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The enduring influence of institutions on universal health coverage: An empirical investigation of 62 former colonies

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ABSTRACT

In this paper, we argue that particular institutional arrangements partly explain the large and persistent differences in health systems and health outcomes observed in former colonies. Drawing on data from the World Health Organization for 62 countries, covering the period 2000–2014, we explore whether economic (risk of expropriation) and health (complete cause of death registries) institutions explain mortality rates and access to healthcare. To identify this relationship, we use settler mortality and the distance of the capital from the nearest major port – factors associated with institutional arrangements – to explain cross-national variation in health outcomes and the universality of health systems. We find that inclusive institutions arrangements – that protect and acknowledge the rights of citizens – are associated with better health outcomes (e.g. lower infant mortality and lower maternal mortality) as well as with better health systems (e.g. more skilled birth attendance and greater immunization). Inclusive institutions not only foster economic growth but improve health and well-being too.

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1. Introduction

On 20 July 2014, after ravaging the West African countries of Liberia, Sierra Leone, and Guinea, the Ebola virus reached Lagos, Nigeria, one of Africa's largest and most densely populated cities (Tilley-Gyado, 2015; WHO, 2014). Panic regarding the epidemic intensified instantly. If the virus was not immediately contained, it risked escalating into an irreversible global crisis. Public health officials worried Ebola would expose persistent governance challenges and coordination problems in the Nigerian health system; but these fears did not materialize. The Nigerian government successfully prevented the mass transmission of Ebola, documenting only 19 infections and 7 fatalities (WHO, 2016). By contrast, the virus reached epidemic proportions in Liberia, Sierra Leone, and Guinea; with more than 28,600 cases and 11,300 deaths (WHO, 2014). The Ebola epidemic illuminates the profound disparities in health systems across West Africa, but these disparities are not only apparent in those few countries directly affected by this localized epidemic. Immunization, infant mortality, and access to healthcare all exhibit jarring levels of inequality between countries, even those with comparable geographies and similar disease burdens (World Bank, 2015). What, then, explains these massive disparities in health coverage and health outcomes brought into stark visibility by the Ebola epidemic (Robinson, Acemoglu, and Johnson, 2003)?

In this paper we argue that institutional differences – the formal and informal constraints on human interaction (North, 1994) – inherited from the colonial period partly explain the large and persistent differences in health systems and the improvements in health they deliver today. Institutions are the rules and regulations of society (Beckfield, 2015; Kalleberg, 2009) and these rules can be, to differing degrees, extractive or inclusive. The former exist when rules do not protect people from exploitation. Extractive institutions, then, may offer little protection for private property, few safeguards against government expropriation, and often fail to recognize the rights of citizens. Extractive institutions, in fact, may be the source of exploitation (Scheidel, 2017). Inclusive institutions, by contrast, are characterized by pluralism, where many people are included in the processes of political and economic governance. They are marked by stricter adherence to law and order, more stringent protection of private property, some constraints on executive power, and more robust recognition of citizenship, hence

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exploitation is often attenuated (Acemoglu, Johnson, and Robinson, 2001).

For many countries, the creation of more extractive (or more inclusive) institutions is rooted in the colonial period, and the influence of these critical junctures on society continues to be felt today (Banerjee and Iyer, 2005; Besley, 1995; Lange, Mahoney, and vom Hau, 2006; Mahoney, 2010). For example, the establishment of extractive institutions by colonial powers constrained economic development in former colonies after independence, affecting whether contemporary societies are richer or poorer (Acemoglu et al., 2001). Colonial institutional legacies may affect health too but here the evidence is far less certain (Lange et al., 2006). Mahoney (2010) has examined this question using data from former Spanish colonies and documents persistent differences in social development over time according to the type of institutions established under colonial rule. While almost all countries improve, their relative position with respect to other former colonies remains relatively stable: that is, those Latin American countries with better life expectancy and infant mortality in 1975 still have better outcomes 30 years later. One important gap in this earlier work, however, is whether these colonial institutions affect health *only* through their impact on economic growth; for 'wealthier is healthier' (Deaton, 2015; Pritchett and Summers, 1996). Of course, as the Ebola example illustrates, institutional arrangements may directly influence health, independent of their effect on development (Kentikelenis, King, McKee, & Stuckler, 2015). And so, whether – independent of development – the inheritance of extractive institutions affects health system coverage and/or health outcomes in the present remains an open question.

Like economic development, institutions may affect health because they stipulate the formal structures and rules governing relations between actors within societies, shaping social interactions and guiding what is fair and reasonable under certain circumstances (Kalleberg, 2011). For example, population health seems to improve when countries foster democracy (Baker, Hone, Reeves, Avendano, & Millett, 2018; Besley and Kudamatsu, 2006; Mackenbach, Hu, and Looman, 2013; Shandra, Nobles, London, & Williamson, 2004), create generous social protection schemes (Lundberg, , 2008; Stuckler, Basu, and McKee, 2010), or regulate food production (Restrepo and Rieger, 2016). Many of these studies have focused on specific policies or institutional rules, such as employment protection legislation (Reeves, Karanikolos, Mackenbach, McKee, and Stuckler, 2014) or maternity leave (Avendano, Berkman, Brugiavini, & Pasini, 2015). However, other studies seek to uncover and classify the underlying institutional ideologies that shape rules and policymaking (Esping-Andersen, 1990). Here we might consider the degree to which societies decommodify healthcare and labour ('welfare regimes' approach, Esping-Andersen, 1990) or how they organize relations between employees and employers within firms ('varieties of capitalism' approach, Hall and Soskice, 2001).

The range of institutions that have implications for health are certainly not only located at the national level (Noy, 2017). International financial institutions, such as the World Trade Organization (WTO), World Bank, or International Monetary Fund (IMF), have had a profound influence on the shape and structure of the economies of low- and middle-income countries, with potentially quite significant health effects (Kentikelenis, 2017; McNeill, 2017; Noy, 2017). The creation and extension of free trade deals may accelerate the spread of unhealthy commodities (Thow, 2009) while the move towards taxation on goods and services rather than income slowed declines in infant mortality (Reeves, 2015). Structural adjustment programmes, too, have exacerbated pressures on healthcare systems that have potentially contributed to the spread of infectious diseases (Kentikelenis, 2017). Recent research has also shown that the impact of such programs implemented by such international institutions is likely dependent on already-established institutions (Noy, 2017).

Despite the importance of supra-national institutions, we focus on the health implications of national-level institutions that seem to have a colonial legacy. For example, one set of institutions that meet these criteria are the rules determining property rights. These institutional rules stipulate who can own land and other assets while also providing protections against the risk of expropriation (de Soto, 2000). Guaranteeing property rights is a form of inclusive institutional arrangements that has been closely linked with economic development, through encouraging investment in physical and human capital, but also with improved health and education among children in specific settings (Besley, 1995; Galiani and Schargrodsky, 2004, 2010).

Another set of inclusive institutions that may directly impact health and be linked to colonial legacies is the establishment of a national registration system of deaths (Acemoglu, Gallego, and Robinson, 2014; Mathers et al., 2005; Szreter, 2007). These institutions are inclusive because they establish a legal identity that is foundational to property rights, voting rights, and other entitlements from the state (Szreter, 2007). Registering deaths (and births) was integral to the development of citizenship and the creation of robust healthcare systems (Szreter, 2007). Death registration systems are not new – England established their system in 1538 – but many less developed countries still do not possess routinized procedures for recording deaths (and births), while in other contexts registration systems are only partial at best (Mathers et al., 2005). Inclusive institutions which create formal legal identities are also central to demographic analysis; for if countries are to take seriously their responsibility to protect and enhance the life expectancy of their citizens, they must have access to accurate data on births and deaths (Szreter, 2007). In focusing on national registration systems, we follow Lange et al. (2006), who stressed the importance of 'state institutions' in fostering social development, because they promoted the 'rule of law' and the creation of state bureaucracies, which are essential to the establishment of effective healthcare systems (Lange, 2004; Lange et al., 2006). Carefully recording deaths, not only ensures that rights are protected, but it also reveals where greater resources are required, allowing healthcare providers of various kinds to target their efforts to those areas where improvement is both needed and possible. As Jha has argued, establishing public registration systems is 'one of the world's best investments to reduce premature mortality' (Jha, 2012).

Clearly, it is possible to a draw a plausible causal connection between many types of institutional arrangements installed in a country and whether a country can ensure healthy lives for all of its citizens (Marmot, Friel, Bell, Houweling, & Taylor, 2008). Despite acknowledging the breadth of possible institutions that may affect health, we focus on property rights and registration systems because they both potentially have links to colonial histories and both have recently been included within the SDGs since they may accelerate progress towards the health goals. At the same time, registration systems have received surprisingly little attention in the previous literature and this paper seeks to address this gap. We argue that the establishment of inclusive or exclusive institutions – such as those pertaining to property rights and registration systems – will shape the structure of societies and this, in turn, may affect the health of populations (Kalleberg, 2011; Reeves, McKee, Basu, and Stuckler, 2014).

We do not, however, suggest that simply adopting inclusive institutions will immediately guarantee that everyone can attain a healthy life. Even when particular institutions have been formally changed, pre-existing institutional arrangements continue to cast a long-shadow over social outcomes (Banerjee and Duflo, 2014). One reason for the durability of these effects is that institutions are

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