

# What role does political leadership stability play in the successful implementation of national healthcare reforms?

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Political leadership stability refers to a government's capacity to maintain consistent, uninterrupted leadership and policy direction over an extended period, avoiding abrupt regime changes, major coups, or intense, violent political unrest. Political stability signals predictability of regime that facilitates successful implementation of broader policy reforms, and critically the national healthcare reforms. A stable government builds trust among stakeholders that greatly aids in securing long-term funding considering national healthcare reforms require systematic, multi-year planning.

A type of national healthcare reforms is the Universal Health Coverage (UHC) reforms wherein stability is especially critical since these are inherently long-term, resource intensive, and politically sensitive. UHC reforms typically require expansion of access to essential services, strengthening health systems, and institutionalizing equitable care by formalizing financing mechanisms of healthcare expenses of masses. In contexts where governments are stable, such reforms are more likely to be consistently implemented and sustained. (Gonani and Muula, 2015). Political instability compromises the integrity of health policy implementation as the political will and commitments of the regimes towards the healthcare reforms and budget allocations may significantly differ. Several developed countries with established democratic systems and stable political leadership, such as Canada, Germany, and Japan, have progressively expanded their health coverage over decades. Their reforms typically been implemented through incremental policy consensus, institutional capacity building, and sustained budget allocations that were protected from sudden political shifts.

The political leadership stability's role is especially significant in developing nations and low-income nations, given these nations often have additional layers of complexity such as skill gaps of professionals and insufficient infrastructure (Kakade et al., 2023). According to the World Health Organization (2008) report on primary healthcare reforms it is necessary to treat UHC as a political goal considering the need to adapt to the changing health challenges, demands and rising expectations of populations. In certain developing countries where political instability has been a recurrent challenge, progress toward UHC has often been slower, uneven, or disrupted. Frequent changes in government leadership, short electoral cycles, and recurrent political crises can interrupt reform momentum, dilute accountability, and lead to stop-start implementations of health financing schemes. For example, in Egypt reform initiatives of Social Health Insurance (SHI) system between 2005 and 2015 encountered significant setbacks, due to disagreements over reform objectives and political contestation surrounding the policy processes. SHI was intended to serve as a pathway toward Universal Health Coverage (UHC) by expanding financial protection and access to healthcare services. Despite the major policy shift in December 2017, when the UHC coverage was extended to all citizens, only 58% of the population was formally insured. Even this nominal coverage did not translate into adequate financial protection, as the population Out of pocket expenses were 72% of its healthcare expenses (Ismail, 2018). Similarly in Pakistan, Khan and Van den Heuvel (2007) found that the frequent regime changes led to centralization of health resources and underbalancing of the power structure limited the wider participation of stakeholders and this hampering the implementation of reforms. Further, in Nigeria, Aregbeshola (2017) found that despite early establishment of National Health Insurance Scheme (NHIS) in 1999, its implementation was formally launched much later in 2005 due to political instability with

population coverage of the scheme in 2013 being less than 5%. This study further stated that that different levels of political willingness across the regime changes had a detrimental impact on the implementation of a social health insurance which serves as a strong foundation of implementation of UHC.

The COVID-19 pandemic represented a different type of health policy reform, that was sudden, large-scale, and shock-driven as compared to the slow, planned trajectory of UHC. The emergency nature of mass vaccination programs pressed governments to rapidly procure vaccines, deploy logistics, and coordinate large-scale public campaigns. In this regard, too, political stability mattered significantly. Stable governments with strong institutional capacity- such as South Korea, Australia, and France, were able to roll out vaccination programs rapidly, coordinate across federal and local levels, and maintain public confidence. Their ability to mobilize resources, maintain supply chains, and communicate consistent messaging was undergirded by predictable leadership and established bureaucratic mechanisms. The pandemic period was coincident with period of political instability in countries such as Afghanistan (Essar et al., 2021) which led to lower-than-average vaccine coverage and low demand for uptake of vaccines with only 13% the population coverage of vaccination until 2022 (Matin et. al, 2023) and 44.05% in 2023. (Wardak et al.,2024). Similarly in Venezuela, decades of political unrest had already the weakened healthcare capacity of public institutions. The political unrest had led to several refugees migrating out of Venezuela, exacerbating the crisis and led to more responsibilities shifting to the neighboring states. Equitable access to vaccines for migrants and refugees became a critical need in countries such as Colombia (Gomez et al., 2024). In Sahel region of Africa that comprises of the nations such as Burkina Faso, Chad, Mali, Niger, and Sudan; the outbreaks of diseases, under immunization and inadequate vaccinations were already persistent owing to political crises, conflicts, escalating violence, displacement, and humanitarian crisis (Sabahelzain et al., 2025; Nechad, 2021). Hemmeda et al. (2022) stated that an accurate assessment of impact of pandemic and vaccination programmes in areas politically conflicted areas such as the Sahel region was challenging as data collection and surveillance systems were frequently disrupted. Furthermore, Abubakar and Abubakar (2021) highlighted that mismanagement of health funding, often exacerbated by political instability, undermined the planning and execution of vaccination campaigns, leading to delays, inequitable distribution, and reduced coverage, particularly among vulnerable and hard-to-reach populations. These combined factors illustrate how instability not only hampers routine immunisation programmes but also limits the effectiveness of emergency health interventions, such as mass vaccination drives during pandemics.

These contrasts illuminate how political leadership stability alongside healthcare capacity is foundational to both steady health system reform and crisis-responsive interventions. Stable regimes can anchor long-term reforms like UHC and navigate temporal shocks such as pandemic vaccinations, while unstable regimes frequently encounter obstacles that compound health inequities and weaken public confidence in government commitments. Ultimately, the predictability and continuity of political leadership are not merely desirable; they are essential components of resilient health systems able to advance both planned reforms and emergent public health responses.

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