stands out as an outlier, with a resilient reform that has endured several significant political upheavals since its adoption. Timing and sequencing were also important. Reforms introduced during critical junctures—periods of political upheaval, economic crises, or social movements—were more likely to succeed (71). These critical junctures opened windows of opportunity for transformative health reforms in Uruguay, Thailand, Kazakhstan, New Zealand, and Tunisia (37,71).

By contrast, countries with mixed reform outcomes—Kenya, Egypt, and Dominica—did not experience clear critical junctures preceding their reforms. I discuss each of these observations in more detail below. Figure 2 presents the main themes and sub-themes, along with country examples, related to the concept of temporality.

THEMES AND SUB-THEMES	COUNTRY EXAMPLES
1 TEMPORALITY	
PATH DEPENDENCE	
Policy inertia impeding reform	DRC, New Zealand, Tunisia
Positive precedence facilitating reform	Thailand, Uruguay
CRITICAL JUNCTURES	
Economic recession → acceptance of redistribution across income groups	Kazakhstan, Thailand, Uruguay
Economic recessions → health budgets reduced and reform reversed	New Zealand
Political changes → opportunity for transformative reform	Kazakhstan, Thailand, Tunisia, Uruguay
Political changes → reform stopped or reversed	New Zealand

Figure 2: Key themes and sub-themes for temporality

Source: Author

New Zealand's health reforms illustrate the enduring influence of path dependence, as even critical junctures and new policy developments failed to fully redress entrenched inequities, ultimately resulting in reform reversals. This trajectory is rooted in the historical legacy of the Treaty of Waitangi (*Te Tiriti o Waitangi*, 1840), which promised partnership and protection for Māori. However, colonial policies led to the dispossession of Māori land and resources, fostering deep socio-economic marginalization (253) (see Appendix 1). In health care, this translated to limited access, under-resourced communities, and disproportionately poor outcomes (254). The welfare state, established under the Social Security Act of 1938, introduced universal health care but failed to confront structural inequities (234,254). The health system remained centralized and one-size-fits-all, perpetuating path dependencies that excluded culturally specific approaches. Hospital-based care dominated, while primary care depended on private GPs operating under a fee-for-service model, generating significant geographic, financial, and cultural barriers for Māori, particularly in rural areas. In the 1930s, New Zealand attempted to establish a fully publicly

financed and delivered national health system; however, the reforms failed due to opposition from GPs. This institutional focus on centralized governance, curative care, and urban centers further entrenched health disparities. Māori communities, particularly in rural areas, faced persistent geographic, financial, and cultural barriers to accessing these services (255). The Waitangi Tribunal, established in 1975, exposed systemic inequities and the Crown's failure to uphold Treaty obligations. It emphasized the need for Māori-led health governance and presented evidence to highlight the Treaty's implications for Māori health (254,256,257). In response, the PHC Strategy (2001), introduced by the Labor government, sought to address these disparities and strengthen primary care. However, entrenched institutional barriers—including inadequate resources for Māori-led PHOs and systemic racism—limited its progress (160,228). DHBs often struggled to partner with Māori iwi and adapt to local needs, as path dependence reinforced centralized and mainstream approaches (256). The 2008 financial crisis marked another critical juncture. Under the National Party, health reforms prioritized efficiency and austerity, resulting in partial retrenchment. Despite this, the coalition role of *te Pāti Māori* helped preserve core aspects of the reform. More recently, the economic downturn caused by the COVID-19 pandemic and Labour's landslide victory in 2020 under Jacinda Ardern created another critical juncture. This was the first single-party majority under the mixed-member proportional (MMP) system, enabling the government to pass the *Pae Ora* legislation, which dissolved the DHBs in 2022. Framed as an efficiency measure, this reform reversed nearly 25 years of decentralization, reflecting a partial return to centralized governance. Reforms such as the Māori Health Authority were introduced to address treaty obligations but were dissolved under the National Party coalition in 2024, and institutional racism and colonial legacies continue to hinder efforts to reduce Māori health disparities. Frequent political shifts and competing priorities have created instability, underscoring the persistent influence of path dependence in New Zealand's health reforms (see Section 2).

Tunisia illustrates the profound influence of historical legacies—including democratic backsliding—and institutional inertia on health care reforms, even in the presence of a critical juncture. Reform attempts

encountered path dependencies and substantial challenges and ultimately failed to gain traction. For decades, Tunisia's health system evolved under authoritarian regimes that emphasized centralized state control. Substantial investments in public health infrastructure during the Habib Bourguiba (1957–1987) and Zine El Abidine Ben Ali (1987–2011) eras improved life expectancy and vaccination coverage but simultaneously deepened inequities (258). Urban centers and hospital-based care were prioritized as visible symbols of state authority, leaving rural areas chronically underserved. This hospital-centric approach became deeply embedded, shaping both institutional norms and public expectations for decades. Rural populations faced inadequate primary care, while health policies frequently prioritized political optics over community needs. The 2011 Jasmine Revolution marked a critical juncture, ending authoritarian rule and exposing entrenched socio-economic inequalities, including disparities in health care access. The revolution created momentum for political and social reforms, including the collaborative Societal Dialog for Health (245). This process culminated in the proposal of the Family Practice Model, which aimed to strengthen PHC, reduce hospital burden, and address inequities by assigning families to dedicated primary care physicians. However, historical legacies presented significant challenges. Decades of urban hospital prioritization left rural health facilities underfunded and health care professionals resistant to shifting toward PHC. Physicians favored urban hospital roles, while patients, accustomed to bypassing primary care, perceived PHC as inadequate. These structural and cultural path dependencies significantly hindered reform implementation. Post-revolution political instability further diluted reform efforts. Frequent changes in leadership disrupted continuity and weakened political commitment to the PHC reform agenda. By 2021, democratic backsliding (see Appendix 1) reinforced centralized governance and closed the window of opportunity for transformative health reforms, leaving Tunisia's health care system constrained by its historical legacies.

Alongside significant political and economic critical junctures, longstanding historical values and path dependencies positively influenced the adoption and sustainability of PHC reforms in Uruguay and Thailand.

Uruguay's health reforms trace back to the early 20th century under President José Batlle y Ordóñez (1903–1907; 1911–1915), who established one of Latin America's earliest welfare states. His administration introduced progressive social and labor reforms, including a strong state role in social services, minimum wages, and health coverage for workers (259,260). These policies laid the foundation for Uruguay's social security system, beginning with the Instituto de Jubilaciones y Pensiones in 1919. They fostered a legacy of state responsibility for welfare, supporting the emergence of strong labor unions and UHC (259–262). By the mid-20th century, Uruguay's health system had expanded but remained fragmented, with services provided by public hospitals and private not-for-profit mutualistas. These mutualistas became a cornerstone of the system but also created inequalities, as wealthier individuals accessed better services, while poorer populations relied on underfunded public options (263). Path dependence reinforced continuing reliance on this fragmented model, perpetuating gaps in access and financial protection. Although the economic crisis of the 1970s and the military dictatorship (1973–1985) weakened the health system through austerity measures and underinvestment, increasing inequalities, the return to democracy in 1985 renewed a focus on social protection and welfare policies, but financial constraints limited the scope of reforms (260). A critical juncture occurred with the 2002 economic crisis (see Appendix 1), which exposed systemic weaknesses and fueled public demand for more equitable health care. This, combined with the election of the Frenté Amplio coalition with an absolute majority in 2005, led to the start of the transformative health reforms under President Tabaré Vázquez (162,264). The universal health insurance model reinforced equity and aligned closely with Uruguay's welfare state traditions. Drawing on the historical health reforms under Battle, economic stabilization in the mid-2000s enabled the expansion of health coverage and improved services, supported by broad public and political consensus and through reforms that strengthened tax extraction. The Frenté Amplio's 15-year period of uninterrupted governance ensured reform continuity, with leaders such as Vázquez and José Mujica institutionalizing universal health insurance and a strong PHC approach as central pillars of Uruguay's social policies (259).

Policy legacies and path dependence similarly influenced Thailand's reform. During the 19th and 20th centuries, state-led development expanded public health infrastructure, particularly in urban areas, driven by the monarchy's emphasis on state-building and responses to public health crises (260). However, access to health care remained limited for rural populations. The post-World War II era saw expanded welfare policies, including the Low-Income Card Scheme (1975) that provided limited health care coverage for the poor and the Social Security Scheme (1990) for private formal sector workers, and laid the foundation for the UCS reform (260,265). Despite these efforts, the system remained fragmented, leaving informal workers with limited access. The Ministry of Health made significant rural health investments in the 1970s and 1980s, including building district hospitals and health centers and introducing a cadre of village health volunteers to address rural underdevelopment and inequality, which had fueled political unrest during this period (260). The 1997 Asian financial crisis (see Appendix 1) marked a critical juncture, exposing deep socio-economic vulnerabilities and intensifying demands for health equity. The crisis, along with changes in the electoral system and the 1997 Constitution's enshrinement of health care as a constitutional right, created a favorable environment for reform (see Section 2.3). Empowered by these changes, reformist bureaucrats and health activists mobilized support for the UCS (120). The Thai Rak Thai Party, led by Thaksin Shinawatra, capitalized on public demand for affordable health care, framing UCS as both economically pragmatic and socially just. Introduced in 2002, UCS leveraged existing public health infrastructure built during the 1970s and 1980s, enabling rapid and effective implementation while reinforcing the public sector's dominance. The UCS established a new path dependency by embedding UHC into Thailand's political and social contract. Its popularity has made it politically resilient, surviving multiple political transitions and military coups (see Appendix 1). The scheme's success has been attributed to its alignment with national priorities (161), institutional resilience and capacity, and broad public support, which generated positive policy feedback effects.

Kazakhstan illustrates how critical junctures enabled a path departure from its historically hospital-centric system toward a PHC-oriented model, while health policy legacies set new positive path-dependent

trajectories. Under the Soviet Union, Kazakhstan inherited the Semashko model, a centralized, state-funded health care system that emphasized hospital care and specialization. The Semashko model entrenched a curative, specialist-oriented approach, sidelining the preventive and community-oriented focus advocated in modern PHC. This legacy created a path dependency where health care resources and professional training were concentrated in hospitals, leaving PHC underdeveloped. By the end of the Soviet era, Kazakhstan's health care system was highly fragmented and urban-centric, with rural populations facing significant barriers to access (201,202). This legacy posed significant challenges for the newly independent nation, which faced the dual burden of transitioning to a market economy and addressing the health needs of its population. Kazakhstan's 1991 independence marked a critical juncture, enabling its health system to break from the Semashko model and symbolically distance itself from Soviet ideology. Under President Nursultan Nazarbayev's leadership, health reform became central to modernization efforts, emphasizing equity and global competitiveness. The 2008 economic crisis was another critical juncture that spurred investments in PHC, and reforms prioritized family medicine and multidisciplinary teams to rebuild public trust and ensure equitable access. Kazakhstan's historical connection to PHC—having hosted the 1978 Alma-Ata Conference—further shaped its reform trajectory. Guided by the principles of comprehensive, community-based care, the government retrained health care providers and integrated family medicine into its health system. The National Program for Health Care Reform and Development (2005–2010), *Salamatty Kazakhstan* (2011–2015), and *Densaulyk* (2016–2019) further institutionalized PHC, strengthening infrastructure and improving health outcomes (201). The 2018 Astana Declaration reaffirmed Kazakhstan's commitment to PHC, bolstering its global reputation. Under Nazarbayev's 30-year presidency, political stability enabled sustained reforms, embedding PHC principles into Kazakhstan's health system and ensuring their resilience.

Kenya, the DRC, Egypt, and Dominica – the countries with either mixed results of reforms or failure of reform adoption (see Table 3) – did not have defined critical junctures preceding their PHC reforms. Historical legacies and path dependencies prevailed and posed challenges to the reforms.

Kenya's health system bears the imprint of its colonial past. Under British rule, health care infrastructure was designed to serve urban elites and European settlers, leaving rural populations neglected. Post-independence efforts to expand access struggled against this foundation, further eroded in the 1980s by Structural Adjustment Programs that introduced user fees and weakened public health investment (266,267), creating a legacy of fragmentation and inequity, making later reforms challenging. The 2010 Constitution marked a transformative moment, devolving health care governance to Kenya's 47 counties and laying the foundation for the PCN reform. However, the legacies of centralization and inequitable capacities negatively affected PCN implementation and scale-up (see Section 2). Rural areas, long deprived of investment, faced logistical and resource challenges that further limited reform efforts. Simultaneously, the dominance of a hospital-centric system, a legacy of past policies, continued to divert resources and political attention from primary care in Kenya's health system. This institutional inertia made transformative change difficult. The persistence of centralized decision-making norms and practices impeded the effective implementation of decentralized health governance. Additionally, shifting political alliances (268), frequent leadership changes, entrenched interests, and bureaucratic resistance slowed the pace of reforms, demonstrating the path-dependent nature of institutional change (269). Despite its promise, the PCN reform has struggled to overcome these historical and systemic barriers, demonstrating how deeply path dependency can shape the success of health care transformation.

In the DRC, the colonial legacy of Belgian rule left a deeply fractured health care system. The colonial government prioritized urban centers and extractive industries, providing minimal services to rural areas through mission hospitals and clinics (270). After independence in 1960, political instability and chronic underinvestment perpetuated these disparities, leaving the health system heavily reliant on external aid (270,271). The 2006 Constitution aimed to address these historical inequities by decentralizing health care governance to provincial authorities. This reform was intended to empower provinces to tailor health services to local needs, reducing dependence on the central government; however, the decentralization process quickly revealed significant weaknesses. Many provinces lacked the institutional capacity to plan

and manage health care effectively, and unclear funding mechanisms left them dependent on inconsistent donor support, while the central government often interfered in provincial decision-making, undermining the autonomy the reform was meant to establish (186,187). The DRC's reliance on external donors and fragmented governance structures created a path dependency that hindered meaningful reform. The provincial health reforms, while well-intentioned, largely failed to achieve their goals, illustrating the enduring influence of colonial legacies and weak institutional frameworks (187,272,273).

Egypt's historical legacies of authoritarianism and welfare policies created path dependence, and while some aspects of the reform were successful, some have faced significant challenges for decades. Rooted in the post-monarchy socialist era, Egypt's health system adopted a centralized Soviet-inspired model, emphasizing state ownership and free health care for all. Under Nasser's leadership in the 1950s and 1960s, Egypt adopted a centralized welfare state model, emphasizing universal access to education and health care as pillars of state legitimacy. This system prioritized curative, hospital-based care, with heavy state control and limited emphasis on preventive or community-based services. While this approach expanded access, it also entrenched inefficiencies, urban biases, and a reliance on state-funded hospitals, sidelining PHC and creating long-standing inequities. In the 1990s, economic liberalization under the Structural Adjustment Programs introduced user fees and private sector involvement in health care, strengthening this interest group (see Section 3). These reforms exacerbated disparities, as rural and underserved populations faced barriers to accessing quality care. However, this period also set the stage for the Family Health Model, driven by donors (see Sections 3 and 4). Despite its potential, implementation was hindered by resource shortages, resistance from entrenched hospital-centric institutions, and public skepticism stemming from long-standing neglect of PHC, especially evident in the failure of the Family Health Funds and increasing use of the public sector. The 2011 revolution marked a critical juncture for the country, exposing deep socio-economic inequalities and renewing calls for equitable health care (see Appendix 1), but the Universal Health Insurance law was repeatedly rejected by the parliament and various interest groups (see Sections 2 and 3).

For Dominica, the devastating Hurricane Maria in 2017 was an important but not unusual event that put the need for reorientation of the health system toward PHC into stark relief. Dominica's health system has been recognized for its strong PHC approach (see Chapter 4). However, over the years, resource constraints and a greater national focus on hospital care have weakened the PHC system. The devastation caused by Hurricane Maria highlighted critical vulnerabilities in Dominica's health infrastructure and prompted efforts to build a more resilient health system centered on PHC. However, decades of path dependence (and interests of powerful groups, described in Section 3) led to the dilution of the PHC focus and a resurgence of investments in hospitals and infrastructure.

The findings suggest that transformative reforms, especially in the countries with sustained and comprehensive reforms (Uruguay, Thailand, and Kazakhstan), have had a critical juncture involving significant political and economic events. The countries without a significant focusing event preceding their reforms, such as Kenya, the DRC, Dominica, and Egypt, have led to mixed results or failure of reform adoption. Other research has shown similar findings on the role of critical junctures like World War II and democratization, leading to welfare and health insurance programs (73,74,76,77,260). Economic crises in Kazakhstan, Uruguay, and Thailand created political momentum for redistribution, making the PHC reforms more acceptable across income groups. This finding aligns with theoretical and empirical evidence comparing multiple countries that the experience or the threat of economic shocks and unemployment makes redistributive policies more acceptable to higher income groups who, in normal circumstances, might be opposed to such policies (274). However, although a critical juncture is a necessary condition, it is not always sufficient for successful reform adoption, especially in the face of resilient path dependencies, as in the case of Tunisia and New Zealand. Economic crises in New Zealand both in 2008 and 2021 shifted priorities towards efficiency over equity, leading to austerity-driven budget cuts from the PHC reform and its eventual reversal. These findings underscore the enduring influence of institutions and interest groups—topics explored in the sections that follow.

2. Institutional context

The findings show that institutional contexts—including political systems, political parties and their electoral bases, constitutional provisions, laws and legislation, and devolution and bureaucracies—influenced the prioritization, design, adoption, and ultimately the implementation and sustainability (or reversal) of PHC reforms. Figure 3 illustrates the key themes and sub-themes showing how institutional contexts shaped PHC reforms across countries.

THEMES AND SUB-THEMES	COUNTRY EXAMPLES
2 INSTITUTIONAL CONTEXTS	
POLITICAL SYSTEMS	
Regime types → mixed reform outcomes across regimes	New Zealand, Uruguay Kazakhstan, Thailand
Representation, coalitions and veto points → transformative/incremental reforms, pace of reforms	New Zealand, Thailand, Uruguay
POLITICAL PARTIES AND THEIR ELECTORAL BASES	
Left-right partisanship → alignment of party ideology and demand of electoral base	Uruguay
Conventional party ideology insufficient to explain reform adoption and continuation	Thailand
Party-voter relationships are not always programmatic but particularistic	Kenya, Tunisia
Electoral rules → reform design and adoption	New Zealand
CONSTITUTIONS, LAWS, AND LEGISLATION	
Constitutional provision of right to health facilitated and protected reforms	Thailand, Uruguay
Unwritten constitution and differing interpretations of rights made reform vulnerable	New Zealand
Successive laws and legislation strengthened and safeguarded reforms	Thailand, Uruguay
Constitutional amendments shaped power dynamics of governments and interest groups	Egypt, Kazakhstan, Tunisia
Constitutional provisions shaped reform design and implementation	DRC, Kenya
DEVOLUTION AND BUREAUCRACIES	
Powerful, professionalized bureaucrats led reform design and safeguarded reform from political changes	New Zealand (till 2020), Thailand
Power delegated to decentralized levels affects reform implementation	DRC, Kenya
Bureaucrats influence reforms through informal veto power	Kazakhstan

Figure 3: Key themes and sub-themes of institutional contexts

Source: Author

2.1. Political systems

The considerable variation in the structure o institutions across the nine countries in the sample compels attention to the role of political systems, primarily regime types and electoral rules, in shaping PHC

reforms. However, as I discuss below, the association of these structures is complex and nuanced and often not intuitive. Political structures influence the distribution of power, the number of veto points, the capacity for transformational change, and the ability of interest groups (see Section 3) to influence policy.

I find that the design and comprehensiveness of reforms, or whether they were sustained, were equally mixed across regime types. New Zealand and Uruguay (democracies) introduced comprehensive PHC reforms, as did Egypt, Kazakhstan, and Thailand (authoritarian regimes) (see Tables 2, 3, and Appendix 1). On the other hand, reforms in Dominica (democracy), Kenya (hybrid regime), and the DRC and Tunisia (authoritarian regimes) were less comprehensive and involved only a few policy levers (see Tables 2, 3, and Appendix 1). Similarly, the trajectory and current status of the reforms were mixed. Uruguay (democracy), Kazakhstan, and Thailand (authoritarian regimes) have sustained and strengthened their reforms over the years. Reforms in Dominica and Kenya (democracies) and Egypt (authoritarian) had mixed results. New Zealand's (democracy) reforms were reversed. Reforms in Tunisia and the DRC (authoritarian regimes) failed to take off.

A substantial body of research suggests that democratic governance positively influences state efforts and welfare outcomes (275–278). Democratic systems enable mechanisms such as electoral competition and freedom of association, allowing interest groups to organize and advocate for redistributive policies. Expanded franchise and heightened political competition compel politicians to appeal to broader constituencies, often addressing income disparities through redistributive policies (41,94,260,279–282). Evidence supports the link between democracy and redistributive public policies, as seen in Uruguay's and New Zealand's health reforms, although sustainability varied in the latter case. Yet authoritarian regimes such as Kazakhstan, Thailand, and Egypt also implemented redistributive policies, challenging the assumption that democracy is essential for such outcomes. Some studies even find little distinction between democracies and non-democracies in social spending (138), or modest effects of democracy on outcomes such as infant mortality (139,283). Unexpectedly, authoritarian regimes often outperform democracies in specific areas, particularly service delivery programs linked to PHC reforms

(139,154,284). Authoritarian leaders, like their democratic counterparts, face redistributive demands and risks to their legitimacy from poor economic performance. Empirical evidence shows that improved public services, such as PHC, enhance citizen trust and regime legitimacy, helping rulers secure citizens' support and prevent unrest (282,285–287).

Congruent with extant literature, the findings highlight that while democracy fosters redistributive pressures, authoritarian regimes can also implement policies that address inequality, driven by their own survival incentives. The mixed findings across democracies and autocracies point toward factors beyond regime types. A key factor is the design of political institutions and the extent to which they allowed the emergence of interest groups, created veto points and attributed power across the branches of the government, and appeared to give citizens greater influence on how transformative and comprehensive reforms were and whether they could be sustained over time (33,44,53,58). Some political and electoral systems are likelier to foster coalition governments and adopt pro-welfare policies than others. Research shows that systems that allocate seats proportionally to parties' vote shares (especially proportional representation (PR) systems) enable smaller parties to gain representation and necessitate coalition governments. In contrast, with their winner-takes-all approach, majoritarian systems often result in single-party governments (288). Coalitional systems are typically more inclusive, representing diverse societal interests, including lower-income groups, and incentivize collective and redistributive policies (44). Conversely, majoritarian systems tend to favor center-right parties, which appeal to median voters in competitive districts and limit redistribution (41,44,281).

In this study's sample, Uruguay, New Zealand, Kazakhstan, and Tunisia have PR systems with varying numbers of veto points. Dominica, the DRC, Egypt, and Thailand have majoritarian or mixed systems leaning toward majoritarian systems, although Thailand had a balanced PR and majoritarian system in 2001 (see Appendix 1). Overall, the findings show that the PR systems created greater opportunities for political pluralism, coalitions (see Section 2.2), and the emergence and participation of diverse interest groups in the reform process (discussed later in this chapter) compared to the majoritarian systems.

However, these characteristics also introduced more veto points, and the multiplicity of actors and the need for coalition-building often slowed decision-making processes and diluted policy initiatives, similar to existing evidence (45,58,289).

The challenges to reforms in PR systems are evident in New Zealand and Tunisia, where the reforms failed to be sustained and adopted (see Table 3). New Zealand's mixed-member proportional system (see Appendix 1) helped the adoption of the PHC reform in 2001, with the greater participation of the legislature and smaller political parties, especially Māori politicians. However, the political system designed to prevent the emergence of a single majority party also led to frequent oscillations of the reform subject to coalitional politics and its eventual retrenchment in 2022-2024. During Tunisia's democratic transition (2011–2021), the PR system fostered political pluralism and enabled the participation of diverse interest groups—embodied in the Societal Dialog for Health. These empowered lower-income groups and civil society advocating for health care services and rights (represented in the Family Practice Model), but, at the same time, opened veto points for physicians and private sector health care stakeholders who eventually opposed and stymied the reform. Coalitional politics also played a critical role in the Tunisian experience (see Section 3).

Similarly, Kenya's multi-party system, has generated more than 90 registered political parties, expanding the inclusion of smaller groups and interests. However, the system has contributed to unstable coalition governments. Especially with ethnic and pork-barrel politics to appeal to local interests, electoral competition and coalition instability have led to a focus on politically visible projects such as hospital construction and health insurance schemes, which offer immediate returns for vote-seeking politicians. Politically influential counties often receive disproportionate health investments. In contrast, PHC reforms, which are less visible and require long-term investment, have been deprioritized and have hindered the nationwide implementation of the PCN reforms, similar to evidence from other studies (50,290,291).

The relatively fewer veto points and lower opposition to the successful reforms in the PR systems of Uruguay and Kazakhstan can be explained by other institutional factors surrounding these systems. Interestingly, Uruguay's system has a large number of formal veto points in its design, including direct democracy through referendums. The system encourages the political participation and empowerment of various interest groups, most notably labor unions and agricultural workers, several of which came together and formed the broad coalition of the Frenté Amplio party. At the same time, physicians, the private sector, urban elites, and right-leaning parties were also active in the civic space. However, the distinguishing factor in Uruguay was the absolute majority win in both houses of the legislature by the Frenté Amplio from 2005 to 2020. This significantly reduced veto points as the party did not have to depend on the usual PR system-related coalitions that might have opposed or diluted the reforms in its formative years. Kazakhstan's authoritarian system understandably had fewer veto points than its democratic counterparts. The president wielded substantial powers, including the authority to issue decrees with the force of law and appoint (or terminate) key officials across government institutions to suppress opposition to reform proposals, prevent rebellions, and maintain authority, as shown in other authoritarian contexts (282). The Kazakh PHC reforms were primarily shaped by the priorities of the executive (especially the president's and prime minister's) (158). However, despite being authoritarian, Kazakhstan's system allowed smaller parties and regional interests to contest and hold parliamentary seats (see Appendix 1), theoretically allowing for diverse input in policy discussions, including NGOs, though these are tightly controlled (158).

As predicted by theory and evidence, veto points in majoritarian systems were relatively fewer than in the PR systems. While Thailand's system in 2001 was technically a mixed system with both majoritarian and PR elements, it leaned more heavily toward majoritarian outcomes due to the large share of seats determined by first-past-the-post (FPTP) (see Appendix 1). The dominance of the FPTP system allowed parties such as Thaksin Shinawatra's Thai Rak Thai Party to secure large majorities, as they performed well in constituency races. In the 2001 elections, Thai Rak Thai won a decisive victory, aided by its

success in single-member districts (discussed later). With its absolute majority in 2001-2006, the party had drastically reduced veto points and potential opposition or dilution from other parties and coalitions in the initial years of the UCS reform's adoption and implementation. Thailand's authoritarian periods are marked by significant military and monarchical influence and frequent military coups. These have shaped Thailand's institutions. The military's influence, especially through its control of the Senate, often aligns reforms with strategic priorities – which the UCS reform has been, given its extreme popularity among Thai citizens as well as the monarchy.

Dominica's FPTP majoritarian system and unicameral legislature create relatively few veto points and rarely produce coalition governments. This streamlined structure made passing policies and responding to disasters during the reform period relatively easy. However, it also limited opposition to the hospital-centric direction of the reforms. The Dominica Labor Party, which has ruled since 2000, leveraged foreign aid to build a large tertiary hospital and polyclinics, which enhanced their political visibility and competitiveness. While politically advantageous, these investments overshadowed the development of more comprehensive PHC reforms.

The authoritarian regimes in Egypt and the DRC more strongly illustrate the role of veto points in political systems. Egypt was a centralized authoritarian state during the first decade of its Family Health Model, and after a brief democratic experience, has returned to strong presidential authority. The current President el-Sisi's health strategy (2024-2030) acknowledges the Family Health Model as the core for PHC in Egypt, and, given the absence of vetoes, is likely to be upheld and sustained (292). Egypt's majoritarian system, combined with its authoritarian regime, tends to exclude and effectively marginalize opposition parties, limiting their ability to mobilize within formal political structures (293). The DRC presents a unique case, having experienced a turbulent political history and extremely weak institutions. The centralized presidency and decentralized administrative structure, introduced as part of its democratic transition, have been undermined by persistent corruption, regional disparities, and a lack of accountability. As Acemoglu and Robinson's (2012) work describes, the DRC's extractive political and

economic institutions prioritize elite interests over public welfare, perpetuating resource mismanagement and neglect of essential services such as health care (86). Constitutional changes in 2011 further weakened electoral legitimacy and fueled political instability, diverting attention from long-term health investments and leading to the failure of Provincial Health Reform to take off.

2.2. Political parties and their electoral bases

Partisanship significantly shapes welfare and health policies through the ideological preferences and priorities of governing parties. Traditionally, left-wing and right-wing governments are thought to adopt policies aligned with the interests of their respective support bases (294). The literature suggests that left-leaning parties, often supported by lower- and middle-income voters, tend to prioritize redistributive policies, expanding welfare programs, and increasing public investment in health services (82,281,295). Conversely, right-leaning parties, backed by wealthier constituencies, generally emphasize fiscal conservatism, privatization, and limited government intervention, which may result in reduced welfare spending or targeted health initiatives (82,281,296). In multiparty or coalition governments, partisanship influences policy bargaining, with competing priorities shaping the scope and direction of welfare programs. Partisan shifts in government can lead to discontinuity in health policies, affecting their sustainability and implementation over time (82,281,294,296). However, findings from this study reveal that while ideological orientation offers a useful heuristic, it is increasingly insufficient. This binary approach overlooks the complexity of party platforms, which can be shaped by factors such as electoral incentives, coalition dynamics, institutional constraints, and public opinion. For example, populist parties may adopt redistributive policies in response to voter demands or to respond to new electoral institutions (Thailand), while left-leaning parties might limit health spending under fiscal constraints or global economic pressures (New Zealand) (294,297–302).

Uruguay offers the clearest example of left-right programmatic partisanship. Uruguay's landmark health reforms were championed and strengthened over 15 years by the leftist Frenté Amplio, whose strong

support base among labor unions and grassroots movements shaped an equity-focused policy agenda. The party's historical alliances with unions and rural communities allowed it to prioritize the interests of marginalized groups while disregarding opposition from elite physician associations and private-sector actors (see Sections 3 and 5). The Frenté Amplio's main electoral base of labor and agricultural workers spread across the country's urban and rural areas, making the reforms of interest to many citizens. This alignment between party ideology and the demands of its support base facilitated the implementation of redistributive health reforms.

However, except for Uruguay, the findings from the other countries in the sample show that the relationship between parties and their voters is neither static – especially in multi-party systems – nor are they solely programmatic (47,50,82,289,298,301). I illustrate this using the findings from New Zealand, Thailand, Kenya, and Tunisia.

In New Zealand, the PHC Strategy was introduced and strengthened under successive Labor Party-led coalitions (1999-2008), prioritizing community-based PHC and including indigenous communities. Aligning with partisan ideology theories, the reform faced pushback and stagnation under the conservative National Party-led coalition governments (2008-2017) (160), although the Māori Party (*Pariti Māori*) was its main coalition partner. The prime argument of this pushback was efficiency and the need for fiscal austerity following the financial crisis (see Appendix 1), again congruent with evidence from other studies on party ideology and reforms (303). However, counterintuitively, a Labor-led coalition, empowered by its unprecedented absolute majority in the parliament in 2020, dismantled the DHBs of its own original PHC Strategy and re-centralized the health system in 2022-23. The rationale was to bring more efficiency in a post-COVID shrinking economy. But at the same time, it set up the Māori Health Authority at the national level to appeal to the Māori electorate and the Māori Party (which had been a coalitional partner of both Labor and the conservative National Party in earlier years). The Māori Health Authority was eventually dissolved by the National and ACT Party coalition in 2024. Similarly, Thailand's UCS reform was successfully enacted by the populist Thai Rak Thai party and has

been systematically sustained and strengthened under its rule till 2006 and then under successive military governments.

As is evident from the discussion on political systems (see Section 2.1), the impact of electoral rules on parties' policy positions and the mutable nature of the relationship between parties and voters is undeniable (294). In Thailand and Uruguay, competitive electoral systems incentivized parties to adopt health reforms as vote-winning strategies. Thailand's 1997 electoral reforms, which replaced multi-member districts with single-member districts and introduced proportional representation for 20% of parliamentary seats, significantly reshaped the political landscape (see Appendix 1). These changes broadened the support bases of political parties, strengthened party cohesion, and allowed voters, for the first time, to cast a vote for a political party to represent them at the national level in addition to voting for their local representative (265,304). The new vote threshold for parliamentary representation further incentivized the two largest parties—the Thai Rak Thai and the Democrat Party—to adopt policies with broad national appeal (265). This shift transformed candidate behavior, with many joining Thai Rak Thai due to its well-crafted policies and national platform. The 2001 introduction of the UCS by Thaksin Shinawatra's populist government exemplifies how electoral competition spurred policies targeting rural and low-income populations, a key voting bloc. Despite Thailand's recurring political instability, the UCS's popularity among these groups cemented its place as a flagship policy. Other research explains how the electoral rules and the geographical distribution of low-income voters condition electoral mobilization strategies and – ultimately – the power of left parties (305). In Uruguay, the electoral reforms of 1997, including a two-round voting system for presidential elections and changes to legislative election rules, aimed to strengthen political parties and reduce fragmentation, fostering more stable and programmatic politics. The two-round voting system reduced the likelihood of fragmented coalitions, indirectly empowering the presidency while also creating incentives for broader consensus-building among political actors. By consolidating party structures, the amendments made it easier for well-organized groups, such as unions, professional associations, and civil society organizations, to engage

with the political process through established parties. This shift strengthened the alignment of interest groups with broader political movements, particularly the Frenté Amplio coalition, which would later drive the health reforms of the 2000s.

My findings also highlight that the relationship between political parties and their voters is neither static – especially in multi-party systems – nor solely programmatic (47,50,82,289,298,301). While traditional theories assume parties promote policies aligned with broad ideological commitments, recent research emphasizes the influence of particularistic strategies. In contexts with weak state capacity and partisanship, parties may adopt targeted policies to appeal to narrow voter groups. For instance, occupationally based welfare programs are often leveraged for clientelist purposes, inhibiting the development of universalist policies. For example, in Thailand pre-2001, there were continuing distinct schemes for civil servants and formal sector workers (306), and Uruguay pre-2005 had narrow insurance for formal sector workers (260,306). Electoral rules, such as multi-member districts and the importance of personal votes, further incentivize particularistic approaches, steering parties away from programmatic coherence.

Additionally, health reforms are often influenced by cross-cutting issues such as regional disparities, ethnic politics, and the role of interest groups, which transcend traditional ideological divisions. Kenya and Tunisia exhibit party systems that diverge from conventional left-right ideological frameworks, shaped instead by ethnic, elite, and religious dynamics. In Kenya, political coalitions are fluid and have historically been based on ethnic and regional affiliations rather than enduring ideologies (268,307). These coalitions, often formed shortly before elections, prioritize winning presidential power at the center (see Appendix 1 and Section 2.3). This unstable, elite-driven partisanship fosters corruption and undermines sustained policy reforms, including health sector initiatives. For instance, the PCN reforms were announced amidst political bargaining between coalition partners (159), illustrating how transient alliances can dictate policy priorities without necessarily institutionalizing long-term change. In Tunisia, partisanship reflects a divide between secular and religious-Islamic ideologies in the post-2011 democratic

transition. Early political dynamics were shaped by the moderate Islamist Ennahda and secular forces such as Nidaa Tounes, whose pragmatic coalition after the 2014 elections sought to balance stability and ideological differences. However, this consensus politics unraveled due to internal fragmentation within Nidaa Tounes and growing disenchantment among voters. By 2019, Nidaa Tounes had collapsed, while Ennahda retained parliamentary influence. Tunisia's political fragmentation, compounded by President Kais Saied's centralization of power since 2021, has weakened party influence and partisanship on governance and reform efforts. The unsuccessful attempts at the Family Practice Model, during Nidaa Tounes' leadership highlight the tension between parties, compromises in coalitions (see Section 2.1), and the eventual failure in the absence of any strong ideological or electoral support base for the reform.

In centralized systems such as Kazakhstan and Egypt, partisanship has limited policy influence. In Kazakhstan, the dominance of the Amaanat (earlier Nur Otan) Party, aligned with the executive, ensures health reforms reflect the ruling government's priorities, with little scope for other ideologies or electoral bases influencing reform choices. Constitutional amendments that expanded proportional representation (see Section 2.3) strengthened the Amanat Party's control over parliament, further consolidating power and reducing potential vetoes. Similarly, in Egypt, pro-government parties, such as the Nation's Future Party, operate within a system tightly controlled by the presidency, leaving opposition parties with minimal influence on policy.

2.3. Constitutions, laws, and legislation

Constitutions and legislation shape health reforms by defining rights, setting institutional mandates, and allocating authority. Seven of nine countries in this study adopted major constitutional or legislative changes during their reform periods. In Uruguay and Thailand, the codification of health rights and successive legislation added legal resilience to sustain the reforms, while in New Zealand, the absence of a written constitution contributed to the reform reversal. In Kenya and the DRC, constitutional amendments influenced the design of PHC reforms. In Kazakhstan, Tunisia, and Egypt, amendments

shaped the power and scope of different arms of the governments and interest groups – increasing or reducing veto powers, thereby influencing the adoption and implementation of reforms.

The constitutional recognition of the right to health was pivotal in shaping the foundation for PHC reforms in Uruguay and Thailand, ensuring these reforms aligned with principles of equity and universality, while key laws and legislation served as institutional safeguards that anchored their reforms, ensuring their resilience against opposition and political and economic fluctuations.

In Uruguay, the 1996 Constitution explicitly recognized health care as a fundamental right and state responsibility, reinforcing the legal foundation for reform. This constitutional guarantee directed health reforms toward equity and universal access, reinforced by legislative frameworks that treated health care as a public good and expanded UHC (162,252,264). Uruguay's comprehensive health reform over 15 years was anchored in a series of laws. A series of laws between 2005 and 2013—beginning with the 2005 Health Reform Law under the Frenté Amplio—created the SNIS, to integrate public and private providers into a unified system, ensuring UHC and equity (306,308,309). Complementing this, the 2007 law established the FONASA, a pooled funding mechanism financed by employer, employee, and state contributions, enabling equitable resource distribution and expanding coverage to previously uninsured populations (310). In 2008, legislation institutionalized RAPs as the foundation of primary care, emphasizing prevention, community-based services, and care continuity. Additional laws, such as those regulating mutualistas in 2013 and defining professional roles of providers in health in 2011, ensured alignment with SNIS standards and improved workforce integration (252,264,306). Budgetary laws during this period bolstered financial sustainability, gradually increasing contributions to FONASA and supporting the reform (162).

Similarly, Thailand's 1997 Constitution, introduced amidst significant political changes to promote democracy and citizen participation, embedded health care as a fundamental right. This was central to adopting the UCS reform without significant opposition. The emphasis on equity and public participation

ensured these reforms targeted underserved populations, reinforcing health access as a core element of national development (265). The 1997 Constitution also institutionalized oversight bodies such as the Constitutional Court, Election Commission, and Anti-Corruption Commission, strengthening accountability mechanisms. These institutions gained significant veto powers, acting as watchdogs over government actions and curbing potential abuses of power. The constitution strengthened civil society and public participation in governance, granting citizens avenues to petition for legislative changes and demand government accountability. It mandated public hearings for major policy decisions, empowering grassroots movements and NGOs to influence national policies. In health, this facilitated the involvement of civil society groups in advocating for the UCS reform and ensured public input during its design and implementation. Key legislation like the National Health Security Act (2002) (311) institutionalized UHC as a legal mandate and established the NHSO to oversee the UCS implementation, ensuring accountability, equitable resource allocation, and efficient service delivery. It also created a legal framework for managing the scheme's financing, with funds pooled from general taxation to ensure equity and sustainability. Complementing the National Health Security Act, the Health Promotion Foundation Act (2001) (312) established the Thai Health Foundation, which used dedicated "sin taxes" on tobacco and alcohol to fund health promotion and prevention programs, indirectly reducing health care costs and bolstering the UCS (313). The National Health Act (2007) also institutionalized public participation in health governance, fostering community involvement in health planning and monitoring, which helped maintain public trust and engagement (314). These legal frameworks provided resilience against political and economic fluctuations by embedding the UCS within Thailand's legal and institutional structures.

New Zealand offers an interesting contrast. New Zealand's lack of a written constitution creates a unique legal environment in which health policy depends on evolving interpretations of legal precedents and foundational agreements, such as the Treaty of Waitangi. Divergent interpretations of this treaty have been the basis of contention and struggle for centuries and have contributed to the systemic marginalization of the Māori, reflecting the challenges of ensuring equity without explicit constitutional guarantees (see

Appendix 1). The lack of codified rights has hindered the integration of Māori perspectives and needs into health reforms, highlighting the importance of clear constitutional provisions in addressing historical injustices (160). The PHC Strategy was a policy instead of a law or constitutional provision, which subsequent governments could easily retrench. The Labor government enacted the *Pae Ora* Act (2022) to dismantle the reform and establish the Māori Health Authority (315), although the Act could not protect it from reversal in 2024 (see Chapter 4).

Constitutional provisions have significantly shaped the design of PHC reforms in Kenya and the DRC, yet both countries face challenges that limit their effectiveness. Kenya's 2010 Constitution and the DRC's 2006 Constitution introduced devolution of power to their regional governments. The 2010 Constitution also explicitly included the right to health for all Kenyans. Kenya's 47 counties and the DRC's 25 provinces were tasked with managing health policies and resources, theoretically allowing for more context-specific and responsive reforms to address local needs – forming the basis of the PCNs and the Provincial Health Reforms, respectively. However, uneven resource allocation, weak governance structures, and overlapping mandates have undermined the reforms, leading to inefficiencies and exacerbating disparities between counties.

Constitutional provisions are critical in shaping the power dynamics of governments and interest groups, directly influencing the adoption and implementation of health reforms. By defining the scope of state authority and the role of stakeholders, these legal frameworks can either expand veto points by empowering certain actors to create environments conducive to reform, as illustrated in Thailand and Uruguay (discussed above) (53,316), or reduce veto points and consolidate powers, as in Kazakhstan, Egypt, and Tunisia.

Kazakhstan limited veto powers through its constitutional amendments and, hence, had minimal opposition to its PHC reform. The 1995 Constitution and subsequent amendments, particularly in 2007 and 2011, entrenched the dominance of the ruling elite by limiting political pluralism and reducing

opposition influence (317,318). These changes concentrated power within the executive and reduced potential veto points to the PHC reform. However, the 2017 amendments introduced elements of decentralization, enhancing the role of local akimats in policy implementation (318). This shift gave akimats greater authority in governance (see Section 2.4), but the overarching centralized control by the executive ensured that local actions remained aligned with the regime's strategic priorities (319).

Egypt and Tunisia had similar experiences of consolidation of power through constitutional amendments but with slightly different outcomes. In Egypt, the 1971 Constitution established a centralized presidential system, granting the president sweeping executive powers, including control over the military, judiciary, and appointment of the prime minister (320). Amendments in 1980 further strengthened the presidency while limiting the influence of the legislature and judiciary, effectively reducing veto powers across other institutions (320). Despite provisions for a multi-party system, the opposition was heavily regulated, and the ruling National Democratic Party dominated political life. Under President Hosni Mubarak, emergency laws and restrictive regulations curtailed civil liberties, consolidating executive authority (see Appendix 1). This concentration of power streamlined decision-making, allowing the government to implement health reforms with minimal opposition but often at the expense of inclusivity and accountability.

The consequences of similar consolidation of power through constitutional amendments had the opposite effect on Tunisia's Family Practice Model. Tunisia's 2021 constitutional amendments marked a significant consolidation of power under President Kais Saied, reducing veto points and undermining the pluralistic governance established by the 2014 Constitution (321) (see Appendix 1). The amendments centralized authority in the presidency, bypassing parliamentary and judicial checks that were integral to Tunisia's post-2011 democratic transition. This shift weakened the role of opposition parties and civil society in policymaking, curtailing their ability to influence or challenge decisions and effectively dismantling the power-sharing framework that had previously fostered political stability. This shift, combined with

political instability and diminished stakeholder participation, led to the stagnation and eventual failure of the Family Practice Model.

The broad and important role of constitutional rights and legislation as institutions is well established (39,47,316). Research analyzing data from 144 countries (1970–2010) highlights that a constitutional right to health significantly enhances well-being by fostering institutional environments that improve health service delivery and contribute to better health outcomes (322). These rights empower diverse actors, including courts, legal systems, and civil society, enabling marginalized communities to advocate for equitable health policies (323–325). Across the sample countries, constitutional guarantees have provided a crucial foundation for PHC reforms, but their effectiveness often hinges on broader political and governance contexts. For example, in Uruguay and Thailand, a series of laws and legislation further strengthened the reforms, while strong opposition from interest groups, inconsistent implementation, and resource disparities hindered the full realization of these rights in Kenya and Tunisia.

An important gap in the literature is its narrow focus on constitutional provisions in democracies, emphasizing rights as the basis for participation and entitlements that lead to better health policies (322). However, my findings suggest that constitutions play a critical role across all regime types and political systems. Drawing from historical institutionalism (see Chapter 2), constitutions and legislation function as "institutions" shaped by political bargains. These institutions establish norms, create winners and losers, and become entrenched over time, offering increasing returns to those who comply while inspiring strong defense from beneficiaries (326). Constitutions go beyond political rhetoric, exerting structural influence by constraining some actors, empowering others, and privileging specific policy directions (Burgess, 1993; Smith, 1988). This is evident in authoritarian contexts like Kazakhstan, Egypt, and Tunisia, where constitutional amendments consolidated power in the executive, eliminating veto points that could oppose policy decisions. Conversely, constitutional changes in Kenya and the DRC enabled decentralization, forming the foundation for reform design. Evidence also highlights that even in democratic contexts, constitutions and legislation influence health reforms post hoc, with stakeholders using them to uphold or

challenge reforms based on their alignment with foundational political principles (327). These dynamics are explored further in the discussion on the politics of ideas later in this chapter.

2.4. Devolution and bureaucracies

The design and functioning of bureaucracies significantly influence PHC reforms. The degree of power delegated to decentralized levels and the agency of street-level and high-level bureaucrats shape the pace, implementation, and sustainability of reforms. The findings also highlight the importance of bureaucratic technical capacity, whether bureaucracies are professionalized or politically appointed, and how both formal and informal veto powers shape bureaucratic influence at decentralized levels. I illustrate these with the cases of Thailand and New Zealand's professional technocrats, Kazakhstan's mid-level akims, and Kenya and the DRC's politically appointed but theoretically autonomous bureaucrats.

Thailand exemplifies the influential role of bureaucracy in designing and sustaining reform, exemplifying what Harris termed "developmental capture" – a takeover of state agencies by networks of reformist bureaucrats who seek to promote inclusive policies of benefit to the broader populace (120). Thailand's bureaucratic dominance is rooted in its pre-democratization era, where bureaucrats wielded significant policymaking power, particularly in technical domains such as health, education, and finance. This influence persisted even after the country's democratic transition in 1997 (328,329). Thailand's professionalized bureaucracy, comprised of career civil servants who rose through the ranks based on seniority and performance, is less susceptible to political appointments than other systems. The Ministry of Public Health is especially technocratic among government institutions, shaped by professional bodies such as the Medical Council and advocacy groups such as the Rural Doctors Movement, which has been an influential force since the 1960s (265). These bureaucrats utilized their strategic positions within the state to institutionalize the UCS reform. They set the agenda and mobilized resources from political, civil, and international actors to push the policy forward, strategically navigating resistance from the medical profession through personal and professional networks. The data shows that figures such as Dr. Sanguan

Nittayaramphong, a career bureaucrat and former president of the Rural Doctors Movement, had championed the idea of UHC for years and were instrumental in designing key aspects of the UCS, directly advised Prime Minister Shinawatra, and built coalitions with civil society to ensure the scheme's adoption. The bureaucrats also leveraged relationships with international organizations to secure technical and ideological support. The high level of technical competence of Thailand's bureaucracy and its historical autonomy emerge as critical factors that sustained the UCS reform despite the country's multiple political upheavals (see Section 1 for a related discussion).

New Zealand's bureaucracy is professionalized and governed by principles of political neutrality. Senior bureaucrats, including chief executives of ministries, are appointed through a merit-based process overseen by the State Services Commission (330). These characteristics might explain how the PHC Strategy continued for over two decades, even with frequent changes in political coalitions during this time and several attempts to scale it back. However, the country's unitary government centralizes policymaking and funding, with local governments and district-level bureaucrats exercising only limited powers. Historically limited local authority may explain why decentralized bureaucrats did not mount stronger resistance to the dissolution of the DHBs and their eventual loss of employment in many cases.

Kenya's 2010 devolution significantly empowered local bureaucrats who gained substantial control over health planning and implementation. Kenya's bureaucracy features professionalized mid-level civil servants, while senior appointments are largely political (331). County-level bureaucrats, introduced after the 2010 Constitution, are more likely to be appointed by governors, making them vulnerable to local political dynamics and high turnover with the frequent changes in political leadership and coalitions. In counties with strong technical and financial capacity, bureaucrats advanced reforms effectively, while weaker counties struggled, exacerbating inequities in health care delivery. The devolution of power also led to persistent tensions between national and county governments over resource distribution and governance roles. National-level bureaucrats often resisted fully relinquishing authority, while county bureaucrats leveraged their new powers to assert influence over local health priorities. These tensions,

compounded by fiscal disputes between governors and the central government, underscored the growing importance of bureaucrats in navigating the decentralized governance structure. By controlling the allocation and utilization of resources, county bureaucrats played a decisive role in determining the pace and focus of health reforms (268,332).

The DRC's experience was similar. Its 2016 devolution reform was designed to empower provinces to address regional health needs effectively. However, the reality was far from the vision. The DRC's bureaucracy is highly politicized, with senior appointments often based on patronage rather than merit. Regional and local bureaucratic posts were frequently awarded to individuals aligned with political elites or factions. Decentralization reforms exacerbated the problem, as provincial governors and administrators were often political appointees loyal to the central government (187,272). This reduced bureaucratic veto power, increased corruption, and weakened state capacity. Provincial governments were burdened with managing health zones and coordinating facilities but lacked the necessary financial resources and administrative capacity. The central government's reluctance to fully relinquish control further hampered progress. Provincial funds were frequently delayed or only partially disbursed, leaving many health zones unable to implement even basic interventions. This led to an uneven rollout of the PHC reforms: wealthier provinces such as Kinshasa and Haut-Katanga made progress in recruiting workers, refurbishing facilities, and launching outreach programs, while conflict-affected and remote areas such as North Kivu and Kasai struggled to provide basic care. The lack of meaningful devolution and continued centralization under President Joseph Kabila undermined provincial autonomy (see Appendix 1), perpetuating regional inequalities and leaving many provinces ill-equipped to meet health care needs. At the same time, widespread corruption made the decentralized levels in the DRC more empowered to extract from their local constituencies (187,272,273). Ultimately, the decentralized framework envisioned to empower local governance became a significant obstacle to the success of health reforms, with weak capacity, inequities, and fragmentation, leaving most ambitions unrealized.

Despite a centralized authoritarian system, Kazakhstan presents an intriguing case of how decentralized governance structures and bureaucrats can influence health reform implementation. Kazakhstan has a centralized bureaucracy where senior officials, including akims (regional governors) and heads of government agencies, are directly appointed by the president. While some middle-tier positions are career-based, political loyalty to the regime is a key factor for advancement. Akims lack formal veto powers or a long-standing institutional role in governance. However, they wielded significant informal veto powers in implementing the PHC reform. Administrators with backgrounds in family medicine, who aligned professionally with the reform's goals, played a pivotal role in advancing the multidisciplinary teams. In contrast, administrators trained in specialist medicine often resisted the reform, favoring traditional hospital-centric models. Additionally, the autonomy of akims in resource allocation and local governance allowed them to influence the prioritization and pace of reform implementation. Regions with proactive akims and supportive hospital administrators saw more effective adoption of multidisciplinary teams, while those with less engagement or resistance experienced slower progress (158).

These findings underscore the influence of informal networks, personal interests, and internal power dynamics within bureaucracies in both designing and implementing reforms, even in authoritarian and centralized states. The power within bureaucracies often stems not from formal hierarchies but from access to critical knowledge, connections, and the ability to navigate ambiguity (333,334). Bureaucrats often use these informal networks to form alliances, negotiate resource allocations, and influence decision-making, shaping reform outcomes in ways that may lead to positive or negative consequences and often deviations from original reform intentions. In Thailand, bureaucrats played a more technocratic role, leveraging expertise to design and advocate for reforms. In contrast, in Kazakhstan, mid-level bureaucrats held significant discretion during implementation, often acting as veto points, even without formal veto powers, akin to Lipsky’s observations about street-level bureaucrats (48). The degree of bureaucratic influence also depends on whether systems are professionalized or politically appointed. In politically appointed bureaucracies like in Kenya and the DRC, turnover linked to political changes often

destabilizes policies, leading to losses of institutional knowledge and discontinuity in service delivery, as discussed by other scholars (335–337). In contrast, professionalized bureaucracies like those in Thailand and New Zealand act as stronger veto points, ensuring reform continuity and resilience to political oscillations. These dynamics highlight the dual nature of bureaucracies: while discretion and informal authority can foster innovation, they also open space for politicization and fragmented implementation.

3. Interest groups

Four primary interest groups—physicians, civil society organizations, donors and international agencies, and citizens—significantly influenced the design, adoption, implementation, acceptance, and sustainability (or reversal) of PHC reforms. Figure 4 presents the main themes and sub-themes related to how key interest groups have influenced PHC reforms across different countries.

THEMES AND SUB-THEMES	COUNTRY EXAMPLES
3 INTEREST GROUPS	
PHYSICIANS	
Strong opposition to reforms	New Zealand, Tunisia
Less/partial opposition to reforms	Egypt, Kenya, Uruguay
Support to reforms	Kazakhstan, Thailand
CIVIL SOCIETY GROUPS	
Advocacy for reforms	New Zealand, Thailand, Uruguay
Agenda setting, reform design, technical support	Thailand, Kazakhstan, Tunisia
Implementation support to reforms	DRC, Kenya
DONORS AND INTERNATIONAL AGENCIES	
Significant roles in reform design, funding, implementation	DRC, Dominica, Egypt, Kenya, Tunisia
Limited influence	Kazakhstan, New Zealand, Thailand, Uruguay
CITIZENS	
High and continued public support to reforms	Thailand, Uruguay
Changing public support towards reforms	Kazakhstan, New Zealand
Low acceptance of reforms	Egypt, Kenya, Tunisia

Figure 4: Key themes and sub-themes related to interest groups

Source: Author

3.1. Physicians

Physicians emerged as a highly influential interest group in PHC reforms, wielding considerable power through professional associations, political connections, and collective action capacity. Their relative influence in shaping or opposing reforms depends on the political system, veto points, and alignment of reforms with their professional interests. Physician opposition varied by country. There was strong opposition in New Zealand and Tunisia, which contributed to the failure of their reforms. Opposition was less in Kenya and Egypt, where the reforms had mixed results. In the countries with successful reforms, physicians played a supportive role (Thailand and Kazakhstan) or could not mount strong enough opposition (Uruguay). I examine why physicians had these varied stances and how they opposed and stymied reforms in some countries but not in others, using existing historical institutionalism and veto point theory (52).

In Tunisia and New Zealand, physicians acted as powerful veto players, leveraging their influence to resist reforms that potentially threaten their professional stature, autonomy, or financial interests.

In Tunisia, efforts to implement the Family Practice Model were derailed by the entrenched interests of physicians, particularly specialists and urban-based physicians. The reform, which aimed to restructure health care by shifting resources and focus from specialized, hospital-based care to community-oriented family medicine, threatened the financial and professional interests of many doctors. The capitation-based payment system, designed to reduce costs and incentivize preventive care, was perceived as a direct threat to their incomes. Specialists, accustomed to patients bypassing primary care for direct referrals, resisted reforms that threatened their patient flow and professional dominance. Professional associations, including the Tunisian Order of Physicians and the Tunisian General Union of Doctors, became vocal opponents, leveraging their political and social capital to obstruct the reform. They mobilized public opinion by framing the Family Practice Model as an untested policy that could worsen health care inequities, reduce quality, and violate patients' rights to specialized care—arguments that resonated with politicians seeking electoral support. Through strikes, protests, and lobbying, these associations pressured

the government to delay and eventually abandon the reform. The broader political economy of the country and the design of its institutions (see Sections 1 and 2) further hindered the reforms. Tunisia's fragmented political landscape, characterized by weak coalitions and competing priorities, left the government vulnerable to organized opposition. Physician associations exploited these divisions within the government and bureaucracy, sidelining reform advocates in the Ministry of Health. Successive governments failed to sustain political leadership or prioritize the reform amidst broader social and economic challenges. Post-revolution democratization created unprecedented space and platforms such as the Societal Dialog for Health, offering interest groups, including physicians, direct influence over policy. While reform-minded physicians and international agencies advocated for change, their numbers were too small to counter the entrenched resistance.

In New Zealand, physician responses to health reforms were mixed, with strong opposition from some quarters. While many physicians in public hospitals and community health settings supported decentralization and the DHBs and PHOs, others viewed the reforms as threats to their professional autonomy and financial stability. The data shows that key points of contention included multidisciplinary teams, task-shifting to non-physicians, and integrating traditional medicine by providers in Māori communities, all of which were seen as undermining physicians' professional monopoly. Additionally, the shift in private GP remuneration from fee-for-service to capitation and performance incentives was perceived as threatening physicians' income stability. The New Zealand Medical Association, at the time in the early 2000s, the largest professional body for physicians expressed cautious support for decentralization but raised concerns about bureaucratic inefficiencies, workforce overburdening – particularly in rural areas – and insufficient investment in workforce development. Interestingly, while the dissolution of the Māori Health Authority in 2024 attracted significant opposition from physicians, the reversal of the PHC Strategy and dissolution of DHBs in 2022-23 met little resistance and was even welcomed by many (338,339). This support stemmed from some key factors: guaranteed employment for public sector health providers under the new centralized system and widespread agreement that DHBs and

PHOs created inefficiencies and inequities. Importantly, this reform reversal was a positive development for private GPs, especially larger GP organizations, who could now get larger and more profitable contracts managed directly at the national level than when they had to compete for smaller contracts managed by PHOs and DHBs. New Zealand's political system, with its PR system (see Section 2.1), also empowered physician and GP associations, allowing them direct and indirect access to policymakers through regular parliamentary briefs, participating in consultations, and involvement in designing a new centralized Health New Zealand. Furthermore, New Zealand's private GP organizations, which operate as business entities with shared financial interests, are far more empowered and organized as interest groups, even more than physician associations. As predicted by collective action theory (57), these organizations were able to effectively influence policies that aligned with their interests. Additionally, although strong in the initial stages of the reform, GP opposition faded as the overall budgets and universal government financing of GP visits increased their patient base and, therefore, incomes. Tacit opposition from GPs re-emerged during the austerity measures prioritizing efficiency and budget cuts following the 2008 economic crisis.

Physicians in Kenya and Egypt supported some aspects of the PHC reforms while opposing others, contributing to their mixed results (Table 3). The two countries' broader political economy also influenced physicians' stances and power.

Kenya's PCN reform elicited mixed responses from physicians. Physicians in underserved rural areas welcomed the emphasis on equitable resource allocation, improved infrastructure, and stronger PCNs. They saw the PCN model as a means to address challenges such as staff shortages, inadequate equipment, and poor patient outcomes, offering hope for professional growth and better working conditions. However, Significant resistance emerged from specialists and hospital-based physicians, who were concerned that the PCN reform would further strain resources in already overstretched secondary and tertiary facilities. Urban-based physicians, particularly in private health care, worried that focusing on public-sector primary care would reduce demand for private services. Additionally, the reform's emphasis

on task-shifting and team-based care, which expanded roles for clinical officers and nurses, was perceived by some physicians as a threat to their professional autonomy and care quality. The country's broader political system influenced the veto power of physician associations. The 2010 Constitution allowed medical workers to unionize and led to the formation of the Kenya Medical Practitioners, Pharmacists, and Dentists Union (KMPDU). The KMPDU's had long advocated for improved working conditions, hiring more doctors, and increasing salaries. A 2017 agreement between the government and KMPDU addressed these demands but remained largely unfulfilled, creating mistrust. Many union members viewed the PCN reform as a departure from this agreement, intensifying their dissatisfaction. As the reform progressed, the KMPDU became a vocal critic of its implementation, citing insufficient transparency, lack of engagement with frontline providers, and inadequate investment in the health workforce. The union organized strikes and protests, highlighting these systemic issues (340,341).

In Egypt, physicians, especially the Egyptian Medical Syndicate (EMS) – the nationwide physician association – supported the Family Health Model in principle, especially its focus on improving maternal health, strengthening referral systems, and introducing emergency obstetric care in health facilities. However, resistance largely stemmed from concerns over threats to their professional autonomy and income, particularly in the context of their private practice and widespread dual practice. Established in 1920, the EMS historically functioned as both regulator of medical standards and advocate for physician interests. Under Nasser's post-revolution socialist regime (see Appendix 1), the EMS was brought under state control, aligning its leadership with government priorities. This subordination persisted during the Mubarak era, with the EMS playing a more technical role (342). However, during this period, the Structural Adjustment Programs increased privatization and growing dual practice among physicians. Tensions started arising when the government tried to restrict dual practice in an attempt to strengthen the public sector facilities. The 2011 Arab Spring revolution marked a turning point, empowering the EMS to adopt a more oppositional stance, organizing strikes and demanding better wages and working conditions. However, this empowerment also enabled the EMS to block reforms perceived as threatening its

members' interests. While framed as resistance to the neoliberal and donor origins of the reform (342), their opposition was rooted in concerns over tighter oversight of dual practices, which had been a significant income source. Physicians opposed the aspects of the reform that sought to regulate private practice, fearing reduced incomes under the proposed capitation-based payment systems and standardized fees. This was one of the key reasons why the Family Health Fund and the Universal Health Insurance law failed to be adopted for almost two decades, and was finally adopted in 2018 after the consolidation of political powers under el-Sisi and elimination of veto points (292) (see Appendix 1 and Section 2).

In Uruguay, physicians' opposition, for the most part, was ineffective due to broader political and institutional dynamics, and the reform was successfully adopted and sustained, although there are aspects that have still faced challenges. The three major Uruguayan physician associations, the Uruguayan Medical Union, the Interior Medical Federation, and Plenario, supported the reform's foundational principles, particularly during the 8th National Medical Convention 2004 (263). Physicians welcomed the goals of an integrated health system, a purchaser-provider split, and a focus on primary care, especially as the economic crisis had left many facing job insecurity, low pay, and poor working conditions (249,263). This support from the physician associations significantly helped the adoption of the reform in its early years.

However, as the reforms progressed, opposition emerged around specific aspects. In the early stages, the Plenario—along with associations representing private insurers, pharmaceutical companies, and medical device and diagnostics firms—opposed the standardized benefits package across providers and insurance plans, changes to provider payment rates, and the shift from fee-for-service to capitation and performance-based payments. Meanwhile, the Uruguayan Medical Union launched a series of strikes in 2007, demanding a significant increase in physician salaries (263). Meanwhile, the Uruguayan Medical Union went on a series of strikes in 2007, demanding a significant increase in physician salaries (263). In the later stages, the redefining of scopes of practice and the manifold increase in family doctors and nurses to deliver primary care services at health clinics and polyclinics faced severe opposition. However,

opposition from physician associations was insufficiently cohesive and organized to effectively derail the reforms. Several factors contributed to this. First, the different physician associations had varied interests and were also politically fragmented; several of their leaders were aligned with opposition parties, such as Colorado and Nacional. This weakened their cohesion. Further, given its leftist ideology, the ties between the Frenté Amplio party and the physician associations are much weaker than those with other interest groups, like labor unions (263) (see Section 2). The absence of institutionalized ties between the ruling party and the physician associations granted the political leadership significant freedom in drawing up health reform plans that went against their interests, as it was not dependent on them to mobilize political support (263). In fact, the government held firm during the physician strikes of 2007, used emergency powers to keep health facilities staffed, and eventually undermined the efforts of the Uruguayan Medical Union (263). The private for-profit insurance market was in its nascent stages in Uruguay during the early 2000s, and with the historical precedence of social health insurance in the country (see Section 1), they could not form a powerful opposition. However, the not-for-profit mutualistas were sufficiently powerful to continue to resist certain additions to the reform (as of 2024) – particularly assigning providers by geographical catchments. Even though the ASSE and RAPs have significantly expanded their capacities with the reform, the private sector remains a key provider (162).

In Thailand and Kazakhstan, physicians supported the reforms, even leading the advocacy, design, and implementation. Thailand's UCS benefitted from substantial physician support, particularly from public sector physicians who saw improvements in working conditions and funding under the reform. The Rural Doctors Movement, led by public health-oriented professionals, played a constructive role. The Movement had long championed equitable access to health care and supported the reforms' focus on strengthening primary care and redistributing resources to rural areas. The society collaborated with reformers within the Ministry of Public Health, including key figures like Dr. Nittayaramphong, a physician and public health leader (see Section 2.4), who mobilized support within the physician community by framing UCS as a step toward equity and efficiency. Subsequent generations of physicians

associated with the Rural Doctors Movement have been in key technocratic and advisory positions, ensuring the continuity of the UCS reform. Physician associations deeply tied to the public sector were actively engaged in consultative processes to address reimbursement rates and clinical autonomy concerns. The UCS's limited impact on private-sector profits and its alignment with public-sector interests minimized opposition.

In Kazakhstan, physician associations played a key role in advancing PHC reforms, including integrating multidisciplinary teams and expanding family medicine. Initiatives such as *Salamatty Kazakhstan* increased public health budgets and physician salaries, strengthening public sector capacity, where most Kazakh physicians worked, minimizing resistance. Dual practice policies, allowing physicians to work in both public and private sectors, further mitigated opposition. There was some opposition from physicians and specialists against transitioning from the traditional physician- and hospital-centered model of care, primarily based on concerns about the dilution of their roles and the challenges of coordinating care among diverse team members. These concerns were tied to the low prestige of family medicine in Semashko-style health systems and skepticism about the effectiveness of non-physician personnel. Some specialist physicians in managerial roles collaborated with akims and regional health departments to resist reallocating resources toward multidisciplinary teams. This alignment of interests – favoring hospital investments, advanced technologies, and specialist care – frequently slowed reform implementation (see Section 2.4) (158). However, physician resistance remained largely passive and ineffective for two reasons. First, a strong high-level political commitment to reforms and Kazakhstan's historical association with PHC was cemented by the Alma-Ata (1978) and Astana (2018) conferences. Upholding Kazakhstan's position as a PHC leader discouraged active opposition from the physician community. Second, the country's authoritarian regime limits the space and power of physicians to display overt confrontations with the government. Physicians are consulted for the design of reforms but in platforms facilitated and led by the government to ensure alignment with state goals (see Section 2.1).

The above findings underscore how physicians' influence interacts with political and institutional structures, shaping the trajectory of health reforms in complex and varied ways. This supports a large body of evidence on how physicians' entrenched interests can obstruct reforms that require significant changes to payment mechanisms, care organization, and the roles of non-physician health workers – similar to findings from other countries (245,343–346). The findings also relate to Immergut's work on how the influence of physicians in health reforms is significantly shaped by the political systems they operate within, particularly the number and nature of veto points (52,59). In systems with multiple veto points, such as fragmented legislatures (e.g., Tunisia and New Zealand), physicians often leverage these points to block reforms that threaten their autonomy or financial interests. Conversely, in systems with fewer veto opportunities (e.g., Thailand and Kazakhstan), reforms are more likely to succeed, as decision-making is consolidated within the executive or a stable majority (52,59). These resonate with the variation in physician responses to PHC reforms across countries in this study, where political structures either amplified or contained their influence. The findings also indicate that physician opposition was mediated by how they gained power and how cohesive they were, linking to theories of historical institutionalism (33) and collective action (57).

3.2. Civil society groups

Civil society groups, including labor unions, advocacy organizations, and health sector experts, have played crucial roles in advancing PHC reforms across diverse political and social contexts. Their influence is particularly evident in agenda-setting, policy design, and advocacy. These groups have played key advocacy roles in New Zealand and Uruguay; policy design, evidence generation, and technical support roles in Thailand, Kazakhstan, and Tunisia; and implementation roles in Kenya and DRC. Their roles, scope, and successful participation have varied depending on the broader institutional context (see Section 2) and the nature of their engagement with citizens, governments, and international donors.

Civil society organizations (CSOs) played an advocacy and activism role in the fight for health equity and rights in New Zealand and Uruguay.

In New Zealand's health reforms, Māori-led organizations, including the Māori Women's Welfare League and Whānau Ora collectives, as well as CSOs such as the Public Health Association of New Zealand framed health care provision as a legal obligation under the Treaty of Waitangi (257). These groups actively participated in consultations, submitted policy briefs, and mobilized public support to shape the reforms and prevent their retrenchment during the pushback in 2008-2017 (see Section 1). This advocacy ensured that Māori health equity remained central to the PHC reform agenda, centering it in PHOs and DHBs and ultimately leading to the creation of the Māori Health Authority, a milestone for Māori self-determination in health care governance. The broader institutional context (see Sections 1 and 2) significantly influenced the civic space for CSOs to operate. New Zealand's democratic system, emphasizing inclusivity and representation, provided an enabling environment for civil society to advocate effectively for equity-focused reforms.

In Uruguay, labor unions emerged as one of the most powerful civil society forces, significantly shaping the trajectory of health reforms. Their strength and influence stemmed from the country's historical legacy of organized labor and social welfare, dating back to early 20th-century reforms under President José Batlle y Ordóñez (259,260) (see Section 1 and Appendix 1). Labor unions gained further prominence during the mid-20th century as key advocates for workers' rights and equity-focused policies. This historical foundation positioned unions as central players in the political economy of reform, particularly under the leftist Frenté Amplio party. The institutional ties between labor unions and the Frenté Amplio were forged during the party's years in opposition when mass mobilization against authoritarian regimes solidified unions as vital political allies (259). These ties became a cornerstone of the Frenté Amplio's governance strategy, with unions forming its primary electoral base (162). Unified in their stance and with strong organizational capacity, unions provided unwavering support for universal health insurance and equity-driven reforms, ensuring alignment with the working population's needs. Their ability to mobilize

public support and negotiate with other stakeholders was instrumental in overcoming resistance from private-sector actors and physician associations (162,263). The Frenté Amplio also leveraged its strong relationships with labor unions to facilitate inclusive stakeholder engagement. Drawing on their experience with mass mobilization, the party created formal platforms, coalitions, and councils that included diverse and often opposing stakeholders. These forums fostered dialog, resolved conflicts, and instilled a sense of inclusion and transparency in the reform process (162). This cohesive and participatory approach, enabled by the unions' broad civic and political influence, legitimized the reforms and ensured their durability by embedding them within Uruguay's long-standing commitment to equity and social justice.

In Thailand, Kazakhstan, and Tunisia, CSOs' roles in agenda-setting, policy design, and coalition building emerged from their technical capabilities and close collaborations with government agencies, ministries of health, and physician associations.

Thailand has a vibrant civil society, but groups focused on defending human rights and freedom of expression and promoting democracy face restrictions, surveillance, criminalization, and prosecution, especially during military rule (173). During democratic periods, such as in 2001, when the UCS was adopted, CSOs have greater freedom to advocate, organize, and influence policymaking. Under military-backed governments, the space for civil society narrowed, with increased restrictions on activism and funding. Despite this, health-focused CSOs often navigated these constraints by framing their work as apolitical and emphasizing service delivery and research over advocacy. Organizations such as the Health Systems Research Institute, the International Health Policy Program, and networks of reform-minded bureaucrats, academics, and activists worked over decades to shape the policy environment (161,347). These groups were instrumental in designing, continuously evaluating, and strengthening the UCS. Their strategic connections with the Ministry of Public Health and the Rural Doctors Movement allowed them to integrate reform ideas into the political agenda. Civil society's ability to frame UCS as a solution to

inequality ensured its adoption and resilience, even amid Thailand's politically turbulent landscape (161,347).

Kazakhstan experienced a similar technical role of professional associations. The PHC reforms were championed by the National Association for Primary Health Care, established in 2018 as a platform for policy actors and domestic and international experts. Mandated by the Ministry of Health and working closely with the Kazakhstan Association of Family Physicians, the Association supported the development of best practices for implementing multidisciplinary teams and training health care professionals in family medicine, aligning with the government's broader goals under the *Salamatty Kazakhstan* program and subsequent reforms. It identified stakeholders at both meso- and micro-levels, assessed their roles in supporting or resisting change and designed initiatives to build their understanding and support for the reforms (158).

Tunisia's experience is similar. CSOs and health-focused associations played a pivotal role in advocating for the Family Practice Model during the post-revolution decade of 2011–2021. The political changes following the 2011 revolution ushered in unprecedented freedoms for CSOs, enabling them to become active agents in the health sector. The Societal Dialog for Health provided an unprecedented platform for civil society participation in health policy, reflecting post-revolutionary commitments to transparency and inclusivity. More than 50 health-focused CSOs formed an alliance to support the public health system, emphasizing its role in upholding the right to health enshrined in Tunisia's 2014 Constitution. These organizations engaged in lobbying efforts with parliamentarians and progressive parties such as Nidaa Tounes, advocating for increased government funding for PHC and positioning the Family Practice Model as a cornerstone of Tunisia's PHC strategy. However, Tunisia's democratic backsliding and President Kais Saied's consolidation of power in 2021 have severely restricted civic space (see Appendix 1 and Sections 1 and 2). CSOs now face increasing restrictions, including public vilification and threats to their funding. In February 2022, Saied accused CSOs of serving foreign interests and proposed banning foreign funding under the pretext of safeguarding national sovereignty (348). These developments have created an

environment of uncertainty and fear, leading to self-censorship and reduced advocacy activities (349,350). The shrinking civic space has undermined the collaborative relationship that once existed between CSOs and state institutions, a key factor in advancing health sector reforms. The potential for legal constraints and diminished international donor support has further strained their operations, complicating efforts to promote equitable health initiatives.

In the DRC, there is little evidence of local CSOs playing a significant role in PHC debates, and although Kenya has a strong local research community, international NGOs, supported by foreign donors (see Section 3.3) have played a crucial role in designing the reforms, providing technical support, and in many cases, directly implementing them. In Kenya, international NGOs like Amref and Pathfinder International, funded primarily by foreign donors, significantly influenced advocacy efforts and policy development supporting PCN reforms. They have participated in reviewing and validating Kenya's Primary Health Care Act (2023), which provides a legal framework for strengthening primary care services, and partnered with county governments to ensure the effective implementation of PCNs, tailoring interventions to meet local needs and improve health outcomes. Other international NGOs such as PATH, Management Sciences Health, the Joint Learning Network, and Results for Development have worked with the MOH to evaluate and document PCN implementation strategies, ensuring alignment with local needs and sustainable practices, as well as creating learning communities. In the DRC, international NGOs directly provide essential health services at provincial health facilities.

The above findings highlight that the role of CSOs in health reforms is deeply shaped by the broader political economy and institutional contexts in which they operate. In contexts such as Uruguay and New Zealand, robust democratic systems and historical legacies of civic engagement provided an enabling environment for CSOs to effectively advocate for equity-focused health reforms, at times taking confrontational positions against the government. In semi-authoritarian settings such as Thailand, Kazakhstan, and Tunisia, CSOs played more technical roles, helping the government’s efforts to design, improve, or implement their reforms. In Kenya and the DRC, limited local CSO involvement contrasts

with the prominent role of international NGOs, whose donor-backed initiatives often fill gaps in state and institutional capacity, frequently designing and implementing reforms. These roles also raise the important question of whose interests CSOs represent across the countries. While in robust democracies, they seem to center citizens' interests, in semi-authoritarian states, they appear to be aiding the government in achieving better health outcomes. In highly donor-driven contexts, such organizations seem to be propagating donor interests, often raising concerns that they reduce reliance on government services and, in turn, lower demand for government provision, undermine political engagement, and erode state legitimacy (351–353).

3.3. Donors and international agencies

Donors and international agencies significantly shaped PHC reform trajectories, particularly in countries heavily reliant on external assistance. Their roles vary based on each country's dependence on development aid, historical contexts, and political landscapes. In Kenya, the DRC, Dominica, Egypt, and, to a large extent, Tunisia, donors and development partners played a significant role in the funding and the implementation of the reforms. Their roles were negligible in Uruguay, Kazakhstan, Thailand and New Zealand.

The strong role of donors and international agencies was evident in Kenya and the DRC in shaping health reforms due to the countries' heavy reliance on external funding (see Appendix 1). In Kenya, donors and international agencies have been instrumental in bringing PHC to the national agenda in various ways. As evident from Section 3.2, most NGOs involved in the PCN reforms have been international organizations with funding from foreign donors. For example, UNICEF's pilot project in Kisumu County, which predated Kenya's national PCN policy, was a prototype for the government's Big 4 Agenda (159). The insights gained from this project informed the Garissa County pilot initiated by the government in 2020, laying the foundation for the eventual national rollout of the PCN plan (159). Donors like the Gates Foundation, USAID, and The World Bank have supported documentation and dissemination of the PCN.

In the DRC, foreign aid has undoubtedly contributed to rebuilding the country and addressing urgent humanitarian needs, but it has also produced several unintended negative consequences, notably weakening the development of robust democratic institutions, as the limited democratic reforms implemented have been driven more by donor-linked pressure than by widespread domestic support (271,354). Furthermore, the lack of an effective government has led some donors to take on state-like roles by directly delivering essential services. This approach has inadvertently diverted resources from critical state functions, as donor-funded projects often offer salaries far exceeding those available in the public sector (271). The principles of aid effectiveness have proven challenging in the DRC due to the low state capacity and legitimacy of the government. This situation creates the risk of a self-perpetuating cycle: the lack of a functioning state leads to development projects that, while addressing immediate needs, can further impede the development of effective governance (271,355). This reliance has often resulted in fragmented and donor-driven programs, with a focus on vertical disease-specific interventions rather than comprehensive PHC strategies.

Similarly, the Family Health Model was introduced in Egypt as part of the Health Sector Reform Program with substantial support from international donors, including the USAID, the World Bank, and the European Commission. These donors provided financial assistance, technical expertise, and policy guidance to facilitate the implementation of the Family Health Model. Additionally, the WHO has provided technical assistance and policy guidance to strengthen PHC through the family-practice-based models in the Eastern Mediterranean Region, including Egypt and Tunisia. The reforms have faced criticisms and overt opposition from local stakeholders, including the media, health professionals, and political parties, for being donor-driven.

In Dominica, the PAHO, the World Bank, and the Caribbean Development Bank provided critical funding and technical expertise to rebuild health infrastructure and integrate disaster preparedness into PHC systems. PAHO collaborated with the Ministry of Health to train community health workers and strengthen primary care services. The Chinese government funded the construction of the Dominica-

China Friendship Hospital to deliver secondary and tertiary care. This collaboration was emblematic of China's growing influence in the Caribbean and demonstrated its approach to health diplomacy. While the hospital brought much-needed resources and advanced technology to Dominica, some critics raised concerns about the sustainability of such projects and the potential for geopolitical motivations overshadowing local health priorities.

3.4. Citizens

Citizens are active participants rather than passive recipients in shaping health reforms through their perceptions, demands, and actions. Their responses determine the extent of political will and the degree of policy implementation. PHC reforms, in particular, often hinge on public acceptance as they attempt to reorient health systems toward equitable and accessible care. Yet, these reforms frequently confront historical trust deficits, cultural preferences for hospital-based care, and mismatches between policy objectives and public expectations.

The reforms in Uruguay and Thailand received broad public support. Uruguay's transition to universal social health insurance resonated strongly with citizens. By reducing OOPE and ensuring equitable access, the reform addressed public concerns about financial protection, especially after the financial crisis and recession. Framing health care as a right and emphasizing household economic security garnered widespread support, embedding the reforms within the social fabric. Similarly, in Thailand, the UCS gained enduring public support through its focus on affordability. The widely popular "30 Baht Scheme" (the popular name for the UCS reform) symbolized financial accessibility, directly appealing to citizens' immediate needs and reinforcing public trust in the system. The UCS's popularity has been a key factor in its resilience, even amidst political instability, demonstrating the power of clear and tangible benefits in securing citizen backing.

In New Zealand, public engagement with the PHC Strategy reform reflected a complex interplay of national values, public opinion, and shifting political priorities. Initially, the reforms resonated with

citizens by promising a more accessible and equitable health system, aligning with New Zealand's strong societal commitment to fairness and collective welfare. But public opinion wavered, especially with the changing ideologies of the political leadership. As implementation progressed, public dissatisfaction grew, fueled by perceptions of inefficiencies, regional inequities, and administrative complexity within the DHB framework. Citizens in underserved regions increasingly voiced frustration about disparities in service provision, while centralized PHO funding faced criticism for inadequately addressing localized needs. These sentiments, combined with changing political narratives, contributed to the eventual retrenchment of the PHC Strategy and the dissolution of DHBs in 2022.

Reforms in Kenya and Kazakhstan faced resistance from citizens, although with different outcomes. In Kenya, the introduction of PCNs encountered significant resistance due to citizens' longstanding mistrust in underfunded and understaffed primary health facilities. Historical neglect of these facilities left them ill-equipped and poorly perceived, making it difficult to convince citizens of the benefits of relying on primary care for their health needs. The health system's emphasis on curative, hospital-based care also reinforced cultural and systemic biases against preventative and holistic PHC approaches. Similar challenges emerged in Kazakhstan, where public attitudes favored specialist and hospital-based care. The transition to family medicine and multidisciplinary teams faced initial skepticism, as citizens accustomed to accessing specialists resisted the idea of primary care as a first point of contact. However, deliberate efforts to engage communities and demonstrate the accessibility and effectiveness of multidisciplinary teams began to shift perceptions. Direct experiences with improved care delivery gradually increased satisfaction and acceptance, underscoring the importance of community engagement in overcoming historical and cultural barriers.

In Egypt, citizens' responses to the Family Health Model have been mixed. Many citizens in underserved areas welcomed the promise of improved primary care and expanded services. However, public dissatisfaction emerged from inadequate implementation and insufficient health infrastructure, particularly

in rural and underserved regions. dissatisfaction arose due to poor implementation and lack of adequate infrastructure (see Section 5).

In Tunisia, following the 2011 revolution, citizens actively engaged in health reform discussions through platforms like the Societal Dialog for Health, marking a shift towards greater inclusivity and transparency (245,356). This large-scale consultation process between the government and its citizens on various health topics aimed at developing a National Health Policy 2030. The process provided new opportunities for citizens and civil society to engage in political decision-making, reflecting a commitment to transparency and inclusivity. However, challenges such as a weak culture of participation and a lack of formal engagement platforms persisted. The civic space for citizens' engagement has shrunk significantly after the democratic backsliding since 2021 (see Sections 1 and 2 and Appendix 1).

Citizens' responses to PHC reforms are dynamic, and shaped by historical, cultural, and socio-political contexts. Public trust, or the lack thereof, plays a critical role in shaping these responses. In contexts like Kenya and Egypt, trust deficits rooted in historical neglect or poor implementation have hindered reforms, while in countries like Uruguay and Thailand, reforms that provided clear financial benefits and addressed public priorities gained widespread acceptance. The politics of PHC reforms is deeply intertwined with the politics of public perception. Citizens' responses reveal that trust and tangible benefits are central to the success of reforms, but these alone are insufficient. Reforms must address systemic inequities, align with cultural norms, and adapt to local realities to achieve sustainable change. Moreover, citizen engagement or their support or opposition to reforms is not static—it is a dynamic process (as seen in New Zealand, Kazakhstan, Egypt, and Tunisia) shaped by the broader political economy and political ideologies.

4. Ideas behind the reform

Ideas critically shape PHC reforms by influencing how challenges are perceived, problems defined, and solutions formulated. Ideas function as framing mechanisms that bridge global norms with local contexts,

influencing the political and institutional frameworks within which reforms occur. The politics of ideas is central to understanding why specific health reforms emerge, endure, or fail. The success of PHC reforms often depends on the effective alignment of ideas with local political, social, and economic contexts. The nine countries analyzed here highlight how the politics of ideas—whether rooted in historical legacies, global health norms, donor influence, or local advocacy—have shaped the design, implementation, and sustainability of PHC reforms.

Countries such as New Zealand, Uruguay, and Thailand demonstrate how deeply embedded, locally-driven ideas facilitate lasting change. Kazakhstan highlights how domestically adapted global health norms can also foster sustainable reform, whereas Kenya and the DRC illustrate the fragility of externally imposed models. Meanwhile, Tunisia, Egypt, and Dominica illustrate the complex interplay between international norms and domestic political economies. Figure 5 summarizes the main themes and sub-themes related to the politics of ideas in PHC reforms across different countries.

THEMES AND SUB-THEMES	COUNTRY EXAMPLES
4 IDEAS BEHIND THE REFORM	
HISTORICALLY ROOTED, LOCALLY-DRIVEN IDEAS	
Shaped reform design	New Zealand, Thailand, Uruguay
Drove long-lasting reforms	Thailand, Uruguay
LOCAL ADOPTION OF GLOBAL IDEAS	
Shaped reform design and sustained change	Kazakhstan
EXTERNALLY-DRIVEN IDEAS	
Shaped reform design but variable interpretations and implementation	DRC, Kenya
INTERPLAY OF INTERNATIONAL IDEAS AND LOCAL POLITICAL ECONOMY	
Shaped reform design but significant changes over time	Dominica, Egypt, Tunisia

Figure 5: Key themes and sub-themes related to the politics of ideas

Source: Author

In New Zealand, the PHC Strategy and the subsequent establishment of the Māori Health Authority exemplify how deeply rooted ideas shaped by historical injustices and persistent advocacy can inform reform design. Drawing on the Treaty of Waitangi (1840)—which enshrined partnership, protection, and participation—Māori leaders emphasized systemic inequities and the necessity of culturally responsive health care. Over decades, Māori leaders and organizations emphasized self-determination and argued that systemic inequality could only be addressed through governance structures by and for Māori. Reports from the Waitangi Tribunal and advocacy from iwi leaders and Māori health providers underscored the failure of the existing health care system to fulfill Treaty obligations and emphasized health inequities, creating a normative framework that informed policy decisions (256,357,358). This aligns with Hall's concept of "policy paradigms," where deeply embedded ideas influence policy evolution (60).

In Uruguay, adopting social health insurance as the foundational reform was deeply tied to labor unions and long-held ideas of equity and social justice. By advocating for health care as a social right, labor unions established a policy paradigm emphasizing redistribution and universal access. The alignment of SHI with Uruguay's political culture ensured its sustainability and widespread acceptance, demonstrating how deeply ingrained societal values can sustain reform (75).

In Thailand, decades of advocacy by reform-minded bureaucrats, academics, and civil society groups built the foundation for the UCS. Framed as both a moral and economic imperative, the reform and the idea of UHC gained political momentum during the 2001 elections when the Thai Rak Thai Party incorporated it into its populist platform. The "30 Baht Scheme" (the popular name for the UCS reform), which promised affordable care, resonated with rural and low-income voters, linking the idea of UHC to equity and efficiency. The reform's endurance, even amid political turbulence, highlights the power of ideational alignment with public aspirations and institutional frameworks.

Kazakhstan's PHC reforms, rooted in the Alma-Ata Declaration (1978), illustrate the enduring influence of global ideas in domestic contexts. As the host of the declaration, Kazakhstan incorporated its principles into a broad understanding of PHC that included social determinants of health. Following independence,

Kazakhstan adopted these global PHC norms to symbolically and ideologically distance itself from the Soviet Union's hospital-centric model. By piloting reforms in "best practice sites" and integrating multidisciplinary teams, Kazakhstan aligned global principles with local needs, creating a more cohesive health system.

In Tunisia, the Family Practice Model reflected international priorities, such as those outlined by the WHO. Framed as a cost-efficient, preventive approach, the model aligned with Tunisia's fiscal constraints while addressing domestic health inequities. However, post-revolutionary political instability and competing priorities often overshadowed investments in the primary care infrastructure required for the model's success. The idea of the Family Practice Model was heavily influenced by the WHO's support for similar models in other countries of the Eastern Mediterranean Region. The Family Practice Model mirrors Egypt's earlier Family Health Model (1999), introduced during economic liberalization under President Mubarak. Influenced by global health institutions like the World Bank and USAID (see Section 3.1), the reform aimed to modernize health care by emphasizing efficiency and universal coverage. However, the reform's desynchronized rollout and lack of institutionalization within the local health system context led to an erosion of trust, leaving the model vulnerable to political opposition and several challenges in its implementation (see Section 5 for related discussion).

Kenya and the DRC emphasize how externally driven ideas have made foundational changes in the countries' constitutions (see Section 2.3), but the countries have grappled with adoption and implementation in practice. Reforms in the two countries emerged from the devolution reforms – an idea supported by The World Bank in several African nations. Devolution aimed to reduce regional disparities by decentralizing health governance to counties in Kenya and provinces in the DRC. While this was framed as a way to improve equity and efficiency, it often masked local political motivations, such as consolidating power or managing dissent. Limited sub-national capacity, coupled with fragmented funding mechanisms (often through donor funds) and weak fiscal capacity of the countries, left the reforms unevenly implemented, exacerbating disparities and stalling progress.

The analysis of PHC reforms across these nine countries highlights the profound role of ideas in structuring not just the design of health systems but their trajectories over time. Far from abstract, ideas represent contested terrains where historical legacies, political power, and global norms intersect, producing distinct reform trajectories. In contexts like Thailand and Uruguay, where ideas aligned with societal values and political movements, they became anchors for transformation, transcending shifts in leadership and political instability. Conversely, in cases like Kenya and the DRC, the dominance of externally driven ideas exposed the fragility of reforms when detached from local histories and socio-political dynamics. The politics of ideas reveals that reforms are not merely technical interventions but deeply embedded in the narratives societies tell about equity, justice, and the role of the state. The ability of an idea to endure, evolve, or collapse is contingent not just on its appeal but on the institutions and actors that champion or contest it. This underscores a critical point: Ideas are neither neutral nor inevitable; they constitute powerful instruments reflecting and reinforcing broader struggles over power, legitimacy, and social order in health systems.

5. The distinct political economy of PHC reforms

In this section, I present the findings motivated by research question 2: *What are the distinct political economy factors of PHC reforms, and how do these factors differ between types of reforms—those focusing on financing versus organization?*

To my knowledge, this study is the first attempt to systematically analyze this question, thereby contributing to theory building. I find that PHC reforms introduce specific changes to health systems, triggering distinct political economy dynamics. These dynamics arise from tensions among interest groups, institutional arrangements, and ideational factors triggered by health systems' reorientation toward PHC. My analysis shows that these dynamics emerge in six key domains: (1) public versus private sector; (2) hospital and specialists versus primary care, (3) physicians versus non-physicians; (4) centralized versus decentralized levels of administration; (5) expanding versus limiting citizens' choice; and (6)

selective versus comprehensive changes. Within each domain, the technical design and content of reforms, particularly their entry point (financing versus organization), influence which interest groups emerge, their power dynamics, and their stance towards supporting or resisting reforms. I discuss these in detail in the subsequent sections. Figure 6 shows a diagrammatic representation of these six domains.

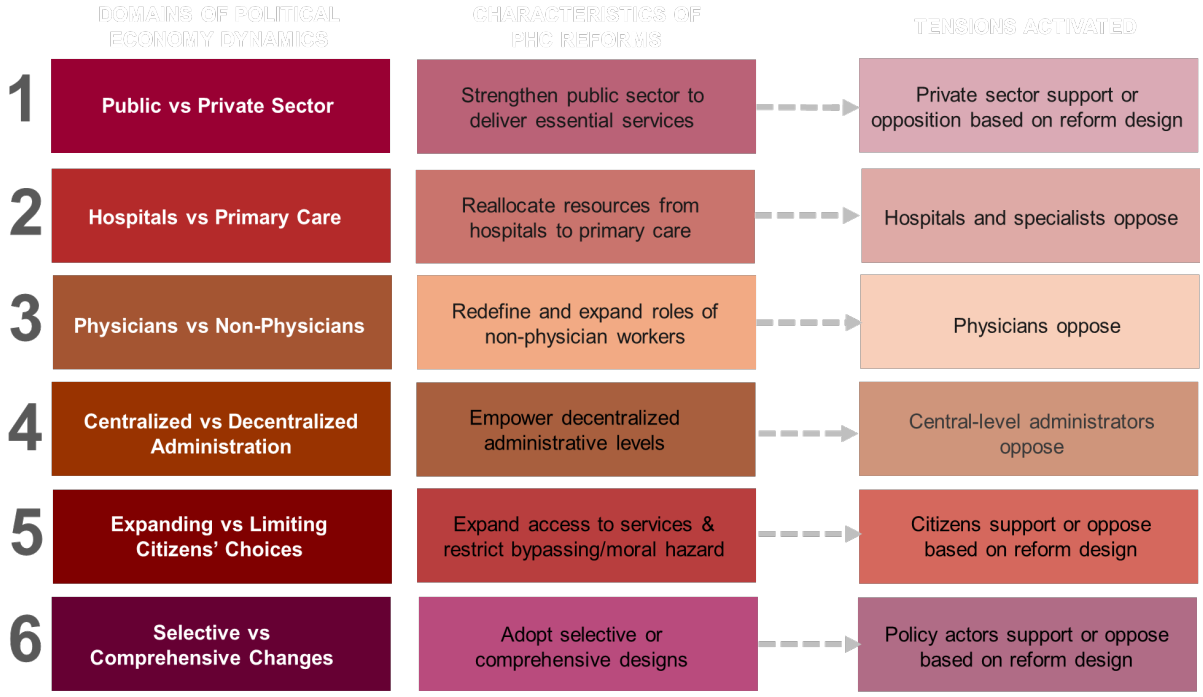

Figure 6: The distinct domains of political economy dynamics of PHC reforms

Source: Author

5.1. Public versus private sector

PHC inherently involves public goods and essential services that are traditionally considered the responsibility of the state towards its citizens. Unsurprisingly, across the nine countries studied, a significant focus of PHC reforms was on strengthening the public sector. This took various forms, including increased public financing for PHC services, expansion and improvement of service delivery in public facilities, and enhanced governance and regulation of the health system. However, prioritizing the public sector inevitably impacted political economy dynamics by influencing private sector interests,

generating resistance or support depending on how reforms affected their revenue, autonomy, or patient base.

In several countries, reforms aimed at increasing public financing and introducing insurance coverage. Increased public financing has generally been well-received—and often demanded—by both public and private sectors. However, the support of the private sector was particularly evident when a share of this increased financing was made available to them, i.e., when the private sector was empaneled by publicly financed reforms to provide care. Expanded financial protection through tax financing or insurance expanded the potential patient base for the private sector, as previously uninsured and low-income populations who could not access care were now able to do so. For instance, in Thailand, UCS included private providers in its network, particularly in urban areas, which helped reduce opposition by creating higher patient volumes and financial incentives. Similarly, in Uruguay, financing reforms expanded the role of *mutualistas*—non-profit health providers with strong ties to social health insurance systems—allowing them to benefit from an enlarged insured population. In New Zealand, the PHC Strategy significantly expanded the universal benefits package and contracted private GPs and GP associations to provide these services, effectively increasing their consumer base and, therefore, gaining private sector support. The reversal of the DHBs and centralization of purchasing through Health New Zealand in 2022 also received private sector support, as consolidated GP organizations could now undertake large-scale national contracts through a single agency. Additionally, financing reforms encountered little opposition in health systems where private health insurers had minimal market presence, such as Thailand, Uruguay, and New Zealand. Private insurance markets in these countries either catered to a small, higher-income segment or played a negligible role in the system. Consequently, these reforms did not threaten the consumer base of private insurers.

Organization-focused reforms aimed at enhancing public sector facilities and expanding services frequently encountered opposition from private providers concerned about potential loss of market share, influence, and revenue. These concerns stemmed from the likelihood of patients opting for free or more

affordable services offered by enhanced public sector facilities. This resistance was particularly evident in health systems where the private sector dominated PHC provision. Private sector dominance was historically present in some countries, such as Kenya's solo practitioners, traditional healers, informal providers, and New Zealand's GPs. In others, the public sector had been the dominant provider, but privatization and defunding of the public sector during Structural Adjustment Programs systematically strengthened the private sector's size and role (Egypt, Kenya, and Tunisia). Conversely, reforms encountered greater support in countries like Kazakhstan and Thailand, where the public sector had historically been dominant. Dual practice—where physicians work in both public and private sectors—further complicated reform dynamics. In Egypt, Kenya, and Tunisia, where dual practice is common, the boundaries between public and private providers are blurred. This overlap allowed physicians to unite in opposition to reforms that sought to restrict dual practice, perceiving such measures as threats to their income and autonomy (see Chapter 4, Table 3, and Section 3.1 for related discussions).

The political economy dynamics of PHC reforms highlight the challenges of navigating public-private sector relationships. While increasing public financing and integrating private providers into public schemes can align interests and reduce resistance, changes to payment mechanisms and organization often provoke significant opposition.

5.2. Hospitals and specialists versus primary care

PHC reforms inevitably involve reallocating resources and restructuring institutional linkages between hospitals and primary care levels. These shifts often entail increasing the proportion of the health budget allocated to primary care, adjusting institutional rules to favor PHC providers, and redefining the incentives and roles of hospitals and primary care facilities to prioritize population health and wellbeing instead of specialized curative services. Such reforms often encounter significant resistance as they challenge entrenched political and institutional preferences that favor hospitals and specialists.

Hospitals are not inherently opposed to financing reforms that expand health budgets or introduce national and social health insurance schemes. These reforms can increase their patient volumes as more individuals gain financial access to hospital-based care (see Section 5.1). In fact, in some countries, such as India and China, insurance reforms have historically increased funding for hospitals, reinforcing their dominance within the health system (115,359).

Resistance from hospitals typically emerges when reforms require reallocating existing budgets from hospitals toward primary care. This tension was particularly evident in Thailand, where the UCS reform proposed that a majority of the government's health budget be directed to primary care facilities and, consequently, a reduction in fund allocations to hospitals. Hospital administrators strongly opposed this redistribution, posing significant challenges to the reformers. To mitigate this opposition, reformers had to sanction supplementary budgets to hospitals during the initial years of the UCS. Similarly, hospitals and specialists in Kenya resisted the financing aspects of the PCN reform, arguing that reallocating resources from an already constrained health budget would further weaken the country's struggling secondary and tertiary care facilities. In contrast, Uruguay's financing reforms faced minimal opposition from hospitals due to the structure of the *mutualistas*, which own both hospitals and primary care facilities. This integrated delivery system benefited from increased aggregate financial resources under the SNIS, ensuring mutual support between hospitals and primary care.

Changes in provider payment mechanisms introduced alongside these financing reforms presented challenges in Thailand and Uruguay. In Thailand, reformers had to accommodate diagnosis-related group payments for hospitals, in addition to global budgets, to reduce resistance. In Uruguay, while capitated payments were successfully introduced, plans for geographical catchment-based enrollment continue to face delays due to stakeholder opposition. Additionally, Thailand's CUPs faced tensions with hospitals and specialists. As fund-holders, CUPs were responsible for contracting and purchasing PHC services from providers, including district and private hospitals. This redistribution of financial power created tensions, especially where hospital administrators resented diminished direct control over resources.

Specialists and hospitals, accustomed to dominating the health care landscape, often viewed CUPs as undermining their traditional roles, leading to resistance against PHC-focused resource allocations. Further complicating matters, CUP administrators frequently lacked the technical capacity and authority to negotiate with powerful hospital administrators or specialist associations effectively.

Organization reforms in this study often involved strengthening human resources and infrastructure at the primary care level and introducing gatekeeping mechanisms to ensure that primary care facilities act as patients' first point of contact. These changes frequently encountered resistance from hospital lobbies and specialists, particularly in health systems where patients traditionally bypassed primary care and sought care directly from hospitals, even for routine health needs.

Organization-focused reforms faced similar resistance from hospitals in Kazakhstan, Tunisia, and Egypt, albeit with different outcomes. In Kazakhstan, Tunisia, and Egypt where health systems historically centered on hospitals and specialists, reforms promoting family medicine and multidisciplinary PHC teams faced significant pushback. Hospitals and specialists argued that these new models of care would dilute the quality of treatment available to patients, who had long depended on specialized care. Further, in Egypt, the Family Health Model introduced similar organization reforms, emphasizing family medicine and gatekeeping. However, these changes remained largely ineffective without complementary financing and provider payment reforms (see Chapter 4, Table 3, and Section 3.1). Patients continued to bypass primary care and seek care directly from hospitals or private providers, undermining the intended focus on PHC. Dominica’s experience illustrates how domestic and geopolitical interests can divert the focus of PHC reforms. Despite a stated emphasis on strengthening primary care, reforms in Dominica shifted towards constructing tertiary and secondary hospitals, reflecting the dominance of hospital-centric care within the system and the political gains from such visible investments.

The dynamics between hospitals, specialists, and primary care providers highlight the inherent challenges in redistributing resources and redefining roles within health systems. Hospitals and specialists often view

PHC reforms as threats to their financial and professional dominance. Resistance tends to be strongest in health systems historically centered on hospitals, where patients and providers alike are accustomed to hospital-based care for all health needs.

5.3. Physicians versus non-physicians

PHC reforms often shift the balance of power and resources between physicians and non-physician health care workers, fundamentally reshaping their roles and relationships within health systems. Physicians hold significant epistemic authority within health systems, derived from specialized training and control over the definition of legitimate medical expertise. This dominance reinforces their place at the top of professional hierarchies, enabling them to influence health care policy, shape public discourse, and serve as gatekeepers to medical services. This power often marginalizes alternative forms of knowledge, such as indigenous or community-based practices, and limit the roles of non-physician providers. In PHC reforms, this epistemic power often manifests as resistance, as physicians perceive task-shifting and the inclusion of alternative practices as threats to their authority and professional identity. They also oppose financing reforms that affect patient volumes, incomes, and autonomy.

Financing reforms that increase overall funding or patient volumes often garner physician support, as these changes enhance their earnings and professional standing. However, resistance frequently arises when such reforms alter payment mechanisms. Fee-for-service or salary-based models provide predictable, individual-focused income streams, rewarding physicians based on their personal performance or fixed pay structures. In contrast, PHC reforms often introduce capitated payments and team-based incentives, which tie physicians' incomes to the performance of multidisciplinary teams, creating financial interdependence with non-physician health care workers. Team-based performance incentives can lead to shared earnings among physicians, nurses, and other health care providers, challenging traditional income hierarchies. Capitated payments or global budgets further encourage physicians to involve non-physician providers to enhance efficiency and maximize outcomes, altering traditional roles and resource distribution. In seven of the nine countries—Egypt, Kenya, Kazakhstan,

New Zealand, Thailand, Tunisia, and Uruguay—reforms attempted to transition from line-item budgets, salaries, or fee-for-service models to capitated payments. Capitation incentivizes disease prevention and health maintenance by transferring financial risk to providers and decoupling income from service volume (like in fee-for-service) or automatic transfers (line-item budgets or salaries). This shift is, therefore, less lucrative for providers and resulted in vehement opposition. For example, in Egypt, Kenya, and Tunisia, physician protests delayed the implementation of these provider payment reforms. Similar resistance has been observed globally, including in the United States, where the American Medical Association has opposed capitation since the 1930s (360,361), and in South Korea, where fee-for-service paid physicians resisted cost-control measures such as diagnostic-related groups and global budgets (362,363). Provider resistance has also significantly delayed or undermined reforms in Taiwan (362), Turkey (113), and Ghana (364).

In New Zealand, the shift to capitated, population-based funding fostered some interprofessional collaboration, particularly in salaried practices where physicians and nurses were employees. However, GPs continued to derive significant portions of their income from direct patient charges (copayments) and fee-for-service payments, reinforcing individual-focused incentives. These income sources, combined with capitated funding through PHOs, created mixed motivations for GPs, challenging the shift toward fully collaborative, team-based care. Performance-based contracting, introduced in 2016, aimed to drive incremental improvements through bonuses tied to system-level performance measures. However, these bonuses were paid to the PHOs and focused on service improvements rather than direct practitioner compensation, creating dissatisfaction among physicians. In Thailand**,** similar payment reforms faced far less resistance. The transition from salaries to capitation payments was relatively smooth, as most health care workers—both physicians and non-physicians—were salaried government employees. Their regular incomes remained unaffected, as capitation payments were directed to CUPs rather than individual physicians.

Organization-focused reforms often prioritize expanding care access by empowering non-physician health workers, such as nurses, community health workers, and social workers, to assume tasks traditionally reserved for physicians. While task-shifting is a pragmatic solution to address workforce shortages and extend PHC coverage, it often disrupts entrenched professional hierarchies, leading to physician resistance.

In New Zealand, reforms proposed to integrate traditional Māori medicine into PHC as part of efforts to address health inequities and honor indigenous practices. Physicians opposed these changes, arguing that incorporating non-Western medical practices undermined professional standards and scientific rigor. These arguments reflected broader concerns about maintaining the dominance of biomedical paradigms and preserving the physician-centric structure of the health care workforce. In Kazakhstan, reforms mandated the delivery of PHC through multidisciplinary teams composed of physicians, nurses, social workers, and psychologists. While some physicians were skeptical, a lack of veto points in the political system, the historical orientation of Kazakh physicians toward PHC, and efforts to train these teams on interprofessional collaboration mitigated resistance (see Sections 1, 2, and 3). Additionally, physicians in Kazakhstan are employed by the public sector and earn salaries. The introduction of multidisciplinary teams did not affect their financial interests. In Kenya, opposition from physicians to multidisciplinary teams stemmed from broader persistent demands for higher salaries, better working conditions, and increased recruitment, which the physician association felt were neglected in favor of investments in non-physician roles (see Section 3.1).

The reactions of non-physician health care workers to PHC reforms were varied, reflecting a mix of support and resistance. Many nurses embraced reforms that expanded their roles and responsibilities, offering greater autonomy and opportunities for leadership in community health programs. However, inadequate training, resources, and compensation often led to frustration, particularly in regions with limited professional development opportunities, such as rural Kazakhstan and Kenya. Psychologists often resisted being a part of the Kazakh multidisciplinary teams as they wanted to be considered professional

clinical workers with the autonomy to have individual practices. In New Zealand, practice nurses largely supported reforms that allowed them to contribute more directly to primary care delivery. Nonetheless, tensions arose due to funding models that failed to compensate for increased workloads. Nurses, salaried employees of GP practices, rarely benefited from cost savings under capitation models, further exacerbating dissatisfaction. Mental health workers, social workers, and Māori providers generally supported the PHC Strategy reform, but they struggled with resource constraints and limited integration into PHO structures, which remained centered around GP practices.

The political economy dynamics between physicians and non-physicians in PHC reforms reveal deep-seated tensions rooted in professional hierarchies, financial interests, and epistemic power. As influential stakeholders, physicians often resist reforms that redistribute resources or challenge their professional dominance, delaying implementation or forcing compromises. Conversely, non-physician health care workers view reforms as opportunities to enhance their roles but require adequate resources, training, and recognition to fully embrace these changes.

5.4. Centralized versus decentralized administration

PHC reforms frequently involve a push towards decentralizing health systems or expanding the roles of existing decentralized administrations. Decentralization typically entails empowering lower levels of administration with greater financial and human resources, along with expanded roles and authority relative to central administrations. However, these shifts often generate new political economy tensions, particularly when reforms create or empower new institutions that redefine the roles and powers of existing ones. These dynamics influence not only the implementation and adoption of reforms but also the tensions between and within centralized and decentralized levels.

Financing-focused PHC reforms in this study have often begun with a centralized approach. In both Thailand and Uruguay, reforms relied on centralized processes to pool resources and ensure equitable distribution. Thailand's UCS established the NHSO, while Uruguay's SNIS created the FONASA (see

Chapter 4). These centralized institutions acted as national-level pooling and purchasing agencies, consolidating resources and risk pools. The unitary political systems in both countries—and, in Thailand's case, its authoritarian regime at the time—supported this centralized design. While these reforms have been successful and sustained, they have faced significant political tensions, similar to conflicts seen in other countries, such as Mexico (76,112), Turkey (113,114), and South Korea (365), where consolidation of pooling disrupted existing power structures. However, decentralization in financing-focused PHC reforms often generated tensions between central purchasing agencies and decentralized entities.

Tensions arising out of decentralization in the purchasing mechanisms in Thailand and New Zealand are noteworthy. Thailand created district-level CUPs that acted as decentralized fund-holders and purchasers for PHC services, balancing centralized resource allocation with local decision-making. The establishment of CUPs redefined the traditional role of the Ministry of Public Health, shifting much of the decision-making for primary care services to the district level and reducing the ministry's direct influence. This decentralization created conflicts, particularly over the NHSO's guidelines. CUP administrators often criticized central allocation formulas for failing to address local needs, such as higher costs in rural areas. The NHSO's centralized control over resource pooling and disbursement further strained relations, as its strict accountability requirements limited the CUPs' flexibility to respond to local priorities. Delays in fund disbursement compounded these tensions, creating operational challenges and frustration at the district level. Tensions also emerged horizontally among the CUPs themselves, stemming from disparities in capacity, resources, and administrative efficiency. CUPs in urban and well-resourced areas often had access to better-trained staff, more robust infrastructure, and greater political influence, enabling them to perform more effectively. In contrast, CUPs in rural or underserved areas faced significant challenges, such as shortages of health care professionals, limited administrative expertise, and weaker bargaining power with local providers.

Similarly, New Zealand introduced decentralized structures under its reform, establishing DHBs to purchase both primary care and hospital services from contracted PHOs (see Chapter 4). However, this

decentralization faced consistent resistance and significant challenges over the two decades of its implementation. Politicians, particularly those in opposition parties, argued that decentralization fragmented the health system and led to duplications in administrative costs, diverting resources from patient care. Policy experts questioned the capacity of DHBs to manage complex purchasing responsibilities and ensure equitable service delivery across regions, pointing to inconsistencies in how different boards implemented national policies. Health professionals often expressed frustration over the variability in funding and service delivery standards between regions, which they felt undermined the principles of a universal health system. Regions with higher administrative capacity or greater political influence tended to perform better, while smaller or less-resourced DHBs struggled to deliver equitable care. This disparity deepened public dissatisfaction, eroding trust in the decentralized model. Inter-DHB tensions also arose, particularly in areas where overlapping responsibilities led to competition for resources or confusion over accountability. For instance, neighboring DHBs occasionally clashed over funding allocation for specialized services, such as tertiary care, creating inefficiencies and delays in service coordination. Additionally, the DHBs faced challenges in aligning their local priorities with national health objectives, further complicating governance. Ultimately, New Zealand dissolved the DHBs, retrenching its reforms and moving towards a re-centralized health system, highlighting the fragility of decentralized governance in politically contentious environments.

Organization-focused PHC reforms often prioritize decentralization as an integral part of their design. In countries such as the DRC, Kenya, and, to varying degrees, Egypt and Tunisia, reforms expanded the roles of decentralized administrators, including regional or local health authorities. These reforms frequently interacted with broader constitutional or political devolution processes (see Section 2.3). In the DRC and Kenya, constitutional devolution transferred the responsibilities for health services to county-level administrations. However, these reforms triggered tensions between national and county governments, particularly over budget allocations and disbursement timelines. Counties with stronger technical and institutional capacity could advance reforms effectively, while weaker counties struggled,

leading to stark disparities in progress. Furthermore, in both countries, decentralization exacerbated patronage politics. County administrations often directed resources disproportionately to electorally significant regions or areas with ethnically aligned populations, reflecting entrenched patronage dynamics in their political systems.

In Tunisia and Egypt, decentralization efforts were hindered by broader political and institutional constraints. In Tunisia, regional health authorities were tasked with overseeing PHC reforms, but their effectiveness was uneven due to weak institutional capacities and resistance from hospital-centric health administrators. In Egypt, the Family Health Model sought to decentralize service delivery but struggled to gain traction without complementary financing reforms, leaving central institutions dominant and local authorities disempowered.

The interplay between centralized and decentralized structures in PHC reforms underscores the deeply political nature of health system restructuring. Decentralization can enable local innovation and responsiveness of PHC reforms but is vulnerable to capacity disparities, patronage politics, and uneven implementation.

5.5. Expanding versus limiting citizens' choices

PHC reforms usually have aspects that both expand and limit citizens' choices for healthcare. Reforms that expand access to newer types of providers, affordable care, and a wider range of services often gain public approval. However, many PHC reforms encounter skepticism, resistance, or outright opposition from the very populations they aim to serve. Citizen dissatisfaction often stems from perceived limitations imposed by the reforms, such as restricted choice of providers through gatekeeping mechanisms or copayments for more expensive drugs, diagnostics, and specialist care. These reactions highlight the complex interplay between citizens' expectations, historical experiences with health care systems, and the structural changes introduced by PHC reforms.

Financing reforms that provide tangible financial benefits often enjoy greater public acceptance. This is especially true for financing reforms that expand provider choice, particularly when private sector providers—previously unaffordable to lower-income households—become accessible through insurance coverage. In Uruguay, the expansion of social health insurance under the SNIS was broadly popular. By reducing financial barriers and improving access to both primary and hospital care (in both public and private sectors), the reforms provided tangible benefits and addressed the immediate concerns of inequity and unaffordability exacerbated by the financial crisis that preceded the reforms (see Section 1). Similarly, in Thailand, the UCS gained widespread support and became a symbol of affordable and equitable health care access.

Organization reforms, particularly those involving gatekeeping mechanisms, often face resistance from citizens. Gatekeeping mechanisms, designed to streamline care by directing patients to appropriate service levels, are often perceived by citizens as restrictive. For many citizens, these mechanisms are viewed as limiting their autonomy in choosing providers or therapies, particularly in contexts where hospital-based care has historically dominated.

Citizen resistance to organization reforms often reflects deeper systemic issues. Historical underinvestment in primary care has led to entrenched perceptions of poor quality, making citizens skeptical of reforms that seek to reposition primary care as the cornerstone of health care systems. This skepticism is compounded by concerns over autonomy, as gatekeeping and other mechanisms are perceived as reducing citizens' control over their health care choices. In many cases, reforms unintentionally amplify these challenges. In Kenya, decades of neglect and chronic underfunding of primary care eroded trust in local health facilities. As a result, citizens frequently bypass primary care centers in favor of hospitals, even for basic or preventive health needs. Efforts to establish PCNs were met with skepticism, as citizens doubted whether these networks could deliver timely and effective care. This preference for hospital-based care has complicated reforms aimed at decentralizing services and strengthening community-level health systems. In Egypt, reforms that introduced gatekeeping through

Family Health Units faced widespread disregard. Citizens continued bypassing public sector primary care in favor of hospitals and private providers. Historical experiences of poor quality, corruption, and user fees during the Structural Adjustment Programs further eroded trust in the public health care system, undermining the intended role of PHC reforms. In Kazakhstan, where hospital and specialist care historically dominated, citizens resisted reforms that emphasized family medicine and community-based services. Gatekeeping policies requiring patients to consult family medicine practitioners before accessing specialists were particularly contentious. Many citizens viewed these changes as barriers to accessing the specialized care they were accustomed to, interpreting gatekeeping as a restriction on health care freedoms rather than a pathway to coordinated care. However, strategic persuasion and community engagement efforts combined with patients' positive experiences with the new primary care providers helped overcome this resistance and gain public acceptance for the reform over time.

Citizen support for PHC reforms depends on their ability to deliver tangible benefits without compromising perceived quality or autonomy. While financing reforms that reduce costs and expand coverage are generally well-received, organization reforms face resistance due to entrenched preferences for hospital-based care and skepticism about the capabilities of primary care systems.

5.6. Selective versus comprehensive changes

PHC reforms are often faced with conflicting ideas of a selective versus a comprehensive approach. They influence both the decision on the scope of services, i.e., whether to focus on a narrow set of services and diseases versus maintaining health and wellbeing, as well as the scope of the reform itself, i.e., whether to focus on one policy lever versus multiple levers. Since the Alma-Ata Declaration in 1978, political-economic priorities and global health governance have deeply influenced debates over selective versus comprehensive PHC (3). Comprehensive PHC, rooted in the Alma-Ata vision, emphasized universal access to a wide range of health services addressing the social determinants of health. However, its ambitious scope faced criticism for being financially and logistically unfeasible, particularly in low-

resource settings. The Rockefeller Foundation and other influential actors championed the concept of selective PHC in the early 1980s, prioritizing cost-effective interventions targeting specific diseases or health outcomes, such as communicable diseases and maternal and child health interventions (3,7). Over time, selective PHC has drawn significant criticism for undermining health systems by neglecting broader structural determinants of health. However, the tension between selective and comprehensive approaches continues to influence PHC reforms, shaping their design, implementation, and resilience.

The findings suggest that irrespective of the entry point of the reform, comprehensive reforms, particularly those with institutional layering—a process of introducing new congruent rules, structures, and mechanisms alongside existing ones in a synchronized manner (65)—have been more resilient and sustainable. This is evident in the comprehensive set of policy levers used by Thailand, Uruguay, Kazakhstan, and New Zealand (for over two decades of the reform) (see Table 3).

Thailand's UCS brought about transformative changes. Its rapid rollout was supported by increased government health budgets and the establishment of the NHSO in 2002. Subsequent additions to this reform, including CUPs, gatekeeping mechanisms, and capitated payments, reoriented the health system toward PHC. This comprehensive strategy enabled the UCS to withstand political instability and shifting coalitions while maintaining public support.

Similarly, Uruguay's SNIS built on financing reforms to establish a resilient health system. Initial changes, such as creating the FONASA and revising provider payment methods, were complemented by organization reforms that strengthened public PHC delivery through the ASSE and established PCNs or RAPs. The Frenté Amplio government's 15-year tenure provided continuity, allowing systematic layering of reforms that embedded PHC into the health system.

Kazakhstan, which started with organization reforms, was another example of taking a comprehensive approach. Initially piloted in "best practice sites," the multidisciplinary team reforms integrating physicians, nurses, social workers, and psychologists generated insights for national scale-up. The

inclusion of social determinants and a multi-sectoral approach, reflected in the temporary merging of the ministries of health and social development, further supported comprehensive goals (158). Over time, Kazakhstan layered financing, provider payment, and governance reforms to align with organization changes, demonstrating the importance of strategic sequencing and institutional coherence.

Conversely, countries influenced by a legacy of selective PHC, such as Kenya, Egypt, Tunisia, and the DRC, have encountered significant difficulties in implementing comprehensive reforms. In these contexts, donor-driven agendas (see Section 3.1), disease-specific focus, and fragmented governance have limited the scope and sustainability of reforms.

In Kenya's PCN, while complementary policies such as the Community Health Policy (2020-2030) and Community Health Strategy (2020-2025), aimed to integrate community-level care and strengthen referral systems, these efforts were not fully aligned with simultaneous changes in financing and provider payment mechanisms, limiting their overall impact. Additionally, there have been minimal efforts to effectively steward the private sector, which delivers a significant proportion of health care services in the country. The slow pace of implementation has resulted in a lack of momentum, particularly among frontline workers and street-level bureaucrats while creating opportunities for resistance from physician associations (see Section 3.1). This combination of factors has left the nascent reform vulnerable to shifting political coalitions and episodes of political unrest.

Egypt's Family Health Model had a very similar trajectory. Initially piloted in three governorates with support from the World Bank, the reform faced challenges during its prolonged nine-year rollout. Over the years, there was incremental expansion and accreditation of providers, and a diploma program in family practice was introduced. However, different components of the model often progressed at different paces. While some family health units were upgraded, training for providers, quality standards, availability of essential medicines, and public engagement lagged (195). This desynchronized cadence created disparities, with some regions benefiting more than others, creating widespread dissatisfaction among

citizens and providers and giving ample fodder for opponents to critique the reform (342). Additionally, critical supporting changes in financing, purchasing, and provider payments to firmly establish PHC as the model of care were repeatedly thwarted (342,366). The long period and slow pace of reforms, combined with an expanded civic space post-2011, gave sufficient opportunities to a wide range of opponents, including civil society, physician associations, political oppositions, and the judiciary, to stymie these reforms for the last 25 years.

The lack of congruent changes in related policy levers contributed to the failure of PHC reforms to take root in Tunisia and the DRC.

Tunisia's Family Practice Model attempted to introduce a new cadre of family medicine physicians without aligning financing, purchasing, governance, and organization of the health system. While changes in provider payments were proposed, the opposition to both the new cadre and capitation payments was very strong. Further, the slow pace of the reform, with its long deliberation process through the Societal Dialog for Health, delayed tangible demonstrations of the reform and allowed opposing interest groups to stall it.

The DRC faced unique challenges due to its crisis-driven, donor-dependent health system and an entrenched selective PHC approach. Most donors directly fund and deliver essential services, often dictated by their specific disease priorities. This focus on targeted interventions and repeated health crises involving communicable diseases has perpetuated a crisis-response mode rather than fostering a strategic, comprehensive, and long-term vision for health system development. The Provincial Health Reforms in the DRC failed to introduce significant changes in financing, purchasing, or provider payment mechanisms, largely due to the highly fragmented nature of these functions within the health system. Institutional weaknesses at the provincial level became evident, with many Provincial Health Divisions struggling with limited financial and human resources to fulfill their expanded roles. While some provinces benefited from early donor support, others lagged, exacerbating regional disparities in health

care delivery. Moreover, partially implemented reforms often operated alongside pre-existing systems, creating a fragmented landscape that lacked the structures necessary to comprehensively support transformative changes. The inconsistent pace and scope of reform left critical health challenges unaddressed, and the absence of cohesive, integrated frameworks undermined the potential for meaningful progress, leading to widespread stalling of the reform agenda.

The experiences of countries implementing PHC reforms illustrate the critical importance of adopting comprehensive approaches that align financing, organization, and governance changes. While selective reforms may achieve targeted gains in the short term, they often fail to address the structural determinants of health, limiting their sustainability and impact. Comprehensive reforms, particularly when layered with congruent institutional changes, build resilience by aligning incentives, fostering public trust, and creating systemic coherence.

This chapter has explored the multifaceted political economy dynamics influencing PHC reforms across nine countries, addressing the research questions and providing a detailed examination of key themes. The findings underscore the interconnected roles of political, institutional, and ideational factors in shaping the adoption, design, and sustainability of these reforms. Across the analyzed contexts, reforms emerged as deeply embedded in historical legacies, institutional frameworks, stakeholder interests, and the politics of ideas, all of which collectively shaped their trajectories. Importantly, this chapter puts forth six domains of political economy dynamics that emerge uniquely within PHC reforms and discusses how these dynamics manifest across different types of policy lever changes—financing versus organization. To the best of my knowledge, this is the first such analysis and represents a significant step toward analyzing the political economy of PHC reforms across health systems.

CHAPTER 6: CONCLUSION AND WAY FORWARD

Research questions and rationale

This study set out to answer two research questions: (1) *How have political economy factors driven PHC reforms across countries?* and (2) *What are the distinct political economy factors of PHC reforms, and how do they differ across different types of PHC reforms—those focusing on financing versus organization?* Recognizing PHC as a cornerstone of equitable, accessible, and sustainable health systems globally, this research aimed to move beyond technical reform designs and explore the political, economic, and institutional forces underpinning health reform trajectories. Why, despite the globally endorsed vision of comprehensive PHC—as articulated since the Alma-Ata Declaration (1978)—has the implementation of reforms yielded such varied trajectories across different national contexts? While technical improvements and health service innovations are essential, it is now widely understood that political economy dynamics are equally critical in determining the success or failure of health reforms. However, while considerable research has examined the political and economic factors shaping development, public service delivery, and health policies—especially health insurance—fewer studies have systematically explored the political economy specific to PHC. Thus, the political economy pertaining to the unique characteristics and challenges inherent in PHC reforms remains under-researched and under-theorized. This is the gap this study aimed to address.

Theoretical and methodological foundations

This inquiry was grounded in a synergistic blend of health systems and political economy theories. The theoretical framework drew on the Control Knob Framework to conceptualize the health system as an interconnected set of policy levers—financing, organization, provider

payments, regulation, and persuasion—that collectively shape health system outcomes (21). Complementing this, a historical institutionalist perspective (36) provided the analytical lens for examining how past decisions, institutional inertia, and evolving power relations shape enduring policy trajectories. This combination of theoretical frameworks allowed for a nuanced interrogation of how reforms are not isolated events but are deeply embedded within and shaped by the evolution of each country's political-economic and health system contexts.

Methodologically, a multi-level approach was adopted: detailed country case studies using process tracing were developed through comprehensive document reviews, key informant interviews, focus groups, and expert consultations across nine countries, undertaken in part as a collaborative project with the WHO. The synthesis relied on a comparative sequential analysis with deductive analysis informed by a historical institutionalist perspective alongside inductive approaches for theory building.

Theory application – a historical institutionalist analysis of PHC reforms

Countries in the sample exhibited varied reform outcomes, specifically regarding comprehensiveness, implementation scale, and sustainability over time. Based on these criteria, Thailand, Uruguay, and Kazakhstan emerge as the successful cases. Dominica, Egypt, and Kenya had mixed results; some aspects of their reforms continued while others struggled. In three countries, the reforms either failed to take off, like in DRC and Tunisia, or were reversed, like in New Zealand.

For research question 1, the findings reveal that the political economy factors influencing PHC reforms operate on several interrelated levels across four key themes: temporality, institutional context, interest groups, and ideas.

Temporality

Temporality—encompassing historical legacies, path dependency, and critical junctures—is central to shaping health reforms. Historical legacies provided a foundation for progress in the countries with successful reforms. Thailand's reform was built on generational investment in PHC infrastructure and staffing. Uruguay leveraged strong welfare traditions with social health insurance building on its long history of labor rights and workers' protections. Kazakhstan, which hosted the Alma Ata Conference, has historical links to core PHC ideas that helped the comprehensive design of the reform. In contrast, in New Zealand, the DRC and Tunisia colonial legacies and path dependence led to policy inertia, restricted policy options, and led to reform reversals.

Critical junctures—periods of political upheaval, economic crises, or social movements—have provided windows of opportunity for transformative change. The successful cases – Uruguay, Thailand, and Kazakhstan – experienced economic crises and capitalized on these to advance redistributive policies and institutional reforms. These three countries also experienced significant political changes, with Thailand and Uruguay electing new political parties and Kazakhstan gaining independence from the former Soviet Union. On the other hand, in New Zealand, economic recessions led to budget cuts for the PHC reform after the 2008 financial crisis, and the post-COVID-19 economic slowdown led to the reversal of the reform in 2022. Although critical junctures can catalyze reform by making redistributive or transformative reforms more acceptable, they are necessary but not sufficient to overcome the constraints imposed by historical legacies and institutional inertia.

Institutional context

The study highlights the significance of institutional design—formal and informal rules, norms, and structures that govern behaviors. Political systems, electoral rules, partisanship, constitutional provisions, and bureaucracies play a decisive role in shaping how reforms are conceived, implemented, and sustained. Some institutional contexts encourage broader coalitions and multiple interest groups, often leading to numerous veto points that can hamper the adoption of transformative PHC reforms or slow the pace of adoption and implementation. Conversely, more centralized or authoritarian systems may push through sweeping changes more readily, though often with limited input from diverse groups. Overall, the findings reveal mixed outcomes in reform comprehensiveness and sustainability across different political regimes.

The successful cases had electoral rules that promoted programmatic politics. In Uruguay and Thailand, changes in electoral rules before the reforms increased programmatic politics, making it more possible to form decisive majorities with common agendas and reducing incentives for individual clientelist politicians. In New Zealand, electoral reforms towards more proportional representation empowered minority parties, including the Māori Party, which helped continue the reform for two decades before its eventual reversal. The successful cases also had fewer veto points during the reform, irrespective of the presence of formal veto gates in their political systems. In Uruguay, although the political system has several veto gates, including referendums and direct democracy, the absolute majority of the Frenté Amplio party reduced opposition to the reform. In contrast, in Kenya, the DRC, and Tunisia, the electoral systems and shifting coalitions encouraged clientelism and created incentives for patronage politics rather than focusing on welfare programs or PHC.

Political parties further affect reform outcomes because they represent differing electoral bases. In the successful cases, the political party had significant support for the reform from their main voter base. In Uruguay, the left-wing Frenté Amplio party's main voter base was labor unions and the rural poor. This base strongly supported the reforms. With this support, the party could push the reform forward despite opposition from elite groups. Similarly, in Thailand and Kazakhstan, the reforms appealed to a large base of supporters, especially the poor. The conventional left-right ideology alone appears to be insufficient to explain the adoption or sustainability of health reforms, as dynamic electoral incentives, shifting coalitions, public opinion, and electoral rules further complicate the role of partisanship. In New Zealand, for example, the same left-leaning Labor Party that introduced the PHC reforms later reversed them, illustrating that political stances can evolve within a single party. Moreover, party-voter relationships are neither static nor exclusively programmatic, as demonstrated by the particularistic, ethnicity-based politics in Kenya and Tunisia.

Constitutions, laws, and legislation are critical institutional safeguards that enable or constrain reform efforts. The successful cases had constitutional provisions and legislation to support their reforms. In Uruguay and Thailand, the right to healthcare in their constitutions and successive legislations served as institutional safeguards for the reforms, protecting them even when support wavered and political leadership changed. In authoritarian regimes, constitutional amendments shaped the power dynamics of different branches of the government and of different interest groups. For example, in Kazakhstan, constitutional amendments consolidated power in the president, reducing most other veto points and opportunities for opposition; since the president supported the reform, it led to a positive result and continuation of the reform. In contrast, in New Zealand, the absence of a written constitution and differing interpretations of the Treaty of

Waitangi (New Zealand's foundational document) made it easier for the Executive to reverse the reform.

The degree of devolution and the role of bureaucracies are crucial. Professionalized, technocratic administrations, as seen in Thailand, enhance reform continuity, while politically appointed bureaucracies in Kenya and the DRC can hinder progress due to turnover and patronage.

Socio-economic contexts also critically shape the scope of PHC reform. Economic constraints and competing priorities may force incremental changes rather than comprehensive overhauls. Likewise, demographic shifts—such as aging populations—can influence the focus and urgency of PHC interventions, and epidemiological shifts, like the rising burden of chronic diseases, may prompt policymakers to strengthen preventive care.

Interest groups

Four major interest groups—physicians, civil society, donors and international agencies, and citizens—dynamically shape PHC reforms, with their power and stances evolving and shifting as reforms expand or change direction.

Physicians often exert significant influence via professional associations and political connections. Physician resistance notably hindered reforms in Tunisia and New Zealand. Conversely, supportive physician engagement was pivotal in Thailand and Kazakhstan, while fragmented physician associations in Uruguay limited their ability to oppose reforms effectively.

Civil society groups, including labor unions and advocacy organizations, adapt their positions in response to shifting policy agendas or political climates. In Uruguay, unions championed equity-

focused reforms, while in Kenya, international NGOs took the lead in design and implementation as the PCN evolved.

Donors and international agencies play significant roles in aid-dependent contexts such as the DRC, Kenya, Egypt, and Dominica, though changing donor priorities resulted in externally driven rather than locally owned strategies. On the other hand, in the successful cases, donor influence was negligible.

Lastly, citizens' perceptions are equally fluid, shaped by evolving trust in public services and tangible benefits, ultimately influencing whether reforms are embraced or resisted, but the successful cases had strong public support for the reforms, while the other countries faced resistance.

Ideas behind the reform

Ideas and ideologies behind PHC reforms critically shape their content, influencing the framing of solutions and their perceived legitimacy. Reforms anchored in local priorities, such as Uruguay's focus on equity or Thailand's economic rationale, often resonate deeply with citizens, boosting public support and political traction. In contrast, externally driven ideas like those in Kenya or the DRC risk mismatching local needs and capacities and limiting impact. Ideological alignment also determines which donors or agencies lend backing; global institutions often champion reforms echoing ideas of UHC, PHC, or specific disease priorities. Whether reforms endure political transitions depends on how ideas align with entrenched institutional norms and stakeholder interests. In New Zealand, deeply rooted concepts of partnership under the Treaty of Waitangi guided the reforms yet faced reversal amid shifting politics. Ultimately, ideas and ideology shape both the sustainability, stability, and overall viability of PHC reforms, strongly

influencing stakeholder perceptions, funding sources, and the likelihood of long-term public support.

Theory building – the distinct political economy of PHC reforms

This research advances knowledge by proposing a novel framework identifying the political economy factors underpinning PHC reforms. By distinguishing between financing-focused and organization-focused reforms, the study illuminates how technical design choices intersect with political economy dynamics. Political economy tensions arise in six domains when health systems shift toward PHC: (i) public versus private sector, (ii) hospitals and specialists versus primary care, (iii) physicians versus non-physicians, (iv) centralized versus decentralized administration, (v) expanding versus limiting citizens' choice, and (vi) selective versus comprehensive changes. The choice of reform entry point (financing or organization) strongly shapes how these tensions unfold.

Financing reforms, which often boost public spending and expand insurance coverage, can align interests across public and private stakeholders by growing patient pools and revenue streams. Yet, the diversion of resources from hospital to primary care and shifts to capitated or performance-based payments frequently encounter fierce resistance from providers, particularly physicians and specialists who fear reduced incomes or diminished professional autonomy. Organization reforms, meanwhile, may face opposition if they expand roles for non-physician health workers or require gatekeeping mechanisms that restrict direct access to hospitals and specialists—especially in contexts where hospital-based, specialist-oriented care is deeply entrenched.

Additionally, shifting authority to decentralized levels can trigger pushback from higher-level administrators. For instance, financing reforms with decentralized purchasing faced opposition in Thailand and New Zealand. In contrast, organization reforms that expand the roles of decentralized administrators can strengthen local implementation power, as seen in Kazakhstan, but also lead to variability in reform outcomes and patronage-based politics in Kenya and the DRC.

PHC reforms that broadened access generally enjoyed strong public support, whereas initiatives restricting hospital or specialist services often encountered resistance. For example, citizens have tended to favor financing reforms, as seen in Thailand and Uruguay, more than organization reforms, as demonstrated in Kenya, Egypt, and Kazakhstan, where people generally prefer hospital-based care.

PHC reforms frequently contend with tensions between narrow, selective strategies and broader, comprehensive approaches requiring coherent changes across multiple policy dimensions. Evidence suggests that reforms with a strong financing entry point or simultaneous adjustments in financing, organization, and governance tended to be more transformative and resilient, as demonstrated in Thailand, Uruguay, and Kazakhstan. Countries like Dominica, Tunisia, and the DRC, which used only a few policy levers, could not sustain their reforms.

These findings contribute to theory building by demonstrating that PHC reforms (and the choices of policy levers) trigger distinct political economy patterns not fully captured in existing health reform literature, which often treats all health system changes as uniform. The analysis addresses a critical gap in our understanding of why some reforms stall or fail while others persist by highlighting how the nature of PHC intensifies conflicts over resource reallocation, professional

hierarchies, and governance structures. It also underscores the importance of sequencing and institutional layering—with coherence across different policy levers—to increase the resilience of reforms. Overall, this work offers a nuanced framework for examining how PHC's emphasis on equity, prevention, and community-based care creates a set of political economy challenges distinct from other health reforms, thereby enriching our grasp of both the opportunities and obstacles inherent in building stronger primary health care systems.

Looking ahead, integrating these theoretical insights into health systems research promises to enrich policy debates and improve reform strategies. Researchers can build on this framework to conduct comparative studies across different political and institutional contexts, thereby deepening our understanding of the mechanisms that facilitate or hinder successful reform. Additionally, using this framework to study the trajectories of different types of PHC reforms within the same country could provide robust tests of hypotheses.

Translating research into policy and practice

The findings from this research have significant implications for both policy and practice in health systems reform. First, by unpacking the political economy factors that shape PHC reforms, the study underscores that reform efforts cannot be viewed solely as technical adjustments. Instead, they must be understood as deeply embedded processes influenced by longstanding and evolving political and institutional dynamics. Policymakers and reform advocates must recognize that technical solutions alone are insufficient for reorienting health systems toward robust PHC. Instead, reform efforts must be strategically designed to address and work within the context of the existing political economy. This means that reform strategies should incorporate political analysis from the outset, identifying potential allies and opponents,

understanding the distribution of power, and timing interventions to coincide with critical political junctures. Policymakers can draw on these insights to design contextually relevant and resilient reforms in the face of shifting political landscapes, their specific health systems, and their reform entry points.

Second, policymakers and practitioners should recognize that the political economy dynamics differ significantly across health reforms. PHC reforms alter distinct institutional dynamics and mobilize distinct interests. Moreover, interest group positions vary according to each reform's design, content, and chosen policy levers. By tailoring political economy analysis to these specific elements, stakeholders can devise more effective strategies that increase the likelihood of successful reform.

Third, there is a strong need to invest in institutional capacity. Strengthening governance structures and technical capacities and ensuring that local and regional entities are empowered to manage and sustain reforms can help mitigate the effects of path dependencies, design more effective reforms, and help sustain reforms, even in the face of political instability.

Fourth, the findings suggest a comprehensive health system approach is essential for PHC. Reforms that simultaneously address financing, organization, provider payment, and governance are more likely to generate synergistic effects, increasing the likelihood of policy feedback effects that reinforce the overall transformation of the health system. Such an integrated approach helps to counterbalance the influence of powerful entrenched interests and ensures that improvements in one area do not inadvertently undermine progress in another.

Finally, this research calls for ongoing dialogue between researchers and policymakers. Bridging the gap between theoretical analysis and practical implementation is crucial. Embedding political economy analysis within policy design enables decision-makers to better anticipate challenges, leverage opportunities, and design more sustainable and equitable PHC reforms. The study's insights provide a roadmap for future research, suggesting that further exploration into the dynamic interplay of political economy factors and health system characteristics will be essential to understand and effectively navigate PHC reforms' complexities fully.

Several promising initiatives are already underway to translate this research into practice. First, capacity-strengthening programs for policymakers and practitioners have aimed to integrate political economy analyses into their work. Notably, two recent programs illustrate this effort: a module on "Navigating the Political Economy and Culture of Change," developed for the WHO Academy's Leadership for PHC course in Geneva (2024-25), and a "Political Analysis for Health Systems" module within the Health System Capacity-Strengthening Program for mid-career professionals in India (2024-25). To further institutionalize these activities, a collaborative effort with the WHO is underway to produce a policy actors' manual on political economy analysis for PHC reforms.

Second, there is a growing push to convene policymakers, practitioners, and researchers in forums dedicated to political economy analysis for health reforms, particularly in PHC. Over the past year, several high-profile events have served as platforms to disseminate and mainstream these insights, including policy roundtables at the World Health Assembly in Geneva (2024), the International Conference on Primary Health Care in Astana (2023), and the Health Systems Global Conference in Nagasaki (2024).

These initiatives reflect a growing movement to integrate political economy perspectives into health system reform practices. By strengthening capacity, sharing practical tools, and fostering dialog among stakeholders, the field can move closer to designing and implementing PHC reforms that are technically sound and politically viable.

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APPENDIX 1

Brief overview of economic and political contexts across the sampled countries

Dominica

Dominica, a small island nation in the Caribbean, has a population of approximately 74,000 as of 2024, with an aging demographic (171). As an upper MIC, its GDP per capita was US$7,860 in 2018 (170). The economy relies heavily on agriculture, tourism, and citizenship investments, but development is constrained by high debt levels, reliance on external finance (with Overseas Development Aid comprising 14.5% of Gross National Income in 2021), and environmental vulnerabilities (178,367–369). Since gaining independence from England in 1978, Dominica has maintained political stability through a parliamentary system modeled on Britain's. Regular elections, universal suffrage, and active civic participation support its democratic resilience, while the unicameral House of Assembly includes both elected representatives and appointed senators (173). Dominica has a multiparty system, with three dominant parties – Dominica Labor Party (which has governed the country since 2000), Dominica United Workers Party, and Dominica Freedom Party. Table 2 presents some key overview indicators.

The Democratic Republic of Congo

The Democratic Republic of Congo (DRC), a resource-rich Central African nation, has a population of approximately 102 million (2023) (171). Despite vast mineral wealth, including cobalt, copper, and diamonds, the DRC is an LIC with a GDP per capita of US$649 (170). Rapid population growth—7.5 times since 1960—has coincided with a 2.5-fold decline in per capita income, exacerbating underdevelopment (170). Politically, the DRC gained independence from Belgium in 1960, establishing a unitary presidential republic. The first elections brought Patrice Lumumba to power as prime minister and Joseph Kasa-Vubu as president, but their democratic government quickly collapsed amid political turmoil, culminating in Lumumba's assassination (370). In 1965, Sese Seko Mobutu seized power and ruled as an authoritarian for

32 years (370). By the 1990s, economic decline and ethnic tensions created an opening for Laurent Kabila, backed by Rwanda and Uganda, to overthrow Mobutu in 1997; however, Kabila's rule soon faced rebellion, plunging the country into civil war (370). Following his assassination in 2001, his son, Joseph Kabila, assumed the presidency. While the war officially ended in 2003. Joseph Kabila won controversial elections in 2006 and 2011, and weak state institutions, alongside persistent internal conflicts, have continued to undermine governance (173). While the DRC has a multiparty system, elections have often been marred by controversy and irregularities, eroding public trust (182). The country has experienced prolonged instability, with a failed coup attempt in May 2024 underscoring ongoing governance challenges, and Eastern Congo remains plagued by conflict with recent violence in 2025 (173). Under Mobutu's regime, state resources were plundered, contributing to economic collapse in the 1990s (370). Post-conflict recovery has relied heavily on international donors (369), who provide crucial funding for infrastructure, health, and governance programs. However, scholars argue that foreign aid has hindered the development of strong democratic institutions, as democratic reforms have been driven more by donor pressure than by genuine domestic support (271,354). Despite international assistance, the DRC remains burdened by widespread poverty, weak and extractive institutions (86). Table 2 presents an overview of economic and political characteristics.

Egypt

Egypt has a population of approximately 112.7 million as of 2023 (218) and a GDP per capita of US$3,513 (170). Egypt's economy has historically relied on agriculture, the Suez Canal, and remittances (371), but struggles with inefficiency and population growth have led to recurring crises (170). Structural Adjustment Programs in the 1990s aimed at liberalization but faced criticism for deepening inequality and significant cuts to social and health sector funding. The 2011 revolution exacerbated economic instability, prompting reliance on donor aid, Gulf Cooperation Council support, and International Monetary Fund (IMF) loans. Major IMF programs in 2016 and 2020 sought to stabilize the economy through reforms, including subsidy cuts and currency devaluation, but rising debt, inflation, and poverty highlight Egypt's ongoing

vulnerabilities and dependence on external support (246,372). Politically, Egypt's modern history has been shaped by significant upheavals. After decades of authoritarian rule under Presidents Anwar Sadat (1970-1981) and Hosni Mubarak (1981-2011), the 2011 Arab Spring revolution brought hopes for democratic transition (173). However, the subsequent political landscape has been marked by instability, including the ousting of President Mohamed Morsi in 2013 following mass protests (173). The current administration, led by President Abdel Fattah el-Sisi since 2014, has sought to consolidate power while implementing economic reforms (173). Although efforts have been made to stabilize governance and attract foreign investment, concerns remain over restrictions on political freedoms, human rights, and the concentration of power (173). Table 2 presents an overview of some key political and economic characteristics.

Kazakhstan

Kazakhstan, spanning Central Asia and Eastern Europe, has a population of approximately 20 million as of 2023 (218), and a GDP per capita of US$10,374 in 2021 (373). An upper MIC, its economy is driven by oil, natural gas, and mineral exports, alongside agriculture, manufacturing, and emerging technology sectors. Since independence from the Soviet Union in 1991, the country has transitioned from a planned economy to a market-oriented system, achieving economic growth but facing challenges in diversification and equitable development (374). In the 1990s, it implemented Structural Adjustment Programs and received International Monetary Fund (IMF) loans to stabilize its post-Soviet economy (374). While donor dependence has declined and the country is now itself a donor, it faces vulnerabilities from its reliance on oil exports, which is evident during the 2008 global financial crisis and the 2020 oil price crash (374). Kazakhstan is a unitary presidential republic with multiple political parties, although the Amaanat Party (formerly Nur Otan) has ruled since independence (173). While other parties are represented in the parliament, there is limited opposition influence in governance. The long rule of its first president, Nursultan Nazarbayev, from 1991 to 2019 established a strong centralized government, fostering economic stability but drawing criticism for authoritarian practices (173). In recent years, attempts have been made at political

reform under President Kassym-Jomart Tokayev, including commitments to decentralization and political inclusivity (173). Table 2 presents some key political and economic characteristics.

Kenya

Kenya is an East African nation with a population of 54 million as of 2023 (218) and a GDP per capita of US$1950 (373). An LMIC, its economy, traditionally driven by agriculture and services, has faced challenges such as inequality, corruption, and external debt (375). In the 1980s and 1990s, Structural Adjustment Programs were implemented under donor pressure and sought to liberalize the economy, but this led to social unrest and weakened public services (266,267). The country remains reliant on foreign aid, with donors funding key sectors such as health and education (369). Kenya has weathered financial crises, including debt distress in the 1990s and the impact of global shocks such as the 2008 financial crisis and COVID-19, underscoring persistent vulnerabilities despite its emerging market status (169,375). A persistent budget deficit marks Kenya's fiscal landscape, and the recent repeal of the 2024/2025 Finance Bill, which proposed tax hikes worth US$2.69 billion, has raised concerns about the pace of fiscal consolidation (375). Kenya gained independence from British colonial rule in 1963, with Jomo Kenyatta becoming its first president. Initially, a one-party state under the Kenya African National Union, political repression and centralized power increased after Kenyatta’s passing and the transition of power to President Daniel Arap Moi. The 1990s saw the introduction of multiparty democracy, following pressure from civil society and international donors. Despite progress, ethnic tensions and election-related violence, particularly in 2007-2008, have repeatedly tested its stability (173). Kenya operates as a unitary presidential republic with devolved governance across 47 counties – subnational administrative units – under the 2010 Constitution, emphasizing regional decision-making and resource allocation (173), but challenges such as corruption, ethnic divisions, and political dynasties continue to shape Kenya’s political landscape (268,269,307). Table 2 presents additional details on key political and economic characteristics.

New Zealand

New Zealand, an island nation in the southwestern Pacific Ocean, has a population of approximately 5.2 million as of 2023 (171). Classified as a high-income economy with a GDP per capita of US$47,072, the country relies heavily on international trade (169). Agriculture remains a cornerstone of the economy, complemented by tourism, technology, and renewable energy (376). In the 1980s, New Zealand underwent significant economic reforms, transitioning from a highly regulated economy to a liberalized, market-oriented system under Prime Minister Roger Douglas of the Labor Party. These changes included subsidy cuts, privatization, and deregulation but caused short-term economic hardship and rising unemployment (377). The 1987 stock market crash heavily impacted New Zealand, exacerbating economic instability, and in the 2000s, the economy diversified, leveraging tourism, education, and technology sectors. However, the global financial crisis of 2008-2009 led to a slowdown, with housing affordability and household debt remaining persistent challenges (377). New Zealand's economy remains resilient, supported by trade, innovation, and sustainable resource management. Originally inhabited by the Māori people, New Zealand became a British colony in 1840 following the signing of the Treaty of Waitangi) between the British Crown and Māori chiefs. The Treaty, regarded as New Zealand's founding document, established a partnership granting Māori sovereignty over their lands and resources while allowing British governance. However, discrepancies between the English and Māori versions led to disputes over land rights and sovereignty (253). New Zealand gained self-governance in 1852 and full independence in 1947, evolving into a parliamentary democracy (173). Its parliamentary system was initially dominated by two major parties, the Liberal Party and the Reform Party, which later merged to form the National Party in 1936. Alongside Labor, founded in 1916, these two have been the dominant parties. In 1996, New Zealand shifted from a First-Past-the-Post electoral system to Mixed Member Proportional Representation (MMP), fostering a multiparty system and coalition-based politics and enabling smaller parties such as the Greens, New Zealand First and ACT to play significant roles in forming governments (378). Coalitions have since become the norm, with agreements often shaping policy directions, reflecting the country’s diverse political

landscape. The failure of successive governments to fully honor the Treaty of Waitangi is frequently cited as a root cause of these disparities, reflecting unresolved tensions over power and resource-sharing arrangements between Māori and the British Crown (253). In recent years, especially in 2024, there have been civil protests to advocate for Māori rights (379). Table 2 presents additional details on political and economic characteristics.

Thailand

Thailand, located in Southeast Asia, has a population of approximately 71 million as of 2023 (171). Classified as an upper-middle-income country, it has a per capita GDP of US$7,182 (169). Thailand's economy transitioned from agriculture-based to industrial and export-driven in the late 20th century. Rapid industrialization in the 1980s and 1990s, supported by foreign investment and export growth, made Thailand one of Southeast Asia’s fastest-growing economies (380). However, the 1997 Asian Financial Crisis exposed vulnerabilities, including high foreign debt and speculative investments, leading to a sharp economic contraction and IMF intervention with fiscal austerity measures (260,381). Post-crisis, Thailand implemented financial and structural reforms, diversifying its economy with strong manufacturing, tourism, and agricultural sectors; however, despite steady growth, challenges such as political instability, income inequality, and dependence on exports have persisted (382). Frequent shifts between democracy and military rule mark Thailand’s political history. Following a bloodless coup, the country transitioned from an absolute monarchy to a constitutional monarchy in 1932 (260). Since then, Thailand has experienced over a dozen coups, with the military maintaining significant political influence. Democratic governance emerged intermittently, with key periods such as 1973–1976, following a student uprising, and 1992–2006, after the "Black May" protests forced the military to step back (383). A milestone in Thailand's democratic evolution was the adoption of the 1997 "People's Constitution," which introduced reforms to enhance transparency, accountability, and public participation which emerged in response to widespread calls for political reform after years of corruption and instability (265). The 2001 elections brought Thaksin Shinawatra and his populist Thai Rak Thai Party to power, ushering in economic growth and rural

development policies but also allegations of corruption and authoritarianism. In 2006, a military coup ousted Thaksin, leading to political instability. The 2014 military coup brought General Prayut Chan-o-cha to power, leading to a military-backed constitution in 2017 and controversial elections in 2019 (173). Thailand remains a constitutional monarchy, with political dynamics shaped by military influence, royalist tradition, and tensions between reformists and conservatives (173). Despite these challenges, Thailand has achieved notable progress in socioeconomic development, positioning itself as a key player in regional trade and integration within the Association of Southeast Asian Nations (382). Table 2 presents additional details on political and economic characteristics.

Tunisia

Tunisia, an LMIC (169) located in North Africa, has a population of approximately 12 million and a GDP per capita of US$3,895 as of 2023 (218). Tunisia's economy has historically relied on agriculture, tourism, and exports like textiles and phosphates (384). Following independence in 1956 from France, state-led development policies dominated until the 1980s, when economic stagnation and high debt led to structural adjustment policies under IMF and World Bank guidance (385). These reforms liberalized trade, privatized state enterprises, and cut subsidies but led to severe cutbacks on social and health sector spending, resulting in inequality. Despite periods of growth, including strong performance in the early 2000s, Tunisia remains heavily dependent on donor support for fiscal stability and development programs (369,372). The 2011 Jasmine Revolution disrupted the economy, exacerbating unemployment and public debt (386). In recent years, economic challenges have been seen, including slow growth, rising inflation, and negotiations for IMF loans to address fiscal deficits and maintain social spending (384). After independence, Tunisia became a secular authoritarian state under President Habib Bourguiba. In 1987, Zine El Abidine Ben Ali seized power through a bloodless coup, continuing authoritarian rule while promoting limited economic reforms (385). Decades of repression and corruption culminated in the Jasmine Revolution, which ousted Ben Ali and sparked the Arab Spring uprisings across the region, and Tunisia transitioned to democracy, adopting a progressive constitution in 2014 and holding free elections, with a multiparty system with a balance of

power between the president and the parliament (293). Nidaa Tounes (a secular party) and Ennahda (an Islamist party) were the two main parties, with over 70 other registered parties (173). However, recent years have seen democratic backsliding, with President Kais Saied consolidating executive authority in 2021, raising concerns about political stability and public trust (173). Table 2 presents additional details on political and economic characteristics.

Uruguay

Uruguay, located in South America, is one of the smallest countries on the continent, with a population of approximately 3.5 million people and a GDP per capita of UD$22,564 as of 2023 (218). Known for its stable economy and progressive policies and classified as a HIC, Uruguay is often considered one of Latin America's most developed nations (169). Historically reliant on agriculture, particularly cattle and wool exports, Uruguay's economy has experienced periods of growth and crises. In the mid-20th century, a welfare state model supported by agricultural revenues began to falter due to declining terms of trade and inefficiency, leading to stagnation by the 1960s (260). The 1980s brought a debt crisis tied to global economic shocks, prompting Structural Adjustment Programs under IMF guidance, which focused on trade liberalization and fiscal austerity (259). The 1999-2002 financial crisis, spurred by regional instability in Argentina and Brazil, severely impacted Uruguay, leading to a sharp recession (260). However, since the mid-2000s, the country has enjoyed sustained growth, driven by agricultural diversification, foreign investment, and robust social policies. Uruguay's economic stability today reflects prudent fiscal management and relatively low dependence on donor aid compared to other nations in the region (387). Following independence from Spanish rule in 1828, Uruguay endured internal conflicts and foreign interventions. The early 20th century saw significant modernization under President José Batlle y Ordóñez, with progressive labor rights, education, and social welfare policies (259). Although the country experienced military rule from 1973 to 1985, it transitioned back to democracy in 1985, becoming one of the most stable and democratic nations in Latin America and a leader in progressive reforms and expansive social protection systems (259). The country had long been dominated by two major political parties, the

Colorado and Blanco (also known as National), until the left-leaning Frente Amplio rose as a political party, came to power in 2005, and won consecutive elections until 2019 (259,260). Uruguay operates as a unitary presidential republic, with Luis Lacalle Pou serving as president since 2020 (173). Table 2 presents additional details on political and economic characteristics.

APPENDIX 2

Disclaimer

The findings, analysis, and conclusions presented in this thesis are solely those of the author and do not reflect the views, policies, or positions of any affiliated and collaborating institutions, including, but not limited to, Harvard University, the Harvard T.H. Chan School of Public Health, and the World Health Organization. Additionally, this thesis does not necessarily represent the perspectives of the Doctoral Committee, research teams, or individuals who participated in the data collection process. Any errors or omissions are the sole responsibility of the author.