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Dina Balalaeva

DEMOCRACY AND QUALITY OF GOVERNANCE: WHAT MATTERS MORE FOR HEALTH?

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This study explores association between political regime, good governance and country social performance measured as Infant Mortality Rate (IMR). It is widely argued that democratic leaders possess more incentives to provide public goods, say, in order to meet median voter's demands, than their authoritarian counterparts, which, inter alia, leads to superior health related capabilities in democracies. Maintaining an assumption that in the modern world public health delivery process may be of greater importance for certain health outcomes than macroeconomic and political factors, say, economic growth, and capitalizing on the observation that an increasing number of nondemocratic regimes perform well on governance and health indicators, whereas many democracies, especially nascent, fare poorly, I argue that it is good governance that matters more for state performance in the healthcare sector than democracy vs. autocracy dichotomy. Utilizing both cross-section and TSCS data analysis, I show that good governance exerts systematic influence upon IMR, whereas political regime characteristics lose their statistical significance once controlled for governance.

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Dina Y. Balalaeva, postdoctoral fellow, researcher at the Laboratory for Political Studies, HSE.

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Introduction

In 2013, in China 1 child out of 71 does not see her 5th birthday, whereas in India it is 1 out of 15 (World Bank, 2013). With child mortality rate being a decent indicator of overall quality of life, these figures smash the conventional wisdom that democratic structures, as is the case with the long-standing democratic traditions in India, are superior to its politically centralized counterparts, as with the Chinese communist party command system, in terms of social performance. Of course, China enjoys much higher per capita income than India, but it is still far from that of the full-fledged Western democracies. One possible explanation may lie in the character of public goods delivery process. For example, local officials in India, despite the highly democratic and constitutionally rooted panchayat system, are often subject to severe local vested interests capture on the basis of caste, social status, or family name (Mathew and Nayak, 1996; Mathew, 2003). In contrast, despite the lack of constitutionally guaranteed system of political competition at the local level, some Chinese villages make use of informal institutions e.g., village temples, that play an encompassing role and make politicians provide an optimal amount of public goods in exchange for reputation (Tsai, 2007). Taken at its extreme ends, these cases are illustrative of the role that formal and informal political institutions may play in country social performance. More importantly, the cases of well-performing noncompetitive states can no longer be confined to simple outliers in the form of rich oil-dependant economies (e.g., Oman), South-Asian stand-alone economic success stories (e.g., Singapore) or leftist regimes (e.g., Cuba).

Many studies claim that democracies outperform nondemocracies in human development including its non-income dimensions such as health and education indicators (Baum and Lake, 2001; Besley and Kudamatsu 2006; Franco et al. 2004; Lake and Baum 2001, 2003; Tsai 2006; Vollmer and Ziegler 2009; Zweifel and Navia 2000, 2003;). The general theoretical argument attributes much success of democracies to politicians being institutionally constrained and thus, highly accountable to voters who demand more public goods and of higher quality, including healthcare services. There is also evidence that bad governance and corruption constitute a palpable barrier to pub-

lic goods delivery in the healthcare sector (e.g, Gupta et al., 2000). I posit that an increasing number of both well-performing authoritarian regimes (judging by health outcomes per se as well as other health stimulating factors e.g., human capital, economic development) and ill-performing transitory democracies calls for the reevaluation of the conventional wisdom.

Rothstein and Teorell (2008) suggest that good governance, by which they imply the impartiality of institutions, might matter more for human development than democratic structure. However, McGuire (2013) points out certain difficulty in distinguishing good governance from democracy and call for further theoretical and empirical investigation. This paper takes up this task and attempts to theoretically and empirically disentangle the effects of political regime and quality of governance on health outcomes. Following the established literature, national "health" is measured as infant mortality rate per 1,000 life births (IMR), which is considered to be a superior proxy for human well-being by several advantages listed in the Research Design Section (McGuire, 2001).

Health-related capabilities are by definition an important component of human capital that, in its turn, largely determines overall human development. Maintaining an assumption that in the modern world public health delivery process may be of greater importance for health outcomes than macroeconomic and political factors, first, I argue that it is quality of healthcare services and thus, governance as such, that exerts a stronger effect upon health outcomes than political regime. In addition, it is plausible to argue, without transcending rational choice paradigm, that both democratic and authoritarian elites possess a strong encompassing interest in developing an efficient healthcare sector. Second, the role of globalization, say, in the form of technology spillovers, must be appreciated since it operates through the same delivery logic, for instance, ad hoc foreign interventions targeted specifically at reducing IMR. These alternative theoretical mechanisms are argued to render democracy/autocracy dichotomy less relevant in explaining health outcomes and put quality of governance and globalization process to the forefront.

Two recent trends lend support to the theoretical proposition above. First, there is an increasing number of well-performing autocracies and ill-performing transition states (as demonstrated in Figure 1), which casts doubt on the common belief that democracies enjoy better governance.

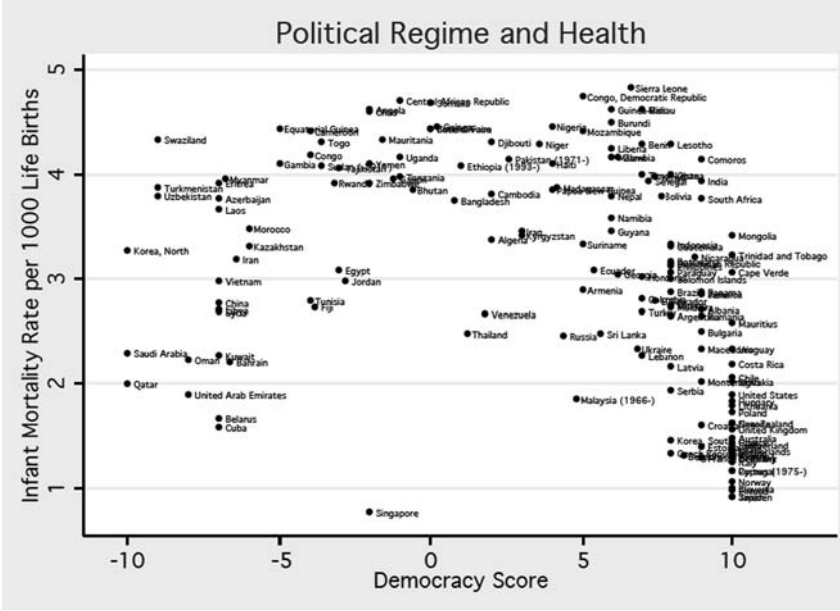

Figure 1. Political Regime and Infant Mortality Rate

Second, many authoritarian states in the recent years deliberately choose to open up their borders and reap positive externalities from globalization process (say, medical technology spillovers or foreign aid from advanced countries), which has been shown to exert positive influence upon IMR (e.g., Deaton, 2004). In this case, quality of governance again determines state's ability to optimally appropriate positive externalities from globalization.

After performing a series of rigorous empirical tests on the extensive cross-section and pooled TSCS datasets, I come to the conclusion that good governance exerts an important independent influence upon health related outcomes, whereas political regime variable loses its statistical significance once controlled for governance characteristics.

The paper is organized as follows. The next section reviews the related studies and points out possible connection between different strands of literature. Section 3 presents the main theoretical argument. Section 4 outlines research design and data description, which follows by results. The last section concludes.

Literature Review

The literature on the non-income components of human development was spurred by Amartya Sen (1999) who emphasizes that economic development is not an end in itself, but rather a means to achieving a more fundamental good i.e., an ability to pursue one's life choices. As obvious as it may sound, in order to do that one has to be alive and healthy in the first place. The public goods nature of healthcare services[1] prompts a strong state role in providing health related services, which makes it crucial to analyze which types of government perform better at this.

Most theoretical mechanisms are built around the notion of redistribution, political competition, and accountability. Some argue that democracies provide more public goods since they represent interests of the median voter who is usually poorer than the average and therefore, support broader redistributive schemes (Acemoglu and Robinson, 2001; Vollmer and Ziegler, 2009). Levels of political participation have been found to increase public goods provision, and thus encourage human development (Besley and Burgess, 2002; Chowdhury, 2004). Other scholars stress the role of elections for raising politicians' stakes of being accountable to voters, which provides the former with strong incentives to provide more and also better public goods (Bates 1984; Bueno de Mesquita et al. 2001; Lake and Baum, 2003). Kiessling (2007) finds that the most important democratic factor impacting IMR is competitiveness of executive recruitment, which leads him to suggest a different plausible channel of influence: a more competitive and hence, more efficient use of resources. The most recent studies (Gerring et al., 2012; McGuire, 2013) argue that it is only a stock of democracy that positively impacts IMR and not a simple measure of democracy level, for it usually takes a long time to develop formal institutions and civil society that constitute necessary prerequisites for democratic leaders to act as predicted in the previous theories, e.g., provide more public goods. This logic inclines Gerring et al. (2012) to doubt why nascent democracies with large institutional gaps and high amount of uncertainty, as opposed to old, full-fledged democratic regimes, would outperform authoritarian states.

The empirical evidence on the relationship between the formal political institutions i.e., political regime, remains mixed at best. Most scholars find a

[1] Even if healthcare services are largely provided by the private sector, as is the case in many countries, it is still government responsibility to regulate private providers through various measures (e.g., Baum and Lake, 2001).

positive relationship between democracy and non-income aspects of human development (Baum and Lake, 2001; Besley and Kudamatsu, 2006; Franco et al., 2004; Lake and Baum, 2003; Tsai 2006; Vollmer and Ziegler, 2009; Zweifel and Navia, 2000, 2003). Some show the statistical significance of democratic age as opposed to democracy score per se (Gerring et al., 2012; McGuire, 2013). Other scholars also find that such influence is either miniscule or absent (Gauri and Khaleghian 2002; McGuire 2004; Pande, 2003; Shandra et al., 2004; Ross, 2006). For instance, Pande (2003) shows that including fixed effects into the analysis by Zweifel and Navia (2000) render their results on the positive influence of regime type on infant mortality almost null.

The empirical literature on impact of governance indicators and their separate aspects, especially control of corruption, on health outcomes seems to have reached a greater consensus. Kaufmann et al. (1999) and Kaufmann et al. (1999) compellingly demonstrate high negative correlation between different governance indicators and infant mortality rate. However, such results must be interpreted with caution since the performed regressions do not include any control variables such as income per capita, education and others that might be of great significance. Gupta et al. (2000) show that higher levels of corruption lead to higher infant mortality rates even when account for other important factors such as GDP per capita and female education. De La Croix and Delavallade (2006) demonstrate that highly corrupt states tend to under-invest in health and education in comparison with, say, physical infrastructure. Under a different research framework, McGuire (2006) finds that health care expenditures do not make any systematic differences for infant mortality outcomes, which invites a closer look at under what conditions increasing healthcare spending would contribute to lowering IMR, and under which it wouldn't. Rajkumar and Swaroop (2008) find that the effect of state healthcare expenditures is conditioned on the level of corruption and bureaucrats' competence. In other words, they demonstrate that "bad" governance significantly diminishes the marginal return from an additional dollar spent on healthcare.

At this point the broader debate on formal and informal institutions must come into play. Which formal institutions are able to produce better governance? The growing number of studies recognizes the failure of nascent democracies, or hybrid regimes, to produce the same excellent governance outcomes as their institutionalized democratic counterparts despite the existence of formal, or constitutional foundations that meet minimal democratic require-

ments (first and foremost, elections). In a path-breaking study, Tsai (2006) shows on the example from the Chinese local politics that informal institutions might be an efficient substitute for the formal ones if the latter are absent or not working. Keefer (2004), for instance, recognizes the imperfect nature of political markets and argues that two important features i.e., lack of information and credibility, might offset beneficial effects of democracy on public goods provision. Later on, Keefer and Vlaicu (2008) remind that as of 2004 more than 33% of democracies demonstrated the same or higher levels of rent-seeking than the median nondemocracy. They blame initial noncredibility of politicians' promises and their reliance on clientelist networks for the delayed political development of some democratizing countries, as it happened, for instance, in Dominican Republic. Empirically, one may safely hypothesize that clientelism and absence of credibility would be reflected in the level of rent-seeking and corruption, which are usually part of any good governance indices (e.g., World Bank Indicators, ICRG index etc.).

The conventional standing in the two blocks of literature surveyed above is the following. There is no agreement on whether democracies outperform nondemocracies on either good governance or health outcomes. There seems to be, however, a broad consensus on the negative impact of corruption and other indicators of bad governance on health outcomes. How formal democratic structures function may heavily depend on their "informal" manifestations e.g., governance efficiency and corruption. If the latter are present for different reasons than incentives derived from formal institutions, say, corrupt personal relations and clientelist networks inherited from the previous regimes, in this context the same formal institutions may not lead to the same successful outcomes. It seems that democracy is not a panacea for either better governance or social outcomes. In the subsequent section I explore the possibility that it is good governance that matters for explaining IMR more than democratic score.

Theory

The nearly universal consensus on democracies being a superior political setup for public goods provision has been recently shaken by the empirically oriented scholars. However, less progress has been achieved in the theoretical realm. This section attempts at fulfilling the gap and explain the seeming absence of association between political regime and health outcomes.

The adequate starting point for the theoretical analysis seems to be explaining the concept of infant mortality rate. Two competing hypotheses on the major causes of sharp decline in mortality rate over centuries, as emphasized in Gauri and Khaleghian (2002), deserve mentioning. First, mortality rate decline as a consequence of improving macroeconomic and social conditions such as economic growth and overall nutrition or, alternatively, as a consequence of efficient public health micromanagement, such as communicable disease control, inspection of wet nurses, skilled attendance at birth or even delivery of clean water, improvement in sanitation systems, conduct of vaccination campaigns, and so on. Each case enjoys supportive evidence (for a detailed historical overview, see Cutler, Deaton, and Lleras-Muney, 2006. Cutler et al. (2006) come to the conclusion that both theoretical propositions are valid, but at different points in history: economic growth and nutrition may have explained much of mortality reduction in the second half of the 18th-first half of the 19th centuries, while public health initiatives and medicine advances (e.g., antibiotics) are responsible for health improvements in the 1850s-1920s and 1930s till nowadays, respectively. For example, the diarrheal disease, which is considered to be the number one cause of death (especially, infant mortality) worldwide, can be easily treated today by low-cost therapy (Cutler et al., 2006). Therefore, it is reasonable to argue that the outcome will largely depend on the delivery process, which makes good governance – first and foremost, efficiency and quality of bureaucracy and absence of corruption, and globalizing process – diffusion of medical advanced technologies – the more direct causes of improvements in health, especially infant mortality rates, than political regime characteristics. Figure 2 clearly demonstrates the near-linear relationship between quality of governance and IMR.

Emphasizing the role of delivery process in health provision and, as a consequence, the role of good governance, is important, but not new. However, what is innovative here, is that appreciating the role of public health micromanagement might deny democracies their commonly assumed advantages i.e., more redistribution[2]. This might be an example when "the bigger" is not

[2] An alternative explanation for why democracies' ability to redistribute may not be of generally ascribed importance is offered by Ross (2006) who meticulously notices that health services enjoy highly inelastic demand, which puts democracies at an advantageous position only if they redistribute to the poor, who, for instance, cannot afford switching to private services, rather than the middle class. According to Ross' example, treatment rate for diarrhea in public health facilities was higher for the richest quintile in 38 out of 42 countries, which indicates indirect support for the proposition that redistributive programs within democracies do not necessarily target the poor. A different example might be drawn from McGuire (2000):

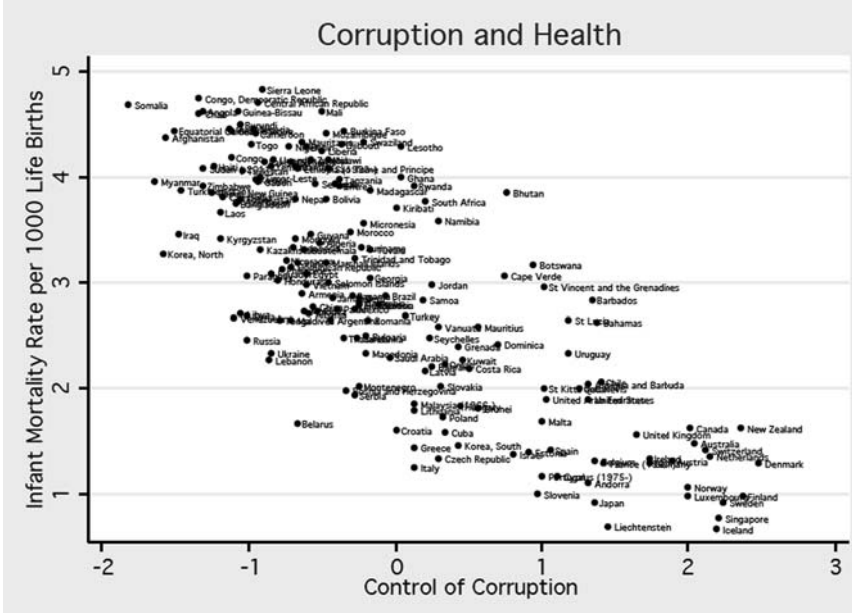

Figure 2. Quality of Governance and Infant Mortality Rate

"the better". I argue further that there is no reason to believe why autocracies will score worse on either domestic or international delivery process.

The increasing number of well-performing and commercially liberalizing authoritarian states (by "well-performing" I mean scoring high on good governance scale and/or socio-economic outcomes) begs for a question, which is largely neglected in the literature, on why unconstrained autocrats would voluntarily improve their governance on the whole; enact ad hoc programs targeted at lowering infant mortality rate in particular (e.g., Pinochet in 1974), and liberalize internationally, given that all these actions may easily undermine their hold on to domestic power.

in Costa Rica, the only country in the Latin American region to enjoy democracy since 1950, in the 1960s only 17% of population were able to obtain health insurance, excluding the poor and the rich (the latter, however, should not hesitate to switch to private providers). Ross' theory is fully consistent with and interpreted as complimentary to the theory suggested in this paper: inelastic demand decreases the role of state in producing certain amount of public goods, but does not downplay the importance of their quality.

I argue that in the modern world political regime characteristics per se should not affect infant mortality rate. It is good governance and globalization process that would matter the most. Following the mainstream literature, good governance is defined as "the capacity of a state to perform its activities in an efficient way and without corruption" (Charron and Lapuente, 2010: 455). Why would an impact of good governance and globalization trump that of democratic regime?

The complete theoretical picture of why political regime characteristics may fail to impact infant mortality rate invites a deeper political reason. If, statistically speaking, political regime characteristics make no difference for health outcomes, there must be an explanation for why some authoritarian states tend to choose governance-improving and/or health-promoting policies.

First, authoritarian regimes are capable of producing good governance. A growing number of scholars turn their attention to the fact that some authoritarian leaders tend to achieve promising political, economic, and social outcomes (e.g., Ross, 2006). If first treated as outliers (e.g., resource blessed Arab countries with very high levels of GDP per capita), now the number of such states is growing, which makes the tendency obvious and begs for a novel explanation. For example, one of the most challenging cases for the modern political economy is the city-state of Singapore, which dictator single-handedly and during an impressively short time period outrooted corruption, let alone country economic success.

Second, nondemocratic heads of state are able to efficiently solve delivery problems. For instance, some dictators directly address the question of high infant mortality rate. For example, under the dictatorship of Pinochet in Chile IMR dropped from 65 to 20 during 1974-84 (McGuire, 2001). Even taking into account a sharp birth rate drop due to the economic recession, much of the success can be attributed to Pinochet's targeted mother/infant programs e.g., "state-sponsored medical checkups for expectant mothers", care of children with malnutrition signs, free milk and food for pregnant women etc. (McGuire, 2001). Command system economies may impose public health initiatives upon workers by coercive means, which may lead to rather efficient outcomes: for example, local doctors system in Cuba, successful mobilization of villages in China to tackle health threats forced by government (Cutler et al., 2006).

McGuire (2001), when analyzing Pinochet's example described above, comes up with several reasons why a dictator was pursuing such benevolent

policies: preventing social protests, creating positive image in the eyes of the international society, and some "paternalistic feelings for mothers and children"[3]. Paradoxically, but scholars tend to ignore that dictators themselves may benefit from good governance and, especially, successful health outcomes such as low infant mortality rate. As Olson (1993: 570) notes about a selfish dictator, "He will then spend money on public goods up to the point where his last dollar of expenditure on public goods generates a dollar's increase in his share of the national income. At this point, the gain to society will, as we know, be the reciprocal of his share". Olson shows that both democratic and authoritarian elites are interested in public goods provision. Democracies usually approach a social optimum due to property rights protection and impartial court system, while autocracies tend to underproduce public goods. Although at the end Olson (Ibid.) speaks about the superiority of democratic political regime, he warns to treat such conclusions with caution because politicians in democracies may easily fall prey to pernicious vested interests and, as a result, underproduce public goods. Autocrats, on the other hand, assume a role of an encompassing interest, which is often missing under democracies, and therefore, are often capable of delivering a decent, although suboptimal, amount of public goods.

Apart from the importance of good governance, this study appreciates the role of globalization tendencies (Martens et al., 2010). Despite different, often opposing views on the beneficial versus detrimental nature of this phenomenon, I side with the optimists who predict that globalization brings along delivering overall foreign aid (Gomanee et al., 2005); providing health-related targeted foreign aid (Mishra and Newhouse, 2009); enabling overall economic growth (Dreher, 2006); diffusing technology transfers and knowledge spillovers (Deaton, 2004; Owen and Wu, 2007)[4]. First, the figures are telling: globally, IMR decreased from 63 deaths per 1000 live births in 1990 to 35 deaths per 1000 live births in 2012 (World Bank, 2013). Second, there are numerous case-study examples when foreign interventions contribute to im-

[3] In addition, target infant mortality programs seem to be rather inexpensive. "Between 1970 and 2000, the mean infant mortality rate among nations fell by almost half, due largely to the spread of low-cost health interventions" (Ross, 2006: 863).

[4] It is reasonable to assume that the usual pernicious implications (such as reducing government social expenditures in developing countries (see e.g., Bergh and Nilsson, 2010a); brain drain of educated workers (see e.g., Mills, 2011); faster spread of infectious diseases (Saker et al., 2007), which are attributed to globalization due to its redistributive nature, largely concern more "luxurious" opportunities, especially in comparison to survival-related capabilities.

proving health indicators, as well as robust empirical findings. For instance, national diarrheal control program in Egypt, 60% of which was funded by international donors, led to the increase in use of life-saving oral rehydration therapy, which reduced infant diarrheal deaths by 82 %, 1982–1987 (Martens et al., 2010). The Expanded Program on Immunization, launched in 1974 by World Health Organization (WHO), and Universal Childhood Immunization Campaign (UCI), conducted by United Nations Children's Fund (UNICEF) in 1985–1990, accounted for important increase in a different, but related health indicator – immunization rate (Gauri and Khaleghian, 2002).

Globalization, per se, however, does not rule out a possibility that autocracies and democracies are not equally able to appropriate its benefits, such as positive externalities and technological spillovers from more advanced countries. This might have constituted a problem in the past, when dictatorships were largely associated with autarky, but not anymore. Starting with the 1970s, liberalizing tendencies swept across the whole world (especially, "Asian tigers", many countries of the Gulf region, Latin American states). Recently, many authoritarian leaders, even though maintaining closed domestic regimes, open up internationally opting for liberalization of prices, trade, finance, FDI etc. In this case, the inclusion of globalization trend as an important factor impacting domestic health outcomes is theoretically warranted[5].

Research Design and Data[6]

To estimate the effect of quality of governance on health outcomes, I first perform a simple cross-section regression analysis. Following standard practice, I average all variables over the most recent 5 years available in the data (2006–2011). To capture the cumulative effect of independent variables and accommodate year-to-year changes, I turn to time-series cross-section (TSCS) data analysis. Different model specifications cover from as many as 189 countries to as little as 100 due to data limitations, once important control variables

[5] It is important to notice that even after the borders are open, country domestic ability to appropriate benefits will depend on the whole array of factors: in order to attract, say, FDI, autocrats need to guarantee foreigners' rights protection, lack of cumbersome bureaucratic procedures etc. Governance indicators utilized in this paper are believed to capture such possibility.

[6] All of the data come from the Quality of Governance Dataset (2013) if not specified otherwise.

are included[7]. To analyze pooled TSCS data, I make use of fixed-effects model that does a better job of controlling for country-specific effects and thus, mitigates omitted variable bias. The standard errors clustered by country should be robust to heteroskedasticity and autocorrelation present in the data. The fixed-effects models, however, draw upon information only from year-to year changes within one country. Since my argument is about both governance indicators and institutional structure, and the latter does not show much variation across time, particularly, within rich democratic states, it is also reasonable to run random-effects model. Across all model specifications the independent variables are lagged 1 year behind the dependent to at least partly protect against the endogeneity problem[8]. A time trend is included across all time-series models in order to mute the impact of global technological progress and other similar influences.

Dependent Variable

As my prime dependent variable, I rely on Infant Mortality Rate per 1000 live births that is most widely used as an indicator of health outcomes and overall human development. Following McGuire (2001), I appreciate several advantages of this measure. First, it reflects adequate nutrition and people's ability to obtain medical care when needed that correspond to important prerequisites for living the lives one has chosen. Second, IMR is regarded a reliable predictor of Life Expectancy at Birth – another widely used indicator of human well-being, whereas the reverse is not true (which makes life expectancy at birth an inferior indicator). Moreover, death of an infant implies more years of life forgone than death of an old person.

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[7] In this paper I choose not to use any data interpolation techniques. First, the empirical tests on the available sample may be interpreted as to strengthen the obtained results since, as compellingly shown by Ross (2006), it is well-performing authoritarian states that tend to underreport data for such indicators as population, income, infant and child mortality rates. Their inclusion may only taint the results in favor of the proposed absence of association between political regime and health outcomes. Second, the previous studies report robust results with samples that exclude all interpolated data (Gerring et al., 2012).

[8] Following McGuire (2013), in some model specifications that are not shown in the main text, but are easily available from the author, I include all independent variables with the lag of 5 years, which can also be a reasonable lag structure. For example, Bulgaria's IMR increased from 14.4 in 1990 to 17.5 per thousand live births in 1997 following its democratic transition (Navia and Zweifel, 2003).

Two broadly used datasets on IMR are available: one from UNICEF (Hall et al. 1999) and the other from the World Bank (2003). I utilize the latter due to its broader state coverage and milder selection bias (Gerring et al., 2012). The variable enters all equations in log specification, which is common practice to correct for its highly uneven character.

Yet, for robustness checks, I experiment with two other variables that reflect survival-related capabilities: child mortality rate, the number of deaths prior to age 1 per 1000 live births; life expectancy at birth, the number of years an infant would live presuming the unchanging mortality rate throughout her life.

Independent Variables

The choice of my main independent variables is dictated by theory that predicts governance and globalization to serve as better indicators of health outcomes than political regime characteristics.

It is an unfortunate, but established fact that up to date there is no fully satisfactory measure of quality of governance and/or corruption. The recent scholarship tends to make broad use of survey- and expert-based indices as opposed to "hard measures" such as conviction rates (for discussion see Charron and Lapuente, 2010). I follow the prevalent approach and employ two alternative measures of governance as my main independent variables. The first comes from the International Country Risk Guide and represents the mean value of three indicators: corruption, law and order, and bureaucracy quality. It covers 146 countries across 1984–2012 time span and ranges from 0 to 1. Yet, in order to ensure robustness of the results, I turn to the widely used World Bank governance indicators. However, in order to ensure the comparability of the ICRG and World Bank measures, I construct my own measure of good governance utilizing only three out of six indicators, namely, control of corruption, bureaucracy quality, and regulatory quality. The indices cover around 191 countries across 1996-2011 time span and range from –2.5 to 2.5. The simple procedure of taking an arithmetic average of these three indices led, however, to an intended result: measures are nearly perfectly correlated and, not surprisingly, show much consistency in the empirical results. Using such index allows to extend dataset up to 153 countries. The results for the key variables are for the most part stable across different samples.

Although not perfect, such measures are believed to incorporate informal institutions and thereby, reflect the true functioning of government, in contrast to formal institutions, such as political regime characteristics. Such distinction is crucial for the theory laid out in the paper since it allows to test for the relative importance of the two in explaining human development outcomes. Indeed, if political institutions and governance were the same, substantively, we will not observe countries with, say, extractive political institutions, and good governance, and empirically, far from perfect correlation between the two (r =.46).

Despite the existence of many alternative political regime measures, Polity IV, although with its own drawbacks, is most popular among scholars, perhaps, due to its extensive cross-country and time span coverage as well as sensitive 21-point scale, ranging from –10 (most authoritarian) to 10 (most democratic). With the purpose of robustness checks, I also employ the widely used Freedom House measure.

Index of globalization comes from Dreher (2006) and measures economic, political, and cultural globalizing trends with the economic aspect given the largest weight. The index represents a weighted average of economic, social, and political globalization. The economic aspect is measured as actual goods and investments flows as well as the existing restrictions e.g., tariffs. The political component is operationalized through the number of embassies and high commissions in a country, membership in the international organizations, and international treaties, participation in the UN peacekeeping missions. The cultural dimension measures tourism intensity, information flows, trade in books etc. To check the robustness against using an alternative measure of globalizing trend, in one of the model specifications I use trade openness (measured as the sum of export and import as a percentage of GDP).

Most model specifications include fixed effects that are supposed to mitigate against omitted variable bias. Yet, they do not take into account time-variant variables, which justifies inclusion of certain controls. Two most relevant control variables are income and female education level. Income has been consistently shown to be one of the most powerful predictors of human well-being, child and infant mortality rates in particular. Income is measured as GDP per capita in constant US dollars. Female education level is also recognized as exerting strong influence upon IMR (see, e.g., Currie and Moretti, 2003). Following the literature, the variable measures the average years of

schooling for females, age of 25 and older. Following Ross (2006), in some of my models I also include log of HIV prevalence rate, which is really hard to control for the government. Prevalence of HIV refers to the percentage of people ages 15–49 who are infected with HIV. Some of the model specifications also include ethnic fractionalization as an independent variable that is believed to show a negative relationship to IMR. Since health outcomes are treated in the theoretical argument as public goods, it is reasonable to see whether health expenditures play a role in improving health-related outcomes (measured as total public and private health expenditures per capita).

Results

My research question concerns the possible causal effect of political institutional characteristics and good governance on human well-being, especially health related capabilities. The hypothesis predicts that it is good governance and globalization trend that matter the most rather than a political regime type per se. In the subsequent tables I present the findings of the cross-section and TSCS analysis with a quite good fit of the models judging by high R values and highly statistically significant F-test values.

Table 1 shows a series of cross-section models that subsequently add alternative independent variables as well as reasonable controls. Model 1 is the very simple bivariate regression that demonstrates the highly significant and rightly signed coefficient for the independent variable of prime interest, namely, quality of governance from ICRG dataset. When political institutional variable is introduced in Model 2, it does not reach statistical importance, whereas governance indicator retains high significance as well as large coefficient magnitude. Model 2 represents the lone case when democracy variable attains significance, which is most probably due to the omitted variable problem (once all the important controls are included in the analysis in the subsequent models (from 4 to 10), the coefficient loses its statistical significance. In Models 3 and 4 income and education controls come out as expected: highly significant and negatively associated with infant mortality rate, which coincides with the empirical results of previous authors. Model 5 and 6 present another independent variable of particular interest, namely, globalization tendency (in Model 5 measured as globalization index, and in Models 6 as trade

Table 1. Influence of Political Regime and Quality of Governance on Health. Cross-Section Analysis. Dependent variable – IMR(ln)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Quality of Governance, ICRG	–4.48***	–4.36***	–1.48***	–1.46***	–0.99***	–1.37***	–0.96***	–0.99***	–0.96***	–1.18***
	(0.21)	(0.25)	(0.3)	(0.29)	(0.33)	(0.29)	(0.28)	(0.33)	(0.33)	(0.41)
Democracy, Polity IV		–0.01	–0.02***	–0.007	0.0005	–0.01	0.004	0.0004	–0.01	–0.001
		(0.01)	(0.007)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
GDP per capita (ln)			–0.57***	–0.43***	–0.32***	–0.42***	–0.29***	–0.31***	–0.28***	–0.34***
			(0.05)	(0.06)	(0.07)	(0.06)	(0.07)	(0.092)	(0.07)	(0.07)
Globalization Index					–0.02**		–0.02**	–0.02**	–0.02**	–0.02**
					(0.007)		(0.006)	(0.007)	(0.007)	(0.007)
Female Education				–0.07***	–0.06**	–0.07***	–0.05*	–0.06**	–0.05*	–0.06**
				(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)	(0.02)
Population(ln)							0.02	–0.003	0.01	–0.006
							(0.02)	(0.03)	(0.03)	(0.03)
Ethnic Fragmentation							0.89***			
							(0.15)			
Trade Openness,%						–0.002***				
						(0.0007)				
Urbanization,%								–0.0006		
								(0.003)		
HIV,%									0.14***	
									(0.03)	
Health Expenditures per capita										4.94*10–5
										(5.22*10–5)
Constant	5.15***	5.14***	8.77***	7.94***	7.77***	8.02***	6.47***	7.795***	7.2***	8.07***
	(0.14)	(0.14)	(0.28)	(0.4)	(0.38)	(0.38)	(0.69)	(0.58)	(0.63)	(0.62)
Observations	138	133	117	116	116	112	115	116	103	116
R2	0.66	0.64	0.84	0.86	0.87	0.87	0.99	0.87	0.9	0.87

Note: the analysis is run by OLS. Robust standard errors are reported in brackets. All the variables are averaged 2006-2011. *** p<0.01, ** p<0.05, * p<0.1.

openness to ensure robustness) that performs as expected throughout all model specifications (Models 5-10). Ethno-linguistic fractionalization (Model 7) and HIV prevalence rate (Model 8), in contrast, leads to an increase in IMR, also in accord with theoretical expectations and previous findings. Health expenditures, population, and measure of urbanization fail to obtain statistical importance.

Table 2 presents further specifications of cross-section analysis, where I experiment with the alternative dependent variables, namely, CMR and Life Expectancy at Birth; include a different measure of democracy and also test my own measure of good governance. It is striking that in all model specifications (except for Models 10–12, where the dependent variable is Life Expectancy at Birth), both measures of good governance – one from ICRG and the other one constructed from the World Bank Governance Indicators – impact IMR and CMR with the hypothesized sign and at the statistically significant level. In contrast, none of the political regime variables, measured either by Polity IV or by Freedom House index, does not achieve statistical significance. Globalization index is statistically significant in almost all model specifications and is shown to reduce both infant and child mortality rate (again, except in Models 10–12 with Life Expectancy at Birth as a dependent variable). Although globalization index and quality of governance are statistically insignificant in these models, neither is political regime variable. Moreover, the coefficient of determination is sharply reduced, which may be indicative of a slightly different theoretical mechanism behind life expectancy. It is possible that the latter reflects other features of human development, which are not included in these regressions. What matters more is that in the benchmark models in Table 2 (Models 1–9 where the main dependent variables are used) good governance measures, in contrast to political regime score, are always statistically significant. The statistical importance of globalization index is indicative of the important omitted variable bias in the previous studies and invites research effort on the precise channels of influence of globalization on domestic health related outcomes.

Table 2. Influence of Political Regime and Quality of Governance on Health. Cross-Section Analysis. Further Specifications

	(1)	(2)	(3)	(4)	(5)
VARIABLES	IMR(ln)				
Quality of Governance, ICRG	–0.99***	–1.01***			–0.78**
	(0.33)	(0.32)			(0.35)
Democracy, Polity IV	0.0005		–0.003		0.001
	(0.01)		(0.01)		(0.01)
GDP per capita (ln)	–0.32***	–0.32***	–0.29***	–0.3***	–0.39***
	(0.07)	(0.07)	(0.07)	(0.07)	(0.08)
Globalization Index	–0.02**	–0.02***	–0.01**	–0.01**	–0.02**
	(0.007)	(0.007)	(0.007)	(0.01)	(0.007)
Female Education	–0.06**	–0.07***	–0.06***	–0.06***	–0.08***
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
Population(ln)	–0.003	–0.002	–0.01	0.006	–0.01
	(0.03)	(0.02)	(0.03)	(0.02)	(0.03)
Democracy, Freedom House		0.005		–0.002	
		(0.02)		(0.02)	
Quality of Governance, WB			–0.29***	–0.29***	
			(0.08)	(0.07)	
Constant	7.825***	7.76***	6.85***	6.61***	8.74***
	(0.55)	(0.59)	(0.58)	(0.59)	(0.59)
Observations	116	117	141	152	116
R^2	0.87	0.87	0.86	0.85	0.87

Note: the analysis is run by OLS. Robust standard errors are reported in brackets. All the variables are averaged 2006–2011. *** p<0.01, ** p<0.05, * p<0.1.

	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	CMR(ln)				Life Expectancy at Birth		
	–0.79**			2.75	2.72		
	(0.35)			(4.66)	(4.65)		
		–0.004 (0.01)		–0.02 (0.12)		0.05 (0.11)	
	–0.38***	–0.34***	–0.35***	4.31***	4.25***	3.75***	3.87***
	(0.07)	(0.09)	(0.09)	(1.1)	(1.05)	(1.31)	(1.31)
	–0.02**	–0.01*	–0.01**	0.03	0.04	0.04	0.02
	(0.007)	(0.01)	(0.006)	(0.1)	(0.09)	(0.1)	(0.09)
	–0.08***	–0.07***	–0.07***	0.64**	0.65***	0.63***	0.62***
	(0.02)	(0.02)	(0.02)	(0.24)	(0.24)	(0.21)	(0.21)
	–0.01	–0.01	0.006	0.56	0.57*	0.66**	0.33
	(0.03)	(0.03)	(0.02)	(0.35)	(0.32)	(0.33)	(0.29)
	0.009		–0.003		–0.08		0.16
	(0.02)		(0.02)		(0.26)		(0.24)
		–0.26***	–0.25***			0.97	1.08
		(0.08)	(0.08)			(1.05)	(1.01)
	8.67***	7.69***	7.40***	14.11**	14.48*	17.74*	23.03**
	(0.63)	(0.65)	(0.67)	(7.11)	(7.46)	(9.07)	(9.304)
	117	141	152	116	117	141	150
	0.87	0.85	0.843	0.7	0.7	0.67	0.66

Table 3. Influence of Political Regime and Quality of Governance on Health. TSCS Analysis

	(1) FE	(2) FE	(3) RE	(4) FE	(5) FE	(6) RE	(7) FE	(8) FE	(9) RE
VARIABLES		IMR(ln)			CMR(ln)			Life Expectancy at Birth	
Quality of Governance, ICRG	–0.17*	–0.17*	–0.18*	–0.25**	–0.25**	–0.25**	4.7***	4.67***	4.64**
	(0.09)	(0.09)	(0.09)	(0.1)	(0.1)	(0.1)	(1.76)	(1.76)	(1.82)
Democracy, Polity IV	0.004*		0.003	0.004		0.002	–0.02		0.03
	(0.002)		(0.002)	(0.00236)		(0.002)	(0.04)		(0.04)
GDP per capita (ln)	–0.13**	–0.13**	–0.19***	–0.13**	–0.13**	–0.21***	1.51	1.53	2.79***
	(0.06)	(0.06)	(0.06)	(0.06)	(0.06)	(0.07)	(1.03)	(1.007)	(1.04)
Globalization Index	–0.005*	–0.004*	–0.006**	–0.005*	–0.005*	–0.006**	0.02	0.02	0.03
	(0.002)	(0.002)	(0.002)	(0.003)	(0.002)	(0.003)	(0.04)	(0.03)	(0.04)
Female Education	–0.09***	–0.1***	–0.12***	–0.07*	–0.07**	–0.11***	–1.69***	–1.69***	–0.39
	(0.03)	(0.03)	(0.02)	(0.04)	(0.04)	(0.02)	(0.46)	(0.45)	(0.29)
Trend	–0.02***	–0.02***	–0.01***	–0.03***	–0.03***	–0.02***	0.38***	0.38***	0.19***
	(0.005)	(0.005)	(0.003)	(0.005)	(0.005)	(0.003)	(0.06)	(0.07)	(0.04)
Population(ln)	0.23	0.24*	0.06	0.17	0.18	0.04	0.84	0.8	0.97*
	(0.14)	(0.14)	(0.05)	(0.14)	(0.14)	(0.05)	(1.5)	(1.52)	(0.54)
Democracy, Freedom House		0.01*			0.01*			–0.05	
		(0.006)			(0.006)			(0.08)	
Constant	46.19***	46.38***	32.88***	54.38***	54.43***	37.76***	–708.7***	–712.7***	–356.8***
	(8.950)	(9.06)	(5.71)	(9.3)	(9.43)	(6.2)	(115.9)	(117.3)	(77.8)
Observations	2,605	2,605	2,605	2,644	2,644	2,644	2,605	2,605	2,605
R2	0.84	0.84		0.84	0.84		0.5	0.5	
Number of countries	117	118	117	117	118	117	117	118	117

Note: the TSCS analysis is run with fixed and random-effects. For FE models, groupwise-clustered standard errors are reported in brackets. All the independent variables are lagged 1 year. *** p<0.01, ** p<0.05, * p<0.1.

Table 4. Influence of Political Regime and Quality of Governance on Health. TSCS Analysis. Further Specifications

	(1) FE	(2) FE	(3) RE	(4) FE	(5) FE	(6) RE	(7) FE	(8) FE	(9) RE
VARIABLES		IMR(ln)			CMR(ln)			Life Expectancy at Birth	
Quality of Governance, WB	–0.09**	–0.05	–0.11***	–0.1**	–0.05	–0.12***	1.43***	1.16**	1.61***
	(0.04)	(0.05)	(0.04)	(0.04)	(0.05)	(0.04)	(0.52)	(0.49)	(0.57)
Democracy, Polity IV	0.0007		0.0008	0.0002		–0.0001	0.02		0.04*
	(0.002)		(0.002)	(0.002)		(0.002)	(0.02)		(0.02)
GDP per capita (ln)	–0.07	–0.11	–0.15**	–0.08	–0.12*	–0.16**	0.39	0.47	1.03*
	(0.05)	(0.06)	(0.06)	(0.05)	(0.07)	(0.07)	(0.49)	(0.5)	(0.55)
Globalization Index	–0.004**	–0.003	–0.005***	–0.004**	–0.003	–0.006***	0.02	0.02	0.034
	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.02)	(0.02)	(0.02)
Female Education	–0.08**	–0.03	–0.13***	–0.05	–0.002	–0.12***	–1.74***	–1.76***	–0.14
	(0.04)	(0.04)	(0.02)	(0.04)	(0.05)	(0.02)	(0.44)	(0.41)	(0.29)
Trend	–0.03***	–0.03***	–0.01***	–0.03***	–0.04***	–0.01***	0.39***	0.4***	0.21***
	(0.005)	(0.006)	(0.002)	(0.005)	(0.006)	(0.002)	(0.05)	(0.05)	(0.03)
Population(ln)	0.25*	0.25*	0.03	0.15	0.15	–0.0009	4.81***	4.59***	2.25***
	(0.13)	(0.14)	(0.03)	(0.13)	(0.14)	(0.04)	(1.65)	(1.63)	(0.61)
Democracy, Freedom House		–0.007			–0.009			0.08	
		(0.006)			(0.007)			(0.06)	
Constant	51.92***	63.39***	31.32***	62.04***	73.01***	35.63***	–784.2***	–793.0***	–391.0***
	(8.63)	(11.31)	(4.35)	(9.14)	(11.68)	(4.87)	(96.24)	(92.76)	(60.69)
Observations	1,380	1,380	1,380	1,483	1,483	1,464	1,380	1,380	1,380
R2	0.81	0.77		0.8	0.77		0.64	0.65	
Number of countries	142	153	142	142	153	142	142	153	142

Note: the TSCS analysis is run with fixed and random-effects. For FE models, groupwise-clustered standard errors are reported in brackets. All the independent variables are lagged 1 year. *** p<0.01, ** p<0.05, * p<0.1.

The results obtained from the cross-section analysis seem robust to TSCS and survive the inclusion of both fixed and random effects[9]. Better governance indicators and globalization are strongly associated with lower infant mortality rates, while the effect of democratic institutions remain statistically negligent.

Tables 3 presents several model specifications with fixed effects (FE) and random (RE) effects with ICRG quality of governance indicator serving as the main dependent variable. In Table 3, the only cases when "good governance" effect is reduced to .1 level of statistical importance are Models 1-3, whereas it regains statistical importance in all the subsequent model specifications (Models 4-12). Globalization index seems to be robust to some model specifications in Table 3,namely random-effects Models 3 and 6. One possible explanation might be that the trend variable coupled with country fixed effects in other model specifications may "pick up" some impact of globalization process, in particular, through technological progress. It is important, however, that democracy variable never reaches statistical significance, that is, seems to have no effect on health.

The results from the TSCS fixed- and random-effects models in Table 4, where the ICRG quality of governance index is replaced with the alternative measure of good governance constructed from the three of the World Bank Governance Indicators, in essence repeat those of the previous TSCS models. However, the quality of governance index now gains statistical significance even when IMR is used as a dependent variable i.e., Models 1-3. Moreover, the index of globalization behaves as expected in most model specifications and at a highly significant level. The most obvious reason is the increase in the number of states (from 118 to around 150). What remains untouched, though, is the consistent insignificance of democracy across all model specifications.

To recapitulate, the inclusion of institutional (democracy score) and governance characteristics together in the same model, as is the case across al-

[9] The results of TSCS analysis are robust to several model specifications that are not included in the paper to economize on space, but easily available from the author upon request. In particular, I run regressions using Driscoll-Kraay standard errors in order to take care of potential cross-sectional correlation (McGuire, 2013). Following Gering et al. (2012), I employ a measure of democracy stock rather than democracy level using the same method of calculation to accommodate a possibility that it is only a fully consolidated democracy that positively affects IMR. I also experiment with the interaction term between political regime and good governance, but it fails to show statistically significant relation to either of alternative measures. None of the robustness checks suggested above disturb the results here.

most all model specifications in this study, does not undermine the statistically significant effect of governance on alternative health measures, whereas democracy variable always remains unimportant. Such findings incline me to conclude that it is governance characteristics that determine certain health outcomes, especially IMR and CMR, rather than political regime type.

Conclusion and Future Research

This paper starts with the notion that several recent studies call the orthodoxy of democracy being a superior institutional design for certain aspects of human development, primarily, health outcomes, into question. The increasing importance of public health delivery process, as opposed to rough provision of health services, coupled with the vast examples of well-performing (as measured by IMR) closed societies, either of communist type or rightist authoritarian regimes, shows potential for parallel political explanation, which is offered in this study.

The presented theoretical and empirical analysis compellingly demonstrates that in the modern world good governance and international processes, namely, globalization, might be of greater importance for explaining health outcomes, measured as IMR and Life Expectancy at Birth, than political regime characteristics. First and foremost, it is argued that the shift from the emphasis on macroeconomic factors, such as economic growth and improved nutrition, to the micromanagement factors, e.g. rehydration therapy, makes delivery services, and as a result, good governance, of major significance for improving health outcomes, in particular, reducing IMR. These services are inexpensive and hardly require increased redistribution, which is widely believed to be a prerogative of democracies. Moreover, even unconstrained autocrats may possess strong incentives to care about their citizens' survival-related capabilities as a prerequisite for, say, quality of labor force that largely defines overall economic growth. Finally, the importance of globalization that acts through the delivery process as well e.g., free trade and FDI flows that bring along important knowledge and technological spillovers, is appreciated and shown to significantly contribute to IMR decline.

The findings of the empirical analysis, both cross-section and time-series, corroborate a hypothesis that good governance and globalization are crucial for determining health outcomes and throw doubt on a widely held view that

democracies outperform autocracies on health-related indicators. This study should be added to the basket of several earlier papers that failed to find any association between political regime characteristics and health outcomes.

The obtained results may have profound policy implications both domestically and internationally. Regardless of their country political regimes scores, state authorities might want to take quality of governance into consideration when making a decision on resources allocation into health sector. On the international arena, it is quality of governance that seems to be a more reasonable criterion, than, say, country democracy score, when making decisions on foreign aid provision.

Finally, the study identifies an important area for future research. What is striking is that if infant and child mortality rates can be dealt with efficiently through health service delivery systems and/or ad hoc health programs, either local or international, infant mortality rate might stop being an efficient indicator of overall human development. In this sense, although theoretically sound and empirically robust, the results presented here must be interpreted only narrowly i.e., in application to IMR. Thus, the future researchers are cautioned against extending these results to explaining overall public goods provision since tracing the origins of social policy outcomes other than IMR, for instance, educational services, may require a different theory and is subject to further empirical testing. Much effort is needed to understand whether these results may be extrapolated to interpreting health outcomes on the whole as opposed to a mere explanation of IMR and CMR reduction. The narrow interpretation of the findings does not undermine their importance; in contrast, it might be the first bell ringing for reevaluating the role of widely used human development indicators.

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Данная статья посвящена исследованию взаимосвязи между политическим режимом, «достойным правлением» и потенциалом человеческого развития, измеряемого коэффициентом младенческой смертности (КМС). В существующей литературе превалирует теория, что демократические лидеры имеют больше стимулов для предоставления гражданам общественных благ, в частности, с целью удовлетворить требования медианного избирателя, чем авторитарные главы государств, а потому демократии опережают автократии по многим социальным показателям, в том числе здоровья. Однако возможно предположить, что в современном мире процесс микроменеджмента в сфере здравоохранения может иметь большее значение для улучшения некоторых показателей здоровья, особенно снижения КМС, чем макроэкономические факторы, например, экономический рост. В этой связи любопытно, что все большее число недемократических режимов достигают высокого качества государственного управления, позитивно влияющего на микроменеджмент, а также показателей здоровья, в то время как многие демократии, особенно гибридные режимы, по данным показателям остаются на низком уровне. Основываясь на приведенных выше теоретических предпосылках и наблюдениях, я делаю вывод, что good governance имеет большее значение для улучшения показателей здоровья, в частности, уменьшения КМС, чем различие в политических режимных характеристиках. Результаты проведенного пространственного и пространственно-временного регрессионного анализа подтверждают гипотезу: good governance оказывает систематическое и статистически важное влияние на КМС, в то время как эффект типа политического режима никогда не обретает статистическую значимость.

Ключевые слова: демократия, «достойное правление», коэффициент младенческой смертности, потенциал человеческого развития

Балалаева Дина Яновна, научный сотрудник Научно-учебной лаборатории политических исследований НИУ ВШЭ.

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и политический анализ

Балалаева Дина Яновна

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(*на английском языке*)

Зав. редакцией оперативного выпуска *А.В. Заиченко*
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