Insider-Outsider Politics and Support for Universal Health Coverage in Low and Middle Income Countries: Evidence from Afrobarometer Surveys

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Abstract

Background. The global health community is increasingly promoting universal health coverage as a solution that can strengthen health systems, raise revenue for health care, and improve social risk protection in low- and middle-income countries (LMICs). Described as "universal prepayment" the national health insurance model has particularly caught on and is being diffused by such actors as the World Bank and Rockefeller Foundation. However, one central political dilemma in establishing systems of universal prepayment in low and middle income countries is the low tax base available to contribute to the financing of health care. Many middle class workers in the formal sector (labor market insiders) may already get insurance through the state or private insurers leaving them little incentive to contribute in tax dollars to a universal coverage system that will primarily benefit indigent workers in the informal sector (labor market outsiders).

Methods. We explore attitudes towards UHC using recent data from Afrobarometer surveys in 32 countries comprising Sub-Saharan and North Africa. The 2016 round of Afrobarometer asks respondent about their willingness to pay more taxes to increase government health spending. We explore predictors of support for paying more in taxes to increase health spending including profession and labor market status. We hypothesize that labor market insiders (professionals working in the formal sector) will be more strongly opposed to UHC financing than labor market outsiders (wage laborers and informal sector) who would presumably benefit more from the system and pay in less. We adjust for other factors likely to affect support for UHC including attitudes towards the government, health care and demographics.

Results. We find that in spite of growing attention to universal coverage among policymakers, support among the average citizen is low, though variable across countries. Over 40% of the public opposes the idea of paying more taxes to increase health spending in 25 countries. Moreover, being a labor market insider is significantly associated with opposition to paying more in taxes to increase government spending on health.

Conclusions. Insider-outsider politics is a framework that has been used to explain divisions within the political left that contribute to social policy retrenchment. Here the framework is used to test why support for UHC might not be as high as we might think among the public at large. As UHC hinges on tax financing structures that demand the small tax paying middle class in a country to finance health care for a large informal sector of low-income, non-tax payers, the widespread support required for universalistic policies may not be forthcoming in LMICs.

Introduction

The global health community is increasingly promoting universal health coverage as a solution that can strengthen health systems, raise revenue for health care, and improve social risk protection in low- and middle-income countries (LMICs). With much anticipation, target 3.8 of the sustainable development goals relates specifically to universal health coverage.

Described as "universal prepayment," the national health insurance (or "single-payer") model has particularly caught on and is being promoted by such actors as the World Bank and Rockefeller Foundation. Experience from developed countries suggests that building a universal coverage system is a politically fraught task. The development of universal health coverage systems in present-day high-income countries occurred over the course of more than a century (Bump 2010). For instance, Germany began scaling up social health insurance in 1883 and could only be said to have achieved universal health coverage in 1998 (Barnighausen and Sauerborn 2002). Despite many attempts, the United States was never able to adopt a universal coverage system after becoming "locked in" to an employer sponsored system with some wrap-around coverage for specific groups (Marmor, 2000). The path to universal coverage is paved with good intentions, but is by no means a linear process.

Research in developed countries on the politics of universal health coverage has focused on three primary explanations for variations in the timing of coverage expansions, particularly the role of interest group opposition, political institutions and public opinion (Steinmo & Watts, 1995; Marmor, Kieke, Lathan, 2006). In regards to public opinion, research has suggested that governments respond to citizens' demands for universal coverage (Jacobs, 1993). A "responsive" government is one that responds to signals from the public, including from opinion polls (Przeworski, Stokes, and Manin 1999). The degree of universality and generosity of social welfare programs is therefore believed to represent the preferences of the median citizen.

However, experiences from critical outlier cases like the US suggests that universal programs can enjoy majority support and yet still are not adopted into law. In the case of the US, strong opposition from mobilized groups coupled with complex voting rules has repeatedly stymied attempts at coverage expansions in spite of the widespread popularity of universalistic "trust fund" programs such as Medicare and Social Security (Hacker, 1998; Marmor, 2000; Shapiro and Jacobs 2010).

One of the most contentious aspects of universal coverage systems concerns its tax financing structure (Fox & Reich, 2015). Taxation is a politically contentious issue. Previous research on the politics of taxation in low and middle income countries has found that the collection of income taxes, which tend to be highly visible but unlikely to provide direct benefit, to be highly unpopular especially among the narrow tax base paying the lion's share of the cost (Lieberman, 2001). Other forms of revenue, such as

consumption taxes and social contributions, which tend to be paid more indirectly or with some promise of specific benefit are modestly more popular. Furthermore, the concept of taxation for universal services provides incentives for citizens to free ride on the tax payments on others, which suggests that those compelled to pay may wish to resist the enactment of such policies, especially if their own direct benefit may be weak. Moreover, many developing countries have weak enforcement mechanisms, which makes tax collection both expensive and potentially ineffective with avoidance and evasion schemes being common. Thus, state leaders attempting to collect income taxes have been highly dependent on the willingness of upper-income groups—who control the lion's share of taxable resources—to pay such taxes.

One central political dilemma in establishing systems of universal prepayment in low and middle income countries is the low tax base available to contribute to the financing of health care. Many middle class workers in the formal sector (labor market insiders) may already get insurance through the state or private insurers leaving them little incentive to contribute in tax dollars to a universal coverage system that will primarily benefit indigent workers in the informal sector (labor market outsiders). This problem is perhaps even more acute in developing countries where, unlike developed countries, the size of the informal sector is large and the tax base small.

Insider-outsider politics is a framework, developed largely with late industrial European countries in mind, that has been used to explain divisions within the political left that contribute to social policy retrenchment. The argument is essentially that while early expansions of social protections were brought about by movements on the political left to guard against economic insecurity and bouts of unemployment, more recent social protections have largely focused effort on protecting the benefits of those already in the labor market often at the expense of those outside the labor market. Insofar as rigid labor market institutions (i.e., generous work-related protection) contribute to increased unemployment, those stuck outside the labor market fail to benefit from these protections. Left-leaning social democratic parties, Rueda argues, are thus no longer representing the interests of the unemployed.

As applied to the present question, the insight from insider-outsider politics suggests is that divisions within the working class may contribute to resistance to the expansion of universal coverage insofar as those who are employed in the formal labor market may not wish to subsidize those outside the labor market or engaged in informal sector employment. There is some existing precedent from health reform to suggest that it may be the case that workers, particularly those already enjoying health benefits, may not want to participate in a tax scheme that subsidizes outside groups. Mexico's largest unions, the union of the Instituto Mexicana del Seguro Social (IMSS), opposed the idea of being pooled with the previously uninsured, resulting in the establishment of a separate national health insurance system for the uninsured (the Seguro Popular) administered through the Ministry of Health, rather than an integrated system. This has arguably reinforced a two-tiered benefits package (Lakin 2008). In

Ghana, unions were strong opponents of the 2.5 percent deduction from their social security contribution to finance UHC (Rajkotia 2007; Agyepong and Adjei 2008).

Here the framework is used to test why support for UHC might not be as high as we might think among the public at large. As UHC hinges on tax financing structures that demand the small tax paying middle class in a country to finance health care for a large informal sector of low-income, non-tax payers, the widespread support required for universalistic policies may not be forthcoming in LMICs. Moreover, paying more in taxes is rarely popular if the direct benefit to be enjoyed in uncertain. The goal of this paper is therefore to assess the overall political support for universal prepayment (or a willingness to pay more taxes to increase health spending) in a set of LMICs as well as the relationship between one's position in the labor market and support for universal prepayment. This research has implications for researchers and practitioners interested in scaling-up access to UHC in LMICs as it presents the best available estimates (even if imperfect) about public support for UHC and its correlates.

Methods

We explore attitudes towards UHC using recent data from Afrobarometer surveys in 32 countries comprising Sub-Saharan and North Africa. The 2016 round of Afrobarometer asks respondent about their willingness to pay more taxes to increase government health spending. We explore predictors of support for paying more in taxes to increase health spending including profession and labor market status. We hypothesize that labor market insiders (professionals working in the formal sector) will be more strongly opposed to UHC financing than labor market outsiders (wage laborers and informal sector) who would presumably benefit more from the system and pay in less. We also explore divisions between those who are employed and unemployed. We adjust for other factors likely to affect support for UHC including attitudes towards the government, health care and demographics. Details on all variables and question wordings are contained in the Appendix.

Dependent variable

Support for Universal Coverage. Respondents were asked the following question regarding their willingness to pay more taxes for public health care using a 5 point likert scale (somewhat/strongly support(oppose); neither support nor oppose; it depends):

> "If the government decided to make people pay more taxes or user fees in order to increase spending on public health care, would you support this decision or oppose it?"

Admittedly, this is not an ideal measure of support for UHC on several fronts. First, it does not specify that the benefits would be universally shared. Rather, the question wording suggests that more money would be spent on the current public health system-

not on a national health insurance scheme per se. Moreover, the question is double-barreled in that there is a sharp difference between paying more in taxes and paying more in user fees. Paying more in taxes implies the potential of redistribution whereas paying more in user fees implies a regressive tax. While those outside the formal labor market may not worry about paying more in taxes, since this would not affect them, they may worry about paying more in user fees. However, in that respect, the question is neutral on who will necessarily benefit or lose in this calculation. Furthermore, the phrasing of the question does reflect the concept of "universal prepayment"- pay a little more upfront to pay less on the backend.

We dichotomize the measure to represent those who somewhat/strongly support willingness to pay more to increase health spending. Those who oppose somewhat/strongly, who neither supported nor opposed or for whom it depended or did not know were coded as not supporting UHC.

Independent variables

Employment status and employment in the formal versus sector. The main independent variable of interest relates to whether an individual can be considered a labor market insider or outsider. Ideally, a labor market insider in this context would represent someone employed in the formal labor market and an outsider either someone who is unemployed or making a living in the informal sector. Unfortunately, the questions on employment in the Afrobarometer do not directly ask about employment in the formal versus informal sector. Rather, it asks about employment status and occupation.

The question about employment status asks whether respondents have a job that pays a cash income. Answering unemployed could mean not working at all or potentially not working in the formal "cash income" economy. Those who responded affirmatively that they had a job that pays a cash income, were coded as employed. The occupation question included categories such as student, housewife/homemaker, agriculture/ farming/fishing/forestry, trader/hawker/vendor and unskilled manual worker (e.g., cleaner, laborer, domestic help, unskilled manufacturing worker), that plausibly constitute trades that represent working in the informal sector. These were coded as informal sector workers whereas others including those reporting being employed in various professional as well as skilled manual professions.

Control variables

We controlled for a number of factors that might also affect support for paying more taxes to increase health spending including citizen's overall orientations towards government and the specific party in power.

Trust in government index. Respondents were asked how much they trust different government institutions (how much do you trust the President, National

Assembly/Ruling Party). Respondents reporting that they trust these institutions a lot were summed to form an index of trust in government. Respondents who trust government more might be more likely to be willing to pay more in taxes to increase spending on health

Government handing health. Respondents were asked about how the current government was handling different health care in the country. Respondents that think that the government is doing a good job handling health care in the country will be more likely to support expanding UHC.

Ruling or opposition party improving health. A separate question asks about whether the ruling party in power or opposition party was most able to address improving health. Higher support for the ruling party may translate into more confidence in the government to provide tax financed health care.

Health clinic in PSU. Respondents with a health clinic nearby may have a more positive (or negative) perception of government expenditure on health care. We therefore included a dichotomous variable representing whether or not the primary sampling unit contained a health clinic.

Demographics. We also included gender, rural residency and income vulnerability (a measure of socio-economic status) to control for how these factors may influence perception of the effectiveness of the response of different actors.

Analysis

We first examine weighted toplines for the dependent variable included in the analysis in each country to get a sense of how supportive citizens are on average towards UHC. Next, we use a series of stepwise regression models to examine whether unemployment or employment in the informal sectors was associated with low support for UHC. We first ran bivariate models for different measures of employment status and then added control variables.

Stratified analysis by region and detailed investigation of specific countries. In addition to the aggregate analysis across countries, we also ran models stratified by countries in North Africa and Sub-Saharan Africa. We expected the divisions between employed and unemployed citizens of North Africa, where informal sector is smaller, to be less stark than among sub-Saharan African citizens, where health coverage rates are lower/more insufficient and a larger portion of the population work in the informal sector, to be more supportive.

We also ran separate models for three ostensibly democratic countries at different stages of pooled financing: Ghana, Kenya and Senegal. We compared Ghana, which adopted a national insurance model in 2003 to Kenya and Senegal which have

each respectively lower degrees of pooled financing. In Senegal, UHC is an issue that is currently receiving a great deal of attention, but this has not been translated in action as of yet. Kenya currently has 20% of the population enrolled in some form of pooled financing and is classified as at an early stage of moving towards UHC. Moreover, Senegal presently displays very high support for UHC (56% of the population) whereas support is very low in Kenya (22%) and intermediate in Ghana (42%), which now has experience with scaling-up UHC for over 10 years (see Graph 1 in Appendix).

We employed VIF tests to assess multi-collinearity among measures and excluded measures with VIFS exceeding 10.

Results

Graph 1 displays the weighted toplines of support and opposition to paying more in taxes to increase spending on health care. The results show wide variations in countries in support for UHC. In 10 counties, support for UHC exceeded opposition. In the remaining 22 countries, opposition outweighed support, often by a lot. Not contained in the graph is the relatively large percentage of the population that were ambivalent about their support for UHC either reporting that they neither supported nor opposed increasing taxes to increase health spending as well as those reporting that the did not know or were unsure ("it depends").

In bivariate associations (**Table 1**) between different insider/outsider constructs, the two that showed significant associations with support for UHC were informal (but not formal sector) employment and economic security/insecurity (reporting having gone without cash income frequently vs never/infrequently). Informal sector employment was positively associated with support for UHC (OR=1.06, $p<0.01$) and economic insecurity was negatively associated with support for UHC (OR=0.95, $p<0.01$) whereas economic security was positively associated with UHC (1.07, $p<0.01$).

In multivariate analysis (**Table 2**), we found that informal sector workers were significantly more likely to support paying more in taxes to increase health spending compared with formal sector workers adjusting for other characteristics, though the effect size was small (OR=1.05, $p<0.05$) in sub-Saharan African countries, but to a lesser extent in North African countries and when the samples were combined (OR=1.04, $p<0.1$). Individuals who were more economically secure were more likely to support UHC as well (1.06, $p<0.01$). Individuals living in urban areas were less likely to support UHC (OR=0.88, $p<0.01$). Higher trust in government and higher educational levels were also associated with higher support for UHC. Gender, having a health clinic in one's primary sampling unit and one's support for the ruling party on health care had no effect on support for UHC, though believing that the government handles health badly was associated with lower support for UHC.

Examining the three country case studies- Senegal, Kenya and Ghana- revealed similar patterns among control variables, but different patterns for informal sector workers (**Table 3**). In all three countries, the informal sector was opposed to paying more in pooled financing to increase health spending and significantly so in Kenya (0.93, $p<0.05$). Economic position did not seem to affect support for UHC, especially in Ghana where no relationship was observed with economic security or informal sector employment.

Discussion

Globally, across countries studied, informal sector employment and economic position did have an impact on support for UHC, but the relationship was not straightforward. As hypothesized, informal sector workers were more likely to support UHC. This supports the idea that informal sector workers who would presumably benefit from expanded health provision, but would not face the tax increase to pay for pooled financing, should be more favorable towards such redistribution from insiders to outsiders. However, in bivariate associations, formal sector workers were not less likely to support UHC and, paradoxically, more economically secure individuals were more likely to support UHC and economically insecure less likely to support UHC. It is possible that those who have experienced deficits of cash income would be concerned about a tax increase or an increase in user fees compared with those who are more economically secure. Nevertheless, this finding draws into question the idea that the economically secure would be more adverse to redistributing to the economically insecure.

Trust in government was associated with greater support for UHC and conversely, perceptions that the government was handling health badly was associated with lower support. This suggests that general faith in government is associated with greater willingness to increase pooled financing.

There was also an urban bias in support for UHC- people in urban areas were less likely to support paying more taxes to increase health spending. This appears to reflect the well know urban bias in political economy whereby urban populations tend to benefit more from public goods often at the expense of rural populations because of their disproportionate political influence (Lipton, 1977; Bates, 1993; Varshney, 2014). To the extent that urban populations already have better access to health services, they may be reluctant to redistribute to rural areas dominated by informal sector agricultural workers.

We also found wide variation in support and opposition to UHC in different countries. Out of the 32 countries studied, 22 had populations where a majority or plurality opposed the idea increasing taxes to expand health spending and only 10 countries had majorities or pluralities that supported it. Future analysis could assess the characteristics of these countries and differences in attitudes within them. The positive

relationship between informal sector work and support for UHC was stronger when the sample was limited to countries in SSA, perhaps because the informal sector may be larger and more diverse than in the three North African countries in the sample. Opposition exceeded support in the three Algeria, Tunisia and Egypt.

Comparing three countries at different stages of UHC adoption revealed differences in preferences across countries. In Kenya, a large majority expressed opposition to UHC (62%) whereas a large majority was supportive in Senegal (56%) and Ghana was fairly neutral (45% oppose, 41% support). Within these countries, informal sector workers were less, not more likely to support UHC.

Limitations. There are a number of limitations to note in this study. First, the measure of support for UHC is imperfect on several fronts. The question is posed in a double-barreled fashion that captures two different types of pooled financing that have very different implications in terms of support. Increasing taxes would imply that the formal sector would be disproportionately affected and may be perceived as a tax increase that could provide limited return on investment. The question also asked about willingness to pay more user fees to increase health financing, which constitutes a regressive tax, but also one that would affect both formal and informal sector workers. In addition, the question asked about willingness to pay to increase health spending, not to increase health insurance coverage. If public services are perceived as of poor quality, then respondents might be less willing to pay more in taxes to subsidize a malfunctioning public health service. This can be seen from the results showing that those with greater trust in government and more supportive of government performance on health were more willing to engage in pooled financing.

A second limitation is the measure of informal sector work. Participants were not directly asked if they pay taxes or if they themselves have health benefits. We made the assumption that certain professions that are "typically" informal- e.g., hawkers, traders, agricultural workers- were in fact informal. We also made the assumption that formal sector workers were likely to have some form of health coverage from the state and would therefore be more likely to oppose expanding that coverage to others, especially those not contributing to the system. This assumption is hard to verify and likely varies country and sector within countries. The somewhat contradictory findings across different analyses on this front may be evidence of the lack of nuance in insider-outsider positionality provided by these blunt measures.

Finally, while the large sample of countries provides a helpful snapshot of support for UHC in the region, the toplines reveal that countries different substantially in overall support and opposition. In Senegal, universal health coverage is currently high on the agenda and gaining momentum- this is reflected in the general support for UHC by a majority of the public. In Ghana, which has had over 10 years of experience with UHC, support for UHC is much more mixed.

In spite of these limitations, this study provides important insight into support for UHC in LMICs, including potential winners and losers in health reform. Unlike health systems in HICs that are largely locked in on an existing policy path, LMICs still have the opportunity to decide which path they will take, decisions which may affect the degree of equity of health systems moving forward.

Conclusion

Support and opposition to pooled financing for health care varied greatly across countries, but in most countries opposition exceed support. There is some evidence that informal sector workers are more supportive of pooled financing that formal sector workers, but there is also evidence that those who are more economically secure of more supportive. As international development agencies continue to promote pooled financing for health, and the issue continues to make its way onto government agendas, it is important to consider which segments of the population stand to win and lose from these reforms and their degree of support.

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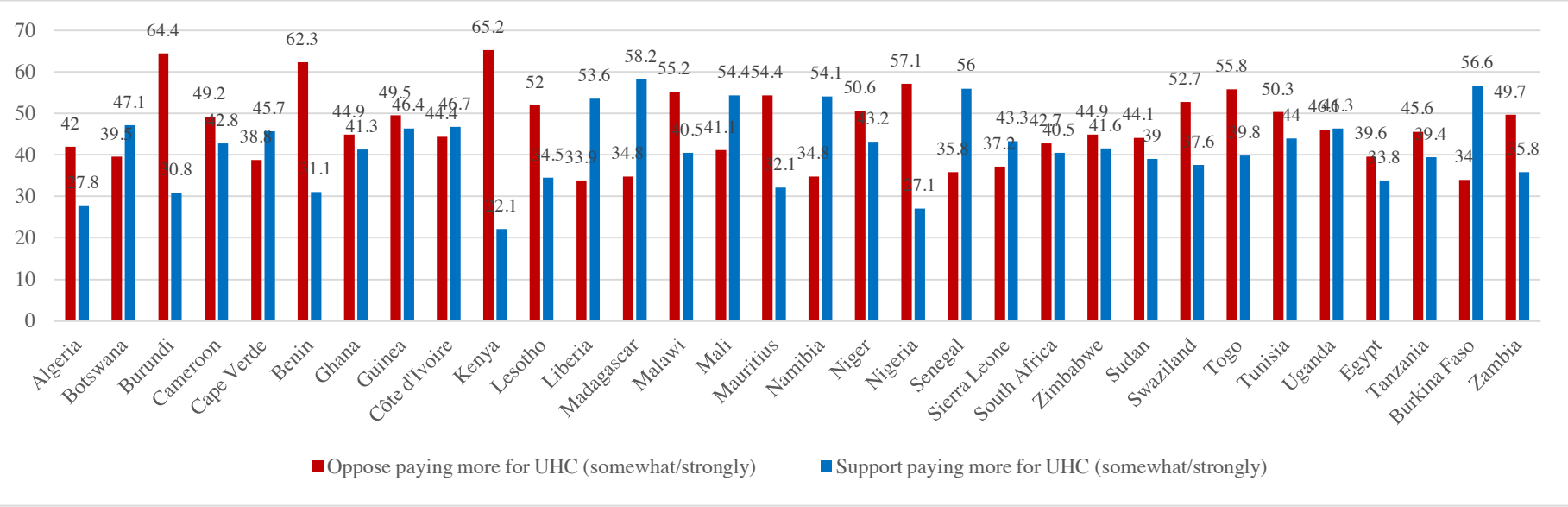
TABLES AND GRAPHS

Graph 1: Percent (weighted) Supporting and Opposing Paying More in Taxes to Increase Health Spending by Country[⊥]



[⊥]Note: Other response options not shown here included: neither support nor oppose, don't know, it depends (don't know and it depends were not elicited)

Table 1: Bivariate Associations btw Insider/Outsider Variables and Support for UHC*

VARIABLES	odds ratio	odds ratio	odds ratio	odds ratio	odds ratio	odds ratio	odds ratio
Unemployed	0.99						
	(0.950 - 1.038)						
Employed		1.02					
		(0.979 - 1.070)					
Informal Sector			1.06***				
			(1.019 - 1.109)				
Formal Sector				0.99			
				(0.939 - 1.040)			
Work for Self					1		
					(0.956 - 1.048)		
Economically Insecure						0.95**	
						(0.908 - 0.989)	
Economically Secure							1.07***
							(1.023 - 1.120)
Constant	0.19***	0.18***	0.18***	0.19***	0.19***	0.19***	0.18***
	(0.160 - 0.219)	(0.157 - 0.216)	(0.158 - 0.216)	(0.165 - 0.225)	(0.164 - 0.224)	(0.165 - 0.224)	(0.155 - 0.212)
Observations	53,935	53,935	53,935	53,935	53,935	53,935	53,935
Number of COUNTRY	36	36	36	36	36	36	36

* Country included but not show

Table 2: Support for UHC by Employment Status*

VARIABLES	All Countries	North Africa	Sub-Saharan Africa
Informal Sector	1.04*	1.04*	1.06***
	(0.996 - 1.092)	(0.996 - 1.092)	(1.016 - 1.116)
Economically Secure	1.06**	1.06**	1.05**
	(1.007 - 1.109)	(1.007 - 1.109)	(1.004 - 1.108)
Government handling health badly	0.79***	0.79***	0.80***
	(0.759 - 0.829)	(0.759 - 0.829)	(0.761 - 0.833)
Ruling party does enough to improve health	1.02	1.02	1.04
	(0.970 - 1.074)	(0.970 - 1.074)	(0.991 - 1.100)
Health clinic in cluster	1.03	1.03	1.03
	(0.982 - 1.073)	(0.982 - 1.073)	(0.982 - 1.076)
Trust government- not at all (ref)			
Little	1.22***	1.22***	1.22***
	(1.146 - 1.292)	(1.146 - 1.292)	(1.144 - 1.294)
Medium	1.36***	1.36***	1.34***
	(1.272 - 1.448)	(1.272 - 1.448)	(1.251 - 1.429)
A lot	1.65***	1.65***	1.63***
	(1.546 - 1.752)	(1.546 - 1.752)	(1.530 - 1.738)
Education, < than primary (ref)			
Secondary	1.14***	1.14***	1.14***
	(1.081 - 1.195)	(1.081 - 1.195)	(1.085 - 1.203)
Secondary +	1.18***	1.18***	1.19***
	(1.097 - 1.270)	(1.097 - 1.270)	(1.099 - 1.283)
Male	1	1	1
	(0.957 - 1.039)	(0.957 - 1.039)	(0.963 - 1.048)
Urban	0.88***	0.88***	0.89***
	(0.842 - 0.925)	(0.842 - 0.925)	(0.844 - 0.930)
Constant	0.17***	0.17***	0.17***
	(0.142 - 0.202)	(0.142 - 0.202)	(0.143 - 0.202)
Observations	49,137	49,137	45,537
Number of COUNTRY	32	32	29

*** p<0.01, ** p<0.05, * p<0.1

Table 3: Comparing Senegal, Kenya, Ghana

	Senegal	Ghana	Kenya
VARIABLES	odds ratio	odds ratio	odds ratio
Informal Sector Worker	0.89	0.96	0.75**
	(0.681 - 1.166)	(0.794 - 1.167)	(0.572 - 0.984)
Economically Insecure	1.07	1.05	0.97
	(0.750 - 1.517)	(0.881 - 1.254)	(0.751 - 1.245)
Government handling health badly	0.66***	0.69***	0.89
	(0.515 - 0.856)	(0.574 - 0.830)	(0.673 - 1.164)
Ruling party does enough to improve health	0.85	1.42***	1.45
	(0.552 - 1.323)	(1.183 - 1.712)	(0.922 - 2.290)
Health clinic in cluster	0.67***	1.11	0.82
	(0.522 - 0.849)	(0.925 - 1.340)	(0.643 - 1.053)
Trust government- not at all (ref)	-	-	-
Little	1.39*	1.05	2.04***
	(0.995 - 1.946)	(0.790 - 1.402)	(1.488 - 2.794)
Medium	1.21	1.21	1.81***
	(0.840 - 1.750)	(0.870 - 1.694)	(1.300 - 2.516)
A lot	1.48**	1.75***	1.89***
	(1.029 - 2.119)	(1.317 - 2.325)	(1.308 - 2.738)
Education, < than primary (ref)	-	-	-
Secondary	1.08	0.93	1.32*
	(0.813 - 1.435)	(0.756 - 1.136)	(0.972 - 1.790)
Secondary +	0.84	0.82	1.04
	(0.539 - 1.303)	(0.590 - 1.144)	(0.683 - 1.592)
Male	0.85	1.1	1.07
	(0.663 - 1.079)	(0.919 - 1.309)	(0.836 - 1.359)
Urban	0.46***	0.72***	0.79*
	(0.358 - 0.603)	(0.589 - 0.869)	(0.609 - 1.032)
Constant	1.42	0.56***	0.09***
	(0.831 - 2.428)	(0.413 - 0.755)	(0.050 - 0.160)
Observations	1,200	2,400	2,397
Number of COUNTRY	1	1	1

*** p<0.01, ** p<0.05, * p<0.1

APPENDIX

Table 1A: Constructs and their Operationalization in the Dataset

Construct	Type of Variable	Question Wording	Response Options	Recode
Support for UHC	DV	If the government decided to make people pay more taxes or user fees in order to increase spending on public health care, would you support this decision or oppose it?	1=Strongly oppose, 2=Somewhat oppose, 3=Neither support nor oppose, 4=Somewhat support, 5=Strongly support , 6=It depends (e.g., on size of the increase) [Do not read], 9=Don't know [Do not read]	(5 6 =1 "support (somewhat/strongly)") (-1 9 98 1 2 3 4=0 "oppose or neutral")
Employment status	IV	Do you have a job that pays a cash income? If yes, is it full-time or part-time? If no, are you presently looking for a job?	No (not looking), 1=No (looking), 2=Yes, part time, 3= Yes, full time, 9=Don't know, 98=Refused to answer, -1=Missing	2, 3=1 "employed part/full time" 1, else= 0 "unemployed/ other"
Informal sector occupation	IV	What is your main occupation? (If unemployed, retired or disabled, what was your last main occupation?)	0=Never had a job, 1=Student, 2=Housewife / homemaker, 3=Agriculture / farming / fishing / forestry, 4=Trader / hawker / vendor, 5=Retail / Shop , 6=Unskilled manual worker (e.g., cleaner, laborer, domestic help, unskilled manufacturing worker), 7=Artisan or skilled manual worker (e.g., trades like electrician, mechanic, machinist or skilled manufacturing worker), 8=Clerical or secretarial, 9=Supervisor / Foreman / Senior Manager, 10=Security services (police, army, private security), 11=Mid-level professional (e.g., teacher, nurse, mid-level government officer), 12=Upper-level professional (e.g., banker/finance, doctor, lawyer, engineer, accountant, professor, senior-level government officer), 95=Other, 99=Don't know, 98=Refused to answer, -1=Missing	1/6=1 "informal sector"; 7/99 -1=0 "formal sector"
Economic insecurity (gone without cash income many times/always)	Control	Over the past year, how often, if ever, have you or anyone in your family: Gone without a cash income?	0=Never, 1=Just once or twice, 2=Several times, 3=Many times, 4=Always, 9=Don't know, 98=Refused to answer, -1=Missing	(3 4=1 "many times/always"; 0 1 2 99=0 "never/infrequently")

Health clinic in PSU	Control	Observation of the enumerator	“Yes” No”	1=Yes; 0=No
Ruling party does enough to improve health	Control	Looking at the ruling and opposition political parties in this country, which would you say is most able to address each of the following matters, or haven’t you heard enough to say? Improving basic health services	1=Ruling Party, 2=Opposition party or parties, 3=Neither of them (DNR), 9=Don’t know/Haven`t heard enough, 98=Refused to answer, -1=Missing	(1=1 "ruling party improving health") (-1 2 3 4 9 98 99=0)
Government handling health badly	Control	How well or badly would you say the current government is handling the following matters, or haven’t you heard enough to say: Improving basic health services?: Handling improving basic health services	1=Very badly, 2=Fairly badly, 3=Fairly well, 4=Very well, 9=Don’t know/Haven’t heard enough, 98=Refused to answer, -1=Missing	(1 2= 1 "gov handling health badly") (-1 3 4 5 9=0 "handling health well") (99=.),
Education	Control	What is your highest level of education?	0=No formal schooling, 1=Informal schooling only (including Koranic schooling), 2=Some primary schooling, 3=Primary school completed, 4=Intermediate school or Some secondary school / high school, 5=Secondary school / high school completed , 6=Post-secondary qualifications, other than university e.g. a diploma or degree from a polytechnic or college, 7=Some university, 8=University completed, 9=Post-graduate, 99=Don’t know [Do not read], 98=Refused to answer, -1=Missing	(-1 0 1 2 98 99= 0 "< primary") (3 4 5=1 "primary-highschool") (6 7 8 9= 2 "high school +")
Gender	Control		Male=1; Female=0	
Urban	Control		Urban=1; Rural=0	