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Letter to the Editor

Government, politics and health policy: Ways forward from Mackenbach and McKee's study

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1. Introduction

Democratic governments, in general, are more accountable and responsive to their populations than non-democratic governments [1], as democracy compels rulers to act for the good of voters via contested elections [2,3]. Along this line of reasoning democracy should produce salutogenic public policies, including health policies, in comparison to non-democracy because in the former citizens have more institutional room for opportunities in promoting their interests and politicians must appeal to a wide range of supporters [4–6]. Furthermore, democracies, on average, may be better built around institutional checks and balances (e.g. accountability agencies like courts, and independent statistical offices), which constrain rulers for the benefit of voters and public good [7–9] and help forward basic freedoms (e.g. freedom of information) and to transform citizen expectations [1]. Therefore, even in case where democracies and non-democracies would pursue similar public policies [10], democracy might well produce more policies serving the public interest if their institutional checks and balances produced less rents (e.g. reduced corruption) in comparison to non-democracies [11–13].

Earlier empirical studies have found that democracy is to some extent associated with higher public health spending [14,15] and with access to and utilization of health services [7,16]. Johan Mackenbach and Martin McKee recently broke new ground in their paper, "Government, politics and health policy: A quantitative analysis of 30 European countries" (hereafter referred to as GPHP-study), by using an extensive dataset of 30 countries, and testing 15 different aspects of government and 18 indicators of health policy between 1990 and 2010 [17]. They were able to show that, measures of quality of democracy and quality of government had many positive associations with process and outcome indicators of health policy, while measures of distribution of power and political representation had few and inconsistent associations. Associations for quality of democracy (average of Freedom House and Polity2 scales, and Voice and accountability index) were robust against more extensive control for confounding variables, including tests in panel regressions with country fixed effects, but associations for quality of government (indexes of Quality of government, Professional public administration, Political stability, Rule of law, and Corruption perception) were not. GPHP did not, however, only offer new empirical findings but also helped to reveal potential pathways for further investigation of the impacts of political macro-variables on health policies. In this paper, we first discuss the use of democracy and health policy measures, as well as what is not measured, in GPHP. Second, we borrow ideas from scholars of comparative-historical analysis and discuss three potential pathways to go forward in studying the associations between government, politics and health policy: configuration of political macro-variables, mechanism-based research, and temporally oriented research.

2. Variables that capture reality

According to political scientists, democracy requires a competition for the people's vote between political organizations or individuals. Most scholars also agree with Robert Dahl's view, such that to make political competition meaningful, high suffrage is also a must [18]. As measuring democracy depends on democratic theory [19,20], one's theory of democracy generates indicators that can be used to test the explanatory power of that particular theory. GPHP, with the pragmatism that characterizes most social epidemiology [21], uses a combination of the Polity 2 index and the Freedom House scale, but offers no theoretical justification for the selection of this measure. The Freedom House scale with 22 components under its political and civil rights attributes [22] represents a fully different definition of democracy when compared with the Polity 2 index with nine components in its attributes: competitiveness of political participation, openness and competitiveness of executive recruitment, and constraints on the chief executive [23]. The use of data available and already coded by other researchers may well lure one into sidestepping the need to justify the choice of indicators. At the same time it may, however, also limit the search of causal explanations, if the association between the measured phenomena are not theoretically well established,

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and putting two different measures together will not automatically increase the theoretical explanatory power but may even decrease it (e.g. SES composite measures). Thus, having empirical data on democracy is better than not having any data but more attention should be paid on what is measured and why [21].

GPHP uses six specific indicators of health policies as their outcome variables (tobacco control scale, alcohol control scale, cancer screening programs, child safety grade, road safety performance score, environmental performance index), to capture the influence of political conditions on implementation of health policies more directly than would be possible by analysing health indicators only. It then uses six behavioural measures to indicate specific behaviours targeted by health policies, and six health measures to indicate specific health outcomes targeted by health policies. This represents an accomplishment in comparison to many previous studies [24]. At times, no theoretical difference is, however, made in GPHP between the six specific indicators of health policy, six behavioural outcomes and six health outcomes, but they are all discussed as health policy indicators, overlooking that investments in health policies do not necessarily translate into superior behavioural outcomes and health outcomes [25,26].

As Schattschneider [27] noted "The flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent". GPHP grasps the distribution of power via four measures, party-political fractionalization, political constraints, fiscal centralization, and consensus democracy. Even if this is an improvement over previous efforts [28], as it helps to take the distribution of power into account, it might not be enough to reveal most power relations. Democracy under capitalism is intimately connected to social class dynamics, and according to critics a capitalist state can never be truly democratic by its nature [29] as the necessary condition for capital accumulation is that the freedom to reap the benefits of economic resources (capital, labour) in the hands of a minority implies the exclusion of others from these benefits [30]. Thus, even if democratic governments by their nature would be more accountable and responsive to their populations than non-democratic governments and even if democracies' institutional system would help them to support accountability, under capitalism democracy's capacity to impact public policies is contingent upon economic power relations, and the theory of democratic accountability and responsiveness can only apply ceteris paribus. In other words, without economic democracy, the minority that accumulates more economic resources ends up having an undue impact on the democratic process [30,31]. Political scientists, such Paul Pierson, have suggested specific theoretically grounded research designs for uncovering the power relations in empirical studies [32].

3. Comparative-historical approach

Following Esping-Andersen's work on welfare regimes [33] and Hall and Soskice's work on varieties of capitalism [34], it may be fruitful for post-GPHP-studies to explain outcomes of political macro-variables by examining how these variables work together in configurations, not only to look independent variables (e.g. quality of democracy, quality of government, distribution of power and political representation) one at a time. To take the example of welfare regimes, Esping-Andersen presented them as macro configurations of institutions created by historical coalitions of particular actors (e.g. the working class and the middle class), which over time institutionalized particular power structures shaping subsequent politics and policies (e.g. unemployment benefits). Therefore, the political equality in a democracy and the economic inequality produced by capitalism did not create similar outcomes in all emerging welfare states but the resolution could largely be explained by simultaneously examining the power of organized groups and the actual historical coalitions they stroke.

For post-GPHP-studies it may not be enough to demonstrate that certain political macro-variables covary with policy outcomes, but one should be able to find a mechanism between them. Comparative-historical analysts often employ empirically grounded mechanism-based explanations in which the mechanisms are identified empirically, either looking for specific mechanisms anticipated in advance or explaining those cases that did not comply with anticipated mechanisms [35,36]. For an example, a recent comparative-historical analysis over eight East Asian and Latin American countries by James McGuire found that democracy often has beneficial impact on provision and utilization of basic health services, but democracy's impact on these policy outcomes is not invariable but contingent upon the national context (e.g. the power of class actors such as the banking sector), and mechanisms through which democracy exerts its impact go well beyond electoral incentives, including freedom of information, freedom to organize, and changes in political culture [37]. Indicating that the latter mechanism is particularly important, long-term democratic experience was in McGuire's study associated more closely than short-term democratic practise with the provision and utilization of many basic health services, while his study did not test the effects of long-term non-democratic practise. Another recent comparative-historical analysis examined long-term political determinants of public health investment in world's largest democracy (India) and world's largest non-democracy (China), showing the major impact of egalitarian development ideology and organized pressure from the working social classes, and helping to understand why democracies sometimes trail non-democracies in public health investments [38]. Whereas India experienced multiple democratic changes in party control, it never experienced significant lower class pressure, never supported an egalitarian development ideology, and allocated few resources to public health throughout the study period of 1947–2011 (a notable exception was the state of Kerala with combination of political pressure from the working classes, flourishing egalitarian ideology, and major public health investments). Instead, China initially championed an egalitarian ideology and invested greatly in public health in 1950s, 1960s, and 1970s before turning away from this ideology in early 1980s because of personnel shifts

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