From Ideals to Implementation: 
Explaining the Global Transition to Universal Heath Coverage

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“We thus find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right.”

– Paul Farmer, *Pathologies of Power*

**ABSTRACT** The world is witnessing a groundbreaking transition to universal health coverage. Yet few researchers have explained why nations as distinct as Rwanda and Thailand, for example, have chosen to implement universal coverage within the last decade or so. An analysis of international politics can help illuminate why the idea that everyone has a right to health has materialized into concrete health policies. This paper argues that both international norm construction and domestic conditions of individual states influence whether or not countries adopt universal health coverage. As a principle norm creator and agenda setter, the World Health Organization’s (WHO) pragmatic, evidence-based framing of universal coverage has enabled it to make a strong argument for UHC. Rather than characterize the WHO as the sole determinant of the transition to UHC, this paper asserts that it serves a catalytic role in shaping countries’ decisions to reform their health systems—global and local limitations also constrain its mandate. National governments have unique economic and political conditions that work to enable or disable policy change. Thus, the powerful convergence of effective norm construction in international networks and greater local capacity has encouraged countries across the globe to reform their health systems.

I. Introduction

Margaret Chan, the current Director-General of the World Health Organization (WHO), claims that “universal health coverage is the single most powerful concept that public health has to offer.”¹ Although universal health care first originated in Europe, today an increasing number of low and middle-income nations are reforming their health care policies and implementing universal health coverage (UHC). While the first wave of reform emerged after World War II, a new “wave”² or “global health transition”³ is taking place across the world. With the exception of the United States, the 25 wealthiest countries in the world have universal health care, and now countries like Vietnam, Mali, and Colombia are making progress toward universal coverage. Almost every low and middle-income country today is currently “engaged in some reform to

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¹ “WHO | Sixty-fifth World Health Assembly.”
³ Rodin and De Ferranti, “Universal Health Coverage.”
expand access to care and improve financial protection.” Nations such as India, China, Indonesia, and South Africa are part of this movement. If successful in their implementation, these four countries alone could provide health coverage for 40% of the global population. Given these sweeping changes, the major puzzle that emerges concerns the cause of the dynamic momentum building for UHC as an international norm. The drivers behind its prevalence in the last decade or so are not obvious, especially given the global economic recession, convoluted governance of global health, and absence of universal health care in the United States. While several authors have described the how part of the UHC phenomenon, far fewer have explained the why.

One of the most convincing potential explanations involves a correlation between a nation’s economic growth and demand or implementation of UHC. The “health financing transition,” or rise in health spending per capita and pooled health expenditures, was observed in 126 countries between 1995 and 2009. Health financing becomes increasingly relevant as countries develop, and some could argue that the rise in income and increased economic ability for people to purchase health insurance pushes countries toward universal coverage. Yet the health financing transition does not ensure the implementation of health reform. The U.S. has witnessed a rise in per capita health spending from $148 to $7,668 from 1960 to 2008 in comparison to Japan, which rose from $171 to $2690. Even in the U.S., 85% of that rise was due to pooled expenditures from public programs. Despite these trends, the U.S. lacks universal health care. Thus, the global financing transition provides a related, but incomplete picture of the UHC transition. Furthermore, while economic factors influence policy change, the pure

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5 Ahoobim et al., The New Global Health Agenda: Universal Health Coverage, 1.
6 Ibid., 2.
economic explanation fails to explain why low-income governments such as Rwanda, the Philippines, and Bangladesh exhibit national health insurance programs. Historically, countries like the United Kingdom have achieved universal coverage with low levels of economic development. Furthermore, the world remains entrenched in a system of economic globalization, neoliberalism, and growing inequality. The macroeconomic state of the modern world favors privatization and market-oriented policymaking, rather than social protection.

To begin to delve into the causes of the current global movement, researchers should instead look toward an explanation based on international politics. Health systems as well as health outcomes are produced through political processes—all health is inherently political. McKee et al., a group of established global health policy researchers, explain that there is no singular explanation for UHC. Rather, they present a multifaceted theory based on five determinants of UHC: the strength of organized labor, economic resources, societal division, existing institutions, and windows of opportunity. While these factors examine local processes, their argument could better link them to international influences. Through a new approach, this paper proposes that theoretical frameworks based on norms offer a cogent analysis of health reform as it pertains to the connection between global and local. Many would consider universal coverage a mere health financing mechanism, but it contains many more social and political nuances. UHC can be considered a norm because of its intrinsic ideological underpinnings: it expresses the fundamental human right to health and seeks to put the concept of global health equity into practice.

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10 McKee et al., “Universal Health Coverage.”
In terms of international human rights law, the idea of universal access to health care is not new. Article 25 of the Universal Declaration of Human Rights (UDHR) declares, “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.” This spawned Article 12 of the International Covenant on Economic, Social and Cultural Rights, which states that everyone has a right to “the highest attainable standard of physical and mental health.”\(^{11}\) As the World Health Organization defines it, health is “a state of complete physical, mental, and social well-being and not merely the absence of disease.”\(^{12}\) In other words, public health addresses whole populations and the social, economic, and political dimensions of health. The right to health does not imply “state handouts” free from individual accountability; rather, it argues that humans deserve to lead healthy lives and exist in healthy societal conditions. It is also enshrined in the WHO’s Constitution (1948), demonstrating its centrality to the WHO’s underlying ideology.\(^{13}\) As the Lancet explains, the right to health materializes into a concrete reality through the multifaceted aspects of health systems.\(^{14}\) Hence, a sociopolitical or normative analysis is essential to a study of health systems and health reform.

In 1978, the World Health Organization (WHO) launched a campaign for primary health care under the slogan, “Health for All by 2000.” Under this banner, the WHO argued that all people deserved access to a basic level of health services and standards. This was to be achieved through holistic restructuring of public health systems and social structures outside of the health sector. This agenda of the early 1980s failed in most respects, as most countries lacked the capacity to implement UHC. Almost the opposite of its original vision, the “selective primary health care” agenda replaced primary health care and instead identified four vertical health

\(^{13}\) “Constitution of the World Health Organization.”
\(^{14}\) Backman et al., “Health Systems and the Right to Health.”
interventions that ultimately lacked effectiveness in terms of health outcomes.\textsuperscript{15} These four were growth monitoring, oral rehydration therapy, breastfeeding, and immunization (GOBI). The politicized promotion of Health for All encountered a resistant ideology of neoliberal policies in the 1980s that derailed the WHO’s agenda. In contrast, the current UHC agenda appears to have successfully taken root worldwide. Even if the systems themselves remain imperfect, many governments are engaged in the process of reform. What makes these two campaigns, primary health care and UHC, different? How can these differences help explain why the world is internationalizing universal coverage?

The central research question I propose is: \textit{why is the world experiencing a global transition to universal health coverage?} This poses a distinct question from the numerous studies\textsuperscript{16-17} on the waves of European health reform, which began in 1948. The present research question rather addresses the current rise of UHC in a diversity of nations, and embeds the unexpected nature of its timing. To answer this question, I will adopt an analysis that positions international institutions as key actors in normative networks. Almost all explanations of the political aspects of UHC evoke, even if through unintentional means, the WHO’s authoritative role in promoting UHC. Although the WHO serves as a primary architect of this movement, it relies on the ideals and action of its Member States. Its Member States each contain specific limitations, opportunities, and complexities. Thus, this campaign takes on a transnational character that pervades both global and local spaces.

To explore how norm diffusion operates for universal health coverage, I propose the below visual analytic (see Figure 1) to explain how the normative ideas of the WHO promote

\textsuperscript{15} Magnussen, Ehiri, and Jolly, “Comprehensive Versus Selective Primary Health Care,” 170.
\textsuperscript{16} Bump, \textit{The Long Road to Universal Health Coverage}.
\textsuperscript{17} \textit{Social Health Insurance Systems in Western Europe}.
health reform. The WHO frames norms that enter a global environment of additional ideas and competing norms; with sufficient domestic political, economic, and institutional abilities, nations may then adopt particular normative frameworks and put them into practice though the implementation of UHC. The messages and actions of international actors, such as the WHO and the World Bank can activate or inhibit this process. For this reason, they serve as norm catalysts. While the first box emphasizes the role of international institutions (and gate keepers within those institutions), the second and third boxes indicate agency of national governments. This graphic representation is not meant to suggest a deterministic linearity free from norm blockage, but rather illustrate the connection between global and local levels of norm realization.

**Figure 1. The transnational production of universal health coverage.**

![Diagram showing the transnational production of universal health coverage.](image)

**Definitions**

Before proceeding, it is worthwhile to note the difference between “universal health coverage” and “universal health care.” Universal health care tends to apply to developed countries, whereas universal health coverage tends to concern developing countries. This is because “care” implies a wider array of health services, while “coverage” implies a more basic standard of coverage for the population. Stuckler et al define universal health coverage as “the existence of a legal mandate for universal access services” and evidence of this access for the
majority of the population. According to the WHO, universal health coverage (UHC) ensures “that all people can use the promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective” without exposing themselves to severe financial hardship. The term universal health coverage encompasses a vast array of health care policies and systems, but includes common features like efficient use of resources, risk-pooling and financial protection, and equity in access to health services. Another broad term, “health system,” refers to various pieces such as the health workforce, financing mechanism, information, health facilities, medicines, and technologies that create the overall health infrastructure in society.

II. Literature Review

A possible way to understand this case would consist of an examination of power politics within international organizations, especially with regard to the United States as a potential norm blocker. This would fall under a realist framework. UHC presents an opportunity to explore a social method of analysis, however, because the U.S. appears to have played a more passive role than expected. I will address this briefly throughout the comparison of the two campaigns. Because the lack of U.S. power politics and of a satisfactory realist explanation justifies a turn toward social theories, I will introduce two major categories of norm theory, early and contemporary. (The latter also includes the idea of “norm localization.”) Norm theorists have applied their theories to a wide range of topics, such as gender and strategic frames.

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19 “WHO | What Is Universal Coverage?”
20 Carpenter, “Women, Children and Other Vulnerable Groups.”
corporations in conflict zones,\textsuperscript{21} and the role of Amnesty International in shaping the standards of human rights.\textsuperscript{22} The first series of theorists developed models of norms that were instrumental at the time, but later challenged by a second body of more contemporary theorists. One reason to classify the time period in which these theories emerged is that the globalization and modernization of the world has largely affected how norms arise and take shape. The original and more modern authors of norm theory differ in the forces, actors, and causal mechanisms used to explain how international norms operate.

After engaging with the relevant theories for a study of universal coverage, I explain how my analysis serves to both counter and expand upon them. The case of universal coverage prompts questions about which types of norm theory can explain variance over time. Given the non-linear nature of its emergence, I find that UHC complicates the classic model of the “norm life cycle” because it has not followed a straightforward ascendancy. Using the ideas of “norm entrepreneurship” and “gate keeping,” I evaluate the WHO in its embodiment of both in the 1980s and 2000s, respectively. A significant aspect of my analysis employs the idea of “framing” and the tactics that the WHO uses to craft its agenda. Finally, an analysis of the domestic factors involved require additional theoretical understandings, which I will explore through a more detailed case study of Mexico.

\textit{Early Norm Theory}

Finnemore and Sikkink, two of the most influential norm theorists, define a norm as a “standard of appropriate behavior for actors with a given identity” and an international norm as a standard of appropriate state behavior. Ruggie writes that norms are “social facts” with a

\textsuperscript{21} Haufler, “Corporations in Zones of Conflict: Issues, Actors, and Institutions.”
\textsuperscript{22} Clark, \textit{Diplomacy of Conscience}.
“legitimate social purpose.”23 Norms serve several functions, such as to organize the international space or to elicit certain changes or actions in the way actors behave. The authors emphasize this constructive nature of norm dynamics, in that they create social transformation and influence the international system. According to Finnemore and Sikkink, norms carry a quality of “oughtness.” While this aspect of normative action is important, the authors fail to consider how norms not only produce, but also reveal commonly held beliefs. Norms also reflect certain values and characteristics of a society that may have emerged through organic or historical means. Thus, a definition of an international norm must consider how it serves both reflexive and prescriptive functions.

Following such definitions, Finnemore and Sikkink establish the basis for conventional norm theory with their work on “norm entrepreneurs”24-25 and the “norm life cycle.” They outline a three-stage process in which norms travel through phases of norm emergence, cascade, and internalization. Norm entrepreneurs work to create or draw attention to issues, oftentimes first from a domestic base and through some sort of organizational platform. They serve as the source of norm emergence and are motivated by a higher moral purpose. Eventually, norms reach a critical threshold of acceptance, deemed the “tipping point.” Each of these stages contains its own set of relevant actors, motives, and dominant mechanisms.26 The relationship between norm entrepreneurs and international institutions is somewhat unclear; even though they argue institutions can serve as the “organizational platform,” elsewhere they claim that they are

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23 Ruggie, Constructing the World Polity: Essays on International Institutionalization.
24 Nadelmann, “Global Prohibition Regimes,” 482.
25 Keck and Sikkink, Activists Beyond Borders.
“not tailored to norm promotion.” In the case of UHC, international institutions—the WHO and the World Bank in particular—have played a fundamental role in norm promotion and advocacy.

While Finnemore and Sikkink provide a rich explanation for norm formation, one essential limitation of the life cycle theory rests in its inability to explain more convoluted paths to norm creation and realization. The linear trajectory of emergence to internalization that these authors propose does not acknowledge the ebb and flow of a single norm. The norm life cycle cannot illuminate why UHC has experienced periods of international attention and disregard. It is possible that UHC could conceptually have fit into certain stages at different points in history, but it has not unraveled from a clear entrepreneurial campaign to a “taken for granted” quality across the world.

Contemporary Norm Theory

In response to this major theoretical framework, myriad other scholars have cited, refuted, and engaged with its tenets. Carpenter and Bob provide an expansion of normative modes of thought, in particular through their discussion of “norm gatekeepers.” In essence, Carpenter argues that norm entrepreneurs are not the only actor involved. She defines norm gatekeepers as “pre-existing, influential, credible organizations within an advocacy sphere who “adopt” new issues” or choose not to. In Carpenter’s analysis, certain actors have a specific, powerful ability to select and reject certain issues presented to them, which in turn shape their agendas. A gatekeeper can be an individual person within a gatekeeping organization. Carpenter explains that “issue adoption occurs when the issue is championed by at least one major

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27 Ibid., 900.
Entrepreneurs seek to turn problems they identify into issues that gatekeepers insert into the transnational advocacy network’s mainstream discourse. This represents a very early stage that serves as prerequisite for a subsequent campaign and establishment of the norm.

In contrast to more conventional claims, Carpenter complicates the categorization of where norm entrepreneurs and influential gatekeepers come from. Rather than assert that they are NGOs and international organizations, respectively, the converse can also occur. The challenges, patterns, and politics of the agents behind norm construction influence how certain ideas are promoted in the international arena. Ideas do not exist in isolation, but are rather attached to specific groups and institutions. The way Carpenter critically examines the diversity of power structures will prove significant for the example of the WHO, which exhibits some but not all qualities of a norm gatekeeper. The analysis of WHO that follows its action in two distinct campaigns will specify and contextualize these characteristics.

A central part of the discussion on how gatekeepers advocate for the issues they adopt involves how these agents frame their ideas. Issues used for political purposes do not exist as objective truths, but rather as a strategically molded ideas aimed to resonate with specific audiences. An extensive body of literature addresses this topic. A frame is a “persuasive device used to ‘fix meanings, organize experience, alert others that their interests and possibly their identities are at stake, and propose solutions to ongoing problems.’” A simpler definition claims that a frame reflects how an issue is conveyed and understood by the public. Frames employ rhetorical tools to encourage a specific normative goal or change. Examining how

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29 Ibid., 209.  
advocates use frames involves understanding the importance of communication and interpretation.

Theorists hold various opinions of why some frames and issues rise and others fail. Nadelmann, Bob, and Price have argued that certain qualities of issues are more likely to gain international attention. Keck and Sikkink also note the importance of intrinsic “issue attributes,” which Carpenter challenges with the idea of “issue concordance” or inter-network linkage between issues. Another rationalization stems from the idea norms’ relationship to others in the so-called “pool,” and the extent to which new norms resonate with existing ones. Perhaps more directly relevant to issues of health care, Bob discusses these mechanisms in the context of human rights. He argues that human rights issues are more likely to garner support if they fit within a category of abuses that is already considered legitimate, such as civil and political rights as opposed to social rights.

Applied to global health, framing and other ideational concepts become relevant when questioning which global health issues emerge or remain invisible. This methodology assumes that items on the international agenda have social underpinnings in addition to material incentives. Framing, agenda setting, and priming have already been discussed in depth in terms of media and communication. One of the few authors to link agenda setting and global health, Reich defines the “international health policy agenda as the policy issues most vigorously promoted by the major international agencies in health.” Shiffman also establishes a valuable framework for why particular global health issues rise and fall, and underscores the necessity of

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33 Carpenter, “Governing the Global Agenda,” 225.
34 Carpenter, “Governing the Global Agenda.”
37 Weaver, “Thoughts on Agenda Setting, Framing, and Priming.”
38 Reich, “The Politics of Agenda Setting in International Health,” 490.
accompanying institutions to help issues ascend and remain on the international agenda. He argues that successful health policy communities are those that use frames that both resonate with elites and benefit from the backing of established institutions.\(^{39}\) Others have examined how discourse effects change in global health policy in other ways, for example by looking at how a shift from state-to-state interactions to global health partnerships occurred.\(^{40}\) Shaping ideas and language around certain global health partnerships influences how they are justified, legitimized, and coordinated.

**Norm Localization**

While Carpenter and other explanations discussed thus far provide useful insights about the initial creation of normative agendas, other theories are needed to explain the connection between norm diffusion and actual political change. As Gutner writes, the link between what occurs “upstream” in the realm of idea propagation and what transcribes “downstream” in the area of outcomes can break.\(^{41}\) Or, the attempt to link the two can fail from the outset. The conditions that enable recipient states to take an international norm and turn it into a reality for its specific population represents a crucial aspect of a normative analysis. Although it can certainly change state behavior, the current global regime structure lacks sufficient formal mechanisms of enforcement. The international human rights project clearly exemplifies this. No matter how international norms are disseminated, they are limited by whether or not states choose to put them into practice.

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\(^{40}\) Harmer, “Understanding Change in Global Health Policy.”
Seeking to address this neglected element of norm construction, Acharya proposes a theory of “norm localization.” He stresses that analyses must look “beyond international prescriptions” and instead focus on the “role of domestic political, organizational, and cultural variables in conditions the reception of new global norms.”

Acharya defines localization as the process in which local actors interpret and modify international norms to suit their domestic identities. This process also involves the techniques of framing and the use of issue congruence, as local actors must ensure that global ideas are congruent with established local customs. This pivot toward a consideration of domestic factors emphasizes the power dynamics and constraints of states or regional groups, whereas previous theories highlighted how international norms emanated from the top. The conditions for norm localization that he identifies remain somewhat vague and difficult to measure. Nevertheless, Acharya makes an important contribution to the literature by emphasizing the contextual factors that affect the likelihood of localization, an idea that asserts a more realistic explanation for how international norms hinge on local capability.

Locating a New Approach

Because the academic literature on how global systems work requires a new space to “accommodate the diversity and creativity of activity” in international networks today, I plan to develop an approach that engages with theory as it connects to the dynamism of the real world. I choose to situate this paper within the kind of norm theory that focuses on “agency rather than structure,” an approach that begins to pick apart the specific levers of change and action. Actors, and the contexts they are shaped by, evolve over time to accommodate the rising tide of

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43 Avant, Finnemore, and Sell, Who Governs the Globe?
44 Ibid., 367.
various social undercurrents throughout the world. Blanket theories that seek to explain the international system as a defined set of roles and behaviors presents a rigid picture of a world that is much more fluid and volatile in actuality. Political scientists must not only seek to examine patterns, but also embrace the complexity associated with power and social change. For this reason, a concentrated study of the WHO and UHC may bring theory to life without determining a definite model applicable to every sphere of norm dissemination.

Part of the central puzzle addressed here revolves around why a norm for universal health coverage has gained wave-like momentum over the past decade or so in comparison to earlier periods of history. Thus, I will compare and contrast two WHO initiatives that involved a recommendation for UHC: the Primary Health Care movement called “Health for All by 2000” and the most recent “health financing” for UHC approach. This approach will provide an alternative to the linear norm life cycle and typical trajectories of norm theorists, because the same norm has assumed quite different forms across both periods. The Health for All proposition was not nearly as successful as the WHO’s involvement in establishing UHC systems in recent history. Comparing the two will allow certain lessons about how norms change over time, as well as what factors seem more successful in prompting health reform. Thus, this paper will offer a complication of Finnemore and Sikkink’s original theory.

In examining these two initiatives, I will first locate my analysis within the “upstream” realm of norm construction. Examining the key differences between Health for All and today’s UHC movement will require a close examination of the WHO as the primary actor. I challenge the notion of institutions as passive conduits for the work of advocates and networks. Adding to the more recent era of norm theorists, I seek to muddy the distinction between entrepreneur and norm gatekeeper, grassroots advocacy group and agenda setter. In line with Shiffman, I argue
that the WHO plays a vital role in agenda setting for global health. Specifically, I identify the Director-Generals of the WHO as the actors with entrepreneurial or gate keeping qualities, because they serve as the face of the organization and ultimately control how the organization chooses its issues and disseminates norms. Like other international institutions, it has its own internal issues of importance that it must shape and reshape. Therefore, I plan to look at how the WHO’s framing and strategic rhetoric enabled or hindered a worldwide norm for universal coverage. The WHO’s leadership has also played a role in voicing their vision, setting a certain tone, and shaping their institutional mandate. The techniques of issue resonance with pre-existing standards and other modifications have impacted its ability to gain credibility within members of the international community. Instead of focusing on one set of actors that seek to cause an authority or institution to adopt an issue, I will categorize the WHO as an institution that itself diffuses carefully calculated norms. The WHO occupies a unique catalytic space, one that is neither fully activist nor institutional in the classic sense.

The other side of the equation—that which involves norm localization, domestic capacity, and political will—also merits consideration. An emblem of the limits of global governance, the WHO prescribes agendas without any guarantee that recipient states will transform them into new health policy. The success of the agenda relies on how states interpret that agenda and how they can implement policy given various national political and institutional environments. States translate the rhetoric of international institutions into concrete change. For this reason, I will examine the political and socioeconomic factors that seem conducive to UHC. The political forces, interactions with other international players, and basic institutional capacity differ across time. Further, the economic status and potential in recipient states also impacts whether or not a norm for UHC becomes localized. Finally, the social aspect must also be
considered, as it exists in a dynamic relationship with international agenda setters and norm diffusers. While states emerge as a product of their individual histories and cultures, international standards may also influence the social framework that governments at least claims to embody. The domestic social landscape may or may not align with their government’s platform.

Although I argue that a broad wave of normative change is occurring, the use of a case study can help contextualize these changes in more depth. To examine how both the WHO and domestic conditions affect whether or not states reform to universal coverage, I will examine Mexico’s history of health reform and the impetus behind its transition to UHC. Mexico presents a fascinating case for various reasons. First, a national health insurance program called Seguro Popular was introduced in 2003 and reached completion in 2012; over 50 million Mexicans are on track to gain access to comprehensive health services with financial protection.45 Thus, this reform offers an example of change that has occurred in the most recent wave of the past decade. Second, the Mexican government seems particularly impacted by the WHO. It has not only located itself within the normative framework of the right to health and UHC, but also is now itself becoming an important voice and advocate. The relationship between Mexico and the WHO will reveal important lessons about how norms are produced through interactions between states and international institutions.

In the following pages, I will use research from political science and health policy journals, reports and documents from the WHO, and other secondary sources. I will consult pieces from The Lancet as well as articles written by the WHO Director-Generals. Meeting notes or transcripts from international meetings and conferences also appear. First, this paper will provide relevant background on the WHO as a global actor. Then, the general architecture will

45 Knaul et al., “The Quest for Universal Health Coverage.”
consist of a comparison between Health for All (1980s) and the current UHC campaign, each contextualized through a close examination of Mexico.

A few limitations and assumptions of this paper need to be acknowledged. First, I assume that a government choosing to reform its health system to one of universal coverage means that it has adopted and realized this norm. Further, the effectiveness of the various models of UHC as methods of improving health outcomes and reducing inequality lies outside the scope of this paper. It is also impossible to draw a direct causal linkage between various factors or actions and the decision-making of governments. A conflux of factors determine why states reform their policies; however, I hope to provide some evidence as to factors and events that likely play a significant role if not a definite causal claim. Finally, the selected case of Mexico is not representative of all countries choosing to reform. The path to universal coverage is complex and distinct across countries. Nevertheless, a case study helps raise questions about the possible patterns and experiences that states may share.

III. Why Health for All Failed: 1978-1980s

This section will examine the campaign for Primary Health Care that the WHO instigated in 1978. I suggest that its framing as a social justice issue had negative consequences, which combined with other international factors caused the demise of its principles in favor of a completely opposite approach. The unraveling of the Alma-Ata initiative demonstrates the limitations of the WHO as a norm catalyzer and agenda setter, in that its constricted authority requires it to make more calculated decisions about how to disseminate its messages and compel governments to undertake health reform. The empirical data on UHC is quite limited for this time period, and the WHO lacks a list of countries with its definition of UHC. Stuckler et al.,
however, indicate that a group of wealthier European nations, including a few outliers such as Japan and Panama, implemented UHC prior to 1980. Within their set of 44 countries they determined have UHC, just a few examples of health reform existed during the 1980s in countries such as Canada and Greece. The failure of Health for All and lack of UHC implementation correlates with the politicization of the WHO and supremacy of neoliberalism of that era.

*The WHO Campaigns for Social Justice*

When countries gained independence from colonial powers in the 1960s and 1970s, they faced new challenges with regard to their ability improve the health systems of their populations. Most of these nations faced an extreme disease burden, and the health status of rural populations in particular began to decline in some places. At the time, international health agencies were pursing a vertical strategy of specific disease eradication, for example by focusing on smallpox, malaria, and yaws. Despite some successes, such as smallpox eradication, health outcomes continued to worsen throughout the 1970s as health spending increased. Because the WHO recognized that this fragmented strategy was not working, they developed a new comprehensive or “horizontal” approach to public health. Tending more toward community-based models like those evidenced in China’s “barefoot doctors,” the WHO moved away from disease-specific programs. More grassroots methods of delivering health care to the rural poor began to challenge traditional mechanisms of the delivery of services, and were resulting in positive improvements.

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In 1978, the WHO redefined their fundamental vision for global health through the Declaration of Alma-Ata, a written document that the WHO Member States adopted at the International Conference on Primary Health Care in Alma-Ata, Kazakhstan. Through unanimous agreement among its Member States, the WHO outlined an alternate agenda that prioritized primary health care (PHC), a plan that called for universal accessibility and coverage, prevention and health promotion, and cross-sector collaboration to address the root social, political, and economic causes of poor health. A few of the goals it advocated for included universal coverage of basic service like health education, adequate clean water and food security, and improved maternal and child health; essentially, Alma-Ata placed several broad agenda items of public health at once. The WHO sought to define a certain standard of health as the basic right of people everywhere, and argued that societies needed to address social ills outside of the health sector alone to guarantee that right. Despite the validity of PHC as a health intervention, the WHO was unable to establish a rights-based philosophy for international health.

The principle role of the Director-General at the time, Halfdan T. Mahler, complicates the distinction between outside entrepreneur and international organization. As discussed earlier, contemporary norm theorists such as Carpenter distinguish between issue definition by norm entrepreneurs and issue adoption by major human rights organizations. Mahler, however, possessed both qualities as an entrepreneurial figure that sought to change the status quo from the inside of an organization. With the goal of reducing health inequities across the world, he proposed the goal of “Health for All by 2000” in 1976 at the World Health Assembly. There, he said, “Many social evolutions and revolutions have taken place because the social structures were crumbling,” and that the structures of public health were crumbling. A leader with charisma

49 Ibid., 168.
and “missionary zeal,” he felt that “social justice” was a “holy word.” His ideological fervor shone through in his speech and writings, which were titled things like “Health and Justice” (1978), “The Political Struggle for Health (1978), “The Meaning of Health for All by the Year 2000.” Mahler and the WHO then assumed an entrepreneurial role by championing this claim and launch the issue into the international normative network for health and human rights.

Mahler’s politicization of the PHC agenda revealed how easily the WHO could characterize itself as a political actor, a label that has served to the detriment of the WHO’s legitimacy. Primary health care as it was envisioned in the late 1970s and early 1980s was “an adjunct to social revolution,” and Mahler was “blamed for transforming the WHO from a technical into a politicized organization.” Because Mahler’s overtly political message did not resonate with them, politicians and development experts derailed the Health for All campaign and ushered in an alternative “Selective Primary Health Care” approach. The narrow, vertical program strategy surged again, as the advocates of the selective model claimed that a comprehensive reform program was too idealistic. His leadership at the WHO constructed the international norm of universal health as a highly ideological matter, a strategy that soon failed.

The rise in selective PHC over Health for All emerged not only because of Mahler’s framing issue, but also because of the power of other competing global frames. These interventions emphasized cost-effectiveness rather than social justice, and the dream for health equity disintegrated in the face of larger global events and shifts in ideologies. The norm that the WHO under Mahler tried to propagate eventually conflicted with its nemesis beginnings in the mid-1980s, as “the prominence of Third World interests began to be displaced by financial and

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52 Ibid., 1871.
private sector involvement in international health.” The WHO’s framing issue was exacerbated by the “currency liberalization, stagflation, the oil and debt crises, and waning interest in overseas development assistance” that “opened the way for a major shift in development strategies.” Thus, Mahler and the top WHO executives who chose to pursue the PHC agenda as a progressive strategy deviated from the predominant ideological bent of the other norm-setters at the time. While theorists Keck and Sikkink focus on the inherent attributes of a norm, this example shows how the particular way that entrepreneurial actors like Mahler mobilize issues matters more than the issue itself.

**Neoliberal Resistance**

A norm does not emerge insolation, but rather enters a global pool of other ideas and actors that can either benefit or hinder its claims. As the World Bank, other international financial institutions and development banks, and private sector interests gained influence, they disseminated free-market principles into the global health regime. Essentially in complete opposition to the Declaration of Alma-Ata, the World Bank outlined a normative agenda for privatization through influential reports such as *Financing Health Services in Developing Countries.* The World Bank possessed more resources and therefore more power, allowing it to emphasize the private sector’s place in health care delivery. Market-based ideas dominated a norm pool in which social and economic rights for the poor already lacked legitimacy, exacerbating primary health care’s ability to resonate.

In the 1980s and early 1990s, the World Bank focused only on the health care sector (as opposed to the multi-sector change that PHC envisioned) and the economic benefit of better

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health. In a 1987 report, the Bank advocated for the use of user fees, or the ability to charge patients, as a financing solution to shrinking public health budgets. Today, the public health community can present evidence of the ineffectiveness, inefficiency, and inequity of user fees.\footnote{Yates, “Universal Health Care and the Removal of User Fees.”} Yet at the time, the scientific evidence and evaluation methods failed to demonstrate how PHC was making gains; this certainly did not help the WHO’s situation.\footnote{Hall and Taylor, “Health for All Beyond 2000,” 20.} If primary health care was an expression of health as a human right, the Bank’s hands-off, private sector-driven approach was just the opposite. With the oil and debt crises and structural adjustment programs, the 1980s became known as the “lost decade of development.”\footnote{Birn, \textit{Textbook of International Health: 3rd Edition}, 166.} During this time, the international community not only rejected the WHO’s frame for its politics and idealism, but also other ideas and forces from competing institutions all converged to silence the WHO’s core message.

The political nature of the WHO’s mandate at the time was powerful enough to upset policymakers in the U.S, who also stifled the ability for PHC to become the global approach to public health. The Heritage Foundation, a conservative think tank, expressed its concern for the WHO’s “anti-free enterprise rhetoric” in a 1985 report titled: \textit{The World Health Organization: Resisting Third World Ideological Pressures}. Starrels, the author, discusses the fears of the Regan Administration about the political undertones inherent in the primary health care approach that deviate from its “technical” mandate. He also conveys anxiety about the relationship between WHO, the U.S., and the United Nations in general. Starrels concludes by saying that the “West has a political responsibility to WHO: to quietly and persistently insist that the Organization adhere to its technical mandate” and to refrain from politicization.\footnote{Starrels, \textit{The World Health Organization: Resisting Third World Ideological Pressures}.} While this report continues to mention that the U.S. still should support the WHO as a UN agency, it conveys...
a weariness within the minds of U.S. policymakers. Therefore, both the U.S. and the World Bank expressed a philosophical opposition to Mahler’s ideas of social justice.

_Mexico’s First Reform: Decentralization (1980s)_

Building on the above offered an analysis of the “upstream” realm of norm construction, the next section will examine the “downstream” domestic conditions of Mexico. International pressures from the World Bank and IMF combined with the weakness of country’s economy hindered the development of a comprehensive health system. Thus, the WHO was unable to catalyze and encourage the state to develop a robust health system of universal health coverage. The government did not localize the right to health because of its capitulation to neoliberal international forces, which was connected to its national political and economic limitations. Considering the visual analytic proposed earlier in Figure 1, the pathway from norm construction to implementation of UHC became blocked at various stages.

A federation of several states, Mexico is a large, upper-middle income country of 109 million people with approximately half of the population below the poverty line.\(^60\) Just after the WHO launched the Health for All campaign, Latin America’s debt reached $327 billion by 1982 as the debt crisis surged. Mexico was the first of several Latin American countries to default on its private loans. A year later, 27 more developing countries were in the process of doing the same.\(^61\) The Partido Revolucionario Institucional (PRI) ruled for most of the 20th century as an authoritarian, hegemonic political party. While some argue that the regime was less repressive than other Latin American countries, the government nevertheless exhibited corruption,

\(^{60}\)“CIA World Factbook: Mexico.”

\(^{61}\)Birn, _Textbook of International Health: 3rd Edition_, 165.
illegitimacy, and antidemocratic behavior.\textsuperscript{62} It was not until the 2000 election of Vicente Fox that Mexico experienced a definitive turning point for its transition to democracy.\textsuperscript{63}

The political conditions in Mexico did not provide a conducive environment for a strong implementation of health reform at the time when the WHO promoted Health for All either. Ward argues that PRI ruled the Mexican government with little concern for the social sector, which includes components of society like education, public health, and housing. They failed to institute reforms that went “beyond ‘papering over the cracks’” during the 1970s and 1980s, a time when the political commitment to social development waned. After 1990, it began to rise again. For example, in that time period the government cut total federal expenditure for the social sector in half.\textsuperscript{64} To further discourage the expansion of the social sector President Miguel de la Madrid (1982-1988) faced growing pressures for democratization, anti-ruling party sentiments, and fiscal reform as the debt crisis materialized. Thus, the political pressures pushed the Mexican government to commit to federalism rather than a system of universal social insurance. The lack of domestic political impetus for public health and other social services served as a crucial restriction on the WHO’s ability to induce policy change in Mexico.

In terms of the economic factors that facilitate UHC development, the Mexican case shows how economic instability detracts from the state’s capacity to carry out reform as well. Over the past three decades or so, the Mexican government has taken a complicated route toward the current structure of its health system. In a comprehensive study of Mexican health policy, Homedes and Ugalde trace the waves of health reform from the 1980s to present day. They describe that the first health reform occurred from 1983-1994, during which neoliberal

\textsuperscript{62} Shirk, \textit{Mexico’s New Politics}, 15.
\textsuperscript{63} Ibid., 2.
\textsuperscript{64} Ward, “Social Welfare Policy and Political Opening in Mexico,” 618.
ideologies and policies resulted in attempts at decentralization and privatization of health services in order to obtain loans from the World Bank and International Monetary Fund. As the Mexican economy suffered in the early 1980s, the incoming international lending institutions demanded that the government decentralize and reduce its expenditures on health and education.65

Yet soon after the imposition from the World Bank, decentralization of Mexico’s Ministry of Health failed for a number of reasons. Only about half of Mexico’s 31 states signed decentralization accords, and eventually those states that did decentralize reversed their course.66 Most of the literature explains that decentralization reforms “failed to improve efficiency, increased health inequities, and had a negative impact on quality.”67 Furthermore, these efforts did not address the underlying problem in Mexico, the segregation of social security and insurance systems by financing, coverage, and eligibility.68 The Mexican health system at the time was designed to only guarantee the rights to health care to the certain insured, salaried employees and excluded the rest of the non-eligible population.69 Deeper pathologies existed within the health system.

Decentralization represented one of the key health policies of the World Bank in the 1980s, and marked the beginning of the prominent role of the Bank as key player in global health policymaking.70 Its policies had a detrimental effect on health systems and health outcomes. The Bank’s approach reflected its desire to set the normative standards for the role of public and private sectors, and its ability to craft policies that fit its principles and philosophical

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65 Homedes and Ugalde, “Twenty-Five Years of Convoluted Health Reforms in Mexico,” 1.
66 Birn, “Federalist Flirtations,” 82.
67 Homedes and Ugalde, “Twenty-Five Years of Convoluted Health Reforms in Mexico,” 2.
68 Birn, “Federalist Flirtations,” 82.
69 Knaul et al., Universal Health Insurance Through Institutional Reform in Mexico, 25.
70 Homedes and Ugalde, “Why Neoliberal Health Reforms Have Failed in Latin America,” 83.
understanding of development.\textsuperscript{71} Thus, the path from norm construction to localization veered through the channel disseminating from the World Bank, not the WHO, because of the economic forces of that era. With the powerful lending requirements and struggling financial state of affairs, a radical, comprehensive overhaul in the name of primary health care and human rights seemed far from the realm of possibility.

IV. Progress Toward Universal Coverage: 2000-present

In contrast to the previous events of the 1980s, the 21\textsuperscript{st} century wave of health reforms shows a marked difference in both upstream aspects of norm construction as well as downstream conditions in favor of universal coverage. This section will explain how the WHO has adjusted its framing strategy and succeeded in leveraging new evidence to make a case for UHC. The WHO also has attached its agenda to those with existing legitimacy within the international pool of norms, such as sustainable economic development. Further, the World Bank also claims to promote UHC around the world today, a stark difference from its policies in the 1980s. These changes correlate with a rise in the number of countries implementing some sort of universal coverage program.

\textsuperscript{71} Ugalde and Jackson, “The World Bank and International Health Policy,” 537.
Table 1. Countries undergoing reforms toward universal coverage systems as of 2012.

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Country</th>
<th>Name</th>
<th>Year Launched</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kyrgyz Republic</td>
<td>Mandatory Health Insurance Fund</td>
<td>1996-2006</td>
</tr>
<tr>
<td></td>
<td>Mali</td>
<td>Mutuelles</td>
<td>2002/2004</td>
</tr>
<tr>
<td></td>
<td>Rwanda</td>
<td>Mutelles de Sante</td>
<td>2003</td>
</tr>
<tr>
<td>Low-middle</td>
<td>Ghana</td>
<td>National Health Insurance Scheme</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>Rajiv Aarogyasri</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rshtriya Swasthya Bima</td>
<td>2008</td>
</tr>
<tr>
<td></td>
<td>Indonesia</td>
<td>Jamkesmas</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td>Nigeria</td>
<td>National Health Insurance System</td>
<td>1999/2006</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>PhilHealth</td>
<td>1995/2005</td>
</tr>
<tr>
<td></td>
<td>Vietnam</td>
<td>Compulsory and Voluntary Health Insurance Schemes</td>
<td>2003/2009</td>
</tr>
<tr>
<td>Upper-middle</td>
<td>Brazil</td>
<td>Unified Health System</td>
<td>1988/1996</td>
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<tr>
<td></td>
<td>Chile</td>
<td>National Health Fund</td>
<td>1979/2005</td>
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<tr>
<td></td>
<td>China</td>
<td>National Health Insurance</td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>Columbia</td>
<td>General System of Social Security in Health</td>
<td>1993</td>
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<tr>
<td></td>
<td>Mexico</td>
<td>Seguro Popular</td>
<td>2003</td>
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<tr>
<td></td>
<td>Thailand</td>
<td>30 Baht Scheme</td>
<td>2002</td>
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<tr>
<td>High</td>
<td>South Africa</td>
<td>National Health Insurance</td>
<td>In process</td>
</tr>
<tr>
<td></td>
<td>Estonia</td>
<td>Estonian Health Insurance Fund</td>
<td>2001</td>
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<tr>
<td></td>
<td>Republic of Korea</td>
<td>National Health Insurance Program</td>
<td>2001</td>
</tr>
<tr>
<td></td>
<td>Taiwan</td>
<td>National Health Insurance</td>
<td>1995</td>
</tr>
</tbody>
</table>

Source: The Joint Learning Network

Table 1 above shows countries currently undergoing reform, which does not include the reform waves of developed European countries during the post-World War II (1948-1973) and post-dictatorship (1978-1986) eras. This table indicates the initial year UHC was launched and any following years in which new UHC legislation was adopted.

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72 Social Health Insurance Systems in Western Europe, 25.
The WHO Casts a Different Vision

In contrast to the rhetoric behind primary health care, the WHO has constructed a pragmatic, evidence-based frame for universal health coverage. Perhaps learning from their past mistakes, the WHO, a few other organizations such as the Rockefeller Center, and progressive international advocates have aligned this issue with the broader goals of human and economic development. In the following pages, this section will trace how the WHO has transmitted this message through three influential technical reports in particular. If Halfdan Maher took on a more entrepreneurial role, Margaret Chan has served as more of an international norm gatekeeper. While she shares the same core belief in primary health care, human rights, and social protection, she has adopted the issue selectively and formulated a message that presents the Organization’s role as a technical resource. In other words, she has selectively placed it on the international agenda in the way she believes is necessary. This change in tone and way of arguing for UHC have correlated with an increase in the number of countries engaged in implementation of UHC reform (Table 1). In addition to these changes within the WHO, the ideology of the international institutions has begun to shift to some degree as well, also aiding the ability for UHC to gain traction.

The WHO’s attempts to refrain from presenting itself as political in nature helped it regain legitimacy, but also yielded mixed results. The first major step in raising global awareness of health systems resulted from the controversial 2000 World Health Systems Report. The WHO ranked the world’s health systems on the basis of several contested indicators, such as responsiveness and fairness in financial contribution. This report even described the previous primary health care programs as “at least partial failures” in most cases. It called for a policy framework of “new universalism” based on “cost effectiveness” for everyone, including the
poor. Given its questionable methodologies and choice to place United States as 37th in the world for overall health system performance, this report set off a firestorm of criticism. In other words, this report catalyzed action by adding health systems to the international discourse. In 2010, the WHO released Health Systems Financing: the Path to Universal Health Coverage, one of the most important WHO documents in the last decade. Since it published the report, 60 countries have approached the WHO with requests for technical support on how to best reform their health systems.

Margaret Chan’s tactics provide an instructive example of how norm gatekeepers select issues and ideas to promote. Carpenter describes that through its selection processes, gatekeepers may try to “reframe an issue in a way suitable to the gatekeeper, allowing it to forestall advocacy frames that would undermine its own work.” This allows the gatekeeper to sustain its “privileged position in the issue creation process.” As the voice of the organization, Chan has used her role to reinforce its apolitical stance. She has used her prominence in high-profile settings to characterize the WHO as a resource rather than an activist organization. In describing UHC at the 2012 World Health Assembly, she said, “This is not rocket science. This is frugal, strategic innovation that sets out to develop a game-changing intervention, and makes ease of use and affordable price explicit objectives.” Chan’s goal of better “health financing” is quite different

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74 Ibid., 347.
76 “WHO | Best Days for Public Health Are Ahead of Us, Says WHO Director-General.”
77 Carpenter, “Governing the Global Agenda,” 223.
from Mahler’s “social revolution”—the language of the WHO emits a mechanical tone for a reason. Despite recognizing that “UHC is a practical expression of society’s concern for health equity,” she realizes that the UHC movement needs “to argue strongly, but not emotionally.”\(^78\) In contrast to Mahler’s missionary zeal, Chan proposes UHC as a common sense matter of efficiency and effectiveness.

The WHO has built its case for UHC also through its connection to *The Lancet*, one of the world’s leading journals for medicine and public health. Together, the WHO and the Lancet hosted a launch event for a special *Lancet* series focused on UHC. The series argues for UHC as a matter of practicality and economic development, and marshals the voices of leading intellectual figures in global health. Rather than make ideological claims, they present an argument based on pragmatism. Jeffrey Sachs, a leading economist in the field of development, writes that low-income countries can also take part. Stating that “good health” is “good economics,” the authors use issue concordance to link the UHC agenda to the broader prosperity of society down to the level of individual families.\(^79\) The advocates use data, now possible with the monitoring and evaluation tools not present for the primary health care campaign, to strengthen their claims. For example, they cite the fact that out-of-pocket fees for health services push 100 million people below the poverty line ever year,\(^80\) in addition to much more specific information about the benefits of universal coverage. The coupling of the UHC agenda to both the human and sustainable development agenda provides a stronger source of resonance with powerful actors than the rights-based argument alone.

\(^78\) Universal Health Coverage - Opportunities and Lessons.
\(^79\) Frenk and De Ferranti, “Universal Health Coverage.”
\(^80\) Evans, Marten, and Etienne, “Universal Health Coverage Is a Development Issue.”
Signs of Change at the World Bank

Although the nature of norm construction has varied considerably from PHC, the position of the World Bank and the international context in which this norm has been re-constructed has also changed. In a presentation in January 2012, the Director of the Health, Nutrition, and Population arm of the World Bank stated that health financing and universal coverage are now one of the priorities for the Bank.\(^8\) It has developed a program called Universal Health Coverage Challenge Program that will aid in “developing knowledge and operational tools to help countries pursue universal coverage and manage fiscal, efficiency and equity challenges and risks.” The views of David de Ferranti, a World Bank economist, illustrate the shift that seems to be occurring in the World Bank’s and other financial institutions. In the 1980s, de Ferranti strongly argued for user fees. Since then, he has become an outspoken voice against user fees and for the UHC campaign.\(^8\)

The World Bank even serves as a partner and funder for some of the major UHC research and organizational hubs, such as the Joint Learning Network and Results for Development Institute. This represents a sharp divergence from the structural adjustment programs of the 1980s and 1990s, the time period when PHC was launched. Although rhetoric by no means implies reality, these changes within the World Bank reflect a significant transition. Apart from its policy on UHC, the Bank has integrated new principles of state ownership, community participation, and multi-sector collaboration—these strategies indicate a divergence from its past approach and in fact sound similar to the original PHC campaign. In general, “The Bank’s

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\(^8\) Baeza, “The World Bank in Health 2012: Challenges, Priorities, and Role in the Global Health Aid Architecture.”
\(^8\) “From User Fees to Universal Healthcare - a 30-year Journey.”
approach to global health over the last ten years presents a transition towards a more ‘soft politics’ form of engagement.”

Relative to the period in the 1980s, both the World Bank and the U.S. seem to have pursued a softer approach. In contrast to the fear of the Heritage Foundation’s earlier reports on the WHO, the U.S. seems to lack an explicit rejection of UHC. According to the Council on Foreign Relations, the U.S. government has worked for many years to help countries attain UHC. Policymakers in the U.S. seem to accept or even encourage universal health coverage abroad, as long as it does not take place at home. Some tension persists, however. According to Global Health Watch, “the US in particular continually pressurizes WHO to…avoid such terminology as ‘the right to health.’” Nevertheless, the wave of UHC across the world may reflect a decline in U.S. legitimacy with regard to health in particular, especially given the debates over the Obama administration’s Affordable Care Act. As the World Bank moves farther away from the policies of the 1980s and 90s, the normative authority of the U.S. with regard to health remains in question, and the WHO strengthens its argument for UHC, a variety of countries continue to embark on a course of health reform. Mexico’s development of UHC will illustrate how these factors played out at the state level.

**Mexico’s Seguro Popular: UHC (2003-2012)**

In contrast to the early attempts at decentralization in the 1980s, the more recent era of Mexico’s history demonstrates how the WHO was able to push its agenda for UHC in Mexico given a different set of political and economic circumstances. Now that Mexico has achieved the

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83 Kay and Williams, *Global Health Governance: Crisis, Institutions, and Political Economy*, 236.
85 *Global Health Watch 1*, 285.
status of an upper-middle income country, financing a transition to UHC became more feasible. This has created the space for a new concept of protection and ability to respond to the agenda that the WHO set forth. This combination of a redefined, evidence-based UHC agenda and new economic possibilities has facilitated the development of UHC in Mexico. The political situation changed and provided an important political opportunity; in 2000, the PRI lost to the Partido de Acción Nacional (PAN) after a 70-year long rule. Julio Frenk was appointed Minister of Health and became a key figure who synthesized these converging factors to launch a health reform program called Seguro Popular in 2003. In 2003, 50% of health expenditures were out-of-pocket. Yet after 9 years of implementation, the country has achieved UHC and incorporated 52.6 million Mexicans into a public insurance scheme. SP has replaced the previous employment-based model that favored salaried workers. It marks a social and conceptual shift from “labour-market-based social security” to “social protection of health, the universal right of access to effective health care.” Despite any shortcomings the program might have as a method of health delivery, the international community deems Mexico as an important part of the UHC global movement as both an advocate and example of successful health policy.

The modified rhetoric of the WHO also shaped the Mexican path toward reform. In numerous publications and evaluations of their own health reform, policymakers in Mexico cite the strong importance of global evidence as a catalyst for priority-setting, national health reform, and implementation of SP. They assert that their poor ranking in the 2000 World Health Report served as a motivating factor for change. The poor rank in the report, combined with increased

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86 “Country and Lending Groups.”
87 Homedes and Ugalde, “Twenty-Five Years of Convoluted Health Reforms in Mexico,” 7.
89 Ibid., 1260.
90 Knaul et al., “Evidence Is Good for Your Health System.”
research and data conducted “catalyzed more in-depth country-level analysis.” Eventually, rankings and research became political tools. The constituencies in favor of UHC gained new information from this report that helped them advocate at a moment of political opportunity, right before the change in administration. As the WHO linked UHC to development, the Mexican Ministry of Health followed because they recognized the power of linking their own health reform with international normative networks. The WHO wielded power in influencing the development of SP, in effect demonstrating how its frame of technicality became the language of Mexican policymakers. Frenk and Gómez-Dantés make an astute point about the use of apolitical technicalities as a method to promote political beliefs. When describing SP, they explain that

the Mexican model may be seen as an option to reconcile two extremes: the selective technocratic approach to the distribution of health care, which provides practical alternatives but purports to be morally neutral, and the rights-based approach, which has a strong value foundation but has lacked operational support.

Therefore, both Mexican policymakers and the WHO share a similar strategy in promoting a global agenda for UHC. This has arisen through specific political calculations and thought processes.

The multitude of papers about Seguro Popular almost all feature the voice of Julio Frenk, whose essential political strategies receive far less attention than Mexico’s evidence-based narrative. Frenk became the Dean of the Harvard School of Public Health in 2009, and previously held an executive position at the WHO in 1998. He also worked for the Bill & Melinda Gates Foundation. Frenk has achieved a level of global health stardom that may also motivate his desire to ensure that Mexico’s reform fulfills its purpose. Because of he seems to

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91 Ibid.
92 Frenk and Gómez-Dantés, “Ideas and Ideals.”
have discovered how to earn respect in global health circles, he has been able to serve as a leading voice and advocate for the WHO’s normative agenda. Frenk co-authored a piece in *The New York Times* with David de Ferranti about the value of universal coverage in which they explain the need to link health to other societal concerns like political stability, job creation, economic growth. Frenk recognizes the political power of framing and issue concordance in agenda setting. This part of Mexico’s path to UHC is key to understanding how norm localization occurs, because it shows a degree of international and state interaction.

While the focus on social services declined in the 1980s, Julio Frenk raised health on the national political agenda through politics. Although focusing on any single individual is sometimes a dangerous analytical approach for political science, Stuckler et al cite the salient position of health ministers as agents of political change. Research shows that ministers of health can “shift the terms of the debate to gain support for change by showing that existing, non-universal, systems are failing” and “basing their arguments on the availability of evidence and the likely resonance of issues with other key stakeholders.” The “evidence” account of change in Mexico, however, deemphasizes the “politically astute set of tactics” that Frenk employed to build a coalition in favor of health reform. Throughout his campaign, the Ministry of Health conflicted with the Ministry of Finance to the point that the Health worked with the president’s office to marginalize Finance. Another source of opposition came from individual states, the left-wing party (Partido de la Revolución Democrática) who desired a national health service, and even the Mexican people who did not want to pay. Thus, Frenk had to use various tactics to overcome these issues and implement UHC.

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93 Ferranti and Frenk, “Toward Universal Health Coverage.”
Throughout the long process of health reform in Mexico, Frenk and other Mexican officials have championed the UHC cause in conjunction with the WHO. As evidenced by their relationship, this case reveals how gatekeeping institutions and state officials find mutual interest in collectively propagating their messages together. In April of 2012, the Mexican government hosted a high-profile event for universal coverage called “The International Forum on Sustaining Universal Health Coverage: Sharing Experiences and Supporting Progress.” At the conference, Margaret Chan gave a laudatory speech, saying that Mexico “gives the world an outstanding example of what can be achieved through high-level political commitment.”

Conveying their leadership in this movement, Mexico adopted a formal declaration on UHC for the participating member countries at the forum. Thus, Mexico gains praise on the international stage as the WHO continues to strengthen its campaign and sustain its own legitimacy.

The neoliberal restrictions that existed in the 1980s no longer inhibit Mexico’s implementation, either. The World Bank in fact started funding a project to support Seguro Popular titled, “Support for the Social Protection System in Health” to expand coverage and strengthen the public sector’s capacity for health reform. The U.S. and Mexico’s relationship involves issues like immigration, drugs, and organized crime, but the U.S. remains passive with regard to health. The U.S. participated in the International Forum as well, but wrote a convoluted “explanation note” that simultaneously praised Mexico’s efforts, recognized the universal right to health, and exempted themselves from it. While the underlying dynamics of this relationship require further research, it seems that the U.S. then plans to remain uninvolved in the UHC campaign in Mexico. Although a realist critique would position the U.S. as a hegemonic power

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95 “WHO | More Countries Move Towards Universal Health Coverage.”
96 “Project: Support for the Social Protection System in Health.”
97 “USA Explanation Note.”
seeking to influence Mexico’s policymaking, the U.S. seems to have taken a more inactive approach. There are various potential reasons for this, such as the fact that Mexico first adopted UHC at a period of U.S. ascendancy. Thus, perhaps the nature of Mexico’s health system did not pose a threat to U.S. power. Another possibility is that the U.S. acceptance of Seguro Popular reflects improving U.S.-Mexico relations. The Economist recently argued that the U.S. should seek partnership with its neighbor,\textsuperscript{98} and even highlighted the progress of SP.\textsuperscript{99}

The Mexican case reveals lessons about how institutions such as the WHO and the state can align to frame and actually institutionalize a particular normative agenda. While the government had previously found itself in economic crisis and dependency on international lending, modern circumstances enabled a different outcome to occur through the political tactics of Frenk and the Ministry of Health. Considering this example, the next section will turn to the broader implications for this study.

V. Conclusion

The original question posed in this paper asked why the idea of universal health coverage has swept the globe and gained traction in countries from such various economic and political backgrounds. While a simple answer would provide a nice theoretical device, the research shows that the reality of the world presents a much more complex story of how universal health coverage has developed. Rather than identify a singular determinant, I have argued that a number of factors converge to bring about health reform. This involves global and local forces, which exist in a dynamic transnational relationship with each other.

\textsuperscript{98} “The Rise of Mexico.”
\textsuperscript{99} “Stretching the Safety Net.”
In the initial stages of norm production, the WHO serves as a central international actor with the power to both define issues or problems from within (like norm entrepreneurs) and set calculated agendas (like norm gatekeepers). From 1978-1980s, the WHO attempted a highly politicized campaign that failed to realize its original vision because of framing issues and competing neoliberal ideologies. By the turn of the century, the WHO had learned to assume a more technical mandate to legitimize their case for UHC, and softened its promotion of it as a social justice issue. This strategy proved more advantageous by resonating with other economic development arguments, and countries like Mexico soon approached the WHO to assist its evidence-based policymaking. This contrast between outcomes, given the constant core set of values about human rights, reveals how important the strategic act of framing and transmitting a normative agenda is to the success of that agenda. Ideas become redesigned and change over time, rather than simply succeed or fail to complete the norm life cycle.

The manner in which countries absorb international norms and put them into practice depends on a range of conditions that may help or hinder norm localization. In the 1980s, political and economic constraints discouraged the implementation of universal coverage in many developing countries in particular. By the 2000s, however, governments began to harness the political and economic potential to reform their health systems. Freed from the neoliberal policies of the 1980s, Mexico translated its rights-based ideals into a UHC system though political tactics and close engagement with the WHO. This example offers a salient lesson about norms in local contexts—that domestic conditions are not static states of being, but also depend on the agency and initiative of local players. This argument offers a more optimistic outlook on how political change occurs, because it shows that historical conditions do not predetermine the fate of a country. The concept of how international norms become mobilized at local levels is
part of a much larger discussion of power dynamics and the ability for states and organizations to coalesce around shared ideals and sound policymaking. The global health regime operates through a complicated body of international actors and institutions, but achieving lasting impact requires the commitment of the local government. In the end, states guarantee human rights, including the right to health, and translate international agendas into action.

To further examine the rise of UHC, an increase in political science research to fill the current gap would benefit our understanding of how health system reform may take shape in the future. This paper is limited in scope, because it does not provide an explanation for health reform to universal health systems that spans history. Another limitation of this paper is that it selects a case of success, as Mexico provides a quintessential example of the reform process and implementation of UHC. Studies on cases of failure that have occurred recently, in which the WHO promoted a similar agenda but failed to push a country to implement UHC, would add an instructive complement to the research presented in this paper. One such example could be the United States, but another emerging middle-income country would likely provide a more relevant comparison. An additional valuable research study to conduct could consist of a detailed examination of the World Bank’s involvement in universal health coverage policy in recent years. The Bank serves as a significant driver of global health policy and its action with regard to UHC will continue to shape the momentum building around the world.

**Defining the Future of Global Health**

The transition to universal coverage represents a critical moment for the international community. The end of the Millennium Development Goals in 2015 should prompt a critical reflection on the past successes and failures, and must usher in different strategies to alleviate
poverty and promote human rights. If UHC continues to gain momentum in the next few years, it has the potential to inform the next major global development agenda. Technical research on the most effective practices and models of UHC in terms of health equity, access, and ability to improve health outcomes need to guide future discourse. Evidence and input from the emerging nations and the grassroots at the forefront of this movement must also become part of the agenda setting process. Many challenges and potential pitfalls exist, such as lack of donor funding to help nations achieve UHC. Gaps in the other areas of health systems like a shortage in the global health care workforce will continue to hinder the quality of health systems. These and other serious challenges will require policymakers to solve problems and form new ways of designing health care. Although it is only one part of the wider global health agenda, the idea of UHC is powerful enough to serve as an umbrella development goal for the post-2015 years. It must synergize with other existing structures and issue-specific agendas—the two are not mutually exclusive and can achieve maximum impact if leveraged together.

The global movement toward UHC may signal the beginning of an international framework that refocuses on the structural mechanisms to address the root causes of poverty and illness, rather than just individual health issues. Better health financing is a part of the greater health system, and is not a panacea for systemic health issues. But it is one method of addressing the root cause of poverty as a barrier to health care. While the future of the UHC movement is uncertain, the evolving discourse about the responsibilities of states and the general population to each other—coupled with the right kind of action—marks a tremendous step forward for the well-being of people everywhere. Reforms that address the entire health system are difficult, tedious, and politically complex, but the potential for sustainable transformations of how people access health care could potentially change the face of global health. At its core, the global
transition to UHC reflects the normalization of the deeper philosophical belief that everyone deserves to thrive regardless of circumstance. The shift toward universal health coverage merits the world’s utmost attention, because it signifies a path forward that encourages governments to exercise the fundamental notion that all human lives have equal value.
Works Cited


