



The politics of universal health coverage

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This is the second in a **Series** of three papers about political science and health

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The UN has declared universal health coverage an urgent global goal. Efforts to achieve this goal have been supported by rigorous research on the scientific, technical, and administrative aspects of health systems design. Yet a substantial portion of the world's population does not have access to essential health services. There is growing recognition that achieving universal health coverage is a political challenge. However, fundamental concepts from the political science discipline are often overlooked in the health literature. This Series paper draws on political science research to highlight the ways in which politics can facilitate, or stymie, policy reform. Specifically, we present a framework of analysis that explores how interests, ideas, and institutions shape universal health coverage. We then examine key considerations relating to the implementation of relevant policies. This Series paper shows that a political understanding of universal health coverage is needed to achieve health for all.

Introduction

Universal health coverage is achieved when all members of a population are able to access essential health services without incurring financial hardship. Health for all has been a global goal since the 1978 Alma-Ata Declaration;¹ however, progress towards the goal has been slow. WHO estimates that by 2030, up to 61% of the world's population will not have access to essential health services, and poor and marginalised people are most likely to be excluded.^{2,3}

There is an urgent need for action—but policy reform does not occur simply because evidence accumulates about the severity of the issue or the benefits of policy change.⁴ Although evidence is undeniably important and should form the basis of health policies, governments routinely make decisions that are inconsistent with scientific and technical evidence. Therefore, achieving universal health coverage should also be viewed as a political challenge. Echoing Amina Mohammed, the UN Deputy Secretary-General, we contend that “universal health coverage can only succeed with strong political commitment at the highest level”,⁵ in addition to effective implementation of relevant health policies.⁶

The process of obtaining government commitment and implementing relevant policies often entails political conflict. Universal health coverage involves the redistribution of resources across income groups, a political process that can rouse intense contestation between different groups. Governments, which have historically ignored poor and marginalised people, are more likely to maintain the status quo than legislate programmes on behalf of these groups. In addition, the implementation of universal health coverage requires substantial and sustained investments in physical infrastructure and human capacity, a process that is deeply affected by politics.

An understanding of political factors is therefore crucial,⁷ and can complement the scientific, technical, and administrative elements of health systems design.⁸ Yet, fundamental concepts from the political science discipline—including the role of interests, ideas, and

institutions—are often overlooked in the health literature. To address this gap, this Series paper provides an overview of different political factors and invites readers to consider how politics can influence the achievement of universal health coverage.

We begin by introducing a framework of analysis that draws attention to the ways in which power is used to advance particular interests, influence societal ideas, and create institutions that privilege some people but disadvantage others. We highlight how these factors can influence government commitment to universal health coverage. We then examine the implementation of the relevant policies. Even the most ambitious and well planned programmes will not reach previously excluded groups without effective implementation. This section highlights the importance of bureaucratic and government capacity to deliver health programmes and health care, the dynamic relationship between policy makers and policy implementers, and the role of non-state actors. Deepening our understanding of the political factors that facilitate, or stymie, policy reform is important if we are to achieve universal health coverage (panel).

Methods

We did a traditional literature review to address the question: what political factors influence the achievement of universal health coverage?⁹ We began with structured conversations among coauthors to identify core scholarly contributions in the fields of political science, public policy, public administration, and health policy. Drawing on our collective expertise, we identified articles for review, and articles that show the importance of interests, ideas, and institutions as explanatory variables that influence health policy outcomes. We used this step as a starting point for organising our search in journal databases (eg, EBSCO host and JSTOR) and popular search engines (eg, Google Scholar), focusing on research that would illuminate the role of interests, ideas, and institutions in health policy outputs and outcomes. We also reviewed the literature on the role of implementation, and implementation science

more generally. The relevant literature was mapped by theme, synthesised, and critically reviewed. The process was iterative and was concluded once a clear understanding of the core themes in the topic statement emerged; themes were backed up adequately by existing literature, and no new themes emerged.

Interests, ideas, and institutions

WHO Director-General, Tedros Adhanom Ghebreyesus, declared that the achievement of universal health coverage “is ultimately a political choice”.¹⁰ Research from the political science discipline sheds light on key aspects of governments’ political choices by drawing attention to the role of interests, ideas, and institutions. Political actors advocate for their own interests, or join up with like-minded allies to form coalitions, pressuring governments to legislate policies and programmes that reflect their specific interests. Political actors’ interests are also underpinned by ideas that shape their attitudes about, for example, the appropriate role of government in health provision. However, political actors do not operate as they please—they must manoeuvre within specific political institutions, following the formal and informal rules of the game. Institutions constrain and shape political actors’ strategies for advancing their interests and, subsequently, their political behaviour. Context varies between countries, and although some institutions can facilitate the introduction of universal health coverage, others can hinder the expansion of relevant health policies.

In the following analysis, we treat interests, ideas, and institutions as distinct concepts to show each factor’s effect on the prospects of universal health coverage. However, this analytical distinction does not preclude the interaction between interests, ideas, and institutions in reality. For instance, actors’ political interests are often derived from their ideas about what ought to be. Support for health policies might vary depending on the ideological positions held by individuals and this, in turn, can motivate them to advocate for particular health policies. Political institutions can also reflect actors’ interests, as political systems are often designed by powerful actors to protect or enhance their influence. In other words, interests, ideas, and institutions are at times interactive variables, but for the purposes of this Series paper, we introduce each as analytically distinct.

Interests

Political actors often seek to maximise their own interests. One way political actors derive their interests is from their socioeconomic status. High-income individuals, for example, have strong incentives to lobby against policies that redistribute their wealth, such as progressive taxation.¹¹ In the USA, wealthy individuals have mobilised their resources—including material resources and political connections—to influence the policy process to their advantage.¹² As public health care

Panel: Advocating for universal health coverage

Advocates for universal health coverage must:

- Understand that universal health coverage is a political challenge; it reflects the contestation of political interests, prevailing ideas and beliefs, and the decisions that are mediated through political institutions
- Support disadvantaged groups in building political power and amplify their voices
- Craft a normative commitment to universalism in health coverage and convince opponents of universal health coverage that access to health care benefits everyone
- Recognise that effective political strategies will vary across different national contexts
- Distinguish between universal health coverage policy design and policy implementation, and address the specific challenges in both

is funded through taxation, high-income individuals have strong incentives to block a government’s commitment to universal health coverage.

Governments tends to prioritise the demands of groups with political power, such as the wealthy, since measures that shift resources away from their interests can provoke opposition and threaten political survival.¹³ However, poor and marginalised people have been able to build political power by organising and mobilising. Individually, these groups might have little access to material resources and political connections, but collectively, they can use coordinated action to pressure governments for change. For example, labour unions have been successful in mobilising their membership, using coordinated strikes and protests to draw attention to their cause and pressure governments for change. Up until the 1990s, the labour movement in Mexico was effective in mobilising and subsequently expanding health-care programmes, in addition to pensions and workers’ compensation.¹⁴ Similarly, in 2020, farmers in India organised to place pressure on the Indian Government,¹⁵ joining trade unions in a nationwide strike with 250 million participants. Tens of thousands of farmers from Punjab, Haryana, Uttar Pradesh, Madhya Pradesh, and Rajasthan participated in a march in Delhi. Through collective action, individuals working together have augmented their ability to pressure governments for policy change.

Another strand of literature links political parties to the expansion of the social policies,¹⁶ arguing that left-leaning parties are more likely to pursue redistributive policies.¹⁷ In the 2000s, voters brought leftist candidates to power in Latin America, redefining the political landscape. A notable feature of this so-called left turn was an emphasis on social policies for reducing poverty and inequality. Today almost every government in Latin America has a means-tested income transfer policy, suggesting that political parties can play a crucial role in health policy expansion.

The power resources theory of social welfare policy reform finds that workers organising in formal union organisations, in conjunction with their support of left-leaning political parties, contributed to the expansion of social services.^{18,19} The UK National Health Service was created in the immediate post-war period, when the Labour Party (with the electoral support of trade and labour unions) won the 1945 general election with an overwhelming majority of seats in the House of Commons. Similarly, the Scandinavian welfare states emerged during a period when labour organisations and social democratic parties were at the peak of their political power. Conversely, the USA has consistently failed to legislate a comprehensive universal health coverage programme, owing to the tremendous power of interest groups that oppose a national health-care system (specifically a single payer or general tax-funded system), the fragmentation and overall political weakness of labour organisations, and the absence of a social democratic or labour political party.

Historically, advocates have primarily been concerned with expanding essential health services to poor individuals. However, focusing on class alone will not guarantee health for all.^{20,21} Feminist scholars have pointed out that many labour unions represent the interests of formal workers—who have historically been men. Women, by contrast, are disproportionately represented in the informal sector in low-income and middle-income countries (LMICs), working as domestic helpers, street vendors, and small-scale farmers. Because women are occupationally diverse and geographically dispersed, their opportunities to build political power through collective action are limited. Plans for universal health coverage should therefore pay attention to both socioeconomic status and women's health when expanding services.

Similarly, class and race are not interchangeable.^{22,23} It cannot be assumed that expanded health policies will automatically result in improvements for racialised minorities. In the USA, improved health outcomes for working class families have not resulted in more equitable health care across racial and ethnic groups.²⁴ Although Canada has a more expansive public health-care programme than the USA, a similar pattern plays out.²⁵ Racism towards Indigenous Peoples continues to permeate the health-care system.²⁶ Therefore, socioeconomic status is one way of measuring marginalisation, but it is not the only way—individuals at the intersection of class, gender, and race experience overlapping forms of oppression.²⁷

A key part of achieving universal health coverage is confronting vested interests in society. For a government to act in the interests of disadvantaged groups, it must overcome political actors that have historically undermined universal health coverage. In the USA, race is (and has long been) a fundamental factor in explaining policy development, implementation, outputs, and outcomes.²⁸ For example, a study showed that some poor,

White Americans opposed government welfare simply because they perceived Black Americans as benefiting.²⁹ Despite it being in their economic interest to support redistribution, a group might not support policy reform. The desire to protect the interests of one's own group can play a key role in whether or not the group supports policy expansion.³⁰

In response to multiple, often overlapping, forms of societal injustice, social movements have emerged. These grass-roots movements are not based on socioeconomic class or workplace profession but are motivated by rights-based causes. Representing the interests of historically marginalised groups, such as women, racialised groups, people with disabilities, and the LGBTQ+ community, individuals have mobilised in broad social movements and pursued collective action to push for policy change. Political actors, acting individually or collectively, can use windows of opportunity—crucial junctures in the political process—to accelerate a preferred policy agenda. These windows of opportunity are created in various ways. For example, sudden, attention-grabbing events can draw attention to the need for government action and create an exogenous opportunity for actors to mobilise and push through health reform.³¹

Other political actors also played pivotal roles in policy expansion. In Thailand, physicians were advocates pushing for health-care expansion. Physicians, motivated by their progressive convictions, mobilised around universal health coverage policies that did not reflect their own political and economic interests. Thai doctors believed in universal health as a matter of principle, and worked to influence the policy process.³²

The expansion of health policies is not just driven by actors outside the state, but also by political actors within the state.³³ Bureaucrats can draw on their intimate knowledge of power relationships within the government to make policies politically and bureaucratically acceptable.³⁴ For example, in Indonesia, bureaucrats with technical expertise (technocrats) strategically used international pressure to court presidential support for policy reform. Technocrats then used executive commitment to place pressure on actors in other ministries to cooperate and expand health policies.³⁵ Therefore, political actors within the government bureaucracy can also play a powerful role.

Ideas

Ideas are beliefs about what is or what ought to be. In and of themselves, ideas are neither good nor bad, they are simply our interpretations of the world. However, political science research draws attention to the link between ideas and power; that is, whose ideas are considered legitimate and how those ideas can be deployed to advance particular agendas matter for health policy reform. As such, a growing body of research shows that ideas have political consequences.^{36–39}

Ideas held by policy makers, for example, can have a substantial effect on health policies. Policy makers' beliefs about the root causes of poor health will shape public policy. Policy makers who believe disadvantaged groups have poor health because of circumstances beyond their control—sometimes called structural conditions, such as unexpected unemployment, poor working conditions, or racial discrimination—are more likely to support redistributive policies like universal health coverage.⁴⁰ By contrast, policy makers who believe health is a product of individual choices, such as a series of poor decisions relating to exercise or diet, for example, are more likely to believe that redistributive policies will dull incentives to make appropriate choices. These ideas shape the way in which policy makers define a policy problem, and subsequently the characteristics of the policy solution they propose.⁴¹

Ideas can also be used in support of a particular agenda. Political actors can create narratives to frame issues in particular ways.⁴² For instance, political actors can depict disadvantaged groups as undeserving of publicly funded health services or as taking advantage of the welfare system.⁴³ This view can shift public support for universal health coverage. Policy makers, looking to maintain favourable public opinion, might subsequently hesitate to legislate universal health coverage. Therefore, opponents of universal health coverage can deliberately construct divisive stereotypes about disadvantaged groups to exclude them from public health care.

By contrast, in Kerala, India, a shared identity between different groups—a sense of we-ness—contributed to progressive social policies that improved health outcomes.⁴⁴ This shared identity prevented different groups from making the distinction between us and them, increasing a group's willingness to support public goods that benefited the broader community. Similarly, in Malawi, cross-ethnic social ties have facilitated trust and cooperation among diverse groups.⁴⁵ Therefore, ideas that facilitate a shared identity can contribute to the expansion of health policies.

Ideas can set policy trajectories on new tracks. In Taiwan and South Korea, for example, mainstreaming the idea of redistributive social welfare contributed to the universalisation of health-care services during a time when most welfare states were cutting back. Public opinion polling during the 1990s indicated that popular opinion was overwhelmingly in favour of introducing more government-administered social welfare, a view that was shared among survey respondents from across different socioeconomic classes. As such, the main political parties, both government and opposition, saw social policy programmes to be key to winning electoral platforms.⁴⁶

Ideas can also serve as coalition magnets, deployed by policy entrepreneurs to bring together disparate actors.⁴⁷ These actors rally around a shared idea,⁴⁷ such as expanded nutrition policies in Indonesia.³⁵ As these ideas

garner wider support, they enjoy a privileged position over other ideas in policy debates. More expansive and inclusive ideas about social policies and universal health coverage can therefore generate normative support for universalist social programmes.

Institutions

Institutions are the rules of the game—they influence which actors have political power, how political power is organised, and how actors mobilise power and participate in the policy process.⁴⁸ Political contestation does not occur in a vacuum, but rather within specific institutional contexts. For example, democratic political institutions can shift political power to poor and marginalised groups. By providing all eligible citizens with voting rights, disadvantaged groups now have the power to choose government officials, such as those that support universal health coverage.⁴⁹ Democratic political institutions also provide expanded opportunities to organise and share information and, thus, build political power. In this context, disadvantaged groups are better positioned to place pressure on governments to expand universal health coverage. As such, the link between democratic regimes and the expansion of health services (and social policies more generally) has been documented.⁵⁰⁻⁵³

However, democratic institutions are not without their challenges. Political manipulation remains a perennial issue.⁵⁴⁻⁵⁶ Politicians might use strategies of vote buying, rather than responding to the demands of disadvantaged groups, to achieve electoral success. Similarly, politicians might distribute public resources to their supporters, rather than to those in greatest need.⁵⁷ These factors can undermine the expansion of universal health coverage. In addition, the plurality of voices in democratic systems can stymie quick decision making. Authoritarian regimes, such as China, have been able to act decisively as there are fewer decision makers. There have also been authoritarian instances of expanded health care, such as in Vietnam and Cuba.

Nevertheless, large-N studies suggest that democratic political regimes are overall associated with better population health, as indicated by lower levels of infant mortality.⁵⁸⁻⁶⁰ Scholars show that democracies outperform authoritarian regimes, even after controlling for quality of governance.⁶¹ Research focused on sub-Saharan Africa reaches similar conclusions. Data from 27 African countries suggest that democratic elections reduce infant mortality rates.⁶² Scholars argue that the increase in the number of countries that are experiencing democratic erosion is hindering progress towards universal health coverage.⁶³ In short, political regimes shape how power is exercised and how decisions are made on universal health coverage and the public provision of basic goods and services.

When the policy making process is institutionally centralised, political power tends to be concentrated within a fewer number of political actors. Generally,

centralised policy processes and concentrated political power allow governments to act decisively and forge political compromises in favour of universal health coverage reform.⁶⁴ For example, neo-corporatist institutions, which are prevalent in Scandinavian countries, confine social policy making processes to tripartite negotiations between the government, labour organisations, and employer associations. As a result of these specific rules, labour unions in neo-corporatist settings are vertically organised and represented by a peak (ie, a single, concentrated organisation) or a national labour association. Employers are similarly organised into a peak organisation in neo-corporatist institutions. In this specific institutional context, cross-class compromises over health care and social security reform are more easily achieved, because other political actors and interests are excluded.

By contrast, when policy making processes are institutionally decentralised and political power is more dispersed, the political system entails opportunities for a greater number of political actors to oppose or block reform. The US political system, for example, fragments power across several branches and levels of government. The policy process is decentralised, involving, in the case of health-care reform, multiple branches of the federal government, state authorities, and several sectoral interest groups (eg, health-care providers, insurers, and the pharmaceutical industry). Given the institutional fragmentation of policy authority and the decentralised health policy process, political actors have many veto points in the political system to block reform.⁶⁵⁻⁶⁸ In summary, US political institutions are designed to prevent excessive centralised power in the federal executive, making it difficult to enact sweeping reforms such as universal health coverage.

Taiwan and South Korea achieved universal health coverage when the two governments legislated and implemented national health insurance (NHI) schemes during the 1990s. The Taiwan Government introduced a single-payer social insurance scheme for health in 1995. The South Korea Government expanded medical insurance coverage to all workers and farmers in the late 1980s and consolidated the insurance funds into a single-payer system in 1998.

Before the introduction of NHI, Taiwan and South Korea provided limited health insurance to select segments of the population. To further their economic development in the post-war period, the then non-democratic governments selectively insured people who were deemed economically productive, including government officials and heavy industrial workers.⁶⁹ However, most citizens were excluded.

The introduction of democracy during the early 1990s prompted the governments in Taiwan and South Korea to pursue NHI reform. Voters supported more inclusive social programmes and the political party system in both places encouraged the governing parties to champion

NHI. Expanded and ultimately universal social programmes such as NHI proved to be winning electoral platforms.

Civil society actors (or expert activists) in the health policy space were crucial in both Taiwan and South Korea, pressuring democratic governments to pursue universal health coverage policies and contributing to the design of national medical and health insurance schemes. Progressive bureaucrats in the health ministries, who had been long-term supporters of expanded health coverage, were empowered to lead social policy reform in the democratic era, a radical shift from previous practices in which social welfare (and health) policies were subsumed under the economic development ministries. In both countries, the idea of redistributive health policy was mainstreamed, as middle-class actors allied with workers, farmers, and vulnerable groups. Despite pressures to privatise or cut back the NHI programmes in Taiwan and South Korea, the two governments have maintained their commitment to universal health coverage.

Implementation

Legislating universal health coverage policy involves the political contestation of interests and ideas, mediated by political institutions. This Series paper has outlined a comparative framework to understand how political power is exercised in health policy making processes. However, turning political commitment to universal health coverage into universal health services delivery requires effective policy implementation. Countries might adopt universal health coverage policies but find it difficult to implement them in practice or to implement them with the desired outcome.⁷⁰ There is an important distinction between health policy design and implementation, as policy reformers will face a different set of challenges.^{71,72}

State capacity is a crucial factor.⁷³ Capable bureaucracies are staffed with technical specialists with domain expertise and experience.⁷⁴ These technocrats make implementation decisions on the basis of evidence rather than political interests or intuition. In the Weberian ideal, capable bureaucrats are rational problem solvers, immune to political interference. If bureaucratic capacity is both strong and relatively autonomous from political interference, such as in east Asia's developmental states, the likelihood of implementing desired policy outcomes is higher.⁷⁵ In contrast, if government bureaucratic capacity is low, governments are much more challenged to effectively implement universal health coverage programmes, despite political pressures, and even political commitment, to expand health services delivery.

Implementing programmes intended to have universal reach is particularly challenging. As universal health coverage involves the expansion of health-care provision to previously marginalised segments of the population, the central government must have the capacity to ensure its street-level or local bureaucrats are able to locally

implement universal health coverage policies faithfully and to the programme's specifications.⁷⁶ Street-level bureaucrats, such as front-line health-care workers, are service providers who implement high-level social policies. These bureaucrats have considerable discretion, shaping how health policies are translated to the local context and how they are experienced by individuals.^{77,78} The behaviours of such bureaucrats can be affected by broader institutional changes. For instance, health sector decentralisation in Honduras has been associated with an increase in staff motivation which, in turn, has improved local service delivery.⁷⁹

Political science analyses the relationship between the principal (eg, central government bureaucracy) and its agents (eg, local programme implementers) by focusing on the vertical power and authority of principals, and the incentives and inducements (eg, performance evaluation) the principal can deploy to ensure that the agents implement the universal health coverage policy.⁸⁰ Effective principals have the capacity and authority to ensure their agents implement policies faithfully and effectively.

Effective principal-agent relationships also depend on flexibility and adaptability to fit local contexts. In this respect, the relationships between government bureaucracies and implementation actors are determined by both the structural features of the governance system (eg, institutions) and the autonomy and latitude that agents can exercise on the ground. In Tanzania, evaluations of the Community Health Fund scheme found that participation of local field staff in programme design and implementation could have played an important role in increasing enrolment by providing contextual knowledge of local sites.⁸¹ Research conducted by the Reach Alliance at the University of Toronto (Toronto, ON, Canada) similarly shows how implementation agents, given their local knowledge about hard-to-reach communities, can more effectively implement universal social programmes (such as universal health coverage) when they have a degree of flexibility to adapt programme requirements to fit local contexts. The balance between principal rigidity and centralised authority on one hand, and agent flexibility on the other, is essential to ensuring an effective principal-agent relationship.

Structural features of the principal-agent relationship also matter. Effective implementation of universal health coverage depends on the state's infrastructural power, as governments must deploy an expansive infrastructure to deliver health services to everyone, everywhere.⁸² Universal health coverage requires that health services reach those who might be geographically distant from urban centres, or those living in poverty who do not have access to government-managed social programmes. These dispersed and varied populations most often reside in rural areas or in highly concentrated urban settlements such as slums. The hard-to-reach populations have poor

access to health services and other infrastructural barriers, such as access to electricity, clean water, roads, communication methods, and transportation.⁸³ This unevenness of far-reaching infrastructure can hamper universal health coverage implementation.

In many parts of the world, the state's ability to provide public goods and basic welfare is limited. In this context, non-state actors—such as domestic and international non-governmental organisations, sectarian political parties,⁸⁴ and faith-based organisations—can play an important role in the provision of health services.⁸⁵ A study of Kenya, Uganda, Botswana, and South Africa showed how under particular conditions, business responses can be focused on ways that assist society in the long term, and not solely on short-term profits.⁸⁶ Therefore, the state's infrastructural power can be strengthened by partnering with non-state actors. Learning from, and even partnering with, private sector actors with specific expertise and implementation channels can optimise the reach of universal health coverage programmes under particular conditions.⁸⁷ New technologies, many of which are being innovated and supplied by private sector actors (eg, mobile health platforms, drone delivery systems, and technology-enabled distant health platforms) can augment government efforts to implement universal health coverage. However, the engagement of the private sector must be approached with caution. Research has shown how private sector organisations, in pursuit of the profit motive, have undermined equitable health outcomes.⁸⁸ Indeed, engaging with the private sector is separate and distinct from the privatisation of the health sector. The privatisation of the health sector entails services that are paid for out of pocket, rendering it inaccessible to poor and marginalised groups.⁸⁹ We contend that health care must be publicly delivered without user fees, or extra billing, if it is to be truly universal.

Conclusion

Universal health coverage is a global goal, at least rhetorically. Despite principled support from international organisations (eg, the UN), global civil society, development philanthropists, professional associations and, most importantly, national governments, the achievement of universal health coverage around the world remains elusive. Moving towards universal health coverage is a complex process.^{90,91} A host of factors need to be aligned for universal health coverage to become a reality, including health systems knowledge, medical expertise, economic and fiscal capacity, and technical policy making skills, among others. This Series paper focuses on the politics of universal health coverage, a dynamic that is underappreciated (and understudied) in global discussions about universal health coverage.

The politics of universal health coverage involves the mobilisation and contestation of interests. Political mobilisation is essential for exercising political power,

For more on the Reach Alliance see <https://reachalliance.org/>

and can take on many different forms, including political lobbying, labour mobilisation, and grass-roots activism. However, the array of political interests alone does not tell the whole story. Political actors hold specific ideas about universal health coverage, including beliefs about the causes of poor health. In addition, societal ideas that coalesce shared identities can play a role, as can ideas that act as coalition magnets. Political mobilisation around universal health coverage occurs in specific institutional contexts. The rules of the political and policy making games vary, and thus institutions have variable effects on the distribution of political power, the organisation of political interests, and the health policy making process. The ability of governments and their non-governmental partners to implement universal health coverage policies presents another political challenge to be overcome.

The global health imperative of universal health coverage has never been more pressing than during the COVID-19 pandemic. We know that robust social safety nets, including universal health coverage, are crucial for both facilitating and enabling broad compliance to public health measures and building trust in governing institutions. Social safety nets ensure, at the most basic level, decent wages to families, access to health care and public health measures, and an income floor to prevent impoverishment. Yet, despite the obvious need for universal access to affordable health—from public health interventions to SARS-CoV-2 testing to treatment and care—never has politics been more of an obstacle to achieving universal health coverage. Several political factors are illuminated by the COVID-19 pandemic. First, contending political interests have become starker during the pandemic: privileged members of society continue to enjoy access to health care, whereas less privileged individuals must do without, despite being substantially more susceptible to the virus. As a result of this divide, the broad-based mobilisation that is required for universal health coverage is increasingly difficult to achieve. Second, the absence of scientific agreement on effective interventions for COVID-19, such as divisive and polarising debates around mask wearing and lockdowns, undermines the consensus-building among technocrats and politicians that is required to achieve universal health coverage. Third, political institutions are failing to adapt to the quickly evolving COVID-19 situation, which could have broader implications for a government's ability to coordinate sub-national or state responses.

The COVID-19 pandemic has made universal health coverage not just an ethical imperative, but a global health priority. Although this Series paper has drawn upon the experiences of both high-income countries and LMICs, LMICs will inevitably face a greater set of challenges in achieving universal health coverage. In addition to resource constraints, many LMICs must grapple with the legacies of colonisation. LMICs operate in an international environment where international actors, such as

international organisations and high-income country trade partners, wield disproportionate control over their domestic policy agendas.

Universalism and the need to reach individuals who have been previously excluded from health systems are essential to ensuring everyone's health, both in the context of public health emergencies such as COVID-19, and the growing burden of chronic disease globally. The pandemic has shown that, although everyone is technically susceptible to COVID-19, susceptibility is not equally experienced within nations and globally. The COVID-19 pandemic has shown that investing in health is not optional, and there is an urgent need to stimulate policy reform towards achieving universal health coverage now. The imperative of including people who are currently excluded has never been clearer, for both moral and health reasons. Universal health coverage is not only the right goal to pursue ethically, but is also for the good of global health.

Contributors

All authors collaborated to identify primary contributions in the fields of political science, public policy, public administration, and health policy. CJH and HK conducted the initial literature review and wrote the first draft. JW did additional research and revised the draft. KS provided support. CJH led the final revisions of the manuscript.

Declaration of interests

We declare no competing interests.

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