The Political Economy of Universal Healthcare:

A Global Comparative Perspective



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To Annamarie, of course

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Abstract

While universal healthcare stands at the centre of the global development agenda, its political and distributive foundations remain poorly understood. This thesis examines the political economy of healthcare through the lens of universalism in social policy: the principle that states should provide comprehensive and equitable access to high-quality services for all. Using a global comparative analysis, the thesis sheds light on three aspects of healthcare universalism: its measurement, social consequences, and political determinants.

The first paper introduces the Healthcare Universalism Index (HUI), a composite indicator capturing 'varieties of universalism' across 204 countries from 1995 to 2023. The analysis reveals moderate global convergence and persistent regional disparities in the HUI, alongside robust evidence that universalism is linked to higher redistribution outcomes – both cross-nationally in the Global North and dynamically in the Global South.

The second paper conceptualises universal social policies as relational 'spaces of equality' that contribute to generalised trust by fostering equitable welfare experiences and social connectedness. Multilevel models across 105 countries demonstrate significant associations between healthcare universalism and trust, with important heterogeneity: public spending plays a stronger role in the Global South, while privatisation erodes trust in the Global North. These effects are strongest among those most likely to opt out of public systems, supporting the idea that universalism fosters cross-class bonds.

The third paper investigates why governments in the Global South adopt universal versus segmented healthcare expansions, drawing on an original reform dataset across 90 countries between 1990 and 2023. Event history analysis finds that left-wing governments and electoral volatility are predictors of universal reforms, while right-wing governments, healthcare privatisation, and labour union strength increase the likelihood of segmented expansion.

In combining theoretical and empirical innovations with a global comparative lens, the thesis repositions healthcare universalism as a multidimensional, relational, and political foundation for understanding inclusive development trajectories.

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Introduction

Universalism – the principle that states should provide comprehensive and equitable access to high-quality social services for the entire population – has become a leading concept in global development and social policy. In his seminal typology, Esping-Andersen (1990) considers universalism as the defining feature of the social-democratic welfare state, distinguishing it from the residual and corporatist models of liberal and conservative welfare regimes. He characterises universalism as the equality of services and benefits "of the highest standard" which crowds "out the market, and consequently constructs an essentially universal solidarity in favour of the welfare state" (Esping-Andersen 1990, 27–28). In this perspective, universalism is not solely a tool of social protection, but instead a foundational component of inclusion, decommodification, and, ultimately, social citizenship (Marshall 1950; Korpi and Palme 1998; Rothstein 1998).

Originally associated with the Nordic welfare states, the principle of universalism has been increasingly expanded to the Global South – particularly through the work of international organisations. This 'new global consensus' on universalism (Leisering 2020) is expressed in the United Nations 'Leaving No One Behind' promise of the 2030 Agenda for Sustainable Development, as well as in a growing number of policy initiatives around the world. Examples include the World Health Organization's (WHO) work on *Universal Health Coverage* (WHO 2010) and *Health for All* (WHO Council on the Economics of Health for All 2023), the International Labor Organization's (ILO) proposal for *Social Security for All* (ILO 2012), and the *Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals* (USP 2030) co-chaired by the World Bank and ILO (USP 2030 2019). Most recently, the United Nations celebrated its 75th anniversary by passing the *Common Agenda,* which calls for a 'renewed social contract anchored in human rights' and a 'new era for universal social protection, including health care and basic income security' (United Nations 2021).

Despite this growing academic and policy interest, few systematic studies measure and analyse universalism comparatively across the world. Contributing to an emerging body of scholarship on the concept, consequences, and determinants of universal social policies in the Global South, this thesis examines the political economy of universalism from a global comparative perspective. It focuses on healthcare as the primary case study of universal welfare provision around the world, both because it is among the largest and most politically salient social policies, and because it stands at the centre of the global development agenda.

More than most other areas of social policy, healthcare is widely seen as a core responsibility of the state and a visible expression of solidarity. As such, I argue that it affects not only individual wellbeing, but also shapes broader societal dynamics of inequality, social trust, and redistributive politics. Conceptually contrasting universalism with segmentation – defined as the institutionalised stratification of access and quality across social groups – this thesis focuses not only on what is redistributed, but on how services are structured, who is included, and whether provision reinforces or reduces social divides. Universalism is understood not as a normative ideal or historical institution, but as a multidimensional policy output that can be analysed and compared across the world.

Structured in three separate but connected papers, the thesis provides a comprehensive analysis of the concept, consequences, and determinants of universalism in healthcare by (1) introducing a new global index of healthcare universalism, (2) proposing and testing a relational theory of universal social policies as 'spaces of equality', and (3) investigating the political economy of healthcare expansion in the Global South. In combining new theoretical perspectives, original data, and a global empirical lens, the thesis contributes to a new research agenda that places healthcare and the Global South at the centre of comparative social policy scholarship.

The remainder of this introduction proceeds as follows: Section 1.1 summarises the research contribution of the thesis, while Section 1.2 motivates the focus on healthcare as a case study of programme universalism. Section 1.3 discusses universalism as a global social policy concept and the use of the terms Global South and Global North. Finally, Section 1.4 provides an overview of the thesis structure, research questions, and empirical strategy.

1. Research contribution: The political economy of universal healthcare

This thesis contributes to the literature on the comparative political economy of welfare and the global politics of social policy (Esping-Andersen 1990; Pierson 1996; Korpi and Palme 1998; Rothstein 1998; van Oorschot 2000; Huber and Stephens 2001; Mares 2003; Béland and Gran 2008; Obinger et al. 2010; Gingrich 2011; Niño-Zarazúa et al. 2012; Montanari and Nelson 2013; Schmitt et al. 2015; Kaasch 2015; Obinger, Schmitt, and Traub 2016; Jacques and Noël 2018; Rueda and Stegmueller 2019; Leisering 2021; Garritzmann, Häusermann, and Palier 2022; Nelson et al. 2023). In particular, it advances a growing body of scholarship on the concept, consequences, and determinants of universal social policies in the Global

South (Mkandawire 2005; Filgueira 2005; Rudra 2007; Sandbrook et al. 2007; Huber and Stephens 2012; Fischer 2012; Seekings 2012; Pribble 2013; Barrientos 2013; Kabeer 2014; Martínez Franzoni and Sánchez-Ancochea 2016; Ferrarini, Nelson, and Palme 2016; Birnbaum et al. 2017; Jahan 2019; Leisering 2020; Agartan 2025). While each paper presents its distinct theoretical and empirical innovations, this section highlights the cross-cutting research contribution of the overall thesis.

First, the thesis advances a multidimensional, output-oriented conceptualisation of universalism. This addresses a key limitation in much of the existing literature on universalism, which often treats it as either a normative aspiration or an institutional artefact that is bound to a specific historical and geographical context. Instead, the thesis operationalises and extends the framework of Martínez Franzoni and Sánchez-Ancochea (2016), which focuses on the dimensions of Coverage, Generosity, and Equity as universally applicable policy outputs. This approach widens the perspective to encompass global 'varieties of universalism', adopts an institution-agnostic output orientation, and enables systematic cross-national and longitudinal comparison. In emphasising the distributional, social, and political consequences of healthcare system segmentation, I further advance the literature by placing equity at the centre of my theoretical contributions.

Second, the thesis suggests a new theoretical perspective that reconsiders universalism as a relational concept that contributes to the social fabric of societies. Specifically, I conceptualise universal social policies as 'spaces of equality' that foster generalised trust by shaping equitable welfare experiences and promoting social connectedness. In this perspective, universalism is considered not only as a distributional principle but also as a relational concept that signifies social hierarchies, shared membership, and mutual obligation. Rather than focusing solely on what is redistributed, this perspective emphasises how policies are structured, who is included, and whether individuals experience themselves as equal participants in collective systems of provision. In doing so, the thesis contributes to emerging research on the macro-social consequences of welfare policies, particularly their role in shaping state–society relations and social cohesion.

Third, the thesis contributes to ongoing debates on the political economy of welfare reform in the Global South by introducing a conceptual distinction between universal and segmented policy expansions – defined by their equity implications rather than policy instruments. Applying this framework to healthcare in emerging welfare states, I theorise that government ideology and electoral volatility shape the policy choice of reform trajectories and that these

are further conditioned by the strength of vested interests. In combining this conceptual lens with a political economy approach, the thesis advances a more systematic understanding of how electoral dynamics and interest groups interact to shape divergent patterns of healthcare expansion.

Fourth, the thesis bridges the fields of comparative political economy and (global) social policy – two areas of scholarship that have often evolved in parallel. While global social policy primarily emphasises the role of international organisations and transnational dynamics for driving welfare change, comparative political economists tend to focus on domestic institutions, electoral dynamics, and interest coalitions. By adopting a global perspective and using universal healthcare as its empirical lens, the thesis further links to development studies and the global health literature by shifting the focus from technocratic barriers to the socio-politics of healthcare expansion. In applying a political economy lens to global social policy questions, and vice versa, I contribute to an integrated understanding of the consequences and determinants of healthcare universalism across diverse contexts.

Fifth, the thesis makes a methodological contribution to the scholarship on universalism by adopting a comprehensive macro-comparative perspective. In contrast to much of the existing literature, which often focuses on regional or national comparative case studies, I systematically analyse universalism across a global sample of countries from all world regions, levels of development, and institutional contexts. Beyond extending existing debates to new contexts, the objective is to leverage this empirical breadth for systematic comparisons across key axes of variation – including between the Global South and the Global North. The thesis thereby contributes to a broader shift in the literature that aims to bring the global periphery to the analytical centre of comparative social policy research.

Finally, the thesis introduces new empirical approaches and datasets for studying universalism in the Global South. This includes the multidimensional Healthcare Universalism Index, a composite indicator to measure 'varieties of universalism' in healthcare across 204 countries from 1995 to 2023. In addition, the thesis presents a new dataset of health system reforms that expanded access to new population groups across 90 Global South countries between 1990 and 2023. Employing the conceptual distinction between universal and segmented expansion, I classify the reforms based on their impact on equity in healthcare provision. In enabling more granular and theoretically grounded analysis, these new empirical tools aim to support future research at the intersection of healthcare politics, development studies, and comparative social policy.

2. Case study selection: Programme versus welfare state universalism

This thesis examines the political economy of universalism through the lens of universal healthcare. In doing so, it shifts the focus from the aggregate analysis of universalism at the welfare state level to specific social policies. Programme universalism describes the equitable and comprehensive provision of benefits or services in specific policy domains – such as education, healthcare, or pensions – while welfare state universalism describes a system of connected universal programmes (Rothstein 1998; Bergh 2004). Although related, the two concepts are not equivalent and therefore require separate analysis and measurement, even though findings on welfare state universalism are frequently extended to programme universalism.[1]

Analyses of universalism at the welfare state level can be problematic, especially in Global South contexts. Firstly, combining indicators across different policy areas holds conceptual and methodological challenges. It is not straightforward to determine how to aggregate measures that are fundamentally different – such as means-tested benefits and healthcare coverage – but even aggregating similar indicators, say legal coverage or expenditure, is questionable because they imply a normative hierarchy in weighting between different programmes.[2] Similarly, when employing aggregated 'black box' measures, such as welfare regimes or social spending, policy effects are likely to be obscured as these measures are often driven by external factors or exhibit limited variation over time (Nelson and Fritzell 2014).

Secondly, the aggregate analysis of welfare state universalism hides substantial within-country variation across policy domains. In line with common critiques of single indicators of 'welfare stateness' (Martínez Franzoni and Sánchez-Ancochea 2021; Kunißen 2023), high overall welfare effort can coexist with segmentation or low quality in specific programmes. For example, a country might provide generous and equitable healthcare, but still have a segmented and exclusionary education system. These significant intra-country variations are analytically relevant but lost in aggregate metrics.

[1] For example, in the context of the 'paradox of redistribution' debate (Korpi and Palme 1998; Brady and Bostic 2015; Jacques and Noël 2018).

[2] For example, even using a simple average of legal coverage across different programmes implies an equal weight for each included programme, which might be questionable when comparing fundamentally different policy areas like healthcare and unemployment or disability benefits.

Finally, and most importantly, aggregate welfare state analysis implicitly assumes that the consequences and determinants of universalism are uniform across programmes. While this may hold in some instances of highly integrated and ideal-type welfare states, it remains unclear if the socio-political mechanisms of universalism apply differently to some policy domains than others – for example, related to differences in welfare norms, modes of delivery, or target groups. Public notions of deservingness, for instance, are likely to affect the politics of universalism differently in healthcare versus cash transfers. These critiques of welfare state level analysis of universalism are exacerbated in contexts of the Global South, where social polices tend to be less institutionalised, more fragmented, and more heavily shaped by external influences. Therefore, the coherence between welfare programmes tends to be weaker, and the conditions for universalism are likely to differ significantly across sectors.

For these reasons, I consider programme universalism a more promising and conceptually precise lens for analysing universal social policies. In this thesis, I focus on universal healthcare as the primary case study for understanding universalism in the Global South. This case study selection reflects not only its prominent role in international and national policy discourse but also its analytical relationship with my key concepts of interest: redistribution, inequality, social trust, and the political determinants of reform.

Healthcare is among the largest and politically most salient welfare programmes in nearly all countries, and, crucially, it is relevant across all levels of development. This stands in contrast to alternative case studies such as pensions or (un-)conditional cash transfers, which are more relevant in specific subsets of countries or are, by design, targeted at specific populations. In contrast, healthcare must respond to the needs of the entire population throughout its life cycle, making it a natural starting point for examining universalism in provision. In its role as a central human capability, healthcare is a key area of government intervention across contexts and is foundational to individuals' experiences with the state, wider society, and the social contract. Moreover, healthcare directly engages with foundational concerns of social policy from an equity perspective: who deserves protection, how much should be provided, and who should bear the cost. It provides not just a site of service delivery, but a socio-political space where notions of state responsibility, solidarity, and social citizenship are contested and institutionalised.

This 'universality' in the relevance of healthcare across national and individual contexts also enables meaningful global comparisons, due to the relative similarities in the institutional structure of healthcare provision and the availability of standardised cross-national data. For

example, while healthcare needs and national circumstances differ greatly across the world, the effective access to healthcare and the level of privatisation can be consistently measured and compared across these contexts.[3] Furthermore, this case study links to well-established and growing literature on the determinants and consequences of universal health coverage (UHC). While conceptually distinct, the connection to this literature expands the relevance of the thesis findings and helps leverage research approaches, empirical methods, and data from related disciplines, such as global health and health economics.

3. Global South versus Global North: Conceptualising 'global' social policy

This thesis considers universalism as a global social policy concept – one that is not confined to the institutional configurations of mature (social-democratic) welfare states, but that increasingly shapes and is shaped by policy developments in the Global South. Today, the Global South is home to the majority of active social policy initiatives worldwide, as reflected in a wide range of national reforms and international agendas such as the Sustainable Development Goals. Far from being peripheral, social policies have become central features of contemporary understandings of 'development' itself, with concepts like multidimensional poverty and human development centring on the expansion of capabilities – like health and education – rather than on economic indicators (Sen 1999; Mkandawire 2004; Alkire and Foster 2011; Jahan 2019).

Historically, the comparative welfare state literature has largely focused on a subset of high-income countries, specifically in Western and Northern Europe, often treating their development trajectories and institutional models as theoretical ideal types. While this literature has provided important insights, including on the concept of universalism, it has limited the scope of comparative analysis and contributed to the marginalisation of policy trajectories in more diverse global contexts.[4] In response to this development, the growing field of global social policy advances broader theoretical perspectives that recognise a diversity in development trajectories, stakeholders, and institutional frameworks (Mkandawire 2004; Deacon 2007; Huber and Stephens 2012; Leisering 2021; Yeates and

[3] In comparison to policy areas such as education or pensions, which are more difficult to standardise and compare across national contexts due to social, economic, and cultural differences in systems of provision and state involvement.

[4] Even within Europe, welfare states in the South – such as Greece, Italy, Spain, and Portugal – have often been treated as outliers in regime typologies, consequently leading to their underrepresentation in comparative research (Castles 1995; Ferrera 1996).

Holden 2022; Obinger and Schmitt 2022). While not necessarily rejecting existing theories of welfare state formation and its effects, this literature often adapts and extends them to incorporate dynamics that are particularly relevant in Global South contexts, such as transnational dynamics, colonial legacies, or the influence of international organisations (Rudra 2007; Seekings 2008; Schmitt et al. 2015; Kaasch 2015; Mkandawire 2020).

While not engaging with broader debates around the concept itself, this thesis employs the Global South as an analytical lens to describe a group of countries that, despite their internal diversity, share geographical, relational, structural, and political characteristics that shape their political economies of welfare (Sud and Sánchez-Ancochea 2022). These include ongoing or more recent experiences with democratisation, external policy influence through international organisations and development aid, limited state capacity and an emerging social contract, weaker institutional legacies, and widespread poverty and deprivation. While these characteristics are not uniformly present in all countries and time periods, they are commonly rooted in their shared colonial and post-colonial histories, economic dependencies, and, ultimately, their place on the global periphery.

Given the historical focus of welfare state scholarship on the experiences of selected countries in the Global North and the growing global relevance of universalism, bringing this global periphery to the analytical centre is a key objective of the thesis. This reframing is not only empirical, but also normative: it challenges the marginalisation of Global South experiences in social policy research, where countries are often considered as outliers, residual cases, or passive recipients of external reforms.

Conceptually, this requires theoretical frameworks that are applicable to and draw on diverse global contexts. Throughout the thesis, I adopt a multidimensional conceptualisation of universalism that focuses on universally applicable policy goals of full coverage, high generosity, and high equity in provision (Martínez Franzoni and Sánchez-Ancochea 2016). In contrast to existing Northern definitions, this approach acknowledges that there are different pathways to achieving universalism – as reflected in the newly coded reform database that classifies healthcare expansions based on their impact on equity in provision rather than the underlying policy instrument. Similarly, the third paper derives its theoretical framework from the electoral consequences of democratisation, while drawing on existing theories of welfare state expansion in the Latin American literature.

Empirically, the thesis brings the Global South to the centre of comparative analysis by adopting a truly global scope. Rather than focusing on specific regions and extending findings to the rest of the world, it aims to represent the 'varieties of universalisms' across all income levels, geographies, and regions.[5] This is achieved by drawing on new and expanded data sources such as the UHC effective coverage index (Lozano et al. 2020), the World Values Survey (Inglehart et al. 2022), and the Varieties of Democracy dataset (Pemstein et al. 2025). Additionally, I introduce two empirical innovations to studying global universalism: the Healthcare Universalism Index and a novel database of healthcare reform across 90 countries of the Global South since 1990.

Finally, both theoretically and empirically, the thesis does not essentialise the concept, consequences, and determinants of universalism to either the Global South or the Global North, but instead treats both as heuristic categories for comparative analysis.[6] Specifically, it focuses on comparing the role of different dimensions of universalism across these groups of countries and connects them with central debates in social policy, such as the 'paradox of redistribution' (Korpi and Palme 1998) and the role of universalism in fostering social trust (Rothstein 1998). Rather than presuming divergence in these relationships, the thesis tests the global applicability of existing theories and the potential uniqueness of Southern political economies of welfare. By bringing these categories into analytical dialogue, the thesis offers new insights into how context conditions the political economy and social effects of universalism around the world.

4. Overview of the thesis

The thesis consists of three interlinked research papers which are tied together through a shared conceptual framework and a global macro-comparative perspective.

Theoretically, each paper draws on a multidimensional conceptualisation of healthcare universalism and distinguishes it from segmentation in healthcare access and quality. The

[5] This global scope inevitably raises tensions between generalisability and contextual specificity. While the thesis leans towards the former in its macro-comparative approach, it does not deny the importance of local dynamics. Rather, it seeks to focus on the consequences and determinants of universalism that are relevant and applicable across many contexts – such as redistribution, trust, and vested interests – and embedding these in a broader comparative framework.

[6] For comparative purposes, the thesis follows the classification of the United Nations Conference on Trade and Development (UNCTAD), defining the Global North as comprising North America, Europe, Israel, Japan, the Republic of Korea, Australia, and New Zealand (UNCTAD 2023). The Global South refers to all other countries. This categorisation is used heuristically to capture broad structural and political differences while recognising internal diversity within each group.

thesis extends existing approaches by placing central emphasis on equity in healthcare provision, theorising universal social policies as 'spaces of equality', and distinguishing between universal and segmented trajectories of healthcare expansion. In particular, the conceptual framework contributes to ongoing efforts to reconsider universalism as a multidimensional and institution-agnostic model that centres on equitable provision. Instead of limiting universalism to a historical fixture in specific welfare regimes, the thesis considers it as a relational and political concept that can take varied forms across different contexts. In theorising universal policies as 'spaces of equality' and linking them to both social outcomes and political incentives, the thesis integrates perspectives from social policy, political economy, and development studies. This approach creates a more dynamic understanding of how universalism shapes, and is shaped by, state–society relations, distributive politics, and the institutional diversity of healthcare systems worldwide.

Methodologically, the thesis adopts a cross-national and macro-comparative approach that integrates country-, policy-, and individual-level data to analyse the consequences and determinants of healthcare universalism from a global perspective. It combines a range of quantitative methods – including panel data analysis, multilevel models, and event history analysis – and introduces two empirical innovations for studying universalism in the Global South: the Healthcare Universalism Index and a new global database of health system reform.

A central feature of the empirical design is the multidimensional operationalisation of universalism, which includes both the construction of a composite index and disaggregated analyses of its underlying dimensions. This approach enables a granular examination of how different aspects of universalism relate to social outcomes and allows for potential variation in mechanisms across contexts. The thesis incorporates multiple levels of analysis by examining how universalism shapes national-level outcomes like inequality, individual-level perceptions such as social trust, and policy-level change in the form of health system reforms. By leveraging a truly global sample covering all world regions, the thesis captures the diversity of healthcare systems and advances a multidimensional, context-sensitive understanding of how universalism emerges from and shapes socio-political outcomes across developmental contexts.

Overall, the thesis is structured around three research questions:

- ***Research question 1:*** *How can we conceptualise and measure healthcare universalism in a global context? Has there been a convergence or divergence in healthcare universalism over time?*
- ***Research question 2:*** *What are the consequences of healthcare universalism around the world? Specifically, how is it associated with redistribution, inequality, and social trust?*
- ***Research question 3:*** *What determines healthcare universalism? Specifically, which political economy factors shape countries' trajectories of healthcare reform in the Global South?*

To answer these questions, the thesis follows an integrated thesis structure comprising three stand-alone research papers. Each presents its own research contribution, theoretical framework, and empirical strategy, and is written in an extended thesis format that includes more material, analyses, and figures than standard journal articles. This format is intended to showcase the breadth of the research conducted for this doctoral project, while also serving as a foundation for shortened journal article versions in the future. The papers are self-contained, with separate numbering for sections, figures, and tables, and references and appendices presented at the end of each manuscript. For the remainder of this thesis, the terms papers and chapters are used interchangeably, with all internal cross-references referring to chapters.[7]

The first paper explores the concept of universalism in healthcare, analyses its global distribution over time, and examines its redistributive consequences. It introduces the Healthcare Universalism Index (HUI), a new composite measure capturing three dimensions of policy outputs: Coverage (measured as effective universal health coverage), Generosity (public health spending), and Equity (healthcare privatisation). Drawing on harmonised international data for 204 countries from 1995 to 2023, I employ an institution-agnostic and multidimensional lens to capture cross-national and longitudinal variation in the global 'varieties of universalism'. The descriptive findings reveal significant improvements in healthcare universalism across most world regions – particularly in lower-income countries –

[7] With the introduction as Chapter 1, the three empirical papers as Chapters 2 to 4, and the conclusion as Chapter 5.

but also growing disparities in Generosity between countries at different levels of human development.

Beyond mapping global patterns, the paper applies the HUI to a classical research question in the social policy literature: the 'paradox of redistribution'. Using a within-between random effects estimator, it investigates whether universalism is associated with more equal redistributive outcomes across countries and over time. The analysis provides robust cross-national and longitudinal support for this hypothesis: countries with higher levels of healthcare universalism tend to exhibit greater social spending, higher redistribution, and lower income inequality. These associations are strongest in the Global North, but also emerge dynamically in the Global South, where within-country improvements in universalism over time are linked to greater redistributive performance, suggesting a dynamic interpretation of the paradox at the policy level.

The second paper examines the social consequences of universalism by analysing the relationship between universal healthcare and generalised trust. Conceptualising universal social policies as 'spaces of equality' that contribute to how individuals experience and perceive society, I argue that universalism fosters social trust through two complementary mechanisms: vertically, by improving the inclusiveness and equity of welfare experiences, and horizontally, by reducing segmentation and promoting social connectedness. Leveraging the Healthcare Universalism Index and individual-level survey data from the World Values Survey and the European Values Study, I test the theorised relationship using a multilevel modelling approach across a global sample of 105 countries from 2000 to 2020.

The results suggest that the consequences of universal healthcare extend beyond health outcomes and matter for the social fabric of societies, with healthcare universalism consistently associated with generalised trust at the individual level. A disaggregated analysis reveals that this effect is primarily driven by the dimensions of Generosity and Equity. However, their relative role varies across contexts: government spending plays a stronger role in fostering trust in the Global South, while privatisation diminishes social trust in the Global North. Notably, the strongest trust effects are observed among individuals who are most likely to opt out of public provision, supporting the hypothesis that universalism fosters cross-class solidarity and reduces social distance.

The third paper investigates the political determinants of healthcare reform in the Global South, examining why some governments pursue universal versus segmented approaches to

healthcare expansion. Drawing on the literature on social policy expansion in emerging democracies, I employ a political economy framework that links healthcare reform trajectories to two key political determinants and their interaction with vested interests: government ideology and electoral volatility. I argue that left-wing governments are more likely to pursue universal reforms due to their ideological alignment with newly enfranchised constituencies, while electoral volatility increases the political costs of clientelism and the appeal of high-visibility policies that signal a commitment towards 'delivering development'.

Empirically, the paper introduces a novel dataset of health system reforms that expanded access to new population groups across 90 countries in the Global South between 1990 and 2023. By classifying reforms as universal or segmented based on their equity implications, I employ an event history analysis to investigate the political and interest-based factors associated with each type of reform. The findings provide robust evidence for the role of politics in shaping healthcare expansion trajectories. Left-wing governments are significantly more likely to adopt universal reform, but are conditioned by the strength of organised labour, while right-wing governments are more inclined to pursue segmented reforms and align with the interests of private healthcare providers. Furthermore, electoral volatility emerges as a strong predictor of universal reforms, with additional analysis supporting the hypothesised mechanism of decreasing incentives for clientelism.

Overall, these three papers provide a comprehensive analysis of the concept, consequences, and determinants of universalism in healthcare from a global perspective. By combining new theoretical perspectives with original data and diverse empirical methods, the thesis advances the understanding of the social and distributive impacts of healthcare universalism, as well as the political conditions under which it emerges. It contributes to a global shift in the comparative welfare state literature and repositions universalism as a strategic policy tool for shaping social cohesion, reducing inequality, and fostering inclusive development trajectories across the world.

5. References

Agartan, Tuba I. 2025. *Universal Health Coverage: Foundations and Horizons*. Bristol: Policy Press.

Alkire, Sabina, and James Foster. 2011. 'Counting and Multidimensional Poverty Measurement'. *Journal of Public Economics* 95(7–8): 476–87.

Barrientos, Armando. 2013. *Social Assistance in Developing Countries*. Cambridge: Cambridge University Press.

Béland, Daniel, and Brian Gran, eds. 2008. *Public and Private Social Policy*. London: Palgrave Macmillan.

Bergh, Andreas. 2004. 'The Universal Welfare State: Theory and the Case of Sweden'. *Political Studies* 52(4): 745–66.

Birnbaum, Simon, Tommy Ferrarini, Kenneth E. Nelson, and Joakim Palme. 2017. *The Generational Welfare Contract: Justice, Institutions and Outcomes*. Cheltenham: Edward Elgar Publishing.

Brady, David, and Amie Bostic. 2015. 'Paradoxes of Social Policy: Welfare Transfers, Relative Poverty, and Redistribution Preferences'. *American Sociological Review* 80(2): 268–98.

Castles, Francis G. 1995. 'Welfare State Development in Southern Europe'. *West European Politics* 18(2): 291–313.

Deacon, Bob. 2007. *Global Social Policy & Governance*. Los Angeles: Sage.

Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

Ferrarini, Tommy, Kenneth Nelson, and Joakim Palme. 2016. 'Social Transfers and Poverty in Middle- and High-Income Countries – A Global Perspective'. *Global Social Policy* 16(1): 22–46.

Ferrera, Maurizio. 1996. 'The "Southern Model" of Welfare in Social Europe'. *Journal of European Social Policy* 6(1): 17–37.

Filgueira, Fernando. 2005. *Welfare and Democracy in Latin America: The Development, Crises and Aftermath of Universal, Dual and Exclusionary Social States*. Geneva: United Nations Research Institute for Social Development.

Fischer, Andrew M. 2012. 'Inequality and the Universalistic Principle in the Post-2015 Development Agenda'. *Official background paper prepared for the global thematic consultation on Addressing Inequalities in the Post-2015 Development Agenda*.

Garritzmann, Julian L., Silja Häusermann, and Bruno Palier, eds. 2022. *The World Politics of Social Investment: Volume I: Welfare States in the Knowledge Economy*. New York: Oxford University Press.

Gingrich, Jane. 2011. *Making Markets in the Welfare State: The Politics of Varying Market Reforms*. Cambridge: Cambridge University Press.

Huber, Evelyne, and John D. Stephens. 2001. *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*. Chicago: University of Chicago Press.

Huber, Evelyne, and John D. Stephens. 2012. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press.

ILO. 2012. *The Strategy of the International Labour Organization. Social Security for All: Building Social Protection Floors and Comprehensive Social Security Systems*. Geneva: International Labour Office, Social Security Department.

Inglehart, Ronald, Christian Haerpfer, Alejandro Moreno, Christian Welzel, Kseniya Kizilova, Jaime Diez-Medrano, Marta Lagos, et al. 2022. *World Values Survey Time-Series (1981-2022) Cross-National Data-Set Version 3.0*. Madrid: JD Systems Institute & WVSA Secretariat. https://www.worldvaluessurvey.org/WVSDocumentationWVL.jsp (March 23, 2024).

Jacques, Olivier, and Alain Noël. 2018. 'The Case for Welfare State Universalism, or the Lasting Relevance of the Paradox of Redistribution'. *Journal of European Social Policy* 28(1): 70–85.

Jahan, Selim. 2019. 'Human Development and Universalism: From Ideas to Policies'. *Journal of Human Development and Capabilities* 20(2): 233–50.

Kaasch, Alexandra. 2015. *Shaping Global Health Policy: Global Social Policy Actors and Ideas about Health Care Systems*. London: Palgrave Macmillan.

Kabeer, Naila. 2014. 'The Politics and Practicalities of Universalism: Towards a Citizen-Centred Perspective on Social Protection'. *The European Journal of Development Research* 26(3): 338–54.

Korpi, Walter, and Joakim Palme. 1998. 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries'. *American Sociological Review* 63(5): 661–87.

Kunißen, Katharina. 2023. *The Independent Variable Problem: Welfare Stateness as an Explanatory Concept*. Wiesbaden: Springer VS.

Leisering, Lutz. 2020. 'The Calls for Universal Social Protection by International Organizations: Constructing a New Global Consensus'. *Social Inclusion* 8(1): 90–102.

Leisering, Lutz. 2021. 'Social Protection in the Global South: An Ideational and Historical Approach'. In *One Hundred Years of Social Protection*, ed. Lutz Leisering. Cham: Palgrave Macmillan, 3–52.

Lozano, Rafael, Nancy Fullman, John Everett Mumford, Megan Knight, Celine M Barthelemy, Cristiana Abbafati, Hedayat Abbastabar, et al. 2020. 'Measuring Universal Health Coverage Based on an Index of Effective Coverage of Health Services in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019'. *The Lancet* 396(10258): 1250–84.

Mares, Isabela. 2003. *The Politics of Social Risk: Business and Welfare State Development*. Cambridge: Cambridge University Press.

Marshall, Thomas Humphrey. 1950. *Citizenship and Social Class, and Other Essays*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2021. 'Are Welfare Regimes a Useful Category? The Cross-Sectoral Variation in Social Policy in Latin America at the End of the Commodity Boom'. *Development Studies Research* 8(1): 294–308.

Mkandawire, Thandika, ed. 2004. *Social Policy in a Development Context*. London: Palgrave Macmillan.

Mkandawire, Thandika. 2005. 'Targeting and Universalism in Poverty Reduction'. *UNRISD Social Policy and Development Programme Paper* 23.

Mkandawire, Thandika. 2020. 'Colonial Legacies and Social Welfare Regimes in Africa: An Empirical Exercise'. In *The Politics of Domestic Resource Mobilization for Social Development*, ed. Katja Hujo. Cham: Palgrave Macmillan, 139–72.

Montanari, Ingalill, and Kenneth Nelson. 2013. 'Health Care Determinants in Comparative Perspective: The Role of Partisan Politics for Health Care Provision'. *International Journal of Comparative Sociology* 54(5–6): 445–66.

Nelson, Kenneth, Ida Borg, Rense Nieuwenhuis, and Susanne Alm. 2023. 'The Political Determinants of Housing Benefits'. *European Sociological Review* 39(1): 104–17.

Nelson, Kenneth, and Johan Fritzell. 2014. 'Welfare States and Population Health: The Role of Minimum Income Benefits for Mortality'. *Social Science & Medicine* 112: 63–71.

Niño-Zarazúa, Miguel, Armando Barrientos, Samuel Hickey, and David Hulme. 2012. 'Social Protection in Sub-Saharan Africa: Getting the Politics Right'. *World Development* 40(1): 163–76.

Obinger, Herbert, and Carina Schmitt. 2022. 'Unemployment Insurance in the Global South since 1950: Drivers of Policy Adoption'. *Global Social Policy* 22(1): 67–83.

Obinger, Herbert, Carina Schmitt, and Stefan Traub. 2016. *The Political Economy of Privatization in Rich Democracies*. Oxford: Oxford University Press.

Obinger, Herbert, Peter Starke, Julia Moser, Claudia Bogedan, Edith Gindulis, and Stephan Leibfried, eds. 2010. *Transformations of the Welfare State: Small States, Big Lessons*. Oxford: Oxford University Press.

van Oorschot, Wim. 2000. 'Who Should Get What, and Why? On Deservingness Criteria and the Conditionality of Solidarity among the Public'. *Policy & Politics* 28(1): 33–48.

Pemstein, Daniel, Kyle M. Marquardt, Eitan Tzelgov, Yi-ting Wang, Juraj Medzihorsky, Joshua Krusell, Farhad Miri, and Johannes Von Römer. 2025. 'The V-Dem Measurement Model: Latent Variable Analysis for Cross-National and Cross-Temporal Expert-Coded Data'. *V-Dem Working Paper* 21(10th edition).

Pierson, Paul. 1996. 'The New Politics of the Welfare State'. *World Politics* 48(2): 143–79.

Pribble, Jennifer. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.

Rothstein, Bo. 1998. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Rudra, Nita. 2007. 'Welfare States in Developing Countries: Unique or Universal?' *The Journal of Politics* 69(2): 378–96.

Rueda, David, and Daniel Stegmueller. 2019. *Who Wants What? Redistribution Preferences in Comparative Perspective*. Cambridge: Cambridge University Press.

Sandbrook, Richard, Marc Edelman, Patrick Heller, and Judith Teichman. 2007. *Social Democracy in the Global Periphery: Origins, Challenges, Prospects*. Cambridge: Cambridge University Press.

Schmitt, Carina, Hanna Lierse, Herbert Obinger, and Laura Seelkopf. 2015. 'The Global Emergence of Social Protection: Explaining Social Security Legislation 1820–2013'. *Politics & Society* 43(4): 503–24.

Seekings, Jeremy. 2008. 'Welfare Regimes and Redistribution in the South'. In *Divide and Deal: The Politics of Distribution in Democracies*, eds Ian Shapiro, Peter A. Swenson, and Daniela Donno Panayides. New York: New York University Press, 19–42.

Seekings, Jeremy. 2012. 'Pathway to Redistribution: The Emerging Politics of Social Assistance Across the Global "South"'. *Journal für Entwicklungspolitik* 28(1): 14–34.

Sen, Amartya. 1999. *Development As Freedom*. Oxford: Oxford University Press.

Sud, Nikita, and Diego Sánchez-Ancochea. 2022. 'Southern Discomfort: Interrogating the Category of the Global South'. *Development and Change* 53(6): 1123–50.

UNCTAD. 2023. *UNCTAD Handbook of Statistics*. New York: United Nations Publications.

United Nations. 2021. *Our Common Agenda – Report of the Secretary-General*. New York: United Nations Publications.

USP 2030. 2019. 'Together to Achieve Universal Social Protection by 2030: A Call to Action'. https://usp2030.org/wp-content/uploads/calltoaction_en.pdf (April 30, 2025).

WHO. 2010. *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization.

WHO Council on the Economics of Health for All. 2023. *Health for All – Transforming Economies to Deliver What Matters: Final Report of the WHO Council on the Economics of Health for All*. Geneva: World Health Organization.

Yeates, Nicola, and Chris Holden. 2022. *Understanding Global Social Policy*. Bristol: Policy Press.

The Healthcare Universalism Index: Measuring Coverage, Generosity, and Equity in Healthcare across the World[8]

Abstract

Universalism has emerged as a guiding principle in global social policy. From the United Nations' pledge to 'Leaving No One Behind' to healthcare inequalities exposed by the Covid-19 pandemic, a growing international consensus recognises that states should provide comprehensive and equitable access to high-quality social services for all. While traditionally associated with welfare states in the Global North, the principle of universal social policy has expanded to the Global South, with a particular focus on healthcare. Despite this growing emphasis, few systematic efforts have been made to measure healthcare universalism globally and over time.

This paper addresses this gap by introducing the Healthcare Universalism Index (HUI), a composite indicator to measure 'varieties of universalism' in global healthcare systems. Employing an institution-agnostic lens, the index focuses on policy outputs and comprises three dimensions: Coverage (measured by effective universal health coverage), Generosity (public health spending), and Equity (healthcare privatisation). Drawing on harmonised international data for 204 countries from 1995 to 2023, the HUI enables comparative and longitudinal analysis of healthcare systems beyond region-specific typologies.

The descriptive findings reveal significant improvements in the HUI across most world regions – particularly in lower-income countries – and moderate trends of global convergence. However, significant inequalities persist between countries at different levels of human development, especially in Generosity, which remains the weakest and most unevenly distributed dimension. While the Covid-19 pandemic acted as a temporary catalyst for narrowing disparities in healthcare universalism, this convergence trend appears short-lived, with early signs of reversal.

[8] An earlier version of this chapter appeared as a background paper for the UNDP 2022 Special Report on Human Security, co-authored with Diego Sánchez-Ancochea (Schillings and Sánchez-Ancochea 2023). The version presented here has been fully revised with new data, a new empirical case study, and updated methodology. All co-authored sections were removed, and the paper represents fully my own work.

Beyond tracing global patterns of convergence and divergence, the paper applies the HUI to a classical research puzzle in the social policy literature: the 'paradox of redistribution'. Employing a within-between random effects estimator, it investigates whether universalism is associated with better redistributive outcomes across countries and over time. The results provide robust evidence for the persistence of the paradox at the global level, with higher levels of healthcare universalism associated with greater social spending, higher redistribution, and lower income inequality. These associations are strongest in the Global North, but they also emerge dynamically in the Global South, where improvements in universalism within countries are linked to greater redistributive performance over time. Overall, this paper emphasises the importance of conceptualising universal healthcare as a multidimensional policy output and reinforces the continued relevance of universalism for advancing equity in health and beyond.

1. Introduction

In recent years, universalism has evolved from a normative aspiration associated with social democratic welfare states to a leading idea in global social policy. The principle that states should provide comprehensive access to high-quality social services for the entire population, regardless of income or status, features prominently in international frameworks such as the 'Leaving no one behind' promise of the Sustainable Development Goals (SDGs). Representing a "new global consensus" on universalism (Leisering 2020), the concept is reflected in the International Labor Organization's (ILO) proposal for *Social Security for All* (ILO 2012), the *Global Partnership for Universal Social Protection* (USP 2030) launched by the World Bank and the ILO, and the United Nations *Common Agenda,* which calls for a "new era for universal social protection" (United Nations 2021).

These developments have gained momentum in the context of healthcare, especially following the Covid-19 pandemic. The pandemic tragically exposed the consequences of inequities in access to healthcare and led to renewed calls for more inclusive and equitable healthcare systems around the globe (Bambra et al. 2020; Okoi and Bwawa 2020; Wang and Tang 2020). This links to the World Health Organisation's (WHO) work on Universal Health Coverage (UHC), which is reflected in SDG Goal 3.8, which aims to ensure universal access to 'quality essential health services' and prevent 'catastrophic health expenditure' (WHO 2025). However, by expanding the focus on coverage and concepts of 'essential health', healthcare universalism draws attention to issues of generosity and equity – factors that are crucial in times where each year 8 million people in lower-income countries die from treatable diseases, 60 percent of which are caused by poor quality care (Kruk et al. 2018).

Despite this growing global consensus, limited empirical research exists on how healthcare universalism can be conceptualised and measured across global contexts. While concepts such as UHC have gained widespread traction in policy and academic circles, existing indicators primarily focus on (legal) access to services and often neglect the quality and equity of provision. Similarly, universalism measures at the welfare state level often rely on narrow institutional models that draw on the historical experience of the Global North, limiting their applicability to more diverse development trajectories. As a result, global comparative analysis of universalism in healthcare remains conceptually underdeveloped and empirically constrained.

This paper addresses this gap by proposing the Healthcare Universalism Index (HUI), a novel composite indicator to measure 'varieties of universalism' in healthcare across 204 countries from 1995 to 2023. Drawing on the conceptual framework by Martínez Franzoni and Sánchez-Ancochea (2016), the HUI combines three dimensions of policy outputs: Coverage (effective UHC), Generosity (public health spending), and Equity (healthcare privatisation). With Coverage as the traditional focus of global healthcare policy, the HUI shifts the attention to aspects of quality and segmentation of healthcare provision. Rather than focusing on specific institutional models of delivery, the index conceptualises universalism as a set of policy outputs that can be applied across diverse development trajectories. In further relying on a small set of widely available macro-indicators, the main purpose of the HUI is to enable the comparative measurement of healthcare universalism across time and country contexts on a global scale.

Analytically, the paper employs the novel index in two ways. Firstly, in a descriptive analysis, I trace the distribution of healthcare universalism across the world from 1995 to 2023. A particular focus lies in investigating global patterns of convergence and divergence in the HUI and its dimensions, asking whether the dispersion in the HUI diminished over time and if low-performing countries caught up with those at the top. Secondly, as an empirical case study, I apply the HUI to a classical question in the social policy literature: the 'paradox of redistribution'. In their seminal work, Korpi and Palme (1998) argue that the more welfare resources are targeted at the poor, the less redistribution is achieved, and inequality and poverty are reduced. They explain this paradoxical relationship with the greater political support for a large welfare state, because the middle class also benefits from generous, universal programmes instead of relying on private alternatives. I argue that healthcare is a particularly useful case study to test this hypothesis, because it is the largest and politically salient social policy in most countries, and measures of universalism on the welfare state level are often conceptually and empirically limited.[9] Using a within-between random effects estimator, the paper tests the hypothesis that higher levels and improvements in healthcare universalism are associated with greater redistribution, higher social spending, lower income inequality, and reduced poverty rates.

[9] For example, due to the unclear interaction between different policy areas, the shortcomings of expenditure-based approaches, and the often sole focus on social protection-related measures (see Section 2.2 for more details).

This paper contributes to two strands of the literature: firstly, to the growing body of scholarship on universal social policy in the Global South, and secondly, to the rich debate on the validity and persistence of the paradox of redistribution. While the universalism concept was historically used to describe a subset of social democratic welfare regimes in the Global North (Esping-Andersen 1990; Rothstein 1998; Kangas and Palme 2005; Kildal and Kuhnle 2005; Nelson 2007; Anttonen, Haikio, and Stefánsson 2012), recent scholarship has expanded the conceptual focus to emerging welfare states in the Global South, however with limited attention to a global comparative perspective (Gough et al. 2004; Mkandawire 2005; Seekings 2008; Pribble 2013; Kabeer 2014; Martínez Franzoni and Sánchez-Ancochea 2016; Ferrarini, Nelson, and Palme 2016; Jahan 2019). The classic Korpi and Palme (1998) paper has sparked a rich but contested literature debating the distributional impacts of social policy design, though this has often been constrained by limitations in measuring universalism (Kenworthy 2011; Marx, Salanauskaite, and Verbist 2013; Brady and Bostic 2015; Ferrarini, Nelson, and Palme 2016; Jacques and Noël 2018; Gugushvili and Laenen 2021).

The paper makes three contributions to the existing literature:

- By focusing on multidimensional policy outputs, the paper employs and operationalises a concept of universalism that goes beyond institutional models rooted in the Global North and instead reflects global 'varieties of universalism'.
- By introducing a novel composite index for 204 countries from 1995 to 2023, the paper advances the empirical study of healthcare universalism in providing a parsimonious and globally comparable measurement tool.
- By applying the HUI to the case study of the paradox of redistribution, the paper contributes a global and policy-level perspective on the relationship between universalism and redistributive outcomes.

The remainder of the paper is organised as follows. Section 2 reviews the concept of healthcare universalism and existing approaches to its measurement. Section 3 presents the construction of the Healthcare Universalism Index. Section 4 explores trends in healthcare universalism, with a focus on exploring global convergence in the HUI. Section 5 applies the HUI to the empirical case study of the classic paradox of redistribution. Section 6 concludes.

2. Defining and measuring universalism

2.1 Defining universalism

Universalism is a polysemic concept that holds varying meanings across disciplines. In theology, it connotes the salvation of all souls; in the philosophy of science, it refers to principles that apply universally across time and space. Despite divergent interpretations, all definitions share the common trait of referring to ideas of unity, totality, and sameness (Stefánsson 2012). In the context of welfare, universalism typically describes policies that apply equally to everyone within a particular group – such as citizens of a country – rather than distinguishing potential beneficiaries based on exclusion criteria, such as means-tests or labour market status (Anttonen, Haikio, and Stefánsson 2012).

2.1.1 Universalism and the Nordic welfare model

The concept of universalism has a long history in the academic and policy literature; however, it is most commonly associated with the Northern European welfare states.[10] Esping-Andersen's (1990) seminal typology considers universalism as a defining characteristic of the social democratic welfare regime, which is characterised by decommodification and social citizenship. In this context, universalism is understood as an alternative to tolerating "a dualism between state and market" and an essential part of a "welfare state that would promote an equality of the highest standards, not an equality of minimal needs" (Esping-Andersen 1990, 27).

The subsequent literature has largely employed this 'institutional model' of universalism that builds on the characteristics of the Nordic welfare model, such as tax financing, centralised provision, and generous social transfers (Rothstein 1998; Kangas and Palme 2005). For example, Blomqvist and Palme (2020, 114) define universal programmes to "formally include all citizens on the same conditions" (policy output), "be financed through public means only" (policy instrument), "be managed by one actor only so that benefits are uniform" (instrument and output), and "offer social benefits that are generous and of high quality" (output). While useful for describing the historical model of universalism in Northern Europe, such a

[10] Kildal and Kuhnle (2005) trace the concept of universalism in social policy and its association with redistribution and equity back to the 19th century. The word 'universal' also appears in works by classic British scholars like Marshall, Beveridge, and Titmuss. However, Stefánsson (2012) notes that the term has only been systematically used in the academic literature since the 1980s, mainly to describe the Scandinavian welfare states.

definition can be limiting because it conflates the ends of universalism with the means to achieve it, thereby narrowing the concept's applicability to a specific institutional context.

In another example of this 'institutional model' of universalism, Andersen (2012) draws on the historical development of the Danish and British welfare system and defines five criteria that create a hierarchy of universalism:

1. Eligibility and entitlements are clearly defined rights, not a matter of discretion.
2. Rules apply to all citizens/residents who could be relevant beneficiaries.
3. Benefits (or services) are financed by general taxes, not by contributions.
4. Benefits are almost the same for all citizens – at the least, nobody is excluded by means-testing.
5. Benefits are adequate.

While this definition also blends policy outputs with instruments, it highlights a conceptual issue. What is the appropriate reference point – or contrast concept – against which universalism is defined? While targeting is most commonly employed, other concepts such as selectivism, residualism, and segmentation have also been considered as 'antitheses' to universalism.[11]

Targeting, understood as directing benefits to a limited group based on income or need, clearly conflicts with Andersen's criteria 2 (universal application) and 4 (uniform benefits), as it restricts access to those who meet narrow eligibility thresholds and typically involves means-testing – antithetical to the idea of universal entitlements (Skocpol 1991; Korpi and Palme 1998; Nelson 2007). Selectivism refers to systems where benefits are awarded based on discretionary or categorical criteria – such as employment, health, or geography – rather than as rights of citizenship (Titmuss 1976; Thompson and Hoggett 1996; Hultqvist and Hollertz 2021). This potentially undermines criterion 1, which demands clearly defined entitlements, and criterion 2, which calls for general rules applying to all citizens.

Residualism describes the principle that the state should be the provider of last resort, only intervening when market or family provision fails – clearly contradicting criterion 2 and implicitly criterion 5, since this often results in limited, inadequate public provision and lack of commitment to social rights (Esping-Andersen 1990; Gough et al. 2004; Spicker 2005).

[11] I provide a short, but non-definitive definition of each of these concepts in the following. This is intended as a brief summary in reference to the universalism concept, but by no means a conclusive conceptual definition (which would warrant a full section or even separate study). For more details, see Béland et al. (2021).

Finally, segmentation refers to the institutionalised fragmentation of social benefits across occupational or social groups, which directly violates criterion 4 by creating stratified systems with differing levels or quality of provision, and may also conflict with criterion 5 when lower-tier services fail to meet adequacy standards (Huber 1996; Barrientos 2009; Martínez Franzoni and Sánchez-Ancochea 2018). Segmentation is particularly prevalent in healthcare systems, where the coexistence of different tiers of public and private provision often reproduces social inequality in access and quality.

While these concepts are all analytically related, each implies a different way of defining universalism if they are taken as opposites on a binary spectrum. This illustrates the second key aspect of the universalism debate: the inherent multidimensionality of the concept. Even in archetypal Nordic countries, significant variations exist, and welfare systems or policies rarely fulfil all criteria of a given definition but rather represent a continuum of universalisms. As Anttonen and Sipilä (2014) highlight, it is therefore more appropriate to speak of 'varieties of universalism' that consist of different dimensions rather than considering it as a binary, fixed institutional model.

Among the many dimensions of universalism that have been proposed in the literature, two stand out as foundational and frequently conflated: membership and allocation (Kildal and Kuhnle 2005). Membership refers to the coverage and eligibility of social policies, that is, the social rights derived from being a member of a particular group or community. Hence, universal inclusion (or coverage) would mean membership for the whole population, such that no one is excluded. Allocation, in contrast, refers to the distribution and usage of benefits across the population. Therefore, universal allocation implies that benefits are equally distributed, available for all, and widely used across the population (Anttonen and Sipilä 2014). Together with related dimensions such as quality or generosity, these dimensions provide a conceptual foundation for analysing the varieties of universalism that emerge across different policy regimes and national contexts, particularly beyond the Global North.

2.1.2 Varieties of universalism in global perspective

Universalism in the Global South is not a new phenomenon. As Naila Kabeer (2014, 3) notes, "the idea of universalism was once central to the development agenda", particularly in the context of postcolonial nation-building efforts. While results often remained truncated and overridden by the neoliberal development paradigm, the concept has regained prominence, driven by regional policy innovations and a renewed emphasis in global development

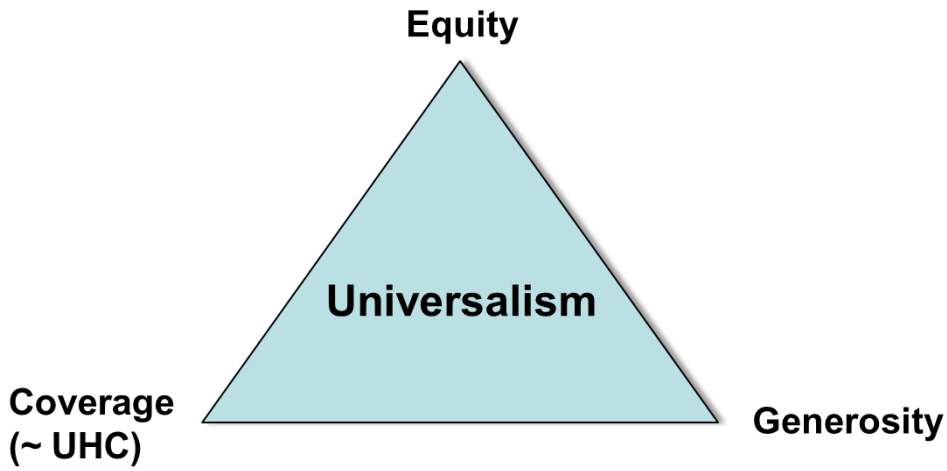
discourses (Kabeer 2014). Ranging from calls for universal social protection to universal health coverage, universalism has become a 'new global consensus' (Leisering 2020) in international development. Reflecting this trend, many countries in the Global South have adopted policies framed in universalist terms (see Chapter 4), even when their institutional arrangements differ substantially from traditional welfare state models (Mkandawire 2004; Gough et al. 2004; Kabeer 2014; Jahan 2019).

A common theme in the literature is the recognition that there is no single institutional path to universalism. Unlike the Nordic experience, which relies on specific models of tax-financing and social citizenship, many countries in the Global South follow diverse trajectories that combine contributory and non-contributory schemes, involve hybrid provision, and gradually extend coverage over time. Rather than treating universalism as a binary attribute tied to specific institutional features, scholars have increasingly highlighted the output-oriented, gradual, and multidimensional character of universalism in these contexts (Mkandawire 2005; Fischer 2012; Pribble 2013; Niedzwiecki 2018). This recognises both the diversity in country contexts and institutional legacies, as well as the need to evaluate policies based on what they deliver rather than how they are designed.

A prominent strand of this literature focuses on what Martínez Franzoni and Sánchez-Ancochea (2016) term 'minimalist' definitions of universalism. These definitions reduce the scope of universalism to its most basic dimension: coverage. In this view, a policy is considered universal if it formally reaches the entire population, regardless of the level, quality, or distribution of benefits. A key example of this is the 'basic universalism' concept, developed by a group of Latin American scholars in the context of the Inter-American Development Bank (Filgueira 2005; Molina 2006). This approach calls for states to provide the entire population with access to a set of essential services, such as primary education, basic healthcare, and old-age transfers. While the level of provision may vary according to fiscal capacity and national context, the principle is that everyone should receive at least a modest level of benefits. Similar notions are reflected in many global policy initiatives, such as the ILO's Social Protection Floors and the WHO's Universal Health Coverage, which primarily track the proportion of the population that has access to certain basic services. Even SDG Target 3.8 on UHC, which mentions quality and financial protection alongside access, remains primarily interpreted through the coverage of a limited set of healthcare access indicators rather than service quality or equity (Hogan et al. 2018).

In comparison to 'maximalist' or 'institutional' models of universalism – which are limited by their institutional contexts – minimalist forms of universalism have the advantage of being more administratively and politically feasible across all levels of development. They provide an entry point for rights-based discourse and allow governments to extend some level of protection to all. However, they are also analytically and normatively limited. By prioritising inclusion over quality or equality, they risk overlooking systems that are universal in name but deeply unequal in practice. Health systems may formally include the entire population while still entrenching disparities in service quality, access, and health outcomes. Programmes that extend minimal benefits to all may mask enduring inequalities, especially when access is stratified across income or occupational groups. In short, minimalist universalism can coexist with entrenched segmentation, social stigma, and path-dependent inequities (Mkandawire 2005; Fischer 2012; Kabeer 2014).

Figure 1. Dimensions of universalism[12]



To address these limitations, I adopt a broader conceptualisation of universalism focused on policy outputs. Following Martínez Franzoni and Sánchez-Ancochea (2016), universal social policies are defined as those policies that reach the entire population with similarly generous benefits, independently of the instruments used to achieve them. This definition comprises three dimensions: Coverage, Generosity (in level and quality) and Equity (both in access and in generosity). As a multidimensional concept, universalism is therefore a continuous variable, with much diversity across countries (Fischer 2012; Pribble 2013).

[12] This figure is based on Martínez Franzoni and Sánchez-Ancochea (2016).

Importantly, rather than treating these dimensions independently, the framework emphasises their joint achievement as the core of what makes a policy truly universal. Consider three scenarios: a system may achieve full coverage but deliver highly inadequate services; it may offer high-quality care but only to a privileged segment of the population; or it may provide highly equitable service but fail to include key demographic groups. In all cases, the absence of one dimension undermines the claim to universalism.

2.2 Measuring universalism: Opportunities and challenges

As with many institutional concepts, operationalising universalism presents a key challenge for comparative analysis on the subject. While the notion of universalism is widely discussed in both social policy and global health, few studies systematically attempt to measure it for a wide sample of countries – especially from a global perspective. Existing quantitative research almost exclusively focuses on high-income countries in the Global North (Korpi and Palme 1998; Nelson 2007; Jacques and Noël 2018),[13] while studies on the Global South tend to rely on qualitative measurements approaches, for example in the form of coding schemes for universal policy outputs and architectures (Pribble 2013; Martínez Franzoni and Sánchez-Ancochea 2016; Niedzwiecki 2018). Even within the Global South literature, empirical studies largely concentrate on Latin America, with only limited efforts to extend measurement frameworks to other regions (Rudra 2007; Seekings 2008; Esser et al. 2009; Mkandawire 2020).

2.2.1 Welfare versus programme universalism

Universalism is often measured at the welfare state level, as a system-level characteristic within broader welfare regime typologies (Esping-Andersen 1990; Wood and Gough 2006; Martínez Franzoni and Sánchez-Ancochea 2021). However, this approach overlooks a key conceptual distinction between welfare state universalism and programme universalism. While the former refers to a system of interconnected universal policies, the latter describes the equitable and comprehensive provision of benefits or services in specific policy domains, such as pensions, healthcare, or social assistance (Rothstein 1998; Bergh 2004). The two concepts are related but not equivalent and hence require separate analysis and

[13] Specifically, OECD countries, due to data limitations.

measurement – even though findings on programme universalism are frequently extended to the welfare state level (and vice versa).[14]

I argue that aggregate measures of universalism at the welfare state level have substantial shortcomings – especially in Global South contexts – and instead suggest focusing on a programme-level approach. Firstly, combining disparate policy areas into one measure presents an aggregation problem of how fundamentally different policy characteristics – say the share of means-tested benefits and the level of service coverage – can be systematically compared and weighted. This issue persists even in the context of qualitative measures, such as welfare regime typologies, where implicit weighting choices determine which programmes carry more analytical weight.[15] Moreover, aggregate measures of 'welfare stateness' also hide substantial and relevant variation across policy domains (Kunißen 2023). For example, a country with high levels of universalism in one policy domain and low levels in another should be analytically distinct from one with medium achievements in both.

Most importantly, system-level measures implicitly assume that the consequences and determinants of universalism are uniform across all policy domains. While this might be true in some cases of highly integrated and coherent welfare states, it seems likely that sector-specific dynamics – such as welfare norms, target groups, or delivery models – produce divergent patterns across programmes. When collapsing these into aggregate 'black box' measures, such as welfare regimes[16] or general social spending, variation between programmes is limited and the actual policy effects are likely to be obscured (Bergqvist, Yngwe, and Lundberg 2013; Nelson and Fritzell 2014). These concerns are especially salient in the Global South, where social policies often remain fragmented, less institutionalised, and shaped by external factors, leading to lower policy coherence and differing conditions for universalism.

[14] For example, in the context of the 'paradox of redistribution' debate (Korpi and Palme 1998; Brady and Bostic 2015; Jacques and Noël 2018). It is unclear whether the empirical case study of universalism in pension benefits by Korpi and Palme (1998) is representative of the overall welfare state or if the effects differ when considering other social policies.

[15] For instance, Esping-Andersen's (1990) original welfare regime typology mainly relies on decommodification scores based on unemployment, pensions, and sickness benefits, while not considering areas like healthcare, education, or family policy. This implicitly gives more analytical weight to income replacement programmes, potentially reflecting the institutional traditions of historic Northern welfare states.

[16] It is important to note that this is not meant as a general critique of the literature on welfare regimes, which has sparked an important literature in comparative social policy, but rather of the use of this tool to explore universalism.

2.2.2 Conceptual pitfalls in global measures of universalism

The key challenge in measuring universalism lies in the conceptual decision of what should be captured empirically, and the associated risks of conflating core characteristics of universalism with its determinants or outcomes. This particularly applies to efforts to develop globally comparative measures of universalism, considering that internationally comparative data is scarce and the diversity of national welfare systems is substantial. For instance, in her seminal contribution to the Southern welfare typology literature, Rudra (2007) includes literacy and infant mortality rates in a commodification index to reflect the effects of past policy efforts. While the intention is to complement spending-based metrics,[17] this approach potentially introduces reverse causality and endogeneity as welfare outcomes are shaped by broader contextual factors that go beyond social policy, including demography, economic development, institutional legacies, and social change (Marchal and Van Lancker 2019). Similarly, in much of the Nordic literature, universalism is often equated with specific institutional characteristics – such as tax financing or national insurance models – that represent instruments rather than the policy output itself (see Section 2.1). This conflation of determinants, outputs, and outcomes introduces substantial measurement bias and weakens cross-national and historical comparability.

Relatedly, a common issue arises from the reliance on narrowly defined proxy indicators. For example, in their cross-national studies of Latin America, Niedzwiecki (2018) employs the share of births attended by skilled personnel as a proxy for access to public health services, while Giraudy and Pribble (2019) use the measles, mumps, and rubella (MMR) vaccination coverage rate to construct a subnational index of healthcare universalism. While such an approach offers clear advantages by capturing otherwise unmeasurable spatial variation, it also risks reducing complex macro-level variables to a single policy output. Individual interventions or policy outputs are often shaped by country-specific contextual factors, such as policy legacies, social norms, or cultural preferences. Moreover, the availability and quality of data for specific interventions may itself be endogenous, reflecting policy interest and programming from national governments or international actors rather than system-wide performance (Merry 2011; Jerven 2013).

A further measurement consideration relates to the distinction between de jure and de facto universalism – that is, between legal coverage and the actual realised access to benefits and

[17] With their well-known shortcomings, see Kunißen (2023) for an overview.

services in practice. While national legislation can be a powerful indicator of public commitments to universal provision, it does not guarantee effective access, quality, or equity on the ground (Öktem 2020). This particularly applies to emerging or nascent welfare states, where legal provisions, for example, the 'right to health', may reflect global policy diffusion or external donor influence, but remain weakly implemented (Backman et al. 2008).[18] In such contexts, non-legal barriers – such as inadequate infrastructure, rural remoteness, or restrictive gender norms – can undermine access and reinforce segmentation, regardless of legal coverage.

Another commonality in many approaches in the literature is to measure universalism by its considered opposite: the degree of targeting or segmentation. For example, Jacques and Noël (2018) use the share of cash benefits that are means-tested to create a universalism index for 20 OECD countries. This approach is based on the notion that universalism and targeting are two ends of a spectrum and hence can be inversely measured. While intuitively appealing, the literature on the Global South emphasises the need to incorporate the multidimensionality of universalism, rather than relying on simple dichotomies of universalist versus targeted policies that might obstruct key system characteristics. For example, even when a country offers non-means-tested benefits, these policies might still not be fully universal if they are only available to a small number of beneficiaries or if their quality is poor.

Instead, drawing on multidimensional concepts of universalism, authors like Fischer (2012) and Pribble (2013) emphasise the need to also reflect these 'varieties of universalism' in measurement approaches. For example, Martínez Franzoni and Sánchez-Ancochea (2018) use a range of ten indicators to measure universalism in Latin America across the three dimensions of Coverage, Generosity, and Equity. These include both output and outcome-related indicators, such as coverage for salaried and non-salaried workers (Coverage), the proportion of births attended by skilled personnel (Generosity), the neonatal mortality rate (Generosity), private health spending (Equity), and inequalities in health insurance coverage (Equity). While this approach usefully captures the multidimensional nature of universalism, it also raises challenges around comparability and the relationships between dimensions. The high number of indicators potentially introduces multi-collinearity, while the implicit weighting may obscure underlying trade-offs between policy outputs. Looking ahead, a more

[18] See also Chapter 4.

parsimonious approach that retains multidimensionality but relies on a smaller set of selected policy output indicators – and explicitly considers their interrelations, weighting, and conceptual trade-offs – may offer a more tractable and analytically useful framework for globally comparative analysis.

3. Constructing the Healthcare Universalism Index

3.1 Overview and concept

This section introduces the Healthcare Universalism Index (HUI), a novel composite indicator to measure 'varieties of universalism' in healthcare across 204 countries from 1995 to 2023. The index builds on the conceptual framework developed by Martínez Franzoni and Sánchez-Ancochea (2016), which defines universalism as a multidimensional policy output encompassing full population coverage, high quality of services, and low levels of segmentation. The HUI combines these three dimensions of policy outputs – Coverage, Generosity, and Equity – into a single, globally comparable index.

Going beyond coverage as the traditional focus of global healthcare policy, the HUI shifts the conceptual focus to aspects of quality and segmentation of healthcare provision.[19] In focusing on concrete policy outputs rather than legal entitlements, policy instruments, or institutional models of delivery, the index operationalises healthcare universalism in a way that is applicable across diverse political, institutional, and development contexts. It assumes that the goals of universalism – the whole population having access to similar, high-quality healthcare services – are shared across the world, but recognises that there are different policy pathways to achieving them.

Drawing on a small set of widely available macro-indicators, the main purpose of the HUI is to provide a parsimonious and theoretically grounded tool to compare healthcare systems over time and across countries. The selected indicators signify system-level characteristics common to all healthcare systems and correspond to the theoretical core of the universalism concept. The three dimensions are measured through normalised subindices and aggregated using a geometric mean with equal weights, following a similar logic to the Human Development Index (HDI). This aggregation method reflects the underlying principle that universalism is not achieved through progress on a single dimension, but through balanced achievement across all three.

The rationale for combining these indicators into a composite index is threefold. Firstly, the selected indicators provide high-level representations of universalism in health systems that

[19] While quality considerations are at least part of the policy discourse, both quality and equity are almost entirely absent in the current measurement of universal healthcare. For example, the official SDG 3.8 indicators only measure the coverage of 'essential services' and the share of the population with 'catastrophic' health expenditures (WHO 2025).

are applicable across diverse country contexts, compared with individual health interventions or inputs that are often shaped by national political, social, or cultural factors (Giraudy and Pribble 2019). Secondly, focusing on a small number of aggregate indicators with good data availability enables the measurement of health universalism on a truly comprehensive level, both across countries and time. In comparison, even the official SDG indicators 3.8.1 and 3.8.2 suffer from significant gaps in data availability: in the analysis period of 2013-2017, no country had data on more than 70% of UHC indicators (WHO 2019). Thirdly, the HUI builds on the conceptual premise that only the joint achievement in all three dimensions can lead to truly universal healthcare systems – and consequently, that their achievement depends on each other. In isolation, high achievements in individual dimensions may obscure problematic outcomes in others, for example, high coverage co-existing with severe inequalities in service quality.

3.2 Dimensions and indicators

The HUI is constructed based on three sub-indices that reflect the three dimensions of universalism: Coverage, Generosity, and Equity. Each dimension is represented by a single macro-level health system indicator that has been chosen based on theoretical significance, global comparability, and data availability. Together, these dimensions provide a parsimonious framework for capturing healthcare universalism across 204 countries and territories[20] between 1995 and 2023.

The dimensions of universalism are operationalised through the following indicators:

- **Coverage**: UHC effective coverage index (Lozano et al. 2020).
- **Generosity**: Government health spending as a percentage of GDP (Global Burden of Disease Collaborative Network 2025a, 2025b).
- **Equity**: Private health spending as a percentage of total health spending (Global Burden of Disease Collaborative Network 2025a, 2025b).

3.2.1 Coverage

The Coverage dimension of the HUI is measured using the UHC effective coverage index developed by Lozano et al. (2020), which estimates the realised access to care adjusted for

[20] The HUI also includes a range of territorial entities that are not universally recognised as independent countries or are politically associated with other states, such as Greenland, Guam, Palestine, Puerto Rico, and Taiwan. For simplicity, these entities are subsumed under the term 'countries' for the remainder of this paper.

country-specific disease burden and population structure. The composite index is based on the *Global Burden of Diseases, Injuries, and Risk Factors Study* (GBD) and comprises 23 life cycle indicators of healthcare, mapped into a matrix of five population groups (such as 'reproductive and newborn' or 'older adults') and five health service domains (such as 'promotion', 'treatment', or 'palliation').

Four of these indicators are direct measures of service coverage, and 19 are estimated based on health and mortality outcomes to proxy for access to quality care.[21] To construct the index, the indicators are weighted by their potential health gains,[22] depending on each country's population structure and disease burden. For example, HIV treatment coverage receives greater weight in countries with high HIV incidence, while countries with a larger share of older adults receive a higher weight for indicators related to their health needs. The index provides a context-sensitive and life-cycle perspective on effective access to healthcare. The data is available for 204 countries from 1990 to 2023 and has been sourced from the Gates Foundation's *2024 Goalkeepers* report and database (Bill & Melinda Gates Foundation 2024).

The UHC effective coverage has been chosen for the HUI as it represents realised rather than theoretical access to care. Unlike measures of legal entitlements, the index captures whether people actually receive access to the specific healthcare services they need, when they need them. As most of the estimates are outcome-based, this approach accounts for a broad range of barriers to healthcare access that might not be covered in traditional measures, including geographical, institutional, or social barriers. Similarly, in contrast to alternative indicators that focus on single interventions – such as vaccination coverage – as representatives of the overall healthcare system, the perspective on life cycle and disease burden makes the index applicable to each country context.

3.2.2 Generosity

The Generosity dimension of the HUI is measured using government health spending as a percentage of GDP, drawing on data from the Institute for Health Metrics and Evaluation (IHME) at the University of Washington (IHME 2025). This indicator measures the extent to which governments commit financial resources to the health sector relative to the size of

[21] The outcome-based indicators are estimated based on mortality ratios from the GBD, assuming that higher survival (relative to disease burden) reflects better access to effective care. For example, a lower cancer mortality – relative to incidence – is assumed to reflect higher effective coverage. For details, see Lozano et al. (2020), Appendix 1.
[22] In disability-adjusted life years for each location-year and age group.

their national economy. The data is based on modelled estimates of the WHO's *Global Health Expenditure Database,* extending and harmonising these for a sample of 204 countries from 1995 to 2023. The data is sourced from the IHME's *Global Health Spending* and *Global Expected Health Spending* databases (Global Burden of Disease Collaborative Network 2025a, 2025b).[23]

Government spending is a well-established measure of generosity in both the global health and comparative welfare literature. It reflects a state's fiscal capacity and political commitment to provide high-quality healthcare for the population. It is based on the conceptual assumption that the state is the central provider of universal healthcare and that achieving universalism requires substantial public investment to enable comprehensive and accessible services for all. While the indicator does not capture the actual quality of care provided, it serves as a high-level proxy for the depth and breadth of public provision and the government's commitment to delivering comprehensive care. Moreover, when used in conjunction with the two other HUI dimensions, it complements the coverage and equity indicators by situating service provision within broader state capacity. Importantly, in measuring government health spending as a share of GDP, this measure accounts for cross-country differences in economic development.

3.2.3 Equity

The Equity dimension of the HUI is measured using private health spending as a percentage of total health spending, based on modelled data from the IHME. This indicator captures the public-private mix in healthcare financing and reflects the degree of segmentation in access to quality care. Similar to the Generosity dimension, the data is drawn from the IHME's *Global Health Spending* and *Global Expected Health Spending* databases, covering 204 countries from 1995 to 2023 (Global Burden of Disease Collaborative Network 2025a, 2025b). For the HUI, all out-of-pocket and private prepaid expenditure is aggregated as private health spending.

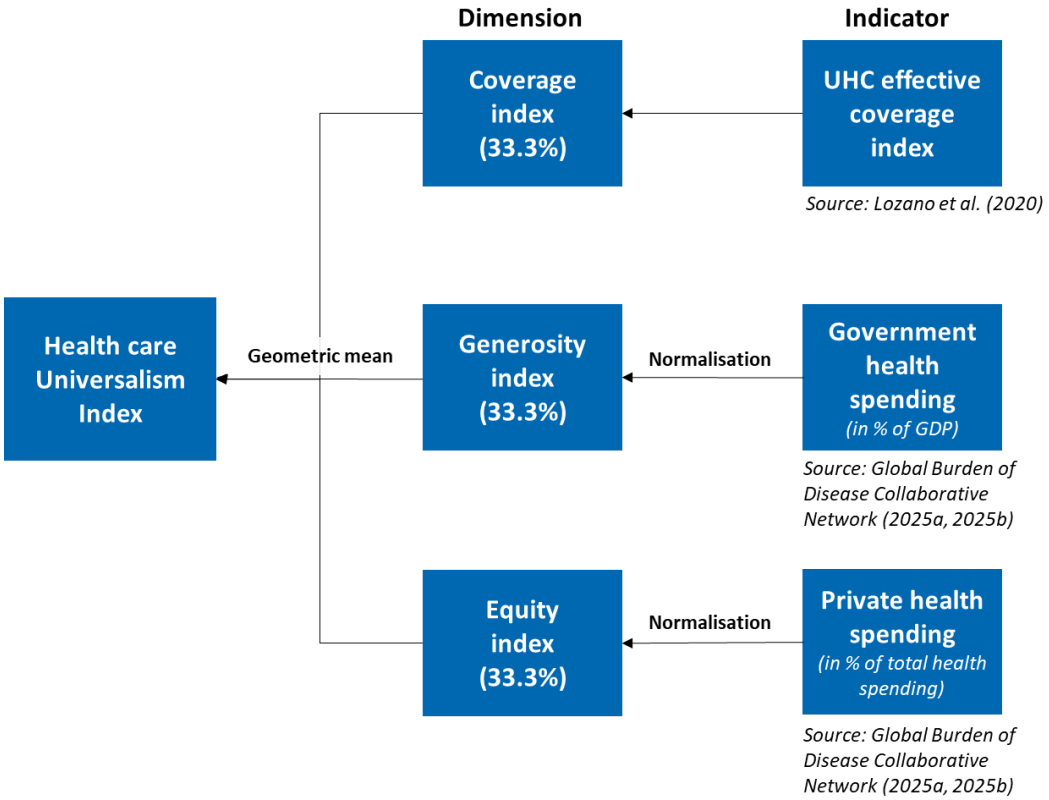
This measure reflects the commodification of healthcare: when private financing dominates, access to quality services becomes increasingly dependent on individuals' ability to pay – in contrast to the universalism principle of equitable services regardless of their socio-

[23] As the *Global Health Spending* database provides estimates until 2022, it has only been used to extend the overall timeseries to 2023. The continuation of the timeline was checked manually and empirically for consistency, with no structural breaks or discontinuities observed between the original and extended data series.

economic status. A high share of private spending, therefore, signals greater segmentation, where wealthier groups can secure superior healthcare, while lower-income groups rely on lower-quality public services or are even excluded altogether. In contrast, a low level of private financing indicates a more unified system of public service provision that offers similar healthcare to all socio-economic groups.

This relies on the underlying assumption that high levels of private spending reflect weaknesses in public provision, which pushes middle- and upper-income groups to choose private alternatives – a phenomenon commonly observed in many Global South contexts (Basu et al. 2012; Martínez Franzoni and Sánchez-Ancochea 2016). This dynamic contributes to the emergence of 'pseudo' or legal multi-tier systems of healthcare provision, where access and quality are stratified by socioeconomic status. The same logic applies to systems where different tiers exist within public provision itself, and lower tiers are associated with significant levels of out-of-pocket spending. Private spending is interpreted not simply as a measure of who pays for healthcare, but as a system-level proxy for segmentation: the extent to which access and quality differ across groups.

Figure 2. Construction of the Healthcare Universalism Index



3.3 Index scaling and aggregation

The HUI is calculated as the geometric mean of three normalised sub-indices in Coverage, Generosity, and Equity – following a similar logic to the Human Development Index. The index is constructed in two steps: first, by normalising each underlying indicator to a 0-1 scale based on aspirational thresholds, and second, by aggregating the sub-indices into a composite score using equal weights. Figure 2 illustrates the construction of the index.

3.3.1 Index scaling

As the first step, each of the selected indicators is normalised to a 0 to 1 scale to create its corresponding dimensional sub-index. As the UHC effective coverage index is already normalised, this procedure only applies to the Generosity and Equity dimensions. To achieve this, the data is rescaled based on normative minimum and maximum thresholds for each indicator, in line with an 'aspirational target' and 'natural zero' approach in composite index construction (OECD 2008; UNDP 2025).

An alternative approach would be to use a min-max scaling method based on the observed extreme values over the sample period. However, such an approach has several limitations: it is sensitive to extreme outliers,[24] dependent on the specific period of time, and lacks theoretical justification. Instead, the HUI relies on normative thresholds that reflect meaningful aspirational goals in global health policy and are robust to future extensions of the index. The relevant thresholds are summarised in Table 1.

Table 1. Limits of the Generosity and Equity indices

Indicator	Minimum	Maximum
Government health spending as a % of GDP	0 percent	10 percent
Private health spending as a % of total health spending	10 percent	75 percent

For the Generosity index, the minimum threshold is 0 percent, reflecting the complete absence of public health spending. The upper bound is set at the aspirational maximum of

[24] Which are quite common in the sample, given that it has (almost) full global coverage.

10 percent of GDP, based on both empirical and normative considerations from the global health literature. A substantial policy and academic literature has focused on the question of how much domestic investment is necessary to achieve universal health coverage, such as the well-known 2001 *Abuja Declaration,* in which African Union member states committed to allocating 15 percent of their government budgets to health (African Union 2001).

As public budgets vary widely and do not necessarily reflect fiscal capacity, the literature has focused primarily on targets in relation to national GDP, with the WHO referencing a target of 5 percent of GDP in policy documents as early as 1981 (Savedoff 2007). In a review of this existing literature and a conservative estimation strategy, Mcintyre, Meheus, and Røttingen (2017) indeed find a target of at least 5 percent of GDP to be the most appropriate for countries across all development levels. This target has since been integrated into a range of high-level policy calls for action, including at the *UN High-Level Meeting on Universal Health Coverage* in 2019 (UHC2030 2019).

Given that the 5 percent target represents a minimum requirement, and the universalism concept goes beyond UHC, a more ambitious upper threshold of 10 percent is employed for the HUI. This acknowledges the substantial investments required not only to enable broad-based coverage but also to ensure high quality and equity of services for all. The limit also aligns with the empirical data, as only eight countries reached or exceeded this threshold at any point during the sample period, making it a meaningful yet aspirational upper bound.

For the Equity index, the lower bound is set at a 10 percent share of private health spending, acknowledging that some private sector provision is both inevitable and acceptable within fully universal systems.[25] This recognises that even in very generous public health systems, some services – such as cosmetic surgery, alternative medicine, or medical tourism – would fall outside of public provision. In being compatible with a limited private sector, the measurement reflects patients' freedom of choice while allowing for some supplementary private services. Empirically, only a small number of countries during the sample period reach this threshold, such as Cuba, Micronesia, Mozambique, and the Solomon Islands, confirming its suitability as a high standard of equity.

[25] An alternative minimum threshold of 5 percent was considered during index construction; however, this would have treated differences between highly equitable countries as meaningful, for example the difference between Cuba at 8.7 percent and the (outlier) Solomon Islands at 3.0 percent in 2022.

The upper threshold of the Equity index is set at 75 percent private health spending, reflecting a level of segmentation and commodification that fundamentally undermines the principles of universalism.[26] At such a high level of market dependence, healthcare can no longer be considered equitable, as access and quality of care are primarily determined by individuals' ability to pay. While a public sector may still formally exist under this threshold, it operates residually, with private provision dominating the health system. As discussed in Section 2.1, such a health system can be defined as being fully segmented with multi-tiered service provision, where higher-income groups opt out of underfunded, inadequate public systems, leaving disadvantaged groups behind.

A private share of 75 percent in health spending signals an entirely residual role of public sector provision, limited to basic or emergency care for the poorest, and is typically characterised by low quality and widespread reliance on out-of-pocket spending. This institutionalisation of inequities in access and quality stands in contradiction to the concept of universalism and ultimately the principles of health as a human right. Therefore, the 75 percent threshold serves as a normative upper bound that reflects full segmentation and the effective absence of equity in healthcare.[27]

Based on these thresholds, the dimension indices are then calculated as:

$$I_{D,ij} = \frac{x_{ij} - x_{min}}{x_{max} - x_{min}}$$

Where $I_{D,ij}$ is the dimension index D for country i and year j, and x_{ij} is the corresponding observation.

As the equity indicator measures the level of (negative) market segmentation, the resulting index is additionally transformed by subtracting it from 1, such that for each sub-index, higher values correspond to more universal outcomes. In rare cases where outlier countries fall

[26] An alternative maximum threshold of 100 percent was considered during index construction; however, this 'natural' upper bound was rejected both conceptually and empirically. Firstly, because the concept of full segmentation does not deny the existence of a public sector, but rather of multiple tiers of provision that tie socioeconomic status to access and quality. Secondly, because it implies an empirical difference between very high levels of private spending, say between 80 and 85 percent, while both describing a scenario where the public sector takes a fully residual role.

[27] Across the sample, a small but significant number of countries have crossed this threshold at some point during the period, including Afghanistan, Bangladesh, India, Sierra Leone, South Sudan, and the Democratic Republic of Congo.

under the minimum threshold for a sub-index, a small positive minimum value of 0.01 is assigned to avoid the collapse of the geometric aggregation method.[28]

3.3.2 Index aggregation

In the second step, the three resulting dimensional indices are aggregated using a geometric mean with equal weights, with the HUI given as:

$$HUI_{ij} = (I_{Coverage,ij} * I_{Generosity,ij} * I_{Equity,ij})^{\frac{1}{3}}$$

The choice for a geometric aggregation method builds on the conceptual understanding of universalism as a balanced achievement across all dimensions. Universalism, as defined in Section 2.1, implies that no single dimension can compensate for severe deficiencies in others – say, high levels of coverage for low equity. Therefore, the geometric mean captures the idea of imperfect substitutability, where high scores in one dimension cannot offset low achievements in others, and where equal achievement across all dimensions is rewarded.[29]

Mathematically, geometric averages make the marginal contributions of each dimension index dependent on the levels of others, that is, gains in Generosity contribute more to HUI growth at high levels of Coverage and Equity, and vice versa. This reflects the concept of diminishing returns, where unbalanced improvements in only one dimension lead to increasingly lower gains in the overall index. While this mathematical property has been criticised in the Human Development Index (Ravallion 2012; Anand 2018), it conceptually fits the context of universalism. For example, one could imagine a scenario where increasing the already high service coverage is less desirable than reducing inequality in access to these services.

The final conceptual choice concerns the weighting scheme. The HUI assigns equal weight to each dimension index based on the theoretical assumption that all are equally important for achieving true universalism. An alternative approach would be to use a Principal Component Analysis (PCA) to determine the weights of each dimension based on the proportion of variance each component explains.[30] However, this approach lacks the theoretical justification of the universalism framework and therefore complicates the

[28] Which account for less than 1.5 percent of the sample: particularly countries affected by crisis and conflict, such as Afghanistan or Yemen.
[29] As an alternative, an arithmetic mean implies perfect substitutability as reductions in one sub-index can be linearly compensated by equal increases in another.
[30] This approach has been used in the context of UHC measurement, for example, by Leegwater, Wong, and Avila (2015).

interpretation of results. Additionally, the PCA method tends to disadvantage indicators with low variation, independent of their theoretical importance – a case that applies especially for relatively 'slow' moving indicators like government spending.

3.4 Validation

To assess the validity of the index, three types of robustness and sensitivity checks are employed to examine if the empirical behaviour of the HUI is consistent with its underlying conceptual framework. First, I evaluate convergent validity by correlating the HUI with a range of health system indicators. Second, I assess the internal structure of the index by using PCA to determine whether the underlying indicators capture a common latent concept. Third, I test the robustness of results by examining the sensitivity of country rankings to alternative modelling choices.

Table 2. Correlation matrix: HUI and selected health system indicators

	HUI	UHC Service Index	OOP health expend.	Under-5 mort. rate	ART coverage	Births attended by pers.	Measles vacc. rate
HUI	**1**						
UHC Service Index	**0.687*****	1					
OOP health expenditure	**-0.791*****	-0.405***	1				
Under-5 mortality rate	**-0.613*****	-0.813***	0.164	1			
ART coverage	**0.520*****	0.596***	-0.439***	-0.439***	1		
Births attended by skilled pers.	**0.504*****	0.774***	-0.217*	-0.834***	0.390***	1	
Measles vaccination rate	**0.446*****	0.637***	-0.242**	-0.569***	0.0853	0.611***	1

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 2 presents the pairwise correlations of the HUI with a set of health system outputs and outcomes that are expected to be positively associated with the concept of healthcare universalism.[31] Most importantly, the HUI shows a strong positive correlation with the official SDG target 3.8.1 indicator of UHC Service Coverage (Hogan et al. 2018). Reflecting the emphasis on Equity, the index strongly correlates negatively with the level of out-of-pocket health expenditure, aligning closely with the SDG 3.8.2 target on financial protection.[32]

[31] All indicators were sourced from the *World Development Indicators* from the World Bank.
[32] The official measurement of this target includes a range of indicators of the population share with health expenditures over a certain threshold, such as 10, 25, or 40 percent of household expenditure

Further positive associations with lower under-five mortality rates, higher antiretroviral therapy (ART) coverage, greater prevalence of births attended by skilled personnel, and higher measles vaccination rates reinforce the HUI's convergent validity. All significant coefficients are in the expected direction, with stronger relationships observed for indicators most directly linked to the HUI's dimensions.

Table 3. Principal Component Analysis of HUI sub-indices

Component	*Eigenvalue*	*Proportion of variance*	*Cumulative variance*
1	**1.985**	**0.6618**	**0.6618**
2	0.675	0.225	0.887
3	-0.340	0.113	1
Variable loadings on first principal component			
Variable		*Loading*	
Coverage		0.530	
Generosity		0.632	
Equity		0.565	

Table 3 summarises the results of the PCA on the three HUI sub-indices of Coverage, Generosity, and Equity. PCA is a dimensionality-reduction technique that transforms a set of (correlated) indicators into a smaller set of orthogonal components that retain most of the variance, where each component can be interpreted as an underlying construct that links the related indicators. Only the first principal component exceeds the conventional eigenvalue threshold of 1.0 (Jolliffe 2002; OECD 2008) and accounts for over 66 percent of the variance, strongly suggesting that the three dimensions jointly capture a coherent, latent concept – supporting their combination in a composite index. Furthermore, all three dimensions load positively and with similar magnitude on the shared component: when converted into PCA-derived index weights (see Section 3.3.2), these loadings correspond to 30.7 percent for Coverage, 36.6 percent for Generosity, and 32.7 percent for Equity – values that closely approximate the equal weighting scheme adopted in the baseline HUI.

or income. While the HUI also shows a negative correlation with these indicators (around -0.33), the data availability is quite limited, with less than 900 observations across the sample.

Table 4 presents the results of various sensitivity checks regarding alternative modelling choices. For each choice, the table reports the correlation and average rank difference between the HUI and the alternative specifications for 2023. The sensitivity checks vary the aggregation method (geometric versus linear), the weighting scheme (PCA-derived weights; alternative normative weights of 50:25:25 and 40:40:20 for Coverage, Generosity, Equity), the normalisation strategy (min-max scaling and alternative bounds at 5 and 100 percent for Equity), and the exclusion of dimensions (dropping Generosity or Equity).

Table 4. Sensitivity of the HUI to alternative specifications

	Correlation	*Average rank difference*	*Maximum rank difference*
Arithmetic mean	0.9865	8.2	87
PCA weights	0.9995	1.3	7
Alternative weights (50:25:25)	0.9888	6.4	40
Alternative weights (40:40:20)	0.9910	6.5	42
Alternative Equity normalisation	0.9894	5.6	48
Min-max normalisation	0.9237	15.5	84
Exclude Generosity dimension	0.8950	20.0	143
Exclude Equity dimension	0.9378	16.0	102

Across nearly all alternatives, the HUI remains highly stable with very high correlation coefficients and only modest differences in country rankings. The PCA-weighted index is almost identical to the baseline HUI, while alternative weighting schemes and wider normalisation thresholds for the Equity dimension have only modest impacts on country ordering. An arithmetic aggregation method has little effect on overall values but leads to larger ranking shifts because countries can linearly compensate for imbalances in their dimension indices. Similarly, min-max normalisation – where each sub-index is scaled using the 1st and 99th percentile values across the sample[33]– produces larger rank differences as outliers increase the overall spread and compress scores for the majority of countries. Finally, as expected, the index is most sensitive to the exclusion of individual dimensions,

[33] Technically, a min-max normalisation would require scaling the indicators by their total maximum and minimum values across the sample. However, this would make the index even more dependent on extreme outliers (such as Niue, which spent over 30 percent of its GDP on health in 2007).

particularly Generosity, which underscores that these dimensions hold distinct and relevant information, warranting their inclusion in the composite index. Overall, these checks indicate that the HUI is robust to reasonable choices about aggregation, weights, and thresholds, while confirming the substantive importance of retaining all three dimensions in one composite index.

3.5 Limitations

The proposed HUI offers a parsimonious and globally comparable tool for assessing healthcare systems, but it has several limitations.

Firstly, each of the selected indicators has empirical constraints. The UHC effective coverage index includes estimates for health gains that are influenced by factors beyond healthcare provision, such as technological advancements or lifestyle changes. Government health spending may be high not because of high quality, but because of inefficiencies, waste, or excessive use of technology. Similarly, private health spending captures a particular dimension of equity, but does not directly measure the extent to which different groups are being covered.

Secondly, due to its focus on national-level indicators, the HUI does not capture sub-national differences in Coverage, Generosity, and Equity. While the UHC effective coverage index incorporates some regional differences in health needs, service access, and quality may still differ widely within countries, for example, between urban and rural areas. Similarly, the HUI assumes the formal public sector as the main provider of healthcare, but does not account for informal healthcare provision, which is significant in many low- and middle-income countries.

Thirdly, due to the construction of the UHC effective coverage index, there is some empirical overlap between the Coverage and Generosity dimension of the HUI. In measuring access to quality care, the index also captures elements that go beyond simple coverage and are likely shaped by public investment. Lastly, while the underlying data are drawn from harmonised global sources, there may still be inconsistencies in country-level reporting, especially in relation to private expenditure. Similarly, as all data sources rely on modelled estimates, measurement errors remain a concern. The HUI aims to minimise these errors by drawing on the same sources from the Institute for Health Metrics and Evaluation and the *Global Burden of Diseases, Injuries, and Risk Factors Study* (IHME 2025).

Despite these limitations, the use of the three indicators simultaneously mitigates some of the shortcomings of each measure. For example, the inclusion of effective coverage helps counterbalance potential overestimation of generosity based solely on public spending, while the geometric aggregation method ensures that no single dimension can compensate for deficiencies in the others. As more disaggregated and globally comparable data become available in the future, the index can be further refined to incorporate more direct measures, particularly for the Generosity and Equity dimensions.

4. Descriptive results: Tracing the distribution and evolution of healthcare universalism across the world

This section explores the descriptive statistics of the Healthcare Universalism Index (HUI) and examines whether there has been a global convergence towards universalism in healthcare between 1995 and 2023. The first sub-section presents a snapshot of the distribution of the HUI in 2023, while the second traces trends in the index and its dimensions over time.

4.1 The HUI in 2023: Global gaps in universalism

Figure 3. The Healthcare Universalism Index in 2023

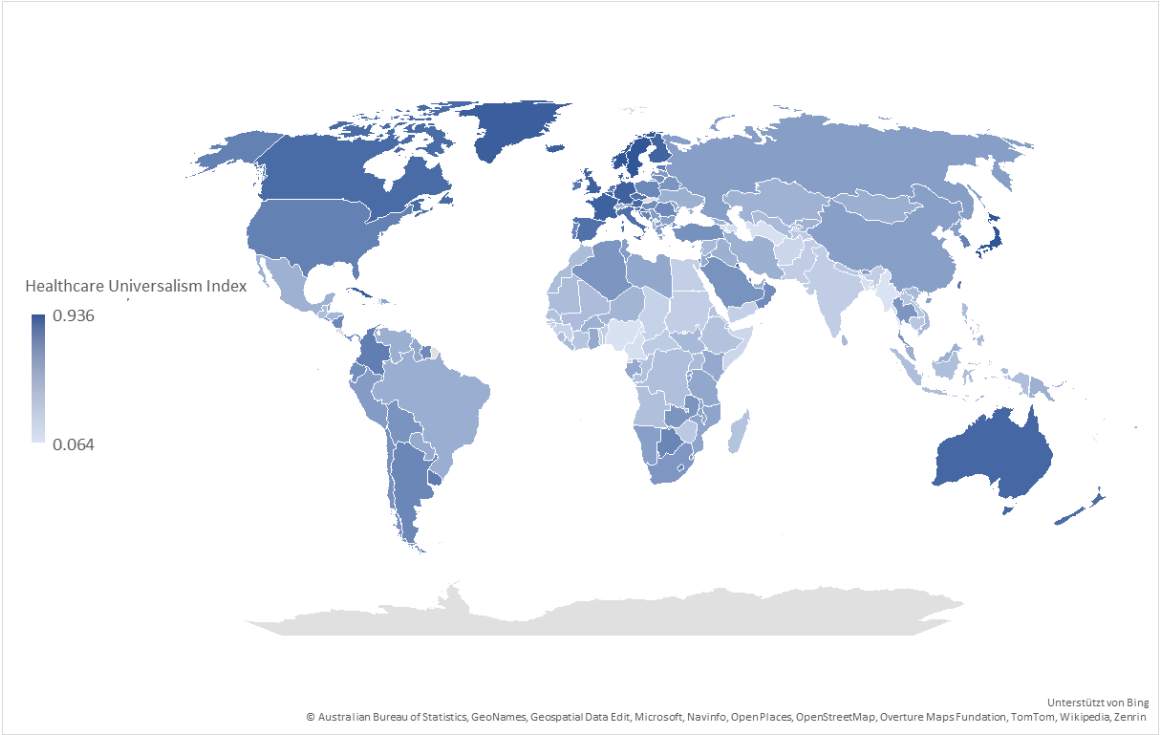
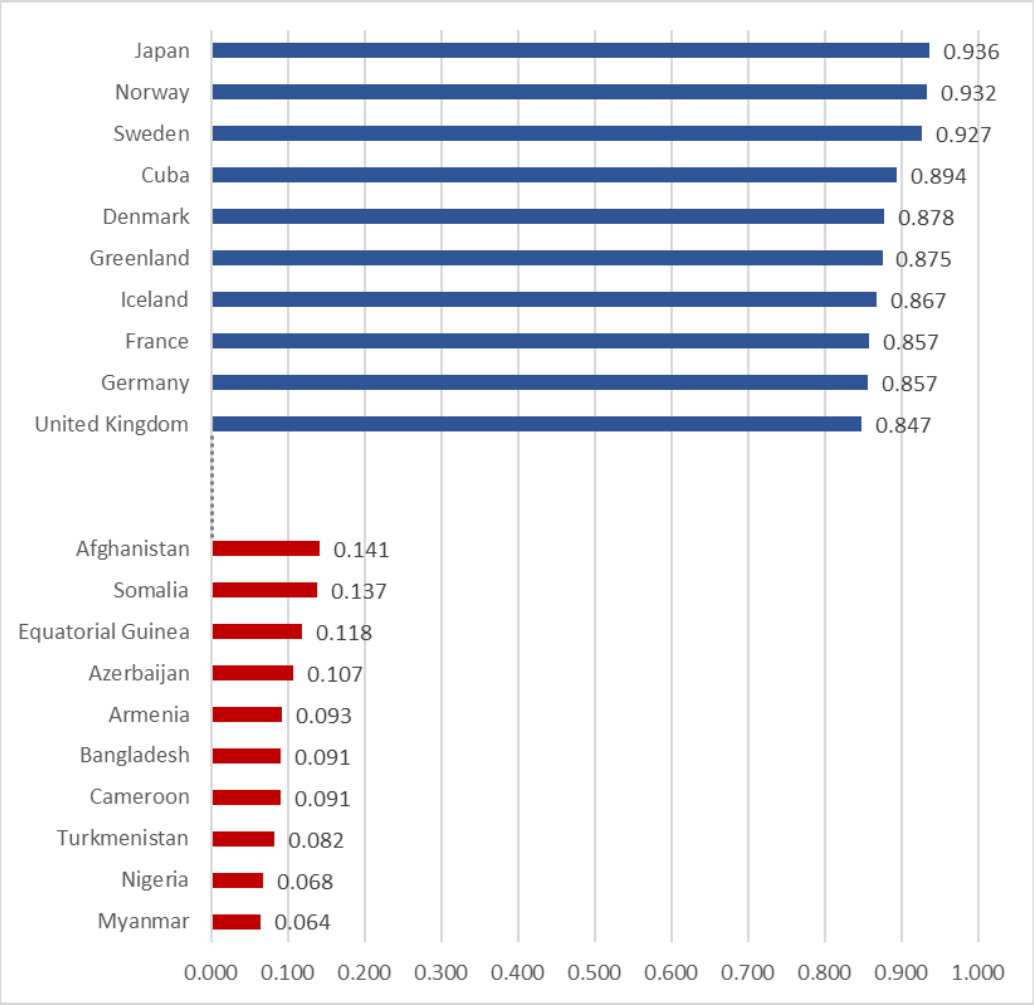


Figure 3 illustrates the global distribution of the HUI for the latest available year, 2023, with the colour intensity indicating the level of healthcare universalism. The distribution reveals high levels of dispersion and regional trends, with significant differences between countries of the Global South and the Global North. Countries with comparatively low HUI scores tend to be concentrated in South Asia, Sub-Saharan Africa, and parts of Central Asia, whereas higher levels of healthcare universalism are found in clusters across Europe, South America, and parts of East Asia.

Figure 4. HUI 2023: Top and bottom ten countries



While there appears to be a general distinction between countries of the Global North and Global South, there is considerable heterogeneity. Countries like Kuwait (0.763), Costa Rica (0.713), the Maldives (0.682), and Lesotho (0.662) perform substantially better than some higher-income countries like the United States (0.667), Hungary (0.585), Cyprus (0.464), or Albania (0.377).[34] As the most prominent exception, Cuba is ranked 4th in the world, overtaking historically universal countries like Denmark, Iceland, and the United Kingdom. For further illustration, Figure 4 presents the 10 countries at the top and bottom of the HUI distribution in 2023.

[34] Interestingly, low scores among many countries of the Global North are due to imbalances in achievements across the three dimensions of universalism. For example, while Uruguay scores almost equally well across coverage (0.71), generosity (0.66) and equity (0.72), countries like the United States are characterised by large differences in dimension scores, especially between coverage (0.86) and equity (0.39). Due to the structure of the HUI as a geometric mean, these imbalances are amplified in the overall score.

Figure 5. Average HUI levels in 2023

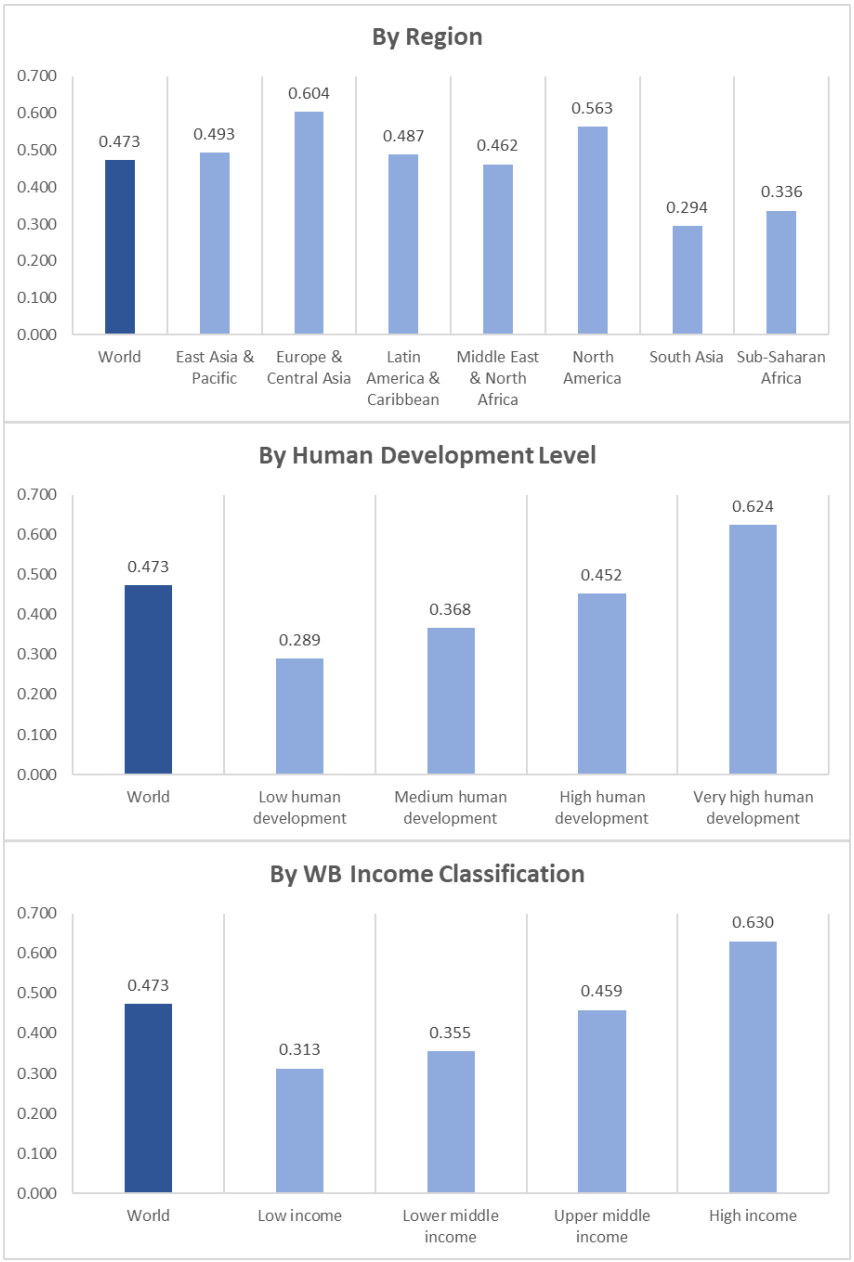
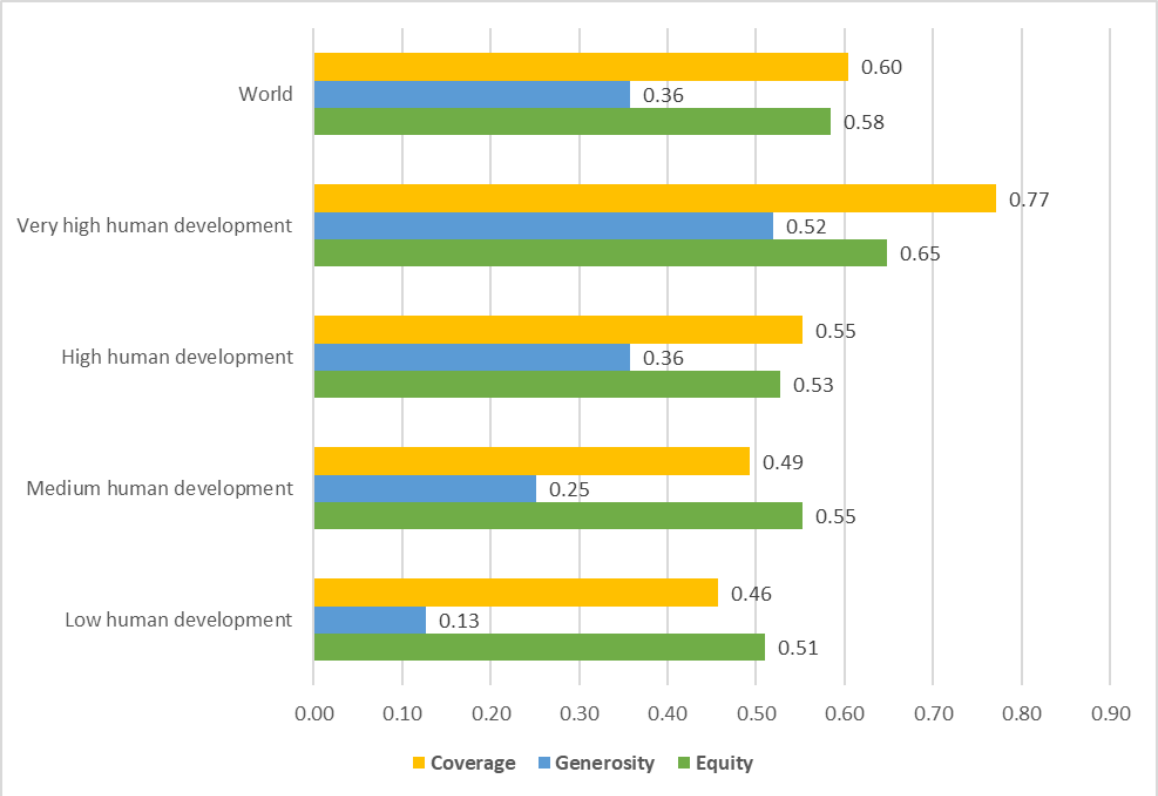


Figure 5 illustrates the average HUI levels by geography, World Bank income classification, and human development for 2023. The regional disaggregation highlights persistent differences in the HUI around the world, with countries in South Asia and Sub-Saharan Africa lagging. In a comparative perspective, East Asia and the Pacific, along with Latin America and the Caribbean, stand out as the regions with the highest average level of universalism in the Global South. Both regions score above the world average and approach the levels of historically more universal regions in Europe and North America.

Consistent with these regional trends, healthcare universalism increases with economic and human development, with high-income and very high human development countries showing the highest average HUI scores. However, an interesting trend emerges when examining the gaps between development levels: the absolute differences in average HUI scores decrease when moving down the income and development scale. For example, while very high human development countries lead with an average score of 0.624, the gap narrows between high (0.452), medium (0.368), and low (0.289) human development countries. This might suggest that countries at lower levels of development face more similar structural constraints to expanding universalism and are therefore more tightly clustered in terms of the HUI levels.

Figure 6. Dimensions of universalism: Average HUI scores in 2023



To further understand the drivers of these country group differences, Figure 6 disaggregates the HUI into its underlying sub-indices by human development level.[35] The average dimension scores reveal two key patterns. Firstly, Generosity emerges as the weakest dimension across all groups, suggesting that limited public health spending is the main barrier to advancing

[35] The remainder of the section presents only the results by human development; the results by income classification are very similar.

universalism across the world. This is issue is particularly pressing for countries in the low and medium human development category, which exhibit concerningly low Generosity levels that are far from the 5 percent of GDP minimum target commonly employed in the global health literature, not to mention the more ambitious universalism threshold.[36]

Secondly, Generosity and Coverage are the main differentiating dimensions between country groups, while Equity is almost equally distributed. While Coverage increases moderately with human development – except for a sharp increase for very high human development countries – Generosity shows the steepest gradient, with substantial differences between each category. In contrast, Equity varies little across groups, with only very highly developed countries performing slightly better. This pattern in Equity can be interpreted from two perspectives: either as a sign of universal progress in limiting segmentation across the development spectrum, or as a sign that countries at all levels similarly struggle with containing the inequitable effects of health marketisation.

4.2 The evolution of the HUI from 1995 to 2023: Modest convergence

Figure 7. HUI and sub-indices, 1995-2023

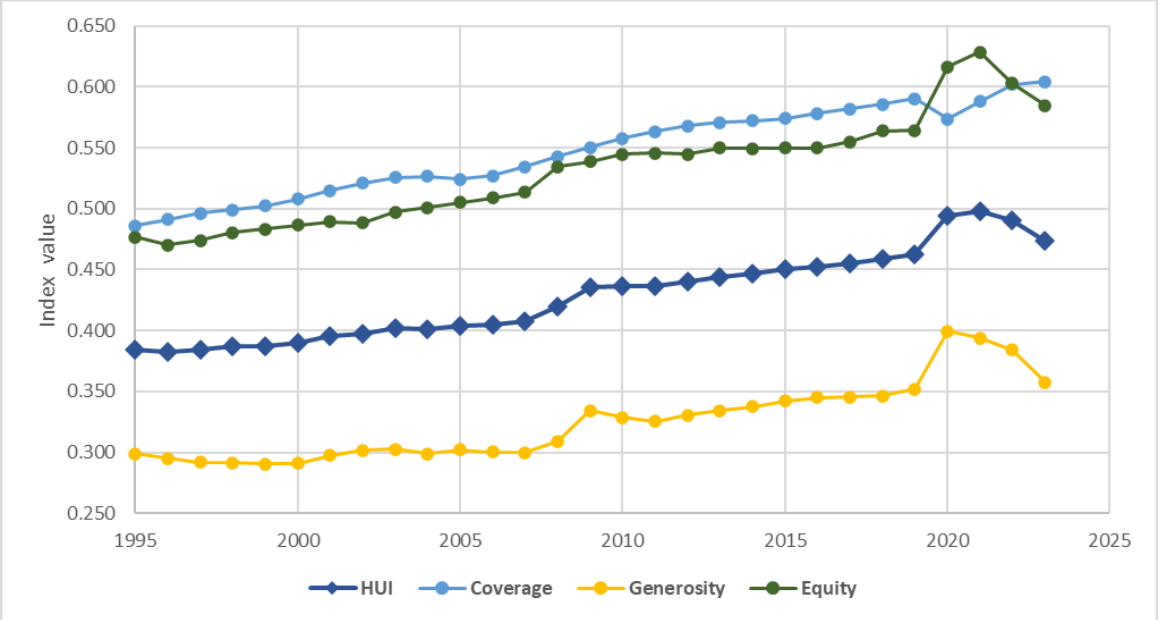


Figure 7 illustrates the trend in the HUI and its dimension indices over the sample period, with the HUI highlighted in bold. Overall, the state of global healthcare universalism improved substantially between 1995 and 2023, with the world HUI increasing by 23 percent from 0.384 to 0.473. Over this period, the HUI showed a steady upward trend with two distinct

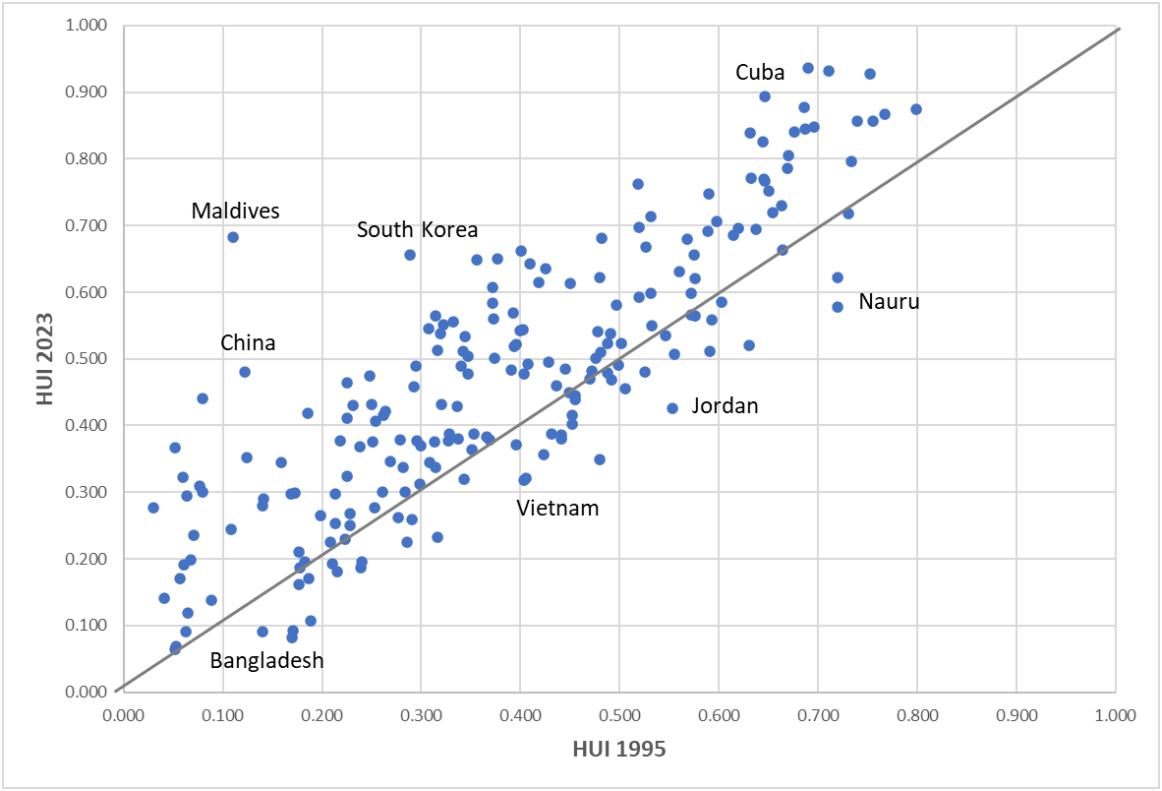
[36] See Section 3.3.2 for details.

accelerations. The first occurs in the late 2000s, primarily driven by gains in Generosity and, to a lesser degree, Equity. This increase appears to reflect the effects of the financial crisis, which led to a reduction in GDP for many countries without a proportionate reduction in public health spending. Since the Generosity indicator is expressed as health expenditure as a share of GDP, this change in the denominator likely contributed to the temporary increase in the index value, potentially in combination with a wave of healthcare reforms adopted in many countries of the Global South during the 2000s (see Chapter 4). The second, more dramatic, increase appears in 2020 and is linked to the Covid-19 pandemic, which triggered widespread expansions in state involvement in response to the emergency. However, unlike earlier expansions in the 2000s, these improvements appear to have been temporary and much progress has reversed, with the HUI falling to almost pre-pandemic levels in 2023.

The sharp rise and decline are evident in the Generosity index, which peaks just at the onset of the pandemic in 2020 but has since fully reversed as the additional pandemic-related public expenditures could not be maintained. A similar trend can be observed for Equity, which likely reflects the temporary effect of increased government intervention and lowered out-of-pocket spending through pandemic measures and vaccination programmes. While Coverage expectedly dropped in 2020, it is the only dimension that continued its moderate expansion path after the initial Covid contraction.

Together, these trends suggest that Covid-19 acted as a shock to global health systems, temporarily boosting government involvement in response to the crisis, especially in terms of Generosity and Equity. The reversal in the years following 2021, however, indicates that these improvements were confined to the immediate pandemic response and could not be institutionalised for the longer term. While future data will provide more certainty, this suggests that hopes for the pandemic to act as a catalyst or 'window of opportunity' for structural change in global health systems might have been short-lived (Amri and Logan 2021; Hiam and Yates 2021; Nisa et al. 2023).

Figure 8. Healthcare Universalism Index 1995 versus 2023



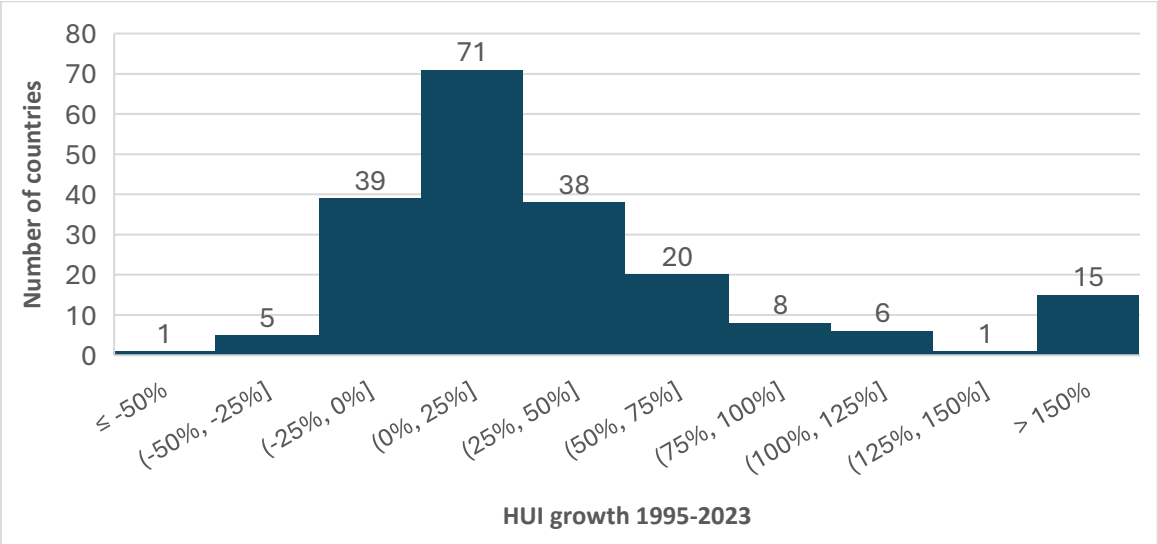
To illustrate the national growth of the HUI over the sample period, Figure 8 presents a scatterplot of the HUI scores in 1995 and 2023 for each of the 204 countries in the sample. The 45-degree line signifies the equality of HUI scores in both years, indicating stagnation in universalism. Consequently, the countries above the reference line have become more universal over time, whereas the countries below the line have experienced a regression in universalism.

The scatterplot shows that HUI growth has been relatively uniform, with the majority of countries increasing their scores by 0 to 50 percent (histogram in Figure 9). However, there are several outliers on both sides of the spectrum. On the positive side, many countries that started at mid to low levels of universalism in 1995 substantially improved their position, partially increasing their HUI scores by more than 100 percent. Examples include populous countries like China, India, and Indonesia, as well as many African countries, such as Cote d'Ivoire, the Democratic Republic of Congo, and Mali.

In an opposing trend, a total of 45 countries experienced a deterioration of universalism that primarily reflects less generous and more segmented healthcare systems. Most prevalent among countries with medium levels of universalism in 1995, this trend is especially strong in Eastern Europe and Central Asia, with countries such as Azerbaijan, Hungary, Moldova,

Mongolia, and Turkmenistan – potentially reflecting a departure from socialist policy legacies. Other negative outliers are crisis- and conflict-affected states, such as the Central African Republic, Iraq, Sudan, Venezuela, and Yemen.

Figure 9. HUI Growth, 1995-2023: Histogram

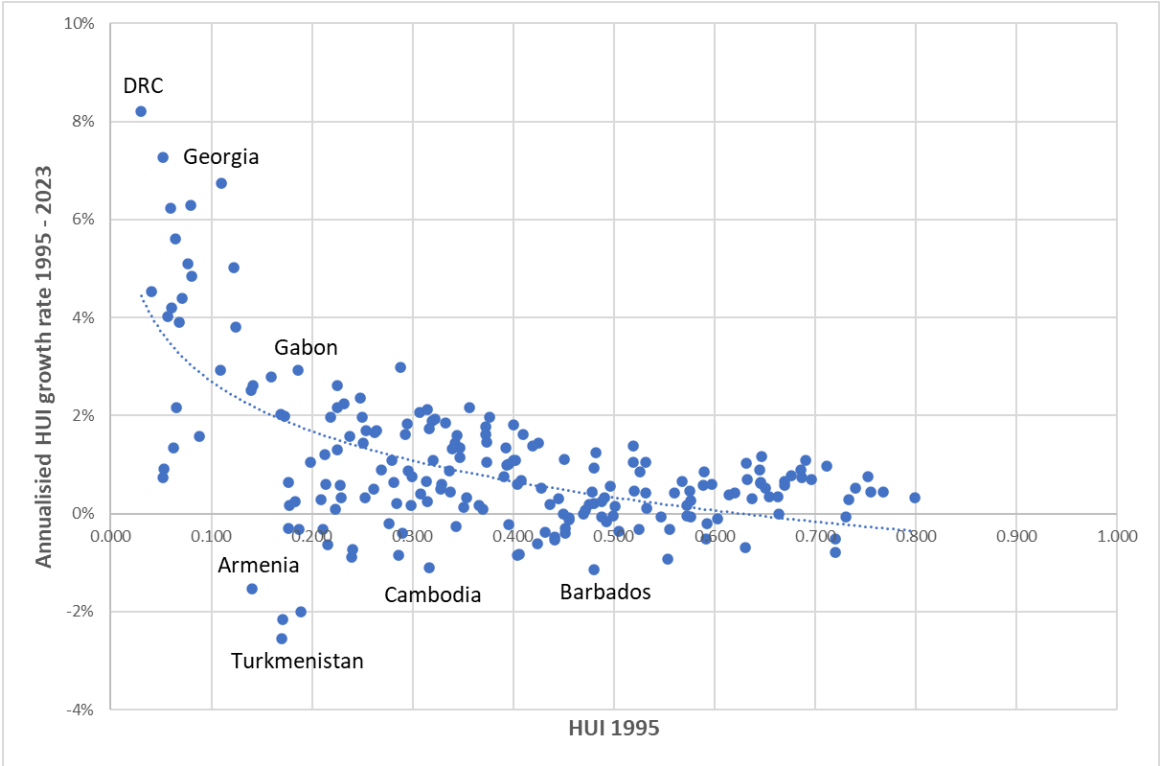


The remainder of the section focuses on the question of convergence in universalism across the world. In this context, convergence refers to differences in the HUI between countries, rather than across regions or within countries themselves. As such, it addresses whether countries have become more similar in terms of healthcare universalism or if global inequalities have increased.

To analyse patterns of convergence, two classic concepts from the economic growth literature are employed: beta and sigma convergence (Sala-i-Martin 1996; Starke, Obinger, and Castles 2008). Beta convergence occurs when countries starting from lower initial levels of universalism grow faster than those that begin at higher levels, implying a process of 'catching-up'. Sigma convergence, on the other hand, refers to a reduction in the overall dispersion of HUI scores across countries, typically measured using the standard deviation or the coefficient of variation. Both forms of convergence are conceptually related but not equivalent, with beta convergence describing growth and sigma convergence describing distribution dynamics. For example, while countries at the bottom might grow faster on average, if growth is uneven and countries at the top continue to advance, the overall dispersion might stagnate or even increase. Therefore, beta convergence is a necessary but not sufficient condition for sigma convergence (Furceri 2005).

For assessing beta convergence, Figure 10 plots each country's annualised growth rate[37] against its initial HUI score in 1995. The clear downward trend confirms the convergent pattern: countries that started from lower levels of universalism have, on average, achieved faster progress than countries with already more universal health systems. For example, countries like Afghanistan, the Dominican Republic, Guinea, Nepal, and Sierra Leone exhibited strong catch-up dynamics, with growth rates exceeding 4 percent per annum. In comparison, countries like Iceland, Sweden, and Germany, which were at the very top of the distribution in 1995, only grew at an annualised rate of 0.3 percent. A simple linear regression analysis confirms this trend and shows that a 0.1 lower HUI score in 1995 is associated with a 0.41 percentage points higher annual growth rate over the sample period – a sizable effect.[38] Despite this global trend of beta convergence, the scatterplot highlights substantial variation, with many countries at lower-medium levels failing to catch up or even falling behind.

Figure 10. Beta convergence: Annualised HUI growth rate by HUI in 1995



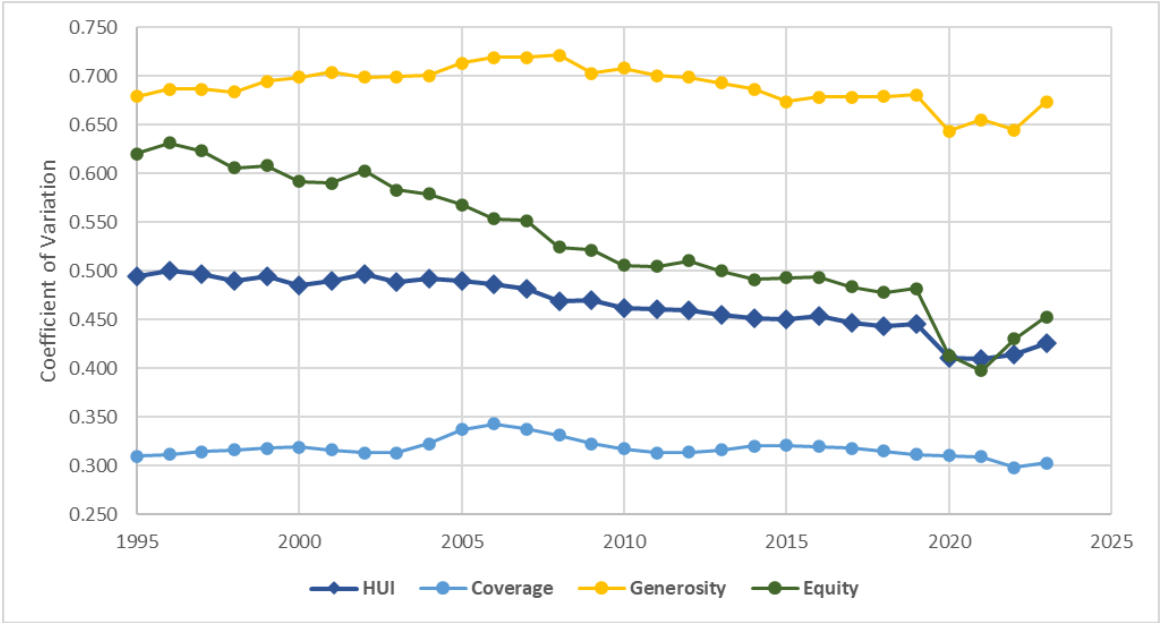
Having established beta convergence as a necessary but not sufficient condition, Figure 11 traces the evolution of the coefficient of variation (CV) in the HUI and its dimensions as a

[37] For the remainder of this section, the HUI growth rates are presented as annual growth rates for easier interpretability.
[38] Not shown.

measure of sigma convergence. Instead of using the standard deviation, which is sensitive to changes in the sample average, the coefficient of variation is employed as a normalised measure of dispersion that allows for meaningful comparison over time. The CV captures relative inequality: a higher value indicates greater variation in healthcare universalism across countries relative to the global mean, while a lower value suggests convergence toward similar levels.

Focusing on the HUI, marked in bold and dark blue, the trend shows modest but significant sigma convergence, with the overall dispersion declining by 14 percent over the sample period. This signifies that health systems have become more similar around the world, with a gradual reduction in cross-country inequalities in universalism. Interestingly, the Covid-19 pandemic marked a brief period of accelerated convergence; however, the following reversal mirrored the overall HUI trend.

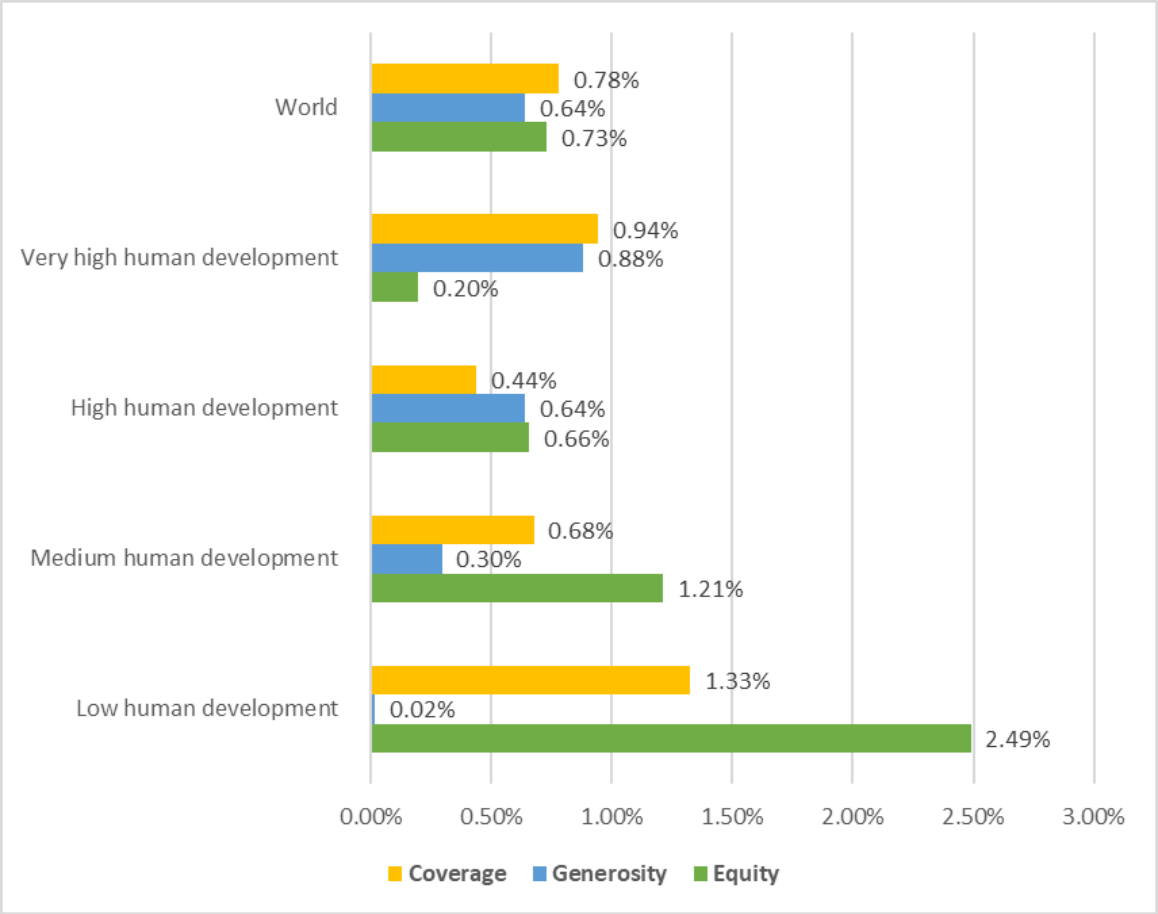
Figure 11. Sigma convergence: Coefficient of variation in HUI and sub-indices



Complementing this finding of modestly declining global inequalities in universalism, the dimensional trends provide more nuance on the drivers of this convergence. The disaggregation shows that change was primarily driven by reductions in dispersion in Equity, with countries converging in their lower share of private health spending. Coverage and Generosity, on the other hand, have remained largely stable – with the former at persistently low and the latter at concerningly high levels – suggesting that global inequalities in both dimensions have remained entrenched despite improvements in their average level (see Figure 7).

To further understand the dimension-specific drivers of convergence trends, Figure 12 presents the annualised growth rates for each sub-index by human development level. It reveals stark differences in progress across both dimensions and country groups. While Coverage exhibits relatively even growth across groups, Generosity and Equity display starkly diverging patterns.

Figure 12. Annualised HUI growth by dimension, 1995-2023



The Equity index demonstrates strong beta convergence, with remarkably rapid growth in medium and low human development countries at substantial rates of 1.2 and 2.5 percent per annum, respectively. By contrast, countries at the top of the development spectrum achieved little progress in this dimension, reflecting sustained segmentation over time. While less developed countries are strongly catching up in terms of Equity, the opposite trend is true for Generosity, with a deep divergence across development levels. While countries with very high human development achieved robust growth (0.88%), progress sharply declined down the development ladder, dropping to just 0.30% for medium and a mere 0.02% for low human development countries.

Together, these trends help explain convergence patterns in the HUI: while improvements in Equity and, to a lesser degree, Coverage have enabled countries at the bottom to catch up, persistent stagnation in Generosity remains a structural barrier for deeper convergence. While the analysis has highlighted modest but significant reductions in the overall cross-country inequalities in healthcare universalism, it also draws attention to the risks of deepening divides in public healthcare spending.

5. Healthcare universalism and the paradox of redistribution[39]

This section applies the HUI to a classic research question in the social policy literature: the 'paradox of redistribution' (Korpi and Palme 1998). The first subsection provides a brief overview of the paradox and subsequent debates, the second outlines the methodology, and the third presents the results.

The rationale for applying the HUI to this case study is twofold. Firstly, the paradox remains arguably the most influential hypothesis in the literature on universalism, making it a natural starting point for testing a new empirical measure. Much of the existing work has been constrained by a lack of systematic cross-national data and instead largely relied on indirect measures of universalism (see Section 2.2). Secondly, I argue that healthcare is a particularly suitable policy area for investigating the paradox on a programme level – both conceptually and empirically.

Conceptually, it is among the most salient and visible[40] social policy areas and should therefore be closely related to the hypothesised mechanism of strengthening cross-class coalitions and the support for redistribution. Healthcare is a policy area where universalism is experienced by a large share of the population, directly affecting the interests of both beneficiaries and non-beneficiaries, and occupying a central place in the social contract. Additionally, it is the largest social policy in most countries, affects a central human capability, and is relevant across all levels of development – making it well suited for a global comparative analysis.

Empirically, approaching the paradox through the lens of healthcare provides an opportunity to examine the role of multidimensionality in universalism, while also avoiding endogeneity in the original empirical formulation, where the measure of universalism – a concentration index of social transfers – is directly linked to the hypothesised outcome of redistribution and inequality. Healthcare, on the other hand, is not part of the redistributive budget but instead is associated with the preceding step of building cross-class coalitions and generating support for redistribution. Additionally, as outlined in Section 2.2.1, healthcare provides an

[39] This section presents an illustrative empirical application of the HUI. As such, the following literature review, methodological discussion, and analysis are kept concise and do not represent an exhaustive treatment of the topic or a standalone paper.

[40] The 'visibility' of social policies is used here to mean the ease with which populations can understand the state's role and responsibility for a specific policy (Gingrich 2014).

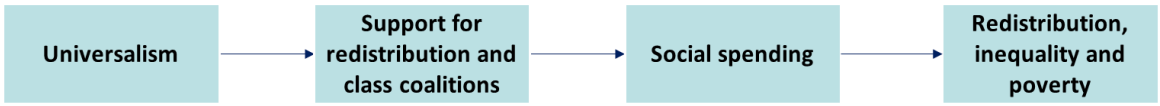
explicit case study of the programme universalism, compared to the existing literature, which often focuses on welfare universalism.

5.1 Overview

In their seminal contribution, Korpi and Palme (1998) argue that welfare state institutions shape the size of the social budget and that there is an inverse relationship between pro-poor targeting and the level of redistribution. Examining the degree of universalism in pension and sickness insurance programmes across a subset of OECD countries in 1985, they find that countries with more encompassing programmes not only achieved higher levels of social spending, but also reduced poverty and inequality more effectively than countries relying on targeted provision. This counterintuitive finding – labelled the 'paradox of redistribution' – is explained by the greater political support for a large welfare state. In universal systems, the middle class also benefits from generous and encompassing programmes, creating an incentive to expand public provision and reducing demand for private alternatives.

Figure 13 illustrates the causal mechanism behind the paradox.[41] Universal welfare institutions are assumed to strengthen support for redistribution by fostering cross-class coalitions between lower- and middle-income groups. This public support is then assumed to determine the level of welfare spending. A larger redistributive budget, in turn, is expected to translate to higher redistribution and lower inequality and poverty.

Figure 13. Hypothesised mechanism behind the paradox of redistribution



Since its original formulation, the paradox of redistribution has received considerable scholarly attention, with several studies revisiting it using various case studies and methodologies (Kenworthy 2011; Marx, Salanauskaite, and Verbist 2013; Van Lancker and Van Mechelen 2015; Brady and Bostic 2015; Ferrarini, Nelson, and Palme 2016; Jacques and Noël 2018). While the association between universalism and inequality reduction has been mostly confirmed by recent studies – at least for specific timeframes and regional contexts – research on poverty reduction and the conjectured mechanism has produced largely inconclusive results, especially on the link between universalism, cross-class coalitions, and

[41] See Gugushvili and Laenen (2021) for a more detailed overview of the causal assumptions and their empirical evidence.

the support for redistribution (Gugushvili and Laenen 2021; Laenen, Roosma, and Achterberg 2025). Other strands of the literature have examined related assumptions embedded in the paradox, including the effectiveness of means-testing as a poverty alleviation strategy, and the determinants of social spending and the support for redistribution (Kittel and Obinger 2003; Nelson 2004, 2007; Castles and Obinger 2007; Rueda and Stegmueller 2019; Jacques and Noël 2021; Gugushvili and Laenen 2021).

Part of the divergence in findings around the paradox reflects differences in how universalism is measured. The original and many subsequent analyses rely on the concentration of social transfers across income groups. However, such measures are sensitive to changes in income and demographic distribution and are endogenously related to redistribution. For example, demographic or economic shifts – such as an ageing population or changes in the labour market – could alter the concentration of benefits without any substantial policy change. Likewise, taxation reforms or other redistributive mechanisms can lead to mechanical changes in the concentration index that are not related to universalism or social policy in general. As an outcome-proximate measure, the concentration index risks conflating universalism with its effects. Therefore, more recent studies move away from redistributive outcomes and instead focus on more direct measures of policy design, such as the share of social cash benefits that are means-tested (Jacques and Noël 2018, 2021), or the coding of national social policy legislation (Van Lancker and Van Mechelen 2015; Marchal and Van Lancker 2019).

From a global comparative perspective, direct empirical tests of the paradox remain rare, also due to data limitations (Ferrarini, Nelson, and Palme 2016; Garcia-Fuente 2021). The existing literature overwhelmingly focuses on high-income democracies, specifically OECD countries, and the limited existing studies expand these to a small set of middle-income countries.[42] However, the political logic underlying the paradox – that broad-based entitlements can generate durable coalitions in support of redistribution – features prominently in debates on welfare expansion in the Global South (Mkandawire 2005; Haggard and Kaufman 2008; Barrientos 2013; Martínez Franzoni and Sánchez-Ancochea 2016). Beyond the case study of the politics of social protection (Niño-Zarazúa et al. 2012; Seekings 2012; Brooks 2015; Lavers and Hickey 2021), universal healthcare emerges as a promising

[42] Mainly those that are part of the *Luxembourg Income Study Database* (LIS).

domain to examine the paradox beyond its OECD origins – due to its political salience, high visibility to voters, and relevance across all levels of development.

While the paradox of redistribution is typically applied in the contexts of cash transfers and income-support programmes, healthcare represents a particularly salient case for examining its underlying political mechanism. The formation of cross-class coalitions in healthcare can be understood through the sector's dual role as both a redistributive and a risk-pooling institution. Unlike targeted cash transfers, universal healthcare benefits a broad middle class not only financially – by replacing out-of-pocket costs with publicly financed services – but also symbolically by guaranteeing access to high-quality care. This creates a shared interest in public provision across income groups, especially when services are of high quality and equitably delivered. Middle- and upper-income groups, who might otherwise opt out of public systems, thus have material incentives to support their further expansion. However, I argue that the implications of universalism go beyond self-interest.

When public services are delivered equitably and provided as a common good, they shape wider attitudes towards society by reducing social distance and shaping equitable welfare experiences (Rothstein 1998; Kumlin and Rothstein 2005; Andrews and Jilke 2016). Universalism can therefore be understood as a relational mechanism: it signifies the degree of social hierarchy embedded in service provision and creates societal 'spaces of equality' where individuals meet on equal terms, develop shared interests, and experience solidarity (see Chapter 3). Fostering a sense of shared membership, universal healthcare allows the middle classes to experience the welfare state not as a distant safety net for others, but as an inclusive institution that addresses their own needs. It can therefore serve as a cornerstone of welfare state legitimacy and expand the political space for redistribution beyond healthcare itself.

5.2 Methodology

To evaluate the paradox of redistribution from a universal healthcare perspective, I employ the HUI and examine its within- and between-country association with four outcome variables derived from the causal chain in Figure 13:

- **Social protection expenditure** as a share of GDP.
- **Income inequality**, measured as the post-tax Gini coefficient.
- **Income redistribution**, measured as the percentage reduction between the pre- and post-tax Gini coefficient.

- **Poverty**, measured as the headcount ratio at the international poverty line of 3.00 US dollars per day (PPP, 2021 prices).

Data on social protection expenditure is drawn from the *IMF Government Finance Statistics,* which provide standardised time series data on expenditures by government function across different levels of governance. Where available, data at the 'general government' level is employed; in cases of missing observations, the 'central government' category is used to maximise coverage.[43] Importantly, to avoid endogeneity, health expenditure is excluded from the social protection statistics to provide an unbiased estimate of the effect of healthcare universalism on the broader welfare budget. Gini coefficients are sourced from the *World Inequality Database*, with the level of redistribution calculated as the percentage reduction in the Gini before and after taxes and benefits. Poverty data is drawn from the World Bank *World Development Indicators,* using the headcount ratio at the international poverty line of 3.00 US dollars per day, adjusted for Purchasing Power Parity (PPP) to ensure comparability across countries at different levels of development.

To test the relationship between healthcare universalism and these outcomes, the analysis follows Jacques and Noël (2018) in employing a within-between random effects model (Bartels 2015; Bell and Jones 2015).[44] This approach decomposes the effects of universalism into two components: (1) between-country effects, reflecting whether more universal systems are associated with higher redistribution and lower inequality across countries, and (2) within-country effects, capturing whether increases in universalism over time are associated with changes in redistributive outcomes. This allows for a more flexible specification than standard fixed effects or random effects models, which either discard all between-country variation or assume that within- and between-effects are equal.

This method is particularly well suited for this context. While most previous work on the paradox of redistribution focuses on cross-sectional relationships rooted in institutional design, the underlying hypothesis can be extended dynamically: if universalism fosters political support for redistribution, then changes in universalism should translate into changes in redistributive effort over time. Moreover, the within-between specification is

[43] Which is a consistent problem in the *Government Finance Statistics* dataset because the 'general government' category is (often) missing if data for one of the lower levels of governance are not available.

[44] To implement this 'within-between' random effects model, the *clustergen* function in STATA is used to separate the within and between-country variation for each covariate. The between effects are represented by the country means, and the within effects describe deviations from this country mean over time.

useful when the key independent variable exhibits relatively low within-country variation, as is often the case with institutional features such as the HUI – especially in some countries of the Global North.

To better understand variation in the type and impact of universalism, regression models are estimated separately for the composite HUI and for its three underlying dimensions: Coverage, Generosity, and Equity. This allows an assessment of whether some dimensions are more closely linked to redistributive outcomes than others. In addition, to examine the potential heterogeneity in effects across levels of development, I conduct a regional subgroup analysis by estimating the models separately for countries in the Global North and Global South. The classification follows the United Nations Conference on Trade and Development (UNCTAD), with the Global North defined as countries in North America and Europe, plus Israel, Japan, South Korea, Australia, and New Zealand; and the Global South as all other countries (UNCTAD 2023). While this paper does not engage in a conceptual debate on these categories, the classification is used heuristically to capture broad structural and socio-political differences, while recognising considerable diversity within each group (Sud and Sánchez-Ancochea 2022).

All regression models include a set of controls to address potential confounders. Drawing on and extending previous approaches,[45] I control for the level of economic development (GDP per capita in Purchasing Power Parity (PPP)), economic growth (annual GDP growth), population size (logged), the unemployment rate (ILO modelled estimate), age dependency ratio (population under 15/over 65 divided by working age population), inflation (annual change in GDP deflator), and urbanisation (share of rural population). These statistics are drawn from the *World Development Indicators* database and the UN DESA *World Population Prospects*. They capture key structural features that may influence both universalism and redistribution, including demographic pressures and fiscal capacity. Finally, all models include region and year fixed effects to account for common shocks and unobserved heterogeneity across time and space. Cluster-robust standard errors are applied at the country level to account for serial correlation in the panel data structure.

Summary statistics for all variables over the sample period of 1995 to 2023 are provided in Table 5.

[45] See, for example, Kenworthy (2011), Marx, Salanauskaite and Verbist (2013), and Jacques and Noël (2018).

Table 5. Summary statistics

	Mean	Standard Deviation	Minimum	Maximum	Obser-vations	Countries
Dependent variables						
Social protection expenditure (in % of GDP)	0.111	0.064	0	0.414	1799	94
Redistribution (% reduction in pre-tax Gini)	0.079	0.109	-0.093	0.625	5713	198
Income inequality (post-tax Gini coefficient)	0.521	0.118	0.147	0.819	5713	198
Poverty rate (at 3.00 USD per day, PPP)	0.105	0.183	0	0.949	1990	170
Explanatory variables						
Healthcare Universalism Index	0.428	0.201	0.03	0.949	5916	204
Coverage Index	0.547	0.177	0.15	0.97	5916	204
Generosity Index	0.325	0.226	0.01	1	5916	204
Equity Index	0.531	0.283	0.01	1	5916	204
Control variables						
GDP per capita (PPP, in thousand USD)	21.45	23.8	0.525	145.5	5485	167
Economic growth (annual, in %)	3.53	6.19	-50.33	149.9	5648	199
Population (in millions)	34.43	131.95	0.009	1438.1	5800	204
Unemployment rate (ILO estimate)	8.17	6.11	0.1	38.8	5274	182
Age dependency ratio (in %)	62.46	18.69	17.3	118.5	5800	200
Inflation (annual change in GDP deflator)	11.26	85.16	-31.56	4800.5	5647	199
Rural population (in % of total population)	42.61	23.78	0	94.58	5800	200

5.3 Results: The global persistence of the paradox of redistribution

Figure 14. Scatterplots: HUI and redistributive outcomes in 2022

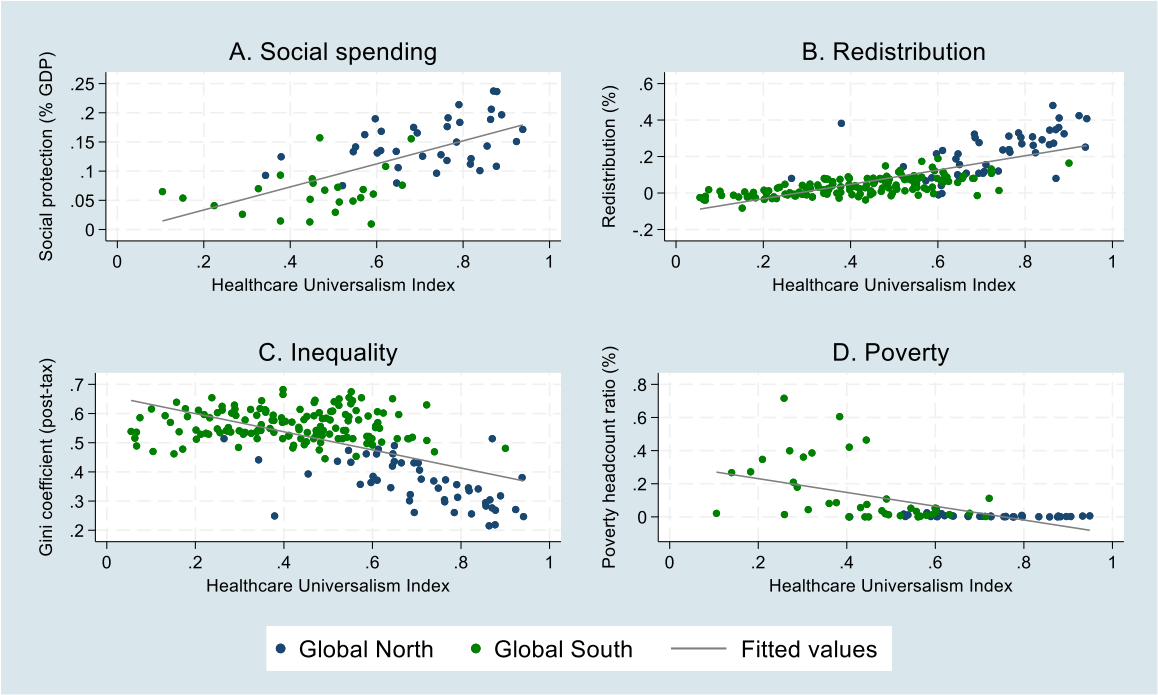


Figure 14 presents the bivariate correlations between the Healthcare Universalism Index and four redistributive outcomes linked to the hypothesised causal mechanism behind the paradox of redistribution. Each panel presents a scatterplot for the year 2022,[46] distinguishing countries in the Global North and the Global South, and includes a fitted regression line to illustrate the overall association. While such cross-sectional associations cannot establish causality or control for confounding factors, they provide an intuitive starting point to visualise variation across countries.

This bivariate approach mirrors the method employed by Korpi and Palme (1998) in their original formulation of the paradox.[47] For the selected year, the cross-sectional patterns broadly confirm the paradox at the global level: higher levels of healthcare universalism are associated with greater social protection expenditure, higher redistribution, and lower income inequality. Poverty displays a weaker and more dispersed negative relationship with the HUI, with considerable variation across countries.[48] Notably, the strength of these

[46] This is used instead of the latest available year, 2023, due to substantial missing data for the social expenditure and poverty time series.
[47] Alongside their well-known typology of social insurance institutions.
[48] It is important to note substantial data limitations for both the poverty and the social spending data, with a high number of gaps for specific years and countries.

associations differs by region: while the correlations between universalism, redistribution, inequality, and – to a lesser extent – social spending are more pronounced in the Global North, the relationship with poverty is stronger in the Global South.

Table 6 presents the results from the within-between random effects models estimating the association between the Healthcare Universalism Index and the four redistributive outcomes: social protection expenditure, redistribution, income inequality, and poverty. As outlined in the methodology, the independent variables are disaggregated into between-country and within-country components to distinguish cross-sectional from longitudinal variation.

The results provide strong support for the global persistence of the paradox of redistribution from a healthcare perspective. Across all three core outcomes – social spending, redistribution, and inequality – the between-country coefficients of the HUI are highly significant and show the expected direction. Countries with more universal healthcare systems allocate a larger share of GDP to social protection, achieve greater redistribution, and have lower levels of income inequality. In terms of magnitude, a one standard deviation increase in the HUI is associated with a 3.2 percentage point rise in social spending, a 6.2 percentage point increase in redistribution, and a 3.3 percentage point reduction in the Gini coefficient – these are substantial cross-sectional effects. The within-country coefficients are smaller in magnitude but remain statistically significant at the 99.9 percent confidence level for redistribution and income inequality. While expectedly smaller than cross-sectional effects, these results suggest that countries that become more universal over time also improve their redistributive performance. These longitudinal patterns provide a dynamic perspective on the paradox of redistribution, suggesting that the effects of universalism are not purely institutional and static but responsive to policy change, which is especially relevant in the contexts of emerging welfare states.

Table 6. Within-between random effects regression of HUI on redistribution outcomes

	(1) Social protection expenditure	(2) Income redistribution	(3) Income inequality	(4) Poverty rate
HUI (between)	**0.151***** **(0.0270)**	**0.310***** **(0.0425)**	**-0.156***** **(0.0337)**	0.187 (0.173)
HUI (within)	0.0267 (0.0204)	**0.124***** **(0.0226)**	**-0.101***** **(0.0302)**	-0.0169 (0.0640)

GDP per capita (between)	0.00198 (0.00910)	0.0442*** (0.0112)	-0.0251* (0.0100)	-0.122*** (0.0218)
GDP per capita (within)	0.00412 (0.0158)	-0.00388 (0.00532)	-0.000113 (0.00890)	-0.181*** (0.0302)
GDP growth (between)	-0.647 (0.335)	-0.415 (0.233)	0.478* (0.222)	0.181 (0.496)
GDP growth (within)	-0.0862*** (0.0196)	-0.00688 (0.00784)	0.00337 (0.00822)	-0.0841 (0.0662)
Logged population (between)	0.00208 (0.00290)	0.00718** (0.00236)	-0.000134 (0.00270)	0.0114* (0.00542)
Logged population (within)	0.00586 (0.0289)	-0.00566 (0.00919)	-0.00790 (0.0151)	-0.183** (0.0564)
Unemployment (between)	0.110 (0.0739)	-0.0285 (0.0730)	0.162 (0.0831)	-0.281 (0.214)
Unemployment (within)	0.232*** (0.0542)	0.119** (0.0386)	-0.0555 (0.0511)	-0.106 (0.104)
Dependency ratio (between)	0.0432 (0.0526)	0.220*** (0.0480)	-0.190*** (0.0485)	-0.0283 (0.131)
Dependency ratio (within)	0.0145 (0.0639)	-0.0368 (0.0212)	0.108*** (0.0320)	0.328*** (0.0848)
Inflation (between)	-0.0113 (0.0279)	-0.0325** (0.0117)	0.0300*** (0.00764)	-0.0118 (0.0267)
Inflation (within)	-0.00705*** (0.00195)	0.000493 (0.000503)	0.00113** (0.000369)	-0.00242 (0.00458)
Rural population (between)	0.00372 (0.0385)	0.0312 (0.0304)	0.0390 (0.0352)	0.101 (0.0825)
Rural population (within)	0.00952 (0.0515)	-0.0373 (0.0346)	-0.0479 (0.0570)	0.210 (0.260)
Region and Year FE	Yes	Yes	Yes	Yes
Observations	1714	4671	4671	1912
Countries	95	171	171	157

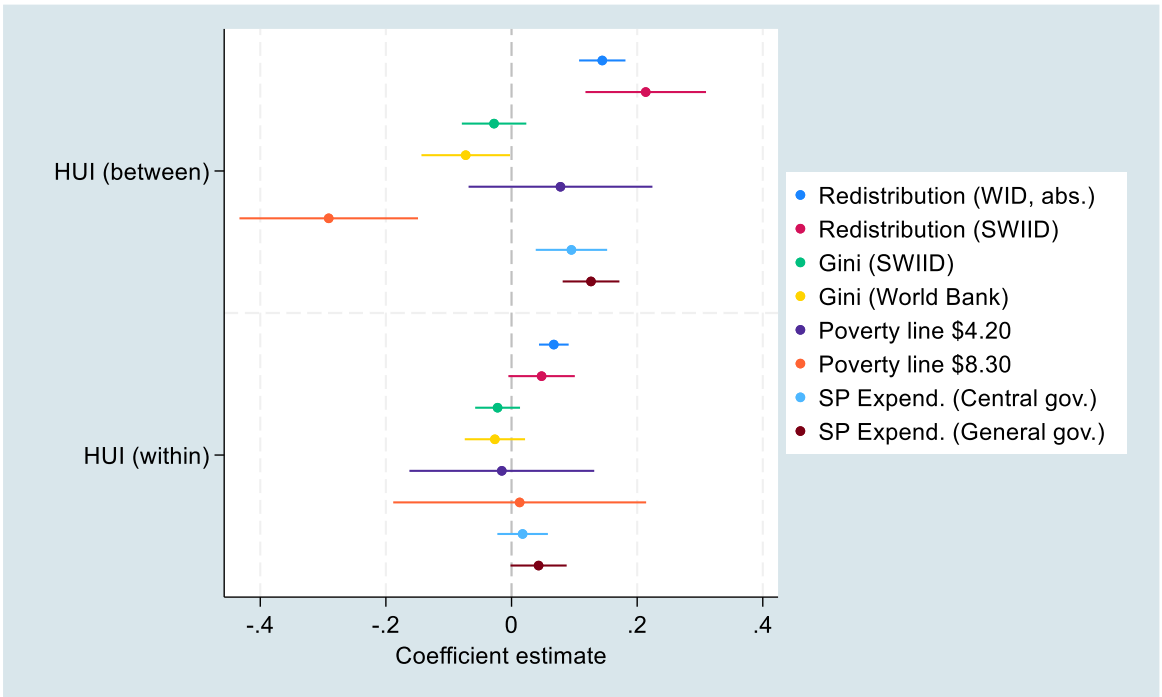
Cluster-robust standard errors in parentheses
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

In contrast to these confirmations of the paradox relationship, the HUI is not significantly associated with poverty rates, neither between nor within countries. While data limitations of the poverty series should be kept in mind, this result can be interpreted in line with the

conceptual context of healthcare universalism. In the context of this paper, universalism is not defined in opposition to low-income targeting, but to segmentation in access and quality of services. As such, stronger associations with inequality are theoretically expected, while links with poverty are likely to be more indirect or driven by potential underlying cross-correlation between segmentation and poverty.

Further supporting the validity of the core findings, the direction and significance of control variables are consistent with theoretical expectations. GDP per capita is negatively associated with poverty and inequality and positively with redistribution, confirming the role of economic development in facilitating redistributive policy. Similarly, inflation is linked to lower redistribution and higher inequality, consistent with the regressive effects of rising prices. Interestingly, between-country differences in unemployment rates show no significant association with any outcomes – potentially due to the prevalence of underemployment and informality in the sample. However, within-country increases in unemployment are positively associated with social expenditure and redistribution, reflecting increased demand for social protection in times of economic distress. Finally, demographic factors also play a role, as countries with larger populations and higher dependency ratios exhibit higher levels of redistribution, suggesting increasing redistributive demands in more demographically burdened societies.

Figure 15. Robustness to alternative outcome specifications



To further validate the core results, Figure 15 presents a range of robustness checks using alternative specifications for the four outcome variables, varying both data sources and measurements. For social expenditure, the robustness of the missing data strategy is tested by restricting the analysis to the expenditures at the 'central government' and 'general government' levels. For redistribution, a different specification measures absolute rather than relative reductions in the post-tax Gini to account for baseline differences between countries, while also employing an alternative data source: the *Standardized World Income Inequality Database* (SWIID, Solt 2020). For income inequality, two alternative data sources for the Gini coefficient are used: the World Bank *World Development Indicators* and the SWIID. Finally, poverty rates are varied using different deprivation thresholds, specifically the two alternative international poverty lines of 4.20 and 8.30 US dollars per day.

Table 7. Within-between random effects regression results by region

	Global South				**Global North**			
	(1) Social spend-ing	(2) Redist-ribution	(3) Gini	(4) Poverty	(5) Social spend-ing	(6) Redist-ribution	(7) Gini	(8) Poverty
HUI (between)	**0.0755*** **(0.0354)**	**0.132***** **(0.0229)**	0.0206 (0.0354)	0.162 (0.102)	**0.134***** **(0.0238)**	**0.273*** **(0.123)**	**-0.267*** **(0.124)**	-0.00661 (0.0107)
HUI (within)	0.0258 (0.0432)	**0.105***** **(0.0195)**	**-0.116***** **(0.0353)**	-0.0364 (0.0834)	**0.0731*** **(0.0314)**	**0.211**** **(0.0713)**	-0.00625 (0.0571)	0.0136 (0.0452)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Region and Year FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	589	3335	3335	922	1125	1336	1336	990
Countries	42	124	124	111	43	47	47	46

Cluster-robust standard errors in parentheses
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Overall, the results are robust to these alternative specifications, with two notable exceptions. Firstly, while the World Bank Gini data yields consistent and significant results for the between-country component of the HUI, the significance of both components disappears when using SWIID data. This potentially reflects differences in data harmonisation and imputation techniques across different datasets. It underscores the sensitivity of the inequality results to the specific operationalisation, opening potential for future research to examine this divergence more systematically. Secondly, in contrast to the baseline findings, the between-country association between the HUI and poverty becomes strongly negative and statistically significant when using the highest USD 8.30 per day poverty

threshold. While this result could be interpreted in support of the original paradox in the domain of poverty, it may be driven by broader developmental differences across the sample – particularly as a large share of the population in lower-income countries falls below this highest poverty threshold.

Finally, to explore developmental differences in the effects of universalism, Table 7 presents the baseline models estimated separately for the Global South and the Global North. Consistent with the bivariate plots, the results reveal heterogeneity across the world, with stronger evidence for the paradox of redistribution in the Global North, both in magnitude and significance. While the associations for social protection spending and redistribution remain robust in both regions, the between-country relationship with inequality is only significant in the North. This may reflect cross-national variation in inequality levels across the sample, or, alternatively, suggest a non-static interpretation of the paradox. In contrast to the North, within-country increases in universalism in the Global South are associated with reductions in inequality over time. Therefore, the disaggregated results confirm both the persistence of the paradox in its original regional context in line with other recent investigations (Brady and Bostic 2015; Jacques and Noël 2018), while also suggesting a more dynamic interpretation in emerging welfare states, where rising universalism, rather than entrenched institutional differences, drives reductions in income inequality.[49]

[49] As a complement, Appendix A presents a disaggregated analysis of the role of the underlying HUI dimensions in driving these results.

6. Conclusion

This paper proposes a new way of measuring healthcare universalism from a global comparative perspective, responding to both the growing international consensus on universalism as a core principle of global social policy and the lack of empirical tools for capturing it. Drawing on Martínez Franzoni and Sánchez-Ancochea's (2016) framework, the Healthcare Universalism Index captures global varieties of universalism in healthcare in a way that is parsimonious, theoretically grounded, and applicable across diverse contexts. Covering 204 countries from 1995 to 2023, the index focuses on a small set of concrete policy outputs – Coverage, Generosity, and Equity – that reflect core characteristics of health systems worldwide, independent of specific historical institutional models. As a balanced composite measure, the HUI underscores that universalism is not achieved through progress in one single domain, but through joint achievement across all three dimensions.

Employing the HUI in a descriptive analysis, the paper traces the global distribution of healthcare universalism and its evolution over time. On the positive side, global healthcare systems have become more universal and converged moderately between 1995 and 2023, with an average growth of 20 and 14 percent, respectively. Countries starting at lower levels of universalism grew faster than those at the top, leading to an overall reduction in the global dispersion of the HUI. Despite these modest but positive trends, substantial regional disparities remain, especially in Generosity, which remains the weakest and most unevenly distributed dimension. Public investment in healthcare remains low across many countries at lower levels of development, posing a structural barrier for deeper convergence. While the Covid-19 pandemic acted as a short-term catalyst for reducing global inequalities, the hopes for sustained structural change appear to have been short-lived, with many gains reversed by 2023.

In further applying the HUI to the empirical case study of the paradox of redistribution, the paper finds robust cross-national and longitudinal support for the core hypothesis of Korpi and Palme (1998): that universalism is positively associated with redistributive outcomes. Across the world, higher levels of healthcare universalism are strongly associated with greater social spending, increased redistribution, and lower income inequality. These associations are especially pronounced in the Global North, but they also emerge dynamically in the Global South, where within-country improvements in universalism over time are linked to improved redistributive performance. The dimensional analysis confirms the significance of all components of the HUI – Coverage, Generosity, and Equity – for shaping

redistributive outcomes, reinforcing both their theoretical coherence and empirical aggregation into a composite index. These findings are consistent with the theoretical mechanism of universal healthcare systems fostering political coalitions by aligning the interests of middle- and low-income groups around shared entitlements, thereby enabling broader social spending and redistribution.

Together, these results contribute to a more nuanced understanding of universalism, redistribution, and inequality in global perspective. They suggest that healthcare systems which not only expand coverage, but also reduce segmentation and enhance quality, are more likely to deliver equitable outcomes – both statically, across countries, and dynamically over time. Moreover, they highlight the limits of existing measurement tools and the need for frameworks that reflect the diversity of institutional pathways across the world.

Building on these findings and empirical innovations, several promising avenues for further research emerge. Firstly, given the ambivalent results of the robustness checks for inequality, future work could examine this relationship more closely by using alternative indicators, such as income shares, or by expanding the conceptual lens to aspects such as multidimensional or gender inequality. Secondly, while the paper provides strong evidence for the outcomes associated with the paradox of redistribution, additional work could investigate the hypothesised mechanism behind this association: the strengthening of cross-class coalitions and the support for redistribution. Future studies could relate the HUI to individual-level survey data on perceptions of and preferences for wider social policy. Finally, another line of research could investigate the social, political, and economic determinants of the HUI and its dimensions, particularly from a longitudinal perspective. While the descriptive analysis highlights substantial regional disparities, it also shows that progress in universalism is possible at all levels of development, raising important questions about which factors enable or constrain positive change.

Overall, this research aims to contribute to a theoretically grounded and globally comparative political economy of universalism by recognising its multidimensional character, contextual variation, and central importance for understanding patterns of redistribution and equity.

7. References

African Union. 2001. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. Abuja, Nigeria: African Union. https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf (July 29, 2025).

Amri, Michelle M., and Dilani Logan. 2021. 'Policy Responses to COVID-19 Present a Window of Opportunity for a Paradigm Shift in Global Health Policy: An Application of the Multiple Streams Framework as a Heuristic'. *Global Public Health* 16(8–9): 1187–97.

Anand, Sudhir. 2018. 'Recasting Human Development Measures'. *LSE International Inequalities Institute Working Paper* 23.

Andersen, Jørgen Goul. 2012. 'Universalization and De-Universalization of Unemployment Protection in Denmark and Sweden'. In *Welfare State, Universalism and Diversity*, eds Anneli Anttonen, Liisa Häikiö, and Kolbeinn Stefánsson. Cheltenham: Edward Elgar Publishing.

Andrews, Rhys, and Sebastian Jilke. 2016. 'Welfare States and Social Cohesion in Europe: Does Social Service Quality Matter?' *Journal of Social Policy* 45(1): 119–40.

Anttonen, Anneli, Liisa Haikio, and Kolbeinn H. Stefánsson, eds. 2012. *Welfare State, Universalism and Diversity*. Cheltenham: Edward Elgar Publishing.

Anttonen, Anneli, and Jorma Sipilä. 2014. 'Varieties of Universalism'. *Draft paper prepared for the UNRISD Conference "New Directions in Social Policy: Alternatives from and for the Global South."*

Backman, Gunilla, Paul Hunt, Rajat Khosla, Camila Jaramillo-Strouss, Belachew Mekuria Fikre, Caroline Rumble, David Pevalin, et al. 2008. 'Health Systems and the Right to Health: An Assessment of 194 Countries'. *The Lancet* 372(9655): 2047–85.

Bambra, Clare, Ryan Riordan, John Ford, and Fiona Matthews. 2020. 'The COVID-19 Pandemic and Health Inequalities'. *Journal of Epidemiology and Community Health* 74(11): 964–68.

Barrientos, Armando. 2009. 'Labour Markets and the (Hyphenated) Welfare Regime in Latin America'. *Economy and Society* 38(1): 87–108.

Barrientos, Armando. 2013. *Social Assistance in Developing Countries*. Cambridge: Cambridge University Press.

Bartels, B. 2015. 'Beyond Fixed versus Random Effects: A Framework for Improving Substantive and Statistical Analysis in Panel, Time-Series Cross Sectional and Multilevel Data'. In *Quantitative Research in Political Science*, ed. Robert Franzese. Thousand Oaks: SAGE Publications Ltd.

Basu, Sanjay, Jason Andrews, Sandeep Kishore, Rajesh Panjabi, and David Stuckler. 2012. 'Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review'. *PLoS Medicine* 9(6): e1001244.

Béland, Daniel, Stephan Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson, eds. 2021. *The Oxford Handbook of the Welfare State. 2nd Edition*. Oxford University Press.

Bell, Andrew, and Kelvyn Jones. 2015. 'Explaining Fixed Effects: Random Effects Modeling of Time-Series Cross-Sectional and Panel Data'. *Political Science Research and Methods* 3(1): 133–53.

Bergh, Andreas. 2004. 'The Universal Welfare State: Theory and the Case of Sweden'. *Political Studies* 52(4): 745–66.

Bergqvist, Kersti, Monica Åberg Yngwe, and Olle Lundberg. 2013. 'Understanding the Role of Welfare State Characteristics for Health and Inequalities – an Analytical Review'. *BMC Public Health* 13(1): 1234.

Bill & Melinda Gates Foundation. 2024. *2024 Goalkeepers Report: The Race to Nourish a Warming World*. https://www.gatesfoundation.org/goalkeepers/report/2024-report/ (October 5, 2025).

Blomqvist, Paula, and Joakim Palme. 2020. 'Universalism in Welfare Policy: The Swedish Case beyond 1990'. *Social Inclusion* 8(1): 114–23.

Brady, David, and Amie Bostic. 2015. 'Paradoxes of Social Policy: Welfare Transfers, Relative Poverty, and Redistribution Preferences'. *American Sociological Review* 80(2): 268–98.

Brooks, Sarah M. 2015. 'Social Protection for the Poorest: The Adoption of Antipoverty Cash Transfer Programs in the Global South'. *Politics & Society* 43(4): 551–82.

Castles, Francis G., and Herbert Obinger. 2007. 'Social Expenditure and the Politics of Redistribution'. *Journal of European Social Policy* 17(3): 206–22.

Eikenberry, Angela M., and Jodie Drapal Kluver. 2004. 'The Marketization of the Nonprofit Sector: Civil Society at Risk?' *Public Administration Review* 64(2): 132–40.

Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

Esser, Ingrid, Tommy Ferrarini, Kenneth Nelson, and Ola Sjöberg. 2009. 'A Framework for Comparing Social Protection in Developing and Developed Countries: The Example of Child Benefits'. *International Social Security Review* 62(1): 91–115.

Ferrarini, Tommy, Kenneth Nelson, and Joakim Palme. 2016. 'Social Transfers and Poverty in Middle- and High-Income Countries – A Global Perspective'. *Global Social Policy* 16(1): 22–46.

Filgueira, Fernando. 2005. *Welfare and Democracy in Latin America: The Development, Crises and Aftermath of Universal, Dual and Exclusionary Social States*. Geneva: United Nations Research Institute for Social Development.

Fischer, Andrew M. 2012. 'Inequality and the Universalistic Principle in the Post-2015 Development Agenda'. *Official background paper prepared for the global thematic consultation on Addressing Inequalities in the Post-2015 Development Agenda*.

Furceri, Davide. 2005. 'β and σ-Convergence: A Mathematical Relation of Causality'. *Economics Letters* 89(2): 212–15.

Garcia-Fuente, Xabier. 2021. 'The Paradox of Redistribution in Time: Social Spending in 53 Countries, 1967-2018'. *LIS Working Paper Series* 815.

Gingrich, Jane. 2011. *Making Markets in the Welfare State: The Politics of Varying Market Reforms*. Cambridge: Cambridge University Press.

Gingrich, Jane. 2014. 'Visibility, Values, and Voters: The Informational Role of the Welfare State'. *The Journal of Politics* 76(2): 565–80.

Giraudy, Agustina, and Jennifer Pribble. 2019. 'Rethinking Measures of Democracy and Welfare State Universalism: Lessons from Subnational Research'. *Regional & Federal Studies* 29(2): 135–63.

Global Burden of Disease Collaborative Network. 2025a. *Global Expected Health Spending 2023-2050*. Seattle: Institute for Health Metrics and Evaluation. https://ghdx.healthdata.org/record/ihme-data/global-expected-health-spending-2023-2050 (July 27, 2025).

Global Burden of Disease Collaborative Network. 2025b. *Global Health Spending 1995-2022*. Seattle: Institute for Health Metrics and Evaluation. https://ghdx.healthdata.org/record/ihme-data/global-health-spending-1995-2022 (July 27, 2025).

Gough, Ian, Geof Wood, Armando Barrientos, Philippa Bevan, Peter Davis, and Graham Room. 2004. *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*. Cambridge: Cambridge University Press.

Gugushvili, Dimitri, and Tijs Laenen. 2021. 'Two Decades after Korpi and Palme's "Paradox of Redistribution": What Have We Learned so Far and Where Do We Take It from Here?' *Journal of International and Comparative Social Policy* 37(2): 112–27.

Haggard, Stephan, and Robert R. Kaufman. 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*. Princeton: Princeton University Press.

Hiam, Lucinda, and Robert Yates. 2021. 'Will the COVID-19 Crisis Catalyse Universal Health Reforms?' *The Lancet* 398(10301): 646–48.

Hogan, Daniel R., Gretchen A. Stevens, Ahmad Reza Hosseinpoor, and Ties Boerma. 2018. 'Monitoring Universal Health Coverage within the Sustainable Development Goals: Development and Baseline Data for an Index of Essential Health Services'. *The Lancet Global Health* 6(2): e152–68.

Huber, Evelyne. 1996. 'Options for Social Policy in Latin America: Neoliberal Versus Social Democratic Models'. In *Welfare States in Transition: National Adaptations in Global Economies*, London: SAGE Publications Ltd, 142–91.

Hultqvist, Sara, and Katarina Hollertz. 2021. 'Individual Need and Societal Claims: Challenging the Understanding of Universalism versus Selectivism in Social Policy'. *Social Policy & Administration* 55(5): 940–53.

IHME. 2025. *Financing Global Health 2025: Cuts in Aid and Future Outlook*. Seattle: Institute for Health Metrics and Evaluation.

ILO. 2012. *The Strategy of the International Labour Organization. Social Security for All: Building Social Protection Floors and Comprehensive Social Security Systems*. Geneva: International Labour Office, Social Security Department.

Jacques, Olivier, and Alain Noël. 2018. 'The Case for Welfare State Universalism, or the Lasting Relevance of the Paradox of Redistribution'. *Journal of European Social Policy* 28(1): 70–85.

Jacques, Olivier, and Alain Noël. 2021. 'Targeting within Universalism'. *Journal of European Social Policy* 31(1): 15–29.

Jahan, Selim. 2019. 'Human Development and Universalism: From Ideas to Policies'. *Journal of Human Development and Capabilities* 20(2): 233–50.

Jerven, Morten. 2013. *Poor Numbers: How We Are Misled by African Development Statistics and What to Do about It*. Ithaca: Cornell University Press.

Jolliffe, I. T. 2002. *Principal Component Analysis*. New York: Springer.

Kabeer, Naila. 2014. 'The Politics and Practicalities of Universalism: Towards a Citizen-Centred Perspective on Social Protection'. *The European Journal of Development Research* 26(3): 338–54.

Kangas, Olli, and Joakim Palme, eds. 2005. *Social Policy and Economic Development in the Nordic Countries*. London: Palgrave Macmillan.

Kenworthy, Lane. 2011. *Progress for the Poor*. Oxford: Oxford University Press.

Kildal, Nanna, and Stein Kuhnle. 2005. 'The Nordic Welfare Model and the Idea of Universalism'. In *The Normative Foundations of the Welfare State*, eds Nanna Kildal and Stein Kuhnle. Abingdon: Routledge, 25–45.

Kittel, Bernhard, and Herbert Obinger. 2003. 'Political Parties, Institutions, and the Dynamics of Social Expenditure in Times of Austerity'. *Journal of European Public Policy* 10(1): 20–45.

Korpi, Walter, and Joakim Palme. 1998. 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries'. *American Sociological Review* 63(5): 661–87.

Kruk, Margaret E., Anna D. Gage, Catherine Arsenault, Keely Jordan, Hannah H. Leslie, Sanam Roder-DeWan, Olusoji Adeyi, et al. 2018. 'High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution'. *The Lancet Global Health* 6(11): e1196–1252.

Kumlin, Staffan, and Bo Rothstein. 2005. 'Making and Breaking Social Capital: The Impact of Welfare-State Institutions'. *Comparative Political Studies* 38(4): 339–65.

Kunißen, Katharina. 2023. *The Independent Variable Problem: Welfare Stateness as an Explanatory Concept*. Wiesbaden: Springer VS.

Laenen, Tijs, Femke Roosma, and Peter Achterberg. 2025. 'It's the Middle That Matters? Income Group Coalitions in Support of Redistributive Welfare Reform'. *International Journal of Social Welfare* 34(2): e70007.

Lavers, Tom, and Sam Hickey. 2021. 'Alternative Routes to the Institutionalisation of Social Transfers in Sub-Saharan Africa: Political Survival Strategies and Transnational Policy Coalitions'. *World Development* 146: 105549.

Leegwater, Anthony, Wendy Wong, and Carlos Avila. 2015. 'A Concise, Health Service Coverage Index for Monitoring Progress towards Universal Health Coverage'. *BMC Health Services Research* 15(1): 230.

Leisering, Lutz. 2020. 'The Calls for Universal Social Protection by International Organizations: Constructing a New Global Consensus'. *Social Inclusion* 8(1): 90–102.

Lozano, Rafael, Nancy Fullman, John Everett Mumford, Megan Knight, Celine M Barthelemy, Cristiana Abbafati, Hedayat Abbastabar, et al. 2020. 'Measuring Universal Health Coverage Based on an Index of Effective Coverage of Health Services in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019'. *The Lancet* 396(10258): 1250–84.

Marchal, Sarah, and Wim Van Lancker. 2019. 'The Measurement of Targeting Design in Complex Welfare States: A Proposal and Empirical Applications'. *Social Indicators Research* 143(2): 693–726.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2018. 'Undoing Segmentation? Latin American Health Care Policy during the Economic Boom'. *Social Policy & Administration* 52(6): 1181–1200.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2021. 'Are Welfare Regimes a Useful Category? The Cross-Sectoral Variation in Social Policy in Latin America at the End of the Commodity Boom'. *Development Studies Research* 8(1): 294–308.

Marx, Ive, Lina Salanauskaite, and Gerline Verbist. 2013. 'The Paradox of Redistribution Revisited: And That It May Rest in Peace?' *IZA Discussion Paper* 7414.

Mcintyre, Di, Filip Meheus, and John-Arne Røttingen. 2017. 'What Level of Domestic Government Health Expenditure Should We Aspire to for Universal Health Coverage?' *Health Economics, Policy and Law* 12(2): 125–37.

Merry, Sally Engle. 2011. 'Measuring the World: Indicators, Human Rights, and Global Governance'. *Current Anthropology* 52(S3): S83–95.

Mills, Anne. 2014. 'Health Care Systems in Low- and Middle-Income Countries'. *New England Journal of Medicine* 370(6): 552–57.

Mkandawire, Thandika, ed. 2004. *Social Policy in a Development Context*. London: Palgrave Macmillan.

Mkandawire, Thandika. 2005. 'Targeting and Universalism in Poverty Reduction'. *UNRISD Social Policy and Development Programme Paper* 23.

Mkandawire, Thandika. 2020. 'Colonial Legacies and Social Welfare Regimes in Africa: An Empirical Exercise'. In *The Politics of Domestic Resource Mobilization for Social Development*, ed. Katja Hujo. Cham: Palgrave Macmillan, 139–72.

Molina, Carlos Gerardo, ed. 2006. *Universalismo basico: una mueva politica social para America Latina*. Washington, DC: Inter-American Development Bank.

Nelson, Kenneth. 2004. 'Mechanisms of Poverty Alleviation: Anti-Poverty Effects of Non-Means-Tested and Means-Tested Benefits in Five Welfare States'. *Journal of European Social Policy* 14(4): 371–90.

Nelson, Kenneth. 2007. 'Universalism versus Targeting: The Vulnerability of Social Insurance and Means-tested Minimum Income Protection in 18 Countries, 1990-2002'. *International Social Security Review* 60(1): 33–58.

Nelson, Kenneth, and Johan Fritzell. 2014. 'Welfare States and Population Health: The Role of Minimum Income Benefits for Mortality'. *Social Science & Medicine* 112: 63–71.

Niedzwiecki, Sara. 2018. *Uneven Social Policies: The Politics of Subnational Variation in Latin America*. Cambridge: Cambridge University Press.

Niño-Zarazúa, Miguel, Armando Barrientos, Samuel Hickey, and David Hulme. 2012. 'Social Protection in Sub-Saharan Africa: Getting the Politics Right'. *World Development* 40(1): 163–76.

Nisa, Claudia F., Xiaoxi Yan, Bibhas Chakraborty, Pontus Leander, and Jocelyn J. Bélanger. 2023. 'COVID-19 May Have Increased Global Support for Universal Health Coverage: Multi-Country Observational Study'. *Frontiers in Public Health* 11: 1213037.

OECD. 2008. *Handbook on Constructing Composite Indicators: Methodology and User Guide*. Paris: Organisation for Economic Co-operation and Development.

Okoi, Obasesam, and Tatenda Bwawa. 2020. 'How Health Inequality Affect Responses to the COVID-19 Pandemic in Sub-Saharan Africa'. *World Development* 135: 105067.

Öktem, Kerem Gabriel. 2020. 'The Welfare State as Universal Social Security: A Global Analysis'. *Social Inclusion* 8(1): 103–13.

Pribble, Jennifer. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.

Ravallion, Martin. 2012. 'Troubling Tradeoffs in the Human Development Index'. *Journal of Development Economics* 99(2): 201–9.

Rothstein, Bo. 1998. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Rudra, Nita. 2007. 'Welfare States in Developing Countries: Unique or Universal?' *The Journal of Politics* 69(2): 378–96.

Rueda, David, and Daniel Stegmueller. 2019. *Who Wants What?: Redistribution Preferences in Comparative Perspective*. Cambridge University Press.

Sala-i-Martin, Xavier X. 1996. 'Regional Cohesion: Evidence and Theories of Regional Growth and Convergence'. *European Economic Review* 40(6): 1325–52.

Savedoff, William D. 2007. 'What Should A Country Spend On Health Care?' *Health Affairs* 26(4): 962–70.

Schillings, Tobias, and Diego Sánchez-Ancochea. 2023. 'The Role of Healthcare Universalism in Advancing Human Security'. *Background Paper for UNDP 2022 Special Report on Human Security* 3–2022.

Seekings, Jeremy. 2008. 'Welfare Regimes and Redistribution in the South'. In *Divide and Deal: The Politics of Distribution in Democracies*, eds Ian Shapiro, Peter A. Swenson, and Daniela Donno Panayides. New York: New York University Press, 19–42.

Seekings, Jeremy. 2012. 'Pathway to Redistribution: The Emerging Politics of Social Assistance Across the Global "South"'. *Journal für Entwicklungspolitik* 28(1): 14–34.

Skocpol, Theda. 1991. 'Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States'. In *The Urban Underclass*, eds C Jencks and P. E. Peterson. Washington, D.C.: The Brookings Institution, 411–36.

Solt, Frederick. 2020. 'Measuring Income Inequality Across Countries and Over Time: The Standardized World Income Inequality Database'. *Social Science Quarterly* 101(3): 1183–99.

Spicker, Paul. 2005. 'Targeting, Residual Welfare and Related Concepts: Modes of Operation in Public Policy'. *Public Administration* 83(2): 345–65.

Starke, Peter, Herbert Obinger, and Francis G. Castles. 2008. 'Convergence towards Where: In What Ways, If Any, Are Welfare States Becoming More Similar?' *Journal of European Public Policy* 15(7): 975–1000.

Stefánsson, Kolbeinn. 2012. 'What Is in a Word? Universalism, Ideology and Practice'. In *Welfare State, Universalism and Diversity*, eds Anneli Anttonen, Liisa Häikiö, and Kolbeinn Stefánsson. Cheltenham: Edward Elgar Publishing.

Sud, Nikita, and Diego Sánchez-Ancochea. 2022. 'Southern Discomfort: Interrogating the Category of the Global South'. *Development and Change* 53(6): 1123–50.

Thompson, Simon, and Paul Hoggett. 1996. 'Universalism, Selectivism and Particularism: Towards a Postmodern Social Policy'. *Critical Social Policy* 16(46): 21–42.

Titmuss, Richard. 1976. *Commitment to Welfare*. London: Allen & Unwin.

UHC2030. 2019. 'Moving Together to Build a Healthier World: Key Asks from the UHC Movement'. In *UN High-Level Meeting on Universal Health Coverage*, https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/UN_HLM_2019/Key_Asks/UHC_Key_Asks_English.pdf (July 29, 2025).

UNCTAD. 2023. *UNCTAD Handbook of Statistics*. New York: United Nations Publications.

UNDP. 2025. *Human Development Report 2025 Technical Notes*. New York: United Nations Development Programme.

United Nations. 2021. *Our Common Agenda – Report of the Secretary-General*. New York: United Nations Publications.

Van Lancker, Wim, and Natascha Van Mechelen. 2015. 'Universalism under Siege? Exploring the Association between Targeting, Child Benefits and Child Poverty across 26 Countries'. *Social Science Research* 50: 60–75.

Wang, Zhicheng, and Kun Tang. 2020. 'Combating COVID-19: Health Equity Matters'. *Nature Medicine* 26(4): 458–458.

WHO. 2019. *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*. Geneva: World Health Organization.

WHO. 2025. 'Universal Health Coverage (UHC)'. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) (July 25, 2025).

Wood, Geof, and Ian Gough. 2006. 'A Comparative Welfare Regime Approach to Global Social Policy'. *World Development* 34(10): 1696–1712.

Appendix

A. HUI dimensions and the paradox of redistribution

Figure A.1 Within-between random effects regression results by dimension

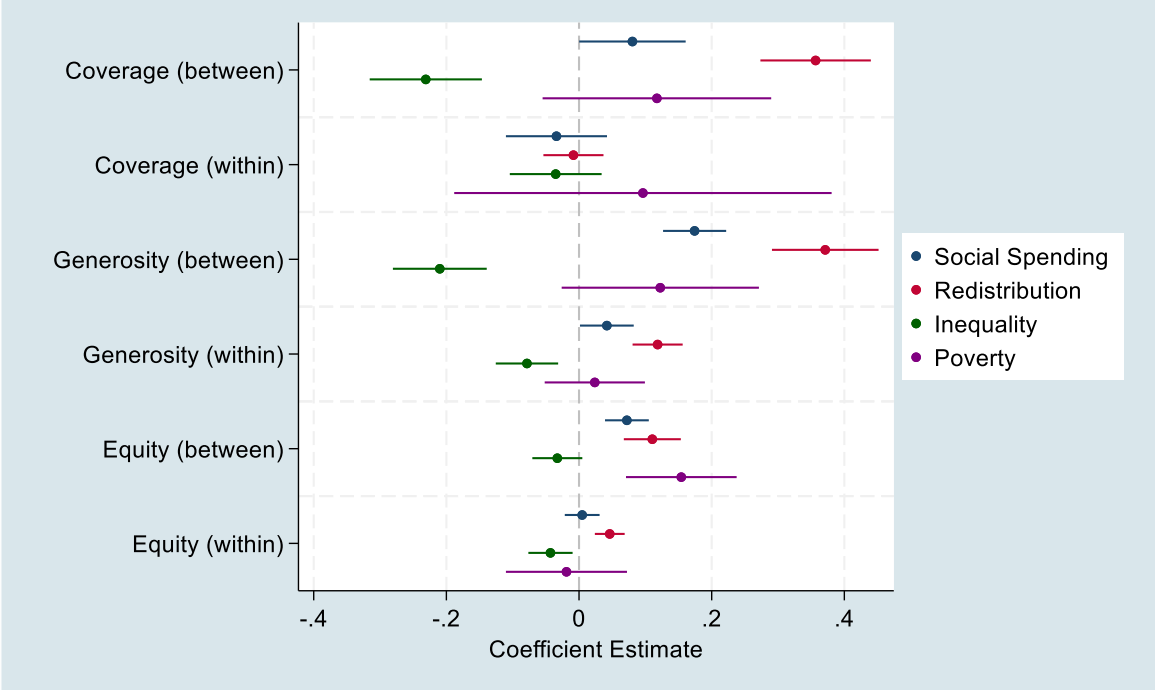


Figure A.1 disaggregates the HUI into its three dimensions – Coverage, Generosity, Equity – to understand which dimension drives the results. Each coefficient pair represents a separate regression using the baseline specification, substituting each sub-index for the composite HUI, with colour coding for the four outcome variables. The dimensional analysis reveals several interesting findings. Focusing on the between-country components, all three dimensional indices[50] are highly significant and show the expected direction for social spending, redistribution, and inequality, in line with the composite HUI results. This underscores the relevance of all types of welfare efforts in shaping redistributive outcomes and reaffirms their aggregation into a composite index. This is particularly remarkable for the Equity dimension – arguably the most controversial and substantial departure from existing UHC approaches – which represents a finding in itself: countries with higher levels of healthcare privatisation have, on average, lower social protection budgets, achieve less redistribution, and have higher income inequality. Given increasing global trends around the

[50] Except for the Equity index for income inequality, which barely misses the 95 percent significance level.

marketisation of healthcare, these findings raise important concerns (Eikenberry and Kluver 2004; Gingrich 2011; Mills 2014).

In terms of magnitude, Coverage and Generosity appear to play the largest role in between-country variation in redistribution and inequality. However, the most pronounced differences across dimensions concern the within-country effects. While all longitudinal effects are insignificant for Coverage, changes in both Generosity and Equity are positively associated with higher redistribution, lower inequality, and – in the case of Generosity – also with increased social spending. These findings support a dynamic interpretation of the paradox, indicating that countries that have expanded the quality and equity of healthcare provision over time have simultaneously improved their redistributive performance. Overall, these results reinforce the persistence of the paradox of redistribution, both static and dynamic, even when focusing on the individual dimensions of the global varieties of healthcare universalism.

Spaces of Equality: A Global Analysis of Universal Healthcare and Social Trust

Abstract

Can universal social policies foster social trust in societies across the world? While universalism is often credited with strengthening trust in advanced welfare states, its social consequences in the Global South remain underexplored. This paper examines the association between universal healthcare and generalised trust by conceptualising universal social policies as 'spaces of equality' that contribute to how individuals experience and perceive society. It identifies two complementary mechanisms through which universalism may shape the social foundations of trust: vertically, by fostering more inclusive welfare experiences; and, horizontally, by reducing segmentation and strengthening social connectedness.

To test this suggested relationship using the salient case study of healthcare, the paper examines the association between 'varieties of universal healthcare' and individual perceptions of generalised trust across a global sample of 105 countries from 2000 to 2020. Employing a multilevel modelling approach, the analysis further adds to the literature by exploring the role of different types of welfare efforts – universal coverage, government spending and privatisation – and by assessing if these vary across stages of development.

The results suggest that the consequences of universal healthcare extend beyond health outcomes and also matter for the social fabric of societies, with healthcare universalism consistently associated with greater generalised trust. The dimensional analysis further reveals the significance of both healthcare generosity and equity, although their relative importance varies across contexts: government spending plays a stronger role in fostering trust in the Global South, while privatisation diminishes social trust in the Global North. Supporting the interpretation of universalism as fostering 'spaces of equality', the trust association is strongest among individuals who are most likely to opt out of public systems of provision – such as the wealthy and highly educated.

By connecting welfare with the social foundations of trust, this paper contributes to a growing literature on the social effects of universal social policy and offers new insights into how welfare institutions might help to (re)build social solidarity in an era of fragmentation and distrust.

1. Introduction

The welfare state has long been considered a cornerstone of social cohesion. In particular, universalism – the principle that states should provide equitable access to high-quality social policies for the entire population – is often credited with fostering social trust in advanced democracies (Rothstein 1998; Rothstein and Stolle 2008; Birnbaum et al. 2017). In contrast to selective or means-tested benefits, universal social policies are thought to reduce perceptions of stigmatisation, unfairness, and resentment between groups, reflecting wider debates about the capacity of welfare state institutions to 'make or break' social trust (Kumlin and Rothstein 2005; Mewes 2024). Social trust, defined as the belief that most other members of society can be trusted, is considered a crucial foundation of democratic stability, collective action, and broader social cohesion (Fukuyama 1995; Putnam 2000). As such, trust is not only a normative goal, but a functional asset for societies navigating increasing socio-economic disparities and political polarisation (Council of Europe 2004; ECLAC 2010; Marmot et al. 2010; McKee et al. 2024; UNDP 2024).

These debates are gaining renewed relevance in the context of the Global South, where universal social policies are increasingly advocated for by international organisations as instruments of inclusive development, and adopted by governments across the Global South: from countries like Costa Rica and Brazil to Mauritius, Nepal, and Uruguay (Mkandawire 2004; Pribble 2013; Kabeer 2014; Martínez Franzoni and Sánchez-Ancochea 2016; Leisering 2020). This global turn to universalism marks a significant shift in development policy and provides new avenues to explore how welfare institutions shape an emerging social contract in contexts with more diverse political economies, state capacities, and historical legacies (Martínez Franzoni and Sánchez-Ancochea 2016; Burchi, von Schiller, and Strupat 2020; Koehler 2021).

Despite the growing relevance of universalism in these settings, limited empirical research exists on its social consequences outside of high-income democracies. Much of the existing literature on its trust-building potential is derived from the institutional context of the European – particularly Nordic – welfare states of the twentieth century. However, it remains unclear whether the same relationship holds beyond their specific historical and geographic setting (Rothstein 1998; Rothstein and Stolle 2008). Therefore, this paper addresses this gap by asking: *Is universalism associated with social trust in a global perspective? Does this relationship vary across the world? And does the strength of this association depend on the specific type of welfare effort considered?* These questions are relevant for both advancing

comparative welfare research and for evaluating the broader social returns of expanding universal social policy in the Global South.

Theoretically, I conceptualise universal social policies as 'spaces of equality' that contribute to the social foundations of trust by shaping equitable welfare experiences, reducing segmentation, and strengthening social connectedness. In this perspective, universalism is considered not only as a distributional principle but also as a relational concept that signifies social hierarchies, shared membership, and mutual obligation. Rather than focusing solely on what is redistributed, this relational view foregrounds how policies are structured, who is included, and whether individuals perceive themselves as equal participants in collective systems of provision.

To examine this suggested relationship empirically at the policy level, healthcare is employed as a central case study of universalism from a global perspective. The rationale for focusing on healthcare is twofold. Firstly, it is among the largest welfare programmes in most countries, and it is relevant across all levels of development. This stands in contrast to programmes such as unemployment benefits or conditional cash transfers, which are typically only present in a subset of countries. Secondly, healthcare constitutes a core domain of state intervention that affects virtually all segments of society, making social hierarchies in provision particularly visible through welfare experiences and membership in a shared risk community. Compared to policy areas that primarily serve specific demographic groups, such as disability or unemployment benefits, healthcare seems, therefore, more likely to shape perceptions of social trust and societal connectedness (Freitag and Bühlmann 2009; Lee 2013; Mewes 2024).

Empirically, the paper examines the association between healthcare universalism and individual perceptions of social trust using harmonised cross-national survey data from the *World Values Survey* (WVS) and the *European Values Study* (EVS) for a global sample of 105 countries between 2000 and 2020. As introduced in Chapter 2, universalism is measured using the Healthcare Universalism Index (HUI) that comprises three dimensions of policy outputs: universal health coverage, government health spending, and the level of healthcare privatisation. Using a multilevel modelling approach, the analysis explores the association between these macro-level indicators and individual-level perceptions of generalised trust. A particular focus lies on understanding regional differences between the Global South and the Global North, and on disentangling the potentially different effects of the three dimensions of healthcare universalism.

This paper contributes to a growing body of research investigating the role of welfare institutions for shaping trust (Rothstein 1998; Rothstein and Uslaner 2005; Rothstein and Stolle 2008; Freitag and Bühlmann 2009; Lee 2013; Bjørnskov and Svendsen 2013; Brewer, Oh, and Sharma 2014; Bergh and Bjørnskov 2014; Kumlin, Stadelmann-Steffen, and Haugsgjerd 2017; Mewes and Giordano 2017; Birnbaum et al. 2017; Akaeda 2021; Herreros 2023; Mewes 2024). Furthermore, the theoretical and empirical contribution of this paper builds on a broader literature on the relationship between welfare provision, social capital, and social cohesion (Arts and Gelissen 2001; Kumlin and Rothstein 2005; van Oorschot and Arts 2005; Hooghe and Stolle 2006; Lister 2007; Janmaat 2011; Kabeer 2014; Edlund and Lindh 2015; Andrews and Jilke 2016; Koehler 2021; Burchi et al. 2022). Across these studies, more generous and universal welfare systems tend to be associated with higher levels of trust and social capital, particularly in the context of advanced democracies in the Global North.

However, three key limitations in the existing literature remain. Firstly, most studies focus on the welfare state as the primary unit of analysis – for example, in the form of welfare regimes – rather than examining specific social policies. This can be problematic because many countries combine universal and segmented programmes within the same welfare system, making it difficult to assess which policy areas contribute to building trust. Beyond obscuring relevant variation between programmes, such aggregated approaches implicitly assume that the effects of universalism are the same across policy domains (Lee 2013; Mewes 2024).[51] Secondly, existing studies overwhelmingly focus on high-income democracies, especially on OECD countries. With an increasing policy focus on expanding universalism around the globe, it is central to expand the empirical lens beyond the existing historical and geographic focus and investigate whether similar relationships can be observed across levels of development. Thirdly, much of the literature relies on singular proxies for welfare efforts, such as aggregate social spending. In line with common critiques of black box measures of 'welfareness', this approach obscures important nuance and variation in policy design, especially with regard to multidimensional concepts like universalism (Nelson and Fritzell 2014; Kunißen 2023).

By addressing these limitations, this paper aims to contribute to the literature in three ways:

- By exploring the case study of universal healthcare, the paper shifts the focus from the aggregate analysis of welfare states to the level of programme universalism.

[51] See Chapter 2 on the distinction between programme and welfare state universalism.

- By drawing on the Healthcare Universalism Index and on international survey data, the paper broadens the research focus to a global perspective.
- By analysing multiple dimensions of universalism, the paper explores the role of different types of welfare efforts, specifically universal coverage, government spending, and privatisation.

The remainder of this paper is organised as follows. Section 2 presents theoretical considerations around the concept of universalism and its relationship with social trust. Section 3 describes the data and methodology. Section 4 presents the results. Section 5 concludes and discusses avenues for future research.

2. Universalism and trust: Theoretical considerations

2.1 Defining universalism[52]

In the context of social policy, universalism describes policies that apply equally to everyone within a particular group, such as citizens of a country, rather than distinguishing potential beneficiaries based on exclusion criteria such as means-testing or labour market status (Anttonen, Haikio, and Stefánsson 2012). There are two dimensions to the definition of universalism that are often conflated in the wider literature: membership and allocation (Kildal and Kuhnle 2005). Membership refers to the formal inclusion and eligibility for social policies, that is, the social rights derived from being a member of a particular community. Hence, universal membership would imply that the policy covers all individuals without exclusion. The second dimension of universalism, allocation, refers to the actual distribution and usage of social policy across the population. A system with universal allocation would mean that benefits are broadly available, of similar quality, and widely used across the population (Anttonen and Sipilä 2014).

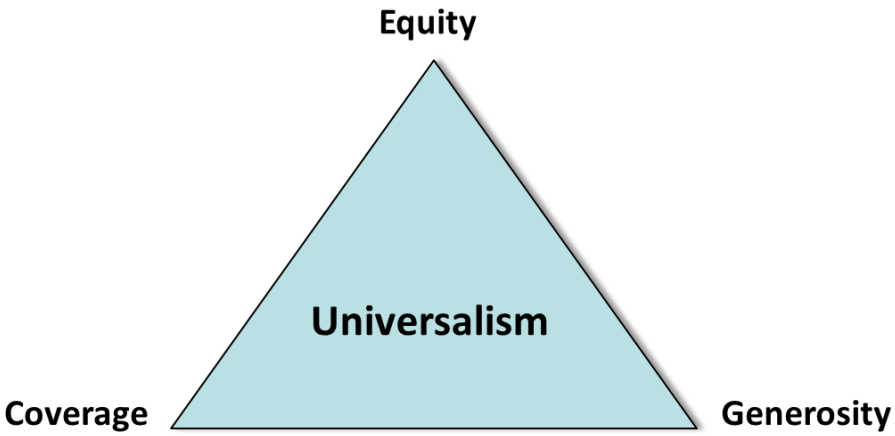
Closely related, Martínez Franzoni and Sánchez-Ancochea (2016) broadly distinguish between two definitions of universalism in the literature. 'Minimalist' definitions solely focus on the coverage of social policies, without taking the level, quality, or equity of benefits into account – thereby corresponding to an emphasis on the membership dimension. In contrast, 'maximalist' definitions are typically derived from the Nordic welfare state model and describe a specific institutional model of social provision that provides tax-funded, generous benefits to the whole population based on citizenship rights.

Neither of these definitions fully captures the diversity and complexity of welfare provision across the world. The minimalist model is overly reductive and normatively limited: in prioritising inclusion alone, it risks overlooking systems that are universal in name but inaccessible or unequal in practice. For example, health systems may formally include the entire population while still entrenching disparities in service access, quality, and health outcomes. Maximalist definitions, on the other hand, often conflate policy instruments (such as taxes) with policy outputs and thereby limit universalism to a specific historic and institutional model of provision. As such, they set an unachievable high bar for most

[52] For more details, see Chapter 2.

countries and fail to acknowledge the 'varieties of universalism' around the globe (Fischer 2012; Pribble 2013; Anttonen and Sipilä 2014).

Figure 16. Dimensions of universalism[53]



This paper adopts Martínez Franzoni and Sánchez-Ancochea's (2016) definition of universalism, which focuses on policy outputs and recognises that there are different ways to achieve them. Universal social policies are defined as those that reach the entire population with similarly generous benefits, regardless of the institutional instruments used to deliver them. This definition comprises three dimensions: Coverage, Generosity (in level and quality), and Equity (both in access and in generosity). Universalism is thus conceptualised not as a binary attribute, but as a continuous and multidimensional policy output, thereby allowing for diversity across countries.

2.2 Social policy and trust

2.2.1 Defining trust

Trust is a foundational concept to the study of social relations and political behaviour, often considered essential for democratic stability, economic growth, and societal wellbeing (Fukuyama 1995; Putnam 2000; Zak and Knack 2001). While frequently employed in the policy and academic literature, the concept often remains ambiguously defined and theoretically contested. Similar to universalism, trust is widely considered a multidimensional concept that comprises different varieties which are analytically distinct but interrelated, each representing a different scope, or radius, in the identity of the trusted.

[53] This figure is based on Martínez Franzoni and Sánchez-Ancochea (2016).

Most commonly, the literature distinguishes between institutional, particularised, and generalised forms of trust (Levi 1998; Uslaner 2002; Newton, Stolle, and Zmerli 2017).

Institutional trust generally refers to the confidence in the fairness, competence, and legitimacy of public institutions such as governments, courts, or the democratic system. It is often considered a political attitude shaped by current trends and events, which leads to high levels of volatility over time (Listhaug and Jakobsen 2017). Particularised trust describes trust in close social relations and in-group members, such as family, neighbours, colleagues, or friends – often based on aspects of familiarity, shared identity, or direct reciprocity (Yamagishi and Yamagishi 1994; Fukuyama 1995; Stolle 2002).

In contrast, generalised trust – also referred to as social trust and used interchangeably in this paper – concerns trust towards people in general, in particular those who are not personally known and are not members of the in-group. It reflects broader attitudes towards the trustworthiness of strangers and wider society. It is not based on specific interactions, but on expectations about how people behave and how society functions (Putnam 2000; Rothstein and Stolle 2008; Newton, Stolle, and Zmerli 2017).

A central distinction in the literature lies between conceptualising generalised trust as a moral disposition or as a rational expectation. Uslaner (2002) argues that social trust is best understood as a deeply held moral belief, often shaped early in life, that most people can be relied upon and share similar fundamental values. More strategic or rationalist approaches, such as Hardin's (2002) model of trust as 'encapsulated interest', focus on expectations of reliable behaviour in repeated interactions, based on the incentives of others to act trustworthy. Both conceptualisations imply different pathways and extents to which trust can be 'created': while moral beliefs tend to be stable over time and often derive from (early) socialisation, expectation-based accounts of trust attribute a clear role to the state (Levi 1998).

This paper adopts a relational and institutional understanding of generalised trust. It views trust not purely as a psychological or cultural trait, but as an outcome of social and institutional conditions. Generalised trust is understood as an expectation towards society at large, encompassing beliefs about others' trustworthiness and a willingness to engage cooperatively in the absence of direct reciprocity, thereby giving an important social role to the design and delivery of welfare policies (Stolle 2002).

Finally, it is important to note that while trust is often discussed alongside, or even interchangeably with, social cohesion or social capital, it is conceptually distinct. Social cohesion typically refers to the degree of solidarity and connectedness in a society, encompassing trust but also norms of belonging, inclusion, and civic participation (Chan, To, and Chan 2006; Schiefer and van der Noll 2017). Social capital, by contrast, mostly treats interpersonal relationships as a resource that individuals can draw upon, and is generally more focused on the benefits of social networks than on societal integration as a whole (Kawachi and Berkman 2014). Trust is an essential feature of both concepts, but it is not equivalent to them and should therefore be distinguished theoretically and analytically.

2.2.2 Literature review

A growing body of research examines how social policy influences trust, particularly generalised trust, in others. Institutional theories of trust argue that welfare state institutions shape norms of reciprocity, fairness, and social citizenship by reducing inequalities, insecurity, and social exclusion (Esping-Andersen 1990; Rothstein 2001; Rothstein and Stolle 2008). As such, social policies affect not only material wellbeing, but also people's expectations about the beliefs and behaviours of others in society, linking to the concept of trust as an expectation-based interaction rather than a moral or behavioural disposition (Stolle 2002).

A longstanding debate in the literature concerns whether the welfare state complements or substitutes trust and wider social capital. Proponents of the 'crowding out' hypothesis argue that comprehensive social policies, despite good intentions, weaken social capital as they stand in competition with informal networks of care and self-help, for example, within families or local communities, undermining societal norms of reciprocity and participation (Wolfe 1989; Fukuyama 2001; van Oorschot and Arts 2005).[54] In contrast, others emphasise how the welfare state fosters social capital by providing security and equality, enabling individuals to engage in civic life and develop trusting relations with others (Skocpol 1996; Rothstein 2001; Rothstein and Uslaner 2005).

Empirically, the evidence of the relationship between the welfare state and social trust is mixed, but tends to favour the 'crowding in' perspective. While some studies find null or even negative associations (van Oorschot and Arts 2005; Gesthuizen, Van Der Meer, and

[54] Most prominently, Putnam (2000) linked the expansion of government programmes in the United States to the erosion of civic engagement and social trust since the 1960s.

Scheepers 2009; Daniele and Geys 2015), many analyses establish a positive relationship between welfare and levels of social trust (Uslaner 2002; Hooghe and Stolle 2006; Larsen 2007; Freitag and Bühlmann 2009; Visser, Gesthuizen, and Scheepers 2018). For example, at the cross-country level, Rothstein and Uslaner (2005) find that more generous and universalistic welfare policies are positively associated with average levels of generalised trust in Europe. Similarly, Brewer, Oh, and Sharma (2014) find that total welfare expenditure is positively correlated with individual perceptions of social trust, even when controlling for reverse causality and a variety of confounding factors.

One reason for mixed empirical findings in the literature may lie in the operationalisation of the welfare state. Many studies rely on aggregate expenditure as a proxy for welfare efforts; however, this approach has been frequently criticised as overly reductionist and dependent on exogenous factors such as labour market structure or demographic composition (Kunißen 2023). Yet, given the suggested theoretical mechanisms in the literature, it is not expenditure per se that shapes trust, but rather the design, type, and quality of the services provided. For instance, Andrews and Jilke (2016) demonstrate that individuals across European countries who have access to better quality services report higher perceptions of social cohesion. Similarly, Lee (2013) finds a differential relationship across policy domains: while spending on active labour market policies is associated with higher social trust on the individual level, social security transfers tend to have the opposite effect.

Beyond quality and type of institutions, another strand of the literature focuses on the effects of universal versus targeted, or means-tested, policy design. While some form of targeted policies might promote social trust by providing additional support and enabling societal participation for the most disadvantaged (Skocpol 1991; Mau 2003), means-testing can also create stigma and increase societal divides by creating categories of ‘deserving’ and ‘undeserving’ poor (Mkandawire 2005; Rothstein and Stolle 2008; Calnitsky 2016). On the other hand, universal policies, by treating everyone equally, can be conducive to fostering trust, shared responsibility, and solidarity among beneficiaries (Birnbaum et al. 2017). Some recent studies provide suggestive evidence of this perspective.

In an event study analysis of the Affordable Care Act in the United States, Mewes and Giordano (2017) demonstrate how a shift towards more universalism did not directly increase social trust, but instead mitigated risk factors associated with low trust. More recently, Mewes (2024) examines the role of means-tested versus universal social spending across a sample of 30 European countries. Emphasising the role of public perceptions of

'deservingness' of different types of welfare programmes, he finds no evidence for an aggregate effect of social protection spending, but strong evidence for the role of universalism in healthcare expenditure to predict within-country changes in social trust over time.

2.3 The relationship between universalism and social trust[55]

This section outlines two theoretical mechanisms through which universal social policies may influence social trust, which is defined as individuals' expectations about the trustworthiness of people in society. The reason for focusing on generalised rather than particularised or institutional trust is twofold. Firstly, while welfare policies also have important interactions with institutional or political trust,[56] this paper focuses on the long-term institutional design of welfare provision – features that are relatively stable for most countries and less affected by short-term political fluctuations. I therefore consider social trust to offer a more suitable lens to assess the social consequences of these institutional foundations, compared to the more immediate and potentially transient effects that policies may have on institutional trust.[57] Secondly, I argue that universalism has implications for wider attitudes towards society that go beyond the realm of close social relations and particularised trust. Specifically, I consider universalism not only as a distributional principle, but as a relational concept that signifies social hierarchies, shared membership, and mutual obligation. This perspective goes beyond redistribution per se, but foregrounds how policies are structured, who is included, and whether individuals perceive themselves as equal members in collective systems of provision.

The suggested relationship between universalism and social trust operates through two interrelated mechanisms – as illustrated in Figure 2. On the horizontal level, that is, relationships among individuals and groups, universalism can create 'spaces of equality' that reduce levels of societal segmentation and foster social connectedness. On the vertical level, that is the relationship between the individual and the state, universalism shapes

[55] This section presents a theoretical framework on mechanisms through which universalism in social policy can shape social trust. The hypothesised mechanism should not be considered in isolation, because trust, as a complex and multi-faceted phenomenon, is clearly influenced by a variety of socioeconomic, ecological, political, and other factors—most of which are beyond the realm of social policy. Nevertheless, the following theoretical framework emphasises how the design of social policy programmes has social implications beyond effectiveness or redistributive concerns.

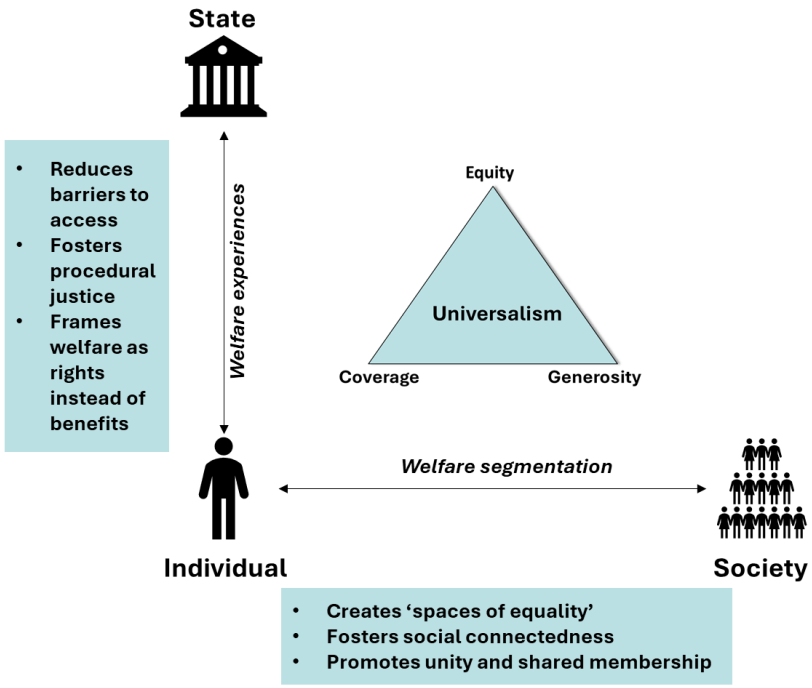
[56] As highlighted by an extensive literature (Sønderskov and Dinesen 2016; Kumlin, Stadelmann-Steffen, and Haugsgjerd 2017; Herreros 2023).

[57] Which are highly relevant as well, for example, with regard to welfare retrenchment. However, the link between institutional trust and universalism, or wider social policy, is not the focus of this paper.

welfare experiences by reducing barriers to access, fostering procedural justice, and advancing rights-based provision. Although vertical experiences are typically linked to institutional trust, I argue that they are also integral to social trust, because citizens' perceptions of society are partly formed and spill over from their interaction with the state.

These two mechanisms can also work in the opposite direction: more segmented (or less universal) systems can negatively shape welfare experiences, increase perceived unfairness, and reinforce social divides. While complementary, they exist on a continuum: some programmes might increase interactions with the state while simultaneously creating more inequalities – for example, by providing different qualities of benefits to different groups. Similarly, while this paper presents a general theoretical perspective on the relationship between universalism and social trust, the strength and relevance of these mechanisms are likely to vary across policy areas. Due to their interpersonal nature, universal relevance, and direct implications for human development, service-based social policies like healthcare and education are particularly salient case studies. In contrast, the horizontal mechanism of shortening social distance might be weaker for cash-based or narrowly demographically targeted policies.

Figure 2. Universalism and trust: Horizontal and vertical mechanisms



2.3.1 Vertical mechanism: Equitable welfare experiences

On the vertical level, individuals' attitudes towards society are shaped, in part, by their experiences with the state and its agents – particularly through welfare institutions (Kumlin and Rothstein 2005). In contrast to public services like national defence or the court system, social policies affect foundational capabilities, like health and education, while also providing an interface where individuals frequently come into personal contact with agents of the state, such as doctors in public hospitals, teachers in schools, or social workers in welfare offices. This perspective links to the wider literature on 'street-level bureaucracy' which emphasises the central role of frontline workers in mediating policy implementation through personal discretion (Lipsky 1980; Brodkin 2012; Lotta et al. 2022). State agents are not merely passive implementers of top-down policy decisions; they hold power in interpreting rules and eligibility criteria in their allocation decisions, often under conditions of scarce resources, time, and information. In doing so, they become not only factors in policy effectiveness but also convey a signal about societal values of fairness, inclusion, and solidarity.[58] Importantly, these effects extend beyond institutional trust and have significant spillover effects, as welfare experiences are extrapolated to trust in wider society, as demonstrated by Sønderskov and Dinesen (2016) and Dinesen et al. (2022).

I argue that universalism, by encompassing broad coverage, generous provision, and equitable access, contributes to welfare experiences that are more inclusive, fair, and trust-enhancing: by reducing barriers to access, fostering procedural justice, and strengthening rights-based provision.

Firstly, universalism lowers access barriers and enables a broader range of beneficiaries to engage with welfare institutions, thereby reducing the 'distance' between individuals and the state. While the direction of this effect is likely to be moderated by the level of equity of provision – for example, in terms of differences between private and public systems – this shortening of distance has the potential to shape experiences of the state as responsive and inclusive. This is particularly important in the context of developing welfare systems, where existing levels of provision often remain low and fragmented. Evidence from Nepal illustrates that the introduction of social pensions and universal child grants, despite challenges in

[58] For example, Kumlin and Rothstein (2005) highlight how discretionary power over means-tested benefits can lead to 'vicious spirals of distrust' on both sides: as state agents (or humans in general) are inherently prone to personal biases in their decision making, potential beneficiaries have an incentive to withhold information to qualify for services, which in turn leads to even greater biases and distrust on the side of bureaucrats, and so on.

implementation and initial financing, led to greater trust in the government and improvement of social relations, especially in rural and underserved areas (Garde, Mathers, and Dhakal 2017; Koehler 2021).[59]

Secondly, building on the argument of Kumlin and Rothstein (2005), universalism promotes procedural justice in the delivery of public services, which is central to how citizens experience welfare systems. By applying consistent rules and ensuring equal treatment of beneficiaries, universal social policies limit bureaucratic discretionary power, which can be perceived as arbitrary and unfair. Means-testing, in contrast, requires frontline officials to assess individuals' eligibility based on income or other socio-economic criteria – a process that is inherently complex and often prone to targeting errors, corruption, and power misuse (van Oorschot 2002; Nelson 2004; Mkandawire 2005). While there is evidence that well-targeted interventions can avoid some of these shortcomings and even increase trust if benefits reach those most in need, there are many examples that fall short of these aspirations (Evans, Holtemeyer, and Kosec 2019). Audin (2020) highlights the case of minimum income grants in China, which are administered by local neighbourhood committees with high discretionary power, causing substantial social pressures, exclusion, and distrust.

Thirdly, universalism fosters trust by framing social benefits as rights, rather than as conditional or discretionary transfers. When welfare is provided as a universal entitlement, it provides agency to beneficiaries as claimants, rather than as passive recipients of social benefits, and reduces the emotional and administrative burden of proving 'deservingness' in interactions with state agents (van Oorschot 2000; Mewes 2024). This shifts welfare experiences from potential acts of charity that can be associated with stigma, dependency, and moral judgement, towards expressions of social citizenship (Marshall 1950; Titmuss 1976; Esping-Andersen 1990). This distinction is especially visible in contexts where universal and targeted programmes coexist. In Brazil, for example, scholars have emphasised the social differences of the targeted *Bolsa Família* conditional cash transfer, which has faced challenges of stigma and resentment, and the universal public healthcare system, which is often considered a symbol of national pride and shared entitlement (Cornwall and Shankland 2008; Layton 2020).

[59] Other examples include Rwanda, South Africa, and Namibia. See Koehler (2021).

2.3.2 Horizontal mechanism: Spaces of equality

Beyond shaping individual welfare experiences, I argue that universalism contributes to fostering trust through a horizontal mechanism by functioning as 'spaces of equality'. In this perspective, social policies can be considered relational constructs that signify and embody social hierarchies, thereby shaping how individuals perceive and relate to each other. In contrast to segmented or means-tested systems of provision, universal social policies bring diverse social groups into contact with the same institutions, on the same terms, and with the same rights. They thereby foster social connectedness, strengthen shared interests, and reduce the symbolic and material boundaries that divide 'us' from 'them'. Scandinavian countries, for example, have historically maintained high levels of social trust not only through redistribution, but also through universal institutions that shorten social distance across socio-economic backgrounds, group memberships, and identities (Rothstein 1998).

On the other hand, when middle and upper classes primarily rely on private services and have little interaction with public systems, social policies cease to be shared spaces and become markers of social difference (Rothstein and Uslaner 2005). Segmented and residual systems, where benefits, and consequently beneficiaries, are sorted into social hierarchies, can often produce a symbolic 'othering' effect in defining who is in and out of the political and moral community (Larsen 2007). This divisive role has been discussed extensively with respect to the psychosocial cost of targeting and the role of stigma on the side of the recipients, but it can also be extended to the group of non-beneficiaries (Mkandawire 2005; Roelen 2020). Social trust can be undermined when groups feel unfairly excluded or alienated – whether due to targeting errors, discrimination, or perceptions of arbitrariness. In Sierra Leone, for instance, the Social Safety Net programme exacerbated social divisions and distrust in a crisis context by failing to reach many of those most in need, creating resentment both among excluded households and more broadly within communities (Babajanian 2012).

By contrast, universal policies not only avoid such resentment, but actively foster social and political togetherness by aligning citizens' incentives in terms of shared membership. When welfare is provided as a universal entitlement, it affirms the equal status of members of society as part of a shared community with mutual rights and obligations.[60] This is

[60] A related literature considers the role of the state in enforcing these obligations and punishing free riders. See Herreros (2023) for an overview. While relevant, this aspect is not the focus of this paper, as the enforcement of obligations is not specific to universalism and also applies to means-tested programmes.

institutionalised through mechanisms of risk pooling and collective financing that embody norms of solidarity and reciprocity (Baldwin 1990; Mau 2003; Béland 2005; Birnbaum et al. 2017). Beyond shaping welfare experiences themselves, universal provision also carries symbolic meaning of societal unity and equality. For this reason, a universal approach to welfare provision was historically at the heart of nation-building efforts in Europe and many countries of the Global South (de Neubourg 2009; Kabeer 2014). For example, Martínez Franzoni and Sánchez-Ancochea (2016) highlight how the Costa Rican Social Insurance Agency "has become a national symbol, intertwined with peace, the rule of law, and social democracy" (Martínez Franzoni and Sánchez-Ancochea 2016, 39).[61]

As Naila Kabeer (2014, 347) powerfully argues, the inclusiveness of social rights is therefore central to social trust itself:

> "…all 'imagined' societies face the challenge of constructing a sufficiently strong sense of belonging among citizens who are strangers to each other to give them a stake in their collective future, the willingness to observe those basic duties that are the other side of the coin to basic rights. Those who are most excluded from the circle of citizenship express the greatest alienation from its values and have the least stake in the flourishing of the communities in which they live. It is both just and reasonable to argue that the extension of rights to those who have been thus historically marginalised must precede expectations of contributions."

[61] Similarly, Béland and Lecours (2008) note how in Canada, the universal health care system has become an integral part of national identity and social citizenship.

3. Methodology

3.1 Empirical strategy

To test the theoretical framework developed in Section 2.2, this paper examines the association between healthcare universalism and individual perceptions of social trust. As outlined, universal social policies are theorised to shape the social foundations of trust through a relational mechanism of reducing segmentation, fostering procedural justice, and strengthening social connectedness. Given that the trust-building effects of universalism likely differ between policy areas and that aggregated welfare measures can obscure important variation, healthcare is employed as a particularly salient and globally relevant case study of the suggested relationship.

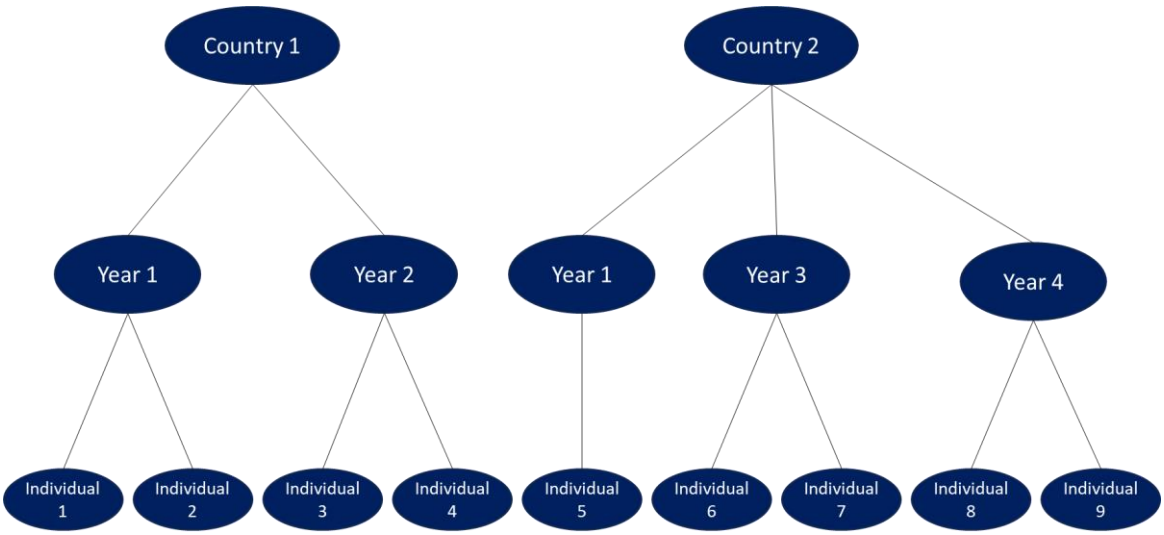
Healthcare is chosen for several reasons. Firstly, it constitutes the largest welfare programme in most countries and affects all segments of the population across the life cycle – in contrast to programmes like unemployment benefits or pensions. Secondly, healthcare is a highly visible domain of state intervention that directly shapes welfare experience and signals shared membership in a collective risk pool. Thirdly, by affecting health as a central capability and making inequalities in provision directly tangible, it is expected to be particularly close to individuals' sense of trust and attitudes towards society (Montanari and Nelson 2013).

Following other recent investigations into the role of welfare design in determining social trust and wider social capital, this study adopts a multilevel modelling approach (Freitag and Bühlmann 2009; Lee 2013; Brewer, Oh, and Sharma 2014; Akaeda 2021; Mewes 2024). The study focuses on analysing individual-level perceptions of social trust using harmonised cross-national survey data, rather than relying on national-level aggregates. While country-level averages of survey responses are frequently used to illustrate macro trends, the statistical analysis of such data can be problematic and cause spurious results when assuming that national-level correlations also hold on the individual level (Fairbrother 2014). Among other factors, such analyses are incapable of accounting for population heterogeneity and individual-level characteristics that might affect both dependent and independent variables, such as socioeconomic background or health status.[62]

[62] Given the theorised impact channel of universalism on trust, as described in Section 2.2, it is likely that individuals' socioeconomic characteristics mediate the relationship. For example, usage and perception of public healthcare provision is likely correlated with respondents' income and health

Therefore, the study combines individual survey responses with national-level characteristics and employs a three-level multilevel model to examine the association between healthcare universalism and social trust at the individual level.[63] The data structure takes the form of comparative longitudinal survey data, meaning that surveys are conducted in the same countries over multiple years, but different individuals are observed each time (Schmidt-Catran and Fairbrother 2016).[64] The nested structure – individuals within country-years within countries, as illustrated in Figure 3 – makes multilevel (or random effects) models the appropriate form of analysis to capture dependencies in the data and avoids conflating within- and between-country variation over time. These models account for the fact that responses from individuals in the same country or survey year are likely to be more similar than responses across countries or sample periods. Importantly, multilevel models are well-suited for unbalanced data, as they produce unbiased estimates, even when the number of years or individuals surveyed varies across countries.

Figure 3. Three-level nested structure of the data



Following Schmidt-Catran and Fairbrother (2016), the analysis models three levels of clustering and treats the 407,826 survey responses as nested within 273 country-years, which are nested within 105 countries. While potentially being 'over-conservative', the

status. If the hypothesis of shortening social distance and promoting solidarity between classes is correct, the strength of the effect can be expected to increase in both variables.

[63] Importantly, the findings presented in this paper are associational in nature and should not be interpreted as causal. While the multilevel approach helps mitigate risks of omitted variable bias and ecological fallacy, the survey design and observational nature of the data limit causal inference. In particular, reverse causality and unobserved confounders cannot be ruled out.

[64] In other words, countries have a longitudinal structure in the data, but not in individuals.

authors emphasise that it is safer to include random effects for all potential levels of variation in order to avoid downward biases in standard errors.

The three-level model takes the following form:

$$ST_{ijk} = \alpha_0(j) + \beta_0 HUI_{jk} + \gamma_0 IC_{ijk} + \gamma_1 MC_{jk} + v_j + u_{jk} + e_{ijk}$$

Where ST_{ijk} represents the social trust indicator for individual i in year j and country k, HUI_{jk} the healthcare universalism indicator in year j and country k, with β_0 as the coefficient of interest. Similarly, MC_{jk} represents a vector of macro controls (such as population and GDP) while IC_{ijk} is a vector of the individual controls (such as age and education). v_j, u_{jk} and e_{ijk} are the error terms on country, country-year, and individual level. To avoid spurious results from time trends and common shocks to all countries and individuals, the model also includes year fixed effects, given by the time-dependent constant $\alpha_0(j)$ (Schmidt-Catran 2016). The analysis is conducted using the MLwiN software, implemented through the Stata *runmlwin* command (Leckie and Charlton 2012).

As a robustness check, Appendix A presents an alternative time-series cross-sectional (TSCS) analysis employing country averages in social trust, consistent with earlier approaches in the literature that investigate related questions on welfare, trust and social cohesion using aggregate cross-country data (Rothstein and Uslaner 2005; van Oorschot and Arts 2005; Robbins 2012; Bjørnskov and Svendsen 2013; Bergh and Bjørnskov 2014; Jacques and Noël 2018).

Across the analysis stages, the focus lies on the previously described Healthcare Universalism Index (see Chapter 2). The HUI is a multidimensional, composite measure that captures cross-national variation in universal healthcare provision by combining three dimensions of policy outputs: Coverage, Generosity, and Equity. Rather than relying on singular indicators of 'welfareness' – such as expenditure or enrolment – the HUI captures a broader conception of universalism that accounts for trade-offs and interactions between its dimensions. This approach not only captures potential imbalances or gaps in welfare provision that would be overlooked in single-indicator measures, but also enables a disaggregated analysis of how different aspects of universalism relate to social trust.

Finally, the study explores regional heterogeneity by examining whether the association between universalism, its dimensions, and social trust differs between countries of the Global North and the Global South. Following the classification of the United Nations

Conference on Trade and Development (UNCTAD), the 'developed' or 'Global North' category is comprised of the countries of North America and Europe, Israel, Japan, South Korea, Australia, and New Zealand, while the Global South refers to all remaining countries (UNCTAD 2023). The reason for analysing the data along these categories is twofold. Firstly, to connect the findings to a growing literature on the determinants and consequences of universal social policies in the Global South (Mkandawire 2004; Gough et al. 2004; Haggard and Kaufman 2008; Pribble 2013; Kabeer 2014; Martínez Franzoni and Sánchez-Ancochea 2016). Secondly, the Global South presents a valuable category of analysis in describing a group of countries that share geographical, relational, structural, and political characteristics – often related to colonial and post-colonial histories – that are likely to impact their development and policy pathways (Sud and Sánchez-Ancochea 2022). With increasing policy interest in expanding universalism around the world,[65] examining whether similar relationships hold beyond the existing geographical focus contributes to a more global understanding of macro-social linkages in welfare provision.

3.2 Measuring healthcare universalism

Following the approach in Chapter 2, this study measures healthcare universalism using three macro-level measures of Coverage, Generosity, and Equity, which are combined into a composite Healthcare Universalism Index. Covering 204 countries and territories from 1995 to 2023, the HUI is constructed as the geometric mean of normalised sub-indices in each of the three dimensions, using the following indicators:

- **Coverage**: UHC effective coverage index (Lozano et al. 2020).
- **Generosity**: Government health spending as a percentage of GDP (Global Burden of Disease Collaborative Network 2025).
- **Equity**: Private health spending[66] as a percentage of total health spending (Global Burden of Disease Collaborative Network 2025).

Going beyond coverage, the HUI shifts the empirical focus to aspects of quality and segmentation of healthcare provision. Rather than capturing legal entitlements or institutional models, it focuses on observable policy outputs that are relevant and applicable across diverse political, institutional, and development contexts. The underlying assumption is that the goals of universalism – the whole population having access to similar, high-quality

[65] See, for example, Leisering (2020).
[66] Private health spending is measured as the sum of out-of-pocket and prepaid private health spending.

healthcare services – are shared across the world, but that countries might pursue different policy pathways to achieving them. The selected indicators reflect system-level characteristics that are widely available, common to all healthcare systems, and correspond to the theoretical core of universalism (as highlighted in Section 2.1). The three dimensions are measured through normalised subindices and aggregated using a geometric mean with equal weights, reflecting the underlying principle that universalism is not achieved through progress in one single dimension, but through balanced achievement across all three.

The UHC effective coverage index (Lozano et al. 2020) comprises 23 life cycle indicators of health care, mapped into a framework of five population groups (such as 'reproductive and newborn' or 'older adults') and five health service domains (such as 'promotion', 'treatment', or 'palliation'). Building on the *Global Burden of Diseases, Injuries, and Risk Factors Study* (GBD) 2019, four of these indicators are direct measures of service coverage, and nineteen are estimated based on health and mortality outcomes as a proxy for access to quality care.[67] To construct the index, all indicators are weighted by a country's disease burden and population structure[68] in order to provide a context-sensitive indicator for effective access to healthcare.

To complement this measure of coverage, the level of government health spending and healthcare privatisation is employed to measure the generosity and equity of health care systems on a global scale. The public and private health expenditure data is drawn from the *Global Health Spending 1995-2022* database (Global Burden of Disease Collaborative Network 2025), which provides modelled estimates of domestic health expenditure for 195 countries from 1995 to 2022. Government health spending is commonly used as an indicator for public efforts and financial commitments to quality health care, whereas the level of privatisation is interpreted as a proxy for the commodification and segmentation of services (Martínez Franzoni and Sánchez-Ancochea 2018). The latter assumes that a large private

[67] The outcome-based indicators are estimated based on mortality ratios from the GBD, assuming higher survival (relative to disease burden) reflects better access to effective care. For example, a lower cancer mortality – relative to incidence – is assumed to reflect higher effective coverage. For details, see Lozano et al. (2020), Appendix 1.

[68] For example, HIV treatment coverage receives greater weight in countries with high HIV incidence, while countries with a larger share of older adults receive a higher weight for indicators related to their health needs.

sector reflects weaknesses in public provision, where higher-income groups access higher-quality services compared to the rest of the population.[69]

3.3 Measuring social trust

To measure social trust and individual-level characteristics, the paper relies on data from the *World Values Survey* (WVS; Inglehart et al. 2022) and the *European Values Study* (EVS 2022). Both comprise a set of standardised, nationally representative surveys on a wide variety of social, political, moral, religious, and economic values and beliefs. As many questions in the two surveys are harmonised, these two data sources can be combined to achieve the most comprehensive and internationally comparable dataset on global socio-political change.[70] This study employs data from waves 4 to 7, covering the period from 2000 to 2020.

As outlined in the theoretical considerations and in following previous approaches, this paper focuses on the concept of generalised trust as the dependent variable (Kumlin and Rothstein 2005; Rothstein and Uslaner 2005; Brewer, Oh, and Sharma 2014; Mewes 2024). It is operationalised using the most commonly employed binary question *"Generally speaking, would you say that most people can be trusted or you can't be too careful in dealing with people?"* With an extensive history in the study of social trust since its original formulation by Rosenberg (1956), this question is chosen for its extensive cross-national and longitudinal coverage, and because it best represents the theorised mechanism of universalism in creating a space of equality and shortening social distance.

Although well established in the literature, this measure is not without limitations. Its binary, single-item format cannot capture the full spectrum and nuance of interpersonal trust, and respondents' interpretation of the question may introduce measurement bias. While generally referring to strangers, the scope of 'most people' is open to interpretation and may be taken to refer to individuals' own community, wider society, or even institutions. Such interpretations are likely to further vary across cultural contexts, personal circumstances, and socio-economic characteristics (Glaeser et al. 2000).[71] Despite these limitations, the survey item remains the most widely used and validated proxy for generalised trust across

[69] To combine all three dimensions in the HUI, both indicators are normalised using normative upper and lower bounds: 0 to 10 percent of GDP for government health spending, and 10 to 75 percent of total health spending for private expenditure. For more details, see the methodology section in Chapter 2.
[70] Using the combined WVS-EVS trend files.
[71] The individual-level controls, year and regional fixed effects included in the analysis aim to mitigate some of this variability in interpretation.

countries and over time, with experimental evidence showing that it strongly correlates with behavioural measures of interpersonal trust (Knack and Keefer 1997; Johnson and Mislin 2012).

3.4 Control variables

Following previous studies on the relationship between social trust, health, and welfare, this study controls for a variety of individual and country-level characteristics.[72] To account for individual-level variation that might affect levels of social trust, the analysis controls for age, gender, marital status, educational attainment, employment status, and income level. Apart from age, all variables are included as categorical variables. Marital status is measured by collapsing the WVS/EVS classification into three broader categories: "*married or living together as married*", "*divorced, separated, or widowed*" and "*single*". Similarly, employment status is collapsed into four broader categories: "*full time, part time, or self-employment*", "*retirement*", "*unemployment*", and "*housewife/househusband, student, and others*". The educational attainment questions ask respondents for their highest level of education achieved, ranging from "*inadequately completed primary education*" to "*university degree/higher education*". For the purposes of this study, these categories were regrouped as primary, upper secondary, and tertiary education. Similarly, household income was classified into three groups: lower, middle, and higher income.[73]

In addition to these standard socio-demographic characteristics, the analysis controls for respondents' subjective health status, ranging from "*very poor*" to "*very good*" on a five-point scale. Given the extensive literature that links wellbeing and trust (Akaeda 2021; Delhey et al. 2018; Mansyur et al. 2008; Subramanian 2002), this additional control accounts for the possibility that the association between universalism and trust may reflect the direct effects of healthcare systems on wellbeing, rather than the hypothesised mechanism of shortening social distance.[74] While not a clinical measure, subjective health is particularly relevant in this context, as interpersonal trust is likely to be shaped more by personal perceptions than by objective health indicators.

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[72] For examples, see Mewes (2024), Akaeda (2021), or Visser, Gesthuizen, and Scheepers (2018).
[73] While these are based on actual income brackets in the EVS, the World Values Survey only includes subjective measures of income levels. Comparing the data between the two, the main difference appears to be the number of respondents that identify as high-income (11.4 percent of respondents in the WVS sample versus 30.5 percent of respondents in the EVS sample).
[74] For example, more generous healthcare systems lead to better health outcomes, which may in turn lead to higher perceptions of trust. See the literature on the relationship between welfare and self-rated health (Bambra and Eikemo 2009; Ferrarini, Nelson, and Sjöberg 2014).

To account for country-level variation, controls are included for the level of economic development, the unemployment rate, and population size – factors that are likely to be correlated with healthcare provision and its resources, as well as with levels of social trust. Economic development is measured as GDP per capita in purchasing power parity (PPP), using data from the World Bank's *World Development Indicators (WDI)*. Unemployment rate estimates are taken from the *ILOSTAT* database and population statistics from the UN DESA *World Population Prospects*.

The descriptive statistics for all dependent and independent variables for the sample period of 2000 to 2020 are presented in Table 1.

Table 1. Descriptive statistics

	Mean	Standard Deviation	Minimum	Maximum	Obser-vations	Countries
Dependent variable						
Generalised trust (in %)	27.3	44.6	0	100	407,826	110
Explanatory variables						
Healthcare Universalism Index	42.8	20.8	3.0	94.9	5916	204
UHC Effective Coverage Index	54.7	17.7	15.0	97.0	5916	204
Government health spending (in % of GDP)	3.34	2.72	0	34.1	5916	204
Private health spending (in % of total)	40.6	19.1	0	96.4	5916	204
Control variables						
Age	43.2	17.0	13	108	422,142	108
Gender	0.53	0.5	0	1	423,005	108
Marital status (categorical)	1.63	0.85	1	3	421,529	108
Employment status (categorical)	2.00	1.23	1	4	416,780	108

Income level (3-stage ordinal)	1.84	0.67	1	3	385,793	108
Self-rated health (5-stage ordinal)	2.18	0.89	1	5	414,830	108
GDP per capita (PPP, in thousand USD)	18.9	20.5	0.63	120.6	4078	198
Unemployment rate (ILO estimate)	8.07	5.97	0.10	37.3	4023	183
Population (in millions)	34.9	133.3	0.01	1412.4	4423	201

3.5 Limitations

While this paper provides new empirical insights into the relationship between healthcare universalism and social trust, several limitations of the research design and data should be acknowledged. Firstly, the analysis is correlational and does not allow for causal inference, both due to the latent nature of the concepts of trust and universalism, and due to the use of observational survey data. Social trust is a complex and multidimensional construct that is shaped by various social, economic, cultural, and institutional factors, many of which lie beyond the realm of healthcare. Therefore, the reported associations should be interpreted as suggestive of universalism as one potential contributing factor to individuals' sense of trust, rather than as evidence of a direct or causal relationship.

Secondly, the analysis is subject to endogeneity risks due to omitted variable bias and potential reverse causality. It is possible that both healthcare systems and trust are jointly affected by unobserved factors, such as party politics or institutional legacies, which are not captured in the regression model. Similarly, countries with higher levels of trust may be more likely to adopt universal policies – for example, if trust increases or mediates public support for redistribution. While the use of multilevel models, fixed effects, and extensive robustness tests alleviates some of these concerns, endogeneity risks cannot be fully eliminated. The robustness checks include an alternative country-level analysis (see Appendix A), different model specifications, and the use of time lags of different lengths.

Thirdly, there are measurement limitations in both the dependent and independent variables. As outlined in Section 3.3, the measure of social trust –though widely employed and experimentally validated – is one-dimensional and carries the risk of varying interpretation across cultural and individual contexts. Likewise, while the HUI represents an output-

focused and internationally comparable measure of healthcare universalism, the indicators of government spending and healthcare privatisation are limited by their reliance on expenditure as an imperfect proxy for the quality and equity of healthcare provision.[75]

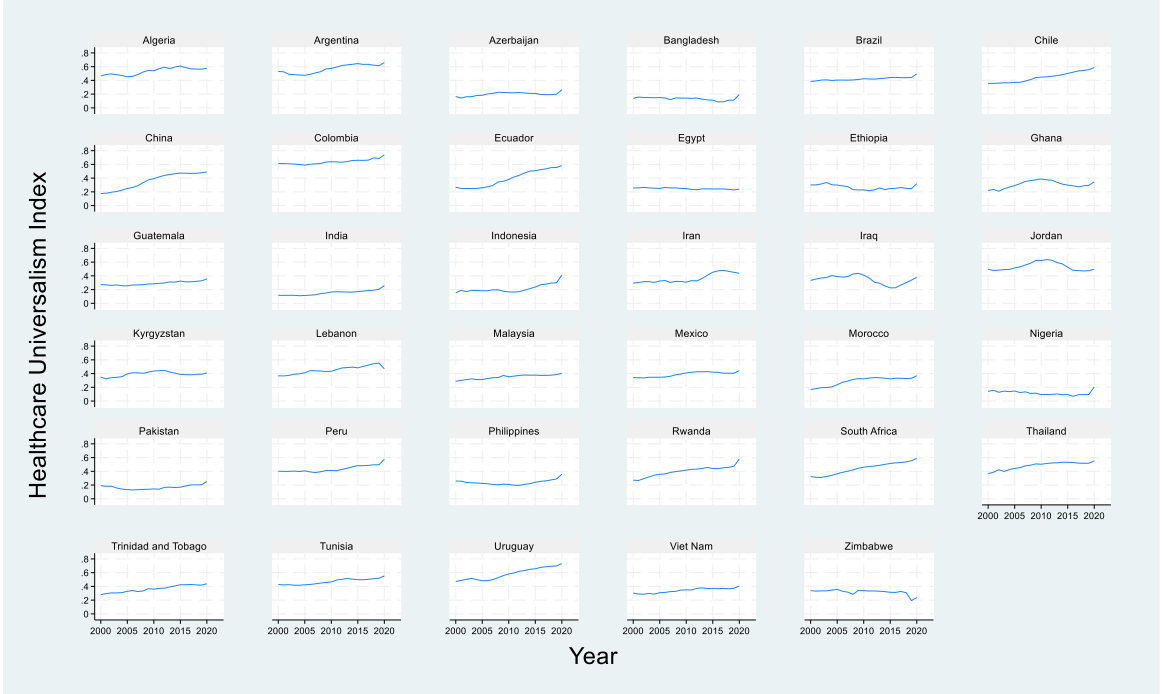
Finally, the large and diverse global sample has both advantages and challenges. The Global South subsample is smaller and often lacks earlier waves in the *World Values Survey*, which reduces statistical power and limits within-country variation.[76] To alleviate some of these power concerns, the Global South countries are pooled for the regional heterogeneity analysis and regional fixed effects, and cluster robust standard errors are employed.

[75] For more details, see Section 3.5 in Chapter 2.
[76] However, this is more likely to downward-bias the estimates or reduce their significance.

4. Results

4.1 Descriptive results

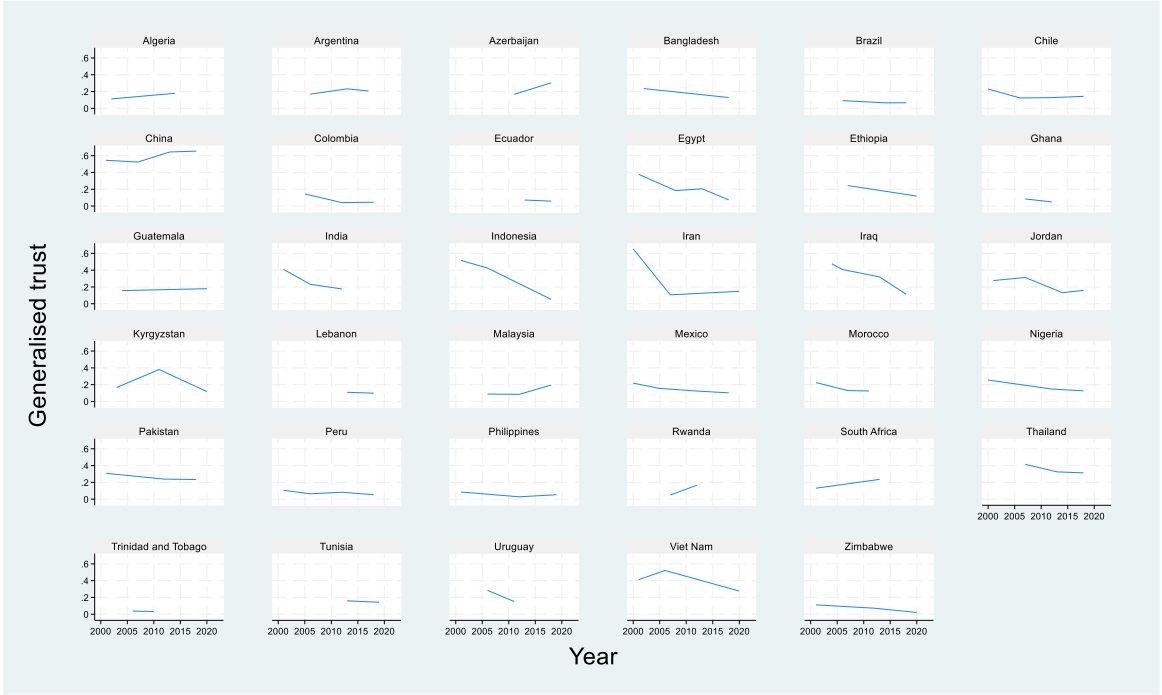
Figure 4. Healthcare Universalism Index across 35 Global South countries, 2000–2020



Figures 4 and 5 illustrate the variation in the Healthcare Universalism Index and generalised trust for the 35 Global South countries with multiple observations on both variables. As one of the contributions of this paper lies in broadening the geographical scope of existing research, these figures focus on illustrative trends within the Global South subset of the sample. Overall, even within a relatively short time frame, the data shows that both trust and universalism are less stable than potentially expected and exhibit substantial variation between 2000 and 2020. The HUI shows a positive trajectory for most Global South countries, with an average growth rate of 35.9 percent over the period of analysis.[77] By contrast, social trust declines in the majority of countries, in line with broader narratives of a global trust crisis (Flew 2021; UNDP 2024; Valgarðsson et al. 2025). In total, 23 out of 35 countries experienced a negative trend in social trust between 2000 and 2020, with an average decrease of 42 percent.

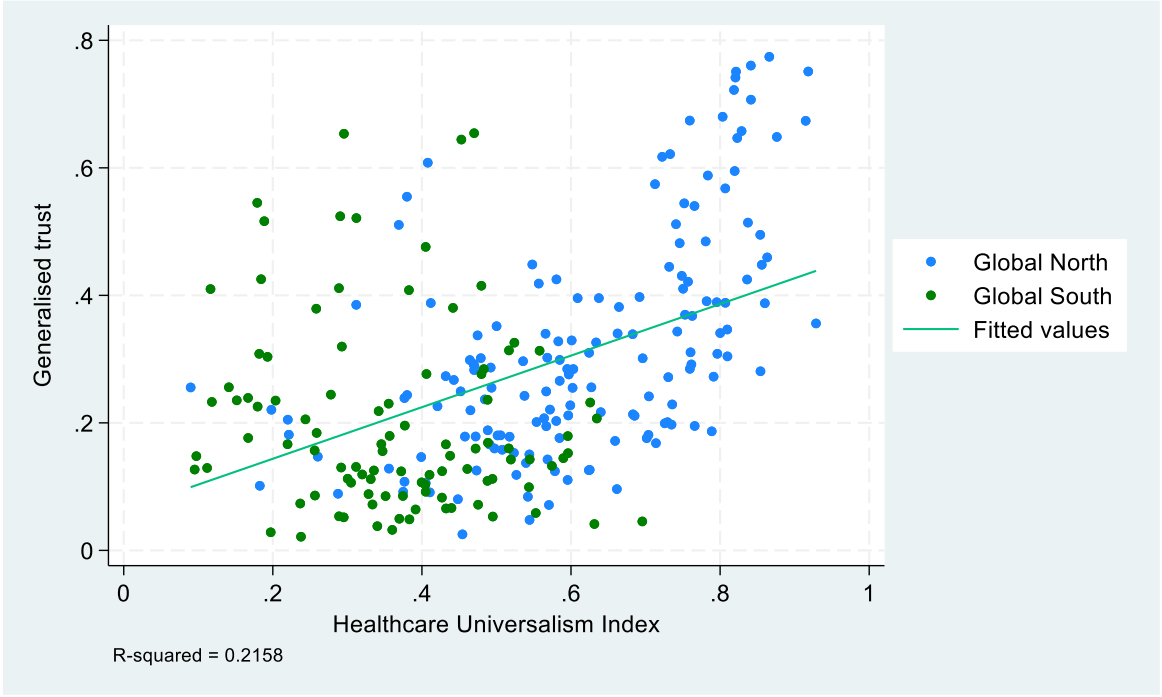
[77] For more details, see Chapter 2.

Figure 5. Generalised trust across 35 Global South countries, 2000–2020



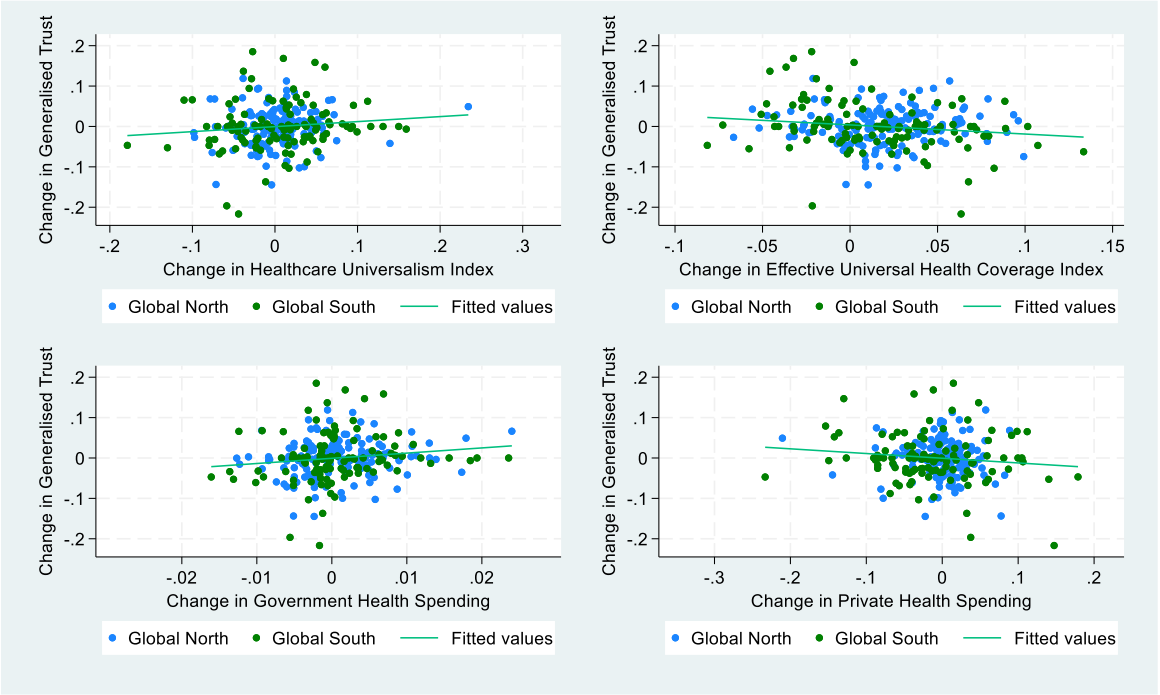
Having established the variation of both key variables over time, Figure 6 plots the level of universalism against the national level of trust, aggregated across all countries and observations in the sample. While the validity of bivariate associations should not be overstated due to the lack of consideration of control variables and time effects, the graph indicates a potential relationship between both variables with a positive correlation coefficient of 0.41. Interestingly, the association appears to be stronger in countries of the Global North, with a correlation coefficient of 0.58, while the data shows more outliers in countries of the Global South.

Figure 6. Bivariate correlation: HUI level and trust



Following Mewes (2024), Figure 7 further plots changes in the HUI and its dimensions against changes in social trust, reinforcing the finding that both variables display meaningful within-country variation over the sample period. For changes in the composite HUI, the data shows a positive correlation coefficient of 0.15, significant at the 95 percent confidence level, indicating that a 1 percent increase in universalism is associated with a 0.15 percent increase in the level of social trust. Similar patterns can be observed across the HUI dimensional variables to measure Generosity and equity: government health spending (as a percentage of GDP) and private health spending (as a percentage of total expenditure). While displaying considerable variation, given the diversity of country experiences, both variables indicate that the expected correlations with increases in government spending and decreases in health privatisation are associated with positive changes in social trust. Interestingly, the variable with the largest variation in the sample, the UHC effective coverage index, has a slightly negative but insignificant correlation with changes in trust, potentially indicating the decreasing role of coverage for trust at higher stages of development.

Figure 7. Bivariate correlations: Changes in HUI, sub-indices, and trust



4.2 Multilevel analysis

Table 2 summarises the results of four multilevel models with an increasing number of controls. In addition to the null model, which only contains the random intercept and no predictors, model 1 tests the simple association between the HUI and generalised trust, while models 2 and 3 include the individual and country-level control variables. As the underlying survey question ("*Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?")* is answered on a binary scale, the regressions are conducted using a logit model and the results are presented as odds ratios (OR) for ease of interpretation.

The null model highlights the structure of the variation across countries and years. As expected, the largest variation appears across countries rather than across country-years, but both variances are highly significant and thereby justify the use of the three-level modelling structure. As the null model includes no predictors, the intercept is given by the unconditional sample mean of the dependent variable – that is, only 27.3 percent of survey respondents think that most people can be trusted.

Table 2. Multilevel regression of HUI on generalised trust

Dependent variable: Most people can be trusted	(0) Null model	(1) HUI only	(2) HUI and individual controls	(3) HUI and full controls
HUI		1.014***	1.015***	1.011**
		(0.00315)	(0.00334)	(0.00359)
Age			1.001	1.001
			(0.00155)	(0.00156)
Age squared			1.000***	1.000***
			(0.0000162)	(0.0000164)
Gender: Female			0.983*	0.984
(Reference: Male)			(0.00828)	(0.00839)
Marital status: Separated/Divorced			0.962**	0.961**
(Reference: Married)			(0.0124)	(0.0125)
Marital status: Single			1.030*	1.030*
			(0.0122)	(0.0123)
Education level: Medium			1.000	0.999
(Reference: Low)			(0.0113)	(0.0114)
Education level: High			1.338***	1.342***
			(0.0164)	(0.0167)
Employment status: Retired			0.895***	0.893***
(Reference: Employed)			(0.0143)	(0.0144)
Employment status: Unemployed			0.882***	0.884***
			(0.0140)	(0.0144)
Employment status: Other			1.012	1.011
			(0.0117)	(0.0118)
Income level: Medium			1.114***	1.120***
(Reference: Low)			(0.0110)	(0.0113)
Income level: High			1.320***	1.332***
			(0.0173)	(0.0177)
Self-rated health: Poor			1.180**	1.184**
(Reference: Very poor)			(0.0641)	(0.0657)
Self-rated health: Fair			1.282***	1.287***
			(0.0675)	(0.0692)
Self-rated health: Good			1.661***	1.675***
			(0.0874)	(0.0900)

Self-rated health: Very good			2.058***	2.090***
			(0.109)	(0.113)
Logged population				1.072
				(0.0445)
GDP per capita (in thous. USD, PPP)				1.012**
				(0.00366)
Unemployment				0.986
				(0.00902)
Constant	0.273***	0.171***	0.205***	0.0550***
	(0.0274)	(0.0292)	(0.0534)	(0.0451)
Year fixed effects	No	Yes	Yes	Yes
Region fixed effects	No	No	Yes	Yes
Var (Country)	0.608***	0.431***	0.459***	0.308***
	(0.0936)	(0.0723)	(0.0733)	(0.0537)
Var (Country-Years)	0.158***	0.203***	0.145***	0.157***
	(0.0176)	(0.0224)	(0.0166)	(0.0180)
N (Countries)	110	110	105	105
N (Observations)	407,826	407,826	353,784	353,784

Coefficients presented as odds ratios; standard errors in parentheses.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Starting with the control variables, most socioeconomic characteristics exhibit the anticipated direction of effects. On the individual level, levels of trust are significantly associated with a person's age,[78] marital status, education level, income, and health status, with single, employed, highly educated, and medium/high income individuals tending to be more trusting. Interestingly, the results show a steep and significant gradient for levels of self-rated health where a person identifying as feeling 'very good' more than twice as likely trusts the average person than a person identifying as feeling 'very poor' – in line with the broader literature on the correlation between (self-rated) health and trust (Jen et al. 2010; Campos-Matos, Subramanian, and Kawachi 2016; Mewes and Giordano 2017). This strong association reinforces the decision to control for this individual-level variable for two reasons: firstly, due to a potential omitted variables bias in not accounting for varying distributions of respondents' health status across countries and time, and secondly, due to separating the

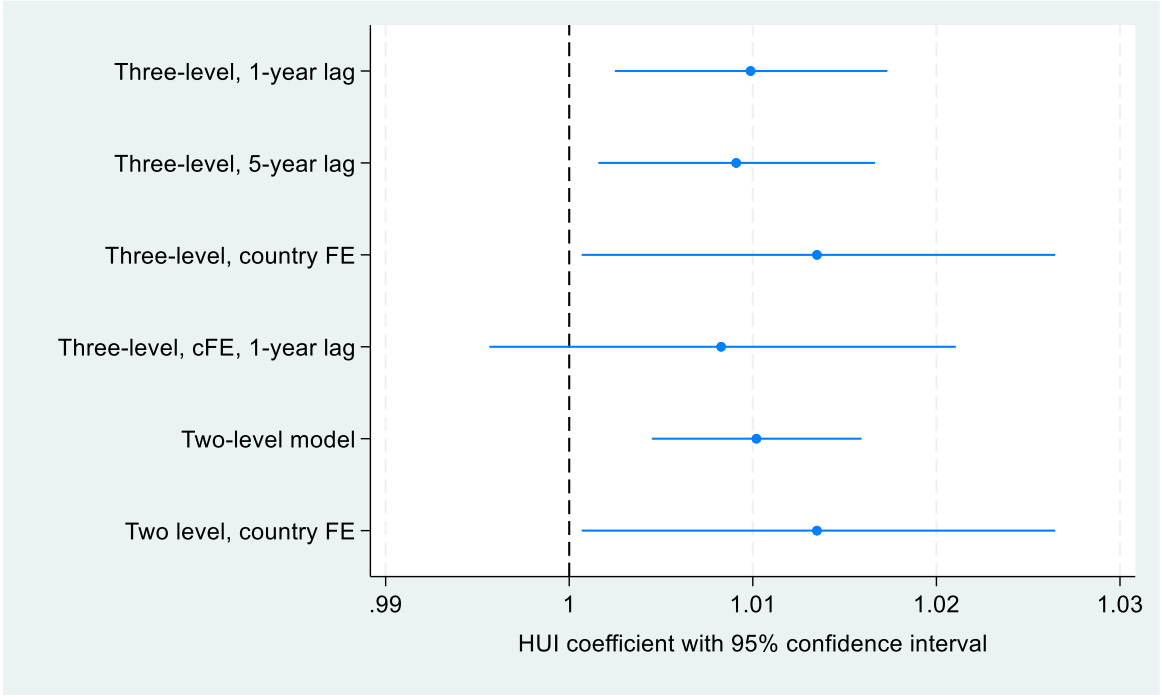
[78] The age effect is very small in magnitude, but appears to be non-linear with only the squared coefficient being significant.

health impact of universalism from the macro-social impacts of reducing segmentation and fostering social connectedness, as theorised in Section 2.2.3.

Regarding the primary indicator of interest, the HUI emerges as a highly significant and positive predictor of generalised trust across model specifications, even when considering a comprehensive set of control variables and adopting a conservative three-level modelling approach. The coefficients are remarkably significant, at the 99.9 percent confidence level for models 1 and 2, and at the 99 percent confidence level for model 3. When interpreting the main coefficient in the full model, a one percent increase in the HUI corresponds with a 1.1 percent increase in the odds that a respondent agrees 'most people can be trusted'. To put this in perspective, at the sample baseline probability of 27.3 percent, moving one standard deviation above the mean HUI increases the predicted likelihood of an average respondent expressing trust by 4.7 percentage points.[79] Considering the low levels of trust in the sample, this represents a substantial and meaningful association.

[79] One of the limitations of odds ratios includes that they are hard to interpret directly, as their magnitude depends on the baseline probability of the outcome variable. However, the effect size can be calculated from the sample statistics as the following. The baseline probability of social trust across the sample is 27.3 percent, corresponding to the odds of $0.375 = \frac{0.273}{0.727}$. One standard deviation increase in the HUI (20.8 percentage points) leads to new odds of $0.375 \times 1.011^{20.8} = 0.471$. Converting these back to a probability $p = \frac{0.471}{1+0.471} = 0.320$. In other words, when keeping all other variables constant at their mean, the predicted probability of expressing trust increases by 4.7 percentage points (from 27.3 to 32.0 percent) for an individual living in a country one standard deviation above the HUI average.

Figure 8. Robustness checks: HUI coefficient across different model specifications



Testing the robustness of the key result, Figure 8 plots the HUI coefficients with a 95 percent confidence interval for six alternative model specifications. The robustness checks include an increasing number of lags to account for potential temporal effects, country fixed effects to restrict the analysis to within-country changes, and a simpler two-level model structure that nests respondents in country-years. The results confirm the baseline model choice as the coefficient remains highly significant and of similar magnitude across all alternative specifications. Importantly, this includes the country fixed effects model, which confirms that there are no systematic differences in the within- and between-country effects. The only exception is the lagged country fixed effect model, which captures the effect of past within-country changes in the HUI on trust and shows no significance at the 95 percent level.[80] The non-significance of lagged changes in universalism suggests a contemporaneous nature of its impact on trust, a finding in line with the intuition that the impacts of healthcare reform take effect close to the time of their implementation.

[80] The same applies for longer lags.

Table 3. Multilevel regression of HUI dimensions on generalised trust

Dependent variable: Most people can be trusted	(1) Coverage	(2) Generosity	(3) Equity	(4) All dimensions
UHC Effective Coverage Index	1.008 (0.00615)			0.994 (0.00686)
Government health spending (% of GDP)		1.143*** (0.0353)		1.178*** (0.0460)
Private health spending (% of total)			0.994* (0.00345)	1.003 (0.00410)
Age	1.001 (0.00156)	1.001 (0.00157)	1.001 (0.00156)	1.001 (0.00157)
Age squared	1.000*** (0.0000164)	1.000*** (0.0000165)	1.000*** (0.0000164)	1.000*** (0.0000165)
Gender: Female *(Reference: Male)*	0.984 (0.00838)	0.984 (0.00842)	0.984 (0.00837)	0.984 (0.00842)
Marital status: Separated/Divorced *(Reference: Married)*	0.962** (0.0125)	0.961** (0.0126)	0.962** (0.0125)	0.961** (0.0126)
Marital status: Single	1.030* (0.0123)	1.029* (0.0123)	1.030* (0.0123)	1.029* (0.0123)
Education level: Medium *(Reference: Low)*	0.999 (0.0114)	0.999 (0.0115)	0.999 (0.0114)	0.999 (0.0115)
Education level: High	1.340*** (0.0167)	1.344*** (0.0168)	1.340*** (0.0166)	1.344*** (0.0168)
Employment status: Retired *(Reference: Employed)*	0.893*** (0.0144)	0.892*** (0.0145)	0.893*** (0.0144)	0.892*** (0.0145)
Employment status: Unemployed	0.885*** (0.0144)	0.884*** (0.0145)	0.885*** (0.0144)	0.884*** (0.0144)
Employment status: Other	1.012 (0.0118)	1.011 (0.0118)	1.011 (0.0118)	1.011 (0.0118)
Income level: Medium *(Reference: Low)*	1.120*** (0.0112)	1.121*** (0.0113)	1.120*** (0.0112)	1.121*** (0.0113)
Income level: High	1.332*** (0.0177)	1.334*** (0.0178)	1.330*** (0.0176)	1.334*** (0.0177)
Self-rated health: Poor *(Reference: Very poor)*	1.183** (0.0657)	1.187** (0.0661)	1.182** (0.0654)	1.188** (0.0661)

Self-rated health: Fair	1.286***	1.290***	1.284***	1.290***
	(0.0692)	(0.0696)	(0.0689)	(0.0696)
Self-rated health: Good	1.672***	1.680***	1.669***	1.679***
	(0.0899)	(0.0905)	(0.0895)	(0.0906)
Self-rated health: Very good	2.083***	2.098***	2.079***	2.098***
	(0.113)	(0.114)	(0.112)	(0.114)
Logged population	1.072	1.061	1.075	1.056
	(0.0447)	(0.0443)	(0.0455)	(0.0449)
GDP per capita (in thous. USD, PPP)	1.013**	1.011**	1.015***	1.014**
	(0.00461)	(0.00349)	(0.00348)	(0.00462)
Unemployment	0.987	0.984	0.989	0.984
	(0.00920)	(0.00897)	(0.00908)	(0.00914)
Constant	0.0497***	0.0770**	0.0955**	0.0975*
	(0.0434)	(0.0630)	(0.0807)	(0.0903)
Year fixed effects	Yes	Yes	Yes	Yes
Region fixed effects	Yes	Yes	Yes	Yes
Var (Country)	0.294***	0.321***	0.326***	0.322***
	(0.0520)	(0.0553)	(0.0561)	(0.0553)
Var (Country-Years)	0.160***	0.152***	0.154***	0.152***
	(0.0183)	(0.0173)	(0.0176)	(0.0174)
N (Countries)	105	105	105	105
N (Observations)	353,784	353,784	353,784	353,784

Coefficients presented as odds ratios; standard errors in parentheses.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

To further understand the driving factors for the identified association between healthcare universalism and generalised trust, Table 3 presents the results of a heterogeneity analysis across the dimensions of the HUI. The analysis follows the same methodology and structure as the full model (model 3 in Table 2), but replaces the HUI with the underlying variables for each of its components of Coverage, Generosity, and Equity. The variables are presented in their original form and are not transformed into normalised sub-indices to facilitate interpretation. As previously described, Coverage is measured using the UHC effective coverage index (Lozano et al. 2020), Generosity as the level of government health spending (in percentage of GDP), and Equity as private health spending (as percentage of total health expenditure).

The dimensional analysis reveals several interesting findings. The Generosity and Equity dimensions remain significant at the 95 percent confidence level and show the expected direction. Higher levels of government spending are associated with an increased likelihood of respondents expressing social trust, while privatisation has the opposite effect. This finding emphasises the central role of public healthcare provision and raises concerns over increasing global trends of marketisation and private sector-led health reforms (Eikenberry and Kluver 2004; Béland and Gran 2008; Gingrich 2011). The effect size is substantive for both dimensions: when all variables are kept constant at their mean, a one-standard deviation difference is associated with a 7.7 percentage point increase in the likelihood of an average respondent trusting most people for government health spending, and a 2.3 percentage point decrease for privatisation.[81] When all three dimensions are included jointly, only Generosity remains statistically significant (at the 99 percent confidence level), suggesting it plays the most influential role in shaping trust. This result should not be considered as evidence that the other dimensions do not matter, given their potential cross-correlation. Instead, it emphasises the central importance of quality and generosity of public healthcare provision, a finding that is especially relevant in light of persistent international disparities in public healthcare investments (see Chapter 2).

Coverage does not emerge as a significant predictor of trust in the dimensional analysis. There are two potential explanations for this. Firstly, this might reflect the different roles of dimensions over time. As coverage forms the foundation of any universal healthcare system, its influence on trust may weaken as systems mature and policy priorities shift towards concerns of quality and equity. Secondly, the effect of universal health coverage on trust may operate indirectly through improved health outcomes, and its significance may be partially absorbed by controlling for individuals' self-rated health (SRH). The latter interpretation is supported by a robustness check using an alternative model specification that excludes the SRH variable, in which the UHC index becomes statistically significant at the 90 percent confidence level. [82]

[81] Based on the same calculation as the pooled HUI coefficient and using the sample standard deviations for government health spending (2.72) and privatisation (19.1).
[82] Not shown here.

Figure 9. HUI and dimension coefficients across regions

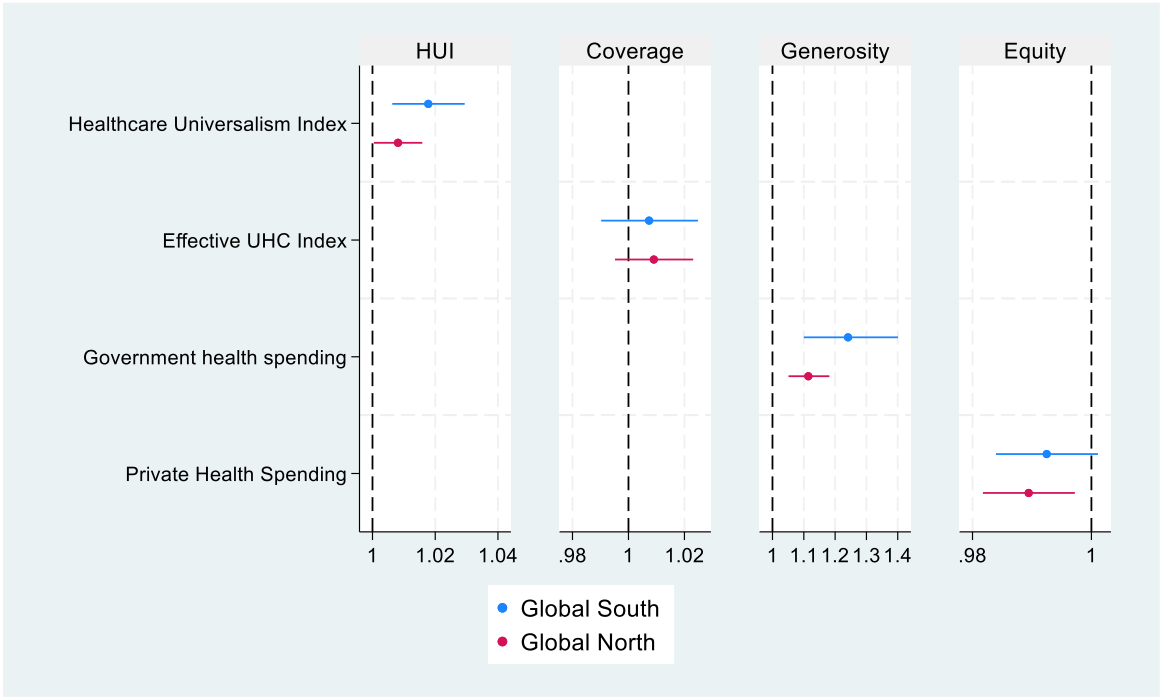


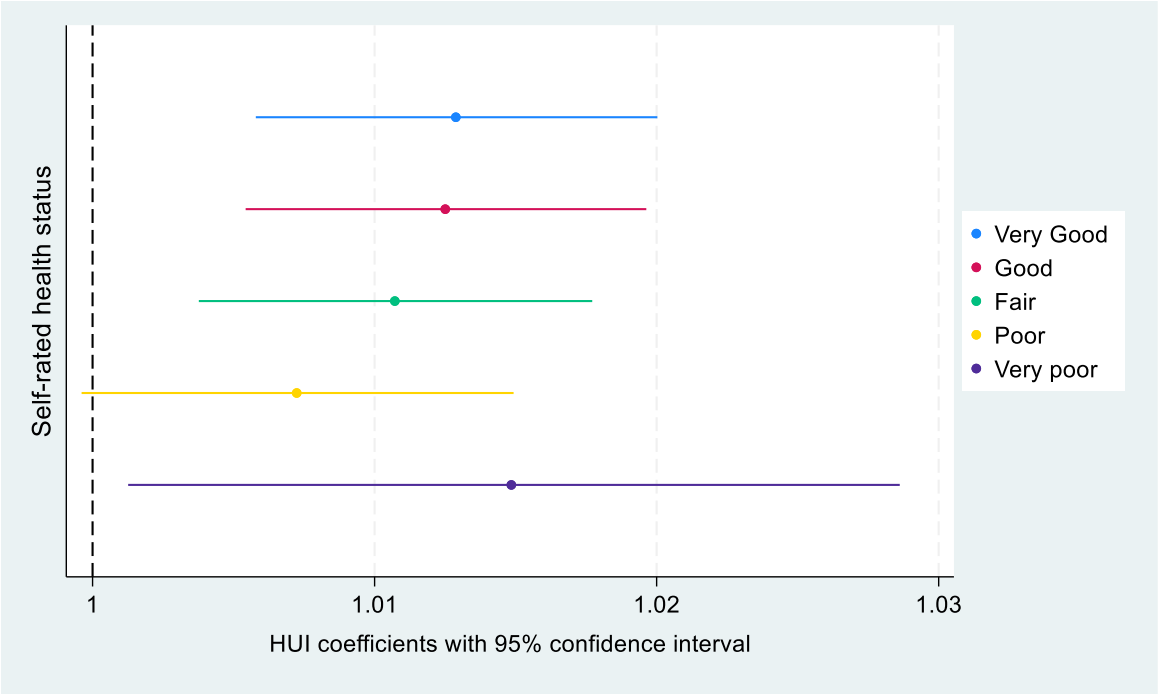
Figure 9 further plots the coefficients for the HUI and its dimensions, disaggregated by country groups in the Global South and Global North.[83] Overall, the results confirm previous findings: Coverage remains insignificant across both regions, while all other coefficients are significant and show the right direction. The only exception is the Equity dimension, where privatisation is only significantly associated with lower trust in the Global North. Furthermore, while the direction remains the same, the magnitude of the aggregate HUI effect appears slightly stronger[84] in the Global South, driven by a larger coefficient of government spending. These results suggest a differential role of universalism dimensions across the world, where government spending plays a stronger role in fostering trust in the Global South, while privatisation diminishes social trust in the Global North.

The section concludes with a heterogeneity analysis across the three key individual-level variables from the main regression models: self-rated health, income, and educational attainment. Figures 10 and 11 present the HUI coefficients for the main model specification (model 3 in Table 2), estimated separately for each category within these variables. Each coefficient reflects the result of a separate regression on a subsample of the data. By

[83] When interpreting the graphs, it is important to keep in mind that the first two dimensions are expected to have odds-ratios above 1, indicating that increases in effective coverage and government spending are associated with higher trust. On the other hand, Equity is expected to have an odds-ratio under 1, suggesting that increases in privatisation are associated with lower trust.
[84] But it is not statistically different.

leveraging the individual-level variation, the analysis offers additional insights into how the relationship between universal healthcare and social trust may differ across social groups and helps contextualise the broader findings in light of the theoretical mechanisms discussed.

Figure 10. Heterogeneity analysis: Self-rated health



As previously discussed, self-rated health serves as a crucial control variable to help disentangle the health impacts of universalism, where better health status correlates with higher trust, from its broader social consequences. The heterogeneity analysis summarised in Figure 10 reveals an intriguing trend: beyond the lowest level of SRH,[85] the results show a consistent upward trend in the magnitude of effects as health status improves. While this difference is not statistically significant across all levels, for example, between 'very good' and 'good', the trend suggests that individuals' health status conditions the relationship between healthcare universalism and social trust.

There are two potential explanations for this pattern. The first interprets SRH as a reflection of individuals' past access to healthcare. In this view, those in better health may not be more trusting because of their health per se, but because it reflects past welfare experiences with a healthcare system that fostered positive attitudes towards society. This interpretation is

[85] Although the coefficient is largest for people who feel 'very poor', this group is by far the smallest in the sample with only 0.7 percent of survey responses, leading to the widest confidence intervals.

supported by the non-significance of the subsample of respondents who self-identify as feeling 'poor' and by robustness checks employing five- and ten-year lagged values of the HUI, which reveal a similar trend.[86]

The second explanation interprets SRH as a proxy for individuals' current exposure to the healthcare system, assuming that respondents who report better health are less likely to require treatment. From this perspective, the positive effect on trust among healthier individuals reflects not direct use, but rather the symbolic and integrative role of universalism. Because those with higher SRH have fewer healthcare needs and subsequent welfare experiences, their trust may be shaped by the relational effect of universalism as 'space of equality' that shortens social distance. In this sense, universal systems may foster trust by signalling a shared commitment to equal rights and mutual responsibility, even among those who benefit less from them. This interpretation is further supported by the heterogeneity analysis in Figure 11, focusing on two key indicators of social stratification: education and income.

Figure 11. Heterogeneity analysis: Education and income

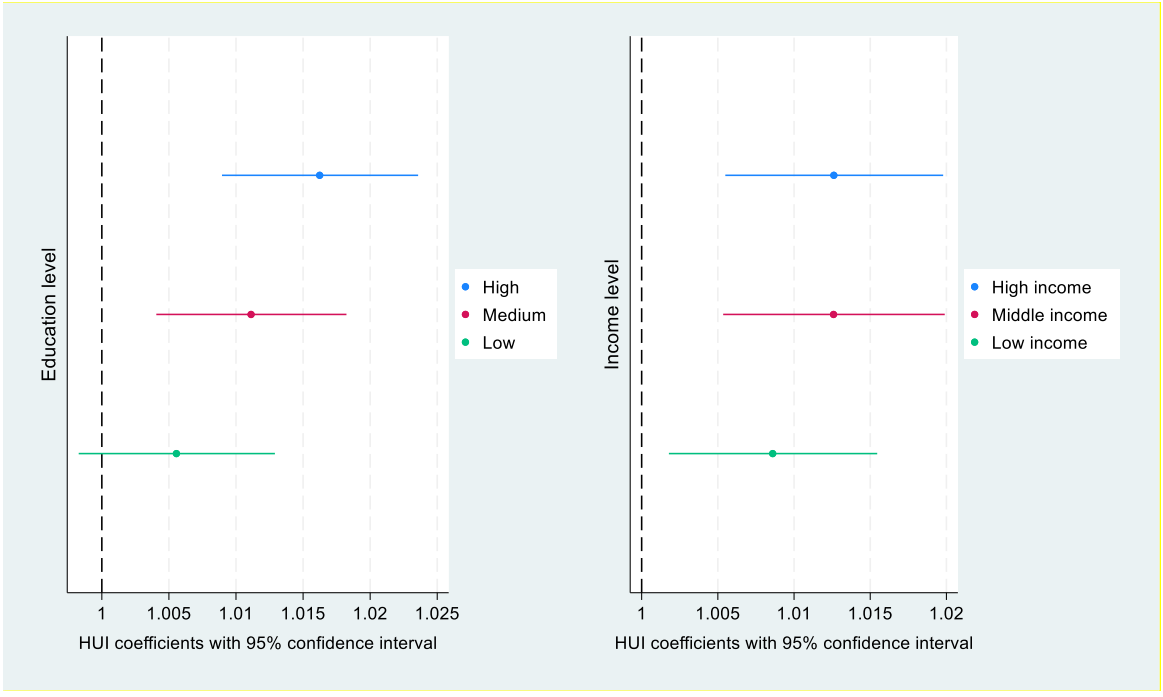


Figure 11 reveals a trend similar to that observed in the self-rated health analysis: the magnitude of the effect of universalism on trust increases with individuals' education and income levels. This gradient is particularly pronounced for the educational variable, where

[86] Not shown here.

the coefficient for the 'low education' subsample even becomes insignificant. The difference is smaller for the income variable, particularly between high and middle income, but remains substantial compared to low-income individuals. It is important to note that the *World Values Survey* only includes subjective measures of income, and therefore, biases in self-identification of respondents must be taken into account. Given the common underreporting by high-income individuals in surveys (Saez and Zucman 2016), it seems likely that the similarity in results of middle and high incomes can be attributed to incorrect self-classifications.

Overall, the findings support a class-based interpretation of the effect of universalism on social trust, with the strongest impact among the middle and upper classes, as measured by both income and education. Hence, the trust-building impact is most pronounced for beneficiaries who are most likely to opt out of public healthcare systems in favour of private alternatives, lending further support to the theory around the creation of 'spaces of equality' and the reduction of social distance (as described in Section 2.2.3). The findings are in line with the hypothesis that universalism reduces social divisions by encompassing broader segments of the population and creating spaces where individuals meet on equal terms, fostering notions of shared membership and mutual obligation. Moreover, the results indicate that through generous services and stronger competition with private sector providers, universalism may incentivise the development of cross-class coalitions and shape shared notions of citizenship and solidarity.

5. Conclusion

This paper has examined the social consequences of universalism by exploring whether and how universal healthcare contributes to fostering social trust in societies around the world. By conceptualising universal social policies as 'spaces of equality' that contribute to how individuals experience and perceive society, it emphasises their relational role in shaping equitable welfare experiences and strengthening social connectedness. Drawing on the HUI and harmonised data from the *World Values Survey* and the *European Values Study*, the paper examines the association between 'varieties of universal healthcare' and individual perceptions of generalised trust using a multilevel modelling approach for 105 countries from 2000 to 2020.

The results suggest that universal healthcare is beneficial not only for health outcomes or reducing inequalities,[87] but also for the social fabric of societies. Across all model specifications, higher levels of healthcare universalism are consistently associated with greater generalised trust. The dimensional analysis highlights the significance of both generosity and equity in healthcare; however, their relative importance varies across stages of development, where government spending is more influential in fostering trust in the Global South and privatisation erodes trust only in the Global North.

The multilevel heterogeneity analysis further supports the interpretation of the results around the 'spaces of equality', with the striking finding that the strongest trust-building effects are observed among beneficiaries who are most likely to opt out of public healthcare systems – as measured by health status, income, or education. The findings align with the hypothesis that universalism fosters cross-class bonds, reduces segmentation, and shortens social distance by encompassing broader segments of the population and signifying shared membership and solidarity.

Building on the above results, there are several promising avenues for further research. Firstly, building on a wider literature on the political economy of social policy reform, the analysis could be expanded to individuals' support of redistribution. While the seminal 'paradox of redistribution' (Korpi and Palme 1998) assumes that there is a direct relationship between universalism and redistributive attitudes, it seems possible that this relationship is mediated by social trust, for example, through concerns about 'free-riding' or perceptions of deservingness (van Oorschot 2000; Larsen 2008). As a starting point, Appendix B provides

[87] See Chapter 2.

some indicative evidence for a potential ‘universalism-trust complementarity’. Secondly, a comparative analysis of different welfare programmes could determine whether the observed associations apply solely to healthcare, as also found by Lee (2013) and Mewes (2024), or if they extend to other social policies. Given their varying role in mature and emerging welfare states, a comparison with policy domains such as education, pensions, or social assistance appears promising with the initial hypothesis that differences in welfare experiences, norms, and visibility shape variation in the trust-building role of universalism.

A third approach is to establish a more causal analysis, for instance, through event studies of universal healthcare reforms. While fully exogenous variation in healthcare provision is rare, the analysis of large-scale policy changes provides a valuable lens to understand the social dynamics of changes in universalism. Lastly, one of the paper’s most intriguing findings is the trust-diminishing role of privatisation and its variation across countries of the Global North and Global South. Against the backdrop of increasing marketisation of welfare around the world, further analysis could explore the determinants of this heterogeneity and link it to broader debates on the role of the private sector in the political economy of redistribution and development.

Overall, the paper contributes to a growing body of research that links welfare to the social foundations of trust and cohesion. In an era marked by growing inequality and social fragmentation, it provides evidence that universal welfare systems may play a vital role in (re)building trust – particularly in the Global South, where new social contracts and welfare states are emerging.

6. References

Akaeda, Naoki. 2021. 'Welfare States and the Health Impact of Social Capital: Focusing on the Crowding-Out and Crowding-In Perspectives'. *Social Indicators Research* 157(3): 841–62.

Andrews, Rhys, and Sebastian Jilke. 2016. 'Welfare States and Social Cohesion in Europe: Does Social Service Quality Matter?' *Journal of Social Policy* 45(1): 119–40.

Anttonen, Anneli, Liisa Haikio, and Kolbeinn H. Stefánsson, eds. 2012. *Welfare State, Universalism and Diversity*. Cheltenham: Edward Elgar Publishing.

Anttonen, Anneli, and Jorma Sipilä. 2014. 'Varieties of Universalism'. *Draft paper prepared for the UNRISD Conference "New Directions in Social Policy: Alternatives from and for the Global South."*

Arts, Wil, and John Gelissen. 2001. 'Welfare States, Solidarity and Justice Principles: Does the Type Really Matter?' *Acta Sociologica* 40(4): 289–99.

Audin, J. 2020. 'Between Control and Compassion: The Politics of Neighbourhood Community Services in Urban China'. In *The Politics of Social Inclusion*, eds Gabriele Koehler, A. Cimadamore, F. Kiwan, and P. Gonzalez. New York: Columbia University Press, 204–34.

Babajanian, Babken. 2012. *Social Protection and Its Contribution to Social Cohesion and State-Building*. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

Baldwin, Peter. 1990. *The Politics of Social Solidarity: Class Bases of the European Welfare State, 1875–1975*. Cambridge University Press.

Bambra, C, and T A Eikemo. 2009. 'Welfare State Regimes, Unemployment and Health: A Comparative Study of the Relationship between Unemployment and Self-Reported Health in 23 European Countries'. *Journal of Epidemiology and Community Health* 63(2): 92–98.

Bartels, B. 2015. 'Beyond Fixed versus Random Effects: A Framework for Improving Substantive and Statistical Analysis in Panel, Time-Series Cross Sectional and Multilevel Data'. In *Quantitative Research in Political Science*, ed. Robert Franzese. Thousand Oaks: SAGE Publications Ltd.

Béland, Daniel. 2005. 'Ideas and Social Policy: An Institutionalist Perspective'. *Social Policy and Administration* 39(1): 1–18.

Béland, Daniel, and Brian Gran, eds. 2008. *Public and Private Social Policy*. London: Palgrave Macmillan.

Béland, Daniel, and André Lecours. 2008. *Nationalism and Social Policy: The Politics of Territorial Solidarity*. Oxford: Oxford University Press.

Bell, Andrew, Malcolm Fairbrother, and Kelvyn Jones. 2019. 'Fixed and Random Effects Models: Making an Informed Choice'. *Quality & Quantity* 53(2): 1051–74.

Bell, Andrew, and Kelvyn Jones. 2015. 'Explaining Fixed Effects: Random Effects Modeling of Time-Series Cross-Sectional and Panel Data'. *Political Science Research and Methods* 3(1): 133–53.

Beramendi, Pablo, Silja Häusermann, Herbert Kitschelt, and Hanspeter Kriesi, eds. 2015. *The Politics of Advanced Capitalism*. Cambridge: Cambridge University Press.

Bergh, Andreas, and Christian Bjørnskov. 2014. 'Trust, Welfare States and Income Equality: Sorting out the Causality'. *European Journal of Political Economy* 35: 183–99.

Birnbaum, Simon, Tommy Ferrarini, Kenneth E. Nelson, and Joakim Palme. 2017. *The Generational Welfare Contract: Justice, Institutions and Outcomes*. Cheltenham: Edward Elgar Publishing.

Bjørnskov, Christian, and Gert Tinggaard Svendsen. 2013. 'Does Social Trust Determine the Size of the Welfare State? Evidence Using Historical Identification'. *Public Choice* 157(1–2): 269–86.

Brewer, Kathryne B, Hans Oh, and Shilpi Sharma. 2014. '"Crowding in" or "Crowding out"? An Examination of the Impact of the Welfare State on Generalized Social Trust: "Crowding in" or "Crowding Out"?' *International Journal of Social Welfare* 23(1): 61–68.

Brodkin, Evelyn Z. 2012. 'Reflections on Street-Level Bureaucracy: Past, Present, and Future'. *Public Administration Review* 72(6): 940–49.

Burchi, Francesco, Markus Loewe, Daniele Malerba, and Julia Leininger. 2022. 'Disentangling the Relationship Between Social Protection and Social Cohesion: Introduction to the Special Issue'. *The European Journal of Development Research* 34(3): 1195–1215.

Burchi, Francesco, Armin von Schiller, and Christoph Strupat. 2020. 'Social Protection and Revenue Collection: How They Can Jointly Contribute to Strengthening Social Cohesion'. *International Social Security Review* 73(3): 13–32.

Calnitsky, David. 2016. '"More Normal than Welfare": The Mincome Experiment, Stigma, and Community Experience'. *Canadian Review of Sociology/Revue canadienne de sociologie* 53(1): 26–71.

Campos-Matos, Inês, S.V. Subramanian, and Ichiro Kawachi. 2016. 'The "Dark Side" of Social Capital: Trust and Self-Rated Health in European Countries'. *The European Journal of Public Health* 26(1): 90–95.

Chan, Joseph, Ho-Pong To, and Elaine Chan. 2006. 'Reconsidering Social Cohesion: Developing a Definition and Analytical Framework for Empirical Research'. *Social Indicators Research* 75(2): 273–302.

Conway, B. A. 2013. 'Addressing the "Medical Malady": Second-Level Agenda Setting and Public Approval of "Obamacare"'. *International Journal of Public Opinion Research* 25(4): 535–46.

Cornwall, Andrea, and Alex Shankland. 2008. 'Engaging Citizens: Lessons from Building Brazil's National Health System'. *Social Science & Medicine* 66(10): 2173–84.

Council of Europe. 2004. 'A New Strategy for Social Cohesion'. https://www.coe.int/t/dg3/socialpolicies/socialcohesiondev/source/RevisedStrategy_en.pdf (October 6, 2025).

Daniele, Gianmarco, and Benny Geys. 2015. 'Interpersonal Trust and Welfare State Support'. *European Journal of Political Economy* 39: 1–12.

Delhey, Jan, Klaus Boehnke, Georgi Dragolov, Zsófia S. Ignácz, Mandi Larsen, Jan Lorenz, and Michael Koch. 2018. 'Social Cohesion and Its Correlates: A Comparison of Western and Asian Societies'. *Comparative Sociology* 17(3–4): 426–55.

Delhey, Jan, and Kenneth Newton. 2005. 'Predicting Cross-National Levels of Social Trust: Global Pattern or Nordic Exceptionalism?' *European Sociological Review* 21(4): 311–27.

Dinesen, Peter Thisted, Kim Mannemar Sønderskov, Jacob Sohlberg, and Peter Esaiasson. 2022. 'Close (Causally Connected) Cousins?' *Public Opinion Quarterly* 86(3): 708–21.

ECLAC. 2010. *Social Cohesion in Latin America: Concepts, Frames of Reference and Indicators*. Santiago de Chile: United Nations Economic Commission for Latin America and the Caribbean.

Edlund, Jonas, and Arvid Lindh. 2015. 'The Democratic Class Struggle Revisited: The Welfare State, Social Cohesion and Political Conflict'. *Acta Sociologica* 58(4): 311–28.

Eikenberry, Angela M., and Jodie Drapal Kluver. 2004. 'The Marketization of the Nonprofit Sector: Civil Society at Risk?' *Public Administration Review* 64(2): 132–40.

Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

Evans, David K., Brian Holtemeyer, and Katrina Kosec. 2019. 'Cash Transfers Increase Trust in Local Government'. *World Development* 114: 138–55.

EVS. 2022. *EVS Trend File 1981-2017, Version 3.0.0*. Cologne: GESIS Data Archive. https://www.gesis.org/en/european-values-study/data-and-documentation/evs-trend-file-1981-2017 (March 23, 2024).

Fairbrother, Malcolm. 2014. 'Two Multilevel Modeling Techniques for Analyzing Comparative Longitudinal Survey Datasets'. *Political Science Research and Methods* 2(1): 119–40.

Ferrarini, Tommy, Kenneth Nelson, and Ola Sjöberg. 2014. 'Unemployment Insurance and Deteriorating Self-Rated Health in 23 European Countries'. *Journal of Epidemiology and Community Health* 68(7): 657–62.

Fischer, Andrew M. 2012. 'Inequality and the Universalistic Principle in the Post-2015 Development Agenda'. *Official background paper prepared for the global thematic consultation on Addressing Inequalities in the Post-2015 Development Agenda*.

Flew, Terry. 2021. 'The Global Trust Deficit Disorder: A Communications Perspective on Trust in the Time of Global Pandemics'. *Journal of Communication* 71(2): 163–86.

Freitag, Markus, and Marc Bühlmann. 2009. 'Crafting Trust: The Role of Political Institutions in a Comparative Perspective'. *Comparative Political Studies* 42(12): 1537–66.

Fukuyama, Francis. 1995. *Trust: The Social Virtues and the Creation of Prosperity*. New York: Free Press.

Fukuyama, Francis. 2001. 'Social Capital, Civil Society and Development'. *Third World Quarterly* 22(1): 7–20.

Garde, Maricar, Nicholas Mathers, and Thakur Dhakal. 2017. 'The Evolution of Nepal's Child Grant: From Humble Beginnings to a Real Driver of Change for Children?' *Global Social Policy* 17(3): 359–64.

Gesthuizen, Tom Van Der Meer, and Peer Scheepers. 2009. 'Ethnic Diversity and Social Capital in Europe: Tests of Putnam's Thesis in European Countries'. *Scandinavian Political Studies* 32(2): 121–42.

Gilbert, Neil. 2002. *Transformation of the Welfare State: The Silent Surrender of Public Responsibility*. New York: Oxford University Press.

Gingrich, Jane. 2011. *Making Markets in the Welfare State: The Politics of Varying Market Reforms*. Cambridge: Cambridge University Press.

Glaeser, Edward L., David I. Laibson, Jose A. Scheinkman, and Christine L. Soutter. 2000. 'Measuring Trust'. *Quarterly Journal of Economics* 115(3): 811–46.

Global Burden of Disease Collaborative Network. 2025. *Global Health Spending 1995-2022*. Seattle: Institute for Health Metrics and Evaluation. https://ghdx.healthdata.org/record/ihme-data/global-health-spending-1995-2022 (July 27, 2025).

Gough, Ian, Geof Wood, Armando Barrientos, Philippa Bevan, Peter Davis, and Graham Room. 2004. *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*. Cambridge: Cambridge University Press.

Gugushvili, Dimitri, and Tijs Laenen. 2021. 'Two Decades after Korpi and Palme's "Paradox of Redistribution": What Have We Learned so Far and Where Do We Take It from Here?' *Journal of International and Comparative Social Policy* 37(2): 112–27.

Haggard, Stephan, and Robert R. Kaufman. 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*. Princeton: Princeton University Press.

Hardin, Russell. 2002. *Trust and Trustworthiness*. New York: Russell Sage Foundation.

Häusermann, Silja, Thomas Kurer, and Hanna Schwander. 2015. 'High-Skilled Outsiders? Labor Market Vulnerability, Education and Welfare State Preferences'. *Socio-Economic Review* 13(2): 235–58.

Herreros, Francisco. 2023. 'The State and Trust'. *Annual Review of Political Science* 26(1): 117–34.

Hooghe, Marc, and Dietlind Stolle. 2006. *Generating Social Capital: Civil Society and Institutions in Comparative Perspective*. New York: Palgrave Macmillan.

Huber, Evelyne, and John D. Stephens. 2012. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press.

Inglehart, Ronald, Christian Haerpfer, Alejandro Moreno, Christian Welzel, Kseniya Kizilova, Jaime Diez-Medrano, Marta Lagos, et al. 2022. *World Values Survey Time-Series (1981-2022) Cross-National Data-Set Version 3.0.* Madrid: JD Systems Institute & WVSA Secretariat. https://www.worldvaluessurvey.org/WVSDocumentationWVL.jsp (March 23, 2024).

Jacques, Olivier, and Alain Noël. 2018. 'The Case for Welfare State Universalism, or the Lasting Relevance of the Paradox of Redistribution'. *Journal of European Social Policy* 28(1): 70–85.

Janmaat, Jan Germen. 2011. 'Social Cohesion as a Real-Life Phenomenon: Assessing the Explanatory Power of the Universalist and Particularist Perspectives'. *Social Indicators Research* 100(1): 61–83.

Jen, Min Hua, Erik R. Sund, Ron Johnston, and Kelvyn Jones. 2010. 'Trustful Societies, Trustful Individuals, and Health: An Analysis of Self-Rated Health and Social Trust Using the World Value Survey'. *Health & Place* 16(5): 1022–29.

Johnson, Noel D., and Alexandra Mislin. 2012. 'How Much Should We Trust the World Values Survey Trust Question?' *Economics Letters* 116(2): 210–12.

Kabeer, Naila. 2014. 'The Politics and Practicalities of Universalism: Towards a Citizen-Centred Perspective on Social Protection'. *The European Journal of Development Research* 26(3): 338–54.

Kawachi, Ichiro, and Lisa F. Berkman. 2014. 'Social Capital, Social Cohesion, and Health'. In *Social Epidemiology*, eds Lisa F. Berkman, Ichiro Kawachi, and M. Maria Glymour. New York: Oxford University Press, 290–319.

Kildal, Nanna, and Stein Kuhnle. 2005. 'The Nordic Welfare Model and the Idea of Universalism'. In *The Normative Foundations of the Welfare State*, eds Nanna Kildal and Stein Kuhnle. Abingdon: Routledge, 25–45.

Knack, S., and P. Keefer. 1997. 'Does Social Capital Have an Economic Payoff? A Cross-Country Investigation'. *The Quarterly Journal of Economics* 112(4): 1251–88.

Koehler, Gabriele. 2021. 'Effects of Social Protection on Social Inclusion, Social Cohesion and Nation Building'. In *Handbook on Social Protection Systems*, eds Esther Schüring and Markus Loewe. Cheltenham: Edward Elgar Publishing, 636–46.

Korpi, Walter, and Joakim Palme. 1998. 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries'. *American Sociological Review* 63(5): 661–87.

Kumlin, Staffan, and Bo Rothstein. 2005. 'Making and Breaking Social Capital: The Impact of Welfare-State Institutions'. *Comparative Political Studies* 38(4): 339–65.

Kumlin, Staffan, Isabelle Stadelmann-Steffen, and Atle Haugsgjerd. 2017. 'Trust and the Welfare State'. In *The Oxford Handbook of Social and Political Trust*, ed. Eric M. Uslaner. Oxford: Oxford University Press, 385–408.

Kunißen, Katharina. 2023. *The Independent Variable Problem: Welfare Stateness as an Explanatory Concept*. Wiesbaden: Springer VS.

Larsen, Christian Albrekt. 2007. 'How Welfare Regimes Generate and Erode Social Capital: The Impact of Underclass Phenomena'. *Comparative Politics* 40(1): 83–101.

Larsen, Christian Albrekt. 2008. 'The Institutional Logic of Welfare Attitudes: How Welfare Regimes Influence Public Support'. *Comparative Political Studies* 41(2): 145–68.

Layton, Matthew L. 2020. 'Welfare Stereotypes and Conditional Cash Transfer Programmes: Evidence from Brazil's Bolsa Família'. *Journal of Politics in Latin America* 12(1): 53–76.

Leckie, George, and Chris Charlton. 2012. 'Runmlwin : A Program to Run the **MLwiN** Multilevel Modeling Software from within *Stata*'. *Journal of Statistical Software* 52(11).

Lee, Cheol-Sung. 2013. 'Welfare States and Social Trust'. *Comparative Political Studies* 46(5): 603–30.

Leisering, Lutz. 2020. 'The Calls for Universal Social Protection by International Organizations: Constructing a New Global Consensus'. *Social Inclusion* 8(1): 90–102.

Levi, Margaret. 1998. 'A State of Trust'. In *Trust and Governance*, eds Valerie Braithwaite and Margaret Levi. New York: Russell Sage Foundation, 77–101.

Lipsky, Michael. 1980. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Lister, Michael. 2007. 'Institutions, Inequality and Social Norms: Explaining Variations in Participation'. *The British Journal of Politics and International Relations* 9(1): 20–35.

Listhaug, Ola, and Tor Georg Jakobsen. 2017. 'Foundations of Political Trust'. In *The Oxford Handbook of Social and Political Trust*, ed. Eric M. Uslaner. New York: Oxford University Press, 559–78.

Lotta, Gabriela, Roberto Pires, Michael Hill, and Marie Ostergaard Møller. 2022. 'Recontextualizing Street-level Bureaucracy in the Developing World'. *Public Administration and Development* 42(1): 3–10.

Lozano, Rafael, Nancy Fullman, John Everett Mumford, Megan Knight, Celine M Barthelemy, Cristiana Abbafati, Hedayat Abbastabar, et al. 2020. 'Measuring Universal Health Coverage Based on an Index of Effective Coverage of Health Services in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019'. *The Lancet* 396(10258): 1250–84.

Mansyur, Carol, Benjamin C. Amick, Ronald B. Harrist, and Luisa Franzini. 2008. 'Social Capital, Income Inequality, and Self-Rated Health in 45 Countries'. *Social Science & Medicine* 66(1): 43–56.

Marmot, Michael G., Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, and Ilaria Geddes. 2010. *Fair Society, Healthy Lives: The Marmot Review*. London: Strategic Review of Health Inequalities in England Post-2010.

Marshall, Thomas Humphrey. 1950. *Citizenship and Social Class, and Other Essays*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2018. 'Undoing Segmentation? Latin American Health Care Policy during the Economic Boom'. *Social Policy & Administration* 52(6): 1181–1200.

Mau, Steffen. 2003. *The Moral Economy of Welfare States: Britain and Germany Compared*. London: Routledge.

McKee, Martin, May C. I. van Schalkwyk, Rachel Greenley, and Govin Permanand. 2024. *Trust: The Foundation of Health Systems*. Copenhagen: European Observatory on Health Systems and Policies.

Meltzer, Allan H., and Scott F. Richard. 1981. 'A Rational Theory of the Size of Government'. *Journal of Political Economy* 89(5): 914–27.

Mewes, Jan. 2024. 'Welfare-State Selectivity, Universality, and Social Trust in Europe, 2002–2019: Bringing Deservingness Back In'. *Journal of European Social Policy* 34(1): 20–35.

Mewes, Jan, and Giuseppe Nicola Giordano. 2017. 'Self-Rated Health, Generalized Trust, and the Affordable Care Act: A US Panel Study, 2006–2014'. *Social Science & Medicine* 190: 48–56.

Mills, Anne. 2014. 'Health Care Systems in Low- and Middle-Income Countries'. *New England Journal of Medicine* 370(6): 552–57.

Mkandawire, Thandika, ed. 2004. *Social Policy in a Development Context*. London: Palgrave Macmillan.

Mkandawire, Thandika. 2005. 'Targeting and Universalism in Poverty Reduction'. *UNRISD Social Policy and Development Programme Paper* 23.

Montanari, Ingalill, and Kenneth Nelson. 2013. 'Health Care Provision: An Exploratory Analysis of Increase, Decline, Converging Trends and Driving Forces in Comparative Perspective'. In *Health Care Systems in Europe under Austerity*, eds Emmanuele Pavolini and Ana M. Guillén. London: Palgrave Macmillan UK, 256–70.

Nelson, Kenneth. 2004. 'Mechanisms of Poverty Alleviation: Anti-Poverty Effects of Non-Means-Tested and Means-Tested Benefits in Five Welfare States'. *Journal of European Social Policy* 14(4): 371–90.

Nelson, Kenneth, and Johan Fritzell. 2014. 'Welfare States and Population Health: The Role of Minimum Income Benefits for Mortality'. *Social Science & Medicine* 112: 63–71.

de Neubourg, Chris. 2009. 'Social Protection and Nation-Building: An Essay on Why and How Universalist Social Policy Contributes to Stable Nation-States'. In *Building Decent Societies*, ed. Peter Townsend. London: Palgrave Macmillan, 63–79.

Newton, Kenneth, Dietlind Stolle, and Sonja Zmerli. 2017. 'Social and Political Trust'. In *The Oxford Handbook of Social and Political Trust*, ed. Eric M. Uslaner. Oxford: Oxford University Press, 37–56.

van Oorschot, Wim. 2000. 'Who Should Get What, and Why? On Deservingness Criteria and the Conditionality of Solidarity among the Public'. *Policy & Politics* 28(1): 33–48.

van Oorschot, Wim. 2002. 'Targeting Welfare: On the Functions and Dysfunctions of Means Testing in Social Policy'. In *World Poverty: New Policies to Defeat an Old Enemy*, eds Peter Townsend and David Gordon. Bristol: Bristol University Press, 171–94.

Pribble, Jennifer. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.

Putnam, Robert D. 2000. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

Robbins, Blaine G. 2012. 'A Blessing and a Curse? Political Institutions in the Growth and Decay of Generalized Trust: A Cross-National Panel Analysis, 1980–2009'. *PLoS ONE* 7(4): e35120.

Roelen, Keetie. 2020. 'Receiving Social Assistance in Low- and Middle-Income Countries: Negating Shame or Producing Stigma?' *Journal of Social Policy* 49(4): 705–23.

Rosenberg, Morris. 1956. 'Misanthropy and Political Ideology'. *American Sociological Review* 21(6): 690.

Rothstein, Bo. 1998. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Rothstein, Bo. 2001. 'The Universal Welfare State as a Social Dilemma'. *Rationality and Society* 13(2): 213–33.

Rothstein, Bo, and Dietlind Stolle. 2008. 'The State and Social Capital: An Institutional Theory of Generalized Trust'. *Comparative Politics* 40(4): 441–59.

Rothstein, Bo, and Eric M. Uslaner. 2005. 'All for All: Equality, Corruption, and Social Trust'. *World Politics* 58(1): 41–72.

Rueda, David, and Daniel Stegmueller. 2019. *Who Wants What? Redistribution Preferences in Comparative Perspective*. Cambridge: Cambridge University Press.

Saez, Emmanuel, and Gabriel Zucman. 2016. 'Wealth Inequality in the United States since 1913: Evidence from Capitalized Income Tax Data'. *The Quarterly Journal of Economics* 131(2): 519–78.

Schiefer, David, and Jolanda van der Noll. 2017. 'The Essentials of Social Cohesion: A Literature Review'. *Social Indicators Research* 132(2): 579–603.

Schmidt-Catran, Alexander W. 2016. 'Economic Inequality and Public Demand for Redistribution: Combining Cross-Sectional and Longitudinal Evidence'. *Socio-Economic Review* 14(1): 119–40.

Schmidt-Catran, Alexander W., and Malcolm Fairbrother. 2016. 'The Random Effects in Multilevel Models: Getting Them Wrong and Getting Them Right'. *European Sociological Review* 32(1): 23–38.

Skocpol, Theda. 1991. 'Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States'. In *The Urban Underclass*, eds C Jencks and P. E. Peterson. Washington, D.C.: The Brookings Institution, 411–36.

Skocpol, Theda. 1996. 'Unravelling from Above'. *The American Prospect* 25: 20–24.

Solt, Frederick. 2020. 'Measuring Income Inequality Across Countries and Over Time: The Standardized World Income Inequality Database'. *Social Science Quarterly* 101(3): 1183–99.

Sønderskov, Kim Mannemar, and Peter Thisted Dinesen. 2016. 'Trusting the State, Trusting Each Other? The Effect of Institutional Trust on Social Trust'. *Political Behavior* 38(1): 179–202.

Stolle, Dietlind. 2002. 'Trusting Strangers – The Concept of Generalized Trust in Perspective'. *Österreichische Zeitschrift für Politikwissenschaft* 31: 397–412.

Subramanian, S. V. 2002. 'Social Trust and Self-Rated Health in US Communities: A Multilevel Analysis'. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 79(90001): 21S – 34.

Sud, Nikita, and Diego Sánchez-Ancochea. 2022. 'Southern Discomfort: Interrogating the Category of the Global South'. *Development and Change* 53(6): 1123–50.

Thewissen, Stefan, and David Rueda. 2019. 'Automation and the Welfare State: Technological Change as a Determinant of Redistribution Preferences'. *Comparative Political Studies* 52(2): 171–208.

Titmuss, Richard. 1976. *Commitment to Welfare*. London: Allen & Unwin.

UNCTAD. 2023. *UNCTAD Handbook of Statistics*. New York: United Nations Publications.

UNDP. 2024. *Human Development Report 2023/2024: Breaking the Gridlock: Reimagining Cooperation in a Polarized World*. New York: United Nations Development Programme.

Uslaner, Eric M. 2002. *The Moral Foundations of Trust*. Cambridge University Press.

Valgarðsson, Viktor, Will Jennings, Gerry Stoker, Hannah Bunting, Daniel Devine, Lawrence McKay, and Andrew Klassen. 2025. 'A Crisis of Political Trust? Global Trends in Institutional Trust from 1958 to 2019'. *British Journal of Political Science* 55: e15.

van Oorschot, and Wil Arts. 2005. 'The Social Capital of European Welfare States: The Crowding out Hypothesis Revisited'. *Journal of European Social Policy* 15(1): 5–26.

Visser, Mark, Maurice Gesthuizen, and Peer Scheepers. 2018. 'The Crowding in Hypothesis Revisited: New Insights into the Impact of Social Protection Expenditure on Informal Social Capital'. *European Societies* 20(2): 257–80.

Wolfe, Alan. 1989. *Whose Keeper? Social Science and Moral Obligation*. Berkeley: University of California Press.

Yamagishi, Toshio, and Midori Yamagishi. 1994. 'Trust and Commitment in the United States and Japan'. *Motivation and Emotion* 18(2): 129–66.

Zak, Paul J., and Stephen Knack. 2001. 'Trust and Growth'. *The Economic Journal* 111(470): 295–321.

Appendices

A. Time-series cross-sectional analysis

A.1 Methodology

As a complement and robustness check for the existing multilevel analysis, this section presents the results of a time-series cross-sectional analysis by focusing on the average level of generalised trust per country by aggregating all survey responses for each available year in the WVS/EVS dataset[88]. While this aggregation of individual-level variables has limitations, such as the inability to account for population heterogeneity, the approach is useful for studying temporal dynamics and for estimating the impact of universalism on the *aggregate level* of trust in a country. In contrast, the multilevel modelling approach described in Section 3.4 provides estimates of the impact of universalism on *individual perceptions* of social trust. While closely related, both methodologies together can reinforce the robustness of the results across time, countries, and individuals, while also revealing the relative importance of individual versus country-level control variables.

To capture both the longitudinal and cross-sectional effect of universalism on trust, the analysis employs a within-between or 'hybrid' random effects (RE) model that distinguishes the within- and between-country variation of the independent variables (Bell and Jones 2015; Bell, Fairbrother, and Jones 2019). These models partition the existing variation into their within- and between-country components by employing the sample mean and the deviation from the sample mean for each covariate in the regression model.

Following Bell and Jones (2015), this approach combines and improves on the advantages of traditional random (RE) and fixed effects (FE) approaches, which can be considered special cases of this more encompassing model. By separating both types of variation, the model provides better interpretability of estimates across time and space – a factor that is especially important in this research context. Until recently, the literature on the trust-building effect of welfare states has almost exclusively drawn upon between-country associations but extrapolated their findings to within-country changes (Mewes 2024).

Importantly, in contrast to standard RE models, the within-between formulation does not assume the equality of coefficients; hence, it allows for the possibility that universalism can have a different association across countries (more universal countries having higher levels

[88] Hence treating the social trust variable as 'pseudo' panel data.

of trust) and over time (changes in universalism lead to higher trust). Additionally, the models address the key issues of standard FE and RE specifications by simultaneously controlling for unobserved country heterogeneity and including time-invariant characteristics (Bartels 2015).

Overall, the within-between random effects model takes the following form:

$$SC_{jk} = \alpha_0(j) + \beta_0(HCU_{jk} - \overline{HCU_k}) + \beta_1\overline{HCU_k} + \gamma_0(MC_{jk} - \overline{MC_k}) + \gamma_1\overline{MC_k} + v_j + u_{jk}$$

Where SC_{jk} represents the average social trust level for year j and country k, HCU_{jk} the healthcare universalism indicator in year j and country k and $\overline{HCU_k}$ the average healthcare universalism indicator for country k across the sample. Similarly, MC represents a vector of macro controls (such as population and GDP) and v_j and u_{jk} are the error terms on country and country-year level. Furthermore, the model includes a time fixed effect, given by the time-dependent constant $\alpha_0(j)$, to control for common trends and shocks to all countries. In this formulation, β_0 represents the coefficient of interest for the within-country effect, and β_1 the coefficient for the between-country effect.

To apply this model in practice, the *clustergen* function in STATA is used to calculate the country means and the deviation from the country mean over time for each covariate (Bartels 2015).

A.2 Time-series cross-sectional results

Table A.1 below presents the results of a hybrid random effects regression of the level and within-country change of the Healthcare Universalism Index on social trust. The first model estimates the baseline results using all relevant controls with year-fixed effects, while the second model additionally includes regional-fixed effects. All regressions, here and in the following, are conducted using cluster-robust standard errors to adjust for correlation within regional groups. To further account for unobserved heterogeneity at the cluster level, additional regional fixed effects are included in the second model specification and in the remaining results of this section (with the necessary exception of the country fixed effects results). This choice is confirmed by the comparison of the two models in Table A.1, which shows a substantial improvement in model fit, with almost no difference in coefficient size, direction, or significance. Given the strong regional trends in universalism, as highlighted in Figure 3 and Chapter 2, this inclusion seems warranted to avoid spurious effects that are driven by clustering and unobserved heterogeneity at the regional level.

Table A.1 Hybrid random effects regression of HUI on generalised trust

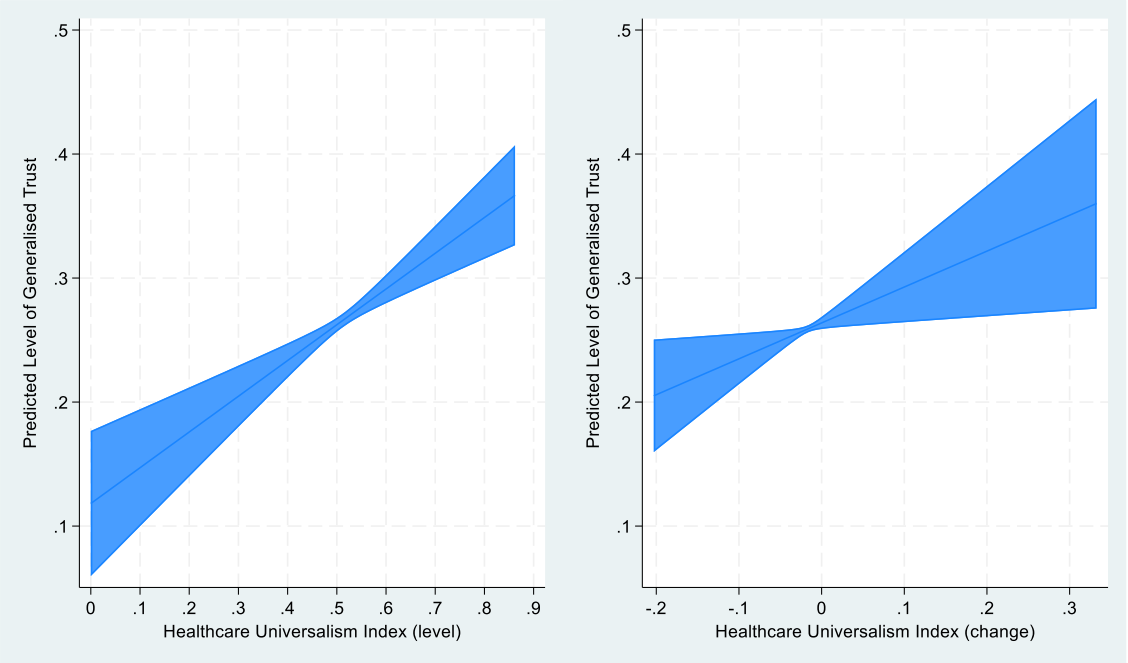
Dependent variable: Most people can be trusted (average)	(1) Baseline results	(2) With regional fixed effects
HUI (level)	0.280***	0.296***
	(0.0616)	(0.0552)
HUI (change)	0.289*	0.283*
	(0.124)	(0.134)
GDP per capita (in thousand USD, level)	0.268**	0.182**
	(0.0884)	(0.0567)
GDP per capita (in thousand USD, change)	0.537*	0.509*
	(0.215)	(0.218)
Unemployment (ILO estimate, level)	-0.466	-0.561*
	(0.318)	(0.274)
Unemployment (ILO estimate, change)	0.210	0.198
	(0.223)	(0.217)
Logged population (level)	0.0162	0.0102
	(0.0164)	(0.0131)
Logged population (change)	-0.146*	-0.142*
	(0.0735)	(0.0728)
Constant	-0.0948	0.0892
	(0.289)	(0.220)
R^2	0.415	0.499
Region fixed effects	No	Yes
Year fixed effects	Yes	Yes
N (Countries)	105	105
N (Observations)	273	273

Cluster-robust standard errors in parentheses.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Across the baseline results in Table A.1, both the level and change in HUI exhibit significantly positive associations with generalised trust – suggesting a relationship between the variables both across countries and over time. A one percent increase in the level of universalism is associated with a 0.27-0.29 percent increase in the national average of social trust, significant at the 99.9 percent confidence level. Taking the lowest and highest level of HUI in the sample, while holding all other variables constant at their mean, this effect translates into

a difference of around 23-25 percentage points in trust – a substantial effect. Figure A.1 illustrates the predicted levels of trust in relation to the sample variation in universalism levels and changes.

Figure A.1. Predicted generalised trust for levels and changes in HUI (holding all other covariates constant at the mean)



Interestingly, the within-country effect of universalism – that is, changes over time – is of similar strength to the between-country effect. Although the effect is slightly less significant, at the 95 percent confidence level, this may be attributed to the larger number of countries in the analysis compared to the number of years, and the HUI exhibiting more variation across countries than over time. Notably, a separate Hausman test conducted on the same model estimated with country and random fixed effects strongly rejects the hypothesis of systematic differences in the HUI effect size in levels and changes. These findings suggest that the relationship between universalism and trust is influenced both by differences between countries, with more universal countries displaying higher levels of trust, and over time, with countries that become more universal also showing increased trust. Thus, these results seem to corroborate the multilevel findings from Mewes (2024), which identify a positive correlation between within-country changes in non-means-tested healthcare spending and individual perceptions of social trust across 30 European countries.

Regarding the control variables, the level and change of economic development, unemployment levels, and population changes emerge as significant predictors of national

levels of generalised trust. Concerning between-country variation, the results align with expectations, indicating that countries with higher GDP per capita and lower unemployment rates tend to exhibit higher levels of trust. However, perhaps surprisingly, the within-country analysis reveals that increases in population size correspond to a reduction in the average level of trust. Notably, these effects appear more pronounced in the Global South subset of the sample, hinting at a developmental explanation behind the phenomenon, with trends such as urbanisation and structural change leading to a weakening of social bonds over time. This hypothesis appears in line with broader declining trends in social trust in the Global South, as depicted in Figure 5, and with prior research on the national determinants of trust (Putnam 2000; Uslaner 2002; Delhey and Newton 2005).

To ensure the validity of the within-country findings, Table A.2 presents a series of robustness checks employing traditional country fixed effects models, as well as incorporating lags and additional control variables. These adjustments are not included in the baseline results to preserve sample size and maintain adequate statistical power, enabling later heterogeneity analysis along country groups, particularly considering the greater prevalence of missing data points among countries in the Global South.[89]

Overall, the results remain consistently significant and positive across all specifications, indicating a robust relationship between healthcare universalism and generalised trust over time. Of particular interest is the observation that both the magnitude and significance of the HUI coefficient diminish when a one-year lag is employed, suggesting a temporal aspect to the effect. Furthermore, additional models incorporating longer lags of two, five, and more years[90] reveal no significant association with trust, hence suggesting a contemporaneous impact of changes in healthcare universalism on social trust. This finding confirms the intuition that the trust impact of changes in healthcare provision, and likely the associated political discourse, primarily manifests within the first two years of their implementation.

[89] For example, the additional control variables of inequality, life expectancy and schooling, only slightly increase the explanatory power of the regression but reduce the number of observations by almost 20 percent. The additional control variables are drawn from the *World Development Indicators*, the *UNESCO Institute for Statistics*, and the *Standardized World Income Inequality Database (*Solt 2020).

[90] Not shown in this paper.

Table A.2. Robustness check: Country fixed effects, lags and additional control variables

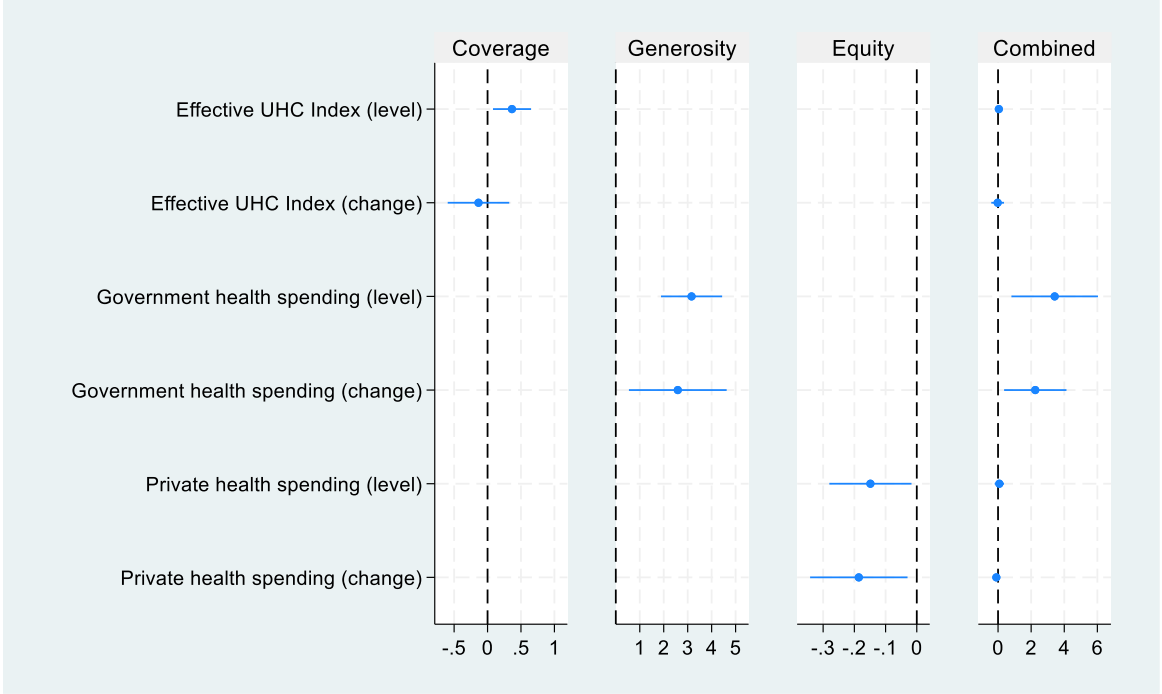
Dependent variable: Most people can be trusted (average)	(1) Country fixed effects	(2) Country FE with HUI lag	(3) Country FE with additional controls	(4) Country FE with additional controls and HUI lag
HUI	0.268*		0.244*	
	(0.112)		(0.094)	
HUI, one-year lag		0.184*		0.155
		(0.74)		(0.076)
GDP per capita (in thousand USD, PPP)	0.646**	0.714**	0.337	0.413
	(0.225)	(0.220)	(0.441)	(0.453)
Logged Population	-0.180*	-0.186*	-0.318**	-0.310*
	(0.0871)	(0.0878)	(0.0823)	(0.0841)
Unemployment (ILO estimate)	0.263	0.243	0.500	0.511
	(0.255)	(0.256)	(0.472)	(0.480)
Inequality (Gini index)			-0.210	-0.251
			(0.743)	(0.713)
Life expectancy at birth			-0.734	-0.740
			(0.905)	(0.899)
Primary school enrolment (in %)			0.137	-0.132
			(0.140)	(0.141)
Constant	3.083*	3.227*	6.195*	6.111*
	(1.452)	(1.465)	(1.908)	(1.886)
R^2	0.238	0.215	0.306	0.300
Country fixed effects	Yes	Yes	Yes	Yes
Year fixed effects	Yes	Yes	Yes	Yes
N (Countries)	105	105	88	88
N (Observations)	273	264	221	213

Cluster-robust standard errors in parentheses.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Expanding the analysis to the individual dimensions of the Healthcare Universalism Index – Coverage, Generosity, and Equity – provides further nuance to its associations with generalised trust. Figure A.2 below plots the coefficients of four separate regression models, all using the baseline specification with regional fixed effects from Table A.2, that replace the composite index with the underlying variables for each dimension: the UHC effective

coverage index (Lozano et al. 2020), government health spending (as percentage of GDP), and private health spending (as percentage of total health expenditure). Except for within-country variation in coverage, all variables remain significant at the 95 percent confidence level in both levels and changes and show the expected direction of effect. In line with the HUI results, a Hausman test reveals no systematic differences in the coefficients for the between- and within-country variation – again suggesting that the relationship with trust is applicable across time and space.

Figure A.2 HUI dimension coefficients in separate hybrid random effects regressions on trust

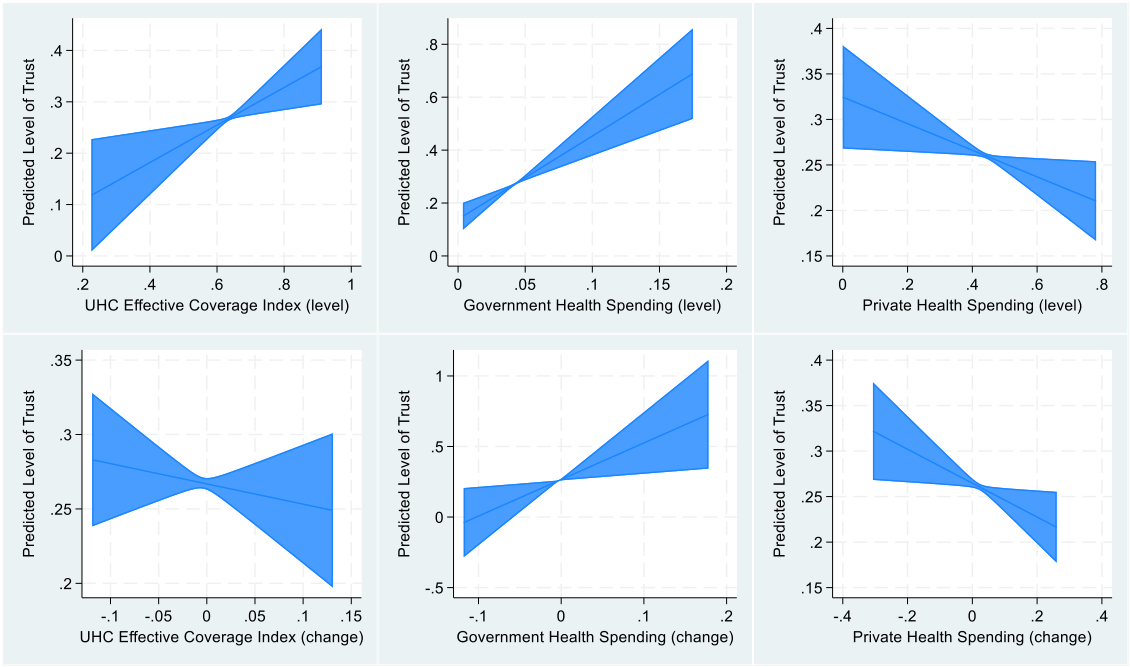


The results of the dimensional analysis highlight several interesting findings. Firstly, the significance and direction of all variables reinforces the notion that all dimensions of universalism matter – countries with higher coverage, greater government health spending and less privatisation exhibit higher levels of interpersonal trust. This finding supports the decision to aggregate all dimensions into a composite universalism index, as each of them demonstrates a meaningful association with trust. The same trend holds for changes over time,[91] where shifts towards more state-provided services versus private sector provision

[91] The only exception in terms of the significance of the dimensional variables is the within-country effect of changes in coverage which shows no correlation with trust. As explored in the regional analysis later, this is probably due to differences in universalism progress across the sample: while coverage is central as a foundational element for the development of any truly universal system, the

correlate with increased trust in countries. While the impact of higher government spending might be intuitively expected, the latter is particularly interesting and an important result of the analysis: across a large sample of countries over a period from 2000 to 2020, healthcare privatisation exhibits a significantly negative association with social trust – both in levels and changes over time. This result supports the theoretical considerations in Section 2.2 regarding the role of segmentation and 'spaces of equality', while also raising concerns around the social impacts of increasing trends in the marketisation of healthcare (Gilbert 2002; Eikenberry and Kluver 2004; Gingrich 2011; Mills 2014).

Figure A.3 Predicted levels for trust for variations in HUI dimensions (holding all other variables constant at their mean)



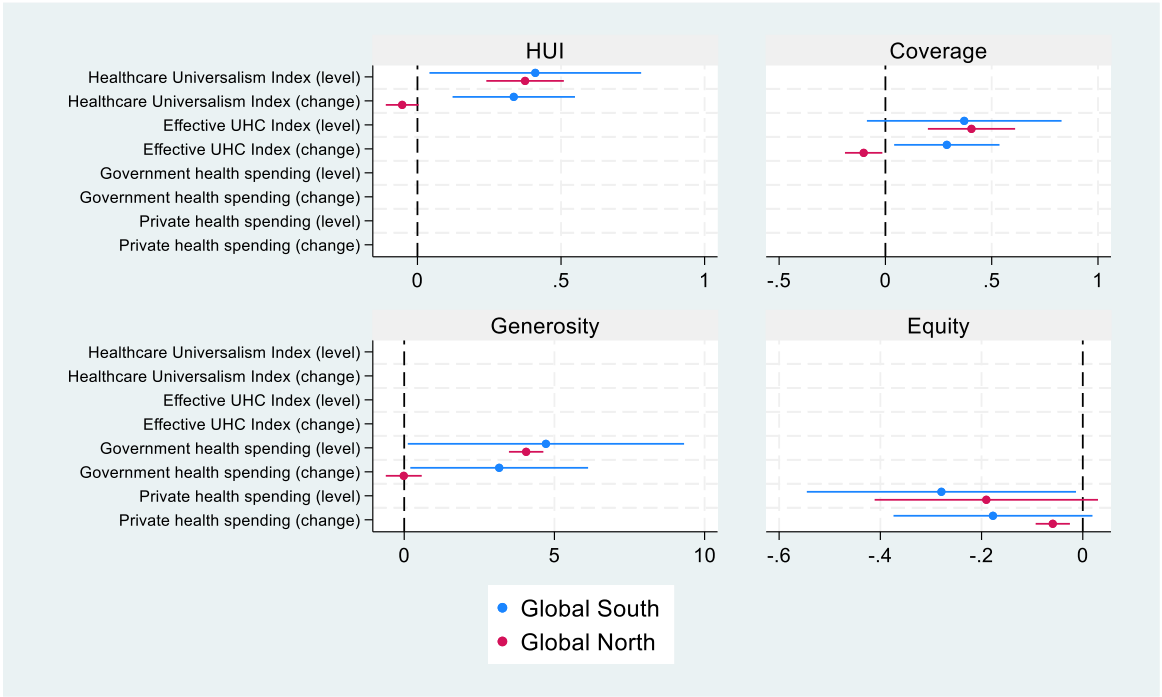
As highlighted by the predictions in Figure A.3, the effect magnitudes of the dimensional variables are non-trivial: for example, a one standard deviation increase in the level of privatisation is associated with a 2.9 percentage points decrease in trust over time. Similarly, a one standard deviation difference in the level of effective UHC coverage is correlated with a 5.9 percentage point higher level of trust across countries. Given a country-level average trust of only 27.3 percent, these are substantial effects.

In terms of the relative importance of each type of welfare effort, both the effect magnitude and the combined regression with all variables show that Generosity plays the most

dimensions of Generosity and Equity likely become more important for determining trust at higher levels of development.

important role among the three universalism dimensions. A one percentage point increase in the level of government health spending, as a share of GDP, is correlated with a substantial increase of 2.6 percentage points in trust over time.[92] Similarly, levels and changes in public expenditure appear as the only significant predictors in the joint regression. While the results of this 'horserace' model do not discount the relevance of the other dimensions of universalism, it underlines the importance of public welfare efforts and suggests the central role of quality and depth of services to shape individuals' sense of trust, likely due to its impact on shaping welfare experiences and increasing the attractiveness of the healthcare system for other classes and social groups – as theorised in Section 2.2.

Figure A.4 HUI and dimension coefficients across regions: TSCS analysis



Finally, Figure A.4 plots the coefficients for the Healthcare Universalism Index and its dimensional variables separately for countries of the Global South and the Global North. This regional heterogeneity analysis tests the consistency of the effect of universalism and different types of welfare efforts across different regions and levels of development, or whether systematic differences exist. It is important to reiterate in this context that the Global South sample is notably smaller, with only 35 countries included at least twice in the *World*

[92] While a one percent increase in health spending might appear large at first, it is not uncommon in the data. The sample average grew by 1.4 percent points between 2000 and 2020 with many outliers at the top of the distribution. For example, such diverse countries like Bolivia, Canada, Rwanda and Japan all increased their expenditure by more than 2.5 percentage points over the period.

Values Survey dataset, leading to relatively smaller statistical power and wider confidence intervals compared to the rest of the sample.

Despite this limitation, the regional heterogeneity analysis reveals several interesting findings. Starting with the composite HUI, the level of universalism appears as a highly significant predictor of social trust in both world regions. However, interestingly, changes over time appear only to affect trust in countries of the Global South – a finding that potentially suggests a procedural or temporal nature of the hypothesised effects.

Building on the theory in Section 2.2, there are two potential explanations for this finding. Firstly, considering that countries in the Global South started from much lower levels and experienced higher rates of growth – as described in the previous section – it is possible that the impact of universalism on trust is not marginal but rather categorical, with large changes in welfare provision and reforms shaping peoples' sense of trust and solidarity instead of small variations in Coverage, Generosity or Equity. Similarly, in line with earlier arguments from Esping-Andersen (1990) and Korpi and Palme (1998), it is conceivable that universalism is a systemic or structural variable that affects trust through the overall welfare regime, which is largely stable in countries of the Global North but still developing in the South. While the latter argument stands in contrast to the results from Mewes (2024), who shows no impact on trust from aggregate changes in social expenditure but from health spending in a European sample, the disparity between the within- and between-country effects suggests longer-lasting effects of institutional trajectories in welfare structure that supersede variations over time, at least in the North.

A second explanation might lie in the changing role of different universalism dimensions over time and across levels of development. This argument is supported by the results presented in Figure A4, which reveal a stark contrast between the two groups of countries: while within-country changes in government spending and effective health coverage are positive and highly significant in the South, changes in privatisation have a significantly negative impact on trust in the North (and vice versa). This strong finding suggests a developmental interpretation of the effect of universal healthcare on trust: while Coverage and Generosity play a central trust-building role in establishing universal systems and reaching a broad-based share of the population, Equity becomes more critical at later stages of development by reducing segmentation and shaping healthcare systems into 'spaces of equality' for citizens to develop trust and solidarity.

B. Extension: Universalism, trust, and the support for redistribution

In this complementary section, an extension to the analysis considers the joint relationship between universalism, trust, and the support for redistribution. It aims to provide indicative evidence on how universalism and trust together might influence political preferences for redistribution in the form of a trust-universalism complementarity. This extension relates the social consequences of universalism to the political economy of the welfare state, and specifically to the 'paradox of redistribution'. In their seminal contribution, Korpi and Palme (1998) argue that welfare state institutions shape the size of the social budget and that there is a trade-off between the targeting of benefits and the amount of resources spent. By analysing the degree of universalism in pension and sickness insurance programmes in a subset of OECD countries, they find that countries with more universal welfare systems spent more on social policies while achieving lower levels of poverty and inequality than countries with more targeted programmes. They explain this so-called paradox with the greater political support for a large welfare state. As the middle class also benefits from generous, encompassing programmes, there is an incentive to expand services further and reduce demand for private alternatives.

While the literature has produced largely inconclusive results on this conjectured mechanism (Gugushvili and Laenen 2021), this section aims to test the hypothetical relationship between universalism and redistributive attitudes, incorporating the potential role of social trust as a mediator. In drawing on previous studies on the relationship between trust and welfare attitudes (Daniele and Geys 2015) and considering the dynamic nature of welfare reform, trust emerges as a promising candidate to influence the conjectured relationship by appealing to citizens' perceptions of solidarity and deservingness.

Building on the insights from Huber and Stephens (2012), who demonstrate that public opinion on social policy can take up to 20 years to materialise, it can be assumed that the introduction or expansion of universal policies initially creates 'spaces of equality' and reduces the distance between individuals, the state, and society before influencing political opinion. These social impacts require time to materialise due to significant policy lags, potential public resistance to change, and the time needed for citizens to engage with and adapt their pre-existing perceptions. These considerations are especially pertinent in countries at earlier stages of development, where capacity constraints and substantial

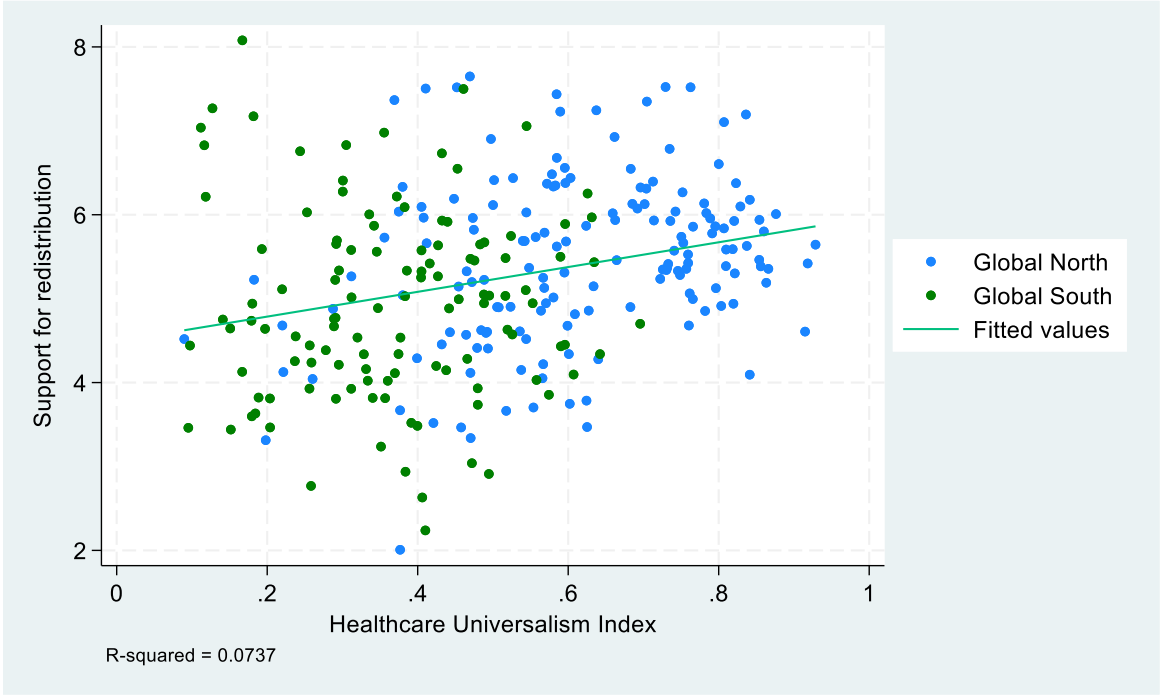
coverage gaps have previously excluded large portions of potential beneficiaries.[93] Consequently, there likely exists a temporal sequence in the impact of universalism on trust, with the combined influence of both factors shaping redistributive preferences over time.

Theoretically, one can assume two extreme cases in which high levels of universalism combined with low levels of trust, and vice versa, will not lead to higher support for redistribution. In the first case of high universalism, low trust might still prevent wider proportions of the population from supporting redistribution if public debates around issues of 'free-riding' or differential contributions drive individuals' perceptions of deservingness of access to benefits (van Oorschot 2000; Larsen 2008; Mewes 2024). Similarly, a low-trust environment is less likely to be conducive to creating the necessary broad-based support for further redistribution, for example, due to differential access and needs patterns across groups, as highlighted in the heterogeneity analysis in Figure 11. In the second case of low universalism and high trust, support for redistribution might remain unaffected because the group of non-beneficiaries of public policies is large, and there are limited incentives for them to improve services. While there might be higher societal levels of trust and solidarity with beneficiaries, political priorities are likely to focus on issues that are relevant for the majority population. Similarly, the prevalence of private alternatives to public welfare programmes is likely to affect attitudes through material self-interest, preventing potentially necessary broad-based political coalitions (Meltzer and Richard 1981).[94]

[93] Still, even the introduction of a fully universal healthcare system in a highly segmented country like the United States will be faced with substantial individual and public resistance before a potentially cohesive effect on trust and solidarity might materialise – as exemplified by the case of the Affordable Care Act of 2010 (Conway 2013; Mewes and Giordano 2017).

[94] Focusing on the experience of countries in the Global South, Martínez Franzoni and Sánchez-Ancochea (2016) further expand on this argument and stress the role of class coalitions for building political support for social spending by increasing the coverage and generosity of welfare policies, thereby creating "redistributive virtuous circles". Only if the middle class sees personal benefits in expanding the services, for example in substituting private alternatives, they will employ their resources and political clout to join forces with the poor.

Figure B.1 Bivariate correlation: HUI and redistributive preferences



The support for redistributive policies is measured using the following question: *"Now I'd like you to tell me your views on various issues. How would you place your views on this scale? 1 means you agree completely with the statement on the left; 10 means you agree completely with the statement on the right; and if your views fall somewhere in between, you can choose any number in between. 'Incomes should be made more equal' (1) versus 'We need larger income differences as incentives for individual effort' (10)."* While keeping the 10-point Likert scale, the question has been recoded for the purposes of the analysis, with high scores indicating that incomes should be made more equal. While this question leaves out the explicit role of the government, it represents respondents' general attitudes towards the importance of redistribution in society. In line with previous research, the question is close to the standard European Social Survey (ESS) question that has been frequently employed to measure the support for redistribution in a European context: *"The government should take measures to reduce differences in income levels"* (Rueda and Stegmueller 2019; Thewissen and Rueda 2019; Häusermann, Kurer, and Schwander 2015).

As a starting point to the analysis, Figure B.1 presents the bivariate correlation between the Healthcare Universalism Index and the average level of redistribution support aggregated across all countries and observations in the sample. While considering the limitations of such simple correlations, the scatterplot suggests a potential relationship with a correlation coefficient of 0.27.

As the next step, the multilevel modelling approach presented in Section 3.1 is employed to further investigate the potential relationship on the individual level. This approach is preferred over the TSCS approach, as preferences for redistribution and the impact of universalism are strongly dependent on individual characteristics (Beramendi et al. 2015; Rueda and Stegmueller 2019). As such, controlling for individual-level heterogeneity is central and avoids potential spurious results from aggregating survey responses on the national level (Fairbrother 2014).

Table B.1 presents the results of four multilevel regression models: one for each of the HUI and social trust individually, and two for both variables jointly. The last model includes an additional interaction effect between social trust and healthcare universalism. The individual-level control variables all show the expected direction of effect, with some interesting findings that support the material self-interest hypothesis in determining the demand for redistribution. All variables that are associated with societal privilege and status are significantly correlated with lower support for redistribution, while the opposite is true for characteristics that are associated with marginalisation. Respondents who identify as female, non-married, low educated, unemployed or retired, and low income all display significantly more positive attitudes towards redistribution than respondents that identify as male, married, mid or high educated, employed and mid or high income. In terms of effect size, education and income appear as the largest factors affecting respondents' attitudes towards redistribution, again reinforcing the potential role of self-interest in redistributive preferences. A similar trend and effect size can be observed with respect to individuals' health status, with a significant gradient for people feeling 'fair', 'good' and 'very good'.

Table B.1 Multilevel regression of HUI and trust on support for redistribution

Dependent variable: Incomes should be made more equal	(1) HUI	(2) Generalised trust	(3) HUI and generalised trust	(4) HUI, generalised trust and interaction
HUI	0.0127*		0.0124*	0.0130*
	(0.00505)		(0.00506)	(0.00506)
Generalised trust		0.148***	0.148***	0.243***
		(0.0116)	(0.0116)	(0.0310)
HUI x Generalised trust				-0.00180***
				(0.000544)
Age	0.00504**	0.00505**	0.00504**	0.00506**

	(0.00182)	(0.00185)	(0.00185)	(0.00185)
Age squared	-0.0000600**	-0.0000613**	-0.0000614**	-0.0000614**
	(0.0000194)	(0.0000197)	(0.0000197)	(0.0000197)
Gender: Female	0.103***	0.107***	0.107***	0.107***
(Reference: Male)	(0.00998)	(0.0101)	(0.0101)	(0.0101)
Marital status:	0.0346*	0.0340*	0.0340*	0.0334*
Separated/Divorced	(0.0152)	(0.0154)	(0.0154)	(0.0154)
(Reference: Married)				
Marital status:	0.0783***	0.0798***	0.0797***	0.0793***
Single	(0.0138)	(0.0140)	(0.0140)	(0.0140)
Education level:	-0.231***	-0.230***	-0.230***	-0.229***
Medium	(0.0129)	(0.0131)	(0.0131)	(0.0131)
(Reference: Low)				
Education level:	-0.419***	-0.427***	-0.427***	-0.424***
High	(0.0146)	(0.0148)	(0.0148)	(0.0149)
Employment status:	0.0634***	0.0654***	0.0654***	0.0651***
Retired	(0.0192)	(0.0195)	(0.0195)	(0.0195)
(Reference: Employed)				
Employment status:	0.104***	0.108***	0.108***	0.108***
Unemployed	(0.0175)	(0.0178)	(0.0178)	(0.0178)
Employment status:	0.0436**	0.0444**	0.0445**	0.0444**
Other	(0.0134)	(0.0136)	(0.0136)	(0.0136)
Income level:	-0.265***	-0.263***	-0.263***	-0.262***
Medium	(0.0114)	(0.0116)	(0.0116)	(0.0116)
(Reference: Low)				
Income level:	-0.595***	-0.598***	-0.598***	-0.597***
High	(0.0158)	(0.0161)	(0.0161)	(0.0161)
Self-rated health: Poor	-0.104	-0.108	-0.108	-0.108
(Reference: Very poor)	(0.0584)	(0.0594)	(0.0594)	(0.0594)
Self-rated health: Fair	-0.293***	-0.301***	-0.301***	-0.300***
	(0.0565)	(0.0574)	(0.0574)	(0.0574)
Self-rated health: Good	-0.362***	-0.378***	-0.378***	-0.376***
	(0.0565)	(0.0575)	(0.0575)	(0.0575)
Self-rated health: Very good	-0.443***	-0.462***	-0.463***	-0.461***
	(0.0572)	(0.0581)	(0.0581)	(0.0581)
Logged population	0.112*	0.108	0.107	0.107
	(0.0559)	(0.0566)	(0.0560)	(0.0559)
GDP per capita	0.00432	0.00812	0.00385	0.00388
(in thous. USD, PPP)	(0.00521)	(0.00446)	(0.00522)	(0.00521)
Unemployment	0.0116	0.0135	0.0108	0.0107

	(0.0141)	(0.0141)	(0.0141)	(0.0141)
Constant	3.563**	3.802***	3.617**	3.593**
	(1.135)	(1.141)	(1.137)	(1.136)
Year fixed effects	Yes	Yes	Yes	Yes
Region fixed effects	Yes	Yes	Yes	Yes
Var (Country)	0.302***	0.311***	0.301***	0.300***
	(0.0760)	(0.0778)	(0.0762)	(0.0761)
Var (Country-Years)	0.518***	0.523***	0.522***	0.522***
	(0.0574)	(0.0582)	(0.0580)	(0.0581)
N	357,173	345,850	345,850	345,850

Standard errors in parentheses
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

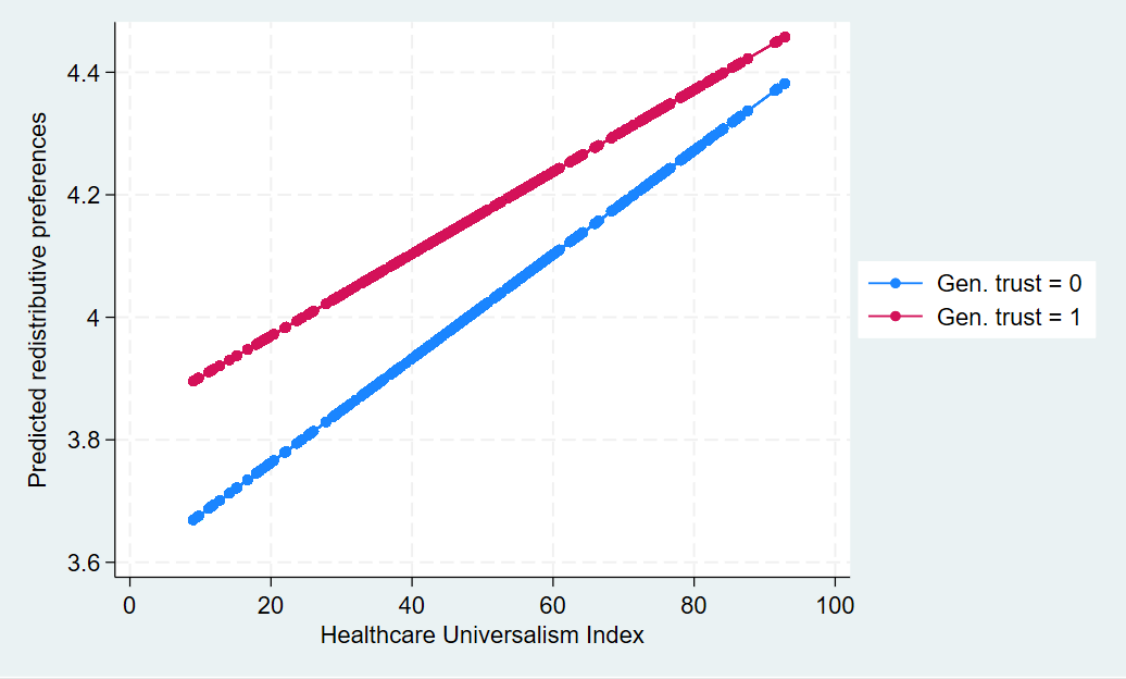
In terms of the country-level control variables, only population size shows a significant association with redistributive preferences in the baseline model with only the Healthcare Universalism Index, but not when trust is included. Interestingly, both economic development and unemployment are insignificant across all models, suggesting that individual characteristics are more important for redistribution preferences than country-level variables—at least from a comparative perspective.

Moving to the variables of interest, Table B.1 shows that both healthcare universalism and social trust are highly significant predictors of respondents' attitudes towards redistribution at the 95 and 99.9 percent confidence levels, respectively. The effect size of both variables appears small but non-trivial compared to other individual- or country-level variables. For social trust, the survey response confirming that the average person can be trusted is associated with a 0.148 point increase in the question on redistributive preferences, which is higher than the effect of identifying as a woman or as unemployed. However, as expected, education, income and health status still outweigh social trust in their role for redistributive preferences. The effect size of healthcare universalism is comparable to population size, with a one standard deviation difference associated with a 0.27 and 0.25 point increase, respectively.

Interestingly, the results reveal a complementarity between universalism and social trust, as both variables increase in strength in the combined models, and their interaction effect is highly significant. While the interaction effect is negative, their combined effect size surpasses that of individual models 1 and 2 for both cases of the binary trust variable. Figure B.2 below illustrates the predicted values of the combined Model 4, with all other variables

held at their sample mean, highlighting the mediating impact of trust. Intriguingly, due to the interaction factor, the complementary effect diminishes with increasing levels of universalism—suggesting that trust has less influence on redistributive preferences in more universal systems.

Figure B.2 Predicted support for redistribution depending on trust.



There are two potential interpretations of this finding. Firstly, given the established positive relationship between trust and universalism, this result might reflect the statistical artefact of positive collinearity between trust and redistributive attitudes. Alternatively, the decreasing mediating impact of trust might reflect the institutional and political economy dynamics in which trust initially fosters the necessary cross-class coalitions to support further social policy expansion. Once these political trajectories are established, trust may become less important for shaping redistributive preferences, as expanding universal 'spaces of equality' increasingly promote notions of solidarity and shared membership, thereby self-reinforcing redistributive attitudes.

Overall, these results provide support for Korpi and Palme's (1998) conjectured mechanism behind the 'paradox of redistribution': higher universalism is associated with higher support for redistribution across the sample – even when accounting for a large number of individual- and country-level characteristics. Additionally, the relationship appears to be mediated through social trust, with the complementarity decreasing as the level of universalism increases.

Universal or Segmented Expansion? The Political Economy of Healthcare Reform in the Global South

Abstract

What explains divergent reform trajectories in the expansion of healthcare across the Global South? While the achievement of universal health coverage stands at the centre of the international development agenda, national implementation remains highly uneven, raising fundamental concerns about the political constraints that shape healthcare reform. While some governments pursue comprehensive reforms to establish unified, equitable healthcare systems, others adopt segmented approaches to expand access while maintaining socio-economic hierarchies in service provision.

This paper employs a political economy framework to examine the conditions under which governments adopt universal versus segmented healthcare reforms. Drawing on the literature on social policy expansion in the Global South, I theorise two main drivers of healthcare reform in emerging democracies and their interaction with vested interests: government ideology and electoral volatility. I argue that left-wing governments are more likely to pursue universal reforms due to their ideological alignment with a newly enfranchised electorate, electoral volatility reduces the incentives for clientelism and increases the appeal of high-visibility policies that signal a commitment towards 'delivering development' for broad-based constituencies. However, these electoral dynamics are conditioned by the power of vested interests, with private healthcare providers and organised labour resisting broad-based expansion to protect their own benefits.

Empirically, I introduce a novel dataset of health system reforms that expanded access or benefits to new population groups across 90 countries in the Global South between 1990 and 2023. Reforms are classified as either universal or segmented, based on their impact on equity in healthcare provision. Using event history analysis, I explore the political and interest-based factors associated with each type of reform. The results provide strong support for the role of politics in healthcare expansion trajectories: left-wing governments are significantly more likely to adopt universal reform, but are constrained by the strength of organised labour, while right-wing governments are more likely to pursue segmented reforms and are conditioned by the level of healthcare privatisation. On the other hand, electoral volatility

emerges as a highly significant predictor of universal reforms, with further analysis supporting the suggested mechanism of decreasing incentives for clientelism.

This paper makes three key contributions to the expanding literature on the political economy of social policy in the Global South: (1) it introduces a new global dataset of healthcare system reform that conceptually distinguishes between universal and segmented expansion; (2) it proposes a theory of electoral volatility as a driver of universal healthcare reform by raising the costs of clientelism and increasing the appeal of visible, broad-based policies; and (3) it tests how vested interests shape the political logic of reform adoption. Overall, the findings challenge technocratic models of healthcare reform and highlight the central role of electoral incentives, ideological preferences, and vested interests in shaping how governments expand access to healthcare.

1. Introduction

What explains variations in countries' reform trajectories for advancing healthcare access in the Global South? Why do some governments adopt ambitious reforms towards universalisation, while others pursue a segmented approach that institutionalises inequalities in healthcare access? While the achievement of universal health coverage (UHC) for all stands at the centre of the international development agenda, as enshrined in Goal 3.8 of the Sustainable Development Goals (SDGs), national implementation remains highly uneven around the world, with gaps continuing to widen between countries of the Global North and the Global South (see Chapter 2). Despite a global policy consensus, 108 of 194 countries have stagnated or regressed in the official SDG target 3.8.1 for universal service coverage since their launch in 2015 (WHO and International Bank for Reconstruction and Development / The World Bank 2023). These concerning trends not only call into question the effectiveness of global policy efforts to advance universal health coverage but also raise fundamental concerns about the political feasibility of universal healthcare reforms.

Rather than signifying a technocratic process, the expansion of healthcare access is inherently political, shaped by competing interests, electoral incentives, and institutional legacies. Drawing on the social policy literature, this paper introduces a conceptual distinction between universal and segmented health system reforms, depending on their impact on equity in healthcare provision. Universal reforms aim to expand access and quality of care by integrating population groups into a unified healthcare system, thereby reducing inequities in provision. By contrast, segmented reforms expand coverage selectively and institutionalise inequalities in healthcare access – for example, by introducing separate healthcare programmes for informal workers or 'the poor' while preserving privileged access for existing welfare insiders, such as formal-sector employees (Martínez Franzoni and Sánchez-Ancochea 2016).

Building on this framework, the paper develops a political economy theory to explain the adoption of universal versus segmented reforms in the Global South. Drawing on the literature on social policy expansion in emerging democracies, I theorise three factors as central to the political process from the perspective of an incumbent government: government ideology, electoral competition, and vested interests. I argue that left-wing governments are more likely to pursue universalism due to their ideological alignment with the shifting policy preferences of a newly enfranchised electorate, while electoral volatility increases the political costs of clientelism and the strategic appeal of high-visibility policies

that signal a commitment towards 'delivering development' for broad-based constituencies. However, these political dynamics are conditioned by vested interests, as private healthcare providers and organised labour may resist broad-based expansion to protect their own benefits. However, the responsiveness to these resistances will be dependent on government ideology.

In focusing on the timing and trajectories of reform, this paper complements rather than competes with existing institutional and ideational theories of welfare state development in the Global South. Previous studies have provided key insights regarding the role of path dependencies, regional diffusion, policy architectures, and welfare norms (Rudra 2007; Haggard and Kaufman 2008; Huber and Stephens 2012; Pribble 2013; Obinger, Schmitt, and Starke 2013; Martínez Franzoni and Sánchez-Ancochea 2016; Leisering 2021). However, existing theories are often limited in their explanation of why countries with similar socio-economic characteristics adopt different reform trajectories, or why some countries do not reform at all. I therefore take these underlying characteristics as given and focus on identifying the political conditions that create potential windows of opportunity for reform adoption.

Empirically, I pursue a macro-comparative approach to exploring the role of political determinants of healthcare system reform in the Global South. Much of the existing comparative literature on welfare state development has focused on specific regions, such as Latin America (Segura-Ubiergo 2007; Huber and Stephens 2012; Pribble 2013; Niedzwiecki 2018) or Asia (Holliday 2000; Wong 2004; Koehler and Chopra 2014; Yang and Kühner 2020), with relatively fewer studies focusing on cross-regional or global comparisons (Rudra 2007; Haggard and Kaufman 2008; Schmitt et al. 2015; Tillin and Duckett 2017; Obinger and Schmitt 2022).[95] While this regional literature has been instrumental in exploring the determinants and complexities of global welfare expansion, it remains unclear if these findings can be generalised across countries with different socio-political and historical trajectories. This paper provides a broader comparative perspective by leveraging global variation and capturing the diverse institutional, political, and economic contexts across all world regions.

To achieve this, I construct a novel dataset of health system reforms across 90 countries in the Global South between 1990 and 2023. This dataset captures the legal adoption of reforms that expanded access or benefits to new population groups, and classifies each reform as

[95] Africa has been another comparative 'blind spot' in the literature, with notable exceptions (Devereux and White 2010; Ulriksen 2012; Niño-Zarazúa et al. 2012; Mkandawire 2020).

either universal or segmented, depending on its implications for equity in healthcare provision. With few exceptions, this new dataset provides near-complete coverage of healthcare system change in the Global South since 1990. Further drawing on the *Varieties of Democracy* (V-DEM) dataset, I then employ an event history approach to examine the interplay of political and interest-based factors in shaping the type of reform pursued.

This study adds to the growing comparative literature that explore the political economy of healthcare (Montanari and Nelson 2013; Reeves et al. 2015; Greer and Méndez 2015; Fox and Reich 2015; Costa-Font, Turati, and Batinti 2020; Immergut et al. 2021; Jacques and Noël 2022) and the determinants of social policy adoption in the Global South (Huber and Stephens 2012; Niño-Zarazúa et al. 2012; Pribble 2013; Brooks 2015; Schmitt et al. 2015; Martínez Franzoni and Sánchez-Ancochea 2016; Carbone and Pellegata 2017; Niedzwiecki 2018; Altman and Castiglioni 2020; Böger and Leisering 2020; Obinger and Schmitt 2022; Barrientos 2022). It makes three key contributions:

- By coding a novel global dataset of health system reform and classifying reforms as universal or segmented, the study expands the research focus both geographically and conceptually.
- By proposing a political mechanism of electoral volatility and constrained clientelism, the study expands the political economy analysis of universal healthcare reforms in the Global South.
- By exploring the mediating role of organised labour and healthcare privatisation, the study explicitly incorporates the role of vested interests in political theories of healthcare system change.

The remainder of this paper is structured as follows. Section 2 reviews existing literature on the political drivers of welfare expansion in the Global South. Section 3 presents the theory, including the conceptual framework of universal and segmented reforms, and a political economy model of reform adoption. Section 4 describes the data and methodology, focusing on the construction of the new health system reform database. Section 5 presents the empirical findings, and Section 6 concludes with a discussion of implications and future research directions.

2. Literature review: Political drivers of welfare expansion in the Global South

This section explores key theoretical approaches to understanding the political drivers of welfare expansion in the Global South. Rather than focusing on technocratic explanations of reform processes, it reviews political theories to explain why and how governments extend social policies to new populations.[96] In employing healthcare as a case study of wider (universal) welfare expansion, the reviewed literature predominantly focuses on the politics of social policy in Southern contexts. [97]

While this section focuses on three major political determinants – regime type, government ideology, and electoral competition – it is important to note that a broader set of social, economic, and political factors has been discussed in the literature on welfare and healthcare expansion. Economic development, policy diffusion, social movements, fiscal capacity, welfare norms, conflict experience, and institutional legacies have all been identified as important influences on the adoption and design of welfare policies in the Global South (Rudra 2007; Haggard and Kaufman 2008; Mesa-Lago 2008; Huber and Stephens 2012; Schmitt et al. 2015; Martínez Franzoni and Sánchez-Ancochea 2016; Obinger and Schmitt 2022). For example, economic and fiscal constraints can limit the feasibility of reforms independent of political factors, while the influence of international organisations and global welfare norms might create reform pressure extending beyond national borders. In line with the conceptual focus of this paper, the following review focuses specifically on the role of national political dynamics.

2.1 Democracy and welfare: A deterministic relationship?

The idea that democracy leads to more and better welfare provision has long been a central and widely accepted claim in the study of social policy. In contrast to authoritarian regimes, democracies are expected to more effectively balance the impacts of advanced capitalism

[96] This section does not focus on technical challenges to healthcare implementation in the Global South context, which have been subject to an extensive health systems and implementation science literature. See, for example, Bloom, Khoury, and Subbaraman (2018), Preker et al. (2021), or Darrudi, Ketabchi Khoonsari, and Tajvar (2022) for an overview.

[97] Despite not arguing that healthcare is representative of all social policies, it is a central case study of universal welfare provision, especially in the Global South. It concerns a central government capability of caring for its population, is the largest and arguably most important welfare programme in most countries, and is close to individuals' perception of the state and its legitimacy (see Chapter 3). Healthcare policy is an inherently political issue that touches on the very essence of the social contract between state and society.

by compensating economic losers, addressing market inequalities, and providing public goods (Iversen 2021). While disagreements remain on the specific mechanism that drives this association – ranging from expanded suffrage to the extension of civil liberties – a substantial literature has established a positive relationship between democratisation and welfare state development (Dorlach 2021).[98]

Several historical studies highlight how expansions in welfare provision coincided with the onset of democracy in such diverse countries as Taiwan, South Korea, Ghana, Mauritius and Costa Rica (Wong 2004; Bangura 2007; Carbone 2011; Martínez Franzoni and Sánchez-Ancochea 2016). For example, Carbone (2011) traces the case study of Ghana in which the political debate and ultimate adoption of the ambitious National Health Insurance Scheme (NHIS) directly followed a period of democratic transition and increasing multiparty competition in the 1990s. Similarly, Uganda's extensive universal primary education programme has been directly linked to the advent of democracy and the country's first competitive elections in 1996 (Stasavage 2005).

Quantitative cross-national studies tend to confirm the positive association between democracy and the adoption of welfare in the Global South, but not without qualifications. Brooks (2015) examines the spread of conditional cash transfers (CCTs) – arguably the defining welfare innovation in recent years of development policy (Lavinas 2013) – across the world and finds democratisation and international diffusion to be the most important determinants of policy adoption. Böger and Leisering (2020) confirm these results in a similar case study of social pensions in the Global South. On a more general level, Schmitt et al. (2015) analyse the emergence of social protection legislation across different areas using a truly comprehensive sample covering 177 countries and territories between 1820 and 2013. Their results reject the democratisation hypothesis, instead finding policy adoption to be a 'transnational event' driven by regional diffusion and the influence of international organisations.

In the context of healthcare, Templin et al. (2021) show that the quality of democracy is significantly positively associated with both universal health coverage and overall healthcare spending, with the strongest relationship in low-income countries, even persisting during

[98] In comparison to the predominant focus of the social policy literature on the experience of advanced industrialised countries, the regime type literature has a distinctly global outlook. The main reason is analytical: while most countries in the Global North have remained democratic and gradually expanded welfare, at least from the second half of the 20th century, regime type changes have been more frequent in Global South contexts (Rudra and Haggard 2005).

recessions. Similarly, Wigley et al. (2020) conduct a synthetic control study to highlight that, although autocracies improve over time, they perform substantially worse than democracies in expanding universal health coverage, lowering out-of-pocket health expenditure, and advancing life expectancy.

This comparative literature stands in a longer history of academic discourse that compares public policy and development outcomes between democratic and non-democratic countries, including in areas like education, inequality, poverty reduction, inflation, and economic growth (Desai, Olofsgård, and Yousef 2003; Ross 2006; Ansell 2008; Scheve and Stasavage 2017; Acemoglu et al. 2019). While this regime type literature has generated central empirical insights, it has three important limitations.

Firstly, the definition of democratic versus autocratic countries has become more fluid over time, both with more countries representing hybrid types of 'illiberal democracies' or 'electoral autocracies', and with countries shifting more frequently between different regime types. While some studies aim to circumvent this problem by relying on continuous indicators of democratic quality, this begs the question whether the effect of regime type on healthcare provision can be considered a level- or a growth-effect – that is, if we should expect variation between autocracies and democracies per se or within democratising countries over time.[99]

Secondly, the regime type argument can be perceived as deterministic and hence unsuitable to explain the varieties of provision between similarly democratic countries or the expansion of healthcare and wider welfare services in non-democratic countries. The latter is especially relevant as democratic backsliding in many countries has been accompanied by substantial expansions of (exclusionary) welfare, while autocratic or populist governments increasingly employ social policies to advance their legitimacy (Rinaldi and Bekker 2020; Rovira Kaltwasser and Zanotti 2021; Szikra and Öktem 2023).

Lastly, and most importantly, the regime type literature remains unclear on the specific democratic mechanisms that are conducive to achieving truly universal healthcare systems. While all democratic, the advancement of free press, universal suffrage, or the rule of law will lead to fundamentally different policy implications and mechanisms for supporting policy reform. Many existing studies point towards the role of electoral factors, with the two most prominent being government ideology and electoral competition.

[99] This aspect tends to get conflated in the literature. While both effects may be equal, they build on different theoretical arguments.

2.2 Government ideology

Scholarship on the relationship between government ideology and social policy builds on the classical Power Resource Theory (PRT) that has been developed to explain the emergence of welfare states in Global North contexts, particularly in Europe (Korpi 1983; Esping-Andersen 1990). At its core, the theory argues that democratisation leads to a shift in power resources between classes, primarily by increasing electoral representation and political mobilisation through political parties and labour unions. This redistribution of power facilitates the advancement of generous and equitable welfare policies by amplifying the demands of working-class citizens, particularly when progressive political parties come to power.

Left-wing political parties, such as social democrats or labour parties, are central to PRT as the electoral representatives of increasingly mobilised labour movements, social advocacy groups, and economically disadvantaged constituencies. This stands in contrast to centrist or right-wing parties, which tend to align with business interests or more privileged voters. Within this framework, both ends of the political spectrum differ in their policy preferences. While the left favours redistributive, universal social policies, the right is expected to prefer residual forms of welfare. Importantly, progressive parties support social policy expansion not as a vote-seeking tool, but instead due to their ideological commitments to principles of redistribution, equality, and social justice (Esping-Andersen 1990; Huber and Stephens 2001).

While PRT has been developed – and debated – based on the historical experience of the European welfare states, its implications have increasingly been applied in Global South contexts. Notably, Huber and Stephens (2012) argue that democratisation and increasing left-wing political power were central to the proliferation of social policies in Latin America. Using a sample of 18 countries from 1970 to 2005, they demonstrate a significant effect of government ideology on poverty and inequality reduction, attributing this to a compositional change in social expenditure towards more redistribution. Contrary to expectations, however, they only find a significant effect of partisanship on health and social security spending in the 2000s – which the authors explain by limited fiscal capacities in previous decades. Expanding on the fiscal argument, Reeves et al. (2015) analyse a broader sample of low- and middle-income countries and find that left-leaning governments tend to be better at mobilising taxes – especially from progressive sources like income, capital, and profits – and use these increased public funds towards social protection programmes, particularly in health.

Additionally, several historical comparative studies provide support and expand the central argument for PRT in Southern contexts. Pribble (2013) confirms the central importance of left-wing political forces to advance universal social policies in Latin America but provides a more fine-grained classification of party characteristics as a combination of ideology and party type. Specifically, she finds that left-wing governments with strong ties to their voter base, as evident in the cases of Brazil, Chile, or Uruguay, are particularly successful in delivering social policy expansion compared to more non-programmatic and electorally oriented parties on the Left. Relatedly, Niedzwiecki and Pribble (2023) emphasise how party ideology not only affects the expansion but also the retrenchment of social policies in the context of unfavourable economic conditions. In tracing 24 policy reforms in Argentina, Brazil, Chile, and Uruguay during the 2010s, they find that left-wing programmatic governments most commonly undertook expansions, while retrenchments were exclusively carried out by the Right in phases of economic pressure.

Interestingly, the popularity of PRT extends beyond the traditional social policy literature to global and public health, with studies focusing on the role of progressive political forces to advance universal health coverage (Costa-Font, Turati, and Batinti 2020; Rizvi et al. 2020).[100] For example, McKee et al. (2013) trace UHC around the world and find 'Left Power' to be the only political determinant of progress, in addition to economic resources, institutions, social divisions, and windows of opportunity. Similarly, Greer and Méndez (2015, 637) argue that "[p]artisan politics are one of the most promising avenues for explaining UHC" and cite the historical successes of left-wing parties in Southern Europe and Latin America in expanding healthcare following democratisation. Taking this argument further, Raphael and Bryant (2006) draw on the traditional welfare regime types and suggest that social democracy and its related programmatic policies are central to universalise healthcare and promote health as a whole.

Despite its popularity, the applicability of PRT in the Global South is not without criticism. Beyond the historical case of European welfare state development, the role of progressive forces has been argued to be a regional phenomenon in Latin America, especially in the context of the 'pink tide' of left-wing governments starting in the late 1990s. While there are various case studies beyond Latin America, such as Mauritius or the Indian state of Kerala, the broader applicability of the theory to global contexts has been questioned (Sandbrook et

[100] A popularity that likely started with Navarro and Shi (2001), Navarro et al. (2006), and others who have extensively discussed the role of political parties on health outcomes and health policies.

al. 2007; Ulriksen 2012; Tillin and Duckett 2017). Specifically, several cross-national studies fail to find empirical support for the hypothesis of differences in social policy preferences between governments of different political alignment (Brooks 2015; Altman and Castiglioni 2020; Shim 2020).

Furthermore, against the predictions of PRT, agents of healthcare system change in many Global South contexts have not been the 'poor' or mobilised labour, but rather elite political forces – such as healthcare professionals in the 'Sanitarista' movement in Brazil, technocrats from the Ministry of Health in Mexico, or top level politicians in Taiwan (Wong 2004; Fox and Reich 2015; Davidian 2021). In many countries, the key proponents of reform have not been left-wing, but right or conservative political forces. For example, the ambitious Universal Health Care Act in the Philippines was signed into law in 2019 by far-right populist president Rodrigo Duterte, and the introduction of the Ghanaian National Health Insurance Scheme in 2003 was a key electoral promise by the conservative New Patriotic Party (Wahab 2019; Schaffar 2021). In these contexts, which counter the predictions of PRT, electoral competition is increasingly suggested as a key determinant of welfare expansion in the Global South.

2.3 Electoral competition

The role of electoral competition as a driver of social policy expansion builds on the classic Median Voter Theorem and the idea that political parties pursue vote-maximising policies, even beyond their own programmatic ties, when they face substantial electoral pressures (Meltzer and Richard 1981). It is assumed that more competitive elections lead to higher responsiveness to voter demands and an incentive to appeal to a broader electorate outside of parties' traditional constituencies, especially to foster cross-class coalitions of voters. Given that large proportions of the electorate are poor and hence likely to favour redistribution, a political strategy focused on expanding welfare appears particularly promising in Global South contexts. In contrast to the partisanship argument, this is not tied to specific political ideologies but rather to specific contexts around elections.[101]

This hypothesis is supported both in the democratisation and historical literature, with several studies providing evidence that increasing electoral pressures were behind the adoption of ambitious social policies in democratically transitioning countries in the Global

[101] However, this does not imply that partisanship and electoral competition do not interact; in fact, electoral factors play an important role in PRT with progressive parties representing an increasingly mobilised lower and middle class. Rather, this strand of the literature suggests that social policy as a vote-seeking strategy is employed across the whole political spectrum.

South. For example, Kjær and Therkildsen (2013) argue that early social policy reforms in Uganda and Tanzania, such as universal primary education, were driven by their first multiparty elections in the 1990s.[102] In Latin America, Ewig (2016) traces policy reform processes towards more equitable healthcare in Brazil, Chile, and Colombia and finds that electoral competition, rather than progressive partisanship, enabled a coalition of politicians and policymakers to overcome resistance from labour unions and previous policy legacies to introduce new universal healthcare systems. Similarly, Pribble (2013) and Fairfield and Garay (2017) argue that welfare policy expansions and progressive tax reforms under right-wing or conservative governments in Latin America were primarily motivated by intense political competition and the need to appeal to wider groups of voters.

On the cross-national level, Altman and Castiglioni (2020) analyse the development of equitable social policies for a panel of Latin American countries between 1990 and 2013, finding no support for the partisan hypothesis, but instead identifying electoral competition, civil society strength, and economic development as the most important determinants of universal welfare expansion.[103] Garay (2016) confirms these results using a novel measure of electoral volatility and specifically emphasises the competition for low-income voters and other welfare outsiders that were previously uncovered by existing policies. Beyond focusing on pure democracies, Carbone and Pellegata (2017) investigate the impact of leadership changes and electoral turnover on healthcare spending across all African countries from 1960 to 2013. While they find the effect to be stronger in fully democratic settings, their results provide support for the electoral competition hypothesis, even in contexts of limited democratic standards and constrained elections.

Despite this positive empirical evidence, the relationship between electoral competition and welfare expansion is not without its complexities.[104] While potentially advancing social policy on the political agenda, this does not necessarily imply that governments pursue the most ambitious, generous, or equitable policies. Instead, they often focus on short-term initiatives with high visibility. Robinson and Torvik (2005) famously caution against the short-termism of

[102] See also Stasavage (2005) and Seekings (2012).
[103] They construct equitable social policies as a weighted index of three measures from the Varieties of Democracy dataset: health equality, education equality, and means-tested versus universalistic welfare programmes.
[104] Interestingly, with the exception of Templin et al. (2021) and few others, electoral competition is not a focus of the public and global health literature on the politics of universal healthcare. As mentioned, the partisanship hypothesis tends to be more popular in these contexts.

governments in Global South contexts when they cannot make credible promises to their electorate, leading to what they call 'white elephant' projects that are highly visible but have little or even negative social benefit. In the context of healthcare, this could lead to a focus on more residual or targeted benefits for specific groups, such as those based on deservingness criteria or clientelism, when voters distrust governments from advancing more system-wide universal reforms. Similarly, Keefer and Khemani (2005) argue that elections in contexts of weak political institutions and strong information asymmetries are less likely to lead to broad-based public policy provision, as politicians may rely on symbolic policies and higher incentives to divert resources to powerful interest groups. Chhibber and Nooruddin (2004) find some support for this hypothesis in India by comparing government expenditures in states with multi-party versus two-party elections. They find that states with competition between only two parties are more likely to provide public goods, which they explain with the need to appeal to a broad-based electorate, instead of a relative majority, to win elections.

Beyond institutions, interest-based factors also mediate the strength and direction of the relationship between electoral competition and social policy expansion. As in other policy fields, expansion efforts are frequently impeded by key interest groups which may resist reform due to their own agendas. For example, in Ghana, the introduction of the National Health Insurance Scheme in 2003 faced significant opposition from organised labour, particularly the Trades Union Congress (TUC), which expressed concerns about the financing model and its potential impact on worker benefits (Agyepong and Adjei 2008). This social protectionist resistance led the government to negotiate concessions, delaying implementation and weakening programme objectives. Similarly, in South Africa, debate over the introduction of fully universal healthcare has been impeded by a coalition of interest groups, labour unions, and political opposition – particularly with the South African Medical Association and private healthcare providers actively lobbying against the proposed reforms, citing fears of resource mismanagement and potential declines in healthcare quality. While the comprehensive National Health Insurance Bill finally passed in 2023 after more than 16 years of political debate and substantially strengthened public healthcare provision, the reform was met with widespread protests and significant electoral losses for the ruling party, the African National Congress, in the following elections (Whyle and Olivier 2023; Everatt 2024).

3. Theoretical framework

3.1 Conceptual lens: Universalism versus segmentation

3.1.1 Defining universal healthcare reform

Before empirically assessing its political determinants, it is essential to define the concept of a 'universal healthcare reform'. Drawing on the theoretical lens of universalism in social policy, I argue that the defining characteristic of a truly universal healthcare system is equity in public service provision – that is, if the whole population has access to the same level and quality of healthcare. In contrast, segmentation occurs when access and quality of public healthcare vary between socio-economic groups.

This distinction suggests two possible pathways for healthcare expansion: universal and segmented reforms. A reform that expands coverage or improves the quality of care can be considered universal if it also advances equity by unifying services in scope and quality. Conversely, a reform is segmented if it institutionalises disparities in healthcare provision between socio-economic groups.

This goes beyond existing definitions of universal health coverage (UHC), which are the focus of a broader public health literature and many policy initiatives, especially by the World Health Organization (WHO 2010, 2025; Darrudi, Ketabchi Khoonsari, and Tajvar 2022). While some existing definitions mention aspects of financial protection, equity considerations are largely absent from the relevant literature on expanding health coverage across the globe. For example, the prominent UHC cube concept by the World Health Organization measures three dimensions of population coverage, service coverage, and out-of-pocket expenditure, but it does not capture the quality of services or differences in coverage or costs between populations (WHO 2010). Similarly, even if both targets of the Sustainable Development Goal 3.8 were achieved – the prevention of 'catastrophic health expenditure' and the guarantee of 'essential health services' for all – this would still allow for a multi-tier system where access to quality healthcare is stratified by income or socio-economic status.

Fundamentally, a system that ties income to access and quality of care cannot be considered truly universal.[105] If health is a fundamental human right – as enshrined in an increasing number of national constitutions around the world – then any fundamental inequalities in

[105] Proponents of the SDG 3.8 definition would likely argue that this is contained in the 'essential healthcare' concept. However, at least in its current measurement and implementation, it focuses on an incomplete set of healthcare provisions and lacks the quality of care.

public healthcare provision between groups should be considered unethical (Backman et al. 2008; Dittrich et al. 2016). While resource constraints and individual health needs must be taken into account, the principle of non-discrimination demands equity in service provision at the health system level, independent of group membership or socio-economic characteristics.[106]

Moving beyond coverage-based definitions, I conceptualise universal healthcare through the broader lens of universalism in social policy. Universalism describes policies that apply equally to everyone within a particular group, such as citizens of a country (Stefánsson 2012; Anttonen and Sipilä 2014). It is often considered in opposition to the concept of segmentation, which limits benefits and services to subsets of the group, resulting in differential levels of access and care. While historically associated with the Scandinavian welfare states, the concept of universalism has increasingly been expanded to the Global South (see Chapter 1 for a more detailed overview).

Martínez Franzoni and Sánchez-Ancochea (2016) propose a multidimensional definition of universalism in the Global South that focuses purely on policy outputs along the dimensions of coverage (who is covered), generosity (what is covered), and equity (what are the differences in access and quality between groups). Universal social policies can be defined as those policies that reach the entire population with similarly generous benefits and services, independent of the instruments used.

This policy-agnostic definition recognises that there are various ways to achieve universalism – such as different delivery models or sources of funding – that do not need to reflect the historical experience of other countries. While many existing 'maximalist' definitions focus on tax-funded, citizenship-based modes of welfare provision modelled after the Scandinavian experience, the same policy instruments might be inappropriate for the socio-economic realities of countries in the Global South – for example, due to high levels of informality, limited tax revenues, or lack of institutional capacity. Thus, the definition of universal healthcare reform presented here does not focus on specific types of policy

[106] Importantly, this distinction is not only normative but has significant political implications. As highlighted in the literature on the paradox of 'redistribution' (Korpi and Palme 1998), universal social policies are more likely to generate cross-class coalitions to sustain welfare provision over time. In contrast, segmented programmes that target specific groups may lack the political support necessary for long-term expansion or improvement. Thus, unification is not just a defining feature of universal reforms in terms of equity, but also crucial to their political viability and institutional durability.

instruments, such as community-based health insurance or social health insurance, but instead focuses on its impact on the equity of the healthcare system.

3.1.2 Universal versus segmented reforms: Three scenarios

To illustrate the difference in universal versus segmented reforms, consider a country that only provides health insurance to one privileged group in society, say public servants,[107] and evaluate potential expansions in each of the three dimensions of universalism.

In the first scenario, an expansion in coverage could involve creating a second health insurance system for a previously uninsured group, such as the 'poor', which provides a different and lower quality set of healthcare services. While this segmented expansion potentially constitutes an improvement of the status quo and might even reduce access inequalities in the short run, the central problem lies in the institutionalisation of differences in service provision between groups. Whereas the status quo improvement might not even materialise given that targeted welfare provision in many countries of the Global South fundamentally suffers from such poor quality, access barriers, and limited availability that makes it effectively unusable (Mkandawire 2005), the institutional segmentation of benefits in two or more 'tiers' will have long-lasting implications in terms of path dependency and policy feedback effects. With a long history in both the Global North and the Global South, many existing case studies and cross-country evidence emphasise how segmented reforms solidify access inequalities due to limited electoral incentives to expand services, and undermine social cohesion by creating new divisions and stigma across criteria of deservingness and legitimacy (Titmuss 1974; Korpi and Palme 1998; Rothstein 1998; Seekings 2008).[108]

In the second scenario, an expansion in generosity could signify the inclusion of additional or higher-quality services under the existing insurance system for the already privileged group, further exacerbating the inequalities in access. Even an overall improvement in healthcare quality across the country, such as by upgrading hospitals, would not change but could even worsen existing inequalities. This is likely if financial, social, or geographical barriers continue to prevent significant proportions of the population from accessing these services, with only the already privileged gaining more access to even better services.

[107] A common starting point for many healthcare systems in the Global South.
[108] See Chapter 3 for more details.

In the third scenario, an expansion of equity could involve extending a health insurance scheme to new groups while maintaining the same benefits, or creating a new unified health insurance system with population-wide coverage that reduces disparities in access and quality. Importantly, both cases constitute an improvement in coverage and generosity as a precondition, at least for the previously uninsured group, while simultaneously reducing segmentation, thus linking with the concept of universalism. As such, I consider this third scenario to be a truly universal reform, while the other two are examples of segmented reforms. This equity-focused definition should, however, not be considered a maximalist aspiration. By acknowledging that welfare state development is a process, it defines any reform that advances equity as universal, even if it starts from a limited level of service and population coverage.[109]

3.2 A political economy lens to universal reform adoption in the Global South

Building on the conceptual distinction between universal and segmented reforms, this paper employs a political economy lens to explain their adoption in the Global South. This theoretical framework focuses on the conditions under which incumbent governments adopt health system reforms that expand access to healthcare for underserved populations. Building on the assumption that governments seek to maximise their chances of staying in power, it considers how electoral incentives and ideological orientation shape the design of health system reforms – and how these interact with vested interests. Health system reforms are defined as policy changes to the structure and equity of national healthcare provision, such as the introduction of new programmes for specific populations, or the unification of existing schemes. In focusing on the highest and most disruptive type of health reform, the framework abstracts from more incremental changes to healthcare delivery, financing, or administration.[110]

[109] Very few countries in the sample start from the point of providing virtually no healthcare. However, even in cases of limited initial coverage, there is a clear conceptual distinction between expanding healthcare by providing similar, low benefits to everyone (for example, in the form of an Essential Benefits Package), versus a targeted programme that provides more generous benefits for privileged groups, such as public servants or formal sector workers.

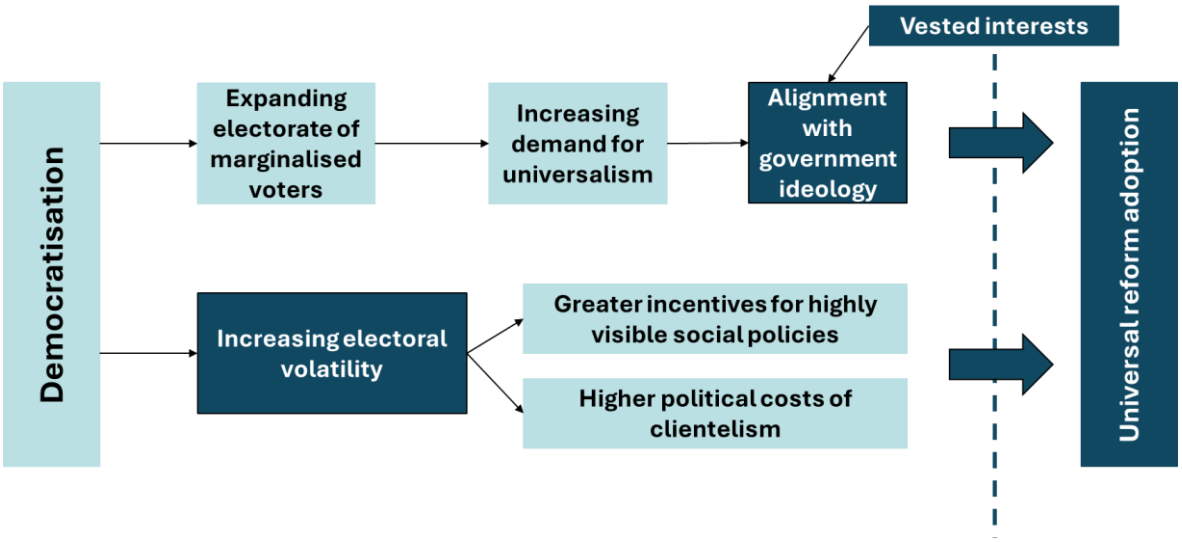
[110] While these aspects are also important to the equity and quality of healthcare provision, I argue that health systems reforms are the most interesting case study for examining the political economy of health reforms, because they are foundational to the system and affect the material interests of the broadest group of stakeholders.

In terms of the seminal framework of Fox and Reich (2015), the theory focuses on the interaction between the *policy design* of the reform proposal and its legislative *adoption*, while omitting aspects of *agenda setting* and *implementation*. It aims to explain *when and why* governments pursue universal or segmented reforms, but not whether they succeed in implementing them.

Overall, this framework complements rather than contradicts existing institutional and ideational theories of welfare state development in the Global South, for example regarding the role of path dependencies, regional diffusion, policy architectures, and welfare norms (Rudra 2007; Haggard and Kaufman 2008; Huber and Stephens 2012; Pribble 2013; Obinger, Schmitt, and Starke 2013; Martínez Franzoni and Sánchez-Ancochea 2016; Leisering 2021). Specifically, I address a gap in the existing literature in theorising when and how countries decide to reform their welfare programmes. While these decisions are shaped by the institutional and ideational background, existing theories are limited in explaining variation across countries with similar characteristics, the persistence of non-reform, and the type of policy expansion pursued. In treating underlying institutional and ideational characteristics as relatively stable, the theory highlights how variation in electoral dynamics, government ideology, and vested interests can shape divergent reform trajectories.

Figure 1 provides a stylised overview of the theoretical framework presented in the following sections.

Figure 1. Overview of theoretical framework



3.2.1 Democratisation and shifting policy preferences for universalism

A common characteristic of many countries in the Global South is a gradual process of democratisation. I argue that this democratisation reshapes the politics of welfare reform, not only by making policy expansion more likely, but also by influencing how expansion occurs. This shift operates through two mechanisms: firstly, by altering policy preferences of an expanding electorate and, secondly, by increasing electoral uncertainty. As a result, governments face increasing pressures to respond to electoral demands rather than rely on welfare provision as a tool for maintaining regime legitimacy – as practised by many illiberal and authoritarian governments (Knutsen and Rasmussen 2018; Duckett and Munro 2022; Szikra and Öktem 2023). My central claim is that while healthcare expansion may appear to be a valence issue, the form of expansion – universal versus segmented – is fundamentally shaped by government ideologies and electoral dynamics.

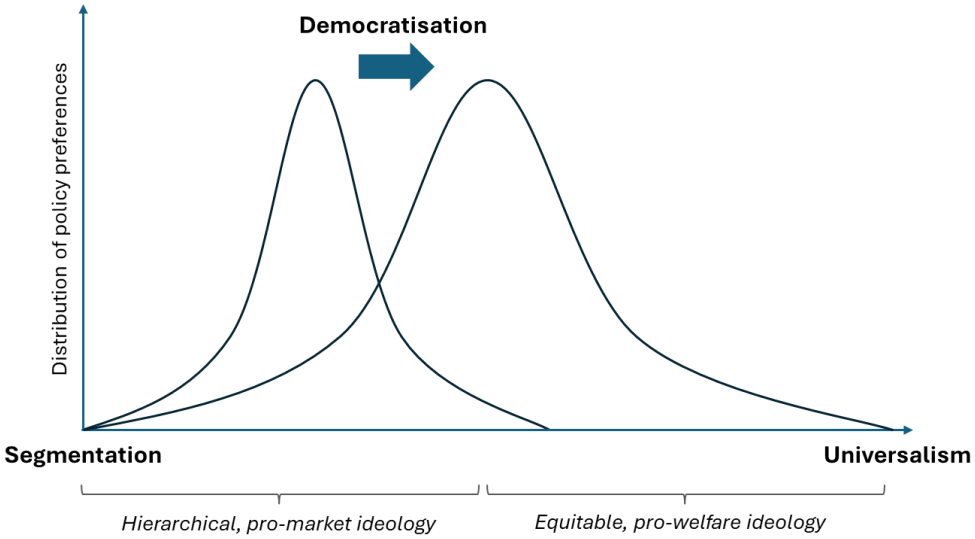
At its baseline, democratisation expands the electorate through political enfranchisement of previously marginalised groups, such as rural or poor populations. Since large parts of the Global South's population live in poverty, work in the informal sector, and lack access to quality public services, newly enfranchised voters will likely not only demand healthcare expansion per se, but also favour equitable over segmented provision. In seeking access to the same benefits as privileged groups, the preferences of these 'healthcare outsiders' for universalism extend beyond material self-interest and are shaped by inequality aversion, expectations of fair treatment, and the desire for social legitimacy through inclusion in a shared system (Rueda 2007; Garay 2016; Holland and Schneider 2017).[111] Considering the role of social inclusion and stigma, marginalised voters in unequal societies are more likely to resist programmes that entrench stratification, even if they receive material benefits from them.

In contrast, in less democratic regimes where a smaller class of enfranchised voters or 'critical supporters' hold political rights, social policy is more likely to be aligned with the segmented preferences of the privileged 'healthcare insiders', such as public servants or urban middle classes (Knutsen and Rasmussen 2018). An increasing electorate of

[111] Extensive research across behavioural economics, political sociology, and comparative politics has shown that preferences for redistribution are shaped not only by self-interest, but also by concerns for fairness, inclusion, stigma and other related factors (Fong 2001; Shayo 2009; Rothstein and Uslaner 2005; Cavaillé and Trump 2015; Rueda and Stegmueller 2019).

marginalised voters with limited access to quality social services is assumed to lead to an overall shift in the distribution of welfare preference towards universalism (Figure 2).[112]

Figure 2. Shifting social policy preferences



Having established that democratisation shifts voter preferences towards universalism,[113] I suggest that the likelihood of an incumbent government responding to these demands depends on its ideological alignment. While party competition in many Global South contexts tends to be characterised by valence issues like education, infrastructure, and social protection (Hagopian 2009; Bleck and Van De Walle 2013), important ideological cleavages remain in the policy pathways to achieve these shared goals, particularly concerning the role of the state in welfare provision. In line with traditional welfare state theories, I hypothesise that parties differ in their preferences for universal or segmented expansion, based on underlying ideological commitments to market versus state solutions, and to normative values of equity versus social hierarchy (Esping-Andersen 1990; Huber and Stephens 2001; Kittel and Obinger 2003; Montanari and Nelson 2013; Obinger, Schmitt, and Zohlnhöfer 2014).

[112] I do not assume uniform preferences across the group of newly enfranchised voters, as there is clearly variation based on cultural, social, and economic characteristics, but simply an average shift towards universalism.

[113] While the most salient case, other theoretical factors beyond democratisation might shift policy preferences towards universalism. Related to political enfranchisement, rural inclusion will likely have a similar effect in contexts of large urban-rural inequalities in welfare access. Similarly, regional and ideational diffusion might affect the preferences of voters when ideas of equity and solidarity in welfare provision increasingly enter public discourse, for example, due to the influence of international organisations or the experience of neighbouring countries (Béland 2005; Weyland 2005; Leisering 2021).

Universal reforms require the expansion or integration of services across socio-economic groups, building on the normative principle of solidarity. They generally involve an expanded role of the state through tax funding, centralised governance, or public provision and hence align with traditional state-led and equity-oriented politics. In contrast, segmented reforms preserve institutional boundaries between groups and reflect normative principles of social hierarchy and deservingness. They often involve a residual role of the state and incorporate market-based mechanisms such as occupational schemes or public-private partnerships, thereby aligning with more hierarchical and market-oriented political ideologies.

I conceptualise government ideology not as a mechanical function of electoral pressures, as in classic Power Resource Theory, but rather as a filter that shapes how governments respond to growing demands for welfare expansion. Specifically, I expect left-wing governments to favour universal reforms due to their ideological congruence with the preferences of an expanded electorate. In contrast, right-wing governments are more likely to pursue segmented approaches that preserve socio-economic hierarchies.

- ***Hypothesis 1a**: Left-wing governments are more likely to adopt universal healthcare reforms.*
- ***Hypothesis 1b**: Right-wing governments are more likely to adopt segmented healthcare reforms.*

3.2.2 Electoral volatility and the political costs of clientelism

In addition to expanding political participation, democratisation also increases the uncertainty of electoral outcomes. Following a Schumpeterian perspective, what defines democracy is not only competition between parties, but also whether incumbents can realistically lose power (Schumpeter 1942; Dahl 1972; Przeworski et al. 2000). I therefore argue that it is not the intensity of electoral competition per se that shape governments incentives to adopt universal reforms – as frequently argued in the literature – but rather its consequence in the form of electoral volatility: the instability and unpredictability of voter support across election cycles.

Specifically, I conceptualise electoral volatility as a distributive risk for incumbent governments. When electoral coalitions are more unstable and voter preferences become more fluid, governments face greater uncertainty about which groups will deliver political returns (Lindvall, Rueda, and Zhai 2023). In such environments, narrower and segmented targeting strategies become less effective and visible; broad-based policies provide a more

viable electoral strategy. I argue that electoral volatility increases the likelihood of universal reform adoption through two main mechanisms: by incentivising governments to adopt highly visible policies that signal developmental commitment to a broad electorate, and secondly, by increasing the electoral cost of clientelism.

In many political systems in the Global South, governments are primarily judged on the basis of their ability to 'deliver development' – that is, achieving progress in central capabilities such as living standards, education, or health for significant proportions of the population (Hagopian 2009; Bleck and Van De Walle 2018). In these contexts, highly visible policies that clearly signal the government's responsibility and commitment to providing broad-based developmental gains are especially valuable under conditions of uncertainty. Drawing on Gingrich (2014), the visibility of welfare policies depends on the ease with which populations can understand the state's role and responsibility for a specific policy.

Universal healthcare reforms are particularly visible in this sense: they affect large parts of the population, relate to a central human capability, and shape the state-society relationship by caring for its citizens. As a result, they can enhance the developmental legitimacy of the state and visibly institutionalise norms of social inclusion (Mkandawire 2004; Kabeer 2014).[114] This is especially relevant in situations of high electoral volatility, where political messaging must resonate across diverse and shifting constituencies and demonstrate a commitment to 'deliver development' to broad-based electorates.

Beyond visibility, electoral volatility undermines the incentives for clientelism, which remains a common feature in many countries in the Global South. Party systems in these contexts are often characterised by strong identity-based divisions – such as ethnic, religious, or regional criteria – rather than traditional class-based alignments (Keefer 2007; Bleck and Van De Walle 2013). In these settings, clientelism and targeted benefits are frequently employed to mobilise support among core constituencies. Segmented reforms, which create parallel systems or targeted programmes for specific groups, may thus function as institutionalised expressions of clientelist politics, allowing governments to distribute resources selectively while preserving existing socio-political hierarchies.

[114] See also Chapter 3.

However, increasing volatility challenges the viability of this strategy by increasing the electoral costs of clientelism.[115] Building on Weitz-Shapiro (2012), the practice of clientelist strategies not only holds electoral benefits for targeted groups but also imposes political costs on those excluded. These costs can arise from both material conflicts and normative considerations. Materially, targeting benefits raises tensions over the allocation of scarce public resources and potentially alienates voters who might consider themselves disadvantaged. Normatively, both beneficiaries and non-beneficiaries may oppose segmented allocation if they consider it inequitable, undemocratic, or stigmatising. These electoral costs are particularly salient in the case of healthcare, where provision is often considered a core state responsibility and inequalities in provision are highly visible.

These political costs are amplified under conditions of electoral volatility. When electoral alignments are stable, governments can more reliably target core electorates and absorb potential backlash from non-core voters. However, as voter preferences become more fluid and constituencies shift, the risk of alienating current or future supporters increases, with marginalised voters today potentially turning into the swing voters of tomorrow. In such contexts of uncertainty, segmented policies that favour specific groups become a riskier and less reliable strategy to secure electoral support. Universal reforms, on the other hand, potentially offer a safer political strategy: they target broad-based electorates, present a visible commitment to equity and development, and reduce the potential of perceived favouritism or exclusion.

- ***Hypothesis 2**: Higher electoral volatility increases the likelihood of universal reform adoption*.

3.2.3 Vested interests as barriers to universal reform adoption

Having outlined two political mechanisms that can advance universal policy reforms – partisan ideology and electoral incentives – it is essential to also consider potential barriers to reform adoption, particularly related to the national political economy context. Given lower institutionalisation of political systems, the disproportionate role of interest groups in

[115] Some scholars argue that electoral volatility incentivises the use of clientelist strategies (Keefer 2007; Kitschelt and Wilkinson 2007). In this chapter, I follow an alternative line of reasoning: electoral volatility undermines the credibility and effectiveness of clientelist exchanges, because it becomes harder to identify which groups will deliver political returns, and riskier to alienate the remainder of the electorate. This trend is evident in elections following regime change, where party systems are yet to be institutionalised and voter alignments to be settled (Tavits 2005; Bleck and Van De Walle 2018). Consequently, I treat volatility as a form of strategic uncertainty, rather than a proxy for electoral competition (Lindvall, Rueda, and Zhai 2023).

policymaking is a further common feature in many Global South contexts (Thomas and Hrebenar 2008; Hagopian 2009). Whereas policy processes in more consolidated democracies are typically mediated through formal channels of parliamentary representation and negotiation, the boundaries between political elites and economic actors tend to be more fluid in emerging political systems. This increases the risk of informal lobbying and elite capture, particularly in reform processes challenging entrenched interests.

With regard to healthcare systems in the Global South, these stakeholders are both 'traditional' market actors such as private sector providers, professional medical associations, or pharmaceutical companies, and welfare insiders who already benefit from existing systems of care (Rueda 2007; Brooks 2008). In many Southern contexts, welfare access is tied to labour market status, as formal employees tend to be the first to be covered by emerging health insurance systems. This makes formal workers a key interest group with powerful representation in the form of labour unions and professional associations (Rudra 2002; Mesa-Lago 2008).[116] Similar to structural reforms in other policy domains like education, taxation, or climate change mitigation, path dependencies and policy feedback effects reinforce the entrenched interests of those groups benefiting from the status quo, increasing their likelihood to mobilise against reforms perceived as a redistribution of resources or loss of privileges (Pierson 1993; Mahoney and Thelen 2009).

Universal reforms are more likely to provoke opposition from market actors and welfare insiders because they involve restructuring existing systems of care. Universalism challenges the economic interests of private providers by strengthening public provision and advancing equity, thereby reducing the attractiveness of private alternatives. This also involves the reallocation of public resources, taxation, and decision-making authority, which can be perceived as a threat by welfare insiders wanting to protect their own benefits. By contrast, segmented reforms typically add layers of service provision with distinct benefits for new populations without fundamentally changing systems of healthcare financing, administration, or service delivery. They thereby preserve existing hierarchies in healthcare access while minimising disruption to vested interests – or, in some cases, even indirectly reinforcing the private sector by institutionalising different systems of care.

[116] For example, countries including Ghana, South Africa, and Malaysia have seen widespread resistance from labour unions against universal healthcare reforms, resulting in varied success of the policies (Carbone 2011; Fox and Reich 2015; Croke et al. 2019).

Given these structural incentives to oppose universal reforms, resistance from vested interests may strongly influence a government's decision-making process through lobbying, public mobilisation, or informal pressure. Even when governments have the political will to pursue universalism, they may anticipate backlash from influential groups and choose segmented reforms as the less disruptive alternative. These anticipation factors are likely compounded by high implementation uncertainty and weak administrative capacity, as governments hand interest groups even greater leverage to attack the policy in later implementation stages.[117]

Therefore, I expect the strength of vested interests to influence the likelihood of adopting universal versus segmented reforms and the effect to vary by government partisanship. In line with the ideological distinction between state- and market-based approaches, I hypothesise that right-wing governments are more constrained by private sector opposition, while left-wing governments face stronger pressure from organised labour.[118]

- ***Hypothesis 3a****: Stronger vested interests, in the form of labour unions or private sector providers, are associated with a lower likelihood of universal reform adoption and a higher likelihood of segmented reforms.*
- ***Hypothesis 3b****: The effect of vested interests differs by partisanship: private sector opposition is more constraining under right-wing governments, while left-wing governments face stronger pressure from organised labour.*

[117] A prominent example is South Africa, which has experienced many setbacks and delays in its attempts towards universal health insurance. These were, in part, due to the political influence of influential private sector actors (Whyle and Olivier 2023).

[118] In line with the literature on ideology and private sector interests (Mkandawire 1994; Béland and Gran 2008; Obinger, Schmitt, and Traub 2016), and left-wing partisanship and labour market insiders (Rueda 2007; Lindvall and Rueda 2014).

4. Methodology

4.1 Empirical strategy

To investigate why governments in the Global South pursue distinct reform pathways when expanding healthcare access, this paper focuses on health system reforms – that is, legal acts that change the overall structure of national healthcare provision, including the creation of a unified public health insurance and the institutionalisation of segmented schemes for different socio-economic groups. Because these reforms involve inherently contested choices over redistribution, state capacity, and the social contract, I expect political factors to play a particularly important role in shaping these, compared with smaller, incremental policy changes. I also expect reforms at this level to be less likely to be merely symbolic or rhetorical ('cheap talk'), as they involve binding legal commitments, substantial resources, and structural changes that reshape the rules of healthcare provision and redistribute access across the population.

In line with other recent studies on the adoption of social policy programmes around the world, this study employs an event history analysis (EHA) to examine the emergence of different types of health system reforms across the Global South (Brooks 2015; Schmitt et al. 2015; Obinger and Schmitt 2022; Barrientos 2022). EHA is a statistical approach specifically designed to analyse the timing and likelihood of discrete events, such as the legal adoption of a reform, over time (Allison 1984; Blossfeld, Rohwer, and Schneider 2019).

EHA is particularly suitable for this study for several reasons. Firstly, EHA allows for the incorporation of both structural and time-varying covariates – such as regime type and electoral dynamics – that may affect reform adoption. Unlike ordinary least squares regression, EHA does not assume time independence of event probabilities; instead, it explicitly models the temporal dimension of the reform process by estimating how the likelihood of reform adoption changes over time and across contexts. Finally, EHA is well-suited for the analysis of rare or single events, which is crucial in this study: large-scale healthcare system reforms are uncommon, and the majority of sample countries experience one universal or segmented reform over the 1990–2023 period at most.

The analysis focuses on the legal adoption of reforms, rather than on potential subsequent reversals, revisions, or their implementation. The research aims to explore the political and institutional conditions under which governments decide to formally adopt a reform that expands healthcare access, regardless of whether and when the reform is fully implemented

later. While implementation outcomes are clearly important, they depend on a variety of administrative, financial, and technical factors that extend beyond politics and the scope of this paper.[119] Focusing on the legal act of adoption hence aligns the dependent variable with the political decision-making process, which is the key explanatory focus here.

Once a country adopts a reform, it is removed from the risk set for that specific reform type (universal or segmented) in later years. This modelling for the first (or only) occurrence of an event is standard practice in EHA, as policy feedback and path dependency effects would bias the likelihood of future reform (Pierson 1993; Mahoney and Thelen 2009; Blossfeld, Rohwer, and Schneider 2019). Therefore, countries are not repeatedly counted if they adopt several universal or segmented reforms over the sample period. Given the focus on rare large-scale health system reforms, these occur in only two and six countries for universal and segmented reforms, respectively.

The dependent variable is modelled as a binary indicator which takes the value of 0 if a county has not yet adopted a type of reform, and 1 for the year of legal adoption (Section 4.2). The model compares country-years for countries that have never or not yet adopted a type of reform with the reform country-years.

Both types of reform (universal and segmented) are coded as separate dependent variables. This empirical choice is grounded in the understanding that universal and segmented reforms represent distinct policy pathways with potentially different political economy drivers. Analysing these separately allows the model to capture potential differences in the political determinants of reform trajectories. For example, organised labour may resist universal expansions in fear of losing access to privileged benefits, but may have a neutral stance towards segmented healthcare expansion targeted at rural or poor populations. As a robustness check, I test an alternative specification that models the dependent variable as a continuum from segmented (-1) to universal reform (+1).[120]

[119] Many reforms in the sample are implemented at a much later point compared to their initial adoption, or even abandoned – planned or unplanned. For example, while Madagascar officially established the *Caisse Nationale de Solidarité en Santé* in 2017 and launched it in one pilot district in 2018, the system was never rolled out and was finally dissolved in 2022 due to administrative and financial challenges (ILO 2022; L'Express De Madagascar 2023). Similarly, mandatory health insurance in Azerbaijan only became fully operational in 2021, despite its adoption in 2007 and several earlier attempts to implement it (Mehtiyev 2021; Guliyev 2023).

[120] This approach has conceptual limitations, as it implicitly assumes an ordinal relationship with 'no reform' as a neutral point.

Given the rarity of the outcome event in relation to the total number of country-years,[121] I employ a complementary log-log (cloglog) regression model to estimate the likelihood of reform adoption. The cloglog model is particularly well-suited for the analysis of infrequent events, as it approximates the hazard function and accounts for the skewed distribution of the outcome variable (King and Zeng 2001). As a robustness check, I estimate a traditional logit and Cox proportional hazards model. The Cox model is commonly employed in EHA, but is limited by its proportional hazards assumption, meaning that the effects of covariates on reform adoption are assumed to be constant over time – an assumption that may not hold given the large heterogeneity in institutional and socio-political characteristics across the sample (Box-Steffensmeier and Zorn 2001). While also included as robustness checks, I generally do not consider fixed effects models as they are likely to introduce selection bias by excluding time-invariant characteristics and, critically, countries that never adopted a type of reform from the sample.

Finally, to account for time dependence, I model the baseline hazard function using a logged time function that reflects the relatively high number of early adopters in the sample. This functional form was selected after testing it against a range of alternative specifications, including linear, polynomial, and spline-based time trends (Beck, Katz, and Tucker 1998). While the results remained stable across alternative trend functions, which are included as robustness checks, the logged time specification provided the best model fit, avoided multicollinearity concerns, and was consistently significant across model variants.

4.2 Dependent variable: Coding and classifying healthcare system reforms

Building on the theoretical framework in Section 3.1, I created a new dataset of healthcare system reforms across 90 countries in the Global South. Covering the period from 1990 to 2023, I coded the timing of all major health system reforms that expanded access or benefits to new populations and classified each reform as either universal or segmented. With few exceptions due to exclusion criteria, this new dataset provides near comprehensive coverage of healthcare system change in the Global South since 1990.

4.2.1 Sample and scope

As the purpose of the paper is to examine the political economy of healthcare reform from a global perspective, the dataset captures a truly comprehensive sample of Global South

[121] With only 1.9 and 2.0 percent of country-years for universal and segmented reforms, respectively.

countries from all world regions. Here, the term Global South refers to a socio-political category that stands in contrast to the historical experience of welfare state development in 'developed countries' (Sud and Sánchez-Ancochea 2022). In terms of inclusion, I follow the classification of the United Nations Conference on Trade and Development (UNCTAD) where the 'developed' or 'Global North' category is comprised of the countries of North America, Europe, Israel, Japan, South Korea, Australia, and New Zealand (UNCTAD 2023). The sample is not limited to a specific governance or regime type, but includes the full range of countries from liberal democracies to closed autocracies (Lührmann, Tannenberg, and Lindberg 2018).[122] While the suggested theoretical mechanism of electoral volatility presumes some degree of electoral contestation, I retain non-democratic regimes in the sample to reflect the diversity of reform pathways in the Global South and to strengthen generalisability. Many autocracies still hold regular multiparty elections and exhibit meaningful variation in both volatility and government partisanship over time. Moreover, the theoretical expectations remain relevant in these contexts and can serve as a counterfactual with the hypothesis that the likelihood of universal reforms increase with democratisation, and vice versa.[123] However, to address potential concerns of regime heterogeneity, I include control variables for regime type and institutional constraints on political competition.

Overall, only three types of countries were excluded from the sample. Firstly, small countries with a population of less than 250,000, with the assumption that healthcare reforms and their political processes are fundamentally different in larger countries due to higher levels of population heterogeneity, regional dispersion, and government decentralisation. Secondly, countries that implemented (quasi) universal healthcare systems before 1990. An example is Mozambique, which introduced a National Health Service and fully abolished private healthcare provision in 1975, and countries like Algeria, Cuba, Sri Lanka, and Mauritius (Farinha 2022). Retaining these countries in the sample would bias the results due to path dependency and policy feedback, which affect the likelihood of further reforms. Finally, countries affected by protracted conflicts on a national scale over the sample period due to the effects on political stability and healthcare capabilities. Examples include Afghanistan, Iraq, Libya, Myanmar, and Syria. These exclusions from the empirical model are in line with

[122] Examples of the latter include China, Iran, Morocco, and Gabon.

[123] Additionally, there may be factors beyond democratisation that increase electoral volatility or shift public preferences towards universalism, such as ideational diffusion, rural enfranchisement, or social mobilisation. In these cases, similar effects on reform trajectories can be expected, as governments respond to new or expanding electoral demands.

the principles of event history analysis that require limiting the sample to units with a realistic probability of experiencing the event, taking into account previous occurrences or structural ineligibility (Allison 1984; Blossfeld, Rohwer, and Schneider 2019).

4.2.2 Time coding and sources

The two dependent variables in this study are the legal adoption of a universal or a segmented healthcare system reform. Based on the available evidence, the coding for each year is as follows:

- 0: The country has not adopted a universal/segmented healthcare system reform (yet).
- 1: The universal/segmented healthcare system reform is officially adopted.
- 2: Years following the initial adoption of a universal or segmented healthcare system reform.[124]

The dependent variable measures the legal adoption of a reform – that is, the formal legal basis for establishing or changing the structure of the healthcare system. This only includes concrete, legally binding system changes and not general frameworks, roadmaps, strategies, or other non-binding political commitments. This is due to the politicised nature of healthcare in many countries, where proposals or plans to reform healthcare systems are frequently used for political signalling, but rarely translated into legislation.[125] For example, while the vast majority of sample countries have endorsed the Sustainable Development Goals and made political commitments to achieving universal health coverage, their levels of concrete policy action and implementation vary widely. Therefore, I do not consider these non-binding political commitments, but only legally adopted reform acts that include concrete provisions for health systems change.[126]

Given the variety of regime types, the legal nature of these adoption acts ranges from the parliamentary approval of laws to presidential decrees. In cases where reforms comprise multiple acts or laws, the year is used when the healthcare benefit structure across groups is established. For example, in Azerbaijan, the general *Law on Medical Insurance* was passed in 1999 in the National Assembly; however, the amendments to this law specifying the creation

[124] Excluded from the EHA.
[125] In many aid-dependent countries, this especially applies to health-related development assistance projects with international organisations such as the WHO or the World Bank, which frequently result in public statements and governmental strategies to advance equitable healthcare.
[126] Constitutional reforms that establish the 'right to health' are also excluded unless they are accompanied by structural changes to healthcare provision.

of a universal, mandatory health insurance were not passed until 2007. Therefore, the year 2007 is used in the analysis (Mehtiyev 2021; Guliyev 2023).

For the data collection, I reviewed three types of documents for each country: academic literature, policy reports from international organisations and non-governmental organisations, and policy documents from national governments. To ensure unbiased results independent of political framing, preference was given to academic literature on the subject, followed by high-quality policy reports.[127] In all cases, I triangulated the information across various sources. If sufficient sources were not available, the country was excluded from the sample.[128]

4.2.3 Classification

Based on the theoretical definition in Section 3.1, I classify each legally adopted reform act as either universal or segmented, depending on its impact on the equity of healthcare provision across the system. A reform is considered universal if it advances the unification of healthcare services in scope and quality, or segmented if it institutionalises differences in healthcare provision between socio-economic groups. The latter is most commonly the case when countries create separate health insurance programmes for 'the poor', alongside more generous programmes for privileged groups, such as civil servants or formal workers. Universal reforms often take the form of a unified national health insurance system, but can also include the consolidation of several previously existing programmes. Unless they change the structure of public provision, reforms that concern the private sector are not included in this classification.[129]

Crucially, the classification in this paper is solely based on the substantive distributive effect of reforms, not on their implementation vehicle, financing structure, or political framing. In acknowledging that there are different ways to achieve universalism, this outcome-focused classification is fully derived from the content of policy changes and their effect on equity in healthcare provision. As such, the classification is based on the direction of change – of

[127] Where necessary, key sources unavailable in English or French were translated using the *Deepl* translator.
[128] For example, Guyana.
[129] One counterexample is Honduras in 2015, which passed the *Ley Marco del Sistema de Protección Social* that privatised the public healthcare system and was met with substantial protests from civil society, labour unions, and the opposition due to its resulting healthcare inequalities (Hasemann Lara 2023).

advancing or reducing segmentation – and not on the baseline characteristics of the health system.[130]

This approach deviates from a substantial existing literature that limits the perspective to specific delivery or financing models, or that employs broad, nominal definitions of what constitutes a universal reform (Lagomarsino et al. 2012; Loffreda et al. 2021; Ly, Bassoum, and Faye 2022; Darrudi, Ketabchi Khoonsari, and Tajvar 2022). As a result, several reforms that are commonly framed as universal – such as the *Universal Health Insurance* in Iran in 1992, the *Régime d'Assurance Maladie Universelle* in Burkina Faso in 2015, or the *Ayushman Bharat programme* in India in 2018 – are instead classified as segmented, because they institutionalised unequal benefits across groups. On the other hand, some reforms that use the same institutional vehicle, such as Community-Based *Health Insurance* in Rwanda and Ethiopia, are classified differently based on their actual equity implications.

To illustrate the classification, consider Ghana and Guatemala as examples for each type of reform. Ghana was one of the first Sub-Saharan African countries to introduce a fully universal health insurance in 2003: the ambitious *National Health Insurance Scheme (NHIS)*. Financed through indirect taxes, insurance contributions, premiums, and development aid, the mandatory scheme covers the whole population with the same generous benefits, while providing co-payment exemptions based on gender, age, and income status. While benefits do not cover all possible health procedures, they provide equal coverage for the most common diseases in the country, including emergency and free maternal care (Alhassan, Nketiah-Amponsah, and Arhinful 2016). On the other hand, Guatemala implemented the *Integrated Health Care System* following the end of the civil war in 1996, expanding health coverage to rural and poor populations. Despite having a constitutional 'right to health' and mandated public healthcare, the so-called *Expansion of Coverage Program* relied primarily on contracting non-governmental and private sector organisations to provide basic care in rural communities. While initially successful in expanding coverage, the quality and breadth of healthcare benefits were limited, and the residual approach to providing a 'basic package'

[130] Several countries in the sample initially pursued a segmented approach to healthcare expansion and only later adopted universal reforms. Indonesia first introduced the segmented *Askeskin* programme in 2004 and later expanded into the community-based *Jamkesmas* system in 2008, both of which were designed as social 'health insurance for the poor'. Despite this initial focus, an alliance of civil society protests, parliamentary action, and support from international organisations pushed for the fundamental reform of the social security system in 2011, leading to the new national health insurance *Jaminan Kesehatan Nasional* that builds on non-profit principles and provides unified benefits to all Indonesian citizens (Pisani, Kok, and Nugroho 2016).

of care for poor and rural populations led to a long-term persistence of healthcare inequalities between the public and private sectors (Lawton 2015; Cross, De La Cruz, and Dent 2019).

4.3 Independent variables: Government ideology and electoral volatility

The independent variables of interest are largely drawn from the *Varieties of Democracy* (V-Dem) dataset version 14 (Coppedge et al. 2024). To measure government partisanship, I use the *Government Coalition Left-Right Index* (GCLRI, *v2xpas_economic_government*). The index is a weighted average of the strengths and ideological leanings of all parties in government, measured at the time of elections (Angiolillo and Wiebrecht 2023). In reflecting the inherent multidimensionality and continuity of party and government ideologies, the index varies between -4 (very left-leaning) and +4 (very right-leaning). The right-left classification within the V-Dem dataset is based on parties' economic positions regarding taxation, regulation, government spending, and the broader role of the state versus the market.

This operationalisation of government partisanship differs from other recent studies of social policy expansion in the Global South, which often focus on the ideology of the largest government party or the president, and use a simple binary or ordinal scale (Brooks 2015; Altman and Castiglioni 2020; Obinger and Schmitt 2022). The GCLRI is preferred for the context of this paper for several reasons. Firstly, because it captures the overall configuration of legislative power, which is likely to be more important for the politics of welfare expansion than the simple ideological leanings of the largest party or the president. This is especially the case when reforms require legislative approval or when the executive faces constraints from coalitional dynamics. Secondly, the index enables greater variation in government partisanship by reflecting the strength of ideological leanings, for example, in distinguishing between far-left and centre-left governments. Thirdly, focusing on economic rather than socio-cultural issues for the right-left classification is central to enabling cross-regional comparisons of government ideologies across the highly diverse sample. While the general applicability of right and left political categories has been questioned in Global South contexts, the focus on the role of the state in the economy is a common ideological foundation across a range of very different political systems (Freire and Kivistik 2013; Shim 2020).

The second key explanatory variable in this study is electoral volatility, which captures the shifting patterns of political support between elections. I employ parliamentary election data

from the V-Party dataset (Lindberg et al. 2022) to calculate the electoral volatility index based on Pedersen (1979). The index sums the net electoral losses and gains of all political parties between elections, ranging from 0 (no change from the last election) to 100 (complete turnover from the last election). This measure reflects the degree of electoral instability faced by incumbent governments and, by extension, the political incentives for vote-maximising behaviour, programmatic appeals, and broad-based reforms.

The electoral volatility index can be calculated using either voting shares (*v2pavote*) or the resulting seat shares (*v2paseatshare*) in parliament. In this paper, I employ seat share volatility for two reasons. Firstly, it has significantly better coverage than voting shares – both due to data limitations and instances where parties run as part of electoral alliances and receive no individual votes. Secondly, because it captures the impact of non-voting and excludes vote switching that has no impact on the seat distribution (Immergut and Abou-Chadi 2014). Since governments' ability to implement policy reforms depends on their parliamentary representation – not just their share of the vote – I assume that incumbents are more responsive to fluctuations in seat distributions rather than in raw vote shares. In calculating a global measure of electoral volatility based on parliamentary shares, this study is one of the first approaches to employ the V-Party dataset to operationalise political competition across a broad sample of countries in the Global South.

To ensure comparability across electoral systems and account for institutional differences in levels of volatility, I further include the widely used *political competition* variable (*e_polcomp*) from the Polity 5 dataset as a control (Marshall and Gurr 2020). The ordinal variable ranges from 1 (Repressed Competition) to 10 (Institutionalised open electoral participation) and captures the level of institutionalisation and restrictions on political competition. Whereas electoral volatility measures realised shifts in party support across elections, the institutional political competition variable captures the 'openness' of the electoral arena – such as legal barriers to party formation or limitations on opposition activity – that may affect baseline volatility levels across political systems. While potentially overconservative, this approach is particularly important given the broad range of regime types and electoral systems included in the sample, while also allowing for clearer identification of the effects of volatility rather than the effect of openness per se.[131]

[131] Importantly, the two variables are not necessarily correlated: a country may have high institutional competition but low volatility (for example, in stable multiparty democracies) or low institutional competition and high volatility (such as party-fragmented electoral authoritarian regimes).

4.4 Mediating and control variables

Having established the two key explanatory variables, I employ two mediating factors in the analysis: healthcare privatisation and labour union strength. Healthcare privatisation is measured as the share of private spending in total health expenditure – building on the underlying assumption that the private-public mix of healthcare provision also reflects the political influence of private providers on policymaking. Data on private healthcare spending is drawn from the Global Health Spending database by combining out-of-pocket and prepaid private health expenditure (Global Burden of Disease Collaborative Network 2025). Labour union strength is measured by the *trade union engagement* variable (*v2catrauni*) from the V-Dem dataset, which estimates the proportion of the population engaged in labour unions (Coppedge et al. 2024).[132] The underlying assumption is that higher rates of unionisation translate to greater political power for organised labour when controlling for underlying institutional and regime characteristics.

The analysis also controls for a variety of potential confounding variables. In line with other recent approaches, [133] I include the level of economic development (GDP per capita in Purchasing Power Parity), economic growth (annual GDP growth), inflation (annual change in GDP deflator), population size, rural population, age dependency ratio (population under 15/over 65 divided by working age population), and regime type. While theory suggests that economic indicators such as GDP growth and low inflation should be associated with social policy expansion (Wilensky 1975), larger populations, greater rural dispersion, and higher dependency ratios may affect a country's ability to implement and finance comprehensive healthcare reforms on a national scale. These statistics are drawn from the World Bank's World Development Indicators database and the UN DESA World Population Prospects.

To take into account the influence of international stakeholders on national policymaking, the analysis controls for the level of development assistance for health. As many countries in the Global South depend on development aid to fund their welfare programmes, the financial dependence on international and bilateral donors is often coupled with significant influence on domestic policy decisions – for example, directly through loan conditionalities, technical assistance, and donor priorities, or indirectly via norm diffusion. The data for this control

[132] Using an ordinal scale from 0 (virtually no unionisation) to 4 (a very large share of the population). An alternative approach is to use unionisation data reported by the International Labour Organisation; however, this dataset suffers from significant limitations in both national and yearly coverage.
[133] See, for example, Brooks (2015), Altman and Castiglioni (2020), and Obinger and Schmitt (2022).

variables is sourced from the *Development Assistance for Health* (DAH) database, which provides estimates for the amount of grants and loans provided for health projects from international and bilateral donors in low- and middle-income countries (Institute for Health Metrics and Evaluation (IHME) 2025).

Building on the outlined democracy-welfare literature, I further control for differences in regime types that go beyond electoral institutions by drawing on the *Regimes of the World* measure in the V-Dem dataset, which classifies countries in four categories from closed autocracy to liberal democracy (Lührmann, Tannenberg, and Lindberg 2018). Additionally, by drawing on a broader literature on policy diffusion and on the results of related studies (Schmitt et al. 2015; Obinger and Schmitt 2022), I include a measure of policy diffusion in the share of other countries in the region that have previously adopted universal/segmented reforms. To further account for potential regional trends, I employ regional fixed effects for all world regions.

Summary statistics for all dependent and independent variables for the sample period from 1990 to 2023 are presented in Table 1.

Table 1. Summary statistics

	Mean	Standard Deviation	Minimum	Maximum	Obser-vations	Countries
Dependent variables						
Universal healthcare reform	0.019	0.14	0	1	2450	90
Segmented healthcare reform	0.020	0.14	0	1	2244	90
Explanatory variables						
Government Coalition Left-Right Index	0.20	1.17	-3.42	2.98	2626	86
Electoral Volatility Index	13.32	12.55	0	68.1	2745	86
Institutional Political Competition	6.22	2.80	1	10	2952	90
Mediating variables						
Trade union engagement (V-DEM)	0.25	1.19	-3.15	3.34	2974	88

Private health spending (in % of total)	50.81	16.68	0.50	93.70	2587	90
Control variables						
Development Assistance for Health (in millions)	138.7	225.7	0	2303.8	2942	90
GDP per capita (PPP, in thousand USD)	8337.5	7985.7	534.8	57,465.2	2921	90
Economic growth (annual, in %)	3.92	7.0	-51.0	149.9	2962	90
Inflation (annual change in GDP deflator)	46.78	559.7	-31.56	26,762.0	2962	90
Population (in millions)	56.93	185.9	0.28	1438.1	3032	90
Rural population (in % of total population)	53.09	21.03	4.23	94.58	3032	90
Age dependency ratio (in %)	72.88	18.65	29.16	118.5	3032	90
Regime type	1.29	0.76	0	3	2977	90
Regional diffusion (% of adopters in the region)	19.46	19.93	0	72.7	3032	90

4.5 Limitations

While this study employs a robust empirical strategy and expands upon existing approaches in terms of variable selection, several limitations must be acknowledged. Although event history analysis and the random-effects model account for time dependence and country-level heterogeneity, the analysis remains observational and should not be interpreted as establishing causality. In particular, two key endogeneity concerns remain: simultaneity and omitted variable bias. While reverse causality is unlikely given the research design, political actors may still anticipate reform and adjust their behaviour accordingly. For example, labour unions may intensify mobilisation, or international organisations may increase development assistance in expectation of policy change. Similarly, while the analysis employs a variety of alternative explanatory variables and robustness checks, there remains a risk that unobserved factors—such as public sentiment, media influence, or elite bargaining—simultaneously drive both healthcare reform adoption and electoral volatility.

Beyond interpreting the results as observational, several limitations related to variable measurement and data selection need to be considered. Firstly, the measure of electoral volatility captures only parliamentary dynamics and not broader contestation in other political realms. It does not account for political competition in other electoral contexts, such as presidential elections, in non-electoral settings, such as public debate or protests, or within parties themselves. Additionally, the measure of government ideology (the *Government Coalition Left-Right Index*) relies on retrospective expert assessments, which may introduce endogeneity concerns if past policy actions, including on healthcare reforms, shape how experts evaluate a government's ideological position. Similarly, the variable on labour union strength assumes that higher union engagement translates into greater political influence; however, this relationship may vary depending on legal frameworks and state-labour relations, for example, in the case of publicly mandated union membership.

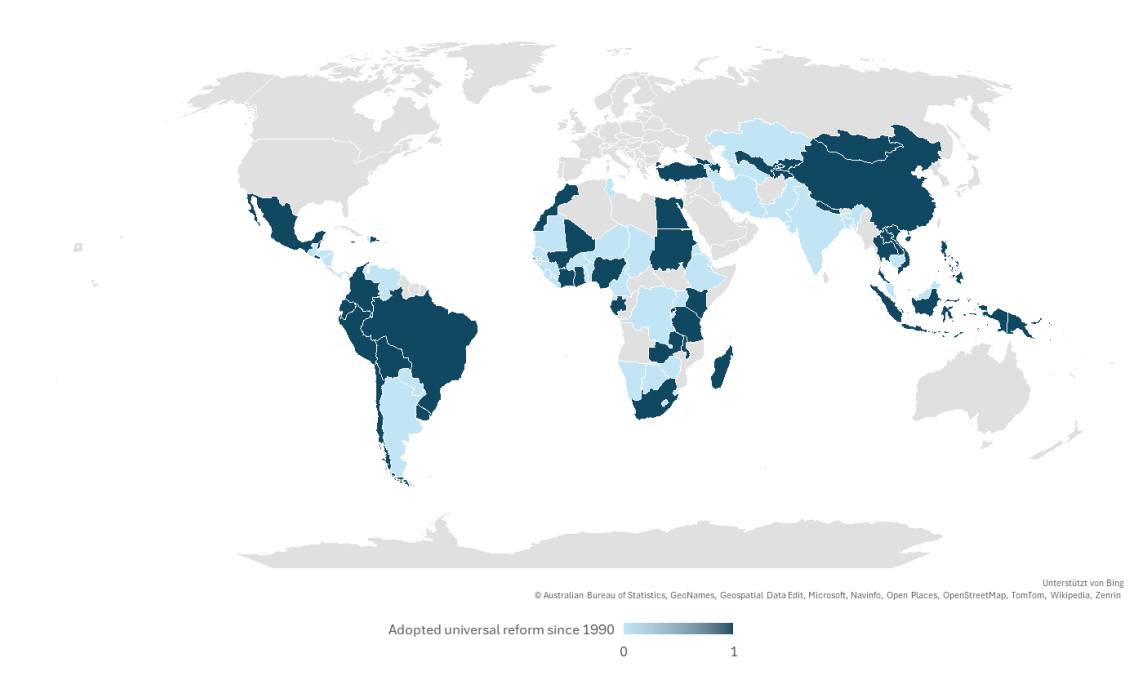
These limitations emphasise the challenges of capturing complex political and institutional dynamics with available internationally comparative data. However, by employing extensive robustness checks and acknowledging these limitations, I aim to mitigate some concerns and provide relevant context for interpreting the results.

5. Results

5.1 Descriptive analysis

5.1.1 Trends in healthcare reforms

Figure 3. Countries adopting universal healthcare reforms since 1990



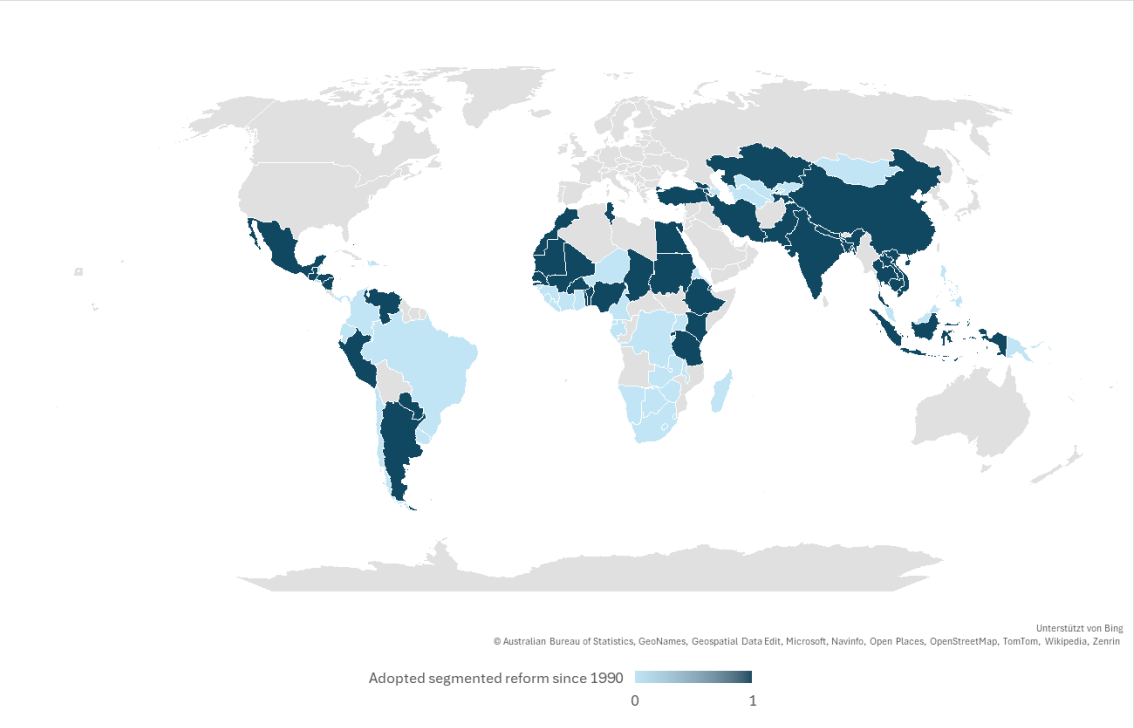
Based on the newly created dataset for this paper, Figure 3 presents the map of countries that have adopted at least one universal healthcare reform since 1990, such as the creation of a national health insurance.[134] Importantly, as highlighted in Section 4.2, this solely captures the fact of a country legally adopting reform, but not its effectiveness or implementation. This highlights two interesting descriptive findings. Firstly, contrary to potential expectations, universal healthcare reforms are prevalent throughout the world and are not limited by region or economic status. Secondly, in line with findings from the literature on social policy diffusion (Brooks 2015; Schmitt et al. 2015), regional clusters of adopting countries exist in Latin America, East Africa, and Southeast Asia.

Overall, since 1990, 46 countries across all world regions have adopted a health systems reform that unified existing benefits or created a new universal system of national healthcare provision. While especially common in Latin America, countries in all parts of Asia and Africa

[134] As they constitute a fundamental restructuring of the healthcare sector, these reforms are relatively rare in the sample and only two countries (Côte d'Ivoire and the Philippines) adopted more than one universal reform during the sample period.

have followed reform trajectories towards equity in healthcare. It is particularly interesting that a substantial number of African countries have taken steps towards universalising their healthcare systems, especially in recent years, with prominent cases such as Nigeria in 2022 and Tanzania and South Africa in 2023. A similar trend can be observed in Southeast Asia during the 2010s, with countries like Laos, Indonesia, Nepal, and the Philippines creating different forms of national health insurance.

Figure 4. Countries adopting segmented healthcare reforms since 1990



By contrast, Figure 4 displays the countries that adopted a segmented health system reform since 1990 – such as creating a separate health insurance for 'the poor' or a multi-tiered system of provision based on socio-economic status.[135] In total, 44 countries adopted such segmented policy changes over the sample period. Several regional clusters emerge, with groups of countries in South and Central Asia, Central America, and West and East Africa following similar reform trajectories.[136]

[135] In comparison to universal reforms, there are a few countries that adopted more than one segmented reform over the sample period: Bolivia, Cambodia, China, Georgia, Iran, and Kazakhstan.
[136] The trends of healthcare privatisation and segmentation have been extensively discussed in the literature on healthcare reform in post-Soviet countries (Balabanova et al. 2012; Rechel, Richardson, and McKee 2014; Semenova et al. 2024).

Importantly, both types of reforms are not mutually exclusive. A substantial number of countries adopted both universal and segmented expansions at different points in time, though not simultaneously, during the sample period. Most commonly, countries follow a trend of adopting a segmented approach first – such as residual community-based health insurance or 'indigent insurance' – and later reforming this towards a more unified system. Examples include Morocco which introduced the *Assurance Maladie Obligatoire* (AMO) and *Régime d'Assistance Médicale* (RAMED) as two separate health insurance systems for formal and informal workers in 2005, which were later unified into the *AMO-Tadamon* programme in 2022 (Harfaoui et al. 2024); or Nigeria which launched the unsuccessful *National Health Insurance Scheme* in 1999 that created a tiered system of provision with a focus on formal workers and private provision, but later adopted the ambitious *National Health Insurance Authority Act* in 2022 that introduced mandatory health insurance, guaranteed a minimum package of services, and integrated all existing health insurance schemes (Ilesanmi, Afolabi, and Adeoya 2023).

Figure 5. Trends in healthcare reforms since 1990

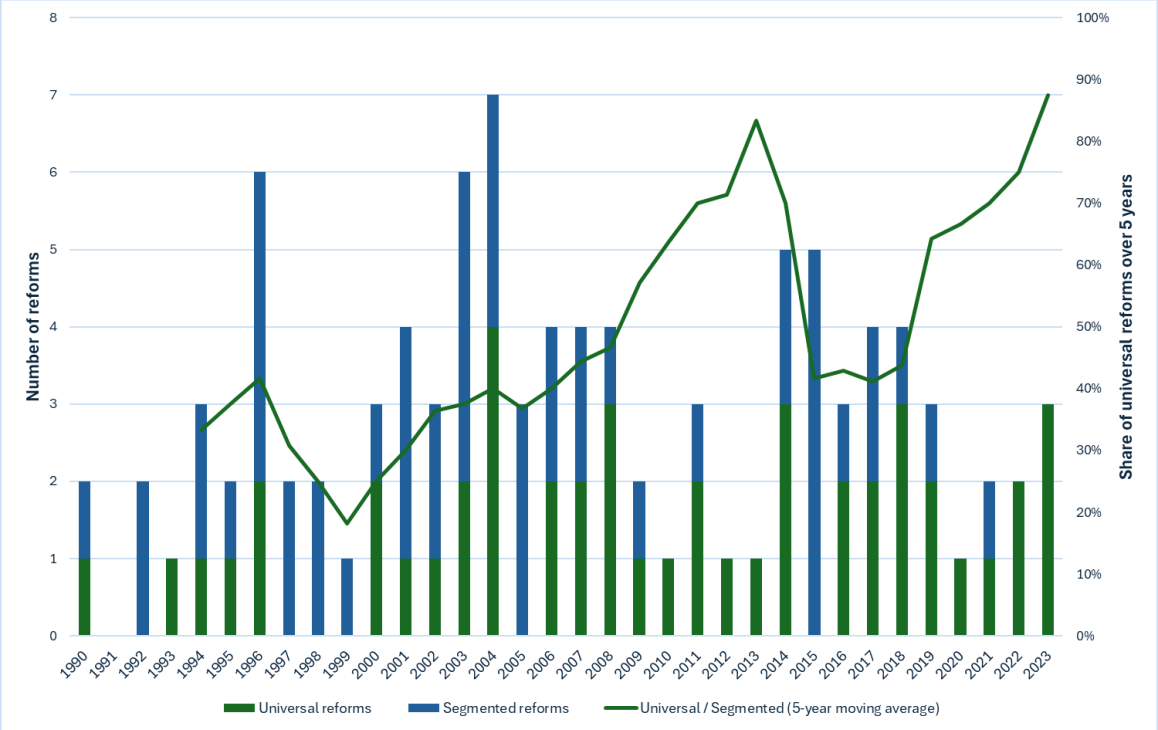
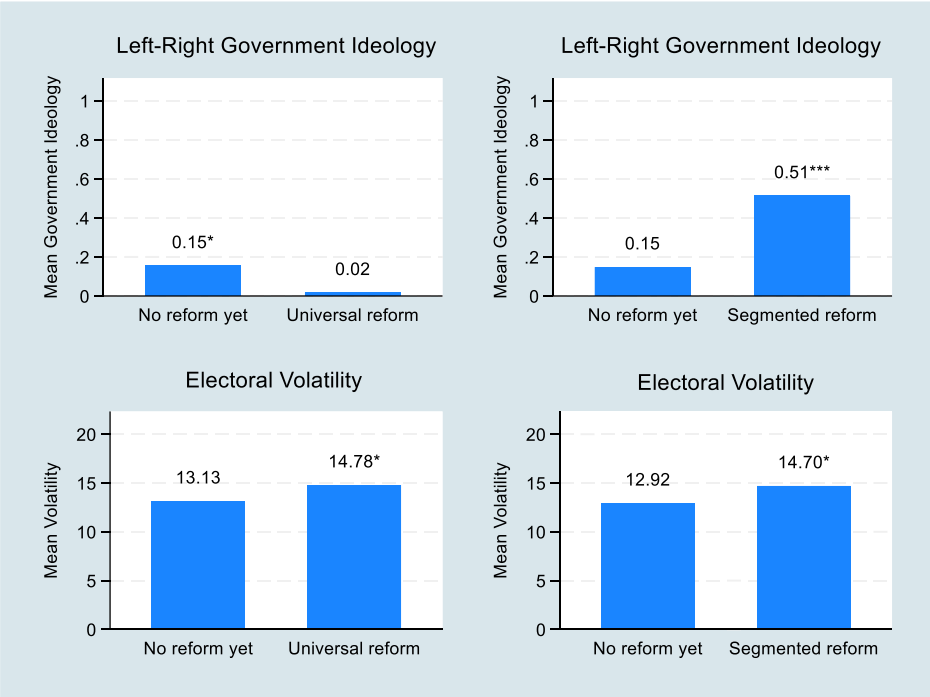


Figure 5 illustrates the distribution of healthcare reforms over time. The blue and green bars represent the types of reforms adopted each year across the sample, while the green line depicts the five-year moving average of the share of universal reforms. The timeline highlights an overall increase in the number of reforms, with comparatively few countries changing their

healthcare systems during the 1990s, to high levels of reform activity in the 2000s and the late 2010s. Furthermore, except for two periods of reversal in the late 1990s and the late 2010s, there has been a steady rise in the share of universal reforms, which has recently reached its highest level. This pattern appears in line with a wider trend towards the universalisation of welfare services in the Global South, as expressed in the Sustainable Development Goals and related policy action (see Chapter 1 for details).

5.1.2 Mean comparison of explanatory variables

Figure 6. Political variables by reform status



To further motivate the event history analysis and provide an overview of the variation in the sample, Figures 6 and 7 present mean comparisons for key variables of interest in country-years where a reform was adopted and country-years when no reform was adopted.[137] To capture differences across reform types, the comparisons are presented side by side, with universal reforms on the left and segmented reforms on the right. For each variable, the significance stars on the reform bar illustrate the results of a two-sided t-test for mean differences. While the results of this simple descriptive analysis should not be overstated, as it does not control for any confounding factors, regional or time trends, the analysis highlights some interesting baseline findings.

[137] This also includes countries which never reformed over the sample period.

Figure 6 presents the key political variables of interest: government partisanship and electoral volatility. Starting with partisanship, the results indicate a baseline difference in government ideology for universal and segmented reform adoption. In line with my underlying theoretical expectations of partisanship-based policy preferences, universal reforms are more likely to be adopted by left-wing governments and vice versa, with both significance and magnitude higher for segmenting reforms.[138] Considering political contestation, there is a common baseline difference in the electoral volatility index, which represents the sum of all gains and losses by political parties in the last election, across both universal and segmented reforms. In both cases, electoral volatility is higher in years when reforms are adopted, potentially suggesting general electoral motives to pursue large-scale health system reforms.

Figure 7. Interest-group variables by reform status

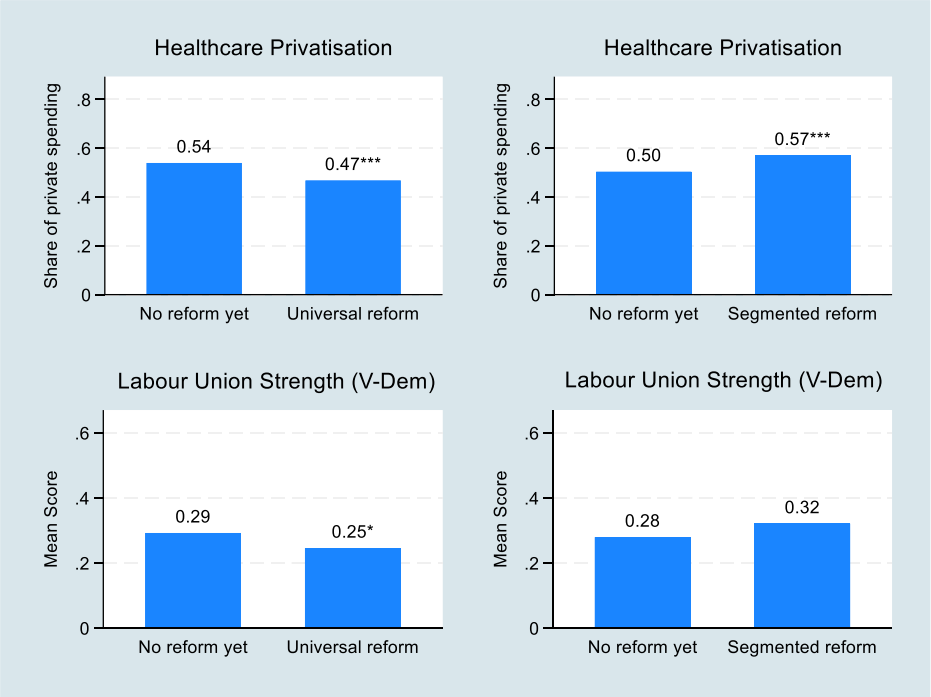


Figure 7 presents mean comparisons for the key interest group variables. Most notably, there is a highly significant difference in the level of healthcare privatisation between reform types. While universal reforms tend to be adopted in contexts of lower private sector provision, segmented reforms are more likely to occur in more privatised healthcare systems. This striking pattern emphasises the importance of considering interest groups in the analysis of healthcare reform dynamics and raises concerns about the potential long-term effects of

[138] Regarding the magnitude, it is important to keep in mind that the underlying variable, the Government Coalition Left-Right Index (Angiolillo and Wiebrecht 2023), is scaled from -4 to 4 and represents a weighted average of the strength and economic ideology of parties in government.

increasing trends of marketisation and private sector-led market development in healthcare (Béland and Gran 2008; Gingrich 2011). A similar, albeit weaker, pattern emerges for labour unions: the difference is statistically significant at the 95 percent confidence level for universal reforms and at the 90 percent level for segmented reforms. In line with theoretical expectations of their social protectionist role in Global South contexts, the mean comparisons indicate that universal reforms are adopted in the presence of weaker unions and segmented reforms in the context of stronger unions .

5.2 Event history analysis

Table 2 presents the central results of this paper. As previously outlined, I employ an event history analysis using a complementary log-log (cloglog) regression model to account for the rarity of the dependent variables across the sample. The table presents the results of a fully specified model that includes all relevant covariates, a logged time trend to account for temporal dependence, and fixed effects for world region and regime type to control for unobserved heterogeneity. The model specification was validated using a series of diagnostic tests and robustness checks, specifically on potential issues of multicollinearity given the large number of covariates. As is common in EHA, the coefficients are presented as odds ratios, with values over 1 indicating an increase in the likelihood of reform adoption and vice versa. Cluster robust standard errors are reported in parentheses. For ease of comparison, results for both dependent variables are presented next to each other.

The results provide strong empirical support for most of the hypotheses presented in Section 3.2, which are examined in turn through the following sub-sections.

Table 2. Complementary log-log regression model of reform adoption

	(1)	(2)
Dependent variable	Universal reform	Segmented reform
Government Left-Right Index	0.634***	1.392***
	(0.108)	(0.177)
Electoral Volatility Index	1.040****	0.990
	(0.0122)	(0.00969)
Institutional Political Competition	0.850	1.304***
	(0.106)	(0.126)
Trade Union Engagement	0.561**	1.025
	(0.161)	(0.224)
Private health spending (in % of total)	0.992	1.047****
	(0.0149)	(0.0111)

Development Assistance for Health (in million USD)	1.001** (0.000512)	1.000 (0.000588)
GDP per capita (in thousand USD, PPP)	0.942 (0.0370)	0.741**** (0.0282)
GDP growth (annual, in %)	1.010 (0.0258)	1.017**** (0.00434)
Inflation (Annual change in GDP deflator)	0.997 (0.00387)	0.983** (0.00688)
Population (in millions)	0.999* (0.000506)	1.002 (0.00497)
Rural population (in % of total)	0.987 (0.0223)	0.994 (0.0161)
Age dependency ratio (in % of working-age population)	0.980 (0.0192)	0.989 (0.0187)
Regional diffusion, lag (% of adopt. countries)	1.059* (0.0355)	1.035*** (0.0110)
Closed autocracy (Ref.: Electoral autocracy)	0.315 (0.273)	1.300 (0.409)
Electoral democracy	3.485** (2.155)	0.165**** (0.0581)
Liberal democracy	16.31** (17.95)	
Region fixed effects	Yes	Yes
Time trend: Log time	Yes	Yes
N (countries)	79	78
N (country-years)	1787	1473

Coefficients presented as odds ratios; cluster robust standard errors in parentheses.
* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$, **** $p < 0.001$

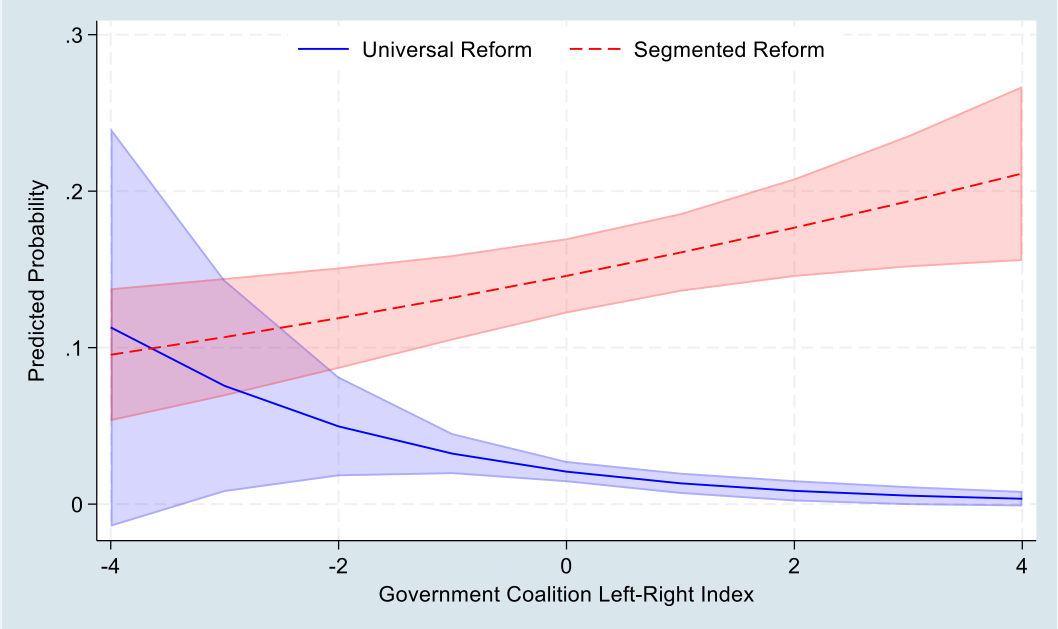
5.2.1 Hypothesis 1: The role of government ideology

In line with my theoretical expectations around the role of government ideology, there is a strong and highly significant association between left-leaning governments and the adoption of universal reforms, and between right-leaning governments and the adoption of segmented reforms. In terms of the effect size, the government ideology variable is scaled from -4 (most left-leaning, pro-state) to 4 (most right-leaning, pro-market). A one-unit increase in the government's ideological composition towards the right is associated with a 36.6 percent

lower likelihood of adopting a universal reform and a 39.2 percent higher likelihood of adopting a segmented reform. These are substantial effects.[139]

Figure 8 plots the predicted probabilities for both types of reform across the ideological spectrum, while holding all other covariates constant. The likelihood of universal reform adoption steeply declines as governments become more right-leaning, even reaching an asymptotic stage after the ideological centre, while the probability of adopting segmented reforms increases in a near-linear fashion with rising market orientation. This highlights a pronounced divergence in policy preferences across the ideological spectrum and hence provides robust support for *Hypotheses 1a* and *1b* that left-wing governments are significantly more likely to adopt universal reforms and right-wing governments favour segmented approaches to health system change.

Figure 8. Predicted probability of reform by government ideology



5.2.2 Hypothesis 2: The role of electoral volatility

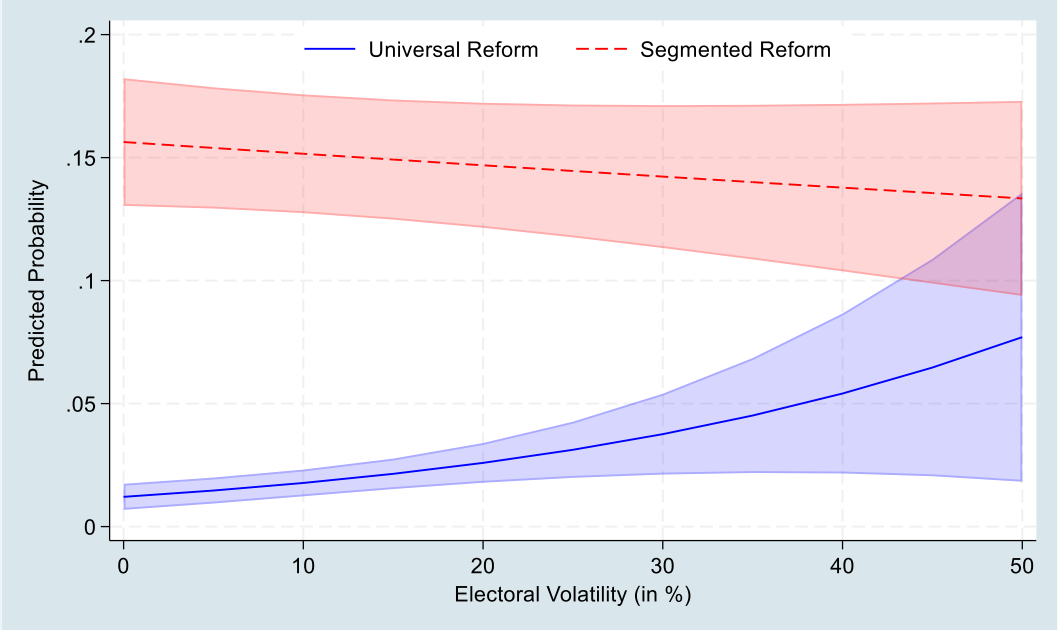
Continuing with the second hypothesis, the results provide strong evidence for the relevance of electoral dynamics for the adoption of universal – but not segmented – reforms. Confirming the theoretical expectations, electoral volatility is positively associated with the adoption of universal reforms at the 99.9 percent confidence level. This is a striking result, given that the

[139] Given that these are odds ratios, it is important to keep in mind that effect sizes relate to the baseline probability of adopting a universal or segmenting reform, which in is 1.9 and 2.0 percent, respectively.

model includes a wide range of political, social, and economic covariates, along with fixed effects for underlying institutional and regional diffferences. Notably, the relationship holds when controlling for levels of institutional political competition, which measure the formal openness and restrictions on electoral competition. While this control variable itself is significant for the likelihood of segmented reforms, potentially reflecting the salience of electoral threats, the results show that even among countries with similar levels of formal political contestation, electoral volatility is strongly linked to the adoption of universal reforms.

In terms of effect size, a one percent increase in electoral volatility is associated with a 4 percent increase in the likelihood of reform adoption. Figure 9 visualises predicted probabilities and shows how the likelihood of a universal reform substantially increases when elections become more volatile, especially from around the 30 percent mark upwards. The results provide strong empirical evidence for *Hypothesis 2* and support the argument that electoral competition encourages universal reforms as a highly visible vote-seeking signal of 'delivering development' for a broad-based electorate.

Figure 9. Predicted probability of reform by electoral volatility

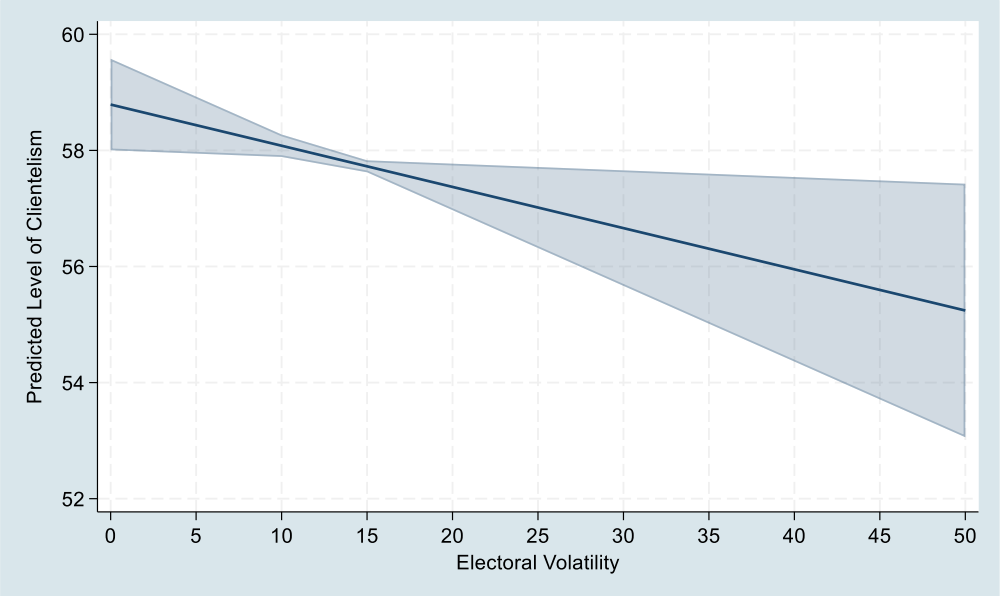


To further explore the hypothesised mechanism linking electoral volatility to the adoption of universal reforms, I examine whether higher volatility is associated with lower incentives for clientelist policymaking. Specifically, I test whether increases in electoral volatility are linked to reductions in clientelism. To ensure that this relationship is not driven by underlying

differences between countries or confounding factors, I focus on within-country changes over time and employ a fixed effects panel regression using the same specification as in the event history analysis.[140] As the dependent variable, I use the clientelism index (*v2xnp_client*) from the V-Dem dataset, aggregating three sub-indicators of vote-buying, particularism in public provision of goods, and clientelist party linkages (Sigman and Lindberg 2019).

The full regression results are presented in Appendix A. They reveal several expected patterns, such as a significantly negative association between clientelism and both economic development and democratisation. The key finding is illustrated in Figure 10: within-country increases in electoral volatility are significantly associated with declines in clientelism. While the magnitude of the effect is modest – with a one standard deviation change in electoral volatility associated with a 0.9 point reduction in the clientelism index – this finding is noteworthy given the large number of controls included and the broader trends of increasing rather than decreasing levels of clientelism across the sample period. While such an analysis cannot establish causality, it provides strong associational evidence consistent with the proposed mechanism that incentives for clientelist decline and opportunities for broad-based universal reforms emerge in volatile electoral environments.

Figure 10. Relationship between clientelism and electoral volatility



[140] Except for the regional diffusion variable and the time trend. Instead of fixed effects, I test a random effects specification, which leads to the same effect direction and significance of the electoral volatility coefficient.

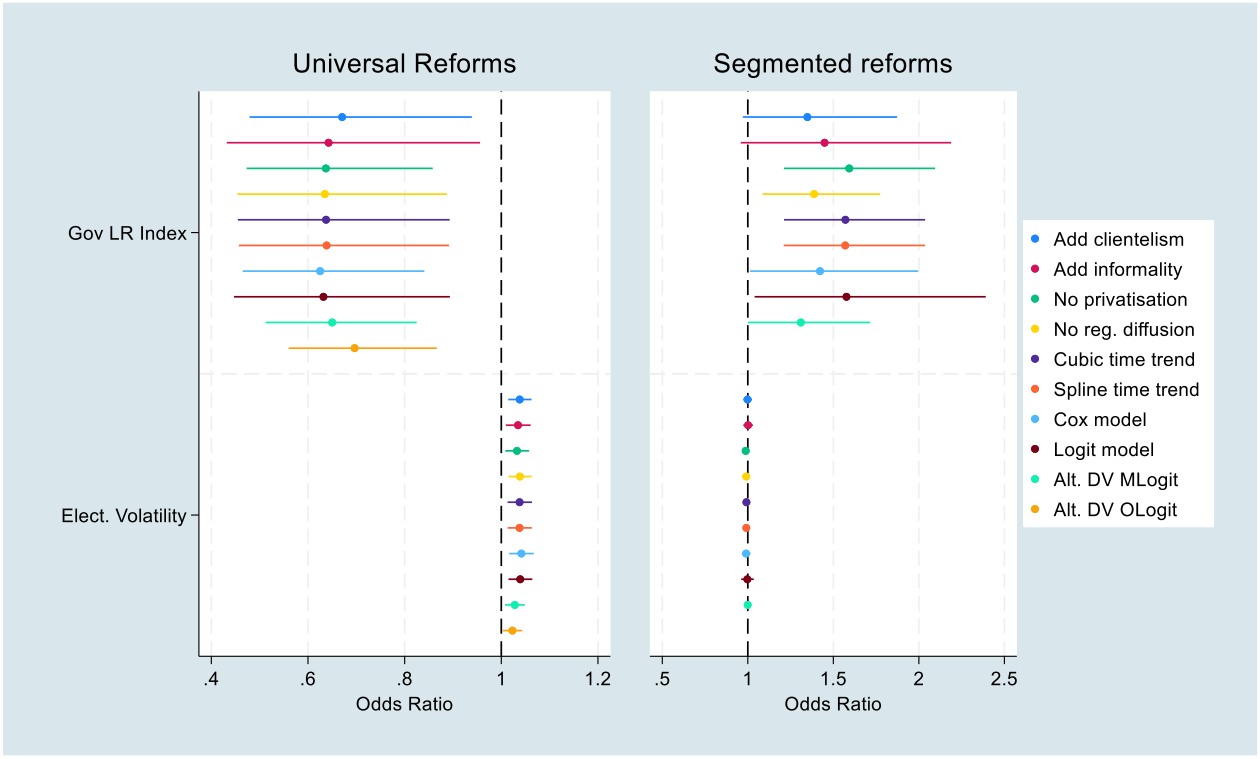
To assess the robustness of the core findings, I conduct a range of sensitivity checks, summarised in Figure 11. These tests vary the selection of control variables, time trends, model specifications, and operationalisation of the dependent variable. Firstly, I estimate two model specifications with additional controls that are not included in the baseline model for theoretical or practical reasons: clientelism, due to its hypothesised role as the underlying mechanism for electoral volatility, and informal employment, due to the limited availability of data. The informal employment data is sourced from the Informal Economy database (Elgin et al. 2021). Secondly, I test the selection of control variables by removing two predictors that could potentially be correlated with the core variables or the time trend, namely privatisation and regional diffusion. Thirdly, I test two alternative baseline hazard functions – cubic polynomials and time splines – in addition to two alternative estimators: a panel logit and a Cox proportional hazard model.

As a final robustness check, I test the conceptual and empirical choice to treat segmented and universal reforms as distinct outcomes rather than ends of a shared policy continuum. Therefore, I construct an alternative dependent variable that measures the direction of change from -1 (segmented reform), 0 (no reform), to +1 (universal reform) and test this using multinomial and ordered logit regressions.[141] To further address potential unobserved time-invariant heterogeneity, I estimate a linear fixed-effects regression using this alternative dependent variable, relying exclusively on within-country variation for estimation.[142] The full results of this most restrictive model specification are provided in Appendix B.

[141] The choice between the two models depends on assumptions around the nature of the policy continuum. While multinomial logits estimate relative differences between unordered outcomes, ordered logit models treat these as ranked along an underlying latent scale, assuming that the effect of predictors is proportional. While the multinomial logit appears to be more appropriate for the conceptual framework of universal and segmented expansion, both are presented here for completeness.

[142] Which was not possible using the Event History Analysis, as it removes all countries with no variation in the outcome variable (that is, countries with no reforms of one type).

Figure 11. Robustness of key predictors across model specifications



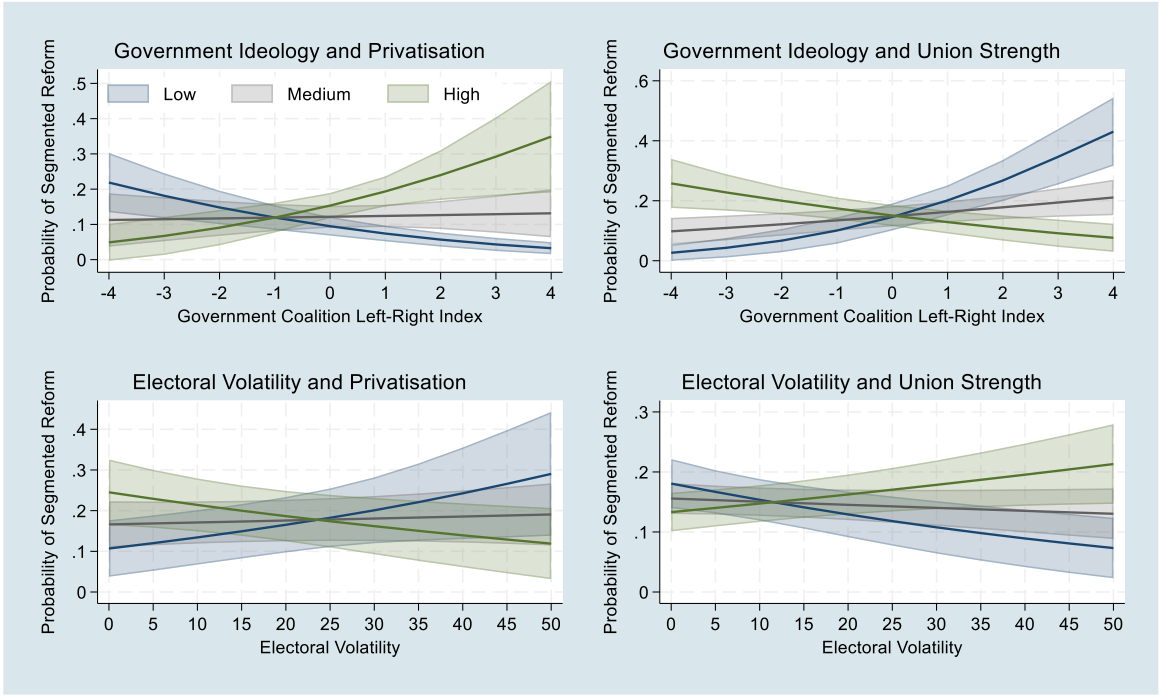
Across the extensive range of robustness checks, the direction and significance of all coefficients remain stable, with only one exception. In the model for segmented reforms, the government ideology index drops in significance just below the 95 percent confidence level when either clientelism or informal employment are included. In the case of clientelism, this is likely a reflection of the suggested theoretical mechanism or, alternatively, due to a positive association between right-wing governments and higher levels of clientelist politics. In the case of informality, the wider confidence interval appears mainly driven by a substantial reduction in sample size; however, it could also be indicative of lesser ideological differences in contexts of high administrative complexity when implementing reforms. Importantly, the results are robust to the use of the alternative dependent variable specification and the fixed-effects model, confirming that the main predictors consistently shape healthcare reform trajectories across both distinct and continuous conceptualisations, as well as under a wide range of modelling assumptions.

5.2.3 Hypothesis 3: The role of vested interests

Having established government ideology and political competition as key determinants of healthcare reform trajectories, I finally explore the role of vested interests. The baseline results (Table 2) reveal several findings in line with theoretical expectations. Most importantly,

the identified interest groups – labour unions, private healthcare providers, and international organisations – are all significantly associated with reform adoption, confirming their relevance as key stakeholders in political economy analyses of health system change. However, the influence of these vested interests differs based on the type of reform pursued. Trade union strength is significantly negatively associated with the likelihood of universal reform, providing empirical support for a social protectionist role of organised labour that focuses on protecting existing benefits and healthcare privileges. Higher levels of healthcare privatisation are significantly positively associated with a greater likelihood of segmented reform, aligning with theoretical expectations that business interests favour policies maintaining socio-economic hierarchies in provision. Perhaps more unexpectedly, development assistance for health –though small in magnitude – is positively associated with the likelihood of universal reform adoption. This finding supports earlier research around the role of international organisations as potential agents of policy diffusion (Béland and Orenstein 2013; Obinger, Schmitt, and Starke 2013; Schmitt et al. 2015). Interestingly, this effect is only significant for universal reforms, suggesting that national factors may play a stronger role in segmented policy expansions.

Figure 12. Mediating role of vested interests in segmented reform adoption



To provide more nuance to these results, I examine the interaction between vested interests and the two key variables of government ideology and electoral competition. Therefore, I re-estimate the baseline specification for both types of reform, incorporating relevant

interaction factors, to examine whether the role of interest-based factors differs based on government partisanship or political volatility. The full regression results are presented in Appendix C.

Regarding universal reforms, all interaction factors are insignificant, and the baseline results remain largely unchanged. This suggests that the influence of vested interests operates independently of government ideology or the level of political competition, potentially due to the comprehensive nature of a potential broad-based reform. In contrast, all interaction factors are significant for the adoption of segmented reforms, as illustrated in Figure 12. The results show that, for segmented reforms, the strength of vested interests dampens or even reverses the baseline effects of political variables. In particular, the finding reinforces the alignment between right-wing governments and private sector interests, and left-wing governments and organised labour. Right-wing governments are even more likely to adopt segmented reforms in the context of high privatisation, while left-wing governments surprisingly turn in favour of segmented reforms when faced with strong trade unions. Similarly, the role of electoral volatility appears to be mediated by the configuration of interest groups: in contrast with the baseline results, electoral volatility emerges as a significant predictor of segmented reform in contexts of high labour union strength or low privatisation, potentially reflecting the general effect of electoral pressures on increasing the political demand for reform, regardless of its distributive scope. Overall, this analysis emphasises how the influence of vested interests shapes political dynamics, particularly in the case of segmented reforms that are likely more susceptible to group-based bargaining and selective policy design.

6. Conclusion

This paper set out to explain why governments in the Global South follow different reform trajectories for expanding access to healthcare, with some pursuing universal systems that aim to provide equity in provision for all, and others adopting segmented approaches that maintain socio-economic inequalities in healthcare access and quality. By considering healthcare expansion as an inherently political process, I employ a political economy framework that theorises reform trajectories to be shaped by electoral incentives, ideological preferences, and the influence of vested interests. I suggest that democratisation can advance the adoption of universal policies through two processes: firstly, through the alignment of policy preferences of left-wing governments and a newly enfranchised electorate, and secondly, through increasing electoral volatility, which increases the political costs of clientelism and the appeal of policies demonstrating a commitment towards 'delivering development' for broad-based constituencies.

By introducing the conceptual distinction between universal and segmented reforms based on their implications for equity in provision, the paper employs a new lens for analysing processes of healthcare expansion. Operationalising this conceptual lens, I construct an original dataset of healthcare system reform across 90 countries in the Global South from 1990 to 2023. The descriptive data reveals compelling trends in global policy adoption, with an increasing share of countries pursuing universal healthcare expansions across all world regions, institutional settings, and socio-economic contexts – emphasising that equitable policy change is possible at all levels of development.

The findings of the event history analysis provide strong support for the theorised relationship and the central role of politics in shaping healthcare expansion trajectories across the world. Left-wing governments and electoral volatility emerge as significant predictors of universal reform adoption, even when controlling for an extensive range of covariates and fixed effects. On the other hand, right-wing governments are significantly associated with the likelihood of segmented reforms, while political competition plays a less important role. Both findings are notably robust to a large number of alternative model specifications, measurements, and estimators. Furthermore, a complementary analysis connects within-country changes in electoral competition to decreasing levels of clientelism, thereby providing supporting evidence for the suggested theoretical mechanism. Finally, confirming their status as key stakeholders in healthcare reform processes, both labour unions and private healthcare providers emerge as significant social protectionist forces, reducing the likelihood of

universal reforms. In the case of segmented reforms, their role interacts with government ideology and electoral volatility, dampening or even reversing the baseline relationships on reform adoption.

Building on these rich empirical findings and methodological innovations, there are several promising avenues for future research. Firstly, while this paper focuses on political factors, a follow-up study could conduct a closer investigation of the socio-economic determinants for each type of reform. For example, while economic growth and inflation emerged as significant covariates in this analysis, future research could examine the underlying macro-economic factors and growth models that may support different types of policy expansion, including the role of international trade, natural resources, or labour market configuration. Relatedly, the current analysis could be expanded by explicitly addressing the role of public opinion and policy feedback effects. Linking these results with the wider political economy of redistribution, future research could investigate the determinants and consequences of different types of reforms on public attitudes towards solidarity, fairness, and trust. Thirdly, an unexpected finding of this analysis is the positive association between health-related development assistance and universal reform adoption. Future analysis could investigate the potential heterogeneity in this relationship by exploring the effect of different donors, areas of intervention, or types of assistance, as well as other factors associated with development assistance, such as potential aid dependence or conditionalities.

Beyond these analytical extensions, there is also considerable scope to expand the reform dataset. Future versions could be expanded with data on reform implementation, funding structures, and specific target groups, enabling a more granular analysis of implications for equity and policy effectiveness. A further promising research agenda would be to apply this framework to other social policies – such as social protection, pensions, or education – where the political economy of universalism and segmentation might differ due to variations in welfare norms, vested interests, and government involvement. The current findings could be further complemented by more regional or sub-regional studies. Given the recent proliferation of universal healthcare reforms in countries like Tanzania, South Africa, and Zambia, Sub-Saharan Africa presents a promising regional case study.

The findings of this study emphasise a central insight: the path to universal healthcare is not merely a question of resources or capacity, but of political choice. Reforms are neither politically neutral nor inevitable. Instead, they are contingent on how power, ideology, and interests align in shaping who gets access to care, and on what terms.

7. References

Acemoglu, Daron, Suresh Naidu, Pascual Restrepo, and James A. Robinson. 2019. 'Democracy Does Cause Growth'. *Journal of Political Economy* 127(1): 47–100.

ADB. 2023. *The Evolution of Mongolia's Health Care System: Reform, Results, and Challenges on the Road to a Healthier Population*. Manila: Asian Development Bank.

Agafitei, Gabriela Alondra. 2023. 'El Sistema Universal de Salud Boliviano y El Acceso Efectivo a La Atención Sanitaria: Un Diagnóstico'. *Revista Latinoamericana de Desarrollo Económico* 21(39).

Agyepong, I. A., and S. Adjei. 2008. 'Public Social Policy Development and Implementation: A Case Study of the Ghana National Health Insurance Scheme'. *Health Policy and Planning* 23(2): 150–60.

Ahmed, Syed Masud, Bushra Binta Alam, Iqbal Anwar, Tahmina Begum, Rumana Huque, Jahangir AM Khan, Herfina Nababan, and Ferdaus Arfina Osman. 2015. 'Bangladesh Health System Review'. *Health Systems in Transition* 5(3).

Ahmedov, Mohir, Bernd Rechel, Vasila Alimova, and Ravshan Azimov. 2007. 'Primary Health Care Reform in Uzbekistan'. *The International Journal of Health Planning and Management* 22(4): 301–18.

Alhassan, Robert Kaba, Edward Nketiah-Amponsah, and Daniel Kojo Arhinful. 2016. 'A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects?' *PLOS ONE* 11(11): e0165151.

Allison, Paul D. 1984. *Event History Analysis: Regression for Longitudinal Event Data*. Newbury Park: Sage.

Altman, David, and Rossana Castiglioni. 2020. 'Determinants of Equitable Social Policy in Latin America (1990–2013)'. *Journal of Social Policy* 49(4): 763–84.

Angiolillo, Fabio, and Felix Wiebrecht. 2023. 'From Individual Parties to Party Systems: A New Approach to Calculate Party Systems' Variables'. *V-Dem Working Paper* 146.

Ansell, Ben W. 2008. 'Traders, Teachers, and Tyrants: Democracy, Globalization, and Public Investment in Education'. *International Organization* 62(2): 289–322.

Anttonen, Anneli, and Jorma Sipilä. 2014. 'Varieties of Universalism'. *Draft paper prepared for the UNRISD Conference "New Directions in Social Policy: Alternatives from and for the Global South."*

Aspinall, Edward. 2014. 'Health Care and Democratization in Indonesia'. *Democratization* 21(5): 803–23.

Backman, Gunilla, Paul Hunt, Rajat Khosla, Camila Jaramillo-Strouss, Belachew Mekuria Fikre, Caroline Rumble, David Pevalin, et al. 2008. 'Health Systems and the Right to Health: An Assessment of 194 Countries'. *The Lancet* 372(9655): 2047–85.

Balabanova, Dina, Bayard Roberts, Erica Richardson, Christian Haerpfer, and Martin McKee. 2012. 'Health Care Reform in the Former Soviet Union: Beyond the Transition'. *Health Services Research* 47(2): 840–64.

Bangura, Yusuf, ed. 2007. *Democracy and Social Policy*. Basingstoke: Palgrave Macmillan.

Barrientos, Armando. 2022. 'Social Investment and Social Assistance in Low- and Middle-Income Countries'. In *The World Politics of Social Investment: Volume I*, eds Julian L. Garritzmann, Silja Häusermann, and Bruno Palier. New York: Oxford University Press, 173–93.

Bautista, Maria Cristina G., Paulyn Jean Acacio-Claro, Nori Benjamin Mendoza, Christian Pulmano, Maria Regina Justina Estuar, Manuel M. Dayrit, Vincent Edward Festin, et al. 2022. 'The 2019 Philippine UHC Act, Pandemic Management and Implementation Implications in a Post-COVID-19 World: A Content Analysis'. *International Journal of Environmental Research and Public Health* 19(15): 9567.

Bayked, Ewunetie Mekashaw, Husien Nurahmed Toleha, Seble Zewdu Kebede, Birhanu Demeke Workneh, and Mesfin Haile Kahissay. 2023. 'The Impact of Community-Based Health Insurance on Universal Health Coverage in Ethiopia: A Systematic Review and Meta-Analysis'. *Global Health Action* 16(1): 2189764.

Beck, Nathaniel, Jonathan N. Katz, and Richard Tucker. 1998. 'Taking Time Seriously: Time-Series-Cross-Section Analysis with a Binary Dependent Variable'. *American Journal of Political Science* 42(4): 1260.

Béland, Daniel. 2005. 'Ideas and Social Policy: An Institutionalist Perspective'. *Social Policy and Administration* 39(1): 1–18.

Béland, Daniel, and Brian Gran, eds. 2008. *Public and Private Social Policy*. London: Palgrave Macmillan.

Béland, Daniel, and Mitchell A. Orenstein. 2013. 'International Organizations as Policy Actors: An Ideational Approach'. *Global Social Policy* 13(2): 125–43.

Bernales-Baksai, Pamela. 2020. 'Tackling Segmentation to Advance Universal Health Coverage: Analysis of Policy Architectures of Health Care in Chile and Uruguay'. *International Journal for Equity in Health* 19(1): 106.

Bicaba, Frank, Lalique Browne, Kadidiatou Kadio, Alice Bila, Abel Bicaba, and Thomas Druetz. 2020. 'National User Fee Abolition and Health Insurance Scheme in Burkina Faso: How Can They Be Integrated on the Road to Universal Health Coverage without Increasing Health Inequities?' *Journal of Global Health* 10(1): 010319.

Bilo, Charlotte, Anna Carolina Machado, and Fabianna Bacil. 2020. *Social Protection in Sudan—System Overview and Programme Mapping*. Brasília: International Policy Centre for Inclusive Growth, Sudan's Ministry of Labour and Social Development and United Nations Children's Fund.

Bleck, Jaimie, and Nicolas Van De Walle. 2013. 'Valence Issues in African Elections: Navigating Uncertainty and the Weight of the Past'. *Comparative Political Studies* 46(11): 1394–1421.

Bleck, Jaimie, and Nicolas Van De Walle. 2018. *Electoral Politics in Africa since 1990: Continuity in Change*. Cambridge: Cambridge University Press.

Bloom, David E., Alexander Khoury, and Ramnath Subbaraman. 2018. 'The Promise and Peril of Universal Health Care'. *Science* 361(6404): eaat9644.

Blossfeld, Hans-Peter, Götz Rohwer, and Thorsten Schneider. 2019. *Event History Analysis with Stata, 2nd Edition*. London: Routledge.

Bodhisane, Somdeth, and Sathirakorn Pongpanich. 2022. 'The Influence of the National Health Insurance Scheme of the Lao People's Democratic Republic on Healthcare Access and Catastrophic Health Expenditures for Patients with Chronic Renal Disease, and the Possibility of Integrating Organ Transplantation into the Health Financing System'. *Health Research Policy and Systems* 20(1): 71.

Böger, Tobias, and Lutz Leisering. 2020. 'A New Pathway to Universalism? Explaining the Spread of "Social" Pensions in the Global South, 1967–2011'. *Journal of International Relations and Development* 23(2): 308–38.

Bonnerjee, Aniruddha. 2014. 'The Maldives: The Shifting Nature of a Welfare State'. In *Development and Welfare Policy in South Asia*, eds Gabriele Koehler and Deepta Chopra. Abingdon: Routledge, 106–28.

Box-Steffensmeier, Janet M., and Christopher J. W. Zorn. 2001. 'Duration Models and Proportional Hazards in Political Science'. *American Journal of Political Science* 45(4): 972.

Brooks, Sarah M. 2008. *Social Protection and the Market in Latin America: The Transformation of Social Security Institutions*. Cambridge: Cambridge University Press.

Brooks, Sarah M. 2015. 'Social Protection for the Poorest: The Adoption of Antipoverty Cash Transfer Programs in the Global South'. *Politics & Society* 43(4): 551–82.

Buguzi, Syriacus. 2024. 'Financing Tanzania's Universal Health Insurance'. *The Lancet* 403(10424): 340.

Carbone, Giovanni. 2011. 'Democratic Demands and Social Policies: The Politics of Health Reform in Ghana'. *The Journal of Modern African Studies* 49(3): 381–408.

Carbone, Giovanni, and Alessandro Pellegata. 2017. 'To Elect or Not to Elect: Leaders, Alternation in Power and Social Welfare in Sub-Saharan Africa'. *The Journal of Development Studies* 53(12): 1965–87.

Cassells, Elsada Diana. 2022. 'The Health Care System in Jamaica'. *CRC 1342 Social Policy Country Briefs* 22.

Castro, Marcia C, Adriano Massuda, Gisele Almeida, Naercio Aquino Menezes-Filho, Monica Viegas Andrade, Kenya Valéria Micaela De Souza Noronha, Rudi Rocha, et al. 2019. 'Brazil's Unified Health System: The First 30 Years and Prospects for the Future'. *The Lancet* 394(10195): 345–56.

Cavaillé, Charlotte, and Kris-Stella Trump. 2015. 'The Two Facets of Social Policy Preferences'. *The Journal of Politics* 77(1): 146–60.

Chhibber, Pradeep, and Irfan Nooruddin. 2004. 'Do Party Systems Count?: The Number of Parties and Government Performance in the Indian States'. *Comparative Political Studies* 37(2): 152–87.

Clark, Mary A. 2015. 'The New Left and Health Care Reform in El Salvador'. *Latin American Politics and Society* 57(4): 97–118.

Connolly, Emilia, Sakshi Mohan, Pakwanja Twea, Thulasoni Msuku, Andreas Kees, Lalit Sharma, Stephanie Heung, Dominic Nkhoma, and Gerald Manthalu. 2024. 'Revision of Malawi's Health Benefits Package: A Critical Analysis of Policy Formulation and Implementation'. *Value in Health Regional Issues* 39: 84–94.

Coppedge, Michael, John Gerring, Carl Henrik Knutsen, Staffan I. Lindberg, Jan Teorell, Kyle L. Marquardt, Juraj Medzihorsky, et al. 2024. 'V-Dem Methodology V14'. *Varieties of Democracy (V-Dem) Project*.

Costa-Font, Joan, Gilberto Turati, and Alberto Batinti. 2020. *The Political Economy of Health and Healthcare: The Rise of the Patient Citizen*. Cambridge: Cambridge University Press.

Croke, Kevin, Mariana Binti Mohd Yusoff, Zalilah Abdullah, Ainul Nadziha Mohd Hanafiah, Khairiah Mokhtaruddin, Emira Soleha Ramli, Nor Filzatun Borhan, et al. 2019. 'The Political Economy of Health Financing Reform in Malaysia'. *Health Policy and Planning* 34(10): 732–39.

Cross, Harry E., Marisela De La Cruz, and Juan Dent. 2019. 'Government Stewardship and Primary Health Care in Guatemala since 1996'. *Public Administration and Development* 39(1): 11–22.

Daff, Bocar Mamadou, Serigne Diouf, Elhadji Sala Madior Diop, Yukichi Mano, Ryota Nakamura, Mouhamed Mahi Sy, Makoto Tobe, Shotaro Togawa, and Mor Ngom. 2020. 'Reforms for Financial Protection Schemes towards Universal Health Coverage, Senegal'. *Bulletin of the World Health Organization* 98(2): 100–108.

Dahl, Robert Alan. 1972. *Polyarchy: Participation and Opposition*. New Haven: Yale University Press.

Darrudi, Alireza, Mohammad Hossein Ketabchi Khoonsari, and Maryam Tajvar. 2022. 'Challenges to Achieving Universal Health Coverage Throughout the World: A Systematic Review'. *Journal of Preventive Medicine and Public Health* 55(2): 125–33.

Davidian, Andreza. 2021. 'Health Reform in Brazil: The *Sanitaristas* as Programmatic Actors'. *European Policy Analysis* 7(S1): 64–95.

De Habich, Midori. 2019. 'Leadership Politics and the Evolution of the Universal Health Insurance Reform in Peru'. *Health Systems & Reform* 5(3): 244–49.

Desai, Raj M., Anders Olofsgård, and Tarik M. Yousef. 2003. 'Democracy, Inequality, and Inflation'. *American Political Science Review* 97(03).

Devereux, Stephen, and Philip White. 2010. 'Social Protection in Africa: Evidence, Politics and Rights'. *Poverty & Public Policy* 2(3): 53–77.

Dittrich, Rebecca, Leonardo Cubillos, Lawrence Gostin, Kalipso Chalkidou, and Ryan Li. 2016. 'The International Right to Health: What Does It Mean in Legal Practice and How Can It Affect Priority Setting for Universal Health Coverage?' *Health Systems & Reform* 2(1): 23–31.

Djahini-Afawoubo, Dossè Mawussi, and Segnon T. Aguey. 2022. 'Mandatory Health Insurance and Health Care Utilization in Togo'. *BMC Health Services Research* 22(1): 1520.

Dominis, Sarah, Abdo S. Yazbeck, and Lauren Alecci Hartel. 2018. 'Keys to Health System Strengthening Success: Lessons from 25 Years of Health System Reforms and External Technical Support in Central Asia'. *Health Systems & Reform* 4(2): 160–69.

Dorlach, Tim. 2021. 'The Causes of Welfare State Expansion in Democratic Middle-income Countries: A Literature Review'. *Social Policy & Administration* 55(5): 767–83.

Dorlach, Tim, and Oya Yeğen. 2023. 'Universal Health Coverage with Private Options: The Politics of Turkey's 2008 Health Reform'. *Studies in Comparative International Development* 58(3): 430–56.

Doshmangir, Leila, Mohammad Bazyar, Arash Rashidian, and Vladimir Sergeevich Gordeev. 2021. 'Iran Health Insurance System in Transition: Equity Concerns and Steps to Achieve Universal Health Coverage'. *International Journal for Equity in Health* 20(1): 37.

Driss Zine Eddine El Idrissi, Moulay, and Mirja Sjoblom. 2023. *Tajikistan: Policy Note on Mandatory Health Insurance*. Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/099122223084135664 (March 13, 2025).

Duckett, Jane, and Neil Munro. 2022. 'Authoritarian Regime Legitimacy and Health Care Provision: Survey Evidence from Contemporary China'. *Journal of Health Politics, Policy and Law* 47(3): 375–409.

Dullak, Roberto, María Isabel Rodriguez-Riveros, Ivani Bursztyn, Maria Stella Cabral-Bejarano, Monica Ruoti, Maria Elsa Paredes, Carmen Wildberger, and Faustina Molinas. 2011. 'Atención Primaria En Salud En Paraguay: Panorámica y Perspectiva'. *Ciência & Saúde Coletiva* 16(6): 2865–75.

Elgin, Ceyhun, M. Ayhan Kose, Franziska Ohnsorge, and Shu Yu. 2021. 'Understanding Informality'. *CEPR Discussion Paper* 16497.

El-Sobky, Ahmed, and Mazen Aladdin. 2024. 'From Reform to Excellence: The Future of Health Care in Egypt'. *The Lancet Global Health* 12(10): e1584–85.

Eriksen, Astrid, Yulia Litvinova, and Bernd Rechel. 2022. *Health Systems in Action: Kazakhstan*. Brussels: European Observatory on Health Systems and Policies.

Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

Espinosa, Veronica, Cecilia Acuna, Daniel De la Torre, and Gina Tambini. 2017. 'La Reforma En Salud Del Ecuador'. *Pan American Journal of Public Health* 41: e96.

Everatt, David. 2024. 'The Long Decline of South Africa's ANC'. *Journal of Democracy* 35(4): 135–48.

Ewig, Christina. 2016. 'Reform and Electoral Competition: Convergence Toward Equity in Latin American Health Sectors'. *Comparative Political Studies* 49(2): 184–218.

Fairfield, Tasha, and Candelaria Garay. 2017. 'Redistribution Under the Right in Latin America: Electoral Competition and Organized Actors in Policymaking'. *Comparative Political Studies* 50(14): 1871–1906.

Farinha, Fernanda. 2022. 'The Health Care System in Mozambique'. *CRC 1342 Social Policy Country Briefs* 25.

Fong, Christina. 2001. 'Social Preferences, Self-Interest, and the Demand for Redistribution'. *Journal of Public Economics* 82(2): 225–46.

Fox, Ashley M., and Michael R. Reich. 2015. 'The Politics of Universal Health Coverage in Low and Middle-Income Countries: A Framework for Evaluation and Action'. *Journal of Health Politics, Policy and Law* 40(5): 1023–60.

Freire, André, and Kats Kivistik. 2013. 'Western and Non-Western Meanings of the Left–Right Divide across Four Continents'. *Journal of Political Ideologies* 18(2): 171–99.

Garay, Candelaria. 2016. *Social Policy Expansion in Latin America*. Cambridge: Cambridge University Press.

Gingrich, Jane. 2011. *Making Markets in the Welfare State: The Politics of Varying Market Reforms*. Cambridge: Cambridge University Press.

Gingrich, Jane. 2014. 'Visibility, Values, and Voters: The Informational Role of the Welfare State'. *The Journal of Politics* 76(2): 565–80.

Global Burden of Disease Collaborative Network. 2025. *Global Health Spending 1995-2022*. Seattle: Institute for Health Metrics and Evaluation. https://ghdx.healthdata.org/record/ihme-data/global-health-spending-1995-2022 (July 27, 2025).

Gobbers, Didier. 2003. 'Côte d'Ivoire : Les Enjeux d'un Système d'assurance Maladie Universelle'. *Rubriques International* 43. https://www.hcsp.fr/docspdf/adsp/adsp-43/ad436166.pdf (July 27, 2025).

Götsch, Julian, Anna Lisa Altenschmidt, and Sina Wächter. 2024. 'The Health Care System in Kenya'. *CRC 1342 Social Policy Country Briefs* 40.

Goursat, Marielle Phe, and Giulio Bordon. 2024. *Assessment of the Cambodian National Social Security Fund's Health Insurance Schemes*. Phnom Penh: International Labour Office.

Greer, Scott L., and Claudio A. Méndez. 2015. 'Universal Health Coverage: A Political Struggle and Governance Challenge'. *American Journal of Public Health* 105(S5): S637–39.

Grundy, John, Paison Dakulala, Ken Wai, Anna Maalsen, and Maxine Whittaker. 2019. 'Independent State of Papua New Guinea Health System Review'. *Health Systems in Transition* 9(1).

Guinness, Lorna, Repon C Paul, Joao S Martins, Auguste Asante, Jennifer A Price, Andrew Hayen, Stephen Jan, Ana Soares, and Virginia Wiseman. 2018. 'Determinants of Health Care Utilisation: The Case of Timor-Leste'. *International Health* 10(6): 412–20.

Guliyev, Farid. 2023. 'Covid-19 and Health Insurance Reform in Azerbaijan'. *Global Social Policy* 23(2): 360–63.

Haggard, Stephan, and Robert R. Kaufman. 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*. Princeton: Princeton University Press.

Hagopian, Frances. 2009. 'Parties and Voters in Emerging Democracies'. In *The Oxford Handbook of Comparative Politics*, eds Carles Boix and Susan C. Stokes. Oxford: Oxford University Press, 582–603.

Haley, Donald Robert, and Sama A. Bég. 2012. 'The Road to Recovery: Egypt's Healthcare Reform'. *The International Journal of Health Planning and Management* 27(1): e83-91.

Harfaoui, Wafaa, Lahcen Belyamani, Aziz Zentar, Brahim Lekehal, and Majdouline Obtel. 2024. 'The New Reform of the National Health System in Morocco: An Opportunity to Meet the Challenges and Improve the Practice of Anesthesiology'. *Cureus* 16(4): e57841.

Harsch, Leonie. 2016. *Social Protection Country Profile: Mauritania*. Beirut: Economic and Social Commission for Western Asia. https://www.unescwa.org/sites/default/files/pubs/pdf/mauritania-social-protection-profile-english_0.pdf (January 9, 2025).

Hasemann Lara, José E. 2023. 'Health Sector Reform in Honduras: Privatization as Institutional Bad Faith'. *Medical Anthropology* 42(1): 62–75.

Holland, Alisha C., and Ben Ross Schneider. 2017. 'Easy and Hard Redistribution: The Political Economy of Welfare States in Latin America'. *Perspectives on Politics* 15(4): 988–1006.

Holliday, Ian. 2000. 'Productivist Welfare Capitalism: Social Policy in East Asia'. *Political Studies* 48(4): 706–23.

Houeninvo, Hilaire Gbodja, Kéfilath Bello, Hashim Hounkpatin, and Jean-Paul Dossou. 2022. 'Developing and Implementing National Health Insurance: Learnings from the First Try in Benin'. *BMJ Global Health* 7(11): e009027.

Huber, Evelyne, and John D. Stephens. 2001. *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*. Chicago: University of Chicago Press.

Huber, Evelyne, and John D. Stephens. 2012. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press.

Ilesanmi, Olayinka Stephen, Aanuoluwapo Adeyimika Afolabi, and Christianah Toluwalope Adeoya. 2023. 'Driving the Implementation of the National Health Act of Nigeria to Improve the Health of Her Population'. *Pan African Medical Journal* 45(157).

ILO. 2022. *Étendre La Protection Sociale En Santé à Madagascar: Etat Des Lieux et Options Vers La Couverture Santé Universelle*. Geneva: International Labour Office.

Immergut, Ellen M., and Tarik Abou-Chadi. 2014. 'How Electoral Vulnerability Affects Pension Politics: Introducing a Concept, Measure and Empirical Application'. *European Journal of Political Research* 53(2): 269–87.

Immergut, Ellen M., Karen M. Anderson, Camilla Devitt, and Tamara Popic. 2021. *Health Politics in Europe: A Handbook*. Oxford: Oxford University Press.

Institute for Health Metrics and Evaluation (IHME). 2025. *Development Assistance for Health Database 1990-2025*. Seattle: Institute for Health Metrics and Evaluation. https://ghdx.healthdata.org/record/ihme-data/development-assistance-health-database-1990-2025 (October 5, 2025).

Iversen, Torben. 2021. 'Democracy and Capitalism'. In *The Oxford Handbook of the Welfare State*, eds Daniel Béland, Stephan Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson. Oxford: Oxford University Press, 259–77.

Jacques, Olivier, and Alain Noël. 2022. 'The Politics of Public Health Investments'. *Social Science & Medicine* 309: 115272.

Kabeer, Naila. 2014. 'The Politics and Practicalities of Universalism: Towards a Citizen-Centred Perspective on Social Protection'. *The European Journal of Development Research* 26(3): 338–54.

Kamath, Rajesh, and Helmut Brand. 2023. 'A Critical Analysis of the World's Largest Publicly Funded Health Insurance Program: India's Ayushman Bharat'. *International Journal of Preventive Medicine* 14(1).

Katsaga, Alexandr, Maksut Kulzhanov, Marina Karanikolos, and Bernd Rechel. 2012. 'Kazakhstan: Health System Review'. *Health Systems in Transition* 14(4).

Keefer, Philip. 2007. 'Clientelism, Credibility, and the Policy Choices of Young Democracies'. *American Journal of Political Science* 51(4): 804–21.

Keefer, Philip, and Stuti Khemani. 2005. 'Democracy, Public Expenditures, and the Poor: Understanding Political Incentives for Providing Public Services'. *The World Bank Research Observer* 20(1): 1–27.

Khan, Salman J, Muhammad Asif, Sadia Aslam, Wahab J Khan, and Syed A Hamza. 2023. 'Pakistan's Healthcare System: A Review of Major Challenges and the First Comprehensive Universal Health Coverage Initiative'. *Cureus* 15(9): e44641.

Khanal, Geha N., Bishal Bharadwaj, Nijan Upadhyay, Tulasi Bhattarai, Minakshi Dahal, and Resham B. Khatri. 2023. 'Evaluation of the National Health Insurance Program of Nepal: Are Political Promises Translated into Actions?' *Health Research Policy and Systems* 21(1): 7.

King, Gary, and Langche Zeng. 2001. 'Logistic Regression in Rare Events Data'. *Political Analysis* 9: 137–63.

Kisa, Adnan, and Mustafa Z. Younis. 2006. 'Financing Health Care For The Poor In Turkey: Is A Temporary Solution Becoming A Permanent Scheme?' *Public Health Reports* 121(6): 764–68.

Kitschelt, Herbert, and Steven I. Wilkinson, eds. 2007. *Patrons, Clients and Policies: Patterns of Democratic Accountability and Political Competition*. Cambridge: Cambridge University Press.

Kittel, Bernhard, and Herbert Obinger. 2003. 'Political Parties, Institutions, and the Dynamics of Social Expenditure in Times of Austerity'. *Journal of European Public Policy* 10(1): 20–45.

Kjær, Anne Mette, and Ole Therkildsen. 2013. 'Elections and Landmark Policies in Tanzania and Uganda'. *Democratization* 20(4): 592–614.

Knutsen, Carl Henrik, and Magnus Rasmussen. 2018. 'The Autocratic Welfare State: Old-Age Pensions, Credible Commitments, and Regime Survival'. *Comparative Political Studies* 51(5): 659–95.

Koehler, Gabriele, and Deepta Chopra, eds. 2014. *Development and Welfare Policy in South Asia*. Abingdon: Routledge.

Korpi, Walter. 1983. *The Democratic Class Struggle*. London: Routledge & Kegan Paul.

Korpi, Walter, and Joakim Palme. 1998. 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries'. *American Sociological Review* 63(5): 661–87.

Kuhonta, Erik Martinez. 2017. 'The Politics of Health Care Reform in Thailand'. In *Towards Universal Health Care in Emerging Economies*, ed. Ilcheong Yi. London: Palgrave Macmillan, 91–118.

Lagomarsino, Gina, Alice Garabrant, Atikah Adyas, Richard Muga, and Nathaniel Otoo. 2012. 'Moving towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia'. *The Lancet* 380(9845): 933–43.

Lavinas, Lena. 2013. '21st Century Welfare'. *New Left Review* 84(6): 5–40.

Lawton, Alexander M. 2015. 'The Right to Health in Indigenous Guatemala: Prevailing Historical Structures in the Context of Health Care'. *Health and Human Rights*. https://www.hhrjournal.org/2015/08/27/the-right-to-health-in-indigenous-guatemala-prevailing-historical-structures-in-the-context-of-health-care/ (December 23, 2024).

Le, Quynh Ngoc, Leigh Blizzard, Lei Si, Long Thanh Giang, and Amanda L. Neil. 2020. 'The Evolution of Social Health Insurance in Vietnam and Its Role towards Achieving Universal Health Coverage'. *Health Policy OPEN* 1: 100011.

Leisering, Lutz. 2021. 'Social Protection in the Global South: An Ideational and Historical Approach'. In *One Hundred Years of Social Protection*, ed. Lutz Leisering. Cham: Palgrave Macmillan, 3–52.

L'Express De Madagascar. 2023. 'Fourniture Des Soins: L'assurance Santé à Mettre En Place'. *Moov*. https://www.moov.mg/article/75563-fourniture-des-soins-lassurance-sante-a-mettre-en-place#body2 (January 14, 2025).

Lindberg, Staffan I., Nils Düpont, Masaaki Higashijima, Yaman Berker Kavasoglu, Kyle L. Marquardt, Michael Bernhard, Holger Döring, et al. 2022. *V-Party Dataset V2*. Gothenburg: Varieties of Democracy (V-Dem) Project. https://www.v-dem.net/vpartyds.html (January 24, 2025).

Lindvall, Johannes, and David Rueda. 2014. 'The Insider–Outsider Dilemma'. *British Journal of Political Science* 44(2): 460–75.

Lindvall, Johannes, David Rueda, and Haoyu Zhai. 2023. 'When Parties Move to the Middle: The Role of Uncertainty'. *British Journal of Political Science* 53(4): 1208–29.

Loffreda, Giulia, Kéfilath Bello, Joël Arthur Kiendrébéogo, Isidore Selenou, Mohamed Ali Ag Ahmed, Jean Paul Dossou, Sophie Witter, and Maria Paola Bertone. 2021. 'Political Economy Analysis of Universal Health Coverage and Health Financing Reforms in Low- and Middle-Income Countries: The Role of Stakeholder Engagement in the Research Process'. *Health Research Policy and Systems* 19(1): 143.

Lührmann, Anna, Marcus Tannenberg, and Staffan I. Lindberg. 2018. 'Regimes of the World (RoW): Opening New Avenues for the Comparative Study of Political Regimes'. *Politics and Governance* 6(1): 60–77.

Ly, Mamadou Selly, Oumar Bassoum, and Adama Faye. 2022. 'Universal Health Insurance in Africa: A Narrative Review of the Literature on Institutional Models'. *BMJ Global Health* 7(4): e008219.

Mahmood, Qamar, and Carles Muntaner. 2013. 'Politics, Class Actors, and Health Sector Reform in Brazil and Venezuela'. *Global Health Promotion* 20(1): 59–67.

Mahoney, James, and Kathleen Thelen, eds. 2009. *Explaining Institutional Change: Ambiguity, Agency, and Power*. Cambridge: Cambridge University Press.

Maritim, Beryl, Adam D. Koon, Allan Kimaina, Cornelius Lagat, Elvira Riungu, Jeremiah Laktabai, Laura J. Ruhl, et al. 2023. '"It Is like an Umbrella Covering You, yet It Does Not Protect You from the Rain": A Mixed Methods Study of Insurance Affordability, Coverage, and Financial Protection in Rural Western Kenya'. *International Journal for Equity in Health* 22(1): 27.

Marshall, Monty G., and Ted Robert Gurr. 2020. *Polity 5 Project: Political Regime Characteristics and Transitions, 1800-2018*. Vienna: Center for Systemic Peace. https://www.systemicpeace.org/inscrdata.html (October 5, 2025).

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.

Martins, Nuno, Joana Borges Henrique, and Fernando Sousa Jr. 2022. *Cabo Verde: Extending Social Protection by Anchoring Rights in Law*. Geneva: International Labour Organization.

McKee, Martin, Dina Balabanova, Sanjay Basu, Walter Ricciardi, and David Stuckler. 2013. 'Universal Health Coverage: A Quest for All Countries But under Threat in Some'. *Value in Health* 16(1): S39–45.

Mehtiyev, Azer. 2021. 'Can the Transition to Compulsory Medical Insurance Reform the Country's Health Care System?' *Baku Research Institute*. https://bakuresearchinstitute.org/en/can-the-transition-to-compulsory-medical-insurance-reform-the-countrys-health-care-system-2/ (January 14, 2025).

Meltzer, Allan H., and Scott F. Richard. 1981. 'A Rational Theory of the Size of Government'. *Journal of Political Economy* 89(5): 914–27.

Mesa-Lago, Carmelo. 2008. *Reassembling Social Security: A Survey of Pensions and Health Care Reforms in Latin America*. Oxford: Oxford University Press.

Mkandawire, Thandika. 1994. 'The Political Economy of Privatisation in Africa'. In *From Adjustment to Development in Africa*, eds Giovanni Andrea Cornia and Gerald K. Helleiner. London: Palgrave Macmillan, 192–213.

Mkandawire, Thandika, ed. 2004. *Social Policy in a Development Context*. London: Palgrave Macmillan.

Mkandawire, Thandika. 2005. 'Targeting and Universalism in Poverty Reduction'. *UNRISD Social Policy and Development Programme Paper* 23.

Mkandawire, Thandika. 2020. 'Colonial Legacies and Social Welfare Regimes in Africa: An Empirical Exercise'. In *The Politics of Domestic Resource Mobilization for Social Development*, ed. Katja Hujo. Cham: Palgrave Macmillan, 139–72.

Montanari, Ingalill, and Kenneth Nelson. 2013. 'Health Care Determinants in Comparative Perspective: The Role of Partisan Politics for Health Care Provision'. *International Journal of Comparative Sociology* 54(5–6): 445–66.

Nauroozi, Hüma. 2024. 'The Health Care System in Rwanda'. *CRC 1342 Social Policy Country Briefs* 39.

Navarro, Vicente, Carles Muntaner, Carme Borrell, Joan Benach, Águeda Quiroga, Maica Rodríguez-Sanz, Núria Vergés, and M Isabel Pasarín. 2006. 'Politics and Health Outcomes'. *The Lancet* 368(9540): 1033–37.

Navarro, Vicente, and Leiyu Shi. 2001. 'The Political Context of Social Inequalities and Health'. *Social Science & Medicine* 52(3): 481–91.

NHIA. 2016. *National Health Insurance, A Shared Responsibility, A Modern Framework for Increasing Health Insurance Coverage in The Bahamas*. National Health Insurance Authority. https://www.nhibahamas.gov.bs/wp-content/uploads/2016/08/NHI-018-Building-a-Healthier-Bahamas-Doc-V2-D4-WEB.pdf (February 13, 2025).

Niedzwiecki, Sara. 2018. *Uneven Social Policies: The Politics of Subnational Variation in Latin America*. Cambridge: Cambridge University Press.

Niedzwiecki, Sara, and Jennifer Pribble. 2023. 'Social Policy Expansion and Retrenchment in Latin America: Causal Paths to Successful Reform'. *Journal of Social Policy*: 1–21.

Niño-Zarazúa, Miguel, Armando Barrientos, Samuel Hickey, and David Hulme. 2012. 'Social Protection in Sub-Saharan Africa: Getting the Politics Right'. *World Development* 40(1): 163–76.

Njie, Hassan, Elina Dale, and Unni Gopinathan. 2023. 'Procedural Fairness in Decision-Making for Financing a National Health Insurance Scheme: A Case Study from The Gambia'. *Health Policy and Planning* 38: i73–82.

Obermann, Konrad, Matthew R. Jowett, Maria Ofelia O. Alcantara, Eduardo P. Banzon, and Claude Bodart. 2006. 'Social Health Insurance in a Developing Country: The Case of the Philippines'. *Social Science & Medicine* 62(12): 3177–85.

Obinger, Herbert, and Carina Schmitt. 2022. 'Unemployment Insurance in the Global South since 1950: Drivers of Policy Adoption'. *Global Social Policy* 22(1): 67–83.

Obinger, Herbert, Carina Schmitt, and Peter Starke. 2013. 'Policy Diffusion and Policy Transfer in Comparative Welfare State Research'. *Social Policy & Administration* 47(1): 111–29.

Obinger, Herbert, Carina Schmitt, and Stefan Traub. 2016. *The Political Economy of Privatization in Rich Democracies*. Oxford: Oxford University Press.

Obinger, Herbert, Carina Schmitt, and Reimut Zohlnhöfer. 2014. 'Partisan Politics and Privatization in OECD Countries'. *Comparative Political Studies* 47(9): 1294–1323.

Osei Afriyie, Doris, Pei Shan Loo, August Kuwawenaruwa, Tani Kassimu, Günther Fink, Fabrizio Tediosi, and Sally Mtenga. 2024. 'Understanding the Role of the Tanzania National Health Insurance Fund in Improving Service Coverage and Quality of Care'. *Social Science & Medicine* 347: 116714.

Osei Afriyie, Doris, Regina Titi-Ofei, Felix Masiye, Collins Chansa, and Günther Fink. 2025. 'The Political Economy of National Health Insurance Schemes: Evidence from Zambia'. *Health Policy and Planning* 40(1): 66–74.

Pace, Virgile. 2022. *Institutional Frameworks in the Area of Health Financing Systems : Chad*. P4H Network. https://p4h.world/app/uploads/2024/10/2024-10-01_Country-Report_Chad.x23411.pdf (February 25, 2025).

Pedersen, Mogens N. 1979. 'The Dynamics of European Party Systems: Changing Patterns of Electoral Volatility'. *European Journal of Political Research* 7(1): 1–26.

Pierson, Paul. 1993. 'When Effect Becomes Cause: Policy Feedback and Political Change'. *World Politics* 45(4): 595–628.

Pisani, Elizabeth, Maarten Olivier Kok, and Kharisma Nugroho. 2016. 'Indonesia's Road to Universal Health Coverage: A Political Journey'. *Health Policy and Planning* 32(2): 267–76.

Preker, Alexander S, Daniel Cotlear, Soonman Kwon, Rifat Atun, and Carlos Avila. 2021. 'Universal Health Care in Middle-Income Countries: Lessons from Four Countries'. *Journal of Global Health* 11: 16004.

Pribble, Jennifer. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.

Przeworski, Adam, Michael E. Alvarez, Jose Antonio Cheibub, and Fernando Limongi. 2000. *Democracy and Development: Political Institutions and Well-Being in the World, 1950-1990*. Cambridge: Cambridge University Press.

Raphael, Dennis, and Toba Bryant. 2006. 'Maintaining Population Health in a Period of Welfare State Decline: Political Economy as the Missing Dimension in Health Promotion Theory and Practice'. *Promotion & Education* 13(4): 236–42.

Rathe, Magdalena. 2018. *Dominican Republic: Implementing a Health Protection System That Leaves No One Behind*. Washington, D.C.: World Bank Group.

Rechel, Bernd, and Ghafur Khodjamurodov. 2010. 'International Involvement and National Health Governance: The Basic Benefit Package in Tajikistan'. *Social Science & Medicine* 70(12): 1928–32.

Rechel, Bernd, Erica Richardson, and Martin McKee, eds. 2014. *Trends in Health Systems in the Former Soviet Countries*. Copenhagen: European Observatory on Health Systems and Policies.

Reeves, Aaron, Yannis Gourtsoyannis, Sanjay Basu, David McCoy, Martin McKee, and David Stuckler. 2015. 'Financing Universal Health Coverage—Effects of Alternative Tax Structures on Public Health Systems: Cross-National Modelling in 89 Low-Income and Middle-Income Countries'. *The Lancet* 386(9990): 274–80.

Reich, Michael R. 2020. 'Restructuring Health Reform, Mexican Style'. *Health Systems & Reform* 6(1): e1763114.

Richardson, Erica, and Nino Berdzuli. 2017. 'Georgia: Health System Review'. *Health Systems in Transition* 19(4).

Ridde, Valéry, Abena Asomaning Antwi, Bruno Boidin, Benjamin Chemouni, Fatoumata Hane, and Laurence Touré. 2018. 'Time to Abandon Amateurism and Volunteerism: Addressing Tensions between the Alma-Ata Principle of Community Participation and the Effectiveness of Community-Based Health Insurance in Africa'. *BMJ Global Health* 3: e001056.

Rinaldi, Chiara, and Marleen P.M. Bekker. 2020. 'A Scoping Review of Populist Radical Right Parties' Influence on Welfare Policy and Its Implications for Population Health in Europe'. *International Journal of Health Policy and Management* 10(3): 141–51.

Rizvi, Syed Shahiq, Rundell Douglas, Owain D Williams, and Peter S Hill. 2020. 'The Political Economy of Universal Health Coverage: A Systematic Narrative Review'. *Health Policy and Planning* 35(3): 364–72.

Robinson, James A., and Ragnar Torvik. 2005. 'White Elephants'. *Journal of Public Economics* 89(2–3): 197–210.

Rosa, Rodríguez-Monguió, and Infante Campos Alberto. 2004. 'Universal Health Care for Colombians 10 Years after Law 100: Challenges and Opportunities'. *Health Policy* 68(2): 129–42.

Ross, Michael. 2006. 'Is Democracy Good for the Poor?' *American Journal of Political Science* 50(4): 860–74.

Rothstein, Bo. 1998. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Rothstein, Bo, and Eric M. Uslaner. 2005. 'All for All: Equality, Corruption, and Social Trust'. *World Politics* 58(1): 41–72.

Rovira Kaltwasser, Cristóbal, and Lisa Zanotti. 2021. 'Populism and the Welfare State'. In *Handbook on Austerity, Populism and the Welfare State*, ed. Bent Greve. Cheltenham: Edward Elgar Publishing.

Rubinstein, Adolfo, María Clara Zerbino, Cintia Cejas, and Analía López. 2018. 'Making Universal Health Care Effective in Argentina: A Blueprint for Reform'. *Health Systems & Reform* 4(3): 203–13.

Rudra, Nita. 2002. 'Globalization and the Decline of the Welfare State in Less-Developed Countries'. *International Organization* 56(2): 411–45.

Rudra, Nita. 2007. 'Welfare States in Developing Countries: Unique or Universal?' *The Journal of Politics* 69(2): 378–96.

Rudra, Nita, and Stephan Haggard. 2005. 'Globalization, Democracy, and Effective Welfare Spending in the Developing World'. *Comparative Political Studies* 38(9): 1015–49.

Rueda, David. 2007. *Social Democracy inside out: Partisanship and Labor Market Policy in Industrialized Democracies*. Oxford: Oxford University Press.

Rueda, David, and Daniel Stegmueller. 2019. *Who Wants What? Redistribution Preferences in Comparative Perspective*. Cambridge: Cambridge University Press.

Ruger, Jennifer Prah, and Daniel Kress. 2007. 'Health Financing And Insurance Reform In Morocco'. *Health Affairs* 26(4): 1009–16.

Saleh, Karima, Bernard Couttolenc, and Helene Barroy. 2014. *Health Financing in the Republic of Gabon*. Washington D.C: The World Bank.

Saleh, Shadi S., Mohamad S Alameddine, Nabil M Natafgi, Awad Mataria, Belgacem Sabri, Jamal Nasher, Moez Zeiton, Shaimaa Ahmad, and Sameen Siddiqi. 2014. 'The Path towards Universal Health Coverage in the Arab Uprising Countries Tunisia, Egypt, Libya, and Yemen'. *The Lancet* 383(9914): 368–81.

Sandbrook, Richard, Marc Edelman, Patrick Heller, and Judith Teichman. 2007. *Social Democracy in the Global Periphery: Origins, Challenges, Prospects*. Cambridge: Cambridge University Press.

Sato, Midori, and Lucy Gilson. 2015. 'Exploring Health Facilities' Experiences in Implementing the Free Health-Care Policy (FHCP) in Nepal: How Did Organizational Factors Influence the Implementation of the User-Fee Abolition Policy?' *Health Policy and Planning* 30(10): 1272–88.

Schaffar, Wolfram. 2021. 'An Authoritarian Reaction to COVID-19 in the Philippines: A Strong Commitment to Universal Health Care Combined with Violent Securitization'. In *The Populist Radical Right and Health*, eds Michelle Falkenbach and Scott L. Greer. Cham: Springer International Publishing, 181–92.

Scheve, Kenneth, and David Stasavage. 2017. 'Wealth Inequality and Democracy'. *Annual Review of Political Science* 20(1): 451–68.

Schmitt, Carina, Hanna Lierse, Herbert Obinger, and Laura Seelkopf. 2015. 'The Global Emergence of Social Protection: Explaining Social Security Legislation 1820–2013'. *Politics & Society* 43(4): 503–24.

Schumpeter, Joseph Alois. 1942. *Capitalism, Socialism, and Democracy*. New York: Harper & Brothers.

Schwettmann, Jürgen. 2022. *Towards Universal Health Coverage. The Cases of Benin; Côte d'Ivoire; Ethiopia; Kenya; Senegal and Zambia*. Bonn: Friedrich Ebert Stifting.

Seekings, Jeremy. 2008. 'Welfare Regimes and Redistribution in the South'. In *Divide and Deal: The Politics of Distribution in Democracies*, eds Ian Shapiro, Peter A. Swenson, and Daniela Donno Panayides. New York: New York University Press, 19–42.

Seekings, Jeremy. 2012. 'Pathway to Redistribution: The Emerging Politics of Social Assistance Across the Global "South"'. *Journal für Entwicklungspolitik* 28(1): 14–34.

Segura-Ubiergo, Alex. 2007. *The Political Economy of the Welfare State in Latin America: Globalization, Democracy, and Development*. Cambridge: Cambridge University Press.

Semenova, Yuliya, Lisa Lim, Zhandos Salpynov, Abduzhappar Gaipov, and Mihajlo Jakovljevic. 2024. 'Historical Evolution of Healthcare Systems of Post-Soviet Russia, Belarus, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, Armenia, and Azerbaijan: A Scoping Review'. *Heliyon* 10(8): e29550.

Sequeira, Magda, Henry Espinoza, Juan Jose Amador, Gonzalo Domingo, Margarita Quintanilla, and Tala de los Santos. 2011. *The Nicaraguan Health System*. Seattle: PATH.

Shayo, Moses. 2009. 'A Model of Social Identity with an Application to Political Economy: Nation, Class, and Redistribution'. *American Political Science Review* 103(2): 147–74.

Shim, Jaemin. 2020. 'Left Is Right and Right Is Left? Partisan Difference on Social Welfare and Particularistic Benefits in Japan, South Korea and Taiwan'. *Journal of International and Comparative Social Policy* 36(1): 25–41.

Sigman, Rachel, and Staffan I. Lindberg. 2019. 'Democracy for All: Conceptualizing and Measuring Egalitarian Democracy'. *Political Science Research and Methods* 7(3): 595–612.

Sirén, Sebastian. 2022. 'The Politics of Universal Health Coverage: Mechanisms in the Process of Healthcare Reform in Bolivia'. In *Causal Mechanisms in the Global Development of Social Policies*, eds Johanna Kuhlmann and Frank Nullmeier. Cham: Palgrave Macmillan, 369–401. https://link.springer.com/10.1007/978-3-030-91088-4_12 (March 16, 2025).

Stasavage, David. 2005. 'The Role of Democracy in Uganda's Move to Universal Primary Education'. *The Journal of Modern African Studies* 43(1): 53–73.

Stefánsson, Kolbeinn. 2012. 'What Is in a Word? Universalism, Ideology and Practice'. In *Welfare State, Universalism and Diversity*, eds Anneli Anttonen, Liisa Häikiö, and Kolbeinn Stefánsson. Cheltenham: Edward Elgar Publishing.

Sud, Nikita, and Diego Sánchez-Ancochea. 2022. 'Southern Discomfort: Interrogating the Category of the Global South'. *Development and Change* 53(6): 1123–50.

Szikra, Dorottya, and Kerem Gabriel Öktem. 2023. 'An Illiberal Welfare State Emerging? Welfare Efforts and Trajectories under Democratic Backsliding in Hungary and Turkey'. *Journal of European Social Policy* 33(2): 201–15.

Tavits, Margit. 2005. 'The Development of Stable Party Support: Electoral Dynamics in Post-Communist Europe'. *American Journal of Political Science* 49(2): 283–98.

Templin, Tara, Joseph L. Dieleman, Simon Wigley, John Everett Mumford, Molly Miller-Petrie, Samantha Kiernan, and Thomas J. Bollyky. 2021. 'Democracies Linked To Greater Universal Health Coverage Compared With Autocracies, Even In An Economic Recession: Study Examines the Associations That Democracy Has with Universal Health Coverage and Government Health Spending in 170 Countries from 1990 to 2019.' *Health Affairs* 40(8): 1234–42.

Thomas, Clive S., and Ronald J. Hrebenar. 2008. 'Understanding Interest Groups, Lobbying and Lobbyists in Developing Democracies'. *Journal of Public Affairs* 8(1–2): 1–14.

Tillin, Louise, and Jane Duckett. 2017. 'The Politics of Social Policy: Welfare Expansion in Brazil, China, India and South Africa in Comparative Perspective'. *Commonwealth & Comparative Politics* 55(3): 253–77.

Titmuss, Richard Morris. 1974. *Social Policy: An Introduction*. London: Allen & Unwin.

Torosyan, Arsen, Piotr Romaniuk, and Krzysztof Krajewski-Siuda. 2008. 'The Armenian Healthcare System: Recent Changes and Challenges'. *Journal of Public Health* 16(3): 183–90.

Touré, Laurence, Pauline Boivin, Yacouba Diarra, Seydou Diabaté, and Valéry Ridde. 2023. 'Innovations in Mutuality: Challenges and Learnings for the Universal Health Insurance Plan in Mali'. *BMJ Global Health* 7: e011055.

Uguru, Nkolika, Udochukwu Ogu, Chibuzo Uguru, and Ogochukwu Ibe. 2024. 'Is the National Health Insurance Scheme a Pathway to Sustained Access to Medicines in Nigeria?' *BMC Health Services Research* 24(1): 403.

Ulriksen, Marianne S. 2012. 'Welfare Policy Expansion in Botswana and Mauritius: Explaining the Causes of Different Welfare Regime Paths'. *Comparative Political Studies* 45(12): 1483–1509.

UNCTAD. 2023. *UNCTAD Handbook of Statistics*. New York: United Nations Publications.

UNICEF. 2024. *Costing of the Social Protection Floor(s) in Belize*. Belize City: United Nations Children's Fund. https://www.unicef.org/belize/reports/costing-social-protection-floors-belize (March 12, 2025).

Wahab. 2019. 'The Politics of State Welfare Expansion in Africa: Emergence of National Health Insurance in Ghana, 1993-2004'. *Africa Today* 65(3): 91.

Weitz-Shapiro, Rebecca. 2012. 'What Wins Votes: Why Some Politicians Opt Out of Clientelism'. *American Journal of Political Science* 56(3): 568–83.

Weyland, Kurt. 2005. 'The Diffusion of Innovations: How Cognitive Heuristics Shaped Bolivia's Pension Reform'. *Comparative Politics* 38(1): 21.

WHO. 2010. *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization.

WHO. 2019. *Strengthening Health Financing Systems in the Eastern Mediterranean Region towards Universal Health Coverage: Health Financing Atlas 2018*. Cairo: World Health Organization. Regional Office for the Eastern Mediterranean.

WHO. 2025. 'Universal Health Coverage (UHC)'. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) (July 25, 2025).

WHO, and International Bank for Reconstruction and Development / The World Bank. 2023. *Tracking Universal Health Coverage: 2023 Global Monitoring Report*. Geneva: World Health Organization.

Whyle, Eleanor Beth, and Jill Olivier. 2023. 'A Socio-Political History of South Africa's National Health Insurance'. *International Journal for Equity in Health* 22(1): 247.

Whyle, Eleanor Beth, and Jill Olivier. 2024. 'Health System Reform and Path-Dependency: How Ideas Constrained Change in South Africa's National Health Insurance Policy Process'. *Policy Sciences* 57(3): 663–90.

Wigley, Simon, Joseph L Dieleman, Tara Templin, John Everett Mumford, and Thomas J Bollyky. 2020. 'Autocratisation and Universal Health Coverage: Synthetic Control Study'. *BMJ*: m4040.

Wilensky, Harold L. 1975. *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*. Berkeley: University of California Press.

Wong, Joseph. 2004. *Healthy Democracies: Welfare Politics in Taiwan and South Korea*. Ithaca: Cornell University Press.

Yang, Nan, and Stefan Kühner. 2020. 'Beyond the Limits of the Productivist Regime: Capturing Three Decades of East Asian Welfare Development with Fuzzy Sets'. *Social Policy and Society* 19(4): 613–27.

Zhang, Jiajia, Dahai Zhao, and Xiyan Zhang. 2024. 'China's Universal Medical Insurance Scheme: Progress and Perspectives'. *BMC Global and Public Health* 2(1): 62.

Appendices

A. Relationship between clientelism and electoral volatility

Table A.1 Panel fixed effects regression model of clientelism

Dependent variable	(1) Clientelism
Government Left-Right Index	0.155
	(0.601)
Electoral Volatility Index	-0.0708*
	(0.0361)
Institutional Political Competition	-0.470
	(0.450)
Trade Union Engagement	-4.136***
	(1.407)
Private health spending (in % of total)	0.0290 (0.0572)
Development Assistance for Health (in million USD)	0.00245 (0.00194)
GDP per capita (in thousand USD, PPP)	-0.0996* (0.0482)
GDP growth (annual, in %)	-0.0142 (0.0268)
Inflation (Annual change in GDP deflator)	-0.0140** (0.00693)
Population (in millions)	0.00510 (0.0108)
Rural population (in % of total)	0.212 (0.148)
Age dependency ratio (in % of working-age population)	-0.0518 (0.0760)
Closed autocracy (Ref.: Electoral autocracy)	-5.228*** (1.907)
Electoral democracy	-6.560*** (2.320)
Liberal democracy	0.0142*** (0.00328)
N (countries)	83
N (country-years)	2349

Cluster robust standard errors in parentheses.
* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$, **** $p < 0.001$

B. Continuous dependent variable and fixed effects

Table B.1 Panel fixed effects regression model of continuous reform variable

	(1)
Dependent variable	Reform
Government Left-Right Index	-0.215****
	(0.0417)
Electoral Volatility Index	0.00905**
	(0.00349)
Institutional Political Competition	-0.0312
	(0.00311)
Trade Union Engagement	-0.00933
	(0.0104)
Private health spending (in % of total)	0.000506
	(0.000552)
Development Assistance for Health (in million USD)	0.00387
	(0.00279)
GDP per capita (in thousand USD, PPP)	0.0196
	(0.0141)
GDP growth (annual, in %)	0.00593
	(0.00409)
Inflation (Annual change in GDP deflator)	-0.000598
	(0.0000561)
Population (in millions)	-0.00434
	(0.000249)
Rural population (in % of total)	-0.0117
	(0.0136)
Age dependency ratio (in % of working-age population)	-0.0427
	(0.0715)
Closed autocracy (Ref.: Electoral autocracy)	-0.343**
	(0.158)
Electoral democracy	0.171
	(0.189)
Liberal democracy	0.257
	(0.320)
N (countries)	83
N (country-years)	2349

Cluster robust standard errors in parentheses.
* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$, **** $p < 0.001$

Table D.1 Interaction effects of political determinants and vested interests

Dependent variable	(1) Universal	(2) Segmented	(3) Universal	(4) Segmented	(5) Universal	(6) Segmented	(7) Universal	(8) Segmented
Government Left-Right Index	0.637***	1.651****	0.982	0.186	0.611***	1.359**	0.575*	1.531
	(0.109)	(0.224)	(0.790)	(.)	(0.106)	(0.174)	(0.185)	(0.588)
Electoral Volatility Index	1.040****	0.998	1.039***	0.990	1.041****	0.981	1.029	1.331***
	(0.0124)	(0.0101)	(0.0123)	(0.0146)	(0.0123)	(0.0120)	(0.0752)	(0.139)
Institutional Political Competition	0.857	1.344***	0.834	1.254	0.879	1.365****	0.967	1.462
	(0.118)	(0.132)	(0.106)	(.)	(0.119)	(0.129)	(0.200)	(0.436)
Development Assistance for Health (in million USD)	1.001**	1.000	1.001**	1.001	1.001**	1.000	1.001	0.999
	(0.000519)	(0.000717)	(0.000500)	(0.000715)	(0.000552)	(0.000577)	(0.000640)	(0.00176)
	0.546*	1.050	0.591*	0.877	0.439**	0.647*	0.685	1.224
	(0.171)	(0.247)	(0.183)	(0.206)	(0.158)	(0.158)	(0.284)	(0.816)
Private health spending (in % of total)	0.992	1.050****	0.989	1.035	0.992	1.049****	0.977	1.136***
	(0.0149)	(0.0118)	(0.0152)	(.)	(0.0152)	(0.0112)	(0.0278)	(0.0540)
Government LR Index X Trade Union Engagement	0.966	0.469****						
	(0.136)	(0.0574)						
Government LR Index X Private health spending			0.992	1.035****				
			(0.0150)	(0.00370)				
Electoral Volatility Index X Trade Union Engagement					1.014	1.038***		
					(0.00904)	(0.0126)		
Electoral Volatility Index X Private health spending							1.000	0.995***
							(0.00128)	(0.00195)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Region fixed effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Time trend: Log time	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
N	1787	1473	1787	1473	1787	1473	1787	1473

Coefficients presented as odds-ratios; robust standard errors in parentheses.
* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$, **** $p < 0.001$

Conclusion

This thesis has examined the political economy of universal healthcare from a global comparative perspective. Situating healthcare within the broader field of social policy, I approached the topic through the lens of universalism: the principle that states should ensure comprehensive and equitable access to high-quality social services for the entire population. Corresponding with an emerging policy consensus in global social policy, I conceptualise universalism not as a purely aspirational goal or a normative ideal, but as a set of institution-agnostic policy outputs that can be applied, measured, and analysed across countries and over time. In exploring these global 'varieties of universalism', I focus on healthcare as the primary case study of universal welfare provision in the Global South – not only because healthcare is among the largest and politically most salient social policies in these contexts, but also because it lies at the heart of human development and the social contract.

How can healthcare universalism be meaningfully compared across countries and over time? What explains its variation between countries and over time? And why does it matter – normatively, socially, and politically? These were central questions that guided the three empirical papers which comprise this integrated thesis. Together, they offer a comprehensive account of the concept, causes, and consequences of universalism in healthcare, combining new theoretical perspectives, original data, and diverse quantitative methods.

Two principles underpin the thesis and each of the papers: a global macro-comparative perspective and a focus on healthcare as a case study of programme universalism. Rather than treating Northern welfare states as the default analytical category, the thesis adopts a truly global perspective by adapting concepts and measurements to diverse national contexts, while also identifying shared patterns and mechanisms. This approach meant placing the Global South at the analytical centre of comparative social policy research, while avoiding essentialist assumptions about the uniqueness or uniformity of either the North or the South. The empirical analysis is accordingly global, covering countries from all world regions and levels of development, and explicitly tests whether and how theoretical frameworks are applicable across different institutional settings.

This global scope inevitably leads to tensions between the generalisability of findings and contextual specificity. By placing greater emphasis on the former, the thesis risks overlooking key local dynamics, such as institutional architectures, governance structures, or social

movements. The objective was not to disregard these differences between countries, but to focus on the consequences and determinants of social policies that are relevant and applicable across many contexts – such as inequality, social trust, and trajectories of healthcare expansion – and to embed these in a broader comparative framework. Therefore, the thesis aims to challenge the marginal position of the Global South within comparative social policy research, where certain groups of countries are often considered as outliers, residual cases, or passive recipients of externally driven reforms.

I consider this analytical shift important and necessary for two main reasons. Firstly, because the Global South comprises the majority of active welfare developments in the world today, with social policies as an integral part of both national and international policymaking, for example, in the context of the Sustainable Development Goals. One could even argue that social policy has become a defining feature of modern notions of 'development' per se, where concepts such as human development or multidimensional poverty centre not on GDP growth, but on the expansion of capabilities like health and education. Considering the scope and scale of policy efforts around the world, excluding this 'silent majority' of country experiences from mainstream welfare scholarship constitutes a key shortcoming.

Second, a global analytical lens expands the range of institutional, socioeconomic, and political variation through which welfare dynamics can be studied, both geographically and across stages of development. This allows for the testing of existing theories in novel contexts, while also opening conceptual space for developing new theoretical frameworks – for instance, regarding social policy as a lens for an emerging social contract. While some scholars situate the (universal) welfare state as a geographically and historically bound phenomenon, it is intuitively unclear why the mechanisms associated with it, such as the effect on redistributive attitudes or political coalitions, should not also be relevant in emerging or less institutionalised settings.[143] For example, if universalism historically contributed to nation-building and social cohesion in the Global North, there appears to be no a priori reason to dismiss its relevance in the Global South.[144]

[143] The most common objections to this relate to differences in state capacity or the 'stateness' of welfare – similar in nature to the famous debate around the 'Southern Model' of welfare provision (Flora 1986; Ferrera 1996). However, these considerations, in my perspective, overstate institutional determinism and understate historical parallels. Many early welfare expansions in Europe were built under conditions of lower capacity and weaker institutions. Even today, considerable variation persists both within and across regions that cannot be solely explained with capacity constraints.

[144] See the literature on social protection and nation-building in the Global South (Haggard and Kaufman 2004; de Neubourg 2009; Hickey 2011; Kabeer 2014; Koehler 2021).

The second guiding principle of the thesis is a shift in analytical focus from the welfare state as a whole to specific welfare programmes. This relates to another form of marginalisation common in the (early) global welfare regime literature: the reduction of diverse Global South experiences into broad residual categories, such as 'informal' or 'insecurity' regimes (Gough et al. 2004; Wood and Gough 2006). While these typologies represent important contributions beyond OECD-centric analyses, they often overlook key variations between policy fields and within regions, ultimately reinforcing a deficit narrative by defining Southern welfare systems primarily by what they lack in relation to Northern models.[145]

In contrast, this thesis focused on the programme level of analysis, examining healthcare as a case study of universalism in a specific and globally salient policy field. As previously outlined, this choice reflects both conceptual and empirical considerations. Conceptually, aggregating levels of universalism across different policy fields is limiting and even potentially distorting, especially in contexts where welfare systems are fragmented and unevenly institutionalised. Even in mostly universalistic countries, generous and equitable healthcare provision might coexist with exclusionary education or pension systems, posing a fundamental aggregation and weighting problem when employing 'black box' aggregate measures like welfare state universalism or welfare regimes. Importantly, this not only obscures variation between different policy areas but also assumes that the determinants and effects of universalism are consistent across them.[146] These problems are magnified in the Global South, where programmes often differ substantially in their institutional development, external influence, and socio-political salience.[147]

Empirically, healthcare provides a universally relevant and globally comparable case study of programme universalism. It is among the largest and often most politically contested social policies in nearly all countries, while it is also at the centre of many national and international development efforts. Furthermore, healthcare responds to the needs of the entire population across the life cycle and closely connects to underlying concepts of equity, solidarity, and citizenship. Crucially, healthcare also lends itself to meaningful global comparison: despite

[145] Interestingly, a parallel to the debate on the 'Southern Model' of welfare in Europe (Ferrera 1996; Bonoli 1997; Arts and Gelissen 2002).
[146] A similar risk to using welfare regimes as a broad analytical category (Nelson and Fritzell 2014; Martínez Franzoni and Sánchez-Ancochea 2021).
[147] A good example is the role of non-traditional social policies in the form of food or agricultural input subsidies, a policy overlooked in much of the social policy literature, but with strong political salience in many Sub-Saharan African countries (Jayne and Rashid 2013; Devereux 2016; Dionne and Horowitz 2016).

major differences in national health systems, key dimensions such as coverage, spending, and levels of privatisation can be meaningfully measured and compared across contexts and over time.

In this sense, the thesis contributes to broader efforts to reconceptualise universalism as a multidimensional, context-sensitive, and policy-specific principle that can take different institutional forms, but whose underlying mechanisms and implications are globally relevant. The following section synthesises the core findings of the thesis that emerge across its three empirical papers, before concluding with reflections on their broader implications for future research and global social policy.

1. Research synthesis and contribution

This thesis makes several cross-cutting contributions to the study of universalism, global healthcare systems, and the politics of redistribution and inequality. By adopting a global empirical lens, it advances ongoing and emerging debates in comparative welfare research, global social policy, and the political economy of development. Each of the empirical papers examines a distinct dimension of healthcare universalism: its measurement, social consequences, and political determinants. Taken together, the thesis offers a multidimensional and multifaceted account of the drivers and outcomes of universalism across diverse global contexts.

1.1 Conceptualising universalism: Multidimensional, relational, and political

The main contribution of the thesis lies in theorising, operationalising, and analysing universalism as a multidimensional, relational, and political concept – rather than as a normative aspiration or historical legacy. Building on and expanding the framework of Martínez Franzoni and Sánchez-Ancochea (2016), the thesis defines healthcare universalism as a multidimensional policy outcome where the entire population has equitable access to high-quality healthcare services, regardless of the institutional instruments used to deliver them. In capturing global 'varieties of universalism', this approach emphasises the joint achievement of concrete policy dimensions – Coverage, Generosity, and Equity – and treats these as distinct, yet interrelated, features of global healthcare systems that shape socio-political outcomes. The Healthcare Universalism Index introduced in Chapter 2 operationalises this framework and demonstrates that global patterns of universalism are more varied than existing measures, such as welfare typologies, might suggest. It reveals

substantial variation, persistent regional inequalities, and moderate trends of global policy convergence.

Moreover, the thesis advances the understanding of universalism not only as a redistributive mechanism but as a relational one. Chapter 3 conceptualises universal welfare institutions as 'spaces of equality' that shape the social foundations of trust through shaping equitable welfare experiences and shortening social distance. This perspective moves beyond purely distributional or effectiveness-based considerations to position universalism as a signifier of social hierarchies, shared membership, and mutual obligation. This relational perspective situates universalism as a part of the institutional infrastructure of cohesive societies: it is not merely about what is redistributed, but how policies are structured, who is included, and whether individuals perceive themselves as equal participants in shared systems of provision.

A further contribution of the thesis is the examination of universalism as a political construct, whose design and trajectory is shaped by electoral, ideological, and interest-based dynamics. Chapter 4 challenges the notion that healthcare expansion is a politically neutral process driven primarily by technocratic considerations or state capacity. It introduces a conceptual distinction between universal and segmented expansions, arguing that reforms can broaden access while simultaneously preserving or deepening socio-economic divides. The results of an event history analysis across 90 countries of the Global South reveal that – in contrast to potential expectations – segmented expansions are not the default path, but a choice shaped by government ideology, electoral volatility, and the configuration of vested interests.

Furthermore, by placing equity at the centre of analysis, the thesis contributes to the literature by emphasising the distributional, social, and political consequences of healthcare segmentation. Rather than treating it as a normative ideal or historical artefact, the thesis conceptualises equity as an integral part of universalism and as the defining feature of universal reforms. As such, equity functions both as an analytical lens and an empirical variable across all three papers, enabling a clear distinction between health systems that merely focus on coverage and those that promote inclusive access to quality healthcare for all. By highlighting how equity shapes and is shaped by income inequality, social trust, and reform politics, the thesis suggests that universal coverage without equity risks reproducing the very patterns of stratification and exclusion it seeks to overcome.

1.2 Interdisciplinary perspectives: Universalism in theory and method

By conceptualising universalism as a multidimensional, relational, and political institution, the thesis bridges and combines interdisciplinary perspectives from comparative political economy, social policy, and development studies to a shared empirical case study of healthcare universalism. Each of the three papers advances a specific theoretical or empirical lens: Chapter 2 engages with the measurement literature on universalism and its relationship with redistribution, Chapter 3 links to debates on social cohesion and the social foundations of trust, and Chapter 4 builds on the political economy of welfare expansion. By applying and adapting these frameworks through a global comparative lens, the thesis tests their validity beyond the historical-geographical case studies for which they were originally developed. In doing so, it shows that the paradox of redistribution persists in the Global North but also exists in the South under specific conditions; that the link between universalism and social trust holds globally, but with differing roles of its dimensions; and that electoral volatility and government ideology affect healthcare expansion trajectories even in emerging welfare states. The thesis thereby contributes to the globalisation of comparative welfare research and highlights how its theories and concepts can be productively applied and adapted to new empirical settings.

The thesis also contributes to the methodological toolset of comparative social policy and health system research by introducing a new index and an original dataset of healthcare reforms. Both tools enable more systematic, cross-national, and longitudinal analysis on a global scale, while also contributing to new conceptual lenses of multidimensionality and segmented policy expansions. The thesis employs these data sources using a diverse methodological skillset, ranging from cross-national panel data analysis to multilevel modelling approaches and event history analyses. The thesis demonstrates the value of combining macro- and micro-level perspectives, disaggregating universalism into its underlying dimensions, and adopting a macro-comparative lens to capture global variation in policy outputs.

1.3 Policy implications: Rethinking universalism

Beyond its academic contributions, the findings of this thesis have important implications for ongoing policy debates on universal health coverage (UHC) and the broader social protection agenda in the Global South. As UHC and universal social protection have taken centre stage in the global development discourse, this thesis calls for an expanded understanding of

universalism that places greater emphasis on generosity and equity, a more critical lens on private sector provision, and closer attention to the political economy of policy change.

In particular, the thesis argues that the key question in global social policy is no longer if universalism should be pursued, but rather in which variety: one that is focused on providing 'essential services' and financial protection against 'catastrophic' health expenditure – as prioritised in the Sustainable Development Goals – or a more expansive form that aims to provide equal access to high-quality care for all. As the thesis demonstrates, this is not merely a technocratic concern, but a choice that matters profoundly for both policy outcomes and the politics of reform. Expanding coverage alone is insufficient: when systems provide low-quality healthcare or preserve socio-economic stratification in access, they risk undermining the very outcomes that universalism seeks to achieve. This is not only a practical policy design challenge, but also an ideational one, with the ideas embodied in welfare provision exemplifying and shaping broader social norms of distributive justice, solidarity, and deservingness.[148]

Furthermore, the thesis calls for a critical lens on the role of the private sector, particularly given the growing focus on public-private partnerships in development cooperation and the broader marketisation of healthcare around the world. Beyond normative ideas of state versus market solutions, the thesis demonstrates throughout its three papers how higher levels of privatisation are associated with weaker redistribution, higher inequality, lower levels of social trust, and reduced likelihood of universal reforms. Even when assuming private sector provision as politically neutral, these outcomes stand in sharp contrast to universally endorsed outcomes of sustainable development – both in the Global North and in the Global South.

Overall, the thesis contributes to broader calls for bringing the 'politics back into healthcare' by recognising it as a contested institution of competing interests, ideas, and power relations that extend beyond technocratic notions of development. The analysis highlights the influence of vested interests, electoral dynamics, and underlying ideologies in reform processes, while also suggesting the role of healthcare as a social arena where notions of state responsibility, solidarity, and social citizenship are continually negotiated. From this perspective, the main barriers to achieving universalism lie not just in a lack of ideas, resources, or institutional capacity, but in the power struggles and politics of policy change.

[148] See Béland (2005), Obinger, Schmitt, and Starke (2013), and Kaasch (2015).

2. Avenues for future research

In contributing to new ways of conceptualising, measuring, and analysing universalism in a global context, this thesis opens several promising avenues for future research. The opportunities for a new research agenda draw on the cross-cutting open questions raised in the three empirical papers, as well as on the limitations of the thesis overall. thesis. In particular, while the focus on associational and macro-level analysis has enabled a global comparative scope, it remains limited in establishing causal mechanisms and taking into account country- or region-specific dynamics. Similarly, analysing universalism at the level of health systems has proven useful for identifying structural variation across contexts and over time, but important gaps remain in terms of data granularity and in capturing micro-level processes – such as policy implementation, political negotiations, or lived experiences of users. Addressing these limitations and building on the theoretical and empirical foundations laid here offers a valuable starting point for a new research agenda on universalism, inequality, and the politics of social policy in a global perspective.

The first, and potentially most ambitious, opportunity lies in extending the analysis beyond healthcare. While the thesis focused on healthcare as a particularly salient and universally relevant case study of programme universalism, the conceptual and methodological frameworks developed – such as the multidimensional approach, the distinction between universal and segmented expansion, or the reform database – can be productively applied to other policy domains, including social assistance, pensions, or education. This would allow for an analysis of within-country variation in universalism across programmes and, crucially, for testing the underlying assumption that its determinants and consequences might differ across sectors.

Social assistance is a particularly promising area for expanding the analysis due to its global prevalence and centrality to development discourse, primarily through the rise of conditional and unconditional cash transfer programmes in much of the Global South (Fiszbein and Schady 2009; Lavinas 2013; Ladhani and Sitter 2020). Comparing healthcare with social assistance is particularly interesting because they represent different functions of welfare – services versus income support – and tend to be associated with distinct welfare norms, stakeholder coalitions, and patterns of political visibility. Therefore, one could expect the

distributive effects and socio-political dynamics of universalism to vary significantly across these sectors, for example, due to different notions of deservingness and solidarity.[149]

Secondly, future research could explore the macro-micro linkages through which universalism, as a relational institution, influences individual attitudes towards social policy and society more broadly. For instance, the findings of Chapter 2 provide a starting point to examine the hypothesised mechanism behind the 'paradox of redistribution' in shaping individuals' support for redistribution and fostering cross-class coalitions. Although a substantial literature has explored these questions, much of the existing evidence remains inconclusive and geographically limited, in part due to measurement limitations and large variation between and within-country programmes (Larsen 2008; Wendt, Mischke, and Pfeifer 2011; Svallfors 2013; Gugushvili and Laenen 2021). Relatedly, while Chapter 3 links universalism to social trust, future work could engage with the literature on policy feedback and focus on wider welfare norms and attitudes, such as institutional trust, solidarity, and deservingness. One particular relationship to explore is the role of universalism for individual perceptions of inequality, which are inherent to the 'spaces of equality' argument in Chapter 3, where universalism is assumed to reduce social distance through lower segmentation. While a substantial body of public opinion research has analysed these mechanisms for healthcare, future research could expand the analysis from a European perspective and employ the new reform dataset to analyse shifts in attitudes before and after policy changes (van Oorschot, Reeskens, and Meuleman 2012; Mewes and Giordano 2017; Popic and Schneider 2018; Immergut and Schneider 2020).

A third promising research direction involves connecting universalism to broader social, political, and institutional factors. While the thesis has shown that universalism is associated with higher levels of trust, greater redistribution, and lower inequality, further work could extend this analysis to outcomes such as health indicators, multidimensional poverty, and broader measures of human development. For example, building on the empirical case study in Chapter 2, future research could investigate how universalism relates to different forms of inequality, such as disparities along gender, regional, rural, or ethnic lines. For these and

[149] As suggested in the recent literature on trust and the welfare state (Lee 2013; Kumlin, Stadelmann-Steffen, and Haugsgjerd 2017; Mewes 2024).

other outcomes, the reform dataset presented in Chapter 4 could be used within more explicitly causal research designs, including event studies and synthetic control methods.[150]

Beyond outcomes, the analysis of the determinants of universalism could expand beyond political economy factors, for example, by engaging with the literature on policy diffusion, colonial legacies, and the influence of international organisations (Rudra 2007; Zohlnhöfer, Obinger, and Wolf 2008; Obinger, Schmitt, and Starke 2013; Mkandawire 2020). In particular, the uneven distribution of 'varieties of universalism' across levels of development offers a promising starting point for investigating the often-posited claim that state capacity is a precondition for the implementation of universal policies. Similarly, the contested relationship between democracy and universalism – which is only implicitly addressed in Chapter 4 – deserves more explicit theoretical and empirical attention, especially in light of regime hybridity and democratic backsliding in many regions (Ansell 2008; Haggard and Kaufman 2008; Knutsen and Rasmussen 2018; Szikra and Öktem 2023).

Finally, there is an opportunity to place the study of universalism within broader debates around sustainable development, social protection, and inclusive growth. In times of fundamental transformations and intersecting crises – including climate change, demographic ageing, technological disruption, and global pandemics – the need for inclusive and resilient welfare institutions is more pressing than ever. These global 'polycrises' are not only interrelated but structurally unequal in their impacts, with countries of the Global South often disproportionately affected but least equipped to respond. Future research could adopt a forward-looking perspective and examine how universalism interacts with emerging issues such as planetary health, ageing and care crises, automation risks, and global inequality (Martínez Franzoni, Sánchez-Ancochea, and Paus 2018; Thewissen and Rueda 2019; Birnbaum and Nelson 2023; Vaalavuo, Nelson, and Kuitto 2025).

The findings of this thesis suggest that universalism may form part of the social foundation for managing these global transformations. By not only providing material protection against risks but also institutionalising core values of solidarity, equity, and human dignity,

[150] There is considerable scope to diversify methodological approaches and adopt more regionally or nationally focused analyses. The macro-comparative framework adopted in this thesis necessarily sacrifices some institutional and historical nuance. Future studies could adopt qualitative comparative case studies to trace how universal or segmented reforms develop over time, how vested interests are managed or contested, and how implementation challenges shape policy outcomes. Such approaches would offer a more granular understanding of the mechanisms explored in this thesis and help uncover sources of variation across regions, countries, and reform trajectories that may be obscured in large-scale cross-national analyses.

universalism could become an essential part of the institutional response to the deep insecurities of the Anthropocene. In contexts of increasing risks and uncertainty, universal social policies not only serve as social safety nets for all but also provide relational spaces of shared solidarity, public trust, and societal resilience. By reducing segmentation and inequality, universalism can strengthen social cohesion as a precondition for effective collective action on global threats.

I consider the global quest for universalism not as a technocratic agenda, but as a political, social, and ethical imperative. Nowhere is it more urgent to follow this imperative than in the Global South, where risks of exclusion are highest, but the potential returns to inclusive, solidaristic social policies are greatest. Universalism is more relevant than ever: not as an artefact of European welfare histories, but as a multidimensional, relational, and political foundation of inclusive development.

3. References

Ansell, Ben W. 2008. 'Traders, Teachers, and Tyrants: Democracy, Globalization, and Public Investment in Education'. *International Organization* 62(2): 289–322.

Arts, Wil, and John Gelissen. 2002. 'Three Worlds of Welfare Capitalism or More? A State-of-the-Art Report'. *Journal of European Social Policy* 12(2): 137–58.

Béland, Daniel. 2005. 'Ideas and Social Policy: An Institutionalist Perspective'. *Social Policy and Administration* 39(1): 1–18.

Birnbaum, Simon, and Kenneth Nelson. 2023. 'Age Universalism Will Benefit All (Ages)'. In *Ageing without Ageism?*, eds Greg Bognar and Axel Gosseries. Oxford: Oxford University Press, 94–112.

Bonoli, Giuliano. 1997. 'Classifying Welfare States: A Two-Dimension Approach'. *Journal of Social Policy* 26(3): 351–72.

Devereux, Stephen. 2016. 'Social Protection for Enhanced Food Security in Sub-Saharan Africa'. *Food Policy* 60: 52–62.

Dionne, Kim Yi, and Jeremy Horowitz. 2016. 'The Political Effects of Agricultural Subsidies in Africa: Evidence from Malawi'. *World Development* 87: 215–26.

Ferrera, Maurizio. 1996. 'The "Southern Model" of Welfare in Social Europe'. *Journal of European Social Policy* 6(1): 17–37.

Fiszbein, Ariel, and Norbert Rüdiger Schady. 2009. *Conditional Cash Transfers: Reducing Present and Future Poverty*. Washington D.C: World Bank.

Flora, Peter. 1986. *Growth to Limits: The Western European Welfare States Since World War II*. Berlin: Walter de Gruyter.

Gough, Ian, Geof Wood, Armando Barrientos, Philippa Bevan, Peter Davis, and Graham Room. 2004. *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts*. Cambridge: Cambridge University Press.

Gugushvili, Dimitri, and Tijs Laenen. 2021. 'Two Decades after Korpi and Palme's "Paradox of Redistribution": What Have We Learned so Far and Where Do We Take It from Here?' *Journal of International and Comparative Social Policy* 37(2): 112–27.

Haggard, Stephan, and Robert Kaufman. 2004. 'Revising Social Contracts: Social Spending in Latin America, East Asia, and the Former Socialist Countries, 1980-2000'. *Revista de ciencia política* 24(1).

Haggard, Stephan, and Robert R. Kaufman. 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*. Princeton: Princeton University Press.

Hickey, Sam. 2011. 'The Politics of Social Protection: What Do We Get from a "Social Contract" Approach?' *Canadian Journal of Development Studies/Revue canadienne d'études du développement* 32(4): 426–38.

Immergut, Ellen M., and Simone M. Schneider. 2020. 'Is It Unfair for the Affluent to Be Able to Purchase "Better" Healthcare? Existential Standards and Institutional Norms in Healthcare Attitudes across 28 Countries'. *Social Science & Medicine* 267: 113146.

Jayne, T.S., and Shahidur Rashid. 2013. 'Input Subsidy Programs in sub-Saharan Africa: A Synthesis of Recent Evidence'. *Agricultural Economics* 44(6): 547–62.

Kaasch, Alexandra. 2015. *Shaping Global Health Policy: Global Social Policy Actors and Ideas about Health Care Systems*. London: Palgrave Macmillan.

Kabeer, Naila. 2014. 'The Politics and Practicalities of Universalism: Towards a Citizen-Centred Perspective on Social Protection'. *The European Journal of Development Research* 26(3): 338–54.

Knutsen, Carl Henrik, and Magnus Rasmussen. 2018. 'The Autocratic Welfare State: Old-Age Pensions, Credible Commitments, and Regime Survival'. *Comparative Political Studies* 51(5): 659–95.

Koehler, Gabriele. 2021. 'Effects of Social Protection on Social Inclusion, Social Cohesion and Nation Building'. In *Handbook on Social Protection Systems*, eds Esther Schüring and Markus Loewe. Cheltenham: Edward Elgar Publishing, 636–46.

Kumlin, Staffan, Isabelle Stadelmann-Steffen, and Atle Haugsgjerd. 2017. 'Trust and the Welfare State'. In *The Oxford Handbook of Social and Political Trust*, ed. Eric M. Uslaner. Oxford: Oxford University Press, 385–408.

Ladhani, Sheliza, and Kathleen C. Sitter. 2020. 'Conditional Cash Transfers: A Critical Review'. *Development Policy Review* 38(1): 28–41.

Larsen, Christian Albrekt. 2008. 'The Institutional Logic of Welfare Attitudes: How Welfare Regimes Influence Public Support'. *Comparative Political Studies* 41(2): 145–68.

Lavinas, Lena. 2013. '21st Century Welfare'. *New Left Review* 84(6): 5–40.

Lee, Cheol-Sung. 2013. 'Welfare States and Social Trust'. *Comparative Political Studies* 46(5): 603–30.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.

Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea. 2021. 'Are Welfare Regimes a Useful Category? The Cross-Sectoral Variation in Social Policy in Latin America at the End of the Commodity Boom'. *Development Studies Research* 8(1): 294–308.

Martínez Franzoni, Juliana, Diego Sánchez-Ancochea, and Eva Paus. 2018. 'Why and How to Build Universal Social Policy in the South'. In *Confronting Dystopia: The New Technological Revolution and the Future of Work*, Ithaca: Cornell University Press, 230–50.

Mewes, Jan. 2024. 'Welfare-State Selectivity, Universality, and Social Trust in Europe, 2002–2019: Bringing Deservingness Back In'. *Journal of European Social Policy* 34(1): 20–35.

Mewes, Jan, and Giuseppe Nicola Giordano. 2017. 'Self-Rated Health, Generalized Trust, and the Affordable Care Act: A US Panel Study, 2006–2014'. *Social Science & Medicine* 190: 48–56.

Mkandawire, Thandika. 2020. 'Colonial Legacies and Social Welfare Regimes in Africa: An Empirical Exercise'. In *The Politics of Domestic Resource Mobilization for Social Development*, ed. Katja Hujo. Cham: Palgrave Macmillan, 139–72.

Nelson, Kenneth, and Johan Fritzell. 2014. 'Welfare States and Population Health: The Role of Minimum Income Benefits for Mortality'. *Social Science & Medicine* 112: 63–71.

de Neubourg, Chris. 2009. 'Social Protection and Nation-Building: An Essay on Why and How Universalist Social Policy Contributes to Stable Nation-States'. In *Building Decent Societies*, ed. Peter Townsend. London: Palgrave Macmillan, 63–79.

Obinger, Herbert, Carina Schmitt, and Peter Starke. 2013. 'Policy Diffusion and Policy Transfer in Comparative Welfare State Research'. *Social Policy & Administration* 47(1): 111–29.

van Oorschot, Wim, Tim Reeskens, and Bart Meuleman. 2012. 'Popular Perceptions of Welfare State Consequences: A Multilevel, Cross-National Analysis of 25 European Countries'. *Journal of European Social Policy* 22(2): 181–97.

Popic, Tamara, and Simone M. Schneider. 2018. 'An East–West Comparison of Healthcare Evaluations in Europe: Do Institutions Matter?' *Journal of European Social Policy* 28(5): 517–34.

Rudra, Nita. 2007. 'Welfare States in Developing Countries: Unique or Universal?' *The Journal of Politics* 69(2): 378–96.

Svallfors, Stefan. 2013. 'Government Quality, Egalitarianism, and Attitudes to Taxes and Social Spending: A European Comparison'. *European Political Science Review* 5(3): 363–80.

Szikra, Dorottya, and Kerem Gabriel Öktem. 2023. 'An Illiberal Welfare State Emerging? Welfare Efforts and Trajectories under Democratic Backsliding in Hungary and Turkey'. *Journal of European Social Policy* 33(2): 201–15.

Thewissen, Stefan, and David Rueda. 2019. 'Automation and the Welfare State: Technological Change as a Determinant of Redistribution Preferences'. *Comparative Political Studies* 52(2): 171–208.

Vaalavuo, Maria, Kenneth Nelson, and Kati Kuitto, eds. 2025. *Social Sustainability in Ageing Welfare States*. Cheltenham: Edward Elgar Publishing.

Wendt, Claus, Monika Mischke, and Michaela Pfeifer. 2011. *Welfare States and Public Opinion: Perceptions of Healthcare Systems, Family Policy and Benefits for the Unemployed and Poor in Europe*. Cheltenham: Edward Elgar Publishing.

Wood, Geof, and Ian Gough. 2006. 'A Comparative Welfare Regime Approach to Global Social Policy'. *World Development* 34(10): 1696–1712.

Zohlnhöfer, Reimut, Herbert Obinger, and Frieder Wolf. 2008. ‘Partisan Politics, Globalization, and the Determinants of Privatization Proceeds in Advanced Democracies (1990–2000)’. *Governance* 21(1): 95–121.