Variations in healthcare provisioning across different countries are most often attributed to the type of regime present in each country under consideration. While the current literature that compares the quality of healthcare across different countries recognizes that, for the most part, democracies generally provide the best healthcare, William Clark and Robert Kaufman have found that there are some autocracies that exhibit healthcare levels that are as high as those of democracies and some that do not. The important question then becomes: What accounts for the variation in healthcare quality among autocracies? To attempt to answer this novel question, a method of analysis may be employed that involves a comparison of different classifications of autocracies and how, if at all, each method explains the remarkable differences seen in the quality of healthcare among autocracies.

**Literature Review**

Healthcare provisioning in all of its forms has been the subject of numerous studies in the past. Studies examining the relationship between regime type (i.e., democracy or autocracy) and healthcare provisioning are especially common. Overall, democracies have been found to be positively correlated with levels of healthcare provisioning across different nations. The studies discussed below are reflective of most of the current literature regarding the relationship between healthcare provisioning and regime type.

A study conducted by James W. McGuire of Wesleyan University, titled *Democracy, Social Provisioning, and Under-5 Mortality: A Cross National Analysis*, compares social service provisioning across ninety-two developing nations. McGuire studies the effect that socioeconomic factors, the provision of basic social services, and democratic experience have on levels of under-5 mortality in these nations. Specifically, these factors are economy, geography, culture, demography, education, family planning, water and sanitation, and healthcare as measured by health spending, personnel, facilities, and access to mother and child health services.
McGuire chooses to focus on these factors because he finds that many studies do not give a significant enough role to social provisioning variables in reducing child mortality in developing nations. These variables, he argues, are as important as the level of a country’s economic growth, which has traditionally been regarded as the factor that most affects child mortality rates. To analyze these factors, McGuire reproduces models used by Filmer and Pritchett (1999). He finds that democratic experience is strongly associated with lower premature mortality, and goes on to suggest that the provision of basic health services may be one route by which democratic experiences lowers premature mortality levels.

Another interesting study, conducted by Andrew Sunil Rajkumar and Vinaya Swaroop, Public Spending and Outcomes: Does Governance Matter?, examines the role of the quality of a nation’s governance on outcomes of public spending on healthcare. Rajkumar and Swaroop find that as governance improves, public health spending becomes more efficient; that is, it reduces child and infant mortality rates. Their underlying assumption is that “poor targeting and/or institutional inefficiencies such as leakage in public spending and weak institutional capacity” are what make public spending ineffective in nations with poor governance. The governance indicators used in this study include voice and accountability, political stability and violence, government effectiveness, regulatory burden, and rule of law and graft. Rajkumar and Swaroop find that as the quality of governance increases, the efficiency of public spending on healthcare increases as well, thus lowering infant and child mortality levels. Therefore, simply increasing the amount of a government’s public healthcare spending is not likely to improve levels of public health as long as the quality of governance remains low.

One study on cross-national healthcare that finds a negative trend between democracy and healthcare in the form of immunization coverage is titled Immunization in Developing Countries: Its Political and Organizational Determinants, conducted by Varun Gauri and Peyvand Khaleghian. Specifically studied are coverage rates of the DTP and measles vaccine, as well as the adoption of the hepatitis B vaccine. Gauri and Khaleghian also study supply-side
factors that affect immunization coverage, including vaccine quality, incentives for workers who perform the vaccinations, and organization of national immunization agencies; these factors, they argue, are not often mentioned in previous literature. Among the study’s more interesting findings is that improved global immunization policies significantly increased immunization coverage rates in all countries at all economic levels studied. This, the authors argue, is probably the result of increased coordinated international policy effort towards immunization. The most interesting finding of this study is that the existence of a democratic government actually lowered immunization coverage rates, except at low income levels. Gauri and Khaleghian identify three possible reasons why this is so: first, democracies are more likely to allocate resources towards curative services such as hospitals and pharmaceuticals rather than immunization; second, governmental elites that favor programs such as immunization have more autonomy in autocratic regimes; third, media coverage of immunization side effects, which is more prevalent in democratic nations, increases concern over these side effects and thus lowers immunization rates.

In low income economies, there are two reasons why the opposite relationship between democracy and immunization is observed: first, autocracy in very poor countries may lead to outright theft of public resources; the second, but less plausible answer according to the authors, a democratic government may be considered more trustworthy than an autocratic government by public communities in poor nations. Another important finding of this study is that national immunization coverage rates seem to be a function of supply-side than demand effects; campaigns such as those to eradicate epidemics and outbreaks of diseases (i.e., diphtheria, pertussis, or measles) are unlikely to increase immunization coverage rates.

Finally, a comprehensive study conducted by Bruce Bueno De Mesquita et al examines the effect of regime type, as measured by winning coalition size, on various indicators of healthcare provisioning. In this study, which can be found in the chapter entitled Institutions, Peace and Prosperity in The Logic of Political Survival, BDM et al hypothesize that as winning coalition size increases, public goods provisioning increases and private goods provisioning
decreases. Core public goods were defined as transparency, civil liberties, political rights, and peace and prosperity, while healthcare, social security, and education were part of the general public goods category. Many healthcare provisioning indicators were examined here: life expectancy, death rate, infant mortality, health expenditure, number of doctors, beds, percentage of low birth weight babies, measles and DPT immunization coverage, and governmental expenditures on social security. The authors find that life expectancy at birth is the single best indicator of the overall health of a population; as winning coalition size increases, life expectancy also steadily increases. The polity with the largest coalition size offered nearly 13.5 more years of life than the polity with the smallest coalition size. The authors of this study, which is the most detailed out of the three described here, find a strong positive correlation between winning coalition size and healthcare quality.

The question proposed in my study stems from the additional finding by BDM et al that autocracies generally have smaller winning coalition sizes in comparison to the size of their selectorate. Although BDM et al find that democracies in general have higher levels of healthcare provisioning than autocracies, they do not explain why there remain large differences in the quality of healthcare between autocracies. Furthermore, the inference made in this study that measures of winning coalition size and the ratio W/S (winning coalition/selectorate) can allow countries to be classified as different types of democracies or, more importantly in this case, autocracies has not been tested. It would therefore be valuable to discover whether W/S actually does help determine what type of regime a country possesses by comparing the quality of healthcare in different nations as W/S, W, and S (as provided by the BDM et al data) increase to the quality of healthcare in different autocracies as measured by a more standard method of classifying countries according to regime type and measuring their performance on several healthcare indicators.

William Clark and Robert Kaufman have found that a triangular pattern emerges when different healthcare indicators (i.e., birth attendance, life expectancy, prenatal care, and
vaccinations) are compared to winning coalition size. This indicates that, while most democracies (i.e., countries with large winning coalitions) tend to score high for these indicators, autocracies (i.e., countries with small winning coalitions) score both high and low. When the same healthcare indicators are run against Polity scores (ranging from -10 to +10 for most autocratic and least autocratic, respectively), a similar upper left triangular pattern is seen. There must then be differences in autocratic regimes, which are not accounted for, that lead to differences in healthcare provisioning, as shown by this data. Examining the effect of changing winning coalition size in types of autocratic regimes to assess healthcare delivery and outcomes in these regimes is essential to understanding why some autocracies seem to provide better healthcare than others.

**Causal Model**

Using the Selectorate theory presented by BDM et al in *The Logic of Political Survival*, autocratic regimes may be roughly divided into three types: those with a small selectorate size (S) and a small winning coalition (W), those with a large S and a small W, and those that do not fit into either of the previous two categories. The significance of the ratio W/S may be explained by describing the difference in the loyalty norm that results when the size of the ratio changes. When W/S is small, members of the incumbent leader’s W generally have a greater loyalty norm; that is, they infer that they have a smaller chance of being included in the challenger’s winning coalition if the challenger is elected and so will not be likely to switch their support from the incumbent to the challenger. The product of the difference between the benefits offered by the challenger and by the incumbent and the ratio W/S describes the incentive of a W member to switch loyalties.

\[
\text{Incentive to switch} = \frac{W}{S} (B_{\text{challenger}} - B_{\text{incumbent}})
\]

In a small W/S single party regime, there should be a strong loyalty norm and, therefore, little incentive to switch support from the incumbent to the challenger. Since the members of a small
W are probably receiving benefits in the form of private goods and are unlikely to switch loyalties, the incumbent does not have much incentive to implement broad and effective public policies, such as those geared towards improvement of public health. Healthcare provisioning in such regimes, then, is likely to be weaker than in regimes with a greater ratio of W/S.

In autocratic regimes with a small W/small S ratio, there is typically a weaker loyalty norm. This is because, since the size of W is similar to the size of S, the ratio W/S is larger than in small W/S regimes. Furthermore, an incumbent winning coalition member can expect to be included in the challenger’s winning coalition, since the winning coalition is roughly equal to selectorate size, and so members of W have a much greater incentive to switch loyalties than do members of W in a small W/S regime. Thus, the product of the difference between the benefits offered by the challenger and those offered by the incumbent and the ratio W/S is larger in this case, indicating a much weaker loyalty norm and a greater incentive to switch. The difference in the loyalty norm, then, helps to explain why I hypothesize that a greater ratio of W/S will lead to better healthcare provisioning than a smaller ratio of W/S. More simply summarized, the causal model is:

\[(W_{small} / S_{large})(B_{challenger} - B_{incumbent}) < (W_{small} / S_{small})(B_{challenger} - B_{incumbent}).\]

Autocracies in the third category, which includes those that have an intermediate ratio of W/S, should demonstrate levels of healthcare that are between those exhibited by the small W/S group and the large W/S group. This is because, as predicted by the causal model, the loyalty norm in this third category should be weaker than that found in small W/S countries but stronger than in large W/S countries. Therefore, the quality of healthcare in this intermediate group is expected to be better than that seen in small W/S countries but worse than that in large W/S countries.

Testing the quality of healthcare in different types of autocracies based on the W/S ratio, as found in data from BDM et al, is one way of determining what causes the variance in healthcare performance variables. An alternative method would be to employ a more traditional
means of categorizing autocratic regimes to explain variations in healthcare performance. This technique would involve classifying autocracies using data on the type of regimes present in various nations, which will be based on a specific set of criteria, and then examining how these different regime types perform in terms of healthcare. Barbara Geddes uses this method to classify autocracies into several different categories: personalist regime, single party regime, military regime, or hybrids of two or more of the aforementioned regime types. Geddes first defines regimes as “sets of formal and informal rules and procedures for selecting national leaders and policies.” She goes on to describe a military regime as one that is formed by a group of officers and then later led by a single officer, leading to political marginalization of the rest of the officer corps. In an ideal single party regime, the party organization exerts some power over the leader, controls the careers of officials, and organizes the distribution of benefits to supporters. Single party regimes also hold regular elections with some competition from opposition parties or within the dominant party. The label of a single party regime is given if other parties are banned, harassed, or disadvantaged in some way or if the dominant party has never lost its control over the executive since coming to power and wins more than two thirds of the seats in the legislature. Finally, Geddes describes personalist regimes as those in which an individual leader, who maintains support bases by providing material rewards, controls the access to and fruits of office. More specific sets of criteria by which each regime type is defined can be found in the Data section of this proposal. In “What Do We Know About Democratization After Twenty Years?,” Geddes discusses differences in democratization experiences across cases in different regions, focusing mainly on the longevity of and transition trends in the three types of autocracies described above. In her words, “different kinds of authoritarianism differ from each other as much as they differ from democracy” (121). Therefore, it is likely that the quality of life experienced by people living in countries governed by each of these regime types is different as well. According to Geddes, single-party regimes are generally more long lasting than the other two types, especially military regimes. She also states that single party regimes generally hold
regular elections with some competition, although the dominant party occupies most of the seats in the legislature (124). Furthermore, “cooptation rather than exclusion is the rule in established single party regimes,” meaning that the unification of different factions within the regime, even if they hold different policy ideas, is valued and so cooperation is more common than in other regime types (129). These are factors that Geddes considers in explaining the longevity of autocratic regimes, but they may also apply in a discussion of the regimes’ healthcare policies. For example, the fact that single party regimes hold elections with some competition makes them slightly more like democracies than other regime types, and so single party regimes may also provide more public goods, as democracies do, since citizens are involved to some small extent in the governing process. The fact that single party regimes last longer than the other two types is also indicative of their greater success. Personalist regimes, for example, are governed by one dominant leader who has a very small support base and is likely to provide mostly private goods; if the country experiences an economic downturn, the leader is likely to be ousted because of an inability to provide sufficient private goods to his supporters (134). Military regimes are even more susceptible to being overthrown, especially by coups or splits in the “officer corps” (135). Single party regimes, on the other hand, “are more likely to be open to all loyal citizens than are personalist regimes and are less likely to limit their clientele to particular clan, regional, or ethnic groups” (134). Geddes’ analysis implies that single party regimes are the most likely to survive and so I predict that perhaps, given some of their characteristics, may be more likely to provide better healthcare as well. Personalist and then military regimes should follow in terms of their abilities to provide higher levels of healthcare to the people living under these respective regimes.

Using two different measures of autocracy to search for causes behind the great variation seen in the quality of healthcare among autocracies will help determine how much the ratio W/S, as described by BDM et al, can explain this difference. If the two measures produce similar results, then it is possible that the W/S ratio can indeed explain why some autocracies provide better care for their people than others. It is possible, however, that Geddes’ classification of
autocracies will lead to more significant findings because it takes into account many different factors of a regime, not just the W/S ratio. It is unlikely that the large variation in healthcare performance of autocracies is caused only by one factor (that is, the W/S ratio); it is more plausible that there are other factors, such as longevity and openness towards citizens, involved in determining the level of healthcare provided by an autocratic government.

**Testable Hypotheses**

The main hypothesis in my study is that as the ratio W/S increases, the incentive for a winning coalition member to switch loyalties increases and, therefore, the loyalty norm should decrease. A lower loyalty norm should, in turn, foster greater competition between incumbent and challenger and give both more incentive to provide public goods, such as improved healthcare.

I also hypothesize that regimes that have neither a very large W/S ratio nor a very small W/S ratio should exhibit intermediate levels of healthcare quality. That is, while regimes with a large W/S ratio (i.e., close to a value of one) should have the highest levels of healthcare, those with a small W/S ratio should exhibit the lowest levels of healthcare, and other regime types should place somewhere in between these two categories.

In terms of Geddes’ classification of autocracies, I predict that as the likelihood of a regime being a single-party regime increases, the quality of healthcare it exhibits should increase as well. Furthermore, I predict that this relationship between healthcare and regime type will be stronger (i.e., more statistically significant) than that exhibited by an increasing W/S ratio. The other regime types should exhibit the following order in terms of decreasingly significant relationship to healthcare: single party hybrid with personalist or military (4), military/single party/personalist amalgam (6), personalist (3), military/personalist hybrid (2), and military (1).
Data

The data collected by BDM et al in The Logic of Political Survival in the chapter titled “Institutions for Kleptocracy or Growth” that describes countries in terms of their W/S ratio will be used to test the hypotheses. This data is amassed for up to 192 different countries and spans the years 1816-2000, although for most of the performance variables analyzed in The Logic of Political Survival, the data covers the period 1950-1999. To estimate the sizes of W, BDM et al use both the Polity IV data collection and the cross-national time series data of Arthur Banks. W is measured from the variables REGTYPE (regime type) from the Banks data, and XRCOMP (competitiveness of executive recruitment), XROPEN (openness of executive recruitment), and PARCOMP (competitiveness of participation) from the Polity IV data. When REGTYPE is not missing data and is not equal to code 2 or 3 (so that the regime type is not a military (code 2) or military/civilian (code 3) regime because military regimes tend to have very small winning coalitions), one point is added to W. when XRCOMP is larger than or equal to code 2, another point is added to W (whereas a code of 1 means that the executive is selected by elections that are either hereditary, rigged, or unopposed). One point is added to W when XROPEN has a value greater than 2 (which indicates that the executive is selected in a method other than heredity). Lastly, one point can be added to W if PARCOMP is given a code 5 (this indicates the presence of regular and stable political groups who regularly compete for political influence). To estimate W, the number of points for W awarded for each regime is divided by the maximum value for W, which is 4. Each regime’s score for W then varies between 0 and 1, with 0 as the minimum value and 1 as the maximum value. Another Polity variable, LEGSELEC (a measure of the breadth of the selectiveness of the members of each country’s legislature), is used to measure the values of S. A code of 0 for LEGSELEC indicates no legislature, a code of 1 means that the legislature is chosen by heredity or by another method that does not involve elections, and a code of 2 indicates that the members of the legislature are directly or indirectly chosen by popular election. As the size of the LEGSELEC variable increases, the likelihood of S being large increases as well. The
value of LEGSELEC is divided by its maximum value of 2 so that it varies between 0 and 1. The variable that BDM et al call Democracy is a value between 0 and 1 for each regime, with scores that are closer to 0 reflecting more autocratic governments and those closer to 1 representing more democratic governments. The value of the W/S ratio is found using the following equation:

$$\frac{(\log((S+1) \times 10))/3}{10}$$

To distinguish democracies, which are not being studied here, from autocracies, the lower half of the BDM et al data on W/S (data on autocracies) will be used. This way, there will be as many autocracies as possible included in the analysis, since there is a large degree of variation in the W/S ratios of autocratic regimes.

The second method of classifying autocratic regimes will involve using data on autocracies collected by Barbara Geddes. Employing this data, countries will then be classified by whether they are governed by single party regimes, personalist regimes, military regimes, or a hybrid of two or more of these different types of regimes. All the regimes existed or began between 1946 and 1997, in countries with a population of more than one million that became independent before 1990. The number of yes answers is divided by the sum of both yes and no answers for each of the criteria mentioned below, and each regime is given a preliminary score between 0 and 1 on each regime type. Depending on which score is higher than the others, Geddes classifies the regimes as either military (1), military/personalist hybrid (2), personalist (3), single party hybrids with either the personalist or military (4), single party (5), and military/single party/personalist amalgam (6). Geddes specifies fifteen criteria, listed below, for a single party regime:

1) Did the party exist prior to the leader’s election campaign or accession to power?

2) Was the party organized to fight for independence or lead some other mass social movement?
3) Did the first leader’s successor or does the leader’s heir apparent hold a high party position?

4) Was the first leader’s successor or is the current heir apparent a member of a different family, clan, or tribe than the leader?

5) Does the party have functioning local level organizations that do something reasonably important, such as distribute agricultural credit or organize local elections?

6) Does the party either face some competition from other parties or hold competitive intra-party elections?

7) Is party membership required for most government employment?

8) Does the party control access to high government office?

9) Are members of the politburo (or its equivalent) chosen by routine party procedures?

10) Does the party encompass members from more than one region, religion, or ethnic group or tribe (in heterogeneous societies)?

11) Do none of the leaders’ relatives occupy very high government office?

12) Was the leader a civilian before his/her accession?

13) Was the successor to the first leader or is the heir apparent a civilian?

14) Is the military high command consulted primarily about security matters?

15) Are most members of the cabinet or politburo-equivalent citizens?

Geddes’ criteria for a military regime are as follows:

1) is the leader a retired or active general or equivalent?

2) Was the successor to the first leader or is the heir apparent a general or equivalent?

3) Is there a procedure in place for rotating the highest office or dealing with succession?

4) Is there a routine procedure for consulting the officer corps about policy decisions?

5) Has the military hierarchy been maintained?

6) Does the officer corps include representatives of more than one ethnic, religious, or tribal group (in heterogeneous societies)?
7) Have normal procedures for retirement been maintained for the most part?

8) Are merit and seniority the main bases for promotion rather than loyalty or ascriptive characteristics?

9) Has the leader refrained from having dissenting officers murdered or imprisoned without a trial?

10) Has the leader refrained from creating a political party to support himself?

11) Has the leader refrained from holding plebiscites to support his personal rule?

12) Do officers occupy positions in the cabinet other than those related to the armed forces?

13) Has the rule of law been maintained?

Finally, Geddes outlines several criteria for a personalist regime:

1) Does the leader lack the support of a party?

2) If there is a support party, was it created after the leader’s accession to power?

3) If there is a support party, does the leader choose most of the members of the politburo-equivalent?

4) Does the country specialist literature describe the politburo-equivalent as a rubber stamp for the leader?

5) If there is a support party, is it limited to a few urban areas?

6) Was the successor to the first leader, or is the heir apparent, a member of the same family, clan, tribe, or minority ethnic group as the first leader?

7) Does the leader govern without routine elections?

8) If there are elections, are they essentially plebiscites (i.e., without internal or external competition)?

9) Does access to high office depend on the personal favor of the leader?

10) Has normal military hierarchy been seriously disorganized or overturned?

11) Have dissenting officers or officers from different regions, tribes, religions, or ethnic groups been murdered, imprisoned, or forced into exile?
12) Has the officer corps been marginalized from most decision-making?

13) Does the leader personally control the security apparatus?

The various healthcare indicator variables can be found in the single score, cross-sectional data set collected by James McGuire. The variables examined in my study can be divided into healthcare delivery mechanism variables and healthcare outcome variables. The delivery mechanisms include: average percentage of pregnant women receiving pre-natal care (prenavg), average percentage of births attended by trained personnel (delivavgx), physicians per 100,000 population (docswb), proportion of one-year-olds immunized (vacchdr), percentage of population with access to safe water (wateavg), percentage of population with access to sanitation (saniavg), health expenditures per capita (hlxepwbx), public health expenditures as a percentage of total GDP (hlxpuwb), and total family planning effort score (rtot). The healthcare outcome mechanisms are: under-5 mortality (u5mr), total life expectancy (lifext), and total fertility rate (fert).

**Empirical Method**

The healthcare indicator variables found in McGuire’s dataset will constitute the dependent variables in my analysis. Separate regressions will be performed for each dependent variable. The levels of these variables should increase as the ratio W/S increases from a small W/S ratio to a larger W/S ratio and as regime type, as measured by Geddes, changes from single party to personalist to military regime. The independent variables, therefore, are the two separate measures of autocracy: the BDM et al measure that uses the size of W, the size of S, and the W/S ratio as a measure, and the Geddes measures that classify autocracies by more traditional means. To assess the effect of each independent variable on each of the dependent variables, the following regression equations will be used:

For the BDM et al measures:

$$\text{Performance} = b_0 + b_1(W) + b_2(G) + b_3(Y) + b_4(I) + b_5(LP)$$
\[ P = b_0 + b_1(S) + b_2(G) + b_3(Y) + b_4(I) + b_5(LP) \]
\[ P = b_0 + b_1(W/S) + b_2(G) + b_3(Y) + b_4(I) + b_5(LP) \]

The coefficients W and S refer to the sizes of the winning coalition and the selectorate, respectively, while W/S refers to the ratio of winning coalition size to selectorate size. BDM et al also include dummy variables such as geographic region and year to ensure that these variables do not affect the results. Each analysis performed by BDM et al includes these variables, and I will also employ them in my analysis. These control variables are geographical location (G), year (Y), logarithm of population (LP), and residual component of real per capita income that is independent of W and S (I).

For Geddes’ classification, the regression equation is:

\[ \text{Performance} = b_0 + b_1(M) + b_2(P) + b_3(MP) + b_4(HS) + b_5(S) \]

The coefficients are military regime (M), personalist regime (P), military-personalist hybrid (MP), single party hybrid with either military or personalist (HS), and single party (S). The type of regime left out, arbitrarily, is the military/personalist/single party amalgam, and I will measure the significance of the other five regime classifications in relation to the amalgam category of regime type. Each variable will then be given a score from 0-1 based on, for example, if the regime is personalist (or single party, military, hybrid, etc.) or otherwise. The significance of the variables will be evaluated separately, and I expect the coefficients on the single party regime should be the most statistically significant when crossed with each of the different healthcare variables from McGuire’s dataset. The second most statistically significant regime type should be single party hybrid with personalist or military, followed by single party/military/personalist amalgam, personalist, military/personalist hybrid, and then finally, military.

Finally, an F test will be performed to assess the collective significance of all five variables together. The similarity or dissimilarity between the qualities of healthcare as explained by the two types of data on autocracies will then be evaluated. At this point, it will be possible to
determine how accurately the BDM et al data on the W/S ratio explains how autocracies measure up in terms of their healthcare.

**Conclusions**

The question of what explains the variation in healthcare performance among autocratic countries is an important one for many reasons. First, the right to high quality healthcare is widely regarded as one that is fundamental for the well-being of all people. Therefore, the inequality seen in the quality of healthcare provided by different countries is troubling, and the task of understanding what causes different types of governments to vary in the quality of healthcare they are able to provide for their people is well worth undertaking. The availability and administration of life-saving vaccines, increased numbers of physicians, and more vigorous efforts to provide health education (i.e., family planning information), prenatal care, and birth attendance can make an enormous difference in the lives of people in all countries. More elementary healthcare needs, such as access to clean water and sanitation, are important because they are the most basic and crucial in preventing outbreaks of illness and disease. These delivery mechanism variables are presumably what ultimately produce long life expectancies, lower mortality rates, and higher fertility rates among populations in different countries. The availability of good healthcare in most democracies, as shown in the Literature Review of this proposal, is a strong argument for the general superiority, in terms of regime type, of democracies to autocracies. The fact that there are autocracies with good healthcare, however, shows that some autocratic regimes must have qualities that are conducive to higher healthcare performance. Discovering the key differences between these autocracies and those that provide poor healthcare is important because it could in the future help propose suitable policy or structural changes in some autocratic regimes that will allow for the availability of higher quality healthcare for people living under those regimes.
The study outlined in this proposal is designed to compare the effectiveness of two different methods of classifying autocracies: the BDM et al method that bases its results on variations in winning coalition and selectorate sizes (which, in turn, indicate the strength of the loyalty norm that leaders ultimately rely on to stay in office), and the classification of autocracies by Barbara Geddes that, conversely, relies on different, specific criteria for identifying three core types of autocratic regimes and their various hybrids. One potential flaw in this method is that the two types of classifications on which its results will be based are not necessarily the only types, or even the broadest types, of classifications that could be employed to test the variation in healthcare among autocracies. It is possible that autocracies cannot just be divided into single party, military, or personalist regimes and that there are autocracies that should be labeled with an entirely different set of criteria under a different name. In Geddes’ data, these may simply be placed into one of the hybrid or amalgam categories with other types of regimes and so it will be impossible to truly account for their effects. Geddes also does not consider monarchies in her data, which, if included, might present some interesting results for the study. On the other hand, the BDM et al measure of autocracy is more plainly laid out, but perhaps oversimplified. The two types of classifications, however, are still relatively straightforward and well researched. If neither measure of autocracy proves to be significant in the results of the study, it can at least be concluded that other methods of classifying autocracies must be employed in future studies to more completely understand the differences between autocracies that provide high quality healthcare and those that do not. Given the above-mentioned flaws, it is therefore still possible to draw some valid conclusions about healthcare quality in different autocracies from the method of study sketched in this proposal.