The Political Economy of Healthcare in India – Draft

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Introduction

The Indian healthcare sector has made significant progress in the last few decades. The under-5 child mortality rate dropped from 126 in 1990 to 34 in 2019, life expectancy rose from 58 years in 1990 to 69.4 years in 2018, and polio, guinea worm disease, maternal, and neonatal tetanus were successfully eradicated from the country.

Despite the progress, healthcare delivery in India remains largely focused on episodic treatment, with inadequate attention to preventive and primary care. With a predominantly family health and infectious disease focus (although even in these areas, the gaps are stark), the system is not geared to deal with the increasing burden of non-communicable diseases. Lack of access, availability, affordability, and quality care have resulted in suboptimal health outcomes for India, well below many of its peer countries, and a significant financial burden of health expenditure at the individual and household level.

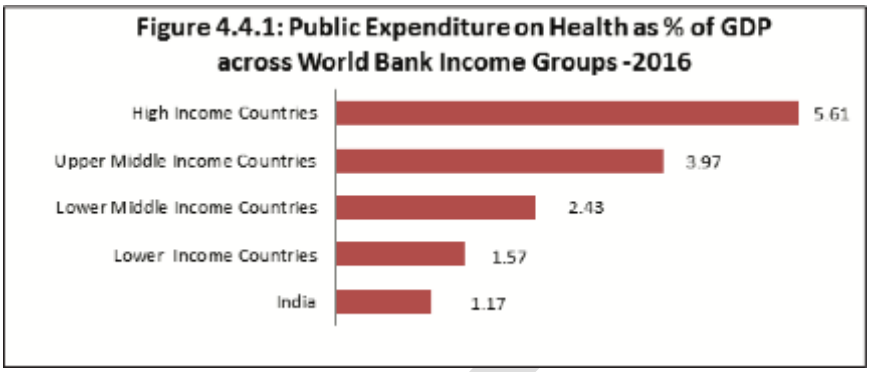
In this paper, we analyse the role of the political economy of health in driving health outcomes and the financial burden of health, and make the case for political attention to healthcare, through increased investments, healthcare reforms and improved capacity to deliver health, both public health and curative. We build on both theoretical frameworks and global and sub national experience, to develop hypotheses for greater political priority to health in India.

The paper is divided into four sections. The first provides a brief summary of the key challenges in the health sector. The second locates these in the political economy of healthcare. The third offers a framework and hypotheses for political priority to health in India. The fourth and final section summarises global and sub national experience, as the rationale for the framework and hypotheses for India.

Challenges in the Indian Healthcare Sector

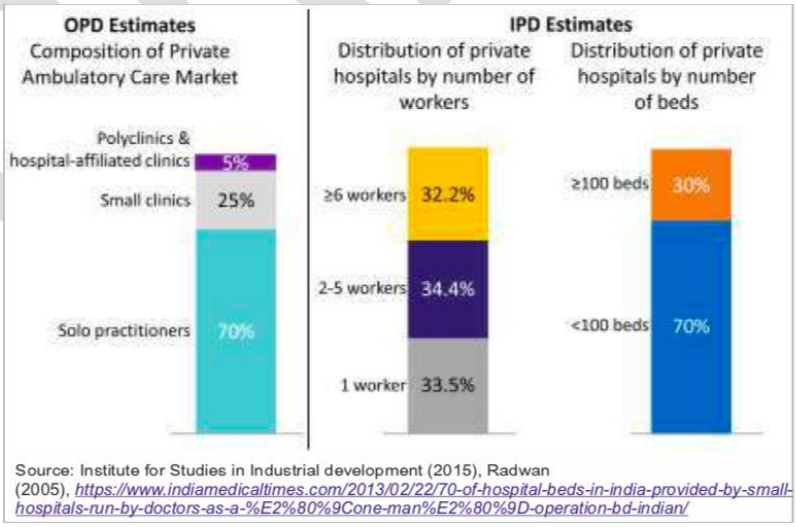
The nature and design of the Indian healthcare system makes it particularly difficult for navigation by patients when faced with an illness. A low quality government-owned health-system, absence of significant formal financial protection, and almost no information on provider quality or performance, leads people to enter a fragmented, under-performing, and fee for service private market with no continuity in patient care (NITI Aayog, 2018; Baeza et. al, 2019).

- Despite persistent demand to increase budgetary allocations to healthcare in India, as well as potential economic benefits from investments in healthcare (Rao et al., 2005; Jamison et al., 2013; Remes et al., 2020), **budgetary allocations to health have remained abysmally low**, lower than several other South and South-East Asian countries.



Source: *Global Health Expenditure Database, World Health Organization accessed from http://apps.who.int/nha/database/select/Indicators/en as on 20.06.2019*

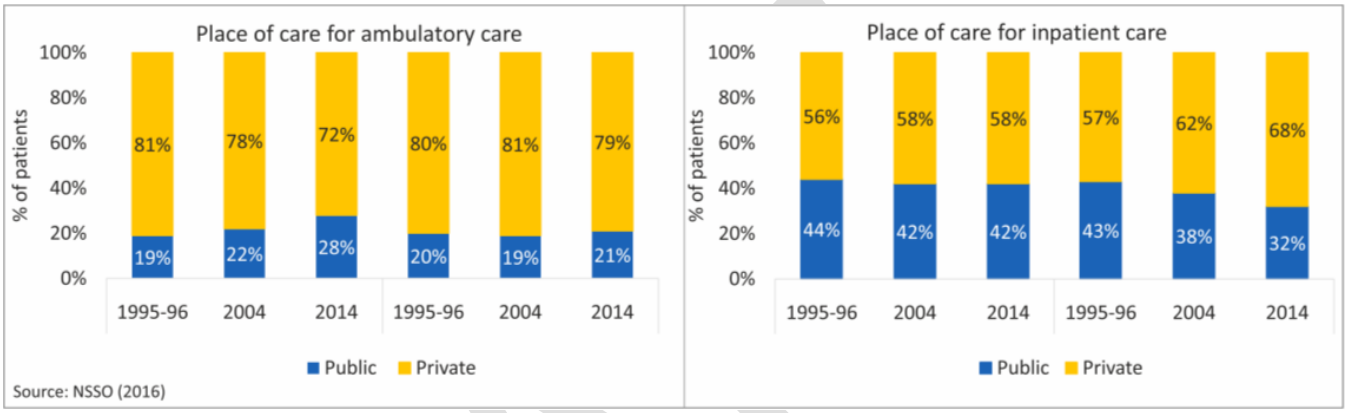
- Healthcare is provided by myriad organisations, institutions, and arrangements in India without any coordination and often with contradictory incentives. The public sector is vertically fragmented across primary, secondary and tertiary care, and across disease categories, with no integration. The private sector is fragmented with solo practitioners and independent clinics comprising 95% of the private ambulatory market.isThe mixed and heterogeneous nature of healthcare provision has resulted in an extremely **fragmented, disorganised, and disaggregated ecosystem**, resulting in gaps in access, quality, and affordability, where patients are left to fend for themselves and seek treatment from multiple service providers without any continuity in service provision (Baeza et. al, 2019).



Source: NITI Aayog (2018). Health systems for a new India: building blocks, New Delhi

- The Indian healthcare system also witnesses horizontal fragmentation with low levels of coordination between the public and the private sectors. With almost 70% of inpatient care and 80% of ambulatory services being provided by the private sector, the Government has had minimal experience leveraging the private sector effectively, with significant regulator and accountability challenges (Baeza et. al, 2019).

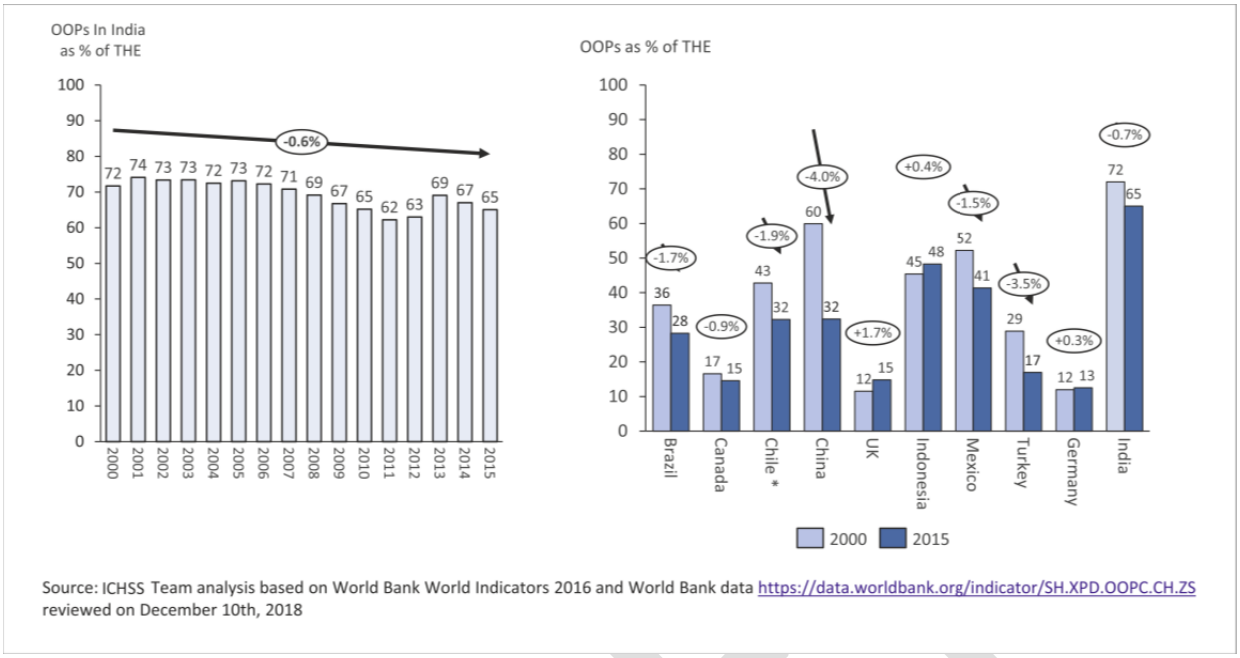
Trend in Utilization of Public and Private Healthcare Facilities



Source: NITI Aayog (2018). Health systems for a new India: building blocks, New Delhi

- Reports suggest **varying quality of care**, as well as gaps in service delivery in both public and private healthcare provision, leading to avoidable mortality and morbidity (NITI Aayog, 2018).

- Like service provision, **health financing in India is fragmented** in terms of both revenue sources and risk pooling. **64% of healthcare expenditure in India comes from out-of-pocket expenditure**, higher than the average in lower middle-income countries (57%), low-income countries (44%), the other BRICS (Brazil – 28%, Russia – 36%, China – 32%, South Africa – 8%), and OECD countries (14%), with the government in India spending 1.1% of the GDP on healthcare (NITI Aayog, 2018; PRS, 2020); divided between the Centre and the States. The government manages several important healthcare pools which are neither efficient nor effective, yet have seen little priority accorded to improving their design and functioning. It is estimated that approximately 4% of the population falls below the poverty line because of healthcare related expenditures (Hooda, 2017), and those already below the poverty line are pushed deeper into poverty. Research across India, Africa and Latin America (Krishna, 2010) found health related expenses to be the prime reason for households descending into poverty (even when income had been secure to begin with) and that millions of households live 'one illness away' from poverty.



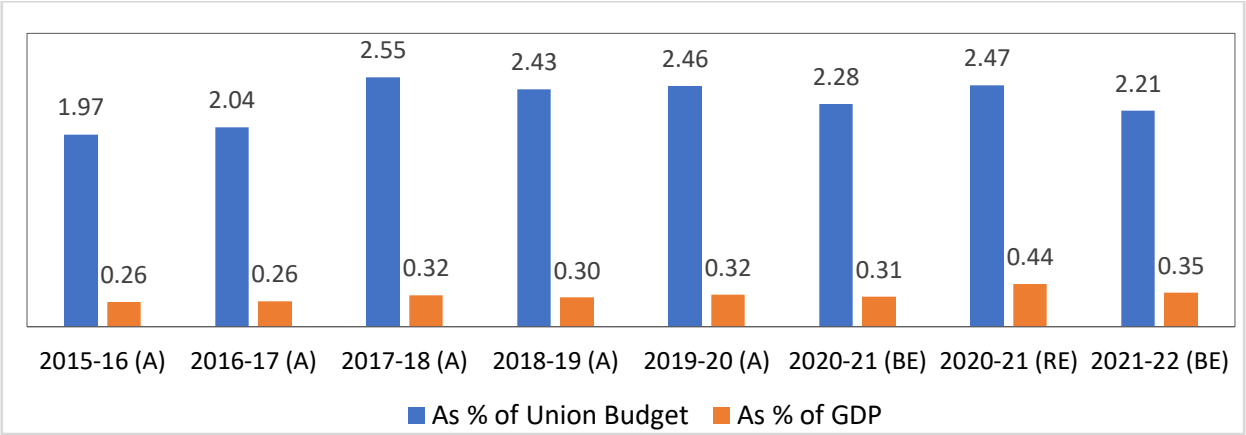
Source: NITI Aayog (2018). Health systems for a new India: building blocks, New Delhi

The political economy of healthcare

The shortcomings of low public investment in health, a fragmented provider landscape across public and private providers as well as across levels of care, an equally fragmented health financing landscape and inefficiencies with risk pools, and challenges with quality care and accountability, have all combined to create challenges in access, quality, expenditure and contributed to poor health outcomes, impeding India's move towards Universal Health Coverage (UHC).

These shortcomings don't necessarily exist because the precise constraints and technical solutions are not known. The Indian health eco-system has been analysed for long, and solutions, although not exhaustive, have also been presented (see NITI Aayog 2018, Planning Commission 2011). The shortcomings exist because despite the knowledge around solutions, policy reform has been minimal, and not well executed. The challenge of reform and its effective implementation (where reform has indeed taken place) has its roots in the lack of political priority to healthcare. Health has rarely made it to being a key policy agenda, possibly because of the contestation in the policy and priority making process across competing priorities in the country. Budget 2021 underlines this, where despite the pandemic through 2020, the budget failed to see any significant priority to health, in allocations (see charts 6 and 7), or system reform. Health spending has not seen any significant increase over several years, either by the Union Government (as a percentage of GDP or as percentage of its total budget), or centre and state governments combined. Continued low investments in health; lack of investments on primary care; absence of reforms that can address fragmentation (in provision and financing), quality and accountability; all combine to suggest that political attention to health has continued to be weak. Health promotion in the country now needs focus on the political barriers to healthcare priority.

Chart 6: Union Government's Budgetary Spending on Health



Source: CBGA, 2021[1]

Chart 7: Total public spend on health as percentage of GDP

Year	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18(BE)
Public Expenditure on Health as Percentage of GDP (%)	1.12	1.07	1.1	1.09	1	0.98	1.02	1.17	1.28

*# Public expenditure on Health from "Health Sector Financing by Centre and States/UTs in India 2015-16 to 2017-18", National Health Accounts Cell, Ministry of Health & Family Welfare. $ "Report of the Technical Group on Population Projections May 2006", National Commission on Population, Registrar General of India; * GDP from Central Statistics Office.*

[1] "Union Government's Budgetary Spending on Health", refers to the aggregate expenditure / allocation from the Union Budget on the Ministry of Health and Family Welfare and the Ministry of AYUSH.

(3) The ratio – *Union Government's Budgetary Spending on Health as % of the GDP* – for 2020-21 (BE) is calculated using the old (pre-COVID) estimate of the GDP for the FY 2020-21, whereas this ratio for 2020-21 (RE) has been calculated using the new (post-COVID) estimate of GDP for the same FY.

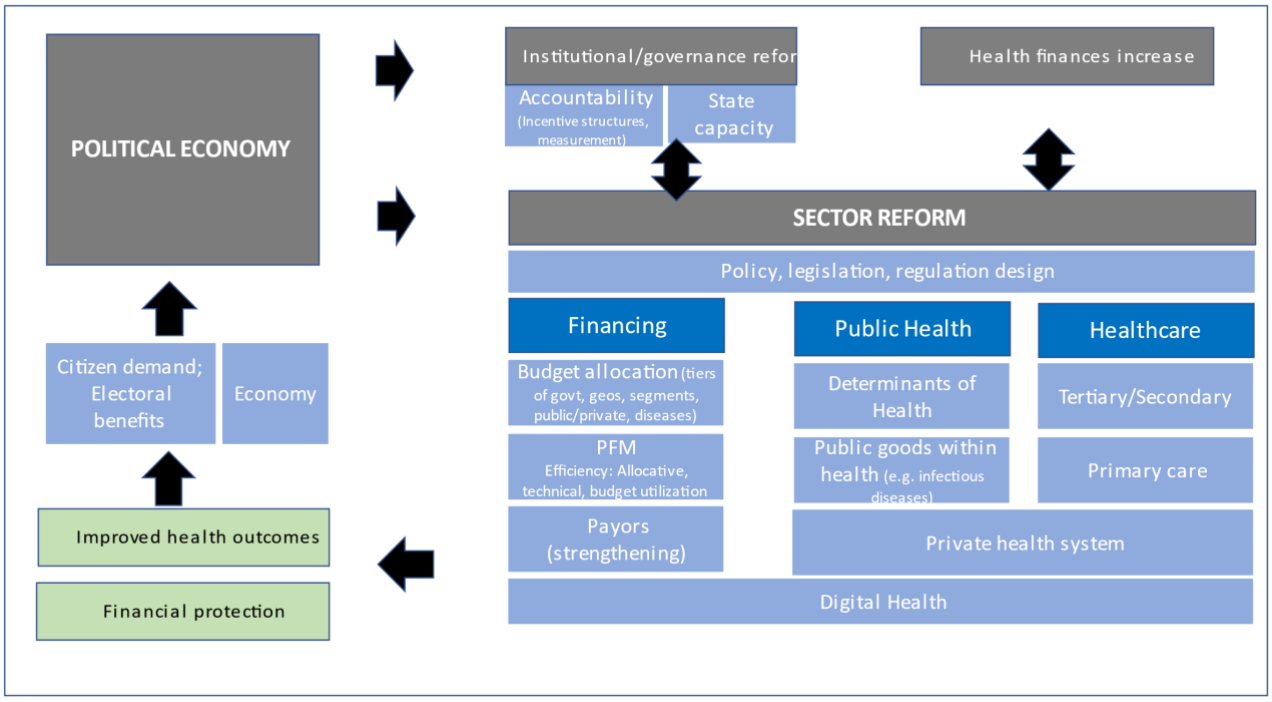
The central role of politics to policy change has been established by many scholars (see Reich, 1995; Walt, 1994 and Bambra et al, 2005). Political and economic factors have been shown to influence who accesses healthcare, quality of healthcare delivery, and health outcomes and its prioritisation within policy processes.

There is significant literature (Gilson et al, 2018, Kingdon 2011, Berger and Luckmann, 1966, Buse et al. 2012, Cobb and Elder, 1972, Edelman, 1988, Shiffman and Smith, 2007, Shiffman, 2009, Campos and Reich, 2018, Sparks et al, 2019) pointing to the multiple factors that drive political commitment to healthcare. Demand from citizens and electoral incentives; concerns about poverty and inequity; macro-economic drivers such as healthcare contribution to human development and growth; and global pressures are some, as evident from the frameworks developed by scholars cited above. Laying out the technical solutions to healthcare challenges is not sufficient to address gaps; the drivers of priority setting and decision making, and the interaction of different actors, political and others, are as critical. Apart from political leaders and national and sub national government, several other institutions such as multilateral organisations, donor governments and philanthropies, citizens and industry bodies influence the process of what decisions are made, by whom and through what process. Health policy thus, can be seen as a complex political process (rather than just technical), driven as much if not more, by 'interests' than by evidence (Reich, 1995).

Political leaders in other countries have been influenced by a combination of drivers, leading to healthcare becoming a political issue and healthcare reforms being a political priority; resulting in increased resources, more efficient and effective use of existing resources, improved design of and outcomes from healthcare systems, increased responsiveness to citizens needs and user satisfaction, and reduced financial risk. Experience from Turkey (Yilmaz, 2017), Thailand (Towse, 2004), Mexico (Ewig, 2016; González-Rossetti & Bossert, 2000; Rossetti & Mogollon, 2000), Iran and China (Mor, 2019) and other global literature (Tuohy and Glied, 2012) points to the critical role played by political commitment in the health systems reform process. India remains an outlier to such processes (admittedly with cross state variations), where despite continuing poor health outcomes and household level financial burden, impairing social and economic progress at individual and national levels, this area has not witnessed adequate political attention.

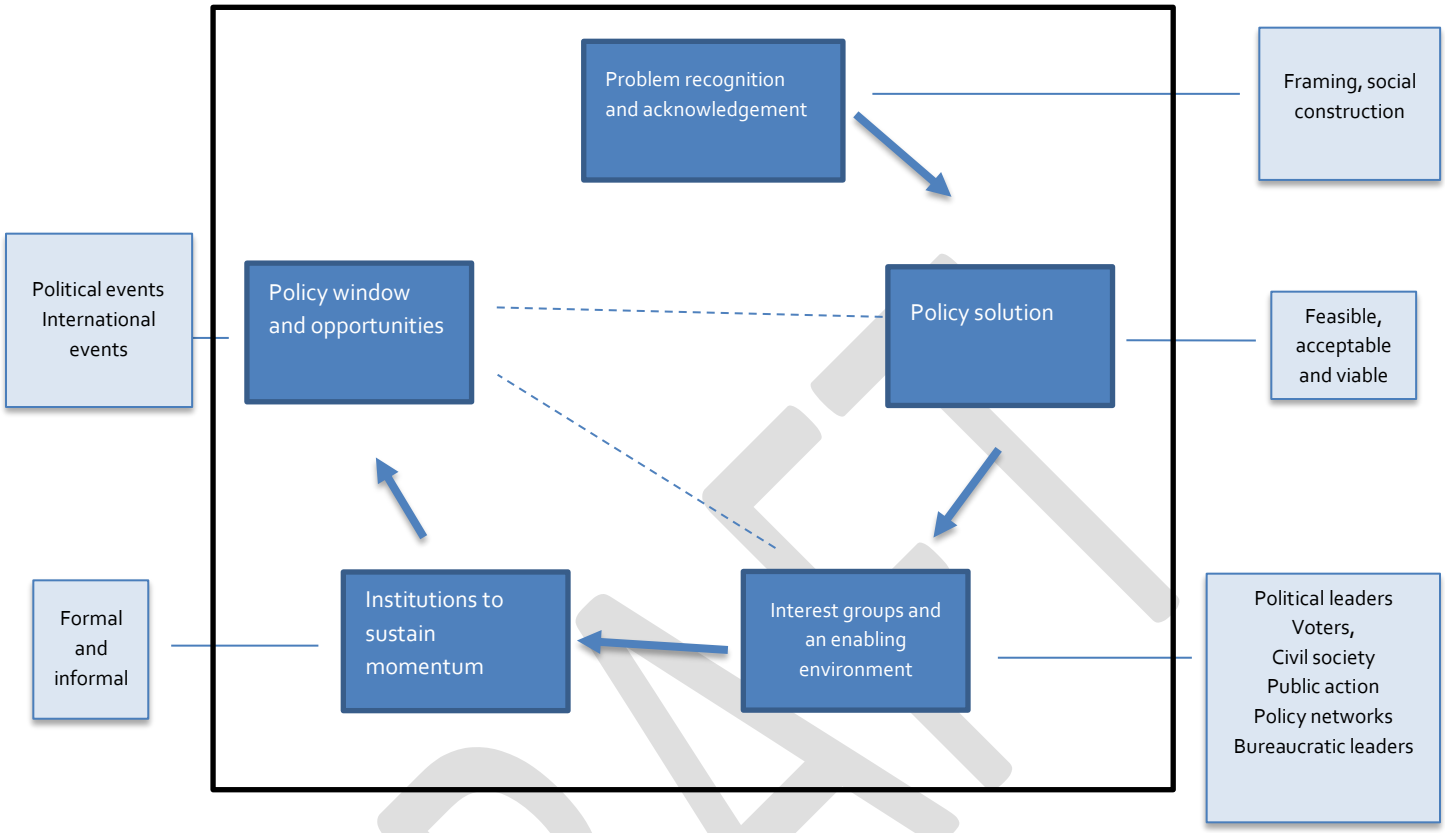
We therefore view political commitment as central to health policy, strengthening health systems, improving health outcomes and financial risk protection, through its ability to drive 1) **resource allocation**, 2) **capacity and accountability in public systems**, 3) **reforms that can in turn strengthen preventive, promotive and curative health** and 4) **improved budget utilisation** through allocative and technical efficiencies. Political committment is fundamental to each of these pillars, which in turn impact and enable other shifts, such as the combination of relevant reforms and increased public resources contributing to financial risk protection for individuals (Chart 8).

Chart 8: Political economy and health



Framework and Hypotheses for Health Priority in India

Based on existing theoretical frameworks (Kingdon 2011, Berger and Luckmann, 1966, Buse et al. 2012, Cobb and Elder, 1972, Edelman, 1988, Shiffman and Smith, 2007, Shiffman, 2009, Campos and Reich, 2018, Sparks et al, 2019) for analysing the political economy of health and the specific context of India, we identify five related elements through which political economy of health can better drive attention to health systems in India. These include 1) recognition and acknowledgement of a problem by political leaders; 2) the presence of feasible and viable policy solutions; 3) interest groups that promote policy change; 4) institutions that sustain momentum around policy change; 5) a political opportunity for introducing the policy. While these would typically be sequential, given that actual policy processes are not an exact science, the starting point and trajectories for political attention could vary significantly by political context.



The landscape of national (or sub national) problems is a contested one and issues compete with each other for public and political attention. In such a context, making healthcare a policy priority in India requires, as a first step, that it be recognised as a problem that impacts key stakeholders, and is therefore acknowledged as a key agenda. Kingdon (2011) and Shiffman (2009) point to the need for going beyond identifying a problem in its objective form, to categorising and promoting it as a problem that is worthy of attention by key stakeholders through a social construction that drives attention and prioritisation. It has to be viewed as an issue which leaders have a stake in. But the mere recognition of an issue as a problem worthy of attention is not enough; action requires a solution, and it is here that Kingdon and others underlines the need for a financially viable, politically and publicly acceptable and technically feasible solution.

Despite the acknowledgement of a problem and its solution by some key leaders, there are likely to be a variety of stakeholders with different interests who exert different kinds of power and influence in promoting or obstructing solutions for the problem. The interplay of these invariably has a strong bearing on the issues that get political priority, and therefore mobilising and engaging with different groups, in the context of construct incentives or disincentives, is key to moving an agenda forward. These processes can take time, during which attention to, and momentum around, the issue needs to be sustained. Global experience has underlined the role of institutions

in sustaining such momentum. Finally, the convergence of these factors and forces lead to converting an issue to a policy through a specific political moment or opportunity.

It is in this frame that understanding the political economy of healthcare and the process of its political prioritisation in India becomes meaningful, not only to lead India towards UHC but to lead the world towards the SDGs. India's federal structure, with varied political economy contexts across states, underlines this, with some states such as Tamil Nadu according greater political attention to healthcare and developing stronger health systems, while others according much lower priority, resulting in poorer health outcomes.

Currently, the challenges of healthcare in India are known. The lack of political attention suggests that the political or economic incentives to addressing healthcare are not clear to leaders. Electoral demands often influence political priority, but India has not seen health as a citizen priority during elections. Post poll surveys of the 2019 and 2014 national elections in India revealed health as a key voting issue for a mere 0.3% and 0.4% of the sample respectively.

Based on the above framing, we suggest the following hypotheses for increasing the political attention to and salience for healthcare in India.

Hypotheses:

- Political attention to health will increase with a positioning of healthcare that makes its political and economic incentives clear
  - Improved healthcare builds human capital, which can contribute to increased growth;
  - Improved health systems can reduce out of pocket expenses on health, thereby reducing levels of poverty and inequality.
  - In a federal structure, space (fiscal and political) and ownership can be available to state leadership to own policy reform, demonstrate leadership and take political 'credit'.
- Political priority for health in India will increase with increased demand from citizens, making health electorally salient;
  - Citizen demand for healthcare can be enhanced by mobilising citizens and creating greater awareness around an increased understanding of the role of the state in delivering healthcare, the role of health in citizens' aspirational journey and the potential for reduction in out of pocket health expenditures, thereby impacting household economic status.
- Demonstrated solution pathways at different governance and administrative levels (sub national and sub state) will garner political interest from relevant leaders, both bureaucratic and political;
  - Identification of clear pathways to health system reform and strengthening, through a combination of public and private provision, with the state as steward and regulator, can offer a coherent response to current constraints.
  - Demonstrated solutions can strengthen citizen confidence and trust in public delivery of health, leading to electoral expectations and incentives.
- Focused institutions (formal or informal) can promote and sustain attention to health system issues.

Global and national experience on political prioritisation of health

The above frame and hypotheses for increasing political priority to health in India has been informed by global and national experience.

Safe motherhood emerged as a political priority in India when "An unpredictable confluence of events concerning **problem definition, policy alternative generation and politics**" took place, as pointed out by Shiffman and Ved (2007). The authors argue that despite one quarter of all maternal deaths occurring in India, the issue was not a political priority in the country until 2005. It was three transformations that led to the emergence of maternal mortality reduction on the national political agenda in a meaningful manner for the first time in 2005.

The first of these transformations was a shift from condition to an acknowledged problem. The severity of the problem had been highlighted as a result of credible data through NFHS surveys. Additionally, several focussing events including a movement promoting safe motherhood by the White Ribbon Alliance of India, hosting of the World Health Day with maternal and child health as the central theme, and negative feedback on the performance of two national programmes initiated in the 1990s helped lift the issue of safe motherhood to problem status. The then Prime Minister's participation at the UN summit in September 2005, where countries' status on health indicators was discussed drew further attention, with the PM expressing concern over 'India's atrociously high maternal mortality rate' (Shiffman & Ved, 2007), upon his return.

The second transformation happened in the form of a consensus building process that resulted in an agreement on the intervention strategy between donors and government officials on safe motherhood, based on extensive dialogue.

Political developments took the form of the third set of transformation, playing a critical role in positioning this as a political priority. The Indian National Congress led alliance came to power in 2004 with a social-equity-oriented National Common Minimum Programme and a promise to increase focus and spending on health, with a priority to primary health care. The government made good on this promise by announcing the NHRM (explicitly listing maternal mortality reduction as a core priority) and the Finance Minister in the 2005-06 budget announced an increase in the allocation for the Departments of Health and Departments of Family Welfare. The global enactment of MDGs, listing maternal mortality reduction as one of its objectives, further contributed to the political push.

Thus, convergence of a clear problem statement, a policy pathway and an enabling political environment, led to the emergence of safe motherhood as a political priority in India, manifesting in the form of the launch of NHRM with an explicit focus on maternal mortality as well as increased budgetary allocations to the departments of Health and Family Welfare in the 2005-06 budget.

Global attention to HIV/AIDS is another example, in large part driven by the **manner in which the problem was constructed** by policy communities to attract attention, and sustained through the

presence of institutions (Shiffman, 2009). Shiffman has argued that the emergence and persistence of political attention was the highest in the case of HIV/AIDS and polio, and minimal in the cases of malnutrition and pneumonia where policy communities have been less successful in creating effective institutions.

The manner in which **actors, ideas and the political context** play a key role, has been highlighted by Shiffman and Smith (2007) in the context of safe motherhood as global priority. Despite two decades of interventions, they argue, safe motherhood received little traction even until 2007. The policy community remained divided over intervention strategies for long (antenatal screening and training traditional birth assistants versus access to emergency obstetric care), diluting credibility with political leaders. Further, "Weak guiding institutions hindered the acquisition of political support" where an inter-agency group included technical officials rather than senior leaders with political clout. Consequently, it was not able to be a strong advocacy voice. The inability to identify clear leadership for the issue from within the UN agencies further constrained the presence of a strong cohesive voice across child survival, newborn and maternal health. Weak mobilisation of grassroots organisations did not facilitate a link between the global policy community and local stakeholders and their realities. While the importance of maternal mortality was recognised by leaders, the framing of the issue did not succeed in its support and prioritisation by political leaders, partly because of the lack of clarity in focus (such as maternal health versus maternal mortality) and its inability to mobilise women's groups.

Shiffman and Smith point out specific characteristic of the issue that prevented it from gaining attention. Twenty years into the movement, deaths from maternal mortality (globally) were not as significant as from other causes such as HIV/AIDS, malaria or child mortality; clear measurement of maternal mortality remained a challenge; and the solutions were not clear and/or simple (such as for example those that can be addressed through a vaccine, as opposed to those that need strengthening the entire health system).

Interest groups and stakeholder politics plays a critical role in political prioritisation, as evident from the experience of Turkey (Sparks et al, 2019) in the context of health financing reforms. Turkey undertook reform aimed at expanding health coverage and improving health outcomes through increasing public investments in health, reducing fragmentation of health financing pools, and adopting strategic purchasing.

In Turkey, an early political economy analysis conducted by the Ministry of Health revealed supportive stakeholders in the form of the Prime Minister, the ruling party (the new government came into power with a health system reform platform to promote equitable access to health services), and external global institutions such as World Bank and WHO (interested in providing financial and technical expertise). This supportive leadership was leveraged by the reform proponents to address the politics of bureaucratic groups, other interest groups, and beneficiary groups. Participation from other ministries in the reform process (Finance and Labour for example) helped gain broader acceptance to deal with bureaucratic politics. The political leadership of the newly elected party ensured that their key electoral base of rural and low income households stood

to gain from these reforms. Interest group politics took the form of provider concerns on compensation and employment conditions, addressed through a combination of performance incentives and a higher allocation to the health budget.

Mexico is another case where stakeholder politics came into play, where health financing reforms were introduced in the early 2000 to expand financial protection and access to health services for the non-salaried population. The reforms took the form of a public insurance programme, *Seguro Popular,* targeted at 45 million people in the informal sector without access to social security. It aimed to provide subsidized insurance for an explicit set of healthcare interventions and coverage for a limited set of high-cost illnesses. The major source of funding for the programme came from federal taxes (with complimentary contributions from the states) along with individual premiums based on a progressive scale with exemptions for the poor. Sparks et. al. (2019) study the interplay between six stakeholder categories to analyse the reform pathway in the country.

Access to comprehensive health services and financial protection in Mexico was limited to the formal workforce and their families, provided by the Mexican Social Security Institute (IMSS) and the Institute for Social Security and Services for Civil Servants (ISSSTE) for private and public sector workers respectively. The rest of the population received health services from the Ministry of Health under public assistance or purchased it in the private market (Dantés et. al., 2015). Upon coming into office in 2000, the Minister of Health intended intended to establish a unified health insurance scheme to bring the formal employed sector and the rest of the population in a single pool. This proposal met with strong opposition by the IMSS, providing health services to 40% of Mexicans, who were concerned that the new programme will grow at the expense of IMSS (Dantés, 2016). Consequently, the idea was dropped and a new plan proposed, focussing only on the population not covered by social security in Mexico.

The plan, requiring an increase in government health expenditure by one percent of the gross domestic product, initially opposed by the Ministry of Finance, was finally approved through engaging the Ministry of Finance in the financial sustainability of the proposed intervention (Dantés et. al., 2015) and leveraging Presidential, legislators' and governors' support for the plan. Opposition to reform from various states was addressed through a promise to increase federal resources to states for the health sector as well as flexibility to states to decide how the resources would be used. Articles on the program published in high impact international journals helped leverage support from international organisations.

India has seen limited attention to the study of the intersection of politics and social policy formulation. The reasons for this may be complex, including its federal nature (with a multi-level governance system), where several social policies being state subjects are driven by multiple different factors across the country (Tillin et al, 2015). Electoral platforms do not seem to be the battlefield for competing policy options; perhaps because voters make only transactional demands on elected representatives or because politicians offer immediate and targeted incentives in a clientelist mode.

Deshpande, Kailash and Tillin identify three critical factors that influence social policy at sub national levels: 1) policy legacies; 2) breadth of social and political coalitions; and 3) political leadership. Experience across Indian states demonstrate how these combine with other aspects of regional political economies to promote specific social policies.

The adoption of health insurance in both Tamil Nadu and Kerala (Kailash and Rasaratnam, 2015) point to the role of state level politics, where both were in large part driven by the state political culture, policy legacies and the potential electoral dividend of insurance. As Kailash and Rasaratnam point out, social welfare has been a key component of the political culture in both states, with political competition converging on high welfare spending and a commitment to welfare provision. The authors also point to public participation through campaigns to be high in both states. Despite the similarities, the precise reasons for prioritisation of insurance in the two states were quite different. In Tamil Nadu, insurance was part of a welfare focus to provide affordable healthcare, with no ideological commitment from the state for public provision. The state responded to the growing demand for private healthcare. In Kerala on the other hand, budgetary constraints and an inability to maintain the public delivery system prompted the change. In both states, the authors note, the policy reform was a response to electoral competition and the growing utilisation of private services by the electorate. It could be argued that the reform emerged at the intersection of policy legacies, social coalitions and strong political leadership. Importantly however, both states moved away from insurance being a demand financing mechanism to introduce modifications aimed at promoting the utilisation of public providers. In both cases, the policy makers prioritised the promotion of public health provision, underlining the interplay between state level politics and electoral motivations as a key driver for health reforms.

In India, the differential experience with PDS reforms in Madhya Pradesh and Chhattigarh, as analysed by Tillin, Saxena and Sisodia (2015), point to the role of political leadership, inter-agency coordination, state-civil society relationship and electoral drivers.

Chhattisgarh, where growth was driven by extractive industries benefitting a narrow elite, the need to provide social benefits to the larger rural population became an electoral imperative, addressed through an almost universal subsidised food entitlement (expansion of the PDS was made possible by revenues from extractive industry led growth). Tillin et al identify three main reasons for PDS being prioritised as a policy agenda including the Supreme Court orders at the national level on the Right to Food, a strong role played by civil society activists and electoral imperatives. An electoral defeat in a by-election, linked with citizens' dissatisfaction with the PDS prompted the chief minister to focus on the PDS and adopt this as an electoral strategy to reach the poorest voters, with a clear and unambiguous message of zero tolerance for political interference. This enabled a strong connect between citizens and the chief minister, removing the need for clientelist relations developed by local politicians, which serve a select few. Chhattisgarh government worked closely with civil society, who helped shape and sustain the reforms.

In contrast, Madhya Pradesh did not see clear or strong political leadership and commitment to PDS reform, in a context where agriculture (higher procurement of wheat) was a higher priority

for the chief minister than PDS and his electoral focus was directed at farmers and other constituencies such as girls and disadvantaged communities. Consequently, the reform interventions which were led by bureaucratic leaders were not well aligned with political incentives. The state government did not partner with civil society actors, and inter agency coordination within the state remained week, possibly due to the absence of clear political guidance from the top. This undermined the reform actions attempted, through local political pressures that sought to retain their patronage, leading to continuation of clientelist relations. The removal of fake entitlement cards, while in itself a worthwhile objective, led to political interference because of disincentives to some.

While India has certainly witnessed some key social policy successes, arguably, political attention is often directed at short term clientelist strategies for electoral gains. Oliver Health and Louise Tillin (2017) have quoted Philip Keefer and Razvan Vlaicu to explain the role of state capacity in this context. Social policy successes are integrally dependent on the capacity of the system to deliver, and where state capacity is weak, relying on social policy delivery is fraught with the risk of unfulfilled commitments. Focusing on short term clientelist approaches, in such a case, may seem a more pragmatic approach electorally but such reliance "in turn, undermines the capacity of the bureaucracy to deliver public goods in an impartial, accountable fashion, creating a vicious cycle", observe Heath and Tillin. The motivation to prioritise social policy is therefore strongly linked with the strength of delivery institutions, and where such institutions deliver effective services, the relationship between citizens and politicians is less driven by clientelist approaches. As the authors note, **"when institutions function well, even in a limited way, voters can see a better link between policy promises and policy implementation and will be less likely to sacrifice their preferred policy outcome for a short-term pay-off. Poor institutional performance, therefore, makes the prospect of direct personal transfers today more attractive than the promise of redistributive public policy tomorrow".**

Table 1: Factors Influencing Political Priority

					Health Program, Turkey	Health financing reform, Iran	Safe motherhood, India	Maternal health, Ghana		Safe Motherhood, Global		Health Insurance, Tamil Nadu		PDS, Chhattisgarh
Problem recognition and acknowledgment		Critical indicators	Quantifiable indicators bringing to light the severity of the issues				X							
		Framing / Social Construction	Packaging information to highlight the need for the issue to be on the policy agenda				X	x						
		Priming	Focus on what information is presented to draw attention to an issue											
		Focusing events	Sudden events drawing attention to an issue				x							
Interest groups	External	External actors/ donors	Donors and international organisations		x		x							
		Voters	Policy priorities of voters, electoral gains									x		X
		Civil society	Grass root organisations working on the issue				X							X
		Public action	Public campaigns on a policy issue									x		
	Mixed	Policy network	Formal institutional group collectives											
		Interest groups	Groups like unions/ medical associations impacted by policy reform											
		Leadership	Individuals who can unite the policy community, push agenda		x	x						x		
	Inte	Bureaucracy	Agencies within the government											
		Policy community	Network of individuals and organisations involved with issue											

r n a l														
Institutional support to sustain momentum	**Domestic**	National and state level institutions enabling policy reform												x
	Global Institutions	International organisations advocating for an issue		x										
Policy windows and opportunities	**Political events**	Political happening at the domestic level giving rise to a space on the policy agenda					x		x			x		
	Political will	Determination of political actors to bring about a policy change			x		X					x		
	International politics	International political events influencing agenda												

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